DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

OCT 19 2018

Dave Richard
Deputy Secretary for Medical Assistance
North Carolina Department of Health and Human Services
2001 Mail Service Center
Raleigh, NC 27699-2001

Dear Mr. Richard:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving North Carolina's (the state) request for a section 1115 Medicaid demonstration project, entitled "North Carolina Medicaid Reform Demonstration" (Project Number 11-W-00313/4), in accordance with section 1115(a) of the Social Security Act (the Act).

This approval is effective January 1, 2019 through October 31, 2024. CMS's approval is subject to the limitations specified in the attached waiver authorities, expenditure authorities, special terms and conditions (STCs), and subsequent attachments. The state will implement the substance use disorder (SUD) component of the demonstration no sooner than January 1, 2019, and the SUD component of the demonstration will expire on October 31, 2023. The state will implement the remaining components under the demonstration no sooner than November 1, 2019, and they will all expire on October 31, 2024. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been listed as waived or as not applicable to expenditures or individuals covered by expenditure authority.

Extent and Scope of Demonstration

Through this section 1115 demonstration, North Carolina seeks to improve beneficiary health outcomes with the implementation of a new delivery system, to maximize high-value care and to ensure sustainability of the state's Medicaid program, and reduce SUD throughout the state. Consistent with the Secretary's authority and with standard practice, this demonstration is being approved for the time periods listed above, subject to the attached STCs.

The demonstration allows the state to transition the state's Medicaid program from fee-for-service (FFS) to a managed care program. As part of the transition to managed care, the state will contract with plans that target high-need Medicaid populations, including plans for beneficiaries with behavioral health (BH) and intellectual/developmental disabilities (I/DD) diagnoses and specialized plans for foster care youth and North Carolina former foster care youth. The state also will implement an enhanced case management and other services pilot program.

This approval authorizes the state to receive federal financial participation (FFP) for the continuum of services to treat addictions to opioids and other substances, including services

provided to Medicaid enrollees with a SUD who are short-term residents in residential and inpatient treatment facilities that meet the definition of an Institution for Mental Diseases (IMD).

Determination that the demonstration project is likely to assist in promoting Medicaid's objectives

Under section 1901 of the Act, the Medicaid program provides federal funding to participating states "[f]or the purpose of enabling each state, as far as practicable under the conditions in such state, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care."

As this statutory text makes clear, a basic objective of Medicaid is to enable states to "furnish ... medical assistance" to certain vulnerable populations (i.e., payment for certain healthcare services defined at section 1905 of the Act, the services themselves, or both). By paying these costs, the Medicaid program helps vulnerable populations afford the medical care and services they need to attain and maintain health and well-being. In addition, the Medicaid program is supposed to enable states to furnish rehabilitation and other services to vulnerable populations to help them "attain or retain capability for independence or self-care," per section 1901 of the Act.

We are committed to supporting states that seek to test policies that are likely to improve beneficiary health because we believe that promoting independence and improving health outcomes is in the best interests of the beneficiary and advances the fundamental objectives of the Medicaid program. Healthier, more engaged beneficiaries also may consume fewer medical services and have a lower risk profile, making the program more efficient and potentially reducing the program's national average annual cost per beneficiary of $7590.[1] Policies designed to improve beneficiary health that lower program costs make it more practicable for states to make improvements and investments in their Medicaid program and ensure the program's sustainability so it is available to those who need it most. In so doing, these policies can promote the objectives of the Medicaid statute.

While CMS believes that states are in the best position to design solutions that address the unique needs of their Medicaid-eligible populations, the agency has an obligation to ensure that proposed demonstration projects are likely to better enable states to serve their low-income populations, through measures designed to improve health and wellness and help individuals and families attain or retain capability for independence or self-care. Medicaid programs are complex and shaped by a diverse set of interconnected policies and components, including eligibility standards, benefit designs, reimbursement and payment policies, information technology (IT) systems, and more. Therefore, in making this determination, CMS considers the proposed demonstration as a whole.

[1] U.S. Department of Health and Human Services 2017 Actuarial Report on the Financial Outlook for Medicaid.

In its consideration of the North Carolina Medicaid Reform Demonstration proposal, CMS examined whether the demonstration was likely to assist in improving health outcomes, whether it would address health determinants that influence health outcomes, and whether it would incentivize beneficiaries to engage in their own health care and achieve better health outcomes. CMS has determined the North Carolina Medicaid Reform Demonstration is likely to promote Medicaid objectives, and the waiver and expenditure authorities sought are necessary and appropriate to carry out the demonstration.

