

North Carolina Medicaid and NC Health Choice Draft Section 1115 Waiver Application

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*Health & Human
Services*

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1. Executive Summary

North Carolina's Medicaid Reform Demonstration represents the culmination of three years of stakeholder engagement and planning to accomplish the joint vision of Governor McCrory and the North Carolina General Assembly.

North Carolina, through the Department of Health and Human Services (DHHS), is pleased to submit this application to the Centers for Medicare & Medicaid Services (CMS).

The waiver represents and builds upon North Carolina DHHS' successes and tradition of developing innovative programs that serve North Carolinians.

At its core, the waiver sets forth a plan to improve the access to, quality of, and cost effectiveness of health care for most of our 1.9 million Medicaid and NC Health Choice (Children's Health Insurance Program, or CHIP) beneficiaries by restructuring care delivery using accountable, next-generation prepaid health plans, redesigning payment to reward value rather than volume, and planning toward true "person-centered" care grounded in increasingly robust patient centered medical homes and wrap-around community support and informatics services.

Background

In September 2015, the General Assembly of North Carolina enacted Session Law (SL 2015-245) (see Appendix A), to transform and reorganize North Carolina's Medicaid and NC Health Choice programs. This legislation directed DHHS to redesign Medicaid and NC Health Choice to achieve the following goals:

- 1) Ensure budget predictability through shared risk and accountability;
- 2) Ensure balanced quality, patient satisfaction, and financial measures;
- 3) Ensure efficient and cost-effective administrative systems and structures; and
- 4) Ensure a sustainable delivery system through the establishment of two types of prepaid health plans (PHPs): provider-led entities (PLEs), and commercial plans (CPs).

The new undertakings reflected in this waiver proposal are logical next steps in North Carolina's progression since the early 1990s toward a well-coordinated care partnership with providers that both leverage and support community-based health care delivery systems. Going forward under the proposed waiver, DHHS will further transform our Medicaid and NC Health Choice programs to a high-performing health care system with accountability for value and outcomes.

The Future

Our vision, as developed in collaboration with our stakeholders, will set the course in North Carolina that will improve Medicaid and NC Health Choice and all of North Carolina's population health by making investments in implementing the provider-driven delivery system and program redesign changes that meet the unique needs of North Carolina. Implementation will be through four broad based initiatives and the corresponding program proposals:

Demonstration Initiative #1: Creating Systems of Accountability for Outcomes

- **Next generation Prepaid Health Plans (PHPs) in a hybrid model**

DHHS will contract with two types of PHPs on a capitated basis, utilizing value-based purchasing principles to achieve our goals. DHHS will build in long-term contracts (four to five years) to encourage investment in transformation.

- **Transformation of primary care medical homes (PCMHs) to person-centered health communities (PCHCs)**

DHHS will build upon our existing successful and nationally-acclaimed enhanced primary care case management (PCCM) and PCMH model and establish expectations for this continued success within the PHP contracts

- **Progress toward integrated behavioral and physical health**

DHHS will focus efforts that improve the integration of behavioral health (encompassing mental health and substance use disorders) and primary care services. This is one of our greatest needs and opportunities.

- **Long-term services and supports (LTSS) for Medicaid-only individuals**

DHHS will implement integrated LTSS for Medicaid-only individuals consistent with our vision of person-centered care under the PHP contracts.

Demonstration Initiative #2: Creating North Carolina Person-Centered Health Communities (PCHCs) and Connecting Children and Families in the Child Welfare System to Better Health

- **Person-Centered Health Communities (PCHCs) to participate in PHP provider networks**

North Carolina's next generation of medical home, the North Carolina PCHC, will build on the current infrastructure, well-documented population management and care management, and transitional care to extend care management activities beyond the current Primary Care Medical Home. The model will build on successful specialty care management programs such as Advanced Pregnancy Medical Homes (APMHs) and will also include provider and PHP financial incentives in addition to value-based payment.

- **Improve rural health access, outcomes and equity**

DHHS will focus on ensuring that beneficiaries in rural areas will benefit from an enhanced focus on access to quality services and that rural providers can leverage tools such as value based purchasing, telemedicine, and robust data analytics to achieve success in decreasing disparities.

- **Enhancing outcomes for children and families in the child welfare system**

DHHS will implement a complementary package of initiatives designed to further improve health and family outcomes for some of our most vulnerable beneficiaries and decrease long-term costs to Medicaid.

Demonstration Initiative #3: Supporting Providers through Engagement and Innovations

- **Practice Supports for Quality Improvement**

DHHS will continue to leverage practice supports to PCMH to ensure development, distribution, and use of population management tools and clinical toolkits; quality measure reporting with peer comparison; quality improvement (QI) coaching; and behavioral health integration.

- **Innovations Center**

Designed in concept after the Oregon Health Authority's Transformation Center, the Innovations Center is intended to support providers with the use of technical assistance and learning collaboratives that foster peer-to-peer sharing of best practices.

- **Health Information Exchange (HIE)**

In order to support provider level transformation, all Medicaid providers must be connected to the NC HIE network by February 2018, and providers involved with all other state-funded health programs must be connected no later than June, 2018.

- **Statewide Informatics Layer**

North Carolina will build a robust population health management tool that can combine both clinical and administrative claims data to better manage patient care, improve health outcomes, and more efficiently direct resources to meet the health care needs of its citizens.

- **Strengthening the Safety Net**

DHHS will use an "essential provider" designation to secure a place for safety net and rural health community providers in the PHP networks and will seek to preserve the current FQHC/RHC wraparound payments while extending this benefit to additional safety net providers.

- **Community Residency and Health Workforce Training**

DHHS will expand critical health workforce programs that ensure Medicaid beneficiaries access to essential services. DHHS will focus on community-based residency trainings that emphasize ambulatory and preventive care that advance the goals of higher value health care to reduce long-term costs.

- **Provider Administrative Ease in PHP Contracts**

The includes provider-related provisions in PHP contracts that are designed to lower provider burden, such as uniform credentialing and requirements for prompt payment from PHPs.

Demonstration Initiative #4: Care Transformation through Payment Alignment

- **Safety Net Hospital Payments**

The waiver proposes direct Medicaid uncompensated care payments to maintain supplemental payment funding levels.

- **Delivery System Reform Incentive Payment (DSRIP) Initiatives**

Funds available for DSRIP initiatives will be tied to reform projects, milestones, and payment for performance and outcomes related to these projects.

- **Incentives in Capitated Payments**

DHHS and its provider partners intend to explore the opportunity for provider-directed value-based payments as part of the PHP capitation payments.

- **Rural and Public Provider Payments**

This initiative will include programs to strengthen the outpatient safety net providers.

In summary, DHHS' goals, as further described in the demonstration application, align fully with the Triple Aim of improving the patient experience of care, improving the health of populations, and containing the per capita cost of health care. DHHS intends to go one step further by pursuing the Quadruple Aim—the Triple Aim + Improved Provider Engagement and Support.

2. CMS Application – Program Description

2.1. Rationale for the 1115 Demonstration

North Carolina is uniquely situated to serve as a laboratory of comprehensive and innovative health care reform that can reduce the State and Federal obligations to health care spending. The new undertakings reflected in this application are the logical next steps in North Carolina's progression since the early 1990s toward a well-coordinated care partnership that both leverages and supports community-based health care delivery systems.

DHHS currently serves over 1.9 million beneficiaries and 80,000 providers in the North Carolina Medicaid and NC Health Choice Programs. Our enrollment has increased by 260,000 beneficiaries since the beginning of 2014. North Carolina has a fiscal and programmatic imperative, as well as a legislative mandate, to innovate and transform Medicaid and CHIP into a new model that is sustainable for the future. Our proposal aims to build upon our legacy of innovative approaches that will lead to our State budget stability and better outcomes.

Transitioning to next-generation PHPs under a state plan or section 1915(b) waiver alone would not authorize the comprehensive reforms that North Carolina must implement in order for managed care and system transformation to be a success. North Carolina is the largest remaining state to transition to capitation and will undergo a major overhaul of our delivery model—one that cannot destabilize our provider networks and result in decreased access for Medicaid and NC Health Choice enrollees. This overhaul includes a transition of approximately \$2 billion in payments, predominantly to hospitals, that must stay in our safety net system, yet have no clear regulatory path for doing so under any authority other than 1115 demonstration authority. Our proposal is a complementary—and necessary—initiative to achieve implementation of PHPs.

In order to ensure a smooth and seamless transition for our beneficiaries and providers to PHPs, build advanced patient centered medical homes through person-centered health communities, address behavioral health systematically and develop our healthcare workforce, DHHS needs CMS to both invest in and support our system-wide transformation goals through the authority provided under an 1115 Demonstration waiver. Session Law (SL) 2015-245 provides DHHS with 18 months following approval of this waiver to implement reform, demonstrating that Governor McCrory and the General Assembly are committed to allowing adequate time to thoughtfully implement reform, smoothing the transition for beneficiaries and providers. For the next few years, Medicaid beneficiaries will receive services in the same way they do now while DHHS will continue to invest in improving program performance on care management, quality, speed of provider payment, and program efficiency. Once implemented, beneficiaries can expect to experience access and coordination of care that is even better than it is today.

2.2. 1115 Demonstration Overview

1) CMS Application Question - Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).

North Carolina's Medicaid Reform Demonstration application represents the culmination of three years of stakeholder engagement and planning to accomplish the joint vision of Governor McCrory and the North Carolina General Assembly. North Carolina, through the Department of Health and Human Services (DHHS), is pleased to submit this application to the Centers for Medicare & Medicaid Services.

The waiver represents and builds upon North Carolina DHHS' successes and tradition of developing innovative programs that serve North Carolinians. A key indicator of our current and potential for future success is the fact that the vast majority of North Carolina primary care providers accept Medicaid and NC Health Choice today.

At its core, the waiver sets forth a plan to improve the access to, quality of, and cost effectiveness of health care for our growing population of Medicaid and NC Health Choice (CHIP) beneficiaries by restructuring care delivery using accountable, next-generation PHPs, redesigning payment to reward value rather than volume, and planning toward true "person-centered" care grounded in increasingly robust patient-centered medical homes (PCMHs) and wrap-around community support and informatics services.

2.2.1. Background

In September 2015, the General Assembly of North Carolina enacted SL 2015-245 (see Appendix A), to transform and reorganize North Carolina's Medicaid and NC Health Choice programs. This legislation directed DHHS to redesign Medicaid and NC Health Choice to achieve the following goals:

- Ensure budget predictability through shared risk and accountability;
- Ensure balanced quality, patient satisfaction, and financial measures;
- Ensure efficient and cost-effective administrative systems and structures; and
- Ensure a sustainable delivery system through the establishment of two types of PHPs: provider-led entities (PLEs) and commercial plans (CPs)

The new undertakings reflected in this waiver proposal are logical next steps in North Carolina's progression since the early 1990s toward a well-coordinated care partnership with providers that both leverages and supports community-based health care delivery systems.

North Carolina has a well-established track record of success in Medicaid, including:

- Our nationally acclaimed statewide **primary care medical home model** creation began in 1998 and continues to provide critical support to our programs. In early 1998, Community Care of North Carolina (CCNC) was launched in select pilot counties. Over the

years, the program expanded to 14 networks covering over 1.4 million Medicaid beneficiaries. Very early in the program development, State leaders and provider stakeholders recognized that creating access to a medical home was important, but additional community-based support was also needed to truly support and manage the Medicaid population and set expectations for better health outcomes and cost containment.

- As a result of North Carolina’s successful program, the federal government created a new category entitled “**Enhanced Primary Care Case Management Programs**” enabling other states to support the infrastructure needed to implement population management. This program design over time has proven its viability in strengthening the medical home by enhancing the ability of the primary care physician to improve care and care outcomes for patients with chronic illnesses through four new program elements, the formation of community-based networks, the introduction of population management tools, care management and clinical support for providers, and availability of data and analytics for providers.
- North Carolina has launched several initiatives funded by CMS that focus on improving specialty care and integration. DHHS views this Demonstration as a clear opportunity to continue promoting CMS priorities while enhancing the medical home delivery model. These grants include:
 - **Child Health Accountable Care Collaborative.** A Center for Medicare and Medicaid Innovation (CMMI) grant for a pilot program to improve the health and life quality of children with complex medical conditions through better care coordination.
 - **Community Pharmacy Enhanced Services Network.** A CMMI grant to CCNC to develop a network of pharmacies that provide enhanced services, such as synchronization of a patient’s chronic medication fill dates, adherence monitoring and coaching, compliance packaging, and home delivery.
 - **CMS Medicare Shared Savings Program (MSSP).** Many of North Carolina’s MSSPs have specialty management initiatives for conditions that require specialty care; e.g., cardiovascular services, gastroenterology, and hip and knee replacements.
 - **Practice Transformation Network.** A CMMI multi-organizational grant to help primary and specialty clinicians achieve large-scale health transformation through peer supported comprehensive quality improvement strategies.
- North Carolina has been making advancements in behavioral health services and intellectual and other developmental disability (I/DD) supports through the section 1915(b)/(c) concurrent waiver, through quasi-governmental, local **behavioral health managed care organizations** (known as LME/MCOs or PIHPs) to coordinate mental health, intellectual/developmental disability (I/DD) and substance use disorder (SUD)

services statewide under capitated payments. They have developed great expertise in serving this population. In the last couple of years, the LME/MCOs have begun to enhance partnerships with primary care and with CCNC care managers and were held accountable for ensuring individuals served by the LME/MCOs have a connection to primary care. In the last couple of years, they have invested more of their Medicaid savings in primary care-behavioral health integration activities and developed innovative ways to partner with physical healthcare providers. However, these projects are very limited due to the LME/MCOs only managing BH and I/DD services, so flexibility to demonstrate unique solutions to enhance and fund these projects is needed.

