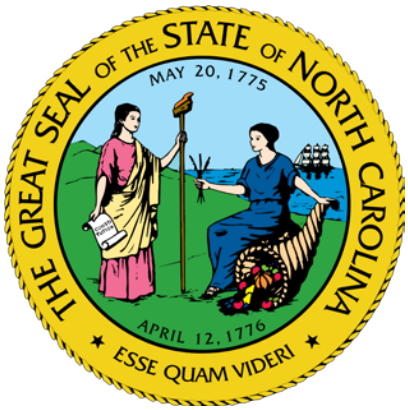

North Carolina Medicaid and NC Health Choice

Amended Section 1115 Demonstration Waiver Application

Prepared by
North Carolina Department of Health and Human Services

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Contents

I. Program Description

This section should contain information describing the goals and objectives of the Demonstration, as well as the hypotheses that the Demonstration will test. In accordance with 42 CFR 431.412(a)(i), (v) and (vii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act). (This summary will also be posted on Medicaid.gov after the application is submitted.)

North Carolina is transitioning its Medicaid and NC Health Choice[1] programs' care delivery system for most beneficiaries and services to managed care, as directed by the General Assembly. The State submits this 1115 demonstration waiver application amendment to implement managed care, advance integrated and high-value care, improve population health, engage and support providers, and establish a sustainable program with more predictable costs. To improve outcomes consistent with North Carolina's health and health care environment, the new managed care program will be paired with initiatives to support and enhance the capabilities of Medicaid providers, strengthen access to care across the State for beneficiaries, and improve health through evidence-based, health-related interventions spearheaded by public–private regional pilot programs. Specifically, the initiatives include the following:

- Designing managed care products tailored for enrollees with high behavioral health needs;
- Strengthening the provider workforce through new initiatives specially designed to address the needs of the Medicaid population;
- Piloting new approaches to telemedicine and supporting providers in optimizing the use of telemedicine in their practices;
- Maintaining access to essential safety-net providers through continuing cost settlements;
- Addressing the health disparities of tribal members through the support of a model Tribal Health System;
- Strengthening federally recognized tribal providers with a tribal uncompensated care pool;
- Addressing the unmet needs that impact the health and health care costs of North Carolinians through public–private regional pilots to identify, test, strengthen and sustain evidence-based interventions that can measurably improve health and reduce costs;
- Increasing access to inpatient and residential substance use disorder and behavioral health treatment through reimbursement for services in institutions of mental disease (IMD); and
- Increasing access to care through the Carolina Cares program, if proposed State legislation is enacted.

These waiver initiatives go hand-in-hand with other special initiatives that the North Carolina Medicaid program is developing, in collaboration with stakeholders. While these special initiatives do not require waiver authority, they complement the requests outlined in this waiver amendment and represent a significant investment in improving care aimed at increasing and enhancing providers' capabilities and ensuring access to integrated, high-value care particularly by recognizing an investment in population health while addressing the unique needs of

[1] NC Health Choice is North Carolina's separate CHIP program. Throughout this demonstration waiver application amendment, "Medicaid" will represent the Medicaid and NC Health Choice programs except when NC Health Choice needs to be specifically mentioned.

high-cost, high-needs target populations, including individuals with complex behavioral health needs, those accessing home- and community-based waiver services, long-term services and supports (LTSS), and youth in foster care. For example:

- Subject to legislative approval, the State is developing benefit packages, care management requirements and network standards tailored to high-needs populations.
- The State will also strengthen its historical focus on primary care and care management through the implementation of Advanced Medical Homes.
- To ensure providers are prepared for the transition to Medicaid managed care with minimal burden, the State will implement a "one-stop shop" centralized credentialing process and provide training, including through "Regional Provider Support Centers."

More information on these and other efforts can be found in "North Carolina's Proposed Program Design for Medicaid Managed Care" on the North Carolina Medicaid Transformation website at files.nc.gov/ncdhhs/documents/files/MedicaidManagedCare_ProposedProgramDesign_REVFINAL_20170808.pdf.

All aspects of this waiver will be consistent with the rights and protections afforded American Indian/Alaskan Native (AI/AN) Medicaid enrollees and Indian Health Care Providers (IHCPs) in the Social Security Act and Indian Health Care Improvement Act. The design of the models and the contractual obligations of the managed care entities will be in sync with the terms and conditions recommended.

