

Section 1915(b) Waiver

STATE OF NORTH CAROLINA

NC MH/IDD/SAS Health Plan

Renewal

April 1, 2013

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Proposal for a Section 1915(b) Waiver MCO, PIHP, PAHP and/or PCCM Program

Face sheet

Please fill in and submit this face sheet with each waiver proposal, renewal, or amendment request.

The State of North Carolina requests a renewal effective **4/1/2013** to the waiver under the authority of section 1915(b) of the Act. **As this waiver serves a large number of individuals dually eligible for Medicare and Medicaid, the State is requesting a five-year renewal period as allowed by the Affordable Care Act.** The Medicaid agency will continue to directly operate the waiver.

The names of the waiver programs are **Cardinal Innovations and North Carolina Innovations**. (Please list each program name if the waiver authorizes more than one program.). **Two separate MH/IDD/SAS capitated programs are requested, Cardinal Innovations (CI), and North Carolina Innovations (NCI). Both programs operate through prepaid inpatient health plans (PIHP) in specified geographic areas of the State. The CI program is run by Cardinal Innovations Healthcare Solutions (formerly Piedmont Behavioral Healthcare) in 15 counties in the State; this PIHP has been operating since the waiver was implemented in 2005. The NCI program is run by PIHPs in the remaining 85 counties in the State where waiver roll-out started in January of 2012 and will continue until April of 2013. The primary purpose for having two separate programs is to allow the Cardinal Innovations program to pilot new 1915(b)(3) services. New 1915(b)(3) services piloted by CIHS may be expanded statewide depending on the outcome of the pilot.**

Type of request. This is a:

- Initial request for new waiver
- Amendment request
 - Replacement pages are attached for specific Section/Part being amended
 - Document is replaced in full, with changes highlighted.
- Renewal request**
 - This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e., Sections A through D) is filled out.
 - The State has used this waiver format for its previous waiver period.**
 - Section A is Replaced in full.
 - Carried over from previous waiver period. The State:
Assures there are no changes in the Program Description from the previous waiver period.
 - Assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.**
 - Section B is Replaced in full.

- Carried over from previous waiver period. The State:
 Assures there are no changes in the Monitoring Plan from the previous waiver period.
 Assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages.

Sections C, "Monitoring Results," and D, "Cost Effectiveness," have been updated/replaced.

Effective Dates: The State is requesting an implementation date of the renewal of **April 1, 2013**

(For beginning date for an initial or renewal request, please choose first day of a calendar quarter if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date.)

State contact: The State contact persons for this waiver are:

Kathy Nichols, Waiver management

Telephone 919 855 4289

Fax 919 715 4715

E-mail: katherine.nichols@dhhs.nc.gov

Christal Kelly (919 814 0066), David Martin (919 814 0067) Waiver cost effectiveness

Fax 919 814 0037

E-mail: christal.kelly@dhhs.nc.gov; david.martin@dhhs.nc.gov

Section A: Program Description

Part I: Program Overview

In April 2005, North Carolina began a pilot project under the authority of this waiver which capitated services for mental health, intellectual and developmental disabilities, and substance abuse services (MH/IDD/SAS) in a five-county area. The pilot project was administered by Piedmont Behavioral Healthcare (PBH), a local management entity (LME) for publicly funded MH/DD/SA services operating as a prepaid inpatient health plan. This 1915(b) waiver operates concurrently with a 1915(c) waiver, Innovations, which provides services to the IDD population.

Important Note: Piedmont Behavioral Healthcare (PBH) has recently changed its name to Cardinal Innovations Healthcare Solutions (CIHS). The new name of the LME/PIHP will be used throughout this amendment.

The NC Department of Health and Human Services (DHHS) submitted amendments to both waivers to CMS in December of 2009 requesting approval to expand the program statewide over time in order to standardize care management and service delivery for individuals with MH/IDD/SAS. Both waiver amendments were approved and the statewide roll-out is underway and scheduled for completion on April 1, 2013.

The goals of this capitated health plan initiative are to:

- **Better tailor services to the local consumer by adopting a consumer-directed care model and focusing on community-based rather than facility-based care.**
- **Enhance consumer involvement in planning and providing services through the proliferation of MH recovery model concepts.**
- **Demonstrate that care can be provided more efficiently with increased local control.**

Public process

The State has increased its commitment to the 1915(b)/(c) waiver program through Session Laws 2011-264 and 2012-151 which require statewide expansion of the waiver program through local management entities (LME) no later than July 1, 2013. The following public venues have been used to provide information and obtain stakeholder input on the statewide waiver roll-out and the current amendment.

1. **Monthly meetings are facilitated between the LME directors and the Division of Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). In addition, monthly meetings are held with the contract monitors. These meetings provide a forum for ongoing discussion and input regarding the waiver expansion.**

- 2. A Departmental Waiver Advisory Committee (DWAC) was established in 2012 to serve as an advisory body to DHHS on statewide implementation of the 1915 b/c Medicaid waivers and ongoing waiver operations. The DWAC has provider, recipient, county commissioner, LME, and state staff representation. All waiver related issues are discussed and stakeholder input and guidance are sought through these meetings. The DWAC meets monthly and all minutes and presentations are posted on the DMA website.**
- 3. The Division of MH/DD/SAS sponsors an External Advisory Team, a stakeholder group with representation from LMEs, providers, professional organizations and consumers, which advises the Division on statutes, rules and policies. DMA and DMH directors and officials attend monthly meetings and provide waiver updates.**
- 4. The Joint Legislative Oversight Committee on Health and Human Services meets monthly and is briefed monthly by the Division of Medical Assistance on the progress of the statewide waiver expansion and negotiations with the U.S. Department of Justice. The LOC is charged with continually examining system wide issues that affect the development, financing, administration, and delivery of mental health, intellectually and developmental disabilities, and substance abuse services, including issues related to governance, accountability and service quality.**
- 5. Consumer, advocate and provider input regarding system-wide performance measures were accessed through public forums held during June 2012. DMA worked with stakeholders to identify participants for six focus groups of up to 15 members each held in three areas across the State on June 14, 19, and 21, 2012, respectively. Participants included people who have experienced mental health and substance use conditions and I/DD and their families; members of the Local and State Consumer and Family Advisory Committees (CFAC); individuals affiliated with the ARC of North Carolina and its local chapters; members of the Departmental Waiver Advisory Committee; members of the National Alliance on Mental Illness – North Carolina and the Autism Society; other advocates; peer support specialists; family providers; and other provider representatives. Many of the participants had multiple affiliations among the groups listed and represented diverse perspectives. The invitation to stakeholders encouraged discussion of their experiences and views on the most important areas to consider when developing performance goals for the mental health/substance abuse and I/DD systems.**
- 6. The State Consumer Family Advisory Committee (SCFAC), which communicates information to the local Consumer Family Advisory Committee, is a primary means of communicating with consumers. The committee meets bi-monthly and DMA and DMH/DD/SAS provide updates on issues that impact and are of interest to consumers. Details of the waiver amendment and expansion have been discussed on an ongoing basis at these meetings.**
- 7. DMA updates providers on the waiver program through monthly and special Medicaid Bulletins. Special Bulletins on the 1915(b)/(c) waiver expansion**

were published in February, March and April of 2012, and two Special Bulletins dedicated specifically to the 1915(c) transition were published in October of 2012.

8. DMA provides updates on waiver implementation at the Training, Instruction, Development and Education (NC- TIDE) biannual conferences. NC- TIDE is a non-profit organization that supports all stakeholders in the public MH/DD/SA service sector. DMA provided waiver updates at the Spring/Fall 2011 and Spring/Fall 2012 conferences.
9. The county departments of social services assist the State in the local administration of the Medicaid program and are primary contacts for many Medicaid recipients. DMA provides information regularly on the waiver expansion to the DSS through formal written communications. In addition, DMA has a team of Medicaid Program Representatives (MPRs) who consult with and provide technical assistance on program changes to their respective counties on a regular basis.
10. DMA presented an update and training on the waiver program at the 2012 National Association for Social Workers (NASW) and Licensed Professional Counselor (LPC) annual conventions.
11. DMA presented an update and training on the waiver program at the 2012 Annual Providers Council.
12. DMA presents waiver updates quarterly at the Benchmarks Provider Association meetings.
13. DMA provided notice to the public and all stakeholders of the waiver renewal and the opportunity to provide input and suggestions via the DMA website. The notification was posted on August 23, 2012.

Tribal consultation

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

Tribal officials of the Eastern Band of the Cherokee, which is the only federally recognized tribe in NC, were notified of the waiver renewal and the opportunity for input on October 19, 2012 through a formal written notice. No comments have been received as of this date.

Program history

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

In 2001, the North Carolina General Assembly initiated reform of the State's mental health, intellectual and developmental disabilities and substance abuse services (MH/IDD/SAS) delivery system through Session Law 2001-437 resulting in the separation of service management and service delivery. Previously, MH/IDD/SAS county programs and area authorities employed care providers and delivered

services directly. The 2001 legislation required them to divest of direct services provision, contract with other public and private providers for service delivery and change their focus exclusively to system management and oversight. County programs and area authorities' new role was that of a local management entity (LME). The specific responsibilities of LMEs, as laid out in NCGS 122C-115, are as follows:

1. Access for all citizens to core services and administrative functions, including a 24-hour a day, seven-day a week screening, triage, and referral process and a uniform portal of entry into care.
2. Provider monitoring, technical assistance, capacity development, and quality control.
3. Utilization management, utilization review, and determination of the appropriate level and intensity of services.
4. Authorization of the utilization of State psychiatric hospitals and other State facilities.
5. Authorization of eligibility determination requests for recipients under a CAP-MR/DD waiver.
6. Care coordination and quality management.
7. Community collaboration and consumer affairs including a process to protect consumer rights, an appeals process, and support of an effective consumer and family advisory committee.
8. Financial management and accountability for the use of State and local funds and information management for the delivery of publicly funded services.
9. Development of a waiting list of persons with intellectual or developmental disabilities that are waiting for specific services.

As the system transition was occurring, the State, in collaboration with a five-county LME, created a pilot program using 1915(b)/(c) waiver authorities. The pilot program allowed the LME to operate as a prepaid inpatient health plan (PIHP) for Medicaid mental health, intellectual and developmental disabilities and substance abuse services. The pilot program was implemented on April 1, 2005. All Medicaid participants in the eligibility groups covered under the waiver and residing in the LME's catchment area were mandatorily enrolled in the single PIHP on April 1, 2005. The LME, formerly Piedmont Behavioral Healthcare, is now known as Cardinal Innovations Healthcare Solutions (CIHS).

During its first year of operation, it was determined that the waiver program had generated savings through care and utilization management strategies, and the State requested and received approval from CMS in December of 2006 to invest the savings in 1915(b)(3) services for CIHS Medicaid recipients. The (b)(3) service package contains cost-effective, supplemental services and supports aimed at decreasing hospitalizations and helping individuals remain in or return to their homes and communities when preferred and appropriate.

Due to the success of the capitated service delivery model, the State requested and obtained approval from CMS in 2010 to expand the model to other LMEs across the

State over time. NC General Statute 122C was amended through Session Law 2011-264 to require the expansion of the waiver program statewide by July 1, 2013. The statute requires each LME, in order to participate in the waivers, to have a catchment area with a population of at least 300,000 by July 1, 2012 and 500,000 by July 1, 2013. The statute provides for LME mergers and interlocal agreements between LMEs with one LME designated as the lead for waiver operations. All LME/PIHP applicants undergo readiness reviews and successful implementation of any required corrective action plans before being approved for waiver participation.

The State pays the PIHPs per member per month (PMPM) payments, and the PIHPs are responsible for making comprehensive provider networks available to waiver participants, authorizing services, processing and paying claims, and conducting utilization and quality management functions. The PIHPs are at financial risk for all Medicaid mental health, intellectual/developmental disabilities and substance services in both the Medicaid State Plan and the concurrent NC Innovations HCBS waiver for persons with IDD.

Oversight of the concurrent waivers is performed by Intra-Departmental Monitoring Teams (IMT) with representation from all divisions within the DHHS involved in the operation of the 1915(b)/(c) waivers. The IMTs meet monthly or quarterly, depending on the implementation status of the respective PIHP, with DMA leading the teams. The Division of Medical Assistance (DMA), the State Medicaid Agency, retains final decision-making authority on all waiver policies and requirements.

A. Statutory Authority

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

- a. **1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
- b. **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
- c. **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: This can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
- d. **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

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

- MCO
- PIHP

This waiver will require that all PIHPs contract only with assertive community treatment (ACT) providers under the State Plan who have fidelity to the latest TMACT models of care. This will ensure that all providers maintain fidelity to the current fidelity model as it is updated. These services will be phased in and available as outlined under the settlement agreement with the United States Department of Justice.

- PAHP
- PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs

to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)

___ Other (please identify programs)

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

- a. **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. The two separate waiver programs are not available throughout the State.
- b. **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program. **The two separate waiver programs do not offer the same 1915(b)(3) services. The State intends to make the 1915(b)(3) services included in this waiver available in all geographic areas once the waiver is fully rolled-out except where noted for the Cardinal Innovations program which will pilot new services and populations. Depending upon the results of the pilot the State may or may not expand the pilot services to additional areas. The State anticipates that the waiver and the full package of non-pilot 1915(b)(3) services will be rolled out and operating statewide no later than July 1, 2013.**
- c. **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.
- d. **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If State seeks waivers of additional managed care provisions, please list here).
- e. ___ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

B. Delivery systems

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

- a. ___ **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or health insurance organization (HIO). Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.
- b. **PIHP:** Prepaid Inpatient Health Plan means an entity that:
(1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.
- PIHPs are paid on a risk basis.
___ PIHPs are paid on a non-risk basis.

Care will be delivered through capitated PIHPs for MH, IDD and SAS. A 1915(c) waiver, North Carolina Innovations, for the IDD population operates concurrently with this waiver and the PIHPs will deliver these services as well. Therefore, the PIHPs will be at risk for MH/IDD/SAS, including inpatient, clinic option and rehabilitation option services, and HCBS under the concurrent HCBS waiver.

- c. ___ **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of, any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.
- ___ The PAHP is paid on a risk basis.
___ The PAHP is paid on a non-risk basis.
- d. ___ **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

e. ___ **Other:** (Please provide a brief narrative description of the model.)

2. **Procurement.** The State selected the contractor in the following manner (required by 42 CFR Part 74 if contract over \$100,000). Please complete for each type of managed care entity utilized (e.g., procurement for MCO; procurement for PIHP, etc):

___ **Competitive** procurement process (e.g., Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience).

___ **Open** cooperative procurement process (in which any qualifying contractor may participate).

X **Sole source** procurement. CMS Regional Office prior approval required.

Prior approval of sole source procurement is requested based on the following information:

Justification for sole source to capitated PIHP entities

North Carolina General Statute 122C designates the local management entities (LME) as the “locus of coordination” for the provision of all publicly-funded MH/IDD/SA services. The statute was amended in 2011 and 2012 through session laws 2011-264 and 2012-151 to require the delivery of publicly funded services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders through LMEs under the authority of 1915(b)/(c) waivers.

The goal of the State is to have a managed system in which the consumer has access, through a single local entity, to all resource streams that finance MH/IDD/SA services and supports needed by consumers. This entity must bring together multiple policies, programs and payment resources and reconcile differing eligibility requirements in order to achieve optimal outcomes. Consumers with serious mental illness, IDD and addictive disorders need highly specialized assistance, distinctive care management strategies, specialized interventions and highly individualized support arrangements. The coordination of these services requires collaboration and cooperative relationships among many agencies, including public health, social services, housing, education, criminal justice and others. Managing care for these consumers requires a high degree of specificity, organization and integration of the management system, including dedicated programs, transaction-specific facilities and a specialized workforce. There must be a strong, ongoing and collaborative relationship between the purchaser and the providers in order to achieve the necessary investment to support these services at the provider level.

North Carolina’s model is based on the assumption that the MH/IDD/SAS local management entities are the only organizations in North Carolina capable of managing the complex service and support needs of the specialty population at this

time. These entities have been in place for over 30 years and have had the ongoing role of protecting vulnerable populations and supporting full participation and inclusion of these consumers in local communities. This is possible due to the local systems and relationships that they have developed over a long period of time. The infrastructure for managing services and supports for these populations is already in place.