- Integrated Behavioral Health Care (IBHC), as defined by the Agency for Healthcare Research and Quality's (AHRQ's) Academy for Integrating Behavioral Health and Primary Care, is a strong priority for North Carolina. Through State, Medicaid and philanthropic support, many health care practices over the years have **integrated behavioral health providers** into some primary care settings to address mild-to-moderate behavioral health and to assist patients with lifestyle issues that contribute to physical illness/disease. However, this is not fully sustainable, so DHHS hopes to pilot opportunities to increase sustainability by better aligning funding sources.
- North Carolina's statewide **telemedicine and telepsychiatry** coverage began in 1999. Consultative services are provided to a variety of settings across the state via well-established partnerships with tertiary centers and other specialty providers. Notably, the statewide telepsychiatry program (NC-STeP) is active in 54 hospitals in 38 counties.¹
- Through a variety of programs DHHS has made **rural health** a priority. North Carolina makes significant investments in the outpatient safety net system that includes: Federally Qualified Health Centers (FQHCs), Rural Health Clinics and Centers (RHCs), Free and Charitable Clinics, Local Health Departments, and School-Based Health Centers. The Office of Rural Health (ORH) assists these sites in assuring access to primary care services. In addition, many of the 384 outpatient safety net system sites provide integrated services that include behavioral health, dental care, and pharmacy services and are often the sole source of obstetrics care for pregnant women in rural areas. Conservatively 1 million vulnerable residents including Medicaid, NC Health Choice, Medicare, and dually-eligible individuals rely on our outpatient safety net system.
- We have made significant **investments in growing the workforce to serve vulnerable populations**, including a \$2.1 million state appropriation for recruitment (through loan repayment incentives) of critical provider types, including primary care physicians, nurse

¹ NC-STeP serves hospital emergency departments across the state of North Carolina providing psychiatric assessments and consultations to patients linked using telemedicine technologies in these Emergency Departments.

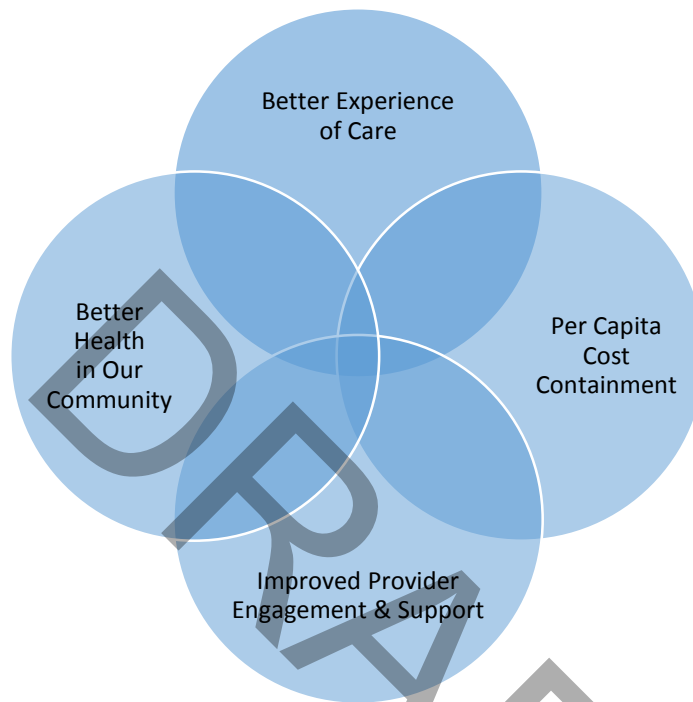
practitioners, physician assistants, dentists, psychiatrists, and general surgeons, in underserved areas across the state. These providers are then required to serve (in person or through telemedicine) low-income and vulnerable populations in North Carolina. Additionally, the NC Area Health Education Center (AHEC) has 16 community-based residencies, and is one of only two AHECs in the country with this program. These residencies have a much higher likelihood of having graduates that stay in North Carolina.

- Our **local health departments (LHDs)** provide residents of all 100 counties of the State a breadth of services that is unique to North Carolina. Many LHDs provide comprehensive primary care, obstetrical care, and dental services, with some serving as designated medical homes for Medicaid beneficiaries. LHDs provide prenatal care in 67 counties, 30 of which do not have an obstetrician. LHDs play a critical role in defining and responding to community-specific needs and outside of emergency rooms, provide a large portion of ambulatory care to indigent clients.
- We **invest in our providers** and create a health care climate that fosters innovation. North Carolina Medicaid has long been a laboratory for provider innovation and experimentation with new models of care. In addition, the NC Quality Center, a national leader in improving hospital quality of care, actively addresses broad quality issues in North Carolina hospitals. CMS has increased the health systems' and providers' level of sophistication with regard to care management, quality and data through Medicare ACOs, re-admission penalties, Medicare transition and chronic condition codes). This has laid the groundwork for the evolution of Medicare policy, such as ACO development, which drives Medicaid innovation as well.
- Our **providers invest in our people**. The vast majority of North Carolina primary care providers accept Medicaid and NC Health Choice and most private and public hospitals in the State now contribute funds via an array of assessments to increase resources available to address the health care needs of uninsured and underinsured individuals in our state. Of significance, North Carolina's PCCM includes about 1,900 practices with more than 6,500 practitioners. Approximately 90% of primary care providers and more than 90% of Ob-Gyns who enroll in Medicaid and NC Health Choice participate actively in the PCCM.

Thanks to these and many more efforts, our program has already achieved a high degree of access and quality of care. Going forward under the proposed waiver, we must further transform our Medicaid and NC Health Choice programs to a high-performing health care system with accountability for value and outcomes. This waiver provides the opportunity to sustain and expand these programs in a coordinated way.

2.3. North Carolina's Demonstration Goal: Achieving the Quadruple Aim

Our goals, as further described in this demonstration application, not only align fully with the Triple Aim of improving the patient experience of care, improving the health of populations, and containing the per capita cost of health care, but also go one step further by pursuing the Quadruple Aim—the Triple Aim+ Improved Provider Engagement and Support.



Under the demonstration, DHHS will build upon the North Carolina Medicaid and NC Health Choice Programs' tradition of innovation, community-based access, and quality. DHHS will restructure care delivery in several ways: using a hybrid model of risk-based health plans; launching the next generation of the PCMH care model via our plan for North Carolina PCHCs; and redesigning payment to reward value and outcomes. Implementing SL 2015-245 to evolve our programs, and improve value and outcomes is critical for a Medicaid program that is currently 23 percent of the State budget.

This proposal is organized by four overarching Demonstration initiatives that create the framework for the Demonstration to support the goals of the Quadruple Aim:

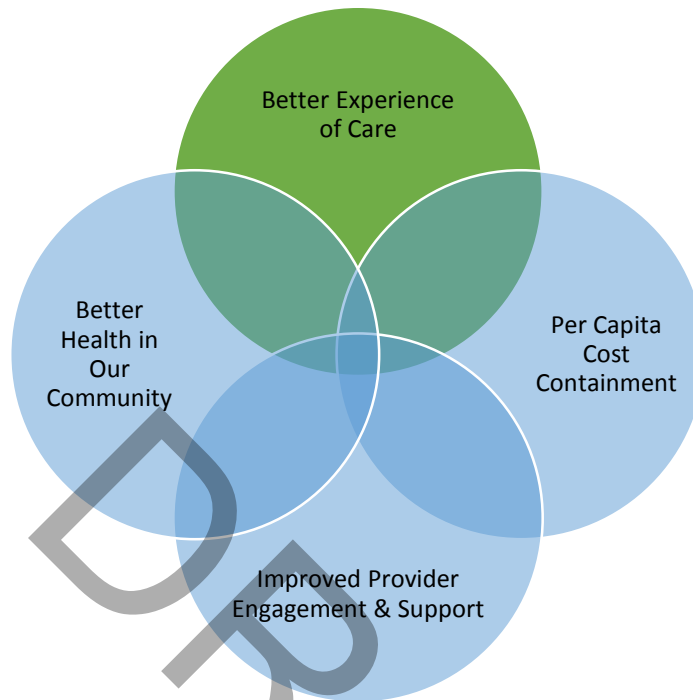
- **Demonstration Initiative #1:** Building a System of Accountability for Outcomes
- **Demonstration Initiative #2:** Creating North Carolina Person-Centered Health Communities (PCHCs) and Connecting Children and Families in the Child Welfare System to Better Health
- **Demonstration Initiative #3:** Supporting Providers through Engagement and Innovations
- **Demonstration Initiative #4:** Care Transformation through Payment Alignment

Our goals are ambitious yet necessary—to ensure the best beneficiary health outcomes and experiences, at a lower cost and greater provider satisfaction. Our proposed initiatives are designed to protect the stability of our safety net providers – both hospitals and essential safety net outpatient provider systems – and to prepare them for success in the reformed model of Medicaid.

Our goals and initiatives are interconnected and mutually reinforcing in order to provide system-wide innovation for beneficiaries, communities, and providers.

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QUADRUPLE AIM #1 BETTER EXPERIENCE OF CARE



2.3.1. Aim #1: Better Experience of Care

Demonstration Initiative #1: Building a System of Accountability for Outcomes

North Carolina will seek to carry out this Initiative through the following approaches:

- Next Generation Prepaid Health Plans (PHPs) in a Hybrid Model
- Transformation of Primary Care Medical Homes (PCMHs) to Person-Centered Health Communities (PCHCs)
- Progress toward integrated behavioral and physical health
- Long-term services and supports (LTSS) for Medicaid-only individuals

2.3.1.1 Next Generation Prepaid Health Plans (PHPs): A Hybrid Model

DHHS will begin contracting with two types of PHPs on a capitated basis, utilizing value-based purchasing principles to achieve our goals. These PHPs will include entities known as PLEs, led by North Carolina providers, and other types of health plans generally operated by commercial managed care companies, referred to as CPs. The presence of PLEs operating side-by-side with CPs will achieve our key goals for consumer choice, provider choice, and provider-led innovation.

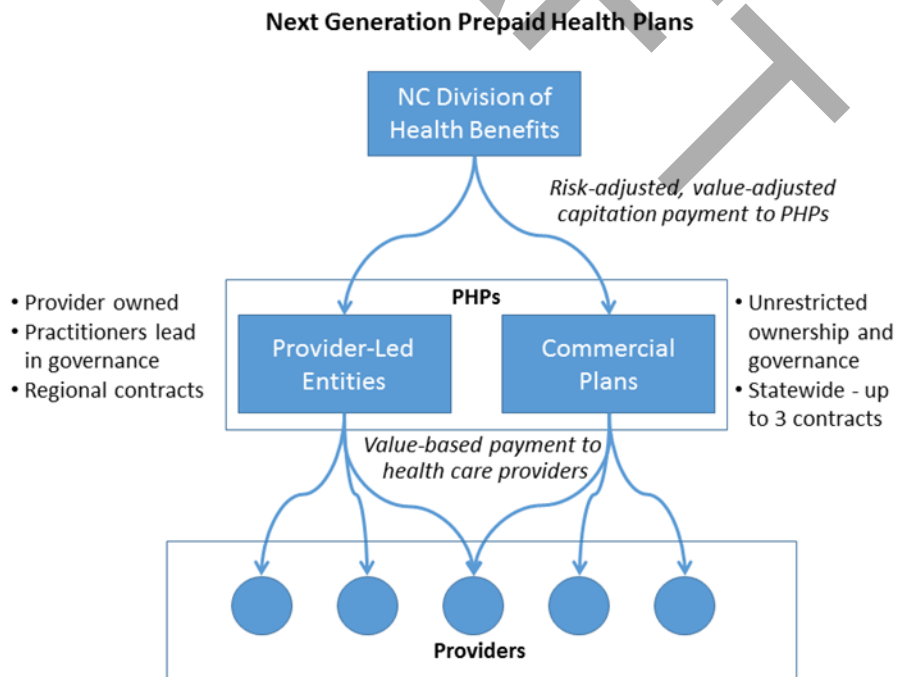
North Carolina providers are accustomed to innovation and evolution. Just as our provider health systems have led in participation in Medicare's Shared Savings Programs, often called ACOs and Medicare Advantage programs, DHHS expects strong participation from our provider

community in our next-generation PHPs. With this participation will come greater provider and beneficiary choice and innovation in Medicaid and NC Health Choice.

This hybrid approach of PLEs and CPs, coupled with standardized metrics and outcomes designed to drive improvement, measured on a provider, practice, PHP, regional and statewide basis, will yield the insight the State needs to learn from the models, ensure oversight and gain an understanding of the best practices that both types of PHPs are using to serve the beneficiaries.

PHPs will support and be held accountable for quality outcomes of North Carolina’s advanced, comprehensive medical home model, or PCHCs. PCHCs, in turn, will be responsible for community-based comprehensive care management spanning interventions for medical needs, behavioral health integration at the care management level, assessment and appropriate interventions to impact social determinants of health, and supports to individuals utilizing LTSS in order to ensure all beneficiaries are reaching and maintaining the highest level of health possible. The PCHC model is discussed in greater detail as a part of Aim #2 in this paper.

DHHS, through the Division of Health Benefits, will pay PHPs on a capitation basis. Capitation rates will be set following all accepted conventions for actuarial soundness. Capitation rates will vary to take into account population risk factors and, if appropriate, geographic health cost variances. In addition, payments to health plans may vary according to the plans’ performance on quality measures that may encompass: delivery of appropriate, evidence-based care; health outcomes of the membership and of groups of enrollees having specific chronic conditions; and/or enrollee and provider satisfaction.



Going further, DHHS expects PHPs to incorporate value-based purchasing concepts into their methods for paying participating providers. Program rules and contracts will call for PHPs to reflect in their compensation of providers the incentives for quality and efficiency that are inherent in the payment from the State to the plans. DHHS will require through PHP contracts that a preponderance of health spending be on a basis other than traditional fee-for-service (FFS). Acceptable methods may include value-modified FFS, episode bundles, shared savings, and capitation, among others.

2.3.1.2 Transformation of Primary Care Medical Homes (PCMHs) to Person-Centered Health Communities (PCHCs)

North Carolina intends to continue and build upon our existing successful and nationally-acclaimed enhanced PCCM and PCMH model including Pregnancy Medical Homes and establish expectations for this continued success within the all PHP contracts. DHHS recognizes this unique point-in time opportunity and responsibility to ensure our transformation renders the best possible quality, value and cost-effective care. Continuation of the medical home model and building this capacity into our PHP model, for both PLEs and CPs, will require ongoing support to existing medical homes, focused on continued practice evolution and recruiting new providers to the medical home model of care delivery.

This transformation of the current medical home model is described in greater detail in Section 2.3.2 as person-centered health communities, or PCHCs. PHPs will support and be held accountable for quality outcomes of PCHCs. PCHCs, in turn, will be responsible for community-based comprehensive care management spanning interventions for medical needs, behavioral health integration at the care management level, assessment and appropriate interventions to impact social determinants of health, and supports to individuals utilizing LTSS in order to ensure all beneficiaries are reaching and maintaining the highest level of health possible.