2) Include the rationale for the Demonstration.

The State's Medicaid program—which serves nearly two million North Carolinians—is essential for ensuring the health of our residents, the durability of our providers, and the strength of our communities. To continue to improve the health of our State and its residents, the North Carolina Medicaid program, with direction from the North Carolina Legislature, will accelerate its efforts to improve outcomes for our beneficiaries and the Medicaid program by promoting value, improving quality and supporting providers.

As a starting point, North Carolina will, pursuant to state law, change how the State delivers care to its Medicaid enrollees by transitioning to a Medicaid managed care program. The State is seeking to delegate direct management of medical services and financial risks to prepaid health plans (PHPs) for most enrollees, as required under General Assembly Session Law 2015-245 and amended by Session Law 2016-121. In June 2016, the State submitted to CMS a waiver application outlining the State's goals as part of this transition. Since then, the State has continued to engage with legislative leaders and stakeholders across North Carolina, releasing a request for public input in April 2017 and a proposed program design with a 30-day public comment period in August 2017. Based on that public input and further review by the State, North Carolina is strengthening the design of its managed care program through several initiatives, including those for which waiver authority is sought through this amended waiver application.

To improve outcomes consistent with North Carolina's environment, the new managed care program will be paired with initiatives to further improve the capabilities of Medicaid providers and strengthen access to care across the state. These initiatives include, among others as described later in this amended application, improving access to care in rural and underserved communities through shared investments in telemedicine and funds for boosting the Medicaid provider workforce pipeline. The State is also proposing strategies to support tribal and other essential safety-net providers, and a new initiative to improve care and lower costs through investments in connecting people to economic and social supports. The Tribe supports telehealth/telemonitoring.

Taken together, North Carolina is requesting approximately $1.2 billion over five years in expenditure authority to successfully implement the targeted initiatives requiring federal waiver authority, which are critical for achieving the goals of improved health and value. (As noted, these waiver initiatives are in addition to the investments in the Medicaid program the State is seeking to make that do not require waiver authority.)

For some initiatives or features described in this amended application, the State Legislature has not yet provided statutory authorization. The application notes throughout where further legislative authorization is required, and the State will update CMS throughout the upcoming legislative sessions.

The balance of this document describes the State's waiver requests for CMS support in achieving the State's three goals for transformation:

1. Measurably improve health, through tailored plans for certain individuals with complex needs, integration of physical and behavioral health for all beneficiaries covered through PHPs, improving access to inpatient behavioral health treatment, and strategies to address enrollees' social determinants of health;
2. Maximize value to ensure sustainability of the program through, among other things, actuarially sound capitation rates; and
3. Increase access to care.

3) Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them.

Measurably Improve Health

- The implementation of tailored plans, the specialized foster care plan, and a tribal option, will increase the quality of care for individuals with serious mental illness, serious emotional disturbance, substance use disorder, and intellectual and developmental disability (I/DD), and for children in foster care.
- The implementation of Medicaid managed care will increase the rate of use of behavioral health services in the appropriate level of care and improve the quality of behavioral health care received.
- The implementation of Medicaid managed care will decrease the long-term use of opioids and increase the use of medication-assisted treatment (MAT) and other opioid treatment services.
- The implementation of Medicaid managed care will increase screening for social determinants of health, including food insecurity, housing, transportation and interpersonal safety/toxic stress.

Maximize High-Value Care to Ensure the Sustainability of the Program

- The implementation of Medicaid managed care will decrease the use of emergency departments for non-urgent use and hospital admissions for ambulatory sensitive conditions.
- The implementation of Medicaid managed care will increase the number of enrollees receiving care management, overall and during transitions in care.

Increase Access to Care

- The implementation of Medicaid managed care, the innovation workforce fund and the introduction of Regional Provider Support Centers will increase the numbers of primary care, obstetric, behavioral health and specialty providers in underserved areas, improve provider satisfaction, and maintain the same level of providers' participation in Medicaid.
- The implementation of Medicaid managed care will increase the use of telemedicine by rural Medicaid enrollees.
- Cost-settled safety-net providers will remain financially stable after the transition to PHPs, and enrollees will access services from these providers at similar rates to prior to managed care implementation.
- The introduction of a tribal uncompensated care pool will expand services for Native Americans, and reduce levels of uncompensated care for services provided by or arranged through the Cherokee Indian Hospital Authority.