Private managed care organizations with the necessary capacity, essential localized experience and relationships and incumbent public behavioral health expertise are virtually nonexistent in North Carolina. The vast majority of North Carolina's employer-based healthcare purchasers have chosen not to furnish benefits through MCOs. The State and local entities have always held all the financial risk and public accountability for public behavioral health services in North Carolina. In light of the absence of other entities with the requisite capacity and local experience this model is how North Carolina has chosen to meet MH/IDD/SAS system goals. Throughout the waiver renewal period, the State will continue its efforts to identify any other entities that may come to have developed the capacity to 1) coordinate all of the public resources; 2) address the unique characteristics of North Carolina's diverse local communities through collaboration with community-based stakeholders; and 3) be found acceptable by the local community's Consumer and Family Advisory Committee. If such entities are identified, the State will examine whether the compelling justification for a sole source continues to exist in subsequent renewal periods.

C. Choice of MCOs, PIHPs, PAHPs and PCCMs

1. Assurances.

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

X The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

Capitated PIHPs are local management entities (LME) coordinating publicly-funded MH/IDD/SA services. North Carolina General Statute 122C designates LMEs as the "locus of coordination" for the provision of all publicly-funded MH/IDD/SA services in the LME's respective geographic coverage area. Under these circumstances, the State does not believe that making only one plan available in each geographic area of the State will negatively impact recipients' access to care.

On the other hand, the State believes that the capitated PIHPs are in a unique position to bring together the services and supports, both formal and informal, and providers, both professional and paraprofessional, that are needed to meet the complex needs of these populations. The LMEs have decades of experience locating and developing services for consumers with MH/IDD/SAS needs, and over the years, have built strong and collaborative working relationships with the providers of these services. These providers support this initiative and consumers have at least as much choice in individual providers as they had in the non-managed care environment. By delivering, managing and paying for services through this one public entity with the appropriate experience, the State has streamlined and simplified the delivery system, better identified those in need of services as well as their level of need and achieved savings which have been reinvested in the system through 1915(b)(3) services.

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

- Two or more MCOs.
- Two or more primary care providers within one PCCM system.
- A PCCM or one or more MCOs.
- Two or more PIHPs.
- Two or more PAHPs.
- Other (please describe).

Enrollees will have free choice of providers within the PIHP serving their respective geographic area and may change providers as often as desired. If an individual joins the PIHP and is already established with a provider who is not a member of the network, the PIHP will make every effort to arrange for the consumer to continue with the same provider if the consumer so desires. In this case, the provider would be required to meet the same qualifications as other providers in the network. In addition, if an enrollee needs a specialized service that is not available through the network, the PIHP will arrange for the service to be provided outside the network if a qualified provider is available. Finally, except in certain situations, enrollees will be given the choice between at least two providers. Exceptions would involve institutional services or highly-specialized services which are usually available through only one facility or agency in the geographic area. All PIHPs contract only with assertive community treatment (ACT) providers under the State Plan who maintain fidelity to the latest TMACT scale or its successor. This will ensure that all providers maintain fidelity to the current ACT model as it is updated. These services will be phased in and available as outlined under the settlement agreement with the United States Department of Justice.

3. **Rural exception.**

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

D. Geographic Areas Served by the Waiver

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

X Statewide – all counties, zip codes or regions of the State.
The program will be statewide as of April 1, 2013.

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

City/County/Region	Type of program (PCCM, MCO, PIHP or PAHP)	Name of entity (for MCO, PIHP or PAHP)
<p>Cabarrus, Davidson, Rowan, Stanly, Union, Alamance, Caswell, Franklin, Granville, Halifax, Vance, Warren, Orange, Person, and Chatham.</p> <p><u>Note: this PIHP operates a separate program that is distinct from the rest of the state. A waiver of statewideness and comparability are requested for this program.</u></p>	<u>PIHP</u>	<u>Cardinal Innovations Healthcare Solutions operating the Cardinal Innovations program</u>
<p>Effective 1-1-12: Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, and Yancey Counties. Effective 10-1-13, these counties will be under a</p>	<u>PIHP</u>	<u>Western Highlands</u>

City/County/Region	Type of program (PCCM, MCO, PIHP or PAHP)	Name of entity (for MCO, PIHP or PAHP)
management agreement with the Smoky Mountain Center, with a full merger occurring by 7-1-14.		
Effective 4-1-12: Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Gates, Hertford, Hyde, Jones, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrell, and Washington Counties	<u>PIHP</u>	<u>East Carolina Behavioral Health (ECBH)</u>
Effective 7-1-12: Alexander, Allegheny, Ashe, Avery, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, Macon, McDowell, Swain, Watauga and Wilkes Coun Effective 10-1-13: Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, and Yancey Counties will be under a management agreement with the Smoky Mountain Center, with a full merger occurring by 7-1-14.	<u>PIHP</u>	<u>Smoky Mountain Center</u>
Effective 12-1-12: Anson, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, and Richmond Counties. Effective 4-1-13: Guilford	<u>PIHP</u>	<u>Sandhills</u>
Effective 1-1-13: Bladen, Columbus, Duplin, Edgecombe, Greene, Lenoir, Nash, Robeson, Sampson, Scotland, Wayne, and Wilson Counties	<u>PIHP</u>	<u>Eastpointe</u>
Effective 2-1-13: Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Surry, and Yadkin Counties	<u>PIHP</u>	<u>Partners</u>
Effective 2 -1-13: Davie, Forsyth, Rockingham, and	<u>PIHP</u>	<u>Centerpoint</u>

City/County/Region	Type of program (PCCM, MCO, PIHP or PAHP)	Name of entity (for MCO, PIHP or PAHP)
Stokes Counties		
Effective 2-1-13: Durham, Cumberland, Johnston, and Wake Counties	PIHP	<u>Alliance</u>
Effective 3-1-13: Brunswick, New Hanover, Pender, Onslow, and Carteret Counties	<u>PIHP</u>	<u>Coastal Care</u>
Effective 3-1-13: Mecklenburg County	PIHP	<u>MeckLink</u>

E. Populations Included in Waiver

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

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

- X** Mandatory enrollment
 ___ Voluntary enrollment

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

- X** Mandatory enrollment
 ___ Voluntary enrollment

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

- X** Mandatory enrollment
 ___ Voluntary enrollment

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

- X** Mandatory enrollment
 ___ Voluntary enrollment

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

- X** Mandatory enrollment

Voluntary enrollment

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

Mandatory enrollment

Voluntary enrollment

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

Mandatory enrollment

Voluntary enrollment

The following groups are also included:

- **Optional categorically needy families and children and all medically needy individuals**
- **Medicaid for Infants and Children**
- **Special Assistance for the Disabled and Special Assistance for the Aged**
- **Medicaid for Pregnant Women (MPW)**
- **Persons receiving refugee assistance (MRFMN, RRFN, MRFNN)**

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

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

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

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

Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

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

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

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

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

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

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

X **Retroactive eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.

X **Other** – Please define.

- **Qualified Medicare beneficiary groups (MQ-B, E, and Q)**
- **Children ages 0 to 3 years, except that all age groups may participate in the HCBS waiver, “NC Innovations”**
- **Non-qualified aliens or qualified aliens during the five-year ban**

F. Services

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

1. Assurances.

X The State assures CMS that services under the waiver program will comply with the following federal requirements:

- Services will be available in the same amount, duration and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b). **(Not applicable to this BH plan.)**

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to

which the waiver will apply and the State's alternative requirement. (See note below for limitations on requirements that may be waived.)

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114 and 431.51 (Coverage of Services, Emergency Services and Family Planning) as applicable, and these contracts are effective for the period **April 1, 2011, through March 31, 2013 – CIHS; 1/1/12 through December 31, 2013 – Western Highlands; 4/1/2012 through 3/31/2014 – East Carolina Behavioral Health; 7/1/2012 through 6/30/2014 – Smoky Mountain Center; 12/1/2012 through 11/30/2014 - Sandhills**

Note: The contracts referenced above have been executed and submitted to CMS but the State has not received approval.

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

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

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

___ PBH or PAHP does not cover emergency services.

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

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

___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services

- from out-of-network providers
- ___ The State will pay for all family planning services, whether provided by network or out-of-network providers.
- ___ Other (please explain):

Family planning services are not included under the waiver.

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

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

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

5. **Early, Periodic Screening, Diagnosis and Treatment (EPSDT) requirements.**

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

Treatment for MH/IDD/SAS conditions identified in EPSDT screenings will be furnished through the PIHPs. Agencies conducting the screenings will coordinate with the PIHPs and service providers.

6. **1915(b)(3) Services.**

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

1915(b)(3) Services.

These services are in addition to and are not duplicative of other services available under the State Plan, EPSDT, IDEA or Rehabilitation Act of 1973. 1915(b)(3) services will be funded through separate 1915(b)(3) capitation rates certified by the State's actuary. Total expenditures cannot exceed 1915(b)(3) resources available in the waiver.

Service	Populations Eligible	Provider Type	Geographic Eligibility	Reimbursement
<p>Respite consistent with the North Carolina (NC) Innovations 1915(c) waiver program definition and limitations.</p> <p>A maximum of 64 units (16 hours a day) can be provided in a 24-hour period. No more than 1,536 units (384 hours or 24 days) can be provided to an individual in a calendar year unless specific authorization for exceeding this limit is approved.</p>	<p>Children ages 3–21 (not living in a child residential treatment facility (RTF)) and adults who are functionally eligible but not enrolled in the NC Innovations 1915(c) waiver program,</p> <p>OR children ages 3–21 who are not functionally eligible for the NC Innovations waiver program but require continuous supervision due to a mental health (MH) (Axis I or II) diagnosis (CALOCUS level III or greater) or substance abuse (SA) Diagnosis (American Society of Addiction Medicine (ASAM) criteria of II.1 or greater),</p> <p>OR children ages 3–21 and adults with a developmental disability (DD) diagnosis.</p>	<p>Providers must meet all NC Innovations waiver provider requirements and be enrolled 1915(c) waiver providers.</p>	<p>Entire capitated service area.</p>	<p>Separate 1915(b)(3) capitation rates certified by the State's actuary. Total expenditures on Respite cannot exceed 1915(b)(3) resources available in the waiver.</p>

Service	Populations Eligible	Provider Type	Geographic Eligibility	Reimbursement
<p>Supported Employment/Employment Specialist consistent with the NC Innovations 1915(c) waiver program Supported Employment definition and limitations and NC Employment First principles.</p> <p>Supported Employment – initial job development, training and support: a maximum of 86 hours (344 units) per month for the first 90 days; Supported Employment – intermediate training and support: a maximum of 43 hours (172 units) per month for the second 90 days.</p> <p>Long Term Vocational Support: a maximum of 10 hours (40 units) per month.</p> <p>Specific authorization must be obtained to exceed these limits. This includes Supported Employment services provided by employment specialist services in Assertive Community Treatment in fidelity with the Tool for Measurement of ACT (TMACT) model.</p> <p>Total expenditures on Supported Employment/Employment Specialist cannot exceed 1915(b)(3) resources available in the waiver.</p>	<p>Persons age 16 and older with intellectual and/or developmental disabilities, who are not eligible for this service under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142, and who are eligible, but not enrolled in the NC Innovations 1915(c) waiver program OR Individuals with Serious Mental Illness and clinically appropriate for Supported Employment or ACT.</p>	<p>Providers for programs for individuals with intellectual and/or developmental disabilities, must meet all NC Innovations waiver provider requirements and be enrolled 1915(c) waiver providers.</p> <p>Providers for programs for individuals with Serious Mental Illness must meet all fidelity provider requirements as outlined by the State for Evidence-Based Practices for individuals with SMI and participate in approved evidence-based supported employment/ACT programs for individuals with SMI. Supported Employment/Employment Specialists are only provided in EBP programs for SMI and will be approved for fidelity and transitioned into the State in a manner that at least complies with the DOJ settlement.</p>	<p>Entire capitated service area.</p>	<p>Separate 1915(b)(3) capitation rates certified by the State's actuary.</p>
<p>Personal Care/ Individual Support Personal Care under the current NC State Plan emphasizes the need for assistance with Activities of Daily Living (ADLs). Some assistance with Instrumental Activities of Daily Living (IADLs) is</p>	<p>Adults ages 18 and older with a diagnosis of SPMI and a LOCUS level of II or greater for Persons between the ages of 18 and 21 may not live in a Medicaid-funded</p>	<p>Paraprofessional staff employed by the contracted provider and supervised by that provider's appropriate qualified professional. The paraprofessional must have a high school degree and two years of experience working with</p>	<p>Adults with SPMI and LOCUS level of II or greater for entire capitated service area.</p>	<p>Separate 1915(b)(3) capitation rates certified by the State's actuary. Total expenditures on Personal Care/Individual Support cannot</p>

Service	Populations Eligible	Provider Type	Geographic Eligibility	Reimbursement
<p>covered, but only to the extent linked to ADLs. This service (Personal Care/Individual Support) is coverable under the State Plan, but NC has not included in its approved State Plan.</p> <p>Personal Care (Individual Support) is not covered under the NC Innovations waiver and is a “hands-on” service for persons with Serious and persistent mental illness (SPMI), a population that is not covered under the NC Innovations waiver. The intent of the service is to teach and assist individuals in carrying out IADLs, such as preparing meals, managing medicines, grocery shopping and managing money, so they can live independently in the community. We envision that the need for the service will “fade” or decrease over time as the individual becomes capable of performing some of these activities more independently.</p> <p>Units are provided in 15-minute increments. No more than 240 units per month (60 hours per month) of Individual Support may be provided unless specific authorization for exceeding this limit is approved.</p>	<p>child RTF.</p>	<p>adults with mental illness.</p> <p>A minimum of 20 hours of initial training will be required.</p>		<p>exceed 1915(b)(3) resources available in the waiver.</p>

Service	Populations Eligible	Provider Type	Geographic Eligibility	Reimbursement
<p>One-time Transitional costs consistent with the NC Innovations 1915(c) waiver program community Transition services definition and limitations.</p>	<p>Adults who are functionally eligible, but not enrolled in the NC Innovations 1915(c) waiver program; OR individuals in the special population receiving treatment planning who have Serious and Persistent Mental Illness (SPMI) who reside in an Adult Care Home determined to be an Institution for Mental Disease; individuals with SPMI transitioning from Adult Care Homes and State Psychiatric Institutions; and individuals diverted from entry into Adult Care Homes due to preadmission screening and diversion.</p> <p>The plan may choose to provide to other populations under 42 CFR 438.6(e) if cost-effective alternatives to State Plan services.</p> <p>Per the May 9, 2002 SMDL #02-008, the individual must be moving out of a licensed facility, their family home, hospital or institution into his or her own home.</p>	<p>Providers must meet all NC Innovations waiver provider requirements and be enrolled 1915(c) waiver providers.</p>	<p>Entire capitated service area.</p>	<p>Separate 1915(b)(3) capitation rates certified by the State's actuary. Transitional costs cannot exceed 1915(b)(3) resources available in the waiver.</p>
<p>Psychosocial Rehabilitation/Peer Supports This service (Psychosocial Rehabilitation/Peer Supports) is coverable under the State Plan, but</p>	<p>Adults ages 18 and older with identified needs in life skills, who: (1) Have an Axis I or II diagnosis present; and</p>	<p>NC certified Peer Support specialists and paraprofessionals, who: (1) Possess a high school degree or GED equivalent; and (2) Are supervised by a</p>	<p>Entire capitated service area</p>	<p>Separate 1915(b)(3) capitation rates certified by the State's actuary. Psychosocial Rehabilitation/</p>

Service	Populations Eligible	Provider Type	Geographic Eligibility	Reimbursement
<p>NC has not included in its approved State Plan. This service has been found to be more cost-effective than Community Supports and is a Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based practice.</p> <p>Peer Support services are structured and scheduled activities for adults age 18 and older with MH/SA disability. Peer Supports are provided by Peer Support staff. Peer Support service is an individualized, recovery-focused service that allows individuals the opportunity to learn to manage their own recovery and advocacy process. Interventions of Peer Support staff serve to enhance the development of natural supports, coping and self management skills, developing of skills for housing, employment, and full community integration.</p> <p>Authorizations will be made as follows:</p> <ul style="list-style-type: none"> • Initial authorization – First 90 days (or when a person is experiencing a period of instability): no more than 20 hours per week individual and/or group. • Step down to sustaining support – After first 90 days and up to subsequent 90-days no more than 15 hours per week except when necessary to address short-term problems/issues. • Intermittent support – After 180 days, no more than 10 hours per week 	<p>(2) Meet LOC criteria for LOCUS Level I or ASAM I.</p> <p>OR individuals in the special population receiving treatment planning who have Serious and Persistent Mental Illness (SPMI) who reside in an Adult Care Home determined to be an Institution for Mental Disease; individuals with SPMI transitioning from Adult Care Homes and State Psychiatric Institutions; and individuals diverted from entry into Adult Care Homes due to preadmission screening and diversion.</p> <p>Persons ages 18–21 may not live in a child RTF.</p>	<p>qualified professional according to 10A NXCAC 27G .0204; and</p> <p>(3) Are not a member of the family of the person receiving Peer Support services.</p> <p>Paraprofessional level providers must meet requirements in 10 NCAC 27G 0104.</p>		<p>Peer Supports cannot exceed 1915(b)(3) resources available in the waiver.</p>