In order to support the evolution of the PCMH to PCHCs as we implement PHPs, DHHS believes an emphasis on practice supports is essential to help support implementation of this next generation medical home, the PCHC model of care and coordination with PHPs. Today, North Carolina Community Care Networks (N3CN) provide practice supports to PCMHs, including helping medical homes become recognized by the National Committee for Quality Assurance (NCQA) as a PCMH; development, distribution, and use of population management tools and clinical toolkits; quality measure reporting with peer comparison; quality improvement (QI) coaching; behavioral health integration; and workflow analysis. Area Health Education Centers' (AHECs) provide support to PCMHs for electronic medical record implementation. N3CN also provides practice support beyond medical homes to network pharmacies and hospitals. DHHS values these activities as critical to the success of medical homes and intends for them to continue under the new program as part of the responsibilities of the PHPs and/or the State (e.g., through the Innovations Center). DHHS' philosophy is to standardize the approach used to provide practice supports while supporting innovation and excellence at the provider and PHP level.

2.3.1.3. Progress toward Integrated Behavioral and Physical Health

The integration of behavioral health (encompassing mental health and substance use disorders) and primary care services is a priority for North Carolina. It is well-established that behavioral health disorders contribute significantly to the cost of physical health. In order to bend the cost curve and better serve our citizens, we must fully address both lifestyle and behavioral health issues in primary care settings for the general population, and provide access to primary care to individuals with severe mental illness and substance use disorders. Additionally, special populations, such as those with intellectual and other developmental disabilities (I/DD) benefit from an integrated approach and providers who are knowledgeable about their unique needs. The state is committed to advancing efforts to create a health system that recognizes the complex interaction of mind and body.

Enhanced Collaboration between Specialty Care and Primary Care

Up to this point, the state has been working to bring specialty mental health and substance use services together with primary care, albeit under separate payment systems with separate accountability measures. For the management of behavioral health and I/DD, North Carolina has been operating under section 1915 (b)/(c) concurrent waiver authority since 2005 as a demonstration pilot in five counties. The waiver was expanded statewide in 2012 over a span of 15 months. The waiver program covers treatment and support services for mental health, substance use, and developmental disabilities. The strengths of the current LME/MCO system that should be built upon include strong clinical management at LME/MCOs and commitment to collaboration and standardization.

The LME/MCOs have been required by contract to use the National Council on Behavioral Health's Four Quadrant Model to guide their close partnerships with the CCNC care managers, and the two groups have established strong working relationships in each region of the state. In addition, the current combination of LME/MCOs and N3CN has allowed for local provider engagement such as exploration of pilots and alternative funding models, an advantage which will be built upon in the next iteration of managed care. There are currently two pilot sites under the LME/MCOs to help improve primary care for individuals with I/DD. Several LME/MCOs are reinvesting managed care savings to support the integration of physical healthcare. For instance, some are supporting primary care-behavioral health integration and others are offering provider trainings on integration of care. The new system for North Carolina should be built upon the existing strengths of the LME/MCO system—strong clinical management; expertise in mental health, developmental disabilities and substance use disorders; innovation; commitment to collaboration and standardization; and dedication to integrated care for individuals with severe mental illness, chronic or severe substance use disorders and intellectual or other developmental disabilities.

Primary Care-Behavioral Health Integration

In February 2010, the DHHS approved the Behavioral Health Integration Initiative (BHI) under CCNC to support the integration of behavioral health services, including mental health and substance use, in primary care practices across North Carolina.

The program provides supports to primary care practices becoming the medical home and coordinating with specialty care managed by the LME/MCOs for those with higher mental health and substance use needs. DHHS has been instrumental in promoting a number of important innovations. They include: addressing treatment of chronic pain; educating primary care physicians related to behavioral health; offering tools for medication management for foster care children; expanding the use of motivational interviewing; demonstrating screening, brief intervention and referral to treatment (SBIRT) for substance use; and promoting integrated primary care and behavioral care. However, full integration, described in the AHRQ Academy for Integrated Care's Lexicon for Behavioral Health and Primary Care Integration, has not been sustainable for most of the primary care providers. Efforts have focused on either providing primary care practices with better resources to deal with behavioral health, or partnering on care coordination/care management for a subset of individuals with the highest needs.

The stage is set for North Carolina to move toward more integrated, whole-person healthcare. With a modest amount of grant funding and support from CCNC and LME/MCOs, providers have shown both their ability to increase access to primary care for individuals with severe mental illness and substance use disorders and better coordinate physical and behavioral health. They have also shown their ability to provide more comprehensive primary care services that include behavioral health support for the general population. LME/MCOs have begun to make investments in these areas as well, but we have proceeded as far as we can without major realignment of payment systems. DHHS first intends to pilot demonstration programs that will better align services and payment to incentivize integration. LME/MCOs will take on more responsibility for physical healthcare for individuals with SMI and substance use disorders, as well as for those with I/DD. Primary care will take more responsibility for individuals with mild-to-moderate behavioral health issues, as well as build capacity to help people with lifestyle behaviors that affect health. Some examples of potential pilots include:

- Implement primary care integration models that supports routine behavioral health screening, integration of behavioral health supports in the primary care setting (licensed professional and/or behavioral health care manager), and supports coordination with the specialty behavioral health system to address care needs of beneficiaries with SPMI, I/DD and SUD.
- Implement multiple levels of primary care-behavioral health integration, with payment structured to support each level. This spectrum of integrated care services will be appropriate to the size and resources of the PCHC.

- Support practices to enhance their ability to provide primary care and support for individuals and families with intellectual and developmental disabilities (I/DD) through I/DD health homes.
- Enhance Community-Based Behavioral Health Clinics and other integrated community options through increasing health accountability via measurement of outcomes.
- Once PHPs are established, provide incentives and performance based payments that are directly linked to BH and I/DD outcomes; Add incentives and performance-based payments to the existing LME/MCOs that will address physical health
- Require the use of health and behavioral health analytics to improve outcomes for beneficiaries with substance use disorders (SUDs), mental illness and I/DD;
- Pilot components of a Special Needs Plan for individuals with severe mental illness, developmental disabilities and severe/chronic substance use disorders
- Create demonstrations that allow for whole person sub-capitation to comprehensive contract provider agencies, possibly including primary care within those behavioral health agencies in order to establish whole-person health homes and enhance the capacity of physical health or BH/SUD providers to address the needs of these populations
- Establish a statewide collaborative in conjunction with the NC Innovation Center to advance innovation in behavior health/physical health integration throughout the State.
- Develop policy and pilots to improve clinical integration of LMEs and health systems/practices and appropriate reimbursement.

2.3.1.4. Long-term Services and Supports (LTSS) for Medicaid-only Individuals

DHHS is proposing to operate this demonstration concurrently with North Carolina's approved Community Alternatives Program for Children and Disabled Adults (CAP/C and CAP/DA) section 1915(c) waivers to enable PHPs to provide LTSS for Medicaid-only individuals. PHP contracts will include all state plan LTSS services, including institutional care, and the waiver services currently authorized through these two section 1915(c) waivers. SL 2015-245 directs DHHS to exclude dual eligibles from the demonstration and to form a Dual Eligibles Advisory Committee to help develop a long-term strategy to cover dual eligibles through capitated PHP contracts. While DHHS plans for the implementation of LTSS for Medicaid-only individuals, DHHS will also carefully plan for the potential inclusion of dual eligibles, including coordination with Medicare and LTSS, consistent with our vision of person-centered care under the PHP contracts.

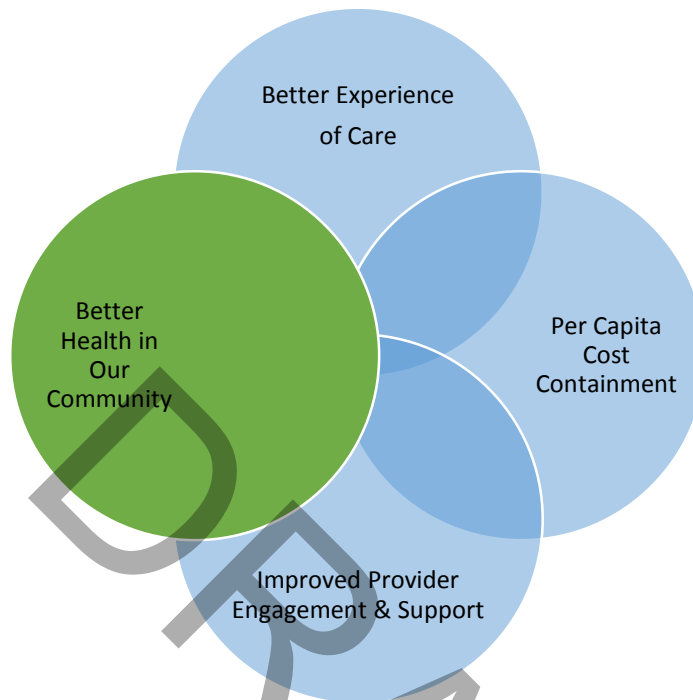
DHHS has greatly benefited from more than two years of stakeholder input that has helped shape our goals for the inclusion of state plan and waiver LTSS in PHPs:

- Support and build a system that promotes consumer choice;

- Build upon our current system by assuring continued access to facility-based services, when necessary, and expanding the continuum of services and variety of settings in which to receive them;
- Support use of enabling technology;
- Invest in service strategies that prevent, delay, or avert the need for Medicaid-funded LTSS through appropriate upstream interventions;
- Recognize and support the key role family caregivers and other natural supports play in supporting an individual’s long-term care needs;
- Ensure LTSS beneficiaries have access to, as needed, “hands on” streamlined service coordination that is responsive to both the clinical and social support needs of the individual; and
- Focus on transitions and opportunity for early interventions related to transition planning.

All I/DD services currently provided through North Carolina’s LME/MCOs will continue to be delivered through the LME/MCOs. The Demonstration will focus on progressing toward integrated behavioral and physical health and planning for the integration of behavioral health services within a single capitated system as required by SL 2015-245.

QUADRUPLE AIM #2 BETTER HEALTH IN OUR COMMUNITY



2.3.2. Aim #2: Better Health in Our Community

Demonstration Initiative: Creating North Carolina Person-Centered Health Communities (PCHCs) and Connecting Children and Families in the Child Welfare System to Better Health

North Carolina seeks reforms through the following strategic initiatives:

- North Carolina Person-Centered Health Communities (PCHCs) to participate in PHP provider networks
- Improve rural health access, outcomes, and equity
- Enhancing outcomes for children and families in the child welfare system

2.3.2.1. North Carolina Person-Centered Health Communities (PCHCs) Participate in PHP Provider Networks

North Carolina's next generation of medical home, the North Carolina PCHC, will build on the current infrastructure, well-documented population management and care management and transitional care performance to extend care management activities beyond the current Primary Care Medical Home and Pregnancy Medical Home. The model will build on successful specialty care management programs and will also include provider and PHP financial incentives with value-based payment.

North Carolina PCHCs will provide comprehensive and coordinated care with the goal of maximizing health outcomes, preventing higher levels of care, reducing needs for formal medical supports and institutional care, and containing per member costs. The model will support access, interdisciplinary team-based care, meeting needs of special populations, continuous quality improvement, and population health management to better serve all populations within Medicaid. The scope will grow to include clinical care management for any CAP/C and CAP/DA Home- and Community-Based Services (HCBS), non-1915(b)/(c) waiver primary behavioral health/substance abuse/intellectual and developmental disability services, and services for children in Foster Care. Other pilot innovations may be developed, for example, use of community health workers and home nursing visitation during pregnancy. The PCHCs will continue to work with the LME/MCOs to assure integration of medical care needs for beneficiaries served by the BH waivers. In addition, active management and coordination of specialty services will be augmented, particularly for children with complex medical diagnoses.

The primary care medical home serves as the foundation of North Carolina's enhanced PCCM as it exists today. As the transition to PHPs continues to evolve, DHHS will be focused on striking the right balance between which functions will be replicated at the State level versus the PHP and/or practice level. Other considerations will focus on how to balance the standardization currently provided by the N3CN program, as well as the flexibility of the PHPs and local practices in order to encourage continued innovation and continuous quality improvement while meeting the needs of local communities.

Key Features of PCHCs

The following PCHC features will be considered for inclusion in PHP contracts:

Person-Centered Care

- Each beneficiary receives a comprehensive health assessment. Comprehensive health assessments include an assessment of actionable social determinants of health in addition to physical health, behavioral health, and LTSS.
- Each designated beneficiary will have a care plan and person-centered goals that are visible to all care team members.
- The care plans will be exchanged electronically.
- The use of non-face-to-face encounters will be incentivized, including telemedicine programs that improve access, outcomes, and efficiency of care.
- All beneficiaries have a choice of primary care provider and medical home.
- Beneficiary experience is measured annually.
- Case management is in the local community.

Enhanced LTSS Integration

- Provides PCHC supports for all CAP/C and CAP/DA beneficiaries.
- Targeted annual LTSS screenings are performed to capture pre-LTSS populations.
- The use of enabling technologies is supported.
- Each LTSS beneficiary receives annual LTSS comprehensive evaluations and coordination for all therapies, DME, PCS, and non-medical LTSS supports for non-waiver recipients with support of the PCMH support infrastructure.

Supports for Children and Youth with Special Health Care Needs (CYSHCN)

- The PCHC will serve as the medical home for children with special health care needs (children in foster care, medically-fragile children, and children with developmental delays/autism).
- Support practices to enhance their ability to provide primary care and support for CYSHCN.

Advanced Pregnancy Medical Home (APMH)

- The APMH would be embedded in the PCHC and provide obstetrical care for pregnant women including risk screening, pregnancy care management for high-risk patients, and advancing evidenced-based practices to obstetric providers.
- The APMH's aims are to improve infant mortality, perinatal costs, low birth weight rate, C-section rates, and post-partum visit rates.
- The APMH would sustain the statewide analytics, quality reporting, physician leadership, and care management infrastructure.