4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the 2 geographic areas/regions of the State where the Demonstration will operate.

The demonstration will operate statewide; the public-private regional partnership pilots to address health-related needs will be implemented in two to four areas of the state, which could include the trust lands of the Eastern Band of the Cherokee.

5) Include the proposed timeframe for the Demonstration.

To timely implement the changes proposed for North Carolina's program, the State seeks an approval of the expenditure authority to pay for substance use disorder services in an IMD as quickly as possible for immediate implementation, and an approval of the remaining waiver requests in mid-February 2018 for a waiver that is effective for five years beginning July 1, 2019.

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

North Carolina proposes several initiatives that affect the Medicaid program outside of eligibility, benefits and cost-sharing. All have a strong relationship to the delivery system changes proposed in that they are aimed at ensuring Medicaid managed care is implemented in a way that advances high-value care, improves population health, engages and supports providers, and promotes sustainability through a combination of care and payment improvements, as well as more predictable costs.

Specifically, these initiatives include:

- Strengthening the provider workforce through new initiatives tailored to the needs of the Medicaid population;
- Piloting new approaches to telemedicine and supporting providers in optimizing the use of telemedicine in their practices;
- Maintaining access to essential safety-net providers through continuing cost settlements;
- Strengthening tribal providers with a tribal uncompensated care pool and model of care delivery; and
- Addressing the unmet needs that impact the health and health care costs of North Carolinians through public–private regional pilots to identify, test, strengthen and sustain evidence-based interventions that can measurably improve health and reduce costs.

Each of these initiatives is described next, and several are described in additional detail in section "IV. Delivery System and Payment Rates for Services."

Strengthening and Expanding Provider Supports

North Carolina, like many other states, has a need to boost its health care workforce in certain areas of the state and for certain kinds of care. Recognizing that financial incentives can attract providers to underserved areas upon completion of training, North Carolina has long supported loan repayment and other incentive programs that target crucial provider types in underserved areas where there is an opportunity to better meet the needs of the Medicaid population. To address this, the State proposes a three-part approach to invest in provider recruitment and retention programs:

1. Conduct a workforce evaluation to rigorously identify gaps in the workforce, particularly as they impact the Medicaid population;
2. Establish an Innovation Workforce Fund targeted to address shortages identified in the workforce evaluation; and

3. Measure the impact of this initiative throughout the course of the waiver.

Supporting and Expanding Telemedicine Services

Increasing access to telemedicine services has the potential to meaningfully improve the health of North Carolinians and lower costs, particularly in rural and underserved areas. The initiative seeks to target these services on improving chronic disease management and prevention, and facilitating primary care and behavioral health integration. As such, the State aims to leverage its existing clinical coverage policies and enhance access for providers and beneficiaries to services delivered via telemedicine by:

- Increasing provider awareness, education and training by supporting the establishment of an independent, statewide telemedicine alliance; and
- Supporting innovative approaches of providers and PHPs to telemedicine, including investing in evidence-based pilots, and ensuring providers have access to necessary equipment, the ability to connect to other providers, and protocols for adapting their practices to accommodate the innovations.

Cost-Settling Essential Safety-Net Providers

Today in North Carolina, certain public providers receive cost settlements from the Medicaid program to cover the difference between total Medicaid reimbursement received for services delivered and the providers' allowable costs—including local public health departments, public ambulance providers and state-owned or -operated skilled nursing facilities. North Carolina proposes to continue making wrap-around payments directly to these providers to cover the difference between PHP reimbursement and providers' costs to ensure beneficiaries have access to these essential providers that have limited ability to offset losses with revenue from other payers.

Establishing a Tribal Uncompensated Care Pool

North Carolina proposes to strengthen tribal providers in North Carolina by establishing a tribal uncompensated care pool (up to $86.6 million). The tribal uncompensated care pool payments will provide payments to the Cherokee Indian Hospital Authority to offset the Authority's uncompensated care costs for services provided directly by or referred through the Authority.