Service	Populations Eligible	Provider Type	Geographic Eligibility	Reimbursement
<p>of individual and/or group.</p> <p>A maximum of 20 units of Peer Support services individual and/or group can be provided in a 24-hour period by any one peer support staff. No more than 80 units per week of services can be provided to an individual. If medical necessity dictates the need for more service hours, consideration should be given to interventions with a more intense clinical component; additional units may be authorized as clinically appropriate.</p>				
<p>NC Innovations Waiver Services – consistent with the NC Innovations 1915(c) waiver program services definition and limitations.</p>	<p>Children ages 3-21 (not living in a child RTF) and adults who are functionally eligible, but not enrolled in the NC Innovations 1915(c) waiver program:</p> <ul style="list-style-type: none"> • Exiting Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MRs). 	<p>Providers must meet all NC Innovations waiver provider requirements and be enrolled 1915(c) waiver providers.</p>	<p>Entire capitated service area.</p>	<p>Separate 1915(b)(3) capitation rates certified by the State's actuary. Total expenditures cannot exceed 1915(b)(3) resources available in the waiver.</p>

Service	Populations Eligible	Provider Type	Geographic Eligibility	Reimbursement
<p>Physician Consultation Communication between a primary care provider and a psychiatrist for a patient-specific consultation that is medically necessary for the medical management of psychiatric conditions by the primary care provider. This service is coverable under the State Plan under physician services.</p> <p>Brief: Simple or brief communication to report tests and/or lab results, clarify or alter previous instructions, integration new information into the medical treatment plan or adjust therapy or medication regimen.</p> <p>Intermediate: Intermediate level of communication between the psychiatrist and the primary care provider. Does not require face-to-face assessment of patient. To coordinate medical management of a new problem in an established patient, evaluate new information and details and/or initiate a new plan of care, therapy or medication regime.</p> <p>Extensive: Complex or lengthy communication, such as a prolonged discussion between the psychiatrist and the primary care provider regarding a seriously ill patient, lengthy communication needed to consider lab results, response to treatment, current symptoms or presenting problem. Staffing of case between psychiatrist and primary care provider to consider</p>	<p>Must be under the care of a primary care provider, and requires a consultation between a psychiatrist and their primary care practitioner for appropriate medical or MH treatment</p> <p>Adults ages 18 and older with Serious Mental Illness and a Locus level of 0 (basic level).</p> <p>Children ages 3–21 with serious emotional disturbance (SED) and a CALOCUS level of 0 (basic level).</p>	<p>Primary care provider or board certified in adult or child psychiatry and holds a current license in the state of NC.</p>	<p>Entire capitated service area.</p>	<p>Separate 1915(b)(3) capitation rates certified by the State's actuary. Total expenditures cannot exceed 1915(b)(3) resources available in the waiver.</p>

Service	Populations Eligible	Provider Type	Geographic Eligibility	Reimbursement
evaluation findings and discuss treatment recommendations, including medication regimen.				
<p>Community Guide Consistent with the NC MH/DD/SA 1915(c) waiver program Community Guide definition and limitations, as described below.</p> <p>Community Guide Services provide support to participants and planning teams that assist participants in developing social networks and connections within local communities. The purpose of this service is to promote self-determination, increase independence and enhance the participant's ability to interact with and contribute to his or her local community. Community Guide services emphasize, promote and coordinate the use of natural and generic supports (unpaid) to address the participant's needs in addition to paid services. These services also support participants, representatives, employers and managing employers who direct their own waiver services by providing direct assistance in their participant direction responsibilities. Community Guide services are intermittent and fade as community connections develop and skills increase in participant direction; however, a formal fading plan is not required. Community guides assist and support (rather than direct and manage) the participant throughout the service delivery process.</p>	Children ages 3–21 and adults who are functionally eligible, but not enrolled in the NC Innovations 1915(c) waiver program.	<p>Providers must meet all NC Innovations waiver provider requirements, as outlined below, and enrolled in the 1915(c) waiver:</p> <p>Community Guide from provider agencies in a non-self directed arrangement must meet the following requirements:</p> <ul style="list-style-type: none"> • Approved as a provider in PIHP provider network • Are at least 18 years old • If providing transportation, have a valid NC or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background check presents no health or safety risk to participant • Not listed in the NC Health Care Abuse Registry • Staff that work with participants must be qualified in CPR and first aid • Staff that work with participants must have a high school diploma or GED • Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP • Paraprofessionals 	Entire capitated service area	Separate 1915(b)(3) capitation rates certified by the State's actuary. Total expenditures cannot exceed 1915(b)(3) resources available in the waiver.

Service	Populations Eligible	Provider Type	Geographic Eligibility	Reimbursement
<p>Community Guide services are intended to enhance, not replace, existing natural and community resources. Specific functions are:</p> <p>(1) Assistance in forming and sustaining a full range of relationships with natural and community supports that allows the participant meaningful community integration and inclusion</p> <p>(2) Support to develop social networks with community organizations to increase the participant's opportunity to expand valued social relationships and build connections within the participant's local community</p> <p>(3) Assistance in locating and accessing non-Medicaid community supports and resources that are related to achieving Individual Support Plan (ISP) goals; this includes social and educational resources, as well as natural supports</p> <p>(4) Instruction and counseling, which guides the participant in problem solving and decision making</p> <p>(5) Advocacy and collaborating with other individuals and organizations on behalf of the participant</p> <p>(6) Supporting the person in preparing, participating in and implementing plans of any type (Individual Education plan (IEP), ISP or service plan)</p> <p>(7) Provide training on the Individual and Family Directed Supports option, if the participant is considering directing services and supports</p> <p>(8) Guidance with</p>		<p>providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.</p> <ul style="list-style-type: none"> • Must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of PBH. This includes national accreditation within the prescribed timeframe • Meets community guide competencies specified by the PIHP • Must meet applicable requirements of NC G.S. 122C (the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985) <p>Community Guide from provider agencies in a self directed arrangement must meet the following requirements:</p> <ul style="list-style-type: none"> • Recommended by managing employer and approved by Agency with Choice • At least 18 years old • Able to effectively read, write and 		

Service	Populations Eligible	Provider Type	Geographic Eligibility	Reimbursement
<p>management of the participant directed budget</p> <p>(9) Providing information on recruiting, hiring, managing, training, evaluating and changing support staff, if the participant is self-directing services</p> <p>(10) Assisting with the development of schedules and outlining staff duties, if the participant is self-directing services</p> <p>(11) Assisting with understanding staff financial forms, qualifications and record keeping requirements, if the participant is self-directing services</p> <p>(12) Providing ongoing information to assure that participants and their families/representatives understand the responsibilities involved with self-direction, including reporting on expenditures and other relevant information and training</p> <p>(13) Coordinating services with the Agency with Choice if the participant is directing services under the Agency with Choice model</p> <p>(14) Informing and coordinating community resources including coordination among, primary, preventative and chronic care providers</p> <p>This service does not duplicate Care Coordination. Care Coordination under managed care includes assisting the participant in the development of the ISP, completing or gathering evaluations inclusive of the</p>		<p>communicate verbally in English, understand instructions and perform record keeping</p> <ul style="list-style-type: none"> • If providing transportation, have a valid NC driver's license, a safe driving record and an acceptable level of automobile liability insurance • Criminal background checks present no health or safety risk to participant • Not listed in the NC Health Care Abuse Registry • Qualified in CPR and First Aid and the customized needs of the participant as described in the individual service plan (ISP) • High school diploma or equivalency and supervised by the managing employer • Clinical oversight by a qualified professional or associate professional under the supervision of a qualified professional in the field of developmental disabilities employed by Agency with Choice • Meets community guide competencies as specified by the PIHP • Must meet applicable requirements of NC G.S. 122C (the MH/DD/SA Act of 1985) <p>Community Guide services cannot be</p>		

Service	Populations Eligible	Provider Type	Geographic Eligibility	Reimbursement
<p>re-evaluation of the level of care, monitoring the implementation of the ISP, choosing service providers, coordination of benefits and monitoring the health and safety of the participant consistent with 42 CFR 438.208(c).</p> <p>The amount of Community Guide services is subject to the amount of the participant's Support Need Matrix Category Budget, as specified in Appendix C-4.</p>		<p>provided by a legally responsible person or a relative or legal guardian.</p>		
<p>In-home Skill Building – This is a short term, intensive Hhabilitation service to remediate one or more documented functional deficits. Individuals will receive a comprehensive assessment to identify areas of functional deficit. Treatment will focus on one or more specific areas, with the primary focus being positive behavior support. Family members will be coached in intervention strategies. Outcome data will be gathered at the conclusion of the intervention and used to measure the efficacy. Services are provided in the person's private home or community.</p>	<p>Individuals with intellectual developmental disability (IDD) diagnoses having three or more functional deficits and needing behavioral support and significant habilitation needs as documented through a functional assessment.</p>	<p>Staff will be trained in the College of Direct Support curriculum and will be professional level.</p>	<p>In the Cardinal Innovations program only</p>	<p>Separate 1915(b)(3) capitation rates certified by the State's actuary. Total expenditures cannot exceed 1915(b)(3) resources available in the waiver.</p>
<p>Transitional Living Skills services are designed to assist children who are or will be transitioning to adulthood with support in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to be successful in the domains of employment, housing, education and community</p>	<p>Children under the age of 21 with an Axis 1 diagnosis and at least one deficit in an IADL and:</p> <ul style="list-style-type: none"> • A CALOCUS Level 1 or greater; or • A LOCUS Level 1 or greater; or • ASAM level 1 or greater 	<p>Staff are highly trained and receive weekly individual and field supervision. Each staff person must:</p> <ul style="list-style-type: none"> • Have a high school diploma or equivalent • Be 21 years of age and have a minimum of two years experience working with children with SED or be 	<p>In the Cardinal Innovations program only.</p>	<p>Separate 1915(b)(3) capitation rates certified by the State's actuary. Total expenditures cannot exceed 1915(b)(3) resources available in the waiver.</p>

Service	Populations Eligible	Provider Type	Geographic Eligibility	Reimbursement
<p>life and to reside successfully in home and community settings. Transitional Living Skills activities are provided in partnership with youth to help the youth arrange for the services they need to become employed, access transportation, housing and continuing education. Services are individualized according to each youth's strengths, interests, skills, goals and are included on an individualized transition plan (i.e. Waiver Plan of Care). It is expected that Transition Living Skills activities take place in the community on an individual basis because the diagnoses of the children make this service inappropriate in a group setting. This service can be utilized to train and cue normal activities of daily living and instrumental activities of daily living. Housekeeping, homemaking (shopping, child care and laundry services), or basic services solely for the convenience of a child receiving Transitional Living Skills building are non-covered.</p>		<p>equivalently qualified by education in the human services field or a combination of work experience and education with one year of education substituting for one year of experience;</p> <ul style="list-style-type: none"> • Pass criminal and professional background checks and motor vehicle screens. • Have completed an approved training in the skills area(s) need by the transitioning youth according to a curriculum 		
<p>Intensive Recovery Support This service provides an array of supports to women with children returning from substance use addiction treatment programs to continue their recovery. The purpose of the service is to assist the individual with the substance use addiction to increase their functioning so they are successful and satisfied in the environment of their choice with the</p>	<p>Women with children that are discharged from SA treatment programs</p>	<p>Individuals meeting the Qualified Professional requirements found in 10A NCAC 27G .0104</p>	<p>In the Cardinal Innovations program only</p>	<p>Separate 1915(b)(3) capitation rates certified by the State's actuary. Total expenditures cannot exceed 1915(b)(3) resources available in the waiver.</p>

Service	Populations Eligible	Provider Type	Geographic Eligibility	Reimbursement
least amount of professional intervention. The supports will include skills training, social skills training to develop positive relationships and stronger support networks, communication, self-advocacy, informed choice, community integration , pre-employment readiness, recovery education and change readiness.				

7. **Self-referrals.**

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

- **Basic benefits (outpatient) – Eight visits per year for adults, 16 visits per year for children**
- **Medically managed detoxification (16 hours/episode)**
- **Mobile crisis – Eight hours per event**
- **Diagnostic assessments – Two per year for adults and children**
- **Evaluation and management (E&M) visits by psychiatric providers - 22 visits per year without PA; no PA required for individuals with SPMI**
- **Facility-based crisis – 16 hours per episode**

Section A: Program Description

Part II: Access

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

A. Timely Access Standards

1. Assurances for MCO, PIHP or PAHP programs.

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

____ The State seeks a waiver a waiver of section 1902(a)(4) of the Act, to waive compliance with of one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply and the State's alternative requirement.

X The CMS Regional Office has reviewed and approved the MCO, PIHP or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206, Availability of Services, and these contracts are effective for the period April 1, 2009, to March 31, 2011.

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

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses to assure timely access to services.

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

1. ____ PCPs (please describe):

2. ____ Specialists (please describe):

3. ____ Ancillary providers (please describe):

4. ___ Dental (please describe):
5. ___ Hospitals (please describe):
6. ___ Mental Health (please describe):
7. ___ Pharmacies (please describe):
8. ___ Substance Abuse Treatment Providers (please describe):
9. ___ Other providers (please describe):

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

1. ___ PCPs (please describe):
2. ___ Specialists (please describe):
3. ___ Ancillary providers (please describe):
4. ___ Dental (please describe):
5. ___ Mental Health (please describe):
6. ___ Substance Abuse Treatment Providers (please describe):
7. ___ Urgent care (please describe):
8. ___ Other providers (please describe):

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

1. ___ PCPs (please describe):
2. ___ Specialists (please describe):
3. ___ Ancillary providers (please describe):
4. ___ Dental (please describe):

- 5. ___ Mental Health (please describe):
- 6. ___ Substance Abuse Treatment Providers (please describe):
- 7. ___ Other providers (please describe):

- d. ___ **Other Access Standards** (please describe)

B. Capacity Standards

1. Assurances for MCO, PIHP, or PAHP programs.

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

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

X The CMS Regional Office has reviewed and approved the MCO, PIHP or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services and these contracts are effective for the period April 1, 2009, to March 31, 2011.

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

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

a. ___ The State has set **enrollment limits** for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.

b. ___ The State ensures that there are adequate numbers of PCCM PCPs with **open panels**. Please describe the State's standard.

c. ___ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.

d. ___ The State **compares numbers of providers** before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal
Pediatricians			
Family Practitioners			
Internists			
General Practitioners			
OB/GYN and GYN			
FQHCs			
RHCs			
Nurse Practitioners			
Nurse Midwives			
Indian Health Service Clinics			
Additional Types of Provider to be in PCCM			
1.			
2.			
3.			
4.			

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

- e. ___ The State ensures adequate **geographic distribution** of PCCMs. Please describe the State's standard.
- f. ___ **PCP: Enrollee Ratio.** The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a Statewide average. Please note any changes that will occur due to the use of physician extenders.

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

<i>Statewide Average: (e.g. 1:500 and 1:1,000)</i>	

g. ____ **Other capacity standards** (please describe):

C. Coordination and Continuity of Care Standards

1. Assurances For MCO, PIHP, or PAHP programs.

- X The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208, Coordination and Continuity of Care, in so far as these regulations are applicable.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply and the State's alternative requirement.

- X The CMS Regional Office has reviewed and approved the MCO, PIHP or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208, Coordination and Continuity of Care, and these contracts are effective for the period April 1, 2009, to March 31, 2011.

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

The following items are required.