Community Pharmacy Enhanced Services Network (CPESN)

- CPESN pharmacies would be embedded within the PCHC. These pharmacies provide enhanced pharmacy services that go above and beyond conventional prescription dispensing and basic patient education.
- Enhanced services include interventions such as synchronization of patient's chronic medication fill dates, adherence monitoring and coaching, compliance packaging, and home delivery.
- Pharmacies additionally offer community pharmacy care management services in close collaboration with the comprehensive medical home and their care management supports to engage in continuous care plan development and reinforcement.

Population Health Management

- Population health management is embedded within the PCHC and leverages health care data to help manage the health care of the Demonstration populations.

- The PCHC's electronic medical record (EMR) is connected to the State's HIE/informatics platform.
- Health assessment data feeds the population management platform. Comprehensive health assessment includes social determinants of health data, which will support the person-centered approach to ensure that beneficiary needs are identified and connections are made.
- Quality measures will be reported through provider-facing population management reporting tools.

2.3.2.2. Improve Rural Health Access, Outcomes and Equity

DHHS strives to address the needs of our beneficiaries and other vulnerable populations to be able to access primary care, behavioral health, specialist care, emergency, and public health services. Healthy People 2020² provides that access to health care is important for an individual's overall physical, social, and mental health status in particular in order to prevent and slow disease progression, detect and treat illnesses, avoid preventable death and improve life expectancy. Health disparities or inequities occur when individuals are prevented from attaining their highest level of health and are often a result of socio-economic differences, impacts of social determinants and decreased geographic access to necessary health care services.

Given that of the 100 counties in the State of North Carolina, 70 are designated as rural counties, DHHS has been instrumental in expanding the availability and accessibility of health care capacity in rural areas. Through these programs we have been able to promote greater health equity for our rural citizens. DHHS developed rural health programs that continue to thrive today and have been successful in recruiting primary care clinicians to rural areas.

DHHS will use the Demonstration as an opportunity to enhance our rural health programs through collaborative partnerships between the DHHS, the PHPs and continued development of the PCHC model of health care delivery. These partnerships will build upon the successes of the existing DHHS programs and will utilize tools such as value-based payment structures, telemedicine/telepsychiatry, and robust data analytics to expand upon the existing primary and specialty care rural infrastructure, provide disruptive technologies to improve access to and efficiency in the delivery of health care services and improve the exchange of necessary member health information to reduce redundant care, enhance timeliness of care, and improve overall coordination of care. Through implementation of these strategies we believe we can successfully deliver on the quadruple aim.

- PCHC structures will include pregnancy medical homes that focus on improving outcomes related to infant mortality. Incentivizing and improving access to pregnancy medical homes will address the health of women before, during and after pregnancy.

Appropriate prenatal care, as well as inter-conception care, care that addresses a woman's health care choices between pregnancies, directly influences the health and well-being of infants. Additionally, programs that provide support to new parents or single mothers work to create supportive communities that can welcome children into healthy families.

- Expanding and proliferating telemedicine can improve access to mental health providers and behavioral health services but it will also be leveraged to support primary care providers who are often tasked with providing specialty services while facing barriers that favor patient volume over patient value and improved outcomes of care. By scaling telemedicine capabilities, support for the existing network of rural primary and specialty care, including mental health providers, can be expanded and outcomes can be improved through collaboration and exchange of information which leads to greater fidelity to evidenced based care.
- Through proliferation of the PCHC model, rural primary care providers can benefit from improved connections with specialists to whom they refer patients and more streamlined exchange of requisite member health information can improve overall care coordination across the system.

2.3.2.3. Enhancing Outcomes for Children and Families in the Child Welfare System

In partnership with county DSS offices, DHHS has identified several opportunities for enhancing outcomes for the children and families served by the child welfare system. North Carolina plans to implement the following strategic initiatives focused on improved outcomes for children and families in the child welfare system:

- Designation of statewide PHP for children in foster care
- Expansion of Fostering Health NC
- Extension of coverage to parents of children in foster care

Designation of a Statewide PHP for Children in Foster Care

DHHS is planning to contract with one of the statewide PHPs to provide specialized services to foster care children, but continue to offer a choice of PHPs to this population. Under this option, DHHS would:

- Develop requirements for a PHP for children served by the foster care program;
- Select the statewide PHP that is most qualified to provide services to children and youth in foster care;
- Require the selected PHP to comply with specialized requirements for this population, including provider network and training requirements; and
- Hold that PHP accountable for providing high-quality, coordinated care specifically tailored to this population.

Parents/county DSS would be able to select from among all PHPs serving the applicable region, but there would be one plan tailored to this population. Thus, a county DSS could choose the designated plan for all or most of the children in its custody, which would reduce the county DSS' administrative burden. Additionally, children and youth enrolled in the designated plan would not need to change PHPs in the instances when they move across regions. This will greatly enhance the continuity of their care.

DHHS is considering whether to also include children in adoptive placement and children receiving in-home services as part of this option.

Expansion of Fostering Health NC

Fostering Health NC began as one pilot under a CMS Children's Health Insurance Program Reauthorization Act (CHIPRA) Demonstration that was awarded to DMA. Fostering Health NC is transitioning to a statewide program and is currently jointly funded by DHHS and the Duke Endowment. It is focused on improving health outcomes for children and youth in foster care. This effort, which is led by the North Carolina Pediatric Society, is working to ensure every child in foster care has a medical home and that they receive services in accordance with standards recommended by the American Academy of Pediatrics (AAP) and the Child Welfare League of America (CWLA) for health care for children in foster care and standards developed by Fostering Health NC such as "Best Practice for Medication Management." Fostering Health NC is focused on building and strengthening medical homes for children and youth in foster care through integrated communications and coordination of care through a partnership among local DSS office, the primary care practice's team, N3CN care manager, the school, the child, and the child's family.

Having a medical home is particularly important to foster and adopted youth because the health care provided prior to and during their time in care is often fragmented, which exacerbates their already high health care needs. Frequent check-ups help identify and treat issues early, mitigating the negative effects of their trauma. A medical home is also important when these children and youth experience a change in placement as it can further assist caregivers to take action to prevent a medical or behavioral health crisis. DHHS will work with Fostering Health NC and its partners to identify methods to maintain and expand this program with the PHPs and PCHCs.

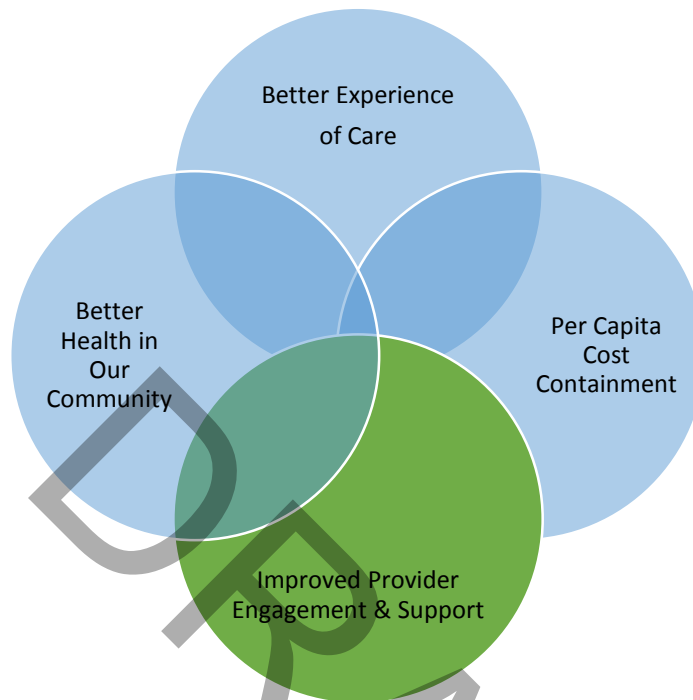
An important component of Fostering Health NC is the ability of county directors of social service to access Medicaid claims data. DHHS across multiple divisions addressed privacy laws to facilitate the exchange of information which is operationalized via Technology Enabled Care Coordination Agreement (TECCA). This provides the care team contact information, office visit and hospital stay histories, current and past medications (along with information on whether/where prescriptions were filled), and immunization records. County DSS use this information to fill information gaps, coordinate care, and identify potential problems early. DHHS would like to maintain county DSS access to this type of data and will address this feature as part of the transition.

Extension of Coverage to Parents of Children in Foster Care

When child maltreatment has been identified, but does not necessitate the removal of the child from the home, Medicaid services are provided to ameliorate the behaviors and conditions that may have led to the maltreatment. Often this includes the provision of comprehensive health services. When efforts to prevent removal are unsuccessful or unsafe, the child(ren)/youth may require foster care services, and parents may lose Medicaid eligibility. Foster care is a temporary living arrangement and, in most cases, the plan is to reunify the child(ren) to preserve the family unit. DHHS seeks to ensure that parents are provided with appropriate and effective comprehensive health services, including behavioral health and substance use disorder services, to increase the likelihood of successful reunification of the child(ren) and family. Thus, DHHS is proposing to the NC General Assembly and CMS to allow parents to retain their Medicaid eligibility while their child(ren) are being served temporarily by the foster care program. This will promote the overall health of our children and families and our communities, and potentially avert long-term costs to Medicaid.

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QUADRUPLE AIM #3 IMPROVED PROVIDER ENGAGEMENT & SUPPORT



2.3.4. Aim #3: Improved Provider Engagement and Support

Demonstration Initiative: Supporting Providers through Engagement and Innovations

Historically North Carolina has brought together the best in health care and innovation to create a partnership between the medical community, providers, and beneficiaries in our Medical Homes. With this Demonstration program, DHHS will design, develop, and implement a pioneering-level of person-centered health community to once again lead the nation in the area of ongoing programmatic improvement by developing and implementing the best and most up-to-date, state of the art healthcare for our State's neediest population.

- Practice Supports for Quality Improvement
- Innovations Center
- Health Information Exchange (HIE)
- Statewide Informatics Layer
- Community Residency and Health Workforce Training
- Provider administrative ease in PHP contracts

2.3.4.1. Practice Supports for Quality Improvement

Minimizing disruption to individual providers and practices is a critical strategic focus in the State. Providers currently interface with one Medicaid entity, N3CN, for practice supports, care

management, and data/reporting. Under the new PHP model, providers may have multiple PHPs with which they will need to interface. In order to ensure high levels of continued provider engagement (i.e., and access and availability), administrative burden, and process standardization must be key considerations both during and after transition to PHPs.

Practice supports will help support implementation of a next generation medical home PCHC model of care. To date, N3CN's practice supports to PCMH have included helping medical homes become recognized by NCQA as PCMH; development, distribution, and use of population management tools and clinical toolkits; quality measure reporting with peer comparison; quality improvement (QI) coaching; behavioral health integration; and workflow analysis. N3CN also provides practice support beyond medical homes to network pharmacies and hospitals. AHECs provide support to PCMHs for electronic medical record implementation. DHHS values these activities as critical to the success of medical homes and intends for them to continue under the new program as part of the responsibilities of the PHPs and/or the State (e.g., through the Innovations Center). DHHS' philosophy is to standardize the approach used to provide practice supports while supporting innovation and excellence at the provider and PHP level.

Ongoing QI and Performance Assessment

The following provides an initial framework for activities focused on provider supports to ensure ongoing QI and performance assessment:

- PCHCs will engage in ongoing QI moving them through the five stages of practice transformation (set by CMS) and across the Quadruple Aim.
- The PCHC model will include a common quality measure data set that is aligned with Meaningful Use, Health Effectiveness Data and Information Set (HEDIS), and Physician Quality Reporting System (PQRS); the measures will be selected based on specific clinical priorities for North Carolina.
- PCHCs will report on measures encompassing acute care, chronic disease care, specialty care and preventive care across pediatric, adult, and obstetric populations.

In addition to these plans, the State will include the planning of additional HIE and practice support programs into the work that will be done through the collaboratives between stakeholders and the NC Innovations Center.

2.3.4.2. North Carolina Innovations Center

SL 2015-245 created the Division of Health Benefits within DHHS. The Division is charged with leading Medicaid and NC Health Choice program transformation, as well as establishing a Medicaid and NC Health Choice Transformation Innovations Center (Innovations Center). Designed in concept after the Oregon Health Authority's Transformation Center, the Innovations Center is intended to support providers with the use of technical assistance and learning collaboratives that foster peer-to-peer sharing of best practices.

The NC Innovations Center will help providers and PHPs achieve the ultimate goals of the Quadruple Aim and help spread the PCHC model throughout the state.

Key features for consideration in the design of the Innovations Center include:

- Learning collaboratives, peer-to-peer networks;
- Clinical standards and supports;
- Innovator agents;
- Council of Clinical Innovators;
- Community and stakeholder engagement;
- Conferences and workshops;
- Technical assistance; and
- Infrastructure support.

2.3.4.3. Health Information Exchange (HIE)

The development of a robust HIE is a critical component in the State's strategy for Medicaid reform. The General Assembly of North Carolina, in SL 2015-241, Sec. 12.5(a)-(g), established a state-managed Health Information Exchange Authority (NC HIEA) to oversee and administer the NC Health Information Exchange Network. The NC HIE Authority (Authority), as of February 29, 2016, assumed operation of the Exchange, a secure, standardized electronic system where providers can share and view real-time patient health information.

By February 2018, all Medicaid providers must be connected to the NC HIE network and no later than June 2018, providers involved with all other state-funded health programs must be connected. This broad connectivity across North Carolina will greatly facilitate our efforts to support coordination of care and lead to improved health outcomes for Medicaid beneficiaries, as well as other patients, across the state.

The Authority will have an Advisory Board, whose members include broad representation from the provider community and health care data experts, as well as the Secretary of Health and Human Services, the Secretary of the Department of Information Technology, and the Director of the North Carolina Government Data Analytics Center. The Board will set the vision, mission, and direction of the HIE as the State looks to increase its usefulness to both the provider community and those responsible for the management of public health programs, such as Medicaid.

The Authority will work with public and private stakeholders to enhance the capacity of the HIE. The initial focus will be expanding the connectivity of providers and hence, the statewide availability of medical records, including allergies, laboratory results, medications, vitals, encounter data, and a bidirectional immunization registry across all care entities. Future plans include the development of chronic and specialized disease registries and analytics, along with connections to behavioral health providers, nursing homes, and pharmacies.

With a standardized set of broad health care data, the State will be well positioned to develop data analytics capacities that will enable the transition from a system that treats patients in a fragmented manner to one that focuses on the total person. Leveraging private and public partners, North Carolina envisions building a robust population health management tool that can combine both clinical and administrative claims data to better manage patient care, improve health outcomes, and more efficiently direct resources to meet the health care needs of its citizens.