Establishing Evidence-Based Public–Private Regional Pilots to Address Health-Related Needs

North Carolina seeks expenditure authority under the waiver (up to $800 million) to establish public–private regional pilots in 2-4 areas of the State, which could include the trust lands of the Eastern Band of the Cherokee. These initiatives will focus on engaging Medicaid beneficiaries in select regions of North Carolina and providing them with information, services and benefits targeted to measurably improve health and lower costs. The pilots will employ evidence-based interventions addressing the following areas of need:

- Housing;
- Transportation;
- Food; and
- Interpersonal safety and toxic stress.

These public–private regional pilots will comprise entities that provide or authorize health and social services and coordinate medical and non-medical care to address social and economic issues that can adversely impact health, and to promote community engagement. Through a competitive procurement process, pilots will be required to identify their geographic region, describe their participants and governance, and define their specific target populations, objectives and evidence-based interventions for health and cost outcomes based on State-defined parameters and contingent on State approval. They will also be required to meet data collection, measurement and reporting requirements to track and document progress toward their objective outcomes. The State's long-term goal is to incorporate successful pilots into the Medicaid managed care program.

Key pilot features are described next.

Pilot Target Populations

Pilots must target individuals with complex health and social needs[2] and/or children and families with children experiencing or at risk of significant and multiple adverse childhood experiences. Populations that may meet the definition include, but are not limited to:

- Children and adults with poorly controlled chronic conditions (e.g., diabetes, asthma)
- Children and adults who are homeless, at risk of being homeless, living in unsafe/unhealthy housing conditions or lack appropriate heat/lights
- Children and adults who are food insecure
- Children who have experienced or are experiencing multiple adverse childhood experiences and/or toxic stress
- Pregnant women with complex social needs such as housing, food and interpersonal violence
- Adults with repeated incidents of avoidable emergency department use, hospital admissions or nursing facility placement
- Elderly and disabled experiencing or at risk of social isolation
- Children, pregnant women and adults with behavioral health or substance use disorders

Pilot applicants must propose one or more target populations, provide rationale on how the populations comply with the State's parameters, and indicate how they will proceed to identify and reach out to the target populations.

Participation in Pilots

Participation by beneficiaries in the pilots will be voluntary with the option to opt-out at any time.

Pilot applicants may indicate that they have a limited capacity to serve all members of their target population and, if so, will be required to propose how they might limit the number of people they will serve. Applicants that propose to limit the number of people they serve will be required to track eligible individuals who want to enroll if the pilot is able to do so in the future.

Pilots' Objectives

The State will require pilot applicants to set at least one specific objective within each category, except for the category marked "optional":

- Increase integration among health and social services entities.
- Improve health care service utilization and/or health care costs for target population.
- Improve health outcomes for target population.
- OPTIONAL: Improve general well-being and reduce non-health care costs for target population.

Pilots will also be required to work with community partners to develop outcomes-based performance metrics to evaluate progress toward those objectives. Pilots will be required to report these metrics to the State on a schedule to be defined by the State. These metrics and reports will allow the State to measure progress across all pilots and reflect the flexibility pilots will have in targeting populations, interventions and objectives.

[2] Patients with complex health and social needs experience poor outcomes despite extreme patterns of hospitalizations or emergency care. Although significant health care resources are spent on these patients, the care they receive has not made them healthy or well. https://www.camdenhealth.org/national-center/

Pilot Evidence-Based Interventions

North Carolina expects pilot applicants to define the evidence-based interventions they will use to improve health and lower costs within the four target domains (housing, food, transportation, and interpersonal safety and toxic stress) during the application process. Below are example interventions the State anticipates pilots may identify; however, any proposed intervention will be contingent on State review and approval.