- a. The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that PBH/PAHP **need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.
 - b. X **Identification.** The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.
- **In order to identify enrollees with special needs, each PIHP is required to identify clients who meet the following criteria:**
 - **Adults who are Seriously Persistently Mentally Ill**
 - **Children who are Severely Emotionally Disturbed**
 - **Individuals with Intellectual Developmental Disability (IDD) who are functionally eligible for ICF-MR**
 - **Female Temporary Assistance for Needy Families recipients with SA dependency diagnoses**
 - **Individuals with co-occurring diagnoses**
 - **Individuals who are IV drug or opiate users**

- Individuals who are transitioning to a home or community based residential setting per the DOJ settlement meeting the following criteria:
 - Individuals with SMI who reside in an adult care home determined by the State to be an Institution for Mental Disease (“IMD”);
 - Individuals with SPMI who are residing in adult care homes licensed for at least 50 beds and in which 25% or more of the resident population has a mental illness;
 - Individuals with SPMI who are residing in adult care homes licensed for between 20 and 49 beds and in which 40% or more of the resident population has a mental illness;
 - Individuals with SPMI who are or will be discharged from a State psychiatric hospital and who are homeless or have unstable housing; and
 - Individuals diverted from entry into adult care homes pursuant to the preadmission screening and diversion provisions under the State’s DOJ settlement.

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

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

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

1. **X** Developed by enrollees’ primary care provider with enrollee participation, and in consultation with any specialists’ care for the enrollee.
2. **X** Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan).
3. **X** In accord with any applicable State quality assurance and utilization review standards.

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

3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees.

N/A

- a. ___ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.
- b. ___ Each enrollee selects or is assigned to a **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.
- c. ___ Each enrollee is receives **health education/promotion** information. Please explain.
- d. ___ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
- e. ___ There is appropriate and confidential **exchange of information** among providers.
- f. ___ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
- g. ___ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
- h. ___ **Additional case management** is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).
- i. ___ **Referrals:** Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs.

- X The State assures CMS that it complies with section 1932(c)(1)(A)(iii) – (iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240 and 438.242, in so far as these regulations are applicable.
- _____ The State seeks a waiver of section 1902(a)(4) of the Act to waive one of more of these regulatory requirements for its PIHP program. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State’s alternative requirement.
- X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114 and 431.51 (Coverage of Services, Emergency Services and Family Planning) as applicable, and these contracts are effective for the period **April 1, 2011, through March 31, 2013 – CIHS; 1/1/12 through December 31, 2013 – Western Highlands; 4/1/2012 through 3/31/2014 – East Carolina Behavioral Health; 7/1/2012 through 6/30/2014 – Smoky Mountain Center; 12/1/2012 through 11/30/2014 - Sandhills**
Note: The contracts referenced above have been executed and submitted to CMS but the State has not received approval.
- X Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this **quality strategy** was submitted to the CMS Regional Office on **the date of submission of this waiver request.**
- X The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** (EQR) of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary).

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

The State puts contracts out for bid every two years with an option to extend for an additional year (maximum duration 3 years). CCME currently has the EQR contract which has been amended to include the new PIHPs.

2. Assurances For PAHP program.

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

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one of more of these regulatory requirements for its PAHP program. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State’s alternative requirement.

___ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, and these contracts are effective for the period ___ to ___.

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

N/A

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

b. ___ **State Intervention:** If a problem is identified regarding the quality of services received, the State will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.

1. ___ Provide education and informal mailings to beneficiaries and PCCMs;

2. ___ Initiate telephone and/or mail inquiries and follow-up;

3. ___ Request PCCM's response to identified problems;

4. ___ Refer to program staff for further investigation;

5. ___ Send warning letters to PCCMs;

6. ___ Refer to State's medical staff for investigation;

7. ___ Institute corrective action plans and follow-up;

8. ___ Change an enrollee's PCCM;

9. ___ Institute a restriction on the types of enrollees;

10. ___ Further limit the number of assignments;

11. ___ Ban new assignments;

12. ___ Transfer some or all assignments to different PCCMs;

13. ___ Suspend or terminate PCCM agreement;

14. ___ Suspend or terminate as Medicaid providers; and

15. ___ Other (explain):

c. ___ **Selection and Retention of Providers:** This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ___ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).

2. ___ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

3. ___ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
 - A. ___ Initial credentialing

 - B. ___ Performance measures, including those obtained through the following (check all that apply):
 - ___ The utilization management system.
 - ___ The complaint and appeals system.
 - ___ Enrollee surveys.
 - ___ Other (Please describe).

4. ___ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

5. ___ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6. ___ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. ___ Other (please describe).

- d. ___ **Other quality standards** (please describe):

Section A: Program Description

Part IV: Program Operations

A. Marketing

Marketing includes indirect MCO/PIHP/PAHP or PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

1. Assurances

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

_____ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities and these contracts are effective for the period **April 1, 2011, through March 31, 2013 – CIHS; 1/1/12 through December 31, 2013 – Western Highlands; 4/1/2012 through 3/31/2014 – East Carolina Behavioral Health; 7/1/2012 through 6/30/2014 – Smoky Mountain Center; 12/1/2012 through 11/30/2014 - Sandhills**
Note: The contracts referenced above have been executed and submitted to CMS but the State has not received approval.

2. Details

a. **Scope of Marketing**

1. X The State does not permit direct or indirect MCO/PIHP/PAHP or PCCM marketing.
2. _____ The State permits indirect MCO/PIHP/PAHP or PCCM marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.
3. _____ The State permits direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

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

1. ___ The State prohibits or limits MCOs/PIHPs/PAHPs from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.
2. ___ The State permits MCOs/PIHPs/PAHPs and PCCMs to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:
3. X The State requires MCO/PIHP/PAHP and PCCM to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

Spanish

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

- i. X The languages comprise all prevalent languages in the MCO/PIHP/PAHP/PCCM service area. Please describe the methodology for determining prevalent languages.

All written materials, including marketing materials, given to recipients by the LME must be translated into “prevalent” languages. Any language that is the primary language of 5% or more of the population is considered prevalent.

- ii. ___ The languages comprise all languages in the MCO/PIHP/PAHP/PCCM service area spoken by approximately ___ percent or more of the population.
- iii. ___ Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. Assurances.

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

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one of more of these regulatory requirements for PIHPs and PAHPs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply and the State's alternative requirement.

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10, Information requirements, and these contracts are effective for the period **April 1, 2011, through March 31, 2013 – CIHS; 1/1/12 through December 31, 2013 – Western Highlands; 4/1/2012 through 3/31/2014 – East Carolina Behavioral Health; 7/1/2012 through 6/30/2014 – Smoky Mountain Center; 12/1/2012 through 11/30/2014 - Sandhills**
Note: The contracts referenced above have been executed and submitted to CMS but the State has not received approval.

2. Details.

a. Non-English Languages

Potential enrollee and enrollee materials will be translated into the **prevalent non-English languages** listed below. (If the State does not require written materials to be translated, please explain.)

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

1. ___ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."
2. The languages spoken by approximately **five** percent or more of the potential enrollee/ enrollee population.
3. ___ Other (please explain).

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

The PIHPs make available to participants with limited English proficiency (LEP) and their legally responsible representative's materials that are translated into the prevalent non-English languages of the State. The PIHPs make interpreter services available to individuals with LEP through a contracts with telephone language lines and/or contracts with individual providers in the community. The PIHPs comply with the DHHS Title VI Language Access Policy.

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

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

X The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe. **(Please see the discussion below in item b regarding “enrollees” and “potential enrollees.”)**

At the time of approval of the Medicaid eligibility application, DMA shall send new eligibles written information explaining how to access services from the PIHPs. Information on the services and benefits provided by the PIHPs and PIHP contact information shall be included. This includes information to understand the capitated PIHP programs. The notices contain basic information regarding the provision of all MH/IDD/SAS through the PIHPs, the process for accessing services, including emergency services and contact information including access sites and telephone numbers.

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

- State
- contractor (please specify) _____

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

c. Enrollee Information

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

- (i) the State
- (ii) State contractor (please specify): _____
- (ii) X the MCO/PIHP/PAHP/PCCM

The PIHPs shall provide each new enrollee, within 14 days, written information on the Medicaid waiver program. Written information must be available in the prevalent non-English languages found in the capitated catchment area. All new enrollee material must be approved by DMA prior to its release, and shall include information specified in the contract between DMA and the PIHPs..

C. Enrollment and Disenrollment

1. Assurances.

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

X The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply and the State's alternative requirement. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C.)

Capitated PIHPs are local management entities coordinating publicly-funded MH/IDD/SA services for over 30 years. The North Carolina General Assembly, in Session Law 2001-437, designated the local area authorities as the "locus of coordination" for the provision of all publicly-funded MH/DD/SA services. Under these circumstances, the State does not believe that waiving disenrollment will negatively impact recipients' access to care because there is no other MH/IDD/SAS system in the service area to deliver these services outside of the PIHP.

As noted earlier, the State believes that the capitated PIHPs are in a unique position to bring together the services and supports, both formal and informal, and providers, both professional and paraprofessional, that are needed to meet the complex needs of these populations. The LMEs have decades of experience locating and developing services for consumers with MH/IDD/SAS needs, and over the years, have built strong and collaborative working relationships with the providers of these services. These providers support this initiative and consumers have at least as much choice in individual providers as they had in the pre-reform non-managed care environment. By delivering, managing and paying for services through this one public entity with the appropriate experience, the State has streamlined and simplified the delivery system; better identified those in need of services as well as their level of need; and achieved a savings which LMEs, as public entities, have reinvested in the system. Private MCOs with this type of experience and relationships with local human service agencies and facilities are largely nonexistent in North Carolina.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56, Disenrollment requirements, and these contracts are effective for the period **April 1, 2011, through March 31, 2013 – CIHS; 1/1/12 through**

December 31, 2013 – Western Highlands; 4/1/2012 through 3/31/2014 – East Carolina Behavioral Health; 7/1/2012 through 6/30/2014 – Smoky Mountain Center; 12/1/2012 through 11/30/2014 - Sandhills

Note: The contracts referenced above have been executed and submitted to CMS but the State has not received approval.

2. **Details.** Please describe the State’s enrollment process for MCOs/PIHPs/PAHPs and PCCMs by checking the applicable items below.

- a. **Outreach.** The State conducts outreach to inform potential enrollees, providers and other interested parties of the managed care program. Please describe the outreach process and specify any special efforts made to reach and provide information to special populations included in the waiver program:
- **The State officially notifies all potential enrollees by sending written communication to each Medicaid participant enrolled in Medicaid in one of the counties participating in the waiver.**
 - **The State Medicaid agency notifies providers prior to program implementation and periodically thereafter through Medicaid Bulletins.**
 - **Consumers with questions on eligibility and enrollment directed to a toll free number for the capitated PIHP member services unit. The unit provides information and referral for benefits assessment as needed.**

b. **Administration of Enrollment Process.**

State staff conducts the enrollment process.

Since this waiver program is for a single capitated PIHP in each catchment area, the State uses its Medicaid Eligibility Information System to identify and enroll persons covered by the waiver.

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

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

Broker name: _____

Please list the functions that the contractor will perform:

___ choice counseling

___ enrollment

___ other (please describe):

___ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.

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

___ This is a **new** program. Please describe the **implementation schedule** (e.g. implemented Statewide all at once; phased in by area; phased in by population, etc.):

This is an existing program that will be **expanded** during the renewal period. Please describe the **implementation schedule** (e.g. new population implemented Statewide all at once; phased in by area; phased in by population, etc.)

The waiver is being modified to expand the waiver statewide and phase in geographic areas of the state according to the schedule provided in the face sheet and in section A1.d of this application.

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

N/A

- i. ___ Potential enrollees will have ___ days/month(s) to choose a plan.
- ii. ___ Please describe the auto-assignment process and/or algorithm. In the description, please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

The State **automatically enrolls** beneficiaries

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

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

___ on a voluntary basis into a single MCO, PIHP, or PAHP, and beneficiaries can opt out at any time. Please specify geographic areas where this occurs: _____

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

___ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

The State does not exempt any enrollees from enrolling in the plan. All Medicaid MH/IDD/SA services are provided through the PIHP to Medicaid enrollees in all areas participating in the waiver.

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

d. Disenrollment:

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

i. Enrollee submits request to State.

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

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

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

N/A The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of ____ months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c). Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

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

N/A The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees. Please check items below that apply:

i. MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:

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

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

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

D. Enrollee rights.

1. Assurances.

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

_____ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State's alternative requirement.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections, and these contracts are effective for the period **April 1, 2011, through March 31, 2013 – CIHS; 1/1/12 through December 31, 2013 – Western Highlands; 4/1/2012 through 3/31/2014 – East Carolina Behavioral Health; 7/1/2012 through 6/30/2014 – Smoky Mountain Center; 12/1/2012 through 11/30/2014 - Sandhills**
Note: The contracts referenced above have been executed and submitted to CMS but the State has not received approval.

X The State assures CMS it will satisfy all Health Insurance Portability and Accountability Act (HIPAA) privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

E. Grievance System

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

- a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
- b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
- c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

Please describe any special processes that the State has for persons with special needs.

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

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

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHPs. Please identify each regulatory requirement waived and the State's alternative requirement.

The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438, Subpart F, Grievance System, and these contracts are effective for the period April 1, 2009, to March 31, 2011.

3. **Details for MCO or PIHP programs.**

a. **Direct access to a State Fair Hearing.**

The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a State Fair Hearing.

The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a State Fair Hearing.

b. **Time frames**

The State's time frame within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is **30** days (between 20 and 90).

Note: The enrollee, or provider on behalf of an enrollee, has 30 days to request an appeal with the PIHP; if the PIHP upholds its original decision, the enrollee, or provider on behalf of an enrollee, has 30 days from the date of the PIHP's notice to the enrollee to file an appeal with the state.

The State's timeframe within which an enrollee must file a **grievance** is **90** days (may not exceed 90).

N/A 4. **Optional grievance systems for PCCM and PAHP programs.** States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the Fair Hearing Process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom, to make a request for a State Fair Hearing or a PCCM or PAHP enrollee's direct access to a State Fair Hearing in instances involving terminations, reductions and suspensions of already authorized Medicaid-covered services.

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

___ The grievance procedure is operated by:

___ the State

___ the State's contractor. Please identify: _____

___ the PCCM

___ the PAHP.

___ Please provide definitions the State employs for the PCCM and/or PAHP grievance system (e.g. grievance, appeals)

___ Has a grievance committee or staff who review and resolve grievances. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.

___ Reviews requests for reconsideration of initial decisions not to provide or pay for a service.

___ Specifies a time frame from the date of action for the enrollee to file a grievance, which is: _____

___ Has time frames for staff to resolve grievances for PCCM/PAHP grievances. Specify the time period set: _____

- ___ Establishes and maintains an expedited grievance review process for the following reasons:_____. Specify the time frame set by the State for this process_____
- ___ Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the grievance.
- ___ Notifies the enrollee in writing of the grievance decision and further opportunities for appeal, as well as the procedures available to challenge or appeal the decision.
- ___ Other (please explain):

F. Program Integrity

1. Assurances.

- The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610, Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:
- (1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
 - (2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.
- The prohibited relationships are:
- (1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
 - (2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;
 - (3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.
- The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:
- 1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
 - 2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
 - 3) Employs or contracts directly or indirectly with an individual or entity that is
 - a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
 - b. could be excluded under 1128(b)(8) as being controlled by a sanctioned individual.

2. Assurances For MCO or PIHP programs

- The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608, Program Integrity Requirements, in so far as these regulations are applicable.
- State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604,

Data that must be Certified, and 42 CFR 438.606 Source, Content, and Timing of Certification.

— The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for MCOs or PIHPs. Please identify each regulatory requirement waived and the State's alternative requirement.

X The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604, Data that must be Certified; 438.606, Source, Content, Timing of Certification; and 438.608, Program Integrity Requirements. These contracts are effective for the period April 1, 2009, to March 31, 2011.

Section B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, States must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, States must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, PCP Capacity, Specialty Capacity, Coordination and Continuity of Care)
Quality	(Coverage and Authorization, Provider Selection, Quality Assessment and Performance Improvement, PCCM Quality)

For each of the programs authorized under this waiver, this Part identifies how the State will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring strategy may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the strategies used to monitor the major areas of the waiver. The second is a detailed description of each strategy.

MCO and PIHP programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the State and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The State must have a quality strategy in which certain monitoring strategies are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring strategies they deem most appropriate for their programs.

For MCO and PIHP programs, a State must check the applicable monitoring strategies in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the State may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the State to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality strategy for PAHP programs. However, States must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under “Program Impact.” However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring strategies to use.