2.3.4.4. Statewide Informatics Layer

With a standardized set of broad health care data developed as discussed above, the State will be well positioned to develop data analytics capacities that will enable the transition from a system that treats patients in a fragmented manner to one that focuses on the total person. Leveraging private and public partners, North Carolina envisions building a robust population health management tool that can combine both clinical and administrative claims data to better manage patient care, improve health outcomes, and more efficiently direct resources to meet the health care needs of its citizens.

- All providers will cooperate in sharing data and care plans to optimize coordination and continuity of care for patients across geographies and over time.
- Consistent infrastructure for coordinated care team management of patients with complex needs.
- Statewide, provider-facing utility for data exchange and population health analytic services.
- Provider-facing tools will incorporate clinical data from state designated HIE, claims data from the PHPs, public health data such as immunizations, as well as data on social determinants of health.
- Accelerate a statewide “learning health system” through the NC Innovations Center which will facilitate rigorous program evaluation, transparency, dissemination of best practices.
- Create mechanisms for engaging and supporting providers in underserved areas to succeed under value-based reform.
- Link behavioral health LME/MCOs and PHPs to common performance metrics in specified populations, aligning incentives for cooperative innovations.
- Explore integrating performance on broader measures of public health and social outcomes (education, housing, corrections) to align incentives for innovative collaboration across all health related and social determinants sectors.

2.3.4.5. Strengthening the Health Care Safety Net

Strengthening our outpatient safety net comprised of FQHCs, RHCs, local health departments, and free and charitable clinics will provide improved access to essential high quality and cost

effective primary medical care and preventive services in rural and underserved communities. Our goal is to maintain and enhance the current safety net infrastructure that serves our State's most vulnerable populations through high quality, cost effective primary care that, in many settings, may also include integrated behavioral health, dental health, pharmacy, care management and other enabling services. The safety net system is critically important to North Carolina's vulnerable and underserved populations:

- The safety net infrastructure serves over 1 million North Carolinians, representing 10% of the population. Of 1 million residents who depend on these providers for primary and secondary care, approximately 32% are Medicaid beneficiaries.
- Approximately one in five North Carolinians, including over a half million Medicaid beneficiaries live in a rural county (e.g., non-metropolitan statistical area). Rural populations are more likely to live in poverty, have co-occurring chronic diseases and have lower life expectancy than individuals living in non-rural areas.

Through state designation as an "essential provider," safety net providers, including all FQHCs, RHCs, local health departments, and free clinics (per SL 2015-245) and veterans homes (which DHHS proposes to designate as an essential provider), will be able to successfully negotiate in good faith with PHPs. DHHS will use this Medicaid "essential provider" designation to secure a place for safety net and rural health community providers in the PHP networks and will seek to preserve the current FQHC/RHC wraparound payments while extending this benefit to additional safety net providers. As we move from an acute payment methodology, this will allow North Carolina to engage in system redesign necessary to change the Medicaid payment methodology. This builds on current federal Medicaid safe guards for FQHCs and RHCs by extending this payment methodology to the primary care safety net providers for services provided to Medicaid beneficiaries.

2.3.4.6. Community-Based Residency and Health Workforce Training

DHHS will work to expand programs designed to ameliorate North Carolina's rural health workforce shortages and underserved communities long-standing health professional service shortages. The State has made sizeable state-only financial investments in supporting increased access through recruitment, loan repayment, community grants, AHEC residency, and new community-based graduate medical education. In addition, HRSA has made investments by providing grant funding for several Teaching Health Centers Graduate Medical Education payment program, pediatric, and three family medicine residencies in North Carolina.

Evidence shows that community-based education programs, built on best practices, will increase critical health care workforce, which ensures Medicaid beneficiaries access to essential services. North Carolina is making an investment to redesign the health system to ensure we have the appropriate team-based workforce needed to succeed in the changing health care environment and will seek support through this demonstration to enhance these investments. DHHS seeks to support and create community-based residency trainings that support the

training of critical workforce with a primary focus on ambulatory and preventive care that advance the goals of higher value health care that reduces long-term costs.

- In order to expand these existing programs, DHHS is requesting Federal match for the state-only funds that are directed to support and build out community-based residency programs. These community based residency programs will include community-based graduate medical education (GME) and with Federal match offer an opportunity to build out team based training to create the future workforce to integrate into the PCHC. Future advanced training programs for essential workforce might include: Nurse Practitioners, Physician Assistants, Therapists, Substance Abuse Counselors, Care Managers and Community Health Workers.
- In addition, DHHS is requesting Federal match for existing state-only funded community-based AHEC, Teaching Health Centers Graduate Medical Education, and new community-based residencies to receive additional GME payments for the services they provide to Medicaid beneficiaries, much like GME payments to academic centers.

2.3.4.7. Provider Administrative Ease in PHP Contracts

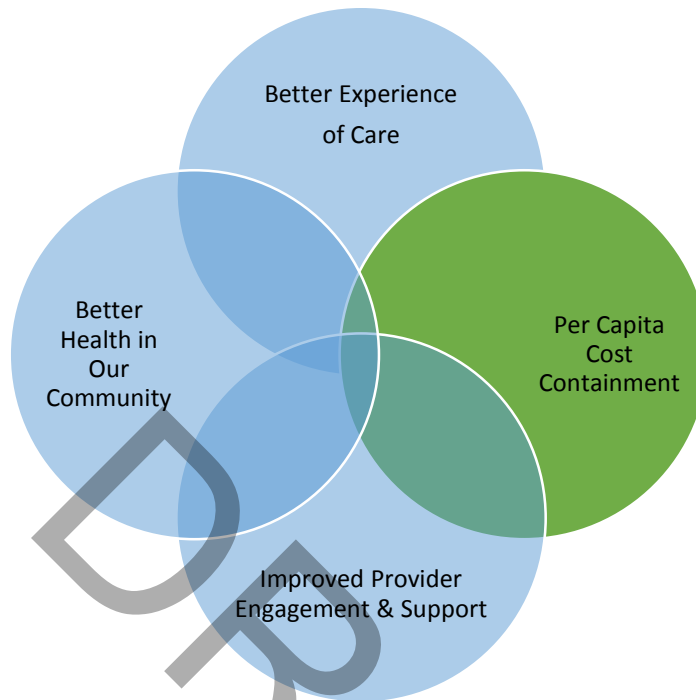
North Carolina recognizes the provider community as a critical partner in driving the success of our state's Medicaid transformation efforts. One of our guiding principles in the development of PHP contracts will be to minimize the administrative burden and disruption to providers and provide the supports needed for providers to drive the success of our new delivery system. For example:

- Consistent with SL 2015-245, all PHPs will be required to use the State's preferred drug list (PDL).
- DHHS' prompt pay requirements for PHPs will be consistent with the standards for commercial insurers. DHHS proposes to require PHPs to process clean claims within 30 calendar days, and, after an initial transition period, pay eighteen percent (18%) interest if they do not meet that timeframe.
- DHHS intends to develop and implement a uniform credentialing process, including a standardized application and a centralized verification process.
- While DHHS will develop a robust set of performance measures to evaluate the system, PHPs, and providers, DHHS proposes that providers be held accountable for meeting a common, simple set of performance measures. These measures will be the same across PHPs, and they will be aligned with other payers to the extent possible.
- DHHS plans to standardize the approach used to provide practice supports (for example, population management tools, clinical toolkits, quality improvement coaching) so that these are consistent across PHPs and minimize the disruption to provider practices.

- DHHS intends to develop an approach to care management that creates consistency across PHPs and practices, supports innovation and excellence at the PHP and/or practice level, and lessens the burden on providers.
- DHHS will work with stakeholders to enhance the capacity, connectivity, and functionality of the HIE and consistent statewide informatics functions.

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QUADRUPLE AIM #4 PER CAPITA COST CONTAINMENT (AND FUNDING STABILITY)



2.3.5 Aim #4: Per Capita Cost Containment (and Funding Stability)

Demonstration Initiative: Care Transformation through Payment Alignment

DHHS must gradually—and carefully—evaluate the historical State, public, and private provider investment in Medicaid through base payments, assessments, intergovernmental transfers, and certified public expenditures (CPEs) and transition this financing to a new model centered around value-based capitation to PHPs. DHHS will transition the direct payments to hospitals and other providers that today help cover Medicaid uncompensated care costs with payments that support the safety net and also invest in structural and functional reforms that will contribute to achieving the Quadruple Aim. Following the implementation of risk-based managed care, a portion of the current supplemental payment funds will be available through incentive payments for projects under the delivery system reform incentive payment (DSRIP) program as well as direct safety net hospital payments.

These funds, both today and in the future, are essential support to safety net providers who partner with DHHS to ensure access for Medicaid enrollees. Once implemented, Medicaid capitated managed care will disrupt these supplemental payment structures in two ways:

- 1) Upper payment limit (UPL) payment programs that provide supplemental payments to providers will likely evolve as Medicaid moves to capitated managed care.
- 2) CPEs can only be used to finance cost reimbursement systems based on incurred expenditures and cannot be utilized to finance capitated managed care payments.

North Carolina proposes a solution that includes direct Medicaid uncompensated care payments, the creation of DSRIP programs, and direct or directed value-based payments to providers. The strategically designed set of funding streams are intended to:

- Drive care improvements and functional reforms to advance our Quadruple Aim.
- Ensure vital funding for Medicaid recipients and other purposes remains intact.
- Provide a smooth transition to ensure system and provider stability.

Our Care Transformation through Payment Alignment proposal will take a multi-pronged, evolutionary approach that includes collaborative planning with all of our stakeholders. The following diagram depicts a high-level view of the program.

Our Care Transformation through Payment Alignment proposal will have several components and initiatives. Many of these concepts will be further developed and defined through collaboration to ensure all of the objectives of the demonstration related to stabilization and support of North Carolina primary care safety net providers. DHHS intends to collaborate with our stakeholders on more detailed design features within Care Transformation through Payment Alignment.

The State's DSH funding and hospital GME funding will remain outside of the demonstration.

2.4. Demonstration Hypotheses and Evaluation Plan

North Carolina will focus on the implementation and impact of Medicaid and NC Health Choice transformation by evaluating the system transformation as a whole using our Quadruple Aim as the foundation of the evaluation. The evaluation will be supported by our plan to use standardized metrics including performance measures, quality improvement, access to care, value-based payments, population health outcomes and our informatics infrastructure including the HIE. The experience and engagement of our beneficiaries and providers will be included as key components of the evaluation.

North Carolina expects that the proposed changes in financing and delivery will lead to improvements in population health and in the quality of care provided to Medicaid and NC Health Choice beneficiaries. In our demonstration, DHHS will focus on a core set of outcomes, incentivize providers in a meaningful way, and consistently introduce new initiatives and incentives when the existing goals are achieved. DHHS will drive significant and broad based improvements to the health care of North Carolina beneficiaries.

2.4.1. The Hypotheses

The State will develop an evaluation design for the Demonstration to test the following research hypotheses through the demonstration:

- 1) Building on North Carolina's current system of primary care and enhanced care management, the Person-Centered Health Communities will drive the primary care integration model by supporting coordinated access to specialty care, providing routine behavioral health screening, diagnosis and management, coordinating social and home-based services, and coordinating with the state's specialty behavioral health system to achieve integrated health goals.
- 2) By requiring outcome and performance measures, and tying measures to meaningful financial incentives for PHPs and providers, the State will improve health care quality and improve beneficiary and provider experience and satisfaction.
- 3) Our hybrid model of PLEs and CPs will create a diverse proving ground where lessons learned can be evaluated against the Quadruple Aim.
- 4) Improved supports for children in foster care: a) Statewide expansion of "Fostering Health NC" and b) designating a PHP for children in foster care will provide continuity of care and reduce unnecessary health care expenditures through dedicated and coordinated care management during the child welfare experience for children in foster care and their families. c) Continuation of Medicaid eligibility (especially to provide behavioral health services) for parent(s) of children temporarily removed from the home, will result in shorter length of foster care episodes. Shorter length of out-home placement will reduce Medicaid expenditures for services during the foster care service provision, as well as Medicaid eligibility for the former foster children after reaching age 18, up to age 26.

2.4.2. Draft Evaluation Questions

The evaluation design for the demonstration will address these hypotheses by focusing on the following questions:

- Which of the following components of the North Carolina PCHC (the next generation PCMH), demonstrate a direct correlation to improved health outcomes for Medicaid and NC Health Choice beneficiaries?
 - Specific components of the model identified for inclusion:
 - Pregnancy Medical Home
 - Integrated LTSS for Medicaid-Only individuals
 - Adolescent Physical and Behavioral Health Screening
 - Children and Youth with Special Health Care Needs (CYSHCN)
 - Community Pharmacy Enhanced Services Network (CPESN)
 - Ongoing Quality Improvement and Performance Assessment at PHP or provider levels
 - Value-Based Payment and Primary Care Incentives
 - Statewide HIE
 - Supports and services to Providers
- Which of the measures of outcomes or performance show the most improvement and are there any meaningful differences in the performance of provider-led entities compared to commercial plans?
 - Access to primary care
 - Access to specialist care
 - Rural health equity
 - Population health
 - Experience of beneficiaries
 - Experience and engagement of providers
- Which value-based models in the demonstration that incentivize and pay for performance shows a correlation to better health outcomes for beneficiaries and/or practice transformation success?
- Does continuity of Medicaid eligibility for parents of children placed in foster care reduce length of stay in foster care, and avert long-term costs to Medicaid?

2.4.3. Data Sources

To support the evaluation, DHHS will leverage existing data collection and informatics assets, and exploit the HIE to gather additional data to begin integrating clinical data with administrative claims data. Further, DHHS intends to incorporate external sources of data, as needed, to provide insight into system performance. Clinical information from the HIE will be integrated with administrative claims data from the PHPs and Fiscal Agent and specialized information sources (e.g., national research or niche sources) to support the creation, monitoring and dissemination of performance and quality metrics and measures.

The creation of integrated data and a comprehensive set of analytics tools will be used to support the operational aspect of managing the delivery of Medicaid for the state (e.g., Provider Supports, Performance and Quality Metrics and Measures), as well as a platform for identifying trends, forming/testing hypotheses, and modelling and monitoring innovation.