Allowing managed care in the state is likely to increase program sustainability by lowering costs to the state and making costs more predictable each year.

Allowing managed care in the state is likely to promote efficiencies that would help ensure Medicaid's sustainability for beneficiaries over the long term. Managed care allows the state to have a more predictable budget each year and may slow the costs of the Medicaid program from growing year over year, which CMS expects will allow beneficiaries to continue receiving Medicaid coverage over the long term in the state. The state will have six Medicaid regions covering the state as part of the Medicaid reform plan. Beneficiaries must have the choice of at least two managed care organizations (MCOs).

The state requested to transition its 1915(c) Home and Community Based Services (HCBS) waivers for Innovation Waiver Services (NC-0423.R02.00) and Traumatic Brain Injury Services (NC-1326.R00.00) into the demonstration. CMS determined the state could effectively operate its HCBS waivers under the 1915(c) authorities concurrently with 1115 authority requiring Medicaid beneficiaries, except those excluded or exempted, to enroll into a managed care plan to receive state plan and HCBS waiver services.

The demonstration is likely to assist in improving health outcomes through a pilot program designed to address certain health determinants.

North Carolina's section 1115 demonstration supports coordinated strategies to address the needs of certain populations and health determinants, as well as promotes health and wellness through greater independence and improved quality of life. The North Carolina Enhanced Case Management and Other Services Pilot Program (the "pilot program") is designed to address eligible enrollees' specific health determinants to improve health outcomes and lower healthcare costs.

The state will implement the pilot program in two to four regions throughout the state to pilot evidence-based interventions addressing housing, transportation, food, and interpersonal safety and toxic stress. Pilot regions will be determined through a competitive procurement process in which Lead Pilot Entities (LPEs) will submit proposals based on target populations, objectives and evidence-based interventions for health and cost outcome. Pilot providers delivering health and social services will coordinate non-medical care to address health determinants potentially adversely affecting health and promotion of community. Under the pilot program, North Carolina will develop a pathway to value-based payments for the pilot providers, Medicaid Prepaid Health Plans (PHPs), and LPEs by incentivizing the delivery of high-quality Enhanced Case Management and Other Services by increasingly linking payments for services to

demonstration outcomes and the gathering of data and experience necessary for complex risk-based models.

CMS has long supported policies that recognize the importance of coordinating care and services to improve the well-being and health of Medicaid beneficiaries. CMS recognizes health determinants can influence health outcomes, and research supports the hypothesis that state's proposed enhanced case management services will improve health outcomes. Similarly, the Rural Health Information Hub supported by the Health Resources and Services Administration acknowledges the importance of transportation in a person's ability to access appropriate and well-coordinated healthcare, purchase nutritious food, and otherwise care for themselves.[2] In addition, Mental Health America affirms interpersonal violence and toxic stress lead to poor outcomes across the lifespan with an individual's health and productivity. The effects of toxic stress in children are known to lead to the development of mood and anxiety disorders, aggression, social skills deficits, peer relations and substance use in children and youth.[3] CMS has not previously approved a demonstration that includes enhanced case management. However, given the potential health benefits of making these services available to certain high-risk and high-need Medicaid beneficiaries, CMS believes that state Medicaid programs should be able to support these activities and test incentives that are appropriate for these populations and are likely to lead to improved health outcomes.

BH I/DD tailored plans will allow the state to address the complex needs of individuals with behavioral health and I/DD diagnoses, and the specialized plan will allow the state to address the complex needs of foster care/former North Carolina foster care youth.

Incorporating tailored plans into the North Carolina Medicaid Reform Demonstration will allow the state to address specific complex needs for the Medicaid BH I/DD populations. The tailored plans will include coverage for whole-person services specifically designed to meet complex needs, including the physical health, BH, and social needs, of these populations. The state anticipates that providing services tailored to these populations will address the healthcare needs and provide high quality care for these complex populations.

The tailored plans will be implemented by the end of third year of the demonstration. Prior to the implementation of BH I/DD tailored plans, BH I/DD qualified beneficiaries will remain in the fee for service Medicaid system for physical health services and in the state's 1915(b) program for BH I/DD services rather than being mandatorily enrolled in the standard plan. Once the BH I/DD tailored plans are implemented, eligible beneficiaries will be transitioned to (or if they had opted into Standard Plans, given the option to transition to) the tailored plan in their region with the option to opt out within 90 days to a standard plan, consistent with the process described in these STCs.