I. Summary chart

States should use the chart on the next page to summarize the strategies used to monitor major areas of the waiver program. If this waiver authorizes multiple programs, the State may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the State should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

Strategy	Program Impact						Access			Quality		
	Choice N/A requesting waiver	Marketing	Enroll Disenroll N/A requesting waiver	Program Integrity	Information	Grievance	Timely Access	PCP/Specialist Capacity	Coordination continuity	Coverage Authorization	Provider Selection	Quality of Care
Accreditation for Deeming				X		X	X	X	X	X	X	X
Accreditation for Participation												
Consumer Self-Report data					X	X	X				X	X
Data Analysis (non-claims)						X	X	X		X		X
Enrollee Hotlines					X	X	X		X	X	X	X
Focused Studies												
Geographic mapping							X	X			X	
Independent Assessment												
Measure any Disparities by Racial or Ethnic Groups							X			X		
Network Adequacy								X			X	

Strategy	Program Impact						Access			Quality		
	Choice N/A requesting waiver	Marketing	Enroll Disenroll N/A requesting waiver	Program Integrity	Information	Grievance	Timely Access	PCP/Specialist Capacity	Coordination continuity	Coverage Authorization	Provider Selection	Quality of Care
Assurance by Plan												
Ombudsman												
On-Site Review		X		X	X	X	X	X	X	X	X	X
Performance Improvement Projects				X			X		X			X
Performance Measures						X	X	X	X	X		X
Periodic Comparison of # of Providers								X			X	
Profile Utilization by Provider Caseload												
Provider Self-Report Data					X							
Test 24/7 PCP Availability												
Utilization Review				X			X			X		X
Other: (describe)												

Strategy	Program Impact					Access			Quality			
	Choice N/A requesting waiver	Marketing	Enroll Disenroll N/A requesting waiver	Program Integrity	Information	Grievance	Timely Access	PCP/Specialist Capacity	Coordination continuity	Coverage Authorization	Provider Selection	Quality of Care
Quality of Life Surveys							X		X		X	X

II. Monitoring Strategies

Please check each of the monitoring strategies or functions below used by the State. A number of common strategies are listed below, but the State should identify any others it uses. If federal regulations require a given strategy, this is indicated just after the name of the strategy. If the State does not use a required strategy, it must explain why.

For each strategy, the State must provide the following information:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. State Medicaid, other State agency, delegated to plan, EQR, other contractor)
- Detailed description of strategy
- Frequency of use
- How it yields information about the area(s) being monitored

- a. Accreditation for ~~Deeming~~ EQRO Non-duplication (i.e. the State's EQR ~~deems~~ will use information from accreditation reviews to assess compliance with certain access, structure/operation, or quality requirements for entities that are accredited)
- ___ National Committee for Quality Assurance (NCQA)
- ___ Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- ___ Accreditation Association for Ambulatory Health Care (AAAHC)
- Other (please describe) **Within three years of contracting, the PIHP must be accredited by NCQA, Utilization Review Accreditation Commission or other accreditation agencies recognized by CMS for non-duplication of EQR activities under 42 CFR 438.360 and 42 CFR 422.158, and approved by the State, so that the State may ensure that it is able to not duplicate EQR review activity requirements in the future to the extent possible.**
- b. ___ Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)
- ___ NCQA
- ___ JCAHO
- ___ AAAHC
- ___ Other (please describe)
- c. Consumer self-report data
- ___ **Consumer assessment of healthcare providers and systems (CAHPS)** (please identify which one(s))
- State-approved survey
- ___ Disenrollment survey
- ___ Consumer/beneficiary focus groups

- **Applicable programs: PIHP**
- **Personnel responsible (e.g., state Medicaid, other state agency, delegated to plan, EQR, other contractor): PIHPs**
- **Detailed description of activity: The PIHP is required by contract to administer a State-determined annual survey for adults and children as part of the annual quality improvement (QI) statistical reporting requirements contained in the contract. The survey will measure consumer perception of the PHIP's performance in the areas of access and timeliness of services and quality of care. Frequency of use: The consumer satisfaction survey is conducted annually. The sample for each survey is drawn from Medicaid enrollees who received a covered service in the previous year.**
- **How it yields information about the area(s) being monitored: Client Satisfaction Survey information is used to monitor:**
 - **Information**
 - **Grievance**
 - **Timely access**
 - **Provider selection**
 - **Quality of care**

The results of the survey will be utilized by the IMT to measure and evaluate the client's perception of the capitated program in monitoring the satisfaction of participants, identifying gaps in services and evaluating needs in future policy development.

The survey will include demographic information including participant's age, gender and race or ethnic group.

The survey responses are analyzed to create a composite and to measure member satisfaction with care. This information is utilized to identify issues for PMs regarding quality of care and to improve the consumer information for member use. After review of the results from the satisfaction survey, the IMT may require a written plan for addressing low performance. The survey instrument and results are included in each PIHP's performance improvement work plan and annual quality evaluation, which are reviewed as part of the EQR processes.

- d. Data Analysis (non-claims)
- Denials of referral requests
- Disenrollment requests by enrollee
- From plan
- From PCP within plan
- Grievances and appeals data
- PCP termination rates and reasons
- Other (please describe)

- **Applicable programs: PIHP**
- **Personnel responsible (e.g., state Medicaid, other state agency, delegated to plan, EQR, other contractor): PIHPs**
- **Detailed description of activity: The PIHPs are required to track grievances and appeals system. THE PIHPS will report to the DHHS annually the number and percentage of denials of treatment authorization requests. grievance and appeal data and denials of treatment authorization requests are included in QM Committee reporting and are reviewed at least annually by the IMT. Data are also included in each PIHP's QI statistical reporting.**
- **Frequency of use: Data are gathered and reported to the DHHS quarterly with quarterly review and annually, at a minimum.**
- **How it yields information about the area(s) being monitored: Grievance and appeal data and denials of treatment authorization requests are used to monitor:**
 - **Grievance**
 - **Timely access**
 - **Primary care provider/Specialist capacity**
 - **Coverage authorization**
 - **Quality of care**

The PIHP will maintain records of grievances and appeals within its internal global Continuous Quality Improvement (CQI) program. The PIHP will also submit QI statistical reports to the DHHS on the number, type and resolution of grievances and appeals. The PIHP will review these reports to identify potential areas of concern in plan performance and will develop corrective action plans, as needed.

This data is integrated as part of the overall State performance improvement process. The data is analyzed to identify trends, sentinel and adverse events. The findings are reported to the QM committee and raised to the IMT committee on at least an annual basis. The Committee members discuss the findings to identify opportunities for improvement. In addition, this information is used to assess the effectiveness of quality initiatives or projects. PMs are implemented when indicated by findings.

- e. **X** **Enrollee hotlines operated by State**
- **Applicable program: PIHP**
 - **Personnel responsible: PIHPs and DHHS**
 - **Detailed description: DHHS operates a Care-Line, which is a toll- free customer hotline 16 hours a day, to address recipient coverage questions and requests for assistance. Concerns or issues that cannot be handled by the hotline staff are referred to the**

appropriate program or person within DHHS. The PIHP is required to operate a toll-free customer service line 24/7 to address enrollee needs and concerns. Frequency of use: The provider's +1 800 number is available 24 hours a day, every day.

- **How it yields information about the area(s) being monitored: The client 800 number is used to monitor:**
 - **Information to beneficiaries**
 - **Grievances**
 - **Timely access**
 - **Coordination/Continuity of care**
 - **Coverage and authorization**
 - **Provider selection**
 - **Quality of care**

The data is used to monitor the above topics by obtaining information from the beneficiaries, resolving issues, identifying and addressing trends. The analysis is reported to the QM committee, which reports to the IMT. The Committee members discuss the findings to identify opportunities for improvement. If deficiencies are noted the contractor must perform corrective action until compliance is met.

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

g. X Geographic mapping of provider network

- **Applicable program: PIHP**
- **Personnel responsible: PIHPs**
- **Detailed description: The PIHPs will maintain geographic mapping of the provider network for the DHHS's review. Through geographic mapping, distribution of provider types across the state is identified. Examples of provider types shown through mapping include psychiatrists, psychologists, and social workers. The PIHPs will use the mapping for their internal provider recruitment and operations as well as for the State's monitoring.**
- **Frequency of use: Geographic mapping is generated and reported at a minimum on an annual basis.**
- **How it yields information about the area(s) being monitored: Geographic mapping information is used to monitor:**
 - **Timely access**
 - **Primary care provider/Specialist capacity**
 - **Provider selection**

The software program produces a report that is analyzed for compliance with the State access and capacity requirements. The analysis is reported to the State annually and is reported to the QM committee and IMT. The Committee

members discuss the findings to identify opportunities for improvement. If deficiencies are noted the contractor must perform corrective action until compliance is met.

- h. ___ Independent assessment of program impact, access, quality and cost-effectiveness
- i. **X** Measurement of any disparities by racial or ethnic groups.
- **Applicable programs: PIHP**
 - **Personnel responsible (e.g., state Medicaid, other state agency, delegated to plan, EQR, other contractor), PIHPs**
 - **Detailed description of activity: The PIHPs will include items on the annual consumer and provider satisfaction survey to assess cultural sensitivity. In addition, the survey will include demographic information including consumer and provider's age, gender and race or ethnic group.**
 - **Frequency of use: PIHP survey is collected and reported to the State at least annually.**
 - **How it yields information about the area(s) being monitored: The measurement of any disparities by racial or ethnic groups will be used to monitor:**
 - **Timely access**
 - **Coverage and authorization of care**

The disparity analysis provides information regarding the effectiveness of the program. This information is utilized for PMs. The primary focus is to obtain information about problems or opportunities for improvement to implement PMs for quality, access, or coordination of care or to improve information to beneficiaries. This analysis will be reported to the QM committee and the IMT at least annually.

- j. **X** Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]
- **Applicable programs: PIHP**
 - **Personnel responsible, (e.g., state Medicaid, other state agency, delegated to plan, EQR, other contractor), PIHP**
 - **Detailed description of activity: Per Accessibility of Services Section of the contract, The PIHPs are required to establish and maintain appropriate provider networks. Additional contract mandates require the PIHPs to establish policies and procedures to monitor the adequacy, accessibility and availability of its provider network to meet the needs of enrollees. The PIHPs shall conduct an analysis of its provider network to demonstrate an appropriate number, mix and geographic distribution of providers, including geographic access of its members to practitioners and facilities.**
 - **Frequency of use: Documentation was submitted at the time of contracting and is submitted any time there is a significant change that would affect**

adequate capacity and services or at enrollment of a new population. Certain network reports are submitted annually.

- **How it yields information about the area(s) being monitored: Network reports provide information on:**
 - **Primary care provider/Specialist capacity**
 - **Provider selection**

The analysis will be reviewed by the DHHS at the beginning of the contract; at any time there has been a significant change in the PIHPs' operations that would affect adequate capacity and services, including changes in services, benefits, geographic service areas or payments or enrollment of a new population in the PIHPs; and annually thereafter. Whenever network gaps are noted, THE PIHPS shall submit to the Division a network development strategy or plan as well as reports to the Division on the implementation of the plan or strategy.

Network adequacy data is reviewed annually by the IMT. The data is used to: 1) develop a quantitative, regional understanding of the healthcare or service delivery system, including the subsystems and their relation; 2) identify needs for further data collection; and 3) identify processes and areas for detailed study. The result of the analysis is reported to the IMT. The Committee members discuss the findings to identify opportunities for improvement. In addition, this information aids in the assessment of the effectiveness of the quality improvement processes. The data from all sources is analyzed for compliance. If indicated the contractor is required to implement corrective action. The identified aspects are integrated into the implementation of PMs.

k. ____ Ombudsman

l. On-site review

- **Applicable programs: PIHP**
- **Personnel responsible (e.g., state Medicaid, other state agency, delegated to plan, EQR, other contractor), DMA and DMH**
- **Detailed description of activity: The DMA and the DMH through the regional monitoring teams will conduct on-site reviews to evaluate compliance with the terms of the contract, compliance with State and federal Medicaid requirements, PBH' compliance with NC G.S. 122C-112.1, and implementation of the PIHP's local business plan. The on-site reviews will consist of both interviews and documentation review. Designated staff on the regional monitoring teams review PIHP policies and processes implemented for the North Carolina MH/IDD/SAS system. Interviews with PIHP stakeholders and confirmation of data may also be initiated**
- **Frequency of use: Annually for new PIHPs. The frequency of on-site reviews may be decreased to every two years at the discretion of DMA for PIHPs with contracts older than two years if DMA determines that other required on-site review activities such as the EQRO are sufficient to assure the**

effective operation of the PIHPs and compliance with State and Federal requirements.

- **How it yields information about the area(s) being monitored. Review provides monitoring information related to:**
 - **Marketing**
 - **Program integrity**
 - **Information to beneficiaries**
 - **Grievance**
 - **Timely access**
 - **Primary care provider/Specialist capacity**
 - **Coordination/continuity of care**
 - **Coverage/authorization**
 - **Provider selection**
 - **Quality of care**

The on-site review allows a review of policies and communication with the contractor staff that perform each of the above processes. For example, during the on-site review, staff monitor coordination/continuity of care by ensuring that regulatory and contractual requirements are met. Also, staff monitor provider selection regulatory requirements and the affiliation process through the on-site reviews. The reviews also obtain additional information that was not provided during State monitoring through conference calls, meetings, documentation requests or reports. The data from all sources is analyzed for compliance.

Any compliance issues found on review will require the submission of a corrective action plan. DMA, DMH and IMT will approve and monitor any corrective action plan.

On-site review – EQR

- **Applicable program: the PIHPS**
- **Personnel responsible: External entity identified by State (CCME)**
- **Detailed description: EQR is a process by which an EQRO, through a specific agreement with the State, reviews PIHP policies and processes for the North Carolina MH/IDD/SAS waiver program. EQR include extensive review of PIHP documentation and interviews with PIHP staff. Interviews with stakeholders and confirmation of data will also be initiated. The reviews focus on monitoring services, reviewing grievances and appeals received, reviewing medical charts as needed, and any individual provider follow up.**
- **Frequency of use: EQR is done annually.**
- **How it yields information about the area(s) being monitored: EQR provides monitoring information related to:**
 - **Marketing**
 - **Program integrity**
 - **Information to beneficiaries**

- Grievance
- Timely access
- Primary care provider/Specialist capacity
- Coordination/continuity of care
- Coverage/authorization
- Provider selection
- Quality of care

The EQR review allows a review of automated systems and communication with the contractor staff that perform each of the above processes. It also obtains additional information that was not provided during State monitoring through conference calls, meetings, documentation requests or quarterly reports. The data from all sources is analyzed for compliance. If indicated the contractor is required to implement corrective action. The IMT reviews as part of the State's quality improvement strategy. The EQRO will compile information for each PIHP and will submit a comprehensive comparison.

m. X PIPs [**Required** for MCO/PIHP]

X Clinical

X Non-clinical

- **Applicable program: PIHP**
- **Personnel responsible: PIHP**
- **Detailed description: The contractor must conduct PIPs that are designed to achieve, through on-going measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. For newly implemented PIHPs, the PIHPs shall develop, implement and report to DMA and DMH a minimum of two PIHP-specific and self-funded PIPs the first year of this contract; one focusing on a clinical area and one focusing on a non-clinical area. For year two of the contract, the PIHPs shall conduct a PIP in addition to the two planned for the first contract year for a total of three. For year three of the contract, the PIHPs shall conduct an additional PIP for a total of four. The project topics will be determined jointly by the PIHPs and DMA from clinical and non-clinical focus areas. At any given time, the established PIHPs will be operating at least four PIPs, and at least one of the four shall be clinical and one non-clinical. The project topics will be determined jointly by the DMA and the PIHPs from the clinical and non-clinical focus areas listed in the contract. PIP topics are chosen based upon the information obtained through other monitoring processes as noted in this section. The QIS provides information about the aspects identify for PIPs. The PIPs must involve the following:**
 1. **Measurement of performance using objective quality indicators.**

2. **Implementation of system interventions to achieve improvement in quality.**
3. **Evaluation of the effectiveness of the interventions.**
4. **Planning and initiation of activities for increasing or sustaining improvement.**

Baselines will be established the first year of each project and the PIHPs will set benchmarks for each project based on currently accepted standards, past performance data or available national data. DMA in consultation with the PIHPs will determine when a project will be terminated. When projects are terminated, the PIHPs will implement new projects as approved by DMA.