2.5. Demonstration Location and Timeframe

4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the Demonstration will operate

The Demonstration will operate statewide.

5) Include the proposed timeframe for the Demonstration

January 1, 2018 through December 31, 2022.

6) Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems

No. The Demonstration will not modify the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost-sharing, or delivery systems.

3. Demonstration Eligibility

| 1) *Describe the populations that will participate in the Demonstration.*

Except as noted below for parents of children in foster care, there are no changes to Medicaid and NC Health Choice (CHIP) eligibility under the Demonstration. Standards for eligibility are set forth under the Medicaid and CHIP state plans. Except as provided below, participation in the Demonstration will be mandatory for all Medicaid eligibility categories, including the aged, blind and disabled, as well as individuals enrolled in NC Health Choice (CHIP). The Medicaid and CHIP state plan and 1915(c) waiver populations will be affected by the Demonstration through the proposal to require enrollment in capitated prepaid health plans (PHPs) in order to receive most Medicaid, CHIP, and section 1915(c) waiver services.

Individuals dually eligible for Medicare and Medicaid, including individuals in categories limited to Medicare cost sharing programs, will not be enrolled in the Demonstration. As directed by the authorizing legislation, Session Law (SL) 2015-245, the North Carolina Department of Health and Human Services (DHHS) will form a Dual Eligibles Advisory Committee to develop a long-term strategy to cover dual eligibles through capitated PHP contracts.

Individuals enrolled in Program for All-Inclusive Care for the Elderly (PACE) and individuals enrolled in Medicaid for emergency services only will not be included in the Demonstration. Medically needy individuals and expenditures for periods of presumptive eligibility will also be excluded from the Demonstration.

Individuals enrolled in the North Carolina section 1915(b)/(c) concurrent waivers will be enrolled in the Demonstration in order to receive Medicaid state plan services not included in the 1915(b)/(c) waiver through mandatory enrollment in PHPs. See question 4 in this section for more details.

DHHS consulted with the Eastern Band of Cherokee Indians (EBCI), North Carolina's only federally-recognized tribe, and supports their request that members of federally-recognized tribes will be included in the Demonstration but will not be required to enroll in PHPs. Members may voluntarily enroll in PHPs on an opt-in basis and may disenroll without cause at any time.

Medicaid Eligibility for Parents of Children in Foster Care

DHHS seeks to ensure parents, who otherwise would have been eligible for Medicaid under existing rules if their child(ren) had not been placed in foster care, are provided with appropriate and effective comprehensive health services, including mental health and substance use disorder services, to increase the likelihood of successful reunification of the child(ren) and family. Thus, DHHS proposes to allow parents to retain their Medicaid eligibility while their child(ren) are being served temporarily by the foster care program. This will promote the overall health of our children and families and our communities. DHHS will request technical assistance from the Centers for Medicare & Medicaid Services (CMS) to determine whether waiver or expenditure authority is required under the Demonstration.

2) Describe the standards and methodologies the State will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan.

When determining whether an individual is eligible, North Carolina will apply the same eligibility standards and methodologies as those articulated in the Medicaid and CHIP state plans with no changes. As noted above, North Carolina will seek technical assistance from CMS to determine whether continuation of Medicaid eligibility for parents of children in foster care (up to the existing parent caretaker income limit) will be determined to be a change to eligibility under the Demonstration.

3) Specify any enrollment limits that apply for expansion populations under the Demonstration.

With the exception of parents of children in foster care, the State is not proposing any population expansions in this application. As noted above, North Carolina will seek technical assistance from CMS to determine whether continuation of Medicaid eligibility for parents of children in foster care will be determined to be a change to eligibility under the Demonstration. If so, the State is not proposing any enrollment limits.

4) Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid state plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.

Assuming approval by January 1, 2018, DHHS projects approximately two million individuals will be eligible for the Demonstration. These projections are based on current state programs, including individuals enrolled in NC Health Choice and North Carolina's section 1915(c) waivers. Individuals with section 1915(c) waiver services to be included in the Demonstration (excluding dual eligibles) are described below:

Community Alternatives Program for Children (CAP/C) and Community Alternatives Program for Disabled Adults (CAP/DA): Approximately 3,600 Medicaid-only individuals. These individuals will be enrolled in the Demonstration in order to receive their state plan and section 1915(c) CAP waiver services through mandatory enrollment in PHPs.

Individuals enrolled in the North Carolina section 1915(b)/(c) concurrent waivers will be enrolled in the Demonstration in order to receive Medicaid state plan services not included in the 1915(b)/(c) waiver through mandatory enrollment in PHPs. All 1915(b)/(c) waiver services provided through North Carolina's local management entities/managed care organizations (LMEs/MCOs), will continue to be delivered through the LME/MCOs. The Demonstration will focus on progressing toward integrated behavioral and physical health and planning for the

integration of behavioral health services within a single capitated system as required by SL 2015-245.

5) To the extent that long-term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State)

The Demonstration does not impact post-eligibility treatment of income. North Carolina will continue to operate its section 1915(c) waivers. Please see Appendix B-5 in the approved section 1915(c) waiver applications.

6) Describe any changes in eligibility procedures the State will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013).

Not applicable. DHHS is not proposing any such changes in eligibility procedures.

7) If applicable, describe any eligibility changes that the State is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014.

Not applicable.

4. Demonstration Benefits and Cost Sharing Requirements

2.1. Eligibility and Cost Sharing

1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP state plan:

Yes No (if no, please skip questions 3 – 7)

All services provided under the Demonstration derive their coverage from North Carolina's Medicaid and CHIP state plans and existing section 1915(c) waivers.

All Medicaid mandatory and optional services and CHIP state plan services will be provided under the Demonstration with the following excluded services:

- LME/MCO (prepaid inpatient health plan) services (applies to Medicaid, not NC Health Choice beneficiaries)
- Dental services
- PACE
- Local education agency (LEA) services
- Children's Developmental Services Agency (CDSAs) services

Indian health/tribal providers will not be required to be part of PHP networks. Members of federally-recognized tribes who opt to enroll in PHPs will be able to access Indian health/tribal providers on an out-of-network basis without authorization from the PHP.

DHHS will operate this 1115 Demonstration concurrent with the following existing section 1915(c) waivers, which will remain in place during the Demonstration period:

- CAP/C
- CAP/DA

All services approved under these waivers will be delivered to non-dual eligibles through the Demonstration (see Section IV), and coverage for these home- and community-based waiver services will continue to be derived from the section 1915(c) waivers. The 1115 Demonstration will provide the authority for these services to be delivered through capitated PHPs.

Individuals enrolled in the North Carolina section 1915(b)/(c) concurrent waivers will be included in the Demonstration in order to receive non-waiver Medicaid state plan services through the PHPs. All 1915 (b)/(c) waiver services currently provided through North Carolina's LMEs/MCOs will continue to be delivered through the LME/MCOs. The Demonstration will focus on progressing toward integrated behavioral and physical health and planning for the integration of behavioral health services within a single capitated system as required by SL 2015-245.

2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP state plan:

Yes No (if no, please skip questions 8 - 11)

Cost-sharing requirements will be the same regardless of whether the benefits are delivered under the state plan or the Demonstration.

3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration (an example is provided):

Not applicable.

4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:

- Federal Employees Health Benefit Package
- State Employee Coverage
- Commercial Health Maintenance Organization
- Secretary Approved

Not applicable.

5) In addition to the Benefit Specifications and Qualifications form:

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf>, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan, (an example is provided).

Benefits are the same under the Demonstration and the state plan and approved section 1915(c) waivers.

2.2. Long-Term Services and Supports

6) Indicate whether long-term services and supports will be provided.

Yes (if yes, please check the services that are being offered)
 No

Except for PACE, all state plan long-term services and supports (LTSS) for the Medicaid only population will be delivered through the Demonstration. 1915(b)/(c) waiver services will not be included under the Demonstration, as those services will continue to be delivered by North Carolina's LME/MCOs.

DHHS will operate this 1115 Demonstration concurrent with the following existing section 1915(c) waivers, which will remain in place during the Demonstration period:

- CAP/C
- CAP/DA

For Demonstration participants, all services approved under these CAP waivers will be delivered through the Demonstration (see Section IV) and coverage authority for these home- and community-based waiver services will continue to be derived from the section 1915(c) waivers. The 1115 Demonstration will provide the authority for these services to be delivered through capitated PHPs.

In addition, please complete the:

*<http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-LTSS-Benefits.pdf>, and
the: <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Long-Term-Services-Benefit-Specifications-and-Provider-Qualifications.pdf>.)*

Not applicable as authority for LTSS services will be derived from the state plan and section 1915(c) waivers, not the 1115 Demonstration.

- Homemaker*
- Case Management*
- Adult Day Health Services*
- Habilitation – Supported Employment*
- Habilitation – Day Habilitation*
- Habilitation – Other Habilitative*
- Respite*
- Psychosocial Rehabilitation*
- Environmental Modifications (Home Accessibility Adaptations)*
- Non-Medical Transportation*
- Home Delivered Meals Personal*
- Emergency Response*
- Community Transition Services*
- Day Supports (non-habilitative)*
- Supported Living Arrangements*
- Assisted Living*
- Home Health Aide*
- Personal Care Services*
- Habilitation – Residential Habilitation*
- Habilitation – Pre-Vocational*
- Habilitation – Education (non-Individuals with Disabilities Education Act of 2004 Services)*
- Day Treatment (mental health service)*

- Clinic Services*
- Vehicle Modifications*
- Special Medical Equipment (minor assistive devices)*
- Assistive Technology*
- Nursing Services*
- Adult Foster Care*
- Supported Employment*
- Private Duty Nursing*
- Adult Companion Services*
- Supports for Consumer Direction/Participant Directed Goods and Services*
- Other (please describe)*

7) Indicate whether premium assistance for employer-sponsored coverage will be available through the Demonstration.

Yes (if yes, please address the questions below)

No (if no, please skip this question)

a) Describe whether the State currently operates a premium assistance program and under which authority, and whether the State is modifying its existing program or creating a new program.

b) Include the minimum employer contribution amount.

c) Describe whether the Demonstration will provide wrap-around benefits and cost-sharing.

d) Indicate how the cost-effectiveness test will be met.

8) If different from the state plan, provide the premium amounts by eligibility group and income level.

There are no changes to cost-sharing provisions already approved in the state plan.

9) Include a table if the Demonstration will require copayments, coinsurance, and/or deductibles that differ from the Medicaid state plan (an example is provided):

Not applicable.

10) Indicate if there are any exemptions from the proposed cost sharing.

Not applicable.

5. Delivery System and Payment Rates for Services

5.1. Prepaid Health Plans

1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP state plan:

Yes

No (if no, please skip questions 2 – 7 and the applicable payment rate questions)

2) Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care, and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.

DHHS will begin contracting with Commercial Plans (CPs) and Provider-Led Entities (PLEs) on a capitated basis, utilizing value-based purchasing principles to achieve our desired goals in the Quadruple Aim. These PHPs will include entities known as PLEs, led by North Carolina providers, and commercial managed care companies. When successful, the presence of PLEs existing side-by-side with CPs will achieve our key goals for consumer choice, provider choice, and provider-led innovation. Currently, North Carolina has several successful ACOs developed throughout the State in partnership with the CMS Center for Medicare & Medicaid Innovation and expects the provider community will continue to innovate in Medicaid as the PHP models are developed.

Introducing new models of choice for both beneficiaries and providers in Medicaid and NC Health Choice is one of our top priorities. This hybrid approach, coupled with standardized metrics and outcomes designed for North Carolina's program, measured on a provider, PHP, regional, and statewide basis, will provide the insight the State needs to compare the models, ensure oversight, and develop an understanding of how both types of PHPs are serving beneficiaries.

At the same time, DHHS will address the financial underpinnings of the current Medicaid provider payments in order to provide a glide path to a capitated model in which provider innovation is encouraged, but disruption to the Medicaid safety-net is minimized.

The State expects the proposed delivery system and financing reforms will lead to improvements in health status and in the quality of care provided to Medicaid and NC Health Choice beneficiaries, while achieving lower costs and high levels of provider satisfaction.

North Carolina will implement the reforms statewide. Please see responses #4-6 below and Sections 3 and 4 for populations affected by the Demonstration.

The EBCI has expressed an interest in developing a sub-regional specialty PLE for the Cherokee community in North Carolina, as well as uncompensated care initiatives for their members. DHHS will work with the EBCI to explore these options during and after the tribal consultation period.

3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

- Managed care*
- Managed Care Organization (MCO)*
 - *Prepaid Inpatient Health Plans (PIHP)*
 - *Prepaid Ambulatory Health Plans (PAHP)*
- Fee-for-service (FFS) (including Integrated Care Models) Primary Care Case Management (PCCM)*
- Health Homes*
- Other (please describe)*

With the exception of members of a federally recognized tribe, North Carolina 1115 Demonstration participants will mandatorily enroll in capitated PHPs (MCOs as defined in 42 CFR 438.2). Within each region, DHHS' intent is that participants will have a choice of PHPs, including a choice of PHP models.

CPs are synonymous with traditional Medicaid MCOs that agree to incorporate North Carolina's standards for next-generation medical homes and value-based purchasing initiatives. PLEs are Medicaid MCOs that also incorporate these standards and meet all of the following criteria:

- A majority of the entity's ownership is held by an individual or entity that has as its primary business purpose the ownership or operation of one or more Medicaid and NC Health Choice providers.
- A majority of the entity's governing body is composed of physicians, physician assistants, nurse practitioners, or psychologists.
- Holds a PHP license issued by the Department of Insurance.

4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the state plan, section 1915(a) option, section 1915(b), or section 1932 option:

All Demonstration enrollees will receive Demonstration services through a single delivery system that utilizes capitated PHPs (federal MCOs). Demonstration enrollees who are enrolled

in LMEs/MCOs for behavioral health, substance use, and intellectual and developmental disability (IDD) services will continue to receive those services through the existing capitated section 1915(b)/(c) concurrent waiver program. LME/MCO services are not included in the Demonstration, but coordination between the LME/MCOs and the PHPs will be a focus of the Demonstration design.

DHHS intends to develop requirements for a PHP to serve foster care children, so that a single statewide PHP is available to coordinate the complex needs of these children. All PHPs in a region will be available for enrollment, but one statewide PHP will be designated as being the most qualified to serve this population.