The state will develop a specialized plan to be offered by PHP for children in foster care meeting a set of care management and medication management requirements specific for this population. This specialized plan will provide coverage to children in county-operated foster

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[2] (Hub 2017)

[3] Shern, D.L. (2014). Impact of Toxic Stress on Individuals and Communities: A review of the Literature. Mental Health America.

care, children in adoptive placements, and former North Carolina foster care youth up to age 26 who aged out of care. Children will be automatically enrolled in the specialized foster care plan with the option to change to the Standard Plan for any reason at any time during the coverage year.

Approving the SUD program will allow the state to address opioid use disorders and other SUDs, which are a serious public health concern in North Carolina.

The SUD program will improve access to high-quality addiction services and is critical to addressing SUD in the state. Under this program, all Medicaid beneficiaries will continue to have access to all current mental health and SUD benefits. In addition, all beneficiaries ages 21 through 64 will have access to additional covered services, authorized under section 1115(a)(2) of the Act, including SUD treatment services provided to individuals with SUD who are short-term residents in residential treatment facilities that meet the definition of an IMD. These services would otherwise be excluded from federal reimbursement.

Elements of the demonstration request CMS is not approving at this time

In the amended demonstration application, the state requested certain additional flexibilities, and CMS is not approving the following at this time. CMS intends to continue discussing flexibilities with the state.

The state requested to provide short-term behavioral health crisis services in the IMD setting for beneficiaries with behavioral health as a primary diagnosis. Consistent with CMS policy, CMS does not currently provide expenditure authority for behavioral health IMD services.

North Carolina requested to incorporate a workforce development program into its demonstration as a two-part approach: complete a workforce development assessment to identify healthcare provider gaps throughout the state and establish a workforce incentive fund to address shortages identified in the workforce assessment through loan repayment and recruitment bonuses for critical provider types. CMS recommends the state develop and implement a one-time workforce development assessment to identify gaps in the healthcare provider workforce throughout the state. Following the analysis and completion of the workforce development assessment, the state may submit a demonstration amendment highlighting identified gaps in the provider workforce, conclusions and recommendations for the workforce development proposal for further consideration.

In its amended demonstration application, the state also requested authority for certain features of a new program entitled Carolina Cares. As described in the amended demonstration application, as proposed, the Carolina Cares program would require beneficiaries in the new adult group to pay monthly premiums and participate in community engagement activities as a condition of eligibility. Enrollees in this program would have been required to be employed or engaged in activities promoting employment to fulfill the community engagement requirement. Failure to pay the monthly premium or complete required community engagement requirements would have led to disenrollment from the program following appropriate notice and a grace period. Enrollees that would have been

exempt from the premium requirement are those with medical or financial hardship, member of a federally recognized tribe or a veteran in transition seeking employment. Enrollees caring for a dependent minor child, an adult disabled child, or a disabled parent; receiving active SUD treatment; or medically frail are exempt from the community engagement requirement. The state does not currently have state legislative authority for the Carolina Cares program, and CMS will not consider this program without state legislative authority.

The state also requested to implement a telemedicine program through two initiatives: the Telemedicine Innovation Fund to support PHPs addressing Medicaid quality strategy goals and unmet needs of the Medicaid population, and the Telemedicine Alliance to administer the Telemedicine Innovation Fund and provide a forum for sharing and disseminating best practices throughout the state. CMS has given the state information about other available resources to facilitate implementing a telemedicine program outside of the 1115 demonstration, and CMS is not approving this request.

The state requested expenditure authority to make wrap-around payments to safety-net providers to cover the difference between PHP reimbursement and provider costs. In the current FFS system, the state is currently covering these costs to ensure beneficiaries have access to providers having a limited ability to offset losses with revenue from other payers. Consistent with current CMS policies, CMS is not approving this request for expenditure authority.

In addition, the state requested expenditure authority to make advanced payments to support capacity building to health home providers delivering health home services to enrollees in a BH I/DD tailored plan. Capacity building funding would support IT supports for the care management agencies and provider and support for training the care management workforce to meet the needs of these complex populations. CMS is not approving this request for expenditure authority and will continue to work with the state on this program.