- **Frequency of use: Two PIPs must be in process each year. The contractor shall report the status and results of each PIP to the IMT. Each PIP must be completed in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care every year.**
- **How it yields information about the area(s) being monitored: PIPs provide monitoring information related to:**
 - **Program integrity**
 - **Coordination/continuity of care**
 - **Quality of care**
 - **Access to care**

PBH reports to the IMT quarterly on their progress with the PIPs.

The data is used to: 1) develop a quantitative, regional understanding of the healthcare or service delivery system, including the subsystems and their relation; 2) identify needs for further data collection; and 3) identify processes and areas for detailed study. The result of the analysis is reported to the State QM Committee and IMT. The Committee members discuss the findings to identify opportunities for improvement. In addition, this information aids in the assessment of the effectiveness of the quality improvement processes. The data from all sources is analyzed for compliance. The identified aspects are integrated into the implementation of continuous quality improvement processes.

- n. X PMs [**Required** for MCO/PIHP]
- Process
 - Health status/outcomes
 - Access/availability of care
 - Use of services/utilization
 - Health plan stability/financial/cost of care
 - Health plan/provider characteristics
 - Beneficiary characteristics
 - **Applicable program: PIHP**

- **Personnel responsible: PIHP**
- **Detailed description: The State has established a comprehensive listing of PM areas for the PIHP's implementation. The PMs including the topics listed above are included in the contract and are listed in the contract. The DMA requires annual QI statistical reporting in the contract. Each measure is described in the contract. THE PIHPS will use all applicable Healthcare Effectiveness Data and Information Set (HEDIS) technical specifications pertaining to the Medicaid population where applicable. The measurement year will be January 1 – December 31 of each contract year.**
- **Frequency of use: Performance indicators are included in the annual QI report and reviewed by the IMT. A year-to-date performance indicators report is submitted as part of the QI Quarterly Report, where feasible. EQR audits are done each year.**
- **How it yields information about the area(s) being monitored: Performance measures provide information related to:**
 - **Grievance**
 - **Timely access**
 - **Primary care provider/Specialist capacity**
 - **Coordination/continuity of care**
 - **Coverage authorization**
 - **Quality of care**

Performance indicator data is reported in the annual QI report and is reviewed by the IMT. The indicators aid in the identification of opportunities for QI. In addition, this information aids in the assessment of initiative effectiveness.

o. **X** Periodic comparison of number and types of Medicaid providers before and after waiver.

- **Applicable programs: PIHP**
- **Personnel responsible (e.g., state Medicaid, other state agency, delegated to plan, EQR, other contractor), PIHPs**
THE PIHPS shall annually report the number and types of Title XIX providers relative to the number and types of Medicaid providers prior to the start date of the contract. The DMA will compare the PIHPs' provider network numbers and types on an annual basis using results from the PIHPs' reported network capacity measure as required in Attachment M of the contract.
- **Frequency of use: Annually**
- **How it yields information about the area(s) being monitored: Performance measures provide information related to:**
 - **Primary care provider/Specialist capacity**
 - **Provider selection**

The analysis is part of the annual QI statistical report and is reported to the QM committee and the IMT. The Committee members discuss the findings to identify opportunities for improvement. If deficiencies are noted the contractor must perform corrective action until compliance is met.

p. ___ Profile utilization by provider caseload (looking for outliers)

q. Provider self-report data
 Survey of providers
 ___ Focus groups

- **Applicable programs: PIHP**
- **Personnel responsible (e.g., state Medicaid, other state agency, delegated to plan, EQR, other contractor), PIHPs**
- **Detailed description of activity: Included in the annual QI statistical reporting, the PIHPs must conduct an annual Provider Satisfaction Survey to include the provider's self-reported satisfaction with the PIHPs' performance in the areas of claims submissions, timeliness of payments, assistance from the PIHPs and communication with the PIHPs. The survey will be determined by the state for consistency and comparability across PIHPs. Frequency of use: Annually**
- **How it yields information about the area(s) being monitored: PMs provide information related to the impact of the managed care program on providers.**

The analysis is part of the QIS and is reported to the IMT. The Committee members discuss the findings to identify opportunities for improvement. If deficiencies are noted the contractor must perform corrective action until compliance is met.

r. ___ Test 24 hours/seven days a week primary care provider availability

s. Utilization review (e.g., ER, non-authorized specialist requests)

- **Applicable programs: PIHP**
- **Personnel responsible (e.g., state Medicaid, other state agency, delegated to plan, EQR, other contractor): PIHPs**
- **Detailed description of activity: The PIHPs are required to conduct statistically valid sample UM reviews on required utilization measures. The PIHPs perform ongoing monitoring of UM data, on-site review results and claims data review. The IMT will review PIHP utilization review processes. PIHPs shall have over and under-utilization reviews through the use of outlier reports and regular utilization reports and analyses.**
- **Frequency of use: Utilization reviews occur at intervals, first within the initial treatment period and then regularly thereafter. Data related to utilization review are reported in the State QI statistical report and are reviewed by the State IMT on an annual basis.**

- How it yields information about the area(s) being monitored: Utilization management data can be used to monitor:
 - Program integrity
 - Timely access
 - Coverage/authorization
 - Quality of care

The data is utilized to indicate opportunities for improvement and to assess compliance with utilization policies and procedures at the provider and contractor level. This information is primarily used for provider and enrollee monitoring and is part of the QI statistical report. The analysis is reported to the IMT. The Committee members discuss the findings to identify opportunities for improvement. If areas for improvement are noted, the PIHPs work with the specific provider noted or incorporate the identified aspects into the implementation of PMs. If the utilization review process identifies issues with program integrity, the contractor shall follow up with providers, recoup overpayments or report abusive or fraudulent claiming to the Medicaid Fraud Control Unit via the State Medicaid Agency.

t. **X Other (please describe). Quality of Life Surveys**

- Applicable programs: PIHPs
- Personnel responsible (e.g., state Medicaid, other state agency, delegated to plan, EQR, other contractor): PIHPs, NC Department of Health and Human Services
- Detailed description of activity: As a part of the August 23, 2012 settlement agreement with the US Department of Justice, the State is implementing quality of life surveys to be completed by persons having a mental illness who are transitioned out of an adult care home or a State psychiatric hospital to community living as a result of the settlement agreement. The PIHPs, through care and transition coordination and in-reach activities, are responsible for facilitating these transitions and making community based services available to support individuals in their transitions.
- Frequency of use: Three surveys are conducted: prior to transition, 11 months after transition and 24 months after transition.
- How it yields information about the area(s) being monitored: Quality of life survey data will be used to monitor:
 - Quality of care
 - Timely access
 - Coordination and continuity
 - Provider selection

The quality of life surveys measure various domains which have been identified as indicators of an individual's perception of quality of life. Pre- and post- transition data will be compared to determine whether the State's goal is being met which is to ensure that services and supports to individuals with SMI and SPMI are of good quality, are supportive of these individuals in achieving increased independence and integration in the community,

maintaining stable housing in a safe environment, and preventing unnecessary hospitalization and/or institutionalization.

Section C: Monitoring Results

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

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

This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.

This is a renewal request.

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

The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

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

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

Please replicate the template below for each activity identified in Section B:

As of the submission of this waiver renewal, the PIHPs bulleted below are participating in the waiver. The last four are referred to as "new" PIHPs throughout this section as all of them have been operating for less than one year and monitoring and reporting activities are still under implementation. The State is monitoring the new PIHPs and the Cardinal Innovations Healthcare Solutions (CIHS) expansion of its coverage area through regular intradepartmental monitoring team meetings and weekly status and metrics reporting in key implementation areas.

- **Cardinal Innovations Healthcare Solutions (CIHS), formerly Piedmont Behavioral HealthCare, a five-county PIHP effective 4/1/2005 which rolled out to 10 additional counties from 10/1/2011-4/1/2012.**

- Western Highlands Network (WHN), effective 1/1/2012
- East Carolina Behavioral Health (ECBH), effective 4/1/2012
- Smoky Mountain Center (SMC), effective 7/1/2012
- Sandhills, effective 12/1/2012

(c.) Strategy - Consumer Self-Report Data: Cardinal Innovations Healthcare Solutions (CIHS) continued to contract with UNC Charlotte Urban Institute to conduct consumer satisfaction surveys in 2011 and 2012. Surveys were sent to a random sample consisting of 10,000 consumers both years with a response rate of six percent and seven percent, respectively. Reporting on annual surveys by the new PIHPs is due June 30, 2013.

Confirmation it was conducted as described:

Yes
 No. Please explain:

Summary of results: Overall, the level of satisfaction with services delivered through the CIHS plan has remained about the same or increased slightly in some areas. The majority of respondents were satisfied most of the time or always, especially with services, staff availability, and appointment times.

Problems identified: Issues identified in the previous renewal, i.e., acknowledgement of receipt of information about the appeal process, how to file a complaint, choice of provider and access to emergency care within the required timeframes, continue to need improvement.

Corrective action (plan/provider level): Continue to educate providers about crisis first responder requirements and provider choice; continue to make appeals/complaint information available to consumers through providers, the PIHP website, written media and PIHP staff.

Program change (system-wide level): N/A

(d.) Strategy - Data Analysis: PIHPs track and report to DMA on unauthorized treatment requests, grievances and denials/appeals of service requests.

Confirmation it was conducted as described:

Yes
 No. Please explain:

Summary of results: During the past two fiscal years, the rate of adverse decisions on service requests was low for Cardinal Innovations Healthcare Solutions (CIHS), 0.82 % and 0.12%, respectively. One reason for the decrease in FY 2012 was expansion and acceptance of prior authorizations from previous UR vendors. Adverse decisions overturned by CIHS upon appeal to the PIHP were at 22% and 44% in the two respective years. Preliminary reporting on adverse decisions by the new PIHPs reflects rates ranging from 1.8% to 22%. Insufficient information on appeals from the new PIHPs is available at this time for analysis of overturned decisions.

For CIHS, the total number of grievances for the first year decreased over the prior renewal period, and more than doubled during the second year largely due to expansion of the plan coverage area. Resolution within the 30-day target ranged from 79% to 94% during the first four quarters, and 75% to 95% during the next four. Preliminary reporting from the new PIHPs shows rates of resolution within 30 days from 70% to 93%. For all PIHPS, primary concerns were around interaction with providers, quality of care, and administrative issues. The service generally receiving the most complaints for all PIHPs is Residential Services for children.

Problems identified: High rate of adverse decisions in some of new PIHPs; resolution of grievances continues to exceed 30-day timeframe.

Corrective action (plan/provider level): Provider education by PIHPs on completing service authorization requests

Program change (system-wide level): DMA to identify issues around resolution of grievances within 30 days and determine whether this is a reasonable timeframe.

(e.) Strategy - Enrollee Hotlines: DHHS operates a customer service line during business hours for inquiries, questions or concerns about all DHHS programs, including Medicaid. Concerns or complaints are routed to and addressed by the appropriate DHHS division or office. All PIHPs operate a toll free access line 24/7 for enrollee questions, appointments, emergency service needs, and other concerns.

Confirmation it was conducted as described:

Yes
 No. Please explain:

Summary of results: Cardinal Innovations Healthcare Solutions (CIHS) had an abandonment rate of 1.8% and 1.9% and an average speed of answering of 5 seconds and 6 seconds, respectively, in CY 2010 and 2011. However, the CIHS back-up contractor consistently had an abandonment rate of over 5%. Weekly reporting by the new PIHPs shows abandonment rates ranging from 1.2% to 6.3% and average speed of answering from 9 to 19 seconds. (Data to address this monitoring strategy are taken from CIHS's annual calendar year reports and the new PIHPs' weekly implementation reporting.)

Problems identified: Abandonment rates in excess of target of 3%.

Corrective action (plan/provider level): CIHS to work with back-up contractor to improve abandonment rates; DMA to continue monitoring and providing technical assistance to the new PIHPs to improve abandonment rates.

Program change (system-wide level): N/A

(g.) Strategy - Geographic Mapping: Please see item (j) regarding the PIHPs' network adequacy studies.

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results: See item (j).

Problems identified: See item (j).

Corrective action (plan/provider level): See item (j).

Program change (system-wide level): N/A

(i.) Strategy - Measure Disparities by Racial/Ethnic Group

Confirmation it was conducted as described:

Yes

No Please explain:

Summary of results: Consumer and provider surveys are used to identify disparities. The CIHS 2011 and 2012 surveys indicate that 94% to 95% of consumers believe both their providers and services meet racial/ethnic requirements; CIHS provider surveys indicate that 82% to 86% of providers find the PIHP's cultural competency training valuable. Survey data for the new PIHPs will not be available until June of 2013.

Problems identified: None

Corrective action (plan/provider level): N/A

Program change (system-wide level): N/A

(j.) Strategy - Network Adequacy Study:

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results: Network capacity studies and gap analyses were conducted by Cardinal Innovations Healthcare Solutions (CIHS) annually and prior to expansion the coverage area, and by the new PIHPs prior to start-up, as required. Access and provider choice appear to be as good as or better than it was prior to waiver implementation, although there is room for improvement in several areas.

The new PIHPs are in the process of implementing geo-mapping software.

Problems Identified:

- Use of hospital emergency departments for behavioral health services
- Access to substance use services

- Shortage of psychiatrists
- Shortage of basic MH/SA services in rural and isolated areas of NC

Corrective action (plan/provider level): See below.

Program change (system-wide level): The State and the PIHPs are working together through the intradepartmental monitoring teams and the DHHS waiver advisory committee (DWAC) to address the identified problems. Goals include increasing appropriate utilization of and access to crisis services to avoid inappropriate ED use; co-location and overall coordination of primary and specialty care to increase access to psychiatric services through collaboration with the State' PCCM program; work with providers and other stakeholders to further develop a continuum of care for both children and adults with substance use issues and to increase access to basic services in rural and isolated areas.

(l.) Strategy - On-Site Review: Confirmation it was conducted as described:

Yes
 No. Please explain:

Summary of Results: All new PIHPs had on-site reviews by the intradepartmental monitoring teams and the State's contractor, Mercer Government Services, to confirm readiness at least 60 days prior to start-up. All PIHPs participating in the waiver had successful reviews and were determined to have basic managed care systems in place and established provider networks. The IMT conducted an on-site review of the original PIHP, Cardinal Innovations Healthcare Solutions (CIHS), in November 2011 and noted continuing improvements in operations since waiver start-up in 2005. Financial management and reporting have improved steadily and financial solvency continues to strengthen.

The EQRO conducted site reviews for contract compliance of CIHS in 2011 and 2012 and the second and third PIHPs to join the program, Western Highlands Network (WHN) and East Carolina Behavioral Health (ECBH) in 2012.

Problems Identified: Challenges experienced by the new PIHPs include implementing enhancements/updates to IT systems to improve claims processing, reporting and overall operations management; expenditure and utilization forecasting; and, coming into full compliance with all contractual managed care requirements. CIHS continues to work toward automation of UM functions and medical records and updating policies and procedures.

Corrective action (plan/provider level): The Division of Medical Assistance and the intradepartmental monitoring teams will continue to provide technical assistance and weekly monitoring of the new PIHPs, as well as monitoring of CIHS's progress on automation of key clinical functions and keeping policies and procedures current.

Program change (system-wide level): N/A

(m) Strategy - Performance Improvement Projects (PIPs):

Summary of Results: The new PIHPs are in the process of implementing at least one clinical and one non-clinical PIP during the first year as required by the contract. An example from one of the new plans is “Consumer Safety: Improving Compliance with First Appointment Timeframes for Urgent Cases.”

CIHS continues to operate at least 4 PIPs ongoing, as required for established PIHPs, which were reviewed by the EQRO in 2011 and 2012. Most recently, two were rated at the high confidence level; both showed improvement over time and one has been retired. The other two PIPs were rated at the confidence and low confidence levels with recommendations for improvement.

Problems Identified: Problems were identified with study design for two CIHS important PIPs, coordination of benefits and metabolic screening related to drug regimen, such that findings can't be validated.

Corrective action (plan/provider level): CIHS to implement EQR recommendations and DMA is monitoring through the IMT; PIPs to be reevaluated by EQRO in 2013.

Program change (system-wide level): N/A

(n) Strategy - Performance Measures:

Confirmation it was conducted as described:

Yes
 No. Please explain:

Summary of results: CIHS annual reports for CY 2010 and 2011 show that performance targets were met for most key indicators. The new PIHPs are reporting key metrics weekly and in the process of implementing all required performance measures.