SDOH DOMAIN	EXAMPLE INTERVENTIONS

Housing	• Housing transition services, such as:
	  o Tenant screening/housing assessment
	  o Assistance with housing application process
	  o Linkages to recovery-oriented supportive housing
	  o Ensuring living environment is not adversely affecting occupants' health by assessing potential health risks
	• Housing and tenancy sustaining services, such as:
	  o Repairs for issues such as mold, pest infestation or malfunctioning heating or air conditioning systems
	  o Modifications to improve accessibility of housing (e.g., ramps, rails) and safety (e.g., grip bars in bathtubs)
	  o Assistance with housing recertification process
	• Medical-legal partnership to provide assistance with housing issues, such as assistance if past criminal record poses barrier to securing housing or breaking lease due to unhealthy living conditions
	• First month's rent consistent with 1915(c)
	• Short-term recuperative care after hospitalization

Food	• Connecting individuals to food supports, such as:
	  o Assistance with applications for FNS and WIC
	  o Locating and referral to food banks or community-based summer and after-school food programs
	• Targeted nutritious food or meal delivery services for individuals with medical or special dietary needs
	• Co-locating food pantries in health care settings
	• Nutrition counseling and education

Transportation	Transportation services to health-related and social services, including pharmacies, grocery stores, farmers' markets, employment assistance sites; social engagement activities such as church, parks and social service agencies; and community engagement activities.
Interpersonal Safety/Toxic Stress	• Evidence-based home visiting programs and parent support (e.g., Parents as Teacher, Nurse Family Partnership, Child Parent Psychotherapy and Child First) screening procedures to identify interpersonal violence for emergency departments, hospitals, primary care offices, and OB providers and linkages to community-based social service agencies • Targeted training for clinicians and therapists in interpersonal violence intervention, promotion of resilience in children with adverse childhood experiences, and trauma-informed care • Community-based prevention and interventions, including linkages to schools and programs such as Reach Out and Read • Dyadic treatment for families • Linkages to programs that increase adults' capacity to participate in community engagement activities

Pilot Entities

- **Participating Entities.** Pilot applicants will be encouraged to collaborate with any willing and qualified partner and must have some form of representation from each county within the pilot area. All pilots must include the following entities:
    - All Medicaid managed care PHPs operational within the region (described further below);
    - At least one health system, provider organization or federally qualified health center/rural health clinic (FQHC/RHC);
    - At least one behavioral health agency or provider organization;
    - At least one public agency, such as a local health department or department of social services; and
    - At least two community partners, such as philanthropic organizations or other community-based organizations.
- **Role of PHPs.** PHPs will be required through contractual obligation to be a participating entity in all pilots operating in any geographic region in which the PHP operates. PHPs will be expected to collaborate with the lead and other participating entities, including participation in meetings, data exchange and coordination with respect to any PHP member enrolled in the pilot.
- The State and EBCI will continue to collaborate in the development of a tribal option that considers and addresses the unique cultural, behavioral health and medical needs of federally recognized tribal members. The tribal option may not be a full-risk health plan initially; however, EBCI and the State are considering the feasibility of a future full-risk arrangement.
- **Lead Entities**. North Carolina will require each pilot to identify a lead entity, which must demonstrate the functional capacity to:
    - Submit completed application and serve as contact for DHHS;
    - Coordinate and collaborate with pilot entities and engage with other pilots to promote efficiency and reliance on evidence-based practices;
    - Develop and submit required reports to DHHS, including reports on outcomes relating to the pilot; and
    - Show financial soundness and competency.

Pilot Financing

- Financing and Budget Requirements
    - Pilot applicants will be required to demonstrate during the application process that they have private dollars to finance a portion of their pilot activities.
    - Pilot applicants will be required to submit a proposed budget with a total requested annual dollar amount, broken down by source of funding and pilot element (e.g., capacity building, interventions).
    - Each pilot will be required to demonstrate sources of funding other than Medicaid for financing services (e.g., ongoing rental payments or subsidies) that cannot be financed through non-waiver authorities or this Medicaid demonstration.
- **Medicaid Funding.** Medicaid expenditures through this demonstration will support the pilots in various ways:
    - Capacity building to develop the programmatic supports necessary to plan, build and operate the project;
    - Reporting on metrics and outcomes; and

- Financing interventions for pilot participants consistent with the demonstration's Special Terms and Conditions and not otherwise covered by Medicaid.

II. Demonstration Eligibility

This section should include information on the populations that will participate in the Demonstration, including income level. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration (an example is provided below; note that populations whose eligibility is not proposed to be changed by the Demonstration do not need to be included). Please refer to Medicaid Eligibility Groups: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf when describing Medicaid State plan populations, and for an expansion eligibility group, please provide the state name for the groups that is sufficiently descriptive to explain the groups to the public.