North Carolina also requested CMS approval of a tribal uncompensated care program as part of the 1115 demonstration. The state requested expenditure authority to receive the 100 percent federal medical assistance percentage under section 1905(b) of the Act for its expenditures on a tribal uncompensated care pool that would support the Cherokee Indian Hospital Authority (CIHA), an Indian Health Service (IHS) hospital. Payments under this program would offset CIHA's cost for delivery of services for uninsured individuals, and unreimbursed costs of Medicaid-covered services would not be included in the uncompensated care costs. CMS is unable to provide section 1115 authority for this proposal. The 100 percent federal match available under section 1905(b) of the Act applies only to Medicaid services received through IHS and tribal facilities, and the proposed uncompensated care payments are not payment for Medicaid services. Section 1115(a)(1) waiver authority extends only to provisions of section 1902 of the Act, and does not extend to provisions of section 1905 of the Act, such as section 1905(b). Nor is CMS able to grant the state's request by providing expenditure authority under section 1115(a)(2)(A) of the Act. Section 1115(a)(2)(A) only permits state expenditures to be regarded as federally matchable. It does not allow applicable federal match rates to be altered.

Consideration of Public Comments

CMS and the state received numerous comments throughout the federal and state comment periods. Consistent with federal transparency requirements, CMS reviewed all of the received public comments along with the summarized public comments submitted by the state, when evaluating whether the demonstration and the proposed projects were likely to promote the objectives of the Medicaid program, and whether the waiver and expenditure authorities sought were necessary and appropriate to implement the demonstration. In addition, public comments were considered in the development of the STCs that accompany this approval, and that will bolster beneficiary protections, including specific state assurances around these protections to further support Medicaid beneficiaries.

Commenters expressed concerns regarding the state's request to implement the Carolina Cares program through the establishment of a new adult group that would charge enrollees a monthly premium and require enrollees to complete work requirements to maintain Medicaid coverage. North Carolina acknowledged the concerns of many of the commenters and expressed the state's commitment to ensuring enrollees have access to affordable health care. The state also acknowledged that it would need state legislative authority to implement the Carolina Cares program. The state does not have legislative authority for the Carolina Cares program and the Carolina Cares program is not being approved under this demonstration.

Additional commenters expressed concerns regarding the state's proposal to transition 1915(c) waivers into the demonstration and the possibility of unintended consequences such as disruptions of continuity of care and reductions in the budget. CMS has decided to approve operation of these waivers concurrently with the 1115 demonstration, which we believe should alleviate the commenter's concerns as the 1915(c) waivers will continue to operate as previously approved. The only difference created by this approval is that the 1915(c) waiver services will now be delivered through managed care plans for these populations under the authority of section 1115 of the Act. The state has been thoughtful in its approach to transition from FFS to managed care and has been working closely with CMS in preparation for the transition. Specifically, North Carolina first came to CMS with an interest in implementing managed care, including Managed Long-Term Services and Supports in June 2016. Since that time, CMS has been providing technical assistance to the state, including preparing the state to meet readiness review expectations under 42 CFR 438.66, which address network adequacy and access. CMS is confident that North Carolina is prepared for the transition to managed care and is able to avoid the unintended consequences identified by commenters.

We received comments regarding the sufficiency of the state's SUD proposal in the amended demonstration. Commenters expressed concerns that the proposal did not align closely with the State Medicaid Director Letter (SMDL) released November 1, 2017. One commenter indicated the state's proposal only seeks permission to reimburse for inpatient and residential care, not addressing care coordination and would not adequately address the opioid crisis or improve SUD services. Another commenter recommended the state incorporate the goals and milestones outlined in the SUD SMDL to ensure the state's residential treatment providers will deliver SUD services consistent with the nationally recognized SUD criteria and provide evidence-based SUD treatment, including medications for treatment in the opioid disorder. The STCs require that the

state not only submit a SUD Implementation Plan Protocol, but that the SUD Implementation Plan Protocol reflect key goals and milestones, including but not limited to the use of nationally recognized SUD-specific program standards to set provide qualifications for residential treatment facilities.

CMS's approval of this demonstration is conditioned upon compliance with the enclosed list of waiver and expenditure authorities and the STCs defining the nature, character and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter. Your project officer for this demonstration is Ms. Sandra Phelps. She is available to answer any questions concerning your demonstration project. Ms. Phelps' contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-1968
E-mail: Sandra.Phelps@cms.hhs.gov

Official communications regarding this demonstration should be sent simultaneously to Ms. Phelps and Ms. Shantrina Roberts, Associate Regional Administrator (ARA) in our Atlanta Regional Office. Ms. Roberts' contact information is as follows:

Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street SW
Atlanta, GA 30303
Telephone: (404) 562-7418
E-mail: Shantrina.Roberts@cms.hhs.gov

If you have any questions regarding this approval, please contact Mrs. Judith Cash, Director, State Demonstrations Group, Center for Medicaid & CHIP Services at (410) 786-9686.

Sincerely,

Seema Verma

Seema Verma

cc: Shantrina Roberts, ARA, CMS Atlanta Region