Problems identified: Although improvements are noted, CIHS has still not met performance target for initiation and engagement of alcohol/drug dependence treatment.

Corrective action (plan/provider level): CIHS will identify barriers to meeting the performance target and provide regular progress reports at intradepartmental monitoring team meetings.

Program change (system-wide level): N/A

(o) Strategy - Periodic Comparison of # of Providers: Please see item (j) above regarding the network adequacy study process.

Confirmation it was conducted as described:

Yes
 No. Please explain:

Summary of results: See item (j) above.

Problems identified: See item (j) above.

Corrective action (plan/provider level): See item (j) above.

Program change (system-wide level): See item (j) above .

(q) Strategy - Provider Self-Report Data: CIHS continued to contract with UNC Charlotte Urban Institute to conduct provider surveys in 2011 and 2012. Web-based surveys were sent to all providers in 2011 and 2012 and the response rate was 34 percent in both years. Initial reporting on annual surveys by the new PIHPs is due June 30, 2013.

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results: A large majority of network CIHS providers (81% in 2011, 83% in 2012) express overall satisfaction with CIHS. Some of the highest ratings were in regard to ethical business practices, fairness of QM investigations, and training in QM, claims, IT, and cultural competency. Room for improvement: provider satisfaction in comparison to other LMEs.

Corrective action (plan/provider level): No significant problems requiring a corrective action were noted.

Program change (system-wide level): N/A

(s) Strategy - Utilization Review/Utilization Management

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results: The new PIHPs are implementing strategies to identify over and under utilization, cost outliers, and special needs populations and taking steps to ensure the appropriate level of care coordination is available to those who need it. They are conducting internal training in areas such as medical necessity, consistency in applying criteria and special needs populations.

CIHS has well established, data driven processes and procedures for managing and reviewing service utilization and identifying enrollees with special health care needs.

Problems identified: No significant problems have been identified. However, close monitoring by the State of this key function will continue throughout statewide waiver expansion.

Corrective action (plan/provider level): N/A

Program change (system-wide level): N/A

Section D – Cost-Effectiveness

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

A complete application includes the State completing the seven Appendices and the Section D. State Completion Section of the Preprint:

- Appendix D1. Member Months
- Appendix D2.S Services in the Actual Waiver Cost
- Appendix D2.A Administration in the Actual Waiver Cost
- Appendix D3. Actual Waiver Cost
- Appendix D4. Adjustments in Projection
- Appendix D5. Waiver Cost Projection
- Appendix D6. RO Targets
- Appendix D7. Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State's CMS Regional Office.

Part I: State Completion Section

A. Assurances

- a. [Required] Through the submission of this waiver, the State assures CMS:
 - The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
 - The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
 - Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
 - Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
 - The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost

Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.

- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances: Christal Kelly

c. Telephone Number: 919 814 0066

d. E-mail: christal.kelly@dhhs.nc.gov

e. The State is choosing to report waiver expenditures based on X date of payment.

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

B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

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

b. X The State makes enhanced payments to contractors or providers.

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

d. Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

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

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by *OMB at the discretion of CMS and OMB*.

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

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

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

- a. ___ MCO
- b. X PIHP
- c. ___ PAHP
- d. ___ Other (please explain):

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

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

- a. ___ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
 - 1. ___ First Year: \$ ___ per member per month fee
 - 2. ___ Second Year: \$ ___ per member per month fee
 - 3. ___ Third Year: \$ ___ per member per month fee
 - 4. ___ Fourth Year: \$ ___ per member per month fee
- b. ___ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.
- c. ___ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost. d. ___ Other reimbursement method/amount. \$ ___ Please explain the State's rationale for determining this method or amount.

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

- a. ___ Population in the base year data
1. ___ Base year data is from the same population as to be included in the waiver.
 2. ___ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)
- b. ___ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.
- c. ___ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

- d. ___ [Required] Explain any other variance in eligible member months from BY to P2: _____
- e. ___ [Required] List the year(s) being used by the State as a base year: _____. If multiple years are being used, please explain: _____
- f. ___ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.
- g. ___ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:

For Conversion or Renewal Waivers:

- a. X [Required] Population in the base year and R1 and R2 data is the population under the waiver.
The R1 and R2 member months were reported quarterly to CMS for the prior waiver period. These member months reflect the enrollment of the Medicaid eligible population groups covered under the waiver in the areas of the state under managed care.
- b. X For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*
The state utilized the first five quarters of data that had been certified by the CMS RO staff. At the time of development of

this renewal, the R2, Q2 data was still "Uncertified" and had not yet been sent to the CMS-64 master file.

**c. X_ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
 Enrollment projections are based on historical enrollment trends and expectations for enrollment changes. The changes in enrollment are primarily due to the expansion of the waiver statewide (as discussed below) and changes in economic conditions and general increases in the population. The enrollment change for the Innovations - CAP-MR MEG also considers the slot increases planned for this population under the concurrent 1915(c) waiver.**

Below is a chart that summarizes the historical membership trends by quarter and MEG used as the basis for determining the P1 and P2 membership trends:

Year/Quarter	MEG 01 AFDC	MEG 02 Blind/Disabled and Foster Children	MEG 03 Aged	MEG 04 Innovations CAP-MR	Total
P1-P5 Qtrly Projected Trends	2.1%	1.9%	0.2%	0.7%	1.8%

R1 and R2 data reflect the four PIHPs implemented under managed care through June 2012. Between July 2012 and April 2013 (the effective date of the renewal), the State is intending to expand the managed care program to the remaining PIHPs at the dates noted below.

- July 1, 2012 Smoky Mountain will have Alexander, Allegheny, Ashe, Avery, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, Macon, McDowell, Swain, Watauga and Wilkes Counties. Effective 10-1-13: Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, and Yancey Counties will be under a management agreement with the Smoky Mountain Center, with a full merger occurring by 7-1-14.**
- December 1, 2012 Sandhills will have Anson, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, and Richmond Counties.**

- **January 1, 2013 Eastpointe will have Bladen, Columbus, Duplin, Edgecombe, Greene, Nash, Lenoir, Robeson, Sampson, Scotland, Wayne and Wilson counties.**
- **February 1, 2013 Partners will have Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Surry, Yadkin counties.**
- **February 1, 2013 Centerpoint will have Davie, Forsyth, Rockingham and Stokes counties.**
- **February 1, 2013 Alliance Center will have Durham, Cumberland, Johnston and Wake counties.**
- **March 1, 2013 MeckLink will begin operations in Mecklenburg county**
- **March 1, 2013 CoastalCare will have Brunswick, Carteret, New Hanover, Onslow and Pender counties.**
- **April 1, 2013 Sandhills will expand their managed care operations into Guilford county.**

The State has incorporated into the projection of this waiver the completion of this statewide implementation. The MMs for the first quarter of P1, April 2013 through June 2013 reflect the addition of the anticipated enrollment for these PIHPs along with the enrollment of the current PIHPs under the waiver. This results in the large percentage increase in enrollment as documented on Appendix D1 from the Base Year to P1.

Per the provisions of the settlement agreement between the US Department of Justice and the State of North Carolina, a population of SMI adults already included in the waiver will be eligible for treatment planning and additional 1915(b)(3) services. This population was already eligible for Medicaid and did not change Medicaid population growth.

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

There are no other variances in the enrollment projections.

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

R1 is April 1, 2011 through March 31, 2012. R2 is April 1, 2012 through March 31, 2013.

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

For Initial Waivers:

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

For Conversion or Renewal Waivers:

- a. [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**:
No differences in services included on Appendix D3. 1915(b)(3) costs reported on Appendix D3 are summarized from the separately certified 1915(b)(3) service rates multiplied by the actual member months under the waiver.

The waiver expenses are summarized directly from the waiver reporting schedules, specifically Schedule F (supplemented by the ad hoc calculations for 1915(b)(3) services).

During the prior waiver period, the State amended the 1915(b) waiver to include the statewide expansion of BH managed care. The actual waiver expenses are specific to the areas in managed care by June 2012. An adjustment was made on Appendix D5 to account for the cost differentials for the PIHPs implemented between July 2012 and March 2013. This is discussed in the State Plan Services Programmatic/Policy/Pricing Change Adjustment section below.

Per the provisions of the settlement agreement between the US Department of Justice and the State of North Carolina, a population of SMI adults already included in the waiver will be eligible for treatment planning and additional 1915(b)(3) services. The new services and utilization for the settlement were made effective with the December 2012 amendment to the prior 1915(b) waiver.

- b. [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account:
NC used audited CMS 64 reports for the basis of the cost effectiveness analysis. All services covered under the waiver

are included in the cost-effectiveness analysis including services impacted by the PIHP (BH pharmacy). Costs for services in the Innovations Program are included in the analysis. Acute care services under the 1932 SPA other than BH pharmacy are excluded from the cost-effectiveness. The State has documented that for a single beneficiary under the 1932 SPA and the (b)(c) concurrent waiver all costs for individuals are reported on either the CMS 64.9 Waiver forms for the 1915(b)(c) concurrent waivers or on the CMS 64.9 Base form with other 1932 SPA costs.

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

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

For Initial Waivers:

- a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
<i>(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)</i>	\$54,264 savings or .03 PMPM	9.97% or \$5,411	\$59,675 or .03 PMPM P1 \$62,488 or .03 PMPM P2
Total	<i>Appendix D5 should reflect this.</i>		<i>Appendix D5 should reflect this.</i>

The allocation method for either initial or renewal waivers is explained below:

a. ___ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*

b. X The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*

The CMS 64.10 reports for the 1915(b) waiver reflect the allocation methodology for administrative expenses approved in previous waivers. General State administrative expenses are allocated to the waiver based on the actual waiver program cost as a percentage of the total Medicaid program cost in each quarter. As the State has expanded managed care and expenses have increased under the waiver, the quarterly percentage for the administrative allocation has increased. During the past waiver period, this quarterly percentage has increased from 1.2% in R1 Q1 to 3.9% in R2 Q1 due to the managed care expansion.

The administrative costs reflected on Appendix D3 are directly from the CMS 64.10 waiver forms and had been reported based on the allocation methodology described above.

The external quality review organization (EQRO) expenses are not currently captured on the CMS 64.10 waiver form. The State has summarized the cost of the EQRO contract and incorporated an adjustment on Appendix D5 to incorporate these costs into the P1 state administration cost projection. The State is in the process of updating the reporting logic for the CMS 64 reports to report these EQRO expenses on the CMS 64.10 Waiver form in the future.

c. ___ Other (Please explain).

H. Appendix D3 – Actual Waiver Cost

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

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of

the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
<i>(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)</i>	\$54,264 savings or .03 PMPM	9.97% or \$5,411	\$59,675 or .03 PMPM P1 \$62,488 or .03 PMPM P2
Total			(PMPM in Appendix D5 Column W x projected member months should correspond)

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

Per the provisions of the settlement agreement between the US Department of Justice and the State of North Carolina, a population of SMI adults already included in the waiver will be eligible for treatment planning and additional 1915(b)(3) services. The new services and utilization for the settlement were made effective with the December 2012 amendment to the prior 1915(b) waiver.

Chart: Renewal/Conversion Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Amount Spent in Retrospective Period (R2 dollars reflective of 6 months of services)	Inflation and Adjustment projected	Amount projected to be spent in Prospective Period
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Respite	\$2,338,707 or \$1.50 PMPM in R1	0% inflation and a \$0.00 adjustment increase in P1	\$1.58 PMPM in P1
	\$1,625,318 or \$1.58 PMPM in R2	4.6% inflation and 0% adjustment equate to \$0.07 increase in P2	\$1.65 PMPM in P2
		4.6% inflation and 0% adjustment equate to \$0.08 increase in P3	\$1.73 PMPM in P3
		4.6% inflation and 0% adjustment equate to \$0.08 increase in P4	\$1.81 PMPM in P4
		4.6% inflation and 0% adjustment equate to \$0.08 increase in P5	\$1.89 PMPM in P5
Supported Employment	\$373,487 or \$0.24 PMPM in R1	0% inflation and a \$1.98 adjustment increase in P1	\$2.18 PMPM in P1
	\$210,548 or \$0.20 PMPM in R2	4.6% inflation and 0% adjustment equate to \$0.10 increase in P2	\$2.28 PMPM in P2
		4.6% inflation and 0% adjustment equate to \$0.11 increase in P3	\$2.39 PMPM in P3
		4.6% inflation and 0% adjustment equate to \$0.11 increase in P4	\$2.50 PMPM in P4
		4.6% inflation and 0% adjustment equate to \$0.12 increase in P5	\$2.62 PMPM in P5
Personal Care (Individual Support)	\$421,932 or \$0.27 PMPM in R1	0% inflation and a \$0.06 adjustment increase in P1	\$0.39 PMPM in P1
	\$337,756 or \$0.33 PMPM in R2	4.6% inflation and 0% adjustment equate to \$0.02 increase in P2	\$0.41 PMPM in P2
		4.6% inflation and 0% adjustment equate to \$0.02 increase in P3	\$0.43 PMPM in P3
		4.6% inflation and 0% adjustment equate to \$0.01 increase in P4	\$0.44 PMPM in P4
		4.6% inflation and 0% adjustment equate to \$0.03 increase in P5	\$0.47 PMPM in P5
One-Time Transitional Costs	\$0 or \$0.00 PMPM in R1	0% inflation and a \$1.13 adjustment increase in P1	\$1.13 PMPM in P1
	\$0 or \$0.00 PMPM in R2	4.6% inflation and 0% adjustment equate to \$0.05 increase in P2	\$1.18 PMPM in P2

		4.6% inflation and 0% adjustment equate to \$0.05 increase in P3	\$1.23 PMPM in P3
		4.6% inflation and 0% adjustment equate to \$0.06 increase in P4	\$1.29 PMPM in P4
		4.6% inflation and 0% adjustment equate to \$0.06 increase in P5	\$1.35 PMPM in P5
Psychological Rehab (Peer Supports)	\$264,671 or \$0.17 PMPM in R1	0% inflation and a \$1.35 adjustment increase in P1	\$1.51 PMPM in P1
	\$164,709 or \$0.16 PMPM in R2	4.6% inflation and 0% adjustment equate to \$0.07 increase in P2	\$1.58 PMPM in P2
		4.6% inflation and 0% adjustment equate to \$0.08 increase in P3	\$1.66 PMPM in P3
		4.6% inflation and 0% adjustment equate to \$0.07 increase in P4	\$1.73 PMPM in P4
		4.6% inflation and 0% adjustment equate to \$0.08 increase in P5	\$1.81 PMPM in P5
Innovations Waiver Services	\$1,917,745 or \$1.23 PMPM in R1	0% inflation and a \$0.00 adjustment increase in P1	\$0.96 PMPM in P1
	\$987,352 or \$0.96 PMPM in R2	4.6% inflation and 0% adjustment equate to \$0.04 increase in P2	\$1.00 PMPM in P2
		4.6% inflation and 0% adjustment equate to \$0.05 increase in P3	\$1.05 PMPM in P3
		4.6% inflation and 0% adjustment equate to \$0.05 increase in P4	\$1.10 PMPM in P4
		4.6% inflation and 0% adjustment equate to \$0.05 increase in P5	\$1.15 PMPM in P5
Physician Consultation	\$0 or \$0.00 PMPM in R1	0% inflation and a \$0.00 adjustment increase in P1	\$0.00 PMPM in P1
	\$0 or \$0.00 PMPM in R2	4.6% inflation and 0% adjustment equate to \$0.00 increase in P2	\$0.00 PMPM in P2
		4.6% inflation and 0% adjustment equate to \$0.00 increase in P3	\$0.00 PMPM in P3
		4.6% inflation and 0% adjustment equate to \$0.00 increase in P4	\$0.00 PMPM in P4

		4.6% inflation and 0% adjustment equate to \$0.00 increase in P5	\$0.00 PMPM in P5
Community Guide	\$0 or \$0.00 PMPM in R1	0% inflation and a \$0.66 adjustment increase in P1	\$0.66 PMPM in P1
	\$284 or \$0.00 PMPM in R2	4.6% inflation and 0% adjustment equate to \$0.03 increase in P2	\$0.69 PMPM in P2
		4.6% inflation and 0% adjustment equate to \$0.03 increase in P3	\$0.72 PMPM in P3
		4.6% inflation and 0% adjustment equate to \$0.03 increase in P4	\$0.75 PMPM in P4
		4.6% inflation and 0% adjustment equate to \$0.04 increase in P5	\$0.79 PMPM in P5
In-Home Skill Building	\$0 or \$0.00 PMPM in R1	0% inflation and a \$0.12 adjustment increase in P1	\$0.12 PMPM in P1
	\$0 or \$0.00 PMPM in R2	4.6% inflation and 0% adjustment equate to \$0.01 increase in P2	\$0.13 PMPM in P2
		4.6% inflation and 0% adjustment equate to \$0.00 increase in P3	\$0.13 PMPM in P3
		4.6% inflation and 0% adjustment equate to \$0.01 increase in P4	\$0.14 PMPM in P4
		4.6% inflation and 0% adjustment equate to \$0.00 increase in P5	\$0.14 PMPM in P5
Transitional Living	\$0 or \$0.00 PMPM in R1	0% inflation and a \$0.06 adjustment increase in P1	\$0.06 PMPM in P1
	\$0 or \$0.00 PMPM in R2	4.6% inflation and 0% adjustment equate to \$0.00 increase in P2	\$0.06 PMPM in P2
		4.6% inflation and 0% adjustment equate to \$0.01 increase in P3	\$0.07 PMPM in P3
		4.6% inflation and 0% adjustment equate to \$0.00 increase in P4	\$0.07 PMPM in P4
		4.6% inflation and 0% adjustment equate to \$0.00 increase in P5	\$0.07 PMPM in P5
Total	\$5,316,542 or \$3.42 PMPM in R1	0% inflation and a \$5.36 adjustment increase in P1	\$8.59 PMPM in P1

	\$3,325,967 or \$3.23 PMPM in R2	4.6% inflation and 0% adjustment equate to \$0.40 increase in P2	\$8.99 PMPM in P2
		4.6% inflation and 0% adjustment equate to \$0.41 increase in P3	\$9.40 PMPM in P3
		4.6% inflation and 0% adjustment equate to \$0.43 increase in P4	\$9.83 PMPM in P4
		4.6% inflation and 0% adjustment equate to \$0.46 increase in P5	\$10.29 PMPM in P5

*New service only piloted in the NC Cardinal Innovations program per waiver of statewideness and comparability

The P1 and P2 projections have been updated to incorporate the expansion of 1915(b)(3) services into the new managed care areas. The numbers are presented on a PMPM basis to allow for comparison to the base year given the expansion of managed care to include new areas.