5) If the Demonstration will utilize a managed care delivery system:

a) Indicate whether enrollment will be voluntary or mandatory. If mandatory, is the State proposing to exempt and/or exclude populations?

Except as noted below, enrollment in PHPs will be mandatory for all Medicaid eligibility categories, including the aged, blind and disabled, as well as individuals enrolled in NC Health Choice (CHIP). Individuals dually eligible for Medicare and Medicaid, including individuals in categories limited to Medicare cost sharing programs, will be excluded from PHPs and not enrolled in the Demonstration. As directed by the authorizing legislation, SL 2015-245/HB 372, DHHS will form a Dual Eligibles Advisory Committee to develop a long-term strategy to cover dual eligible through capitated PHP contracts.

Individuals enrolled in PACE and individuals enrolled in Medicaid for emergency services only will not be enrolled in PHPs and will not be included in the Demonstration. Medically-Needy individuals will also be excluded from PHPs and the Demonstration. Individuals in a period of presumptive eligibility will be excluded from the Demonstration. All periods of retroactive eligibility for individuals enrolled in the Demonstration will be excluded from the PHP contracts, but included in the Demonstration.

DHHS consulted with the EBCI, North Carolina's only federally-recognized tribe, and supports their request that members of federally-recognized tribes will be included in the Demonstration but will not be required to enroll in PHPs. Members may voluntarily enroll in PHPs on an opt-in basis and may disenroll without cause at any time.

b) Indicate whether managed care will be statewide, or will operate in specific areas of the State.

Managed care through PHPs will be statewide.

c) Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the State).

DHHS is planning statewide implementation of PHPs within 18 months of CMS approval, as required by SL 2015-245, and will not phase in managed care implementation.

d) Describe how the State will assure choice of MCOs, access to care, and provider network adequacy.

As noted above, it is DHHS' goal that Demonstration participants will have a choice of PHP models, including at least one CP and one PLE. It is DHHS' intent to contract with no fewer than four PHPs in each region (where membership is sufficient), thus assuring choice of PHPs (MCOs) in each region.

Development of access and availability standards is a key component of design of the PHP program, and the ability of a PHP to meet those access standards will be a critical milestone in the State's determination that a PHP is ready to enroll beneficiaries. DHHS will carefully consider model network requirements, including CMS requirements for Essential Community Providers, Medicare Advantage, and Qualified Health Plans, as well as requirements from other states and recommendations from Medicaid advisory groups, when finalizing North Carolina's standards. DHHS will monitor and evaluate access and availability on an ongoing basis, and will revise the standards as necessary to ensure beneficiaries have timely access to covered services.

The access and availability standards may vary for rural versus metropolitan/urban areas, and will reflect findings from the development of the AMRP required by the federal Medicaid FFS access rule, which became effective January 4, 2016. Given the rural nature of certain areas of the State, North Carolina has already implemented telemedicine and telepsychiatry solutions to address unmet needs. DHHS is interested in exploring the continued role of telemedicine and telepsychiatry in meeting access gaps and availability in geographic regions where results of the AMRP determine certain provider types and/or specialty capacity is not as robust as it could be. DHHS will also designate certain providers as "essential providers" for PHP networks, including FQHCs/RHCs, local health departments, and free and charitable clinics.

In developing the standards, DHHS will take into consideration potential competition between PLEs and CPs to ensure all PHPs are appropriately incented when it comes to developing networks that are viable and aligned with DHHS' transformational goals. Some of these related standards include rate floors, antitrust, and good faith negotiations.

Importantly, DHHS intends to fully comply with federal Medicaid requirements for access to care and network adequacy that are pending publication in a final rule expected in 2016 and will be able to provide a more detailed plan for access and network adequacy in light of these requirements once they are published. DHHS will do this by specifying, monitoring, and enforcing access and availability standards for PHPs. These standards will include, at a minimum, time and distance standards for specified provider types (e.g., primary care, specialty care, hospitals, pharmacies, and LTSS).

DHHS may also incorporate additional standards such as appointment availability and office waiting time.

e) Describe how the managed care providers will be selected/procured.

DHHS will select PHPs through a competitive procurement. As noted above, it is DHHS' goal that Demonstration participants will have a choice of PHP models, including at least one CP and one PLE. It is DHHS' intent to contract with no fewer than four PHPs in each region (where membership is sufficient), thus assuring choice of PHPs (MCOs) in each region.

6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.

All Medicaid state plan mandatory and optional services and CHIP state plan services will be provided under the Demonstration with the following excluded services:

- **LME/MCO services:** LME/MCO (PIHP) services covered under the concurrent section 1915(b)/(c) waivers were excluded from the PHP contracts in the authorizing legislation until four years after the date capitated contracts begin.
- **Dental services:** Dental services were excluded from the PHP contracts in the authorizing legislation.
- **PACE:** PACE is a separate, capitated delivery system from the PHP model and will remain an option for qualifying individuals.
- **LEA services:** LEA services for Medicaid beneficiaries are provided in accordance with Part C of the Individuals with Disabilities Education Act (IDEA) and funded via certified public expenditures, making a transition to capitated PHPs difficult and potentially disruptive to the delivery of these services.
- **CDSA services:** CDSA services for Medicaid beneficiaries are provided in accordance with Part C of IDEA and funded via certified public expenditures, making a transition to capitated PHPs difficult and potentially disruptive to the delivery of these services.

Indian health/tribal providers will not be required to be part of PHP networks. Members of federally-recognized tribes who opt to enroll in PHPs will be able to access Indian health/tribal providers on an out-of-network basis without authorization from the PHP.

DHHS will operate this 1115 Demonstration concurrent with the following existing section 1915(c) waivers, which will remain in place during the Demonstration period:

- CAP/C
- CAP/DA

All services approved under these waivers will be delivered to non-dual eligibles through the Demonstration through PHPs, and authority for these home- and community-based waiver services will continue to be derived from the section 1915(c) waivers. The 1115 Demonstration will provide the authority for these services to be delivered through capitated PHPs.

5.2. Long-Term Services and Supports

7) *If the Demonstration will provide personal care and/or LTSS, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration*

Yes

No

Yes, the Demonstration will provide LTSS for Medicaid-only individuals, including personal care services, and will provide continued opportunities for self-direction of the same services described in the CAP/C and CAP/DA section 1915(c) waivers for individuals enrolled in PHPs. Financial management services (FMS) to support self-direction will be available to PHP enrollees and DHHS is exploring contractual options for these FMS services.

8) *If FFS payment will be made for any services, specify any deviation from state plan provider payment rates. If the services are not otherwise covered under the state plan, please specify the rate methodology.*

Not applicable.

6. Payments

9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.

DHHS intends to develop actuarially sound capitation rates for payments to PHPs and expects PHPs to develop value-based payment (VBP) methodologies within these capitated rates. Within the current FFS system, providers are reimbursed based on volume, regardless of whether the services result in quality outcomes. Our goal is to use PHP capitation and other contract elements to drive change down to the provider level through reimbursement that is based on value rather than volume. North Carolina expects value-based purchasing by PHPs to contribute to the paradigm shift occurring in the State across payers focusing on value and quality. Value-based care, and the emerging delivery systems and provider reimbursement methodologies that support it, can drive significant improvements in helping North Carolina achieve its goal of the Quadruple Aim.

FQHCs and RHCs will receive their federally-mandated reimbursement rates through a combination of payments from the PHPs and “wrap around” payments from DHHS. North Carolina also seeks authority under the Demonstration to extend the State’s ability to continue supplemental “wrap around” payments to limited provider types (local health departments and RHC-like rural clinics) once payment for these services have been included in the PHP contracts. In North Carolina, these clinics are a vital part of the fabric of our fragile rural health safety net system and will help ensure our ability to improve rural health access, outcomes and equity.

DHHS is encouraged by the support shown by CMS for VBP in the preamble to the June 2015 proposed Medicaid managed care rule, and will need to evaluate the final rule to determine whether any exceptions to these rules will be requested for VBP as part of the Demonstration.

10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.

North Carolina Care Transformation through Payment Alignment

As discussed in Section I, the State will implement Medicaid payment reforms through North Carolina using a blended approach that includes direct payments to Medicaid safety net hospitals for Medicaid uncompensated care, delivery system reform incentive payment (DSRIP) programs, risk-based incentive payments paid as a part of the managed care rates, and rural/safety net provider payments. These initiatives are designed to ensure stability within our safety net providers and prepare for success in delivery system reforms.

The Care Transformation through Payment Alignment proposal has several components and initiatives that will foster statewide preparation for the delivery system changes. Anchored by

our successful Primary Care Medical Home program, DHHS intends to collaborate with our stakeholders on more detailed design features within this initiative.

Program features include:

- 1) Planning and development of four components of the funding programs to support safety net providers as the Medicaid and NC Health Choice programs during and after the transition to risk-based managed care:
 - a) **Safety Net Hospital Payments.** The funding for this program will be designated to ensure ongoing stabilization to safety net hospitals for Medicaid uncompensated care.
 - b) **DSRIP Initiatives.** Funds available in these programs will be tied to traditional DSRIP projects, milestones, and payment for performance and outcomes related to these projects.
 - c) **Incentives in Capitated Payments.** This component will explore the opportunity for provider-directed VBPs as part of the PHP capitation payments.
 - d) **Rural and Public Provider Payments.** This program will include programs to strengthen the outpatient safety net providers.

Disproportionate Share Hospital (DSH) and Graduate Medical Education (GME) payments will not be included in the waiver. Those payments will continue as provided for under the Medicaid state plan authority.

Components under these payment programs will allow projects and initiatives to incentivize provider engagement, as well as ensure ongoing safety net provider stability.

- 2) Standardized Performance Metrics for Care Transformation through Payment Alignment initiatives

The choice of performance process and outcome measures will be based on the projects and initiatives and will include:

- Measures of infrastructure development and participation
- System redesign
- Clinical outcome improvement of chronic conditions
- Population health improvement
- Readmission reduction, reduction in emergency department visits

- 3) Performance Payments for Care Transformation through Payment Alignment initiatives

Incentive payment methodologies will be established based on the milestones of the projects and initiatives established under the Care Transformation through Payment Alignment.

- Performance payments will be tied to achievement of specific measures and/or project specific measures.

- Performance payments will be tied to achievement of population and/or community measures.
- Accountable provider networks will have the ability to allocate performance payments to providers in their respective networks.

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7. Implementation of Demonstration

7.1. Implementation Schedule

1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.

North Carolina will implement the Demonstration through enrollment in risk-based contracts within 18 months after approval of the Demonstration (and any other necessary state plan and waiver amendments) by CMS. At this point, DHHS does not intend to implement PHPs using a phase-in approach.

DHHS proposes the following timeline for issuance of the PHP request for proposal (RFP) and selection of PHPs. This timeline is subject to revision and assumes CMS approval of the Demonstration by January 1, 2018. SL 2015-245 requires that capitation begin and beneficiary enrollment be complete within 18 months following CMS approval. Based on these key milestones, DHHS has developed the proposed timeline outlined below.

HYPOTHETICAL TIMELINE – ASSUMING CMS APPROVAL ON JANUARY 1, 2018

KEY ACTIVITY	DATE (Assuming 1115 is approved Jan. 1, 2018)
Submit waiver application	June 1, 2016
Draft RFP (including contract)	October 2016–January 2018
CMS approval of the 1115	January 1, 2018
Consult with Joint Legislative Oversight Committee on terms and conditions of the RFP	February 2018
RFP issued	March 2018
PHP proposals due	June 2018
PHP awards	September 2018
Readiness reviews	November 2018–June 2019
PHP go live	July 1, 2019

7.2. Enrollment and Auto-Assignment

2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.

Below is a description of DHHS' plans for use of an enrollment broker and an auto-assignment process to support beneficiary selection and enrollment in PHPs. This is separate from the Medicaid eligibility determination and Medicaid enrollment process, which will continue to be a function of the county DSS.

DHHS is mindful of pending federal regulations that will ultimately govern the requirements for enrollment brokers and auto-assignment and will include a proposal for a beneficiary support system for individuals who will receive LTSS through PHPs. DHHS will further define our plans in light of these requirements when final rules are published, as they are expected to be finalized in 2016, in time for DHHS planning for the operational details of the program.

a) Enrollment Broker

To support the successful transition to capitated managed care, DHHS intends to contract with an enrollment broker to provide education, outreach, and enrollment activities to help beneficiaries first select a primary care provider/practice (if they do not already have one) and then choose and enroll in a PHP with consideration for current provider relationships. The enrollment broker will be selected through a competitive procurement and will be required to meet the independence and conflict of interest requirements in federal regulations (42 CFR 438.10).

The enrollment broker will conduct choice counseling, which includes activities such as helping beneficiaries select a primary care provider/practice if they do not have an existing one, answering questions and providing information (in an unbiased manner) on available PHPs, and advising on what factors to consider when choosing among the PHPs. The enrollment broker will also distribute and process enrollment materials and enroll beneficiaries in a PHP.

The EBCI has expressed an interest in being able to assist members of federally-recognized tribes in their choice of PHPs and DHHS will explore this concept further with EBCI during the tribal consultation period.

Proposed federal regulations would require DHHS to provide a beneficiary support system that includes assistance to beneficiaries in understanding managed care, choice counseling, training for network providers on community-based resources, and supports that can be linked with covered benefits, and functions specific to LTSS. Therefore, DHHS will further define its plans for enrollment support when final rules are published.

b) Auto-Assignment Process

After a robust process for informing potential enrollees about PHP enrollment, if a beneficiary does not choose a PHP, DHHS will develop an auto-assignment process so that all potential enrollees are assigned to a PHP. DHHS proposes that the process for beneficiary assignment to PHPs first consider beneficiary factors, such as continuity of care and family linkages, with a focus on preserving primary care relationships. These factors would include whether the beneficiary's current or historical primary care provider is participating with a PHP, whether another of the beneficiary's providers (including LTSS providers) is participating with a PHP, whether a family member is enrolled with a PHP, and previous enrollment with a PHP. After consideration of beneficiary factors, DHHS proposes to consider overall program goals, such as balancing PHP enrollment. In particular, DHHS intends to assign beneficiaries to help PHPs achieve a minimum enrollment threshold as needed to ensure financial viability and to not exceed a maximum threshold at least during the first year.

DHHS is also proposing to designate one of the statewide PHPs to provide specialized services to children and youth in the foster care program. This will be considered in the auto-assignment process.