Table 1 describes all eligibility groups impacted by the demonstration. As described in section "IV. Delivery System and Payment Rates for Services," some populations will transition to Medicaid managed care at the outset of the demonstration, while other populations will be phased into managed care.

TABLE 1. ELIGIBILITY GROUPS IMPACTED BY DEMONSTRATION

ELIGIBILITY GROUP	SOCIAL SECURITY ACT AND CFR CITATIONS	INCOME LEVEL
MANDATORY STATE PLAN GROUPS		
Low Income Families (Parents/Caretaker Relatives)	1931 42 CFR 435.110	45% of FPL
Transitional Medical Assistance	408(a)(11)(A) 1931(c)(2) 1925 1902(a)(52)	185% of FPL
Extended Medicaid due to Child or Spousal Support Collections	408(a)(11)(B) 42 CFR 435.115 1931(c)(1)	No income test
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care	1902(a)(10)(A)(i)(I) 473(b)(3) 42 CFR 435.145	No income test
Former Foster Care Children up to Age 26	1902(a)(10(A)(i)(IX)	No income test
Qualified Pregnant Women and Children	42 CFR 435.116 1902(a)(10)(A)(i)(III) 1905(n)	45% of FPL
Mandatory Poverty Level Related Pregnant Women	1902(a)(10)(A)(i)(IV) 1902(l)(1)(A)	196% of FPL
Mandatory Poverty Level Related Infants	1902(a)(10)(A)(i)(IV) 1902(l)(1)(B)	210% of FPL
Mandatory Poverty Level Related Children Aged 1-5	1902(a)(10)(A)(i)(VI) 1902(l)(1)(C)	210% of FPL

ELIGIBILITY GROUP	SOCIAL SECURITY ACT AND CFR CITATIONS	INCOME LEVEL
Mandatory Poverty Level Related Children Aged 6-18	• 1902(a)(10)(A)(i)(VII) • 1902(l)(1)(D)	133% of FPL
Deemed Newborns	• 1902(e)(4) • 42 CFR 435.117	Automatically eligible
Individuals Receiving SSI	• 1902(a)(10)(A)(i)(II)(aa) • 42 CFR 435.120	Automatically eligible
Individuals Who Are Essential Spouses	• 42 CFR 435.131 • 1905(a)	SSI standard (Closed to new enrollment)
Institutionalized Individuals Continuously Eligible Since 1973	42 CFR 435.132	SSI standard (Closed to new enrollment)
Blind or Disabled Individuals Eligible in 1973	42 CFR 435.133	SSI standard (Closed to new enrollment)
Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972	42 CFR 435.134	SSI standard (Closed to new enrollment)
Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April 1977	• 1939(a)(5)(E) • 42 CFR 435.135 • Section 503 of P.L. 94-566	SSI standard
Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI	• 1634(b) • 42 CFR 435.137	100% of FPL
Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	• 42 CFR 435.138 • 1634(d)	100% of FPL
Working Disabled under 1619(b)	• 1902(a)(10)(A)(i)(II) • 1905(q) • 1619(b)	200% of FPL
Disabled Adult Children	1634(c)	SSI standard
Individuals Dually Eligible for Medicare and Medicaid Who are Eligible to Enroll in BH I/DD Tailored Plans	Various	Various
OPTIONAL STATE PLAN GROUPS		
Children with Non-IV-E Adoption Assistance	• 1902(a)(10)(A)(ii)(VIII) • 42 CFR 435.227	Applicable children's group
Independent Foster Care Adolescents	• 1902(a)(10)(A)(ii)(XVII) • 1905(w)	No income test
Children under 21 Not Receiving Cash	• 1902(a)(10)(A)(ii)(I) – (IV) • 1905(a)(i) • 42 CFR 435.222	45% of FPL
Families Who Would Qualify for Cash if Requirements Were More Broad	• 1902(a)(10)(A)(ii)(III) • 42 CFR 435.223 • 1905(a)	45% of FPL
Optional Poverty Level Related Pregnant Women and Infants	• 1902(a)(10)(A)(ii)(IX) • 1902(l)(2)	196% of FPL