The 1915(b)(3) service cost projection incorporates the actual 1915(b)(3) spending from the R1 and R2 time periods as well as the recently approved 1915(b) waiver amendment related to the changes to the 1915(b)(3) services as required by the State's settlement with the US Department of Justice. As this was recently approved, the actual spending has not yet occurred related to the requirements of the DOJ settlement. Thus, the P1 projections reflect the carry-forward of the approved 1915(b)(3) PMPMs from P2 of the prior waiver period specific to each MEG necessary to implement the DOJ settlement.

The changes authorized in the recent 1915(b) waiver amendment related to the US DOJ settlement include additional 1915(b)(3) services out of existing waiver savings already granted under the prior approved 1915(b) waiver authority for the optional state plan services: peer supports and one-time transitional costs (transition year stability resources (TYSR)) for the new special population; as well as supported employment/employment specialists for the SMI population only under evidence-based practices where the practices are clinically appropriate. These services will be phased in and available as outlined under the settlement agreement with the United States Department of Justice. The new services and utilization for the settlement were made effective with the December 2012 amendment to the prior 1915(b) waiver.

In-home skill building and transitional living 1915(b)(3) services as well as Independent Support for substance abusing women with dependent children are also being piloted using a waiver of statewideness and comparability to pilot the new populations and services in the separate NC Cardinal Innovations program.

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

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

Basis and Method:

1. ___ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.

2. X The State provides stop/loss protection (please describe):

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

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

1. X [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in

addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs (**Column D of Appendix D3 Actual Waiver Cost**). Regular State Plan service capitated adjustments would apply.

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

As part of the State's settlement with the US DOJ, the State will be awarding incentives to PIHPs upon the successful transition of members of the target population to home and community-based residences. These incentives will be based upon the criteria for successful transitions as outlined in the US DOJ settlement and the PIHP contracts. The incentives were calculated based on the State's experience in the Money Follows the Person (MFP) program based on actual expenses of the Transition Teams. The State estimated the costs of these transitions included those costs in the amendment approved in December 2012. This renewal seeks authority to pay some of those costs via incentive payments. Because the payments are already included in the cost of the waiver and North Carolina has committed to stringent monitoring under the settlement agreement, this will ensure that the total payments to PIHPs do not exceed waiver cost-effectiveness.

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

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

I. Appendix D4 -- Conversion or Renewal Waiver Cost Projection and Adjustments.

If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

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

1. X [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual trend rate used is: **2.2% from 7/30/2012 to 3/31/2013**. Please document how that trend was calculated:

This is the actual trend rate experienced by the State from 2010 through the first quarter of R2 and reflects the capitation payments and anticipated pharmacy spending for the July 2012 through March 2013 time period.

2. X [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of

either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (*i.e., trending from present into the future*).

i. State historical cost increases. Please indicate the years on which the rates are based: base years **2010, 2011, 2012**. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). **Mercer considers historical year over year trends, as well as rolling averages in making these estimates.** Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

For the prospective trend analysis, three years of waiver reported data was available to assist in the development of the trend assumptions. As noted above, this amounted to approximately 2.2% trend from 2010. This waiver cost trend has been managed to a low rate of growth over the waiver period through the utilization management of services. To assist in the projection of future trends, Mercer also performed an actuarial analysis of trend consistent with the capitated rate-setting process. The actuarial analysis focused on trends in the actual encounter data which should be more indicative of future rate-setting trends. Mercer also reviewed current FFS data for the counties in North Carolina that will be implemented under managed care. This data provided a supplemental source for the waiver and rate-setting trend review, specifically for the pharmacy wraparound services.

In the analysis of waiver and rate-setting trends, Mercer considers historical year over year trends, as well as rolling averages in making these estimates. No adjustments for programmatic, policy, or pricing changes were necessary; therefore, trend estimates do not duplicate the effect of any changes.

The final annual trend assumptions incorporating the nine months of actual trend from the end of R2 to the beginning of P1 as well as the prospective trend for 12 months of P1 are documented in the following chart.

Time Period	Trend Assumption
End of R2 (9/30/2010) to Start of P1 (4/1/13)	2.2%
P1 (4/1/13-3/31/14)	4.2%
Annualized Trend From End of R2 to End of P1	3.3%
P2-P5 Trend Rate	4.2%

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

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

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

Mercer did not estimate cost changes separate from the utilization changes. No adjustments for programmatic, policy, or pricing changes were necessary; therefore, trend estimates do not duplicate the effect of any changes.

b. X State Plan Services Programmatic/Policy/Pricing Change Adjustment:

These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that

adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

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

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

2. X An adjustment was necessary and is listed and described below:

- i. ___ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ **Determine adjustment for Medicare Part D dual eligibles.**
 - E. ___ Other (please describe):
- ii. ___ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
- iii. ___ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

- iv. Changes brought about by legal action (please describe):
 For each change, please report the following:
 - A. The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. Other (please describe): _____
- v. Changes in legislation (please describe):
 For each change, please report the following:
 - A. The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. Other (please describe): _____
- vi. Other (please describe):
 A. The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
- B. The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
- C. Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
- D. X Other (please describe): _____

The State incorporated two distinct program adjustments in the calculation of the projected cost for this waiver renewal. Note: both of these adjustments were approved through previous waiver amendments.

1. Expansion of waiver to additional counties (phase-in)

As mentioned earlier, the State is in the midst of expanding the managed care program statewide. As of June 2012, the State has implemented the managed care program with four PIHPs. Between July 2012 and April 2013, the State is scheduled to implement managed care in the rest of the state through seven contracts with other PIHPs. To incorporate the expected costs for the entire state in this waiver renewal, Mercer summarized the current capitation rates for the PIHPs currently under managed care and currently reported against the waiver. The State has worked with Mercer to develop capitation rates for each of the seven PIHPs that will be implemented between July 2012 and March 2013. Mercer calculated the average capitation rate for the upcoming seven PIHPs by MEG. Mercer compared

the average PMPM by MEG for the current PIHPs from R2 with the average PMPM for the PIHPs that will be implemented by April 2013. Mercer calculated PMPM adjustment factors to incorporate the cost differentials for the statewide expansion and applied an adjustment by MEG in column J of Appendix D5

2. DOJ Settlement - Per the provisions of the settlement agreement between the US Department of Justice's Civil Right Division's (CRD) and the State of North Carolina, the State has agreed to expand Medicaid-funded services to meet the needs of specific target populations. The State has agreed to expand the availability of ACT services in fidelity with the TMACT model as well as expand treatment planning responsibilities of the PIHPs under 42 CFR 438.208(c) to include a separate special needs population made up of the US DOJ settlement target population. The service expansion and number of individuals targeted will grow over the next eight years. Mercer calculated specific adjustment factors for each of the five projection years under this waiver renewal. The adjustments added the incremental additional costs to each projection year of the required expansions under the DOJ settlement. We have applied upward adjustments to the P1-P5 projections in column N of Appendix D.5 to the 1915(b) only MEGs. The new services and utilization for the settlement were made effective with the December 2012 amendment to the prior 1915(b) waiver.

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

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

2. An administrative adjustment was made.

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

ii. Cost increases were accounted for.

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

- B. Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
- C. State Historical State Administrative Inflation. The actual trend rate used is: _____. Please document how that trend was calculated:

D. Other (please describe):

Per the provisions of the settlement agreement between the US Department of Justice's Civil Right Division's (CRD) and the State of North Carolina, the State has agreed to expand oversight and management of Medicaid-funded services to meet the needs of specific target populations. As these costs are expected to be incurred annually, an adjustment of 1.1% was applied in addition to trend in column AH of Appendix D.5 in the P1 projection. This adjustment amounted to \$0.10 PMPM. The new oversight and management positions for the settlement were made effective with the December 2012 amendment to the prior 1915(b) waiver.

In addition as noted earlier, the external quality review organization (EQRO) expenses are not currently captured on the CMS 64.10 Waiver form. The State has summarized the cost of the EQRO contract and incorporated an adjustment on Appendix D5, Column AH to incorporate these costs into the P1 admin cost projection. This adjustment amounted to \$0.12 PMPM.

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

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: **2010, 2011, 2012** In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). **Mercer considers historical year over year trends, as well as rolling**

averages in making these estimates. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

The annualized administrative cost trend rate from 2010 through 2012 were approximately 11%. This was largely driven by lower PMPMs in 2010. Recently, these trends have returned to the expected 3-4% growth range. Based on this data and state expectation of administrative trends, the administrative costs have been projected using a 3.0% annualized administrative trend factor.

As the administrative cost projection associated with the waiver is developed on a PMPM basis, Mercer did not make an adjustment to the administrative projection due to the expansion of managed care. It is assumed similar PMPM State administrative costs will be incurred under the expanded waiver.

- B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above **_3.3% for P2-P5.**

The quarterly CMS 64 reports have exhibited a general upward trend in state administrative costs from 2010 to 2012 as indicated by the 11%. As discussed above, the administrative costs have been trended using a 3% inflation factor.

- d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1. X [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: **_-5% per Appendix D3_____**. Please provide documentation.

The actual 1915(b)(3) capitation rate trends have flattened in the recent waiver year. As such, no additional trend is assumed for the period from R2 to P1.

2. X [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

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

1. Please indicate the years on which the rates are based: base years. **July 2009 through September 2012**

Spending on 1915(b)(3) services began in July 2007. As reflected in the 1915(b)(3) capitation rate, the State spending on these services has moderated in R2 of this waiver period in alignment with the State Plan services. To project P1 PMPMs for 1915(b)(3) services, we have assumed 0% trend for current 1915(b)(3) utilization outside of the adjustment noted below to reflect the approved amendment in December 2012 specific to the requirements of the DOJ settlement. For future waiver periods (P2 – P5), the 1915(b)(3) utilization is anticipated to increase at levels consistent with the State Plan trends and has been set accordingly.

Note: as the State converts from a fee-for-service delivery system and expands managed care, the PIHPs are expected to use more cost-effective care, have tighter utilization controls, and more care coordination. The PIHPs are also expected to offer the full array of 1915(b)(3) services throughout the NC Innovations program. New 1915(b)(3) services will be tested in the separate NC Cardinal Innovations pilot program, through a waiver of statewideness and comparability.

2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):
Mercer considers historical year over year trends, as well as rolling averages in making these estimates

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from Section D.I.J.a. above 3.3% for P1 and 4.2% for P2-P5.

The 1915(b)(3) service cost projection incorporates the actual 1915(b)(3) spending from the R1 and R2 time periods as well as the recently approved 1915(b) waiver amendment related to the changes to the 1915(b)(3) services as required by the State's settlement with the US Department of Justice. As this was recently approved, the actual spending has not yet occurred related to the requirements of the DOJ settlement. Thus, the P1 projections reflect the carry-forward of the approved 1915(b)(3) PMPMs from P2 of the prior waiver period specific to each MEG.

The changes authorized in the recent 1915(b) waiver amendment related to the US DOJ settlement include additional 1915(b)(3) services out of existing waiver savings already granted under the prior approved 1915(b) waiver authority for the optional state plan services: peer supports and one-time transitional costs (transition year stability resources (TYSR)) for the new special population, which is the USDOJ target population; as well as supported employment/employment specialists for the SMI population only under evidence-based practices where the practices is clinically appropriate. These services will be phased in and available as outlined under the settlement agreement with the United States Department of Justice. The new services and utilization for the settlement were made effective with the December 2012 amendment to the prior 1915(b) waiver.

In-home skill building and transitional living 1915(b)(3) services as well as Independent Support for substance abusing women with dependent children are also being piloted using a waiver of statewideness and comparability to pilot the new populations and services in the separate NC Cardinal Innovations program.

The adjustment to carry-forward the prior approved spending levels associated with the State's settlement with the US DOJ is reflected in Column AB of Appendix D5 for the P1 PMPM.

- e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.

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

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

3. Explain any differences:

f. **Other Adjustments** including but not limited to federal government changes. (Please describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
 - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
 - ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)*:** Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

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

1. ___ No adjustment was made.

2. ___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

J. Appendix D5 – Waiver Cost Projection

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

K. Appendix D6 – RO Targets

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

L. Appendix D7 - Summary

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

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

Enrollment projections are based on historical enrollment trends and expectations for enrollment changes. The changes in enrollment are primarily due to changes in economic conditions, the expansion of managed care to new areas, and general increases in the population. The enrollment change for the Innovations - CAP-MR MEG also considers the slot increases planned for this population under the concurrent 1915(c) waiver. The projected enrollment growth is 1.8% per quarter.

The State has incorporated into the projection of this waiver the completion of this statewide implementation. The MMs for the first quarter of P1, April 2013 through June 2013 reflect the addition of the anticipated enrollment for these PIHPs along with the enrollment of the current PIHPs under the waiver. This results in the large percentage increase in enrollment as documented on Appendix D1 from the Base Year to P1.

Per the provisions of the settlement agreement between the US Department of Justice and the State of North Carolina, a population of SMI adults already included in the waiver will be eligible for treatment planning and additional 1915(b)(3) services. This population was already eligible for Medicaid and did not change Medicaid population growth.

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

In the analysis of waiver and rate-setting trends, Mercer considers historical year over year trends, as well as rolling averages in making these estimates. No adjustments for programmatic, policy, or pricing changes were necessary; therefore, trend estimates do not duplicate the effect of any changes.

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

For the prospective trend analysis, three years of waiver reported data was available to assist in the development of the trend assumptions. As noted above, this amounted to approximately 2.2% trend from 2010. This waiver cost trend has been managed to a low rate of growth over the waiver period through the utilization management of services. To assist in the projection of future trends, Mercer also performed an actuarial analysis of trend consistent with the capitated rate-setting process. The actuarial analysis focused on trends in the actual encounter data which should be more indicative of future rate-setting trends. Mercer also reviewed current FFS data for the counties in North Carolina that will be implemented under managed care. This data provided a supplemental source for the waiver and rate-setting trend review, specifically for the pharmacy wraparound services. The prospective trend assumed from R2 to the end of P1 is 3.3% and 4.2% from P1 to P2 though P5.

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

Part II: Appendices D.1-7

Please see attached Excel spreadsheet