DHHS proposes to review the assignment process after the first year to determine whether the assignment process should consider PHP quality, for example reflect the results of selected performance measures. DHHS proposes that PHP quality performance would be considered after beneficiary factors. Thus, beneficiaries who were not assigned to a PHP based on beneficiary factors would be assigned based on PHP performance. For example, the highest rated PHP could receive more default assignments than the next rated plan.

c) Supports for Individuals Eligible Enrolled in PHPs for LTSS

DHHS recognizes the importance of ensuring participants can receive conflict-free education, enrollment/disenrollment assistance, and advocacy. DHHS intends to leverage its enrollment broker to support this system and will engage stakeholders to build a process that ensures the necessary supports are available to enable Demonstration participants to be informed and navigate through system of the LTSS provided by the PHPs.

7.3 Procurement

3) If applicable, describe how the State will contract with managed care organizations to provide Demonstration benefits, including whether the State needs to conduct a procurement action.

DHHS will conduct a competitive procurement in order to contract with PHPs.

8. Demonstration Financing and Budget Neutrality

8.1. Financing

| 1) Financing

Federal policy requires that section 1115 Demonstration applications be budget neutral to the federal government. This means that an 1115 Demonstration cannot cost the federal government more than what would have otherwise been spent absent the 1115 Demonstration. The particulars of budget neutrality, including methodologies, are subject to negotiation between DHHS and CMS.

DHHS is proposing a per capita budget neutrality model for the populations covered under the Demonstration. Actual Demonstration expenditures for these populations will be applied against the without-waiver budget limit.

DHHS is also proposing an aggregate cap budget neutrality model for the Payment Alignment for Care Transformation Initiative, including uncompensated care payments and DSRIP that DHHS is requesting under the Demonstration.

North Carolina currently uses a combination of financing sources for the State share of Medicaid payments, including State General Fund, intergovernmental transfers, certified public expenditures, and provider assessment revenues. It is critical to the stability of the safety-net system that DHHS be able to successfully transition the financing of Medicaid from today's model to the transformed model of tomorrow. A key focus of DHHS' efforts going forward will be to work with provider and other funding sources to develop a plan to transition this funding to one that is sustainable after implementation of PHPs.

8.2. Estimate of the expected increase or decrease in annual enrollment and in annual aggregate expenditures

| 2) Estimate of the expected increase or decrease in annual enrollment and in annual aggregate expenditures, including historic enrollment or budgetary data, if applicable.

The following projections utilize state fiscal year (SFY) 2015, historical aggregate per capita cost trend and enrollment trend data for the program, based on the populations expected to be enrolled in the Demonstration.

	Historical Enrollment and Budgetary Data					
	SFY 2011 (7/1/2010 - 6/30/2011)	SFY 2012 (7/1/2011 - 6/30/2012)	SFY 2013 (7/1/2012 - 6/30/2013)	SFY 2014 (7/1/2013 - 6/30/2014)	SFY 2015 (7/1/2014 - 6/30/2015)	5 Year Total
Members	1,540,410	1,593,119	1,628,745	1,677,202	1,818,809	8,258,285
Historical Aggregate Expenditures	\$ 5,326,729,064	\$ 6,287,379,355	\$ 6,191,935,043	\$ 7,577,222,227	\$ 7,655,574,621	\$33,038,840,311

	Demonstration Years (DY)					
	DY 01 (1/1/2018 -	DY 02 (1/1/2019 -	DY 03 (1/1/2020 -	DY 04 (1/1/2021 -	DY 05 (1/1/2022 -	5 Year Total
Members	1,984,907	2,025,613	2,068,287	2,113,033	2,159,974	10,351,814
Estimated Aggregate Expenditures	\$ 9,617,763,981	\$10,269,342,336	\$10,972,001,556	\$11,730,218,374	\$12,548,984,673	\$55,138,310,920

3) Please complete the Demonstration financing and budget neutrality forms, respectively, and include with the narrative discussion. The Financing Form: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Demo-Financing-Form.pdf> includes a set of standard financing questions typically raised in new section 1115 demonstrations; not all will be applicable to every demonstration application. The Budget Neutrality form and spreadsheet: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Budget-Neutrality-Form.pdf> includes a set of questions with respect to historical expenditure data as well as projected Demonstration expenditures.

The financing and budget neutrality forms will be included in the submission to CMS after DHHS has received public input on the Demonstration proposal.

9. List of Proposed Waivers and Expenditure Authorities

1) Provide a list of proposed waivers and expenditure authorities.

See Table A below.

2) Describe why the State is requesting the waiver or expenditure authority, and how it will be used.

Table A below describes the authorities requested under this demonstration. DHHS will review this request in light of the final Medicaid managed care regulations once those rules are finalized.

TABLE A – WAIVER AND EXPENDITURE AUTHORITIES REQUESTED

WAIVER/EXPENDITURE AUTHORITY SECTION CITATION	TYPE	PROPOSED WAIVER/EXPENDITURE AUTHORITY LANGUAGE	DESCRIPTIVE REASON FOR WAIVER/EXPENDITURE AUTHORITY REQUEST
1. Amount, Duration, and Scope of Services Section 1902(a)(10)(B) and 1902(a)(17)	Waiver Authority	To the extent necessary to permit North Carolina to offer coverage through PHPs that provide additional or different benefits to enrollees, than those otherwise available to other eligible individuals.	To permit North Carolina to implement mandatory managed care through PHPs for Demonstration participants. PHPs may offer additional benefits, such as health education and value-added services not available to other Medicaid beneficiaries not participating in the Demonstration.
2. Freedom of Choice Section 1902(a)(23)(A)	Waiver Authority	To the extent necessary to enable North Carolina to restrict freedom of choice of provider through the use of mandatory enrollment into MCOs for Demonstration participants.	To permit North Carolina to implement mandatory managed care through PHPs and their network providers for Demonstration participants.
3. Statewideness Section 1902(a)(1)	Waiver Authority	To the extent necessary to allow North Carolina to implement managed care statewide on a phase-in basis if part of final program design.	To permit North Carolina to implement statewide mandatory managed care through PHPs for demonstration enrollees on a phased-in basis as necessary.

WAIVER/EXPENDITURE AUTHORITY SECTION CITATION	TYPE	PROPOSED WAIVER/EXPENDITURE AUTHORITY LANGUAGE	DESCRIPTIVE REASON FOR WAIVER/EXPENDITURE AUTHORITY REQUEST
4. Expenditures for targeted provider Medicaid uncompensated care costs (Safety Net Hospital Payments)	Expenditure Authority	Expenditures for care and services that meet the definition of “medical assistance” contained in section 1905(a) of the Act that are incurred by eligible providers for uncompensated Medicaid medical care costs of medical services provided to Medicaid eligible or uninsured individuals.	Expenditures to providers to stabilize and invest in safety-net providers to ensure access to care as North Carolina transforms Medicaid payments from FFS to capitation under PHPs.
5. Expenditures for delivery system reform incentive payments	Expenditure Authority	Expenditures for incentive payments under a DSRIP program.	Expenditures to eligible providers to stabilize and invest in safety-net providers and enable North Carolina to transform to a system of VBP as the State transitions from FFS to capitation under PHPs.
6. Expenditures for non-hospital clinic and local health department expenditures that support rural health	Expenditure Authority	Expenditures for Rural and Public Provider Initiatives.	Expenditures to eligible FQHC and RHC-like clinics and local health departments to preserve funding levels through “wrap-around” payments.
7. Expenditures for community-based residency and enhanced training programs	Expenditure Authority	Expenditures for outpatient community-based residency and enhanced training programs.	Expenditures to support rural health access through funding for outpatient community-based residency and enhanced team-based training programs. GME-like payments for eligible Area Health Education Centers (AHECs), Teaching Health Centers Graduate Medical Education (THCGME) programs, and community-based residency program for services provided to a Medicaid recipient.

WAIVER/EXPENDITURE AUTHORITY SECTION CITATION	TYPE	PROPOSED WAIVER/EXPENDITURE AUTHORITY LANGUAGE	DESCRIPTIVE REASON FOR WAIVER/EXPENDITURE AUTHORITY REQUEST
8. Expenditures for value-based payment methodologies within capitated PHPs	Expenditure Authority	Expenditure for capitation payments to incent managed care plans to engage in activities that promote performance targets and identify strategies for VBP models for provider reimbursement.	To enable North Carolina to incent capitated PHPs to adopt VBP models for provider reimbursement.
9. Expenditures for parents of foster care children who would otherwise be Medicaid eligible except for the placement of their child(ren) into the child welfare system.	Expenditure Authority	Expenditures for parents of foster care children who would otherwise be Medicaid eligible except for the placement of their child(ren) into the child welfare system.	To continue Medicaid eligibility for parents of children placed temporarily in foster care in order to address the comprehensive health care needs of the parents and increase the likelihood of successful reunification of the children with the family.

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10. Public Notice

| 1) Prior public notice activities

Medicaid reform in North Carolina began with Governor McCrory's declaration, upon taking office in January 2013, that the Medicaid system needed to be reformed. In February 2013, the Department issued a request for information (RFI) inviting suggestions for Medicaid reform. More than 160 responses were received from stakeholders. The Secretary of DHHS and Medicaid Director conducted a listening tour as well.

In its June 2013 budget bill, the General Assembly directed DHHS to study Medicaid reform options and requested the Governor appoint a Medicaid Reform Advisory Group to guide the effort. The Advisory Group was comprised of a senator, a representative, and three citizen experts chosen by the governor. DHHS leaders and staff devoted hundreds of hours listening to stakeholders' ideas. Diverse groups such as beneficiary advocates, medical associations, behavioral health providers, health system executives from urban and rural areas, county health departments, representatives from teaching hospitals and medical schools, community health center directors, pharmacists, representatives from long-term care facilities, and others contributed valuable input.

Through the fall/winter of 2013-14, Governor McCrory hosted two meetings of North Carolina health industry leaders at the Governor's mansion and the Medicaid Reform Advisory Group met three times in public forums to consider reform options. These efforts culminated in March 2014 with DHHS delivering a Medicaid reform plan to the General Assembly. That plan was tailored to North Carolina's needs. It proposed vesting North Carolina health care providers with principal responsibility and accountability for delivering improvements in quality and efficiency.

In the fall of 2014 and early 2015, the Division of Medical Assistance (DMA) began work on clinical measures for the envisioned reform. DMA leaders met with medical and hospital leaders to solicit their priorities and concerns regarding quality measurement in general. Subsequently, a white paper Quality Measurement Framework was developed. National measure sets relevant to Medicaid were surveyed for measures consistent with the principles set forward in the framework. A draft measure set appropriate for key Medicaid populations was created. Follow up meetings on the framework and the draft measures set were held with representatives of professional associations, the NC ACO Collaborative, the Division of Public Health and Local Health Departments and the NC Community Health Center Association. A second draft based on this feedback awaits further work.

A combination of advocates and providers met on multiple occasions throughout 2014 to address whole person integration in the Long-term Services and Supports Community (LTSS). The intent of the meetings was a strategic planning effort under DHHS' Medicaid Reform initiative. As part of the strategic planning, each services' stakeholder group (providers, families, beneficiaries, advocates, and other staff) reviewed both intermittent services

(Hospice, HIT, Home Health, and post-acute NF), and long range services (CAP DA, CAP C, PDN, PCS, NF, and PACE).

In its 2014 session, the North Carolina House of Representatives unanimously adopted a bill to enact the Governor's plan. Ultimately, the Senate did not fully concur and the session ended without the passage of legislation. In the 2015 session, leaders of the two chambers teamed up to design a compromised Medicaid reform bill, which was enacted as SL 2015-245 in September 2015.

Since the passage of SL 2015-245, DHHS has proactively sought input from key stakeholders across the state, including physicians, patients, patient advocates, hospitals, potential PHPs and many more. DHHS has met with more than 50 stakeholder groups and collected written feedback used to develop this draft 1115 Demonstration application.

All along, DHHS has recognized and leveraged input from all of North Carolina's Medicaid stakeholders as crucial to the success of reform. Our proposed model evolved over time as DHHS and legislative leaders listened to and engaged with stakeholders. It reflects a spirit of collaboration that has informed this process and that will ensure the acceptance of the upcoming changes. DHHS will continue seeking input throughout the finalization of the 1115 Demonstration and implementation of Medicaid reforms.

| 2) *Remainder of Section Reserved*

This section is reserved for information to be included in the final Demonstration application submitted to CMS. DHHS will post the draft waiver application for public notice no later than March 7, 2016, and will collect public comments through April 18, 2016, in accordance with federal rules for 1115 Demonstrations. DHHS will also have a 60-day consultation period with EBCI, in accordance with the State Plan, expected to begin on March 2, 2016. Once the public notice period is completed and DHHS has considered public comments, this section of the waiver application will be completed. This will include:

- Details of the public comment process, including the public notice, start and end date of the public notice period, DHHS' process for seeking public input, and stakeholder involvement in providing feedback on this proposed application.
- A synopsis of public comments received during the comment period and DHHS' response to the public comments.

Stakeholders interested in more information on the public notice period can visit DHHS' website at www.ncdhhs.gov/nc-medicaid-reform.

Written comments may also be mailed to:

Division of Health Benefits
North Carolina Department of Health and Human Services
2501 Mail Service Center
Raleigh, NC 27699-2501

Written comments may be delivered in person to:

Division of Health Benefits
North Carolina Department of Health and Human Services
101 Blair Drive
Raleigh, NC 27603

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11. Demonstration Administration

Please provide the contact information for the State's point of contact for the Demonstration application.

Name and Title: Rick Brajer, Secretary
North Carolina Department of Health and Human Services

Telephone Number: 919 855 4800 (office), 919 715 4645 (fax)

Email Address: Rick.Brajer@dhhs.nc.gov

Address: 101 Blair Drive
2001 Mail Service Center
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Name and Title: Dee Jones, Chief Operating Officer Division of Health Benefits
North Carolina Department of Health and Human Services

Telephone Number: 919 855 3197

Email Address: Dee.Jones@dhhs.nc.gov

Address: 2104 Umstead Drive
2501 Mail Service Center
Raleigh, NC 27699-2501

12. Appendix A

Session Law 2015-245 is available

at: <http://www.ncleg.net/Sessions/2015/Bills/House/PDF/H372v8.pdf>

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