ELIGIBILITY GROUP	SOCIAL SECURITY ACT AND CFR CITATIONS	INCOME LEVEL
Individuals Eligible for but Not Receiving Cash	• 42 CFR 435.210 • 1902(a)(10)(A)(ii)(I) • 1905(a) • 1902(v)(1)	Applicable cash group
Poverty Level Aged or Disabled	• 1902(a)(10)(A)(ii)(X) • 1902(m)(1)	100% of FPL
Poverty Level Blind	1905(a)(IV)	100% of FPL
Certain Women Needing Treatment for Breast or Cervical Cancer	• 1902(a)(10)(A)(ii)(XVIII) • 1902(aa)	250% of FPL
Ticket to Work Basic Group	1902(a)(10)(A)(ii)(XV)	• 150% of FPL for unearned income • Enrollment fee if countable income above 150% of FPL • Enrollment fee plus premium if income above 200% of FPL • Full buy-in if income above • 450% of FPL
Ticket to Work Medical Improvements Group	1902(a)(10)(A)(ii)(XVI)	• 150% of FPL for unearned income • Enrollment fee if above 150% of FPL • Enrollment fee plus premium if income above 200% of FPL • Full buy-in if income above • 450% of FPL
1915(C) WAIVER POPULATIONS		
Innovations Waiver	1915(c) waiver	Various
Traumatic Brain Injury (TBI) Waiver[3]	1915(c) waiver, not yet implemented	Various
ADDED POPULATION (IF PROPOSED STATE LEGISLATION IS ENACTED)		
New Adult Group (“Carolina Cares”)	1902(a)(10)(A)(i)(VIII)	133% of FPL

In addition, children in NC Health Choice (211% of FPL) will be mandatorily enrolled in a PHP. Members of federally recognized tribes, including members of the Eastern Band of Cherokee Indians (EBCI), may voluntarily enroll in PHPs on an opt-in basis.

The groups listed in Table 2 will not be affected by the demonstration and will continue to receive Medicaid benefits through the service delivery system under the approved state plan or under existing waivers.

TABLE 2: GROUPS EXCLUDED FROM ENROLLMENT IN PHPS AND THE DEMONSTRATION

GROUP NAME	SOCIAL SECURITY ACT AND CFR CITATIONS
Qualified Medicare Beneficiaries	• 1902(a)(10)(E)(i) • 1905(p)

[3] The State submitted an application for its TBI waiver to CMS Feb. 29, 2016. The waiver request is undergoing CMS review and, if approved, will apply to qualifying individuals enrolled in the Alliance Behavioral Health LME-MCO (Cumberland, Durham, Johnston and Wake counties).

GROUP NAME	SOCIAL SECURITY ACT AND CFR CITATIONS
Qualified Disabled and Working Individuals	• 1902(a)(10)(E)(ii) • 1905(s) • 1905(p)(3)(A)(i)
Specified Low Income Medicare Beneficiaries	• 1902(a)(10)(E)(iii) • 1905(p)(3)(A)(ii)
Qualifying Individuals	• 1902(a)(10)(E)(iv) • 1905(p)(3)(A)(ii)
Medically Needy Pregnant Women except those covered by Innovations or TBI waivers (pending legislative change)	• 1902(a)(10)(C)(ii)(I) • 42 CFR 435.301(b)(1)(i) and (iv)
Medically Needy Children under 18 except those covered by Innovations or TBI waivers (pending legislative change)	• 1902(a)(10)(C)(ii)(I) • 42 CFR 435.301(b)(1)(ii)
Medically Needy Children Age 18 through 20 except those covered by Innovations or TBI waivers (pending legislative change)	• 42 CFR 435.308 • 1902(a)(10)(C)
Medically Needy Parents and Other Caretaker Relatives except those covered by Innovations or TBI waivers (pending legislative change)	• 1902(a)(10)(C) • 42 CFR 435.310
Medically Needy Aged except those covered by Innovations or TBI waivers (pending legislative change)	• 1902(a)(10)(C) • 42 CFR 435.320 and 435.330
Medically Needy Blind except those covered by Innovations or TBI waivers (pending legislative change)	• 1902(a)(10)(C) • 42 CFR 435.322 and 435.330
Medically Needy Disabled except those covered by Innovations or TBI waivers (pending legislative change)	• 1902(a)(10)(C) • 42 CFR 435.324 and 435.330
Medically Needy Blind or Disabled Individuals Eligible in 1973 except those covered by Innovations or TBI waivers (pending legislative change)	42 CFR 435.340 (Closed to new enrollment)
Presumptively Eligible Pregnant Women	• 1902(a)(47) • 1920
Presumptively Eligible MAGI Individuals	• 1902(a)(10)(A)(i), (III), (IV), (VI), (VII), (IX) • 1902(a)(10)(A)(ii), (IX)(XVIII), (XXI) • 1902(a)(47)(B) • 42 CFR 435.603
Individuals Dually Eligible for Medicare and Medicaid, except those eligible to enroll in BH/IDD tailored plans	Various
Individuals Participating in the Program of All-Inclusive Care for the Elderly (PACE)	Various
Individuals Receiving Refugee Medical Assistance	45 CFR Part 400
Individuals Participating in the NC Health Insurance Premium Payment (HIPP) program	Various
Individuals with Limited or no Medicaid Coverage (e.g., eligible for emergency services, or individuals receiving presumptive eligibility)	Various
Individuals Eligible for Family Planning Services[4]	• 1902(a)(10)(A)(ii)(XXI) • 42 CFR 435.214
Prison Inmates[5]	• 1905(a)(29)(A) • 42 CFR 435.1009, 1010

[4] Contingent on receipt of State legislative authority

[5] Eligibility limited to during inpatient stays. 42 C.F.R. 435.1010. Contingent on receipt of State legislative authority

GROUP NAME	SOCIAL SECURITY ACT AND CFR CITATIONS
Medicaid-only Beneficiaries Receiving Long-Stay Nursing Home Services	• 1931 • 1902(a)(10)(A)(i)(VIII)
Community Alternatives Program for Children (CAP/C)	1915(c) waiver
Community Alternatives Program for Disabled Adults (CAP/DA)	1915(c) waiver

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

North Carolina will use the modified adjusted gross income standards and methodologies consistent with the State Plan to determine eligibility for all populations whose eligibility has changed under the demonstration.

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

The State will retain current enrollment limits for the 1915(c) Innovations and Traumatic Brain Injury waivers, which will be folded into the 1115 demonstration. These waivers' enrollment limits and the timing for incorporating them into the 1115 demonstration are:

TABLE 3. INNOVATIONS AND TBI WAIVERS ENROLLMENT AND DEMONSTRATION INCORPORATION TIMING

WAIVER	ENROLLMENT LIMIT	TIMING TO INCORPORATE INTO 1115 DEMONSTRATION
Innovations Waiver	12,488	Year 3 of Managed Care Launch
Traumatic Brain Injury Waiver	255	Year 3 of Managed Care Launch

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

Of the 2 million current enrollees, approximately 1.5 million would be enrolled in managed care.

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

The demonstration does not impact post-eligibility treatment of income.

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

Information provided below is based on proposed State legislation to adopt "Carolina Cares." If enacted by the State Legislature, Carolina Cares enrollees would be required to make premium payments and meet work requirements as conditions of eligibility.

Premiums

- Carolina Cares enrollees with incomes > 50% of FPL would be required to pay monthly premiums of 2% of income.

- Individuals who demonstrate the following would be exempt from the premium requirement:
  - Medical hardship;
  - Financial hardship;
  - Membership of a federally recognized tribe; or
  - Status as a veteran in transition seeking employment.
- Enrollees that fail to pay premiums within 60 days of their due date would be disenrolled from Medicaid, unless they can demonstrate an exemption from the premium requirement (see "Table 2. Groups Excluded from Enrollment in PHPs and the Demonstration") prior to the end of the 60-day period. Re-enrollment would be permitted only after back due premiums were repaid.

Work Requirements

- Carolina Cares enrollees would be required to be employed or engaged in activities to promote employment.
- Individuals exempt from the work requirement, as specified in the proposed legislation,[6] would include those who are:
  - Caring for a dependent minor child, an adult disabled child or a disabled parent;
  - Receiving active treatment of substance use disorder; or
  - Medically frail.

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

Not applicable.

[6] The State and EBCI will work with the General Assembly to address the application of work requirements for tribal members.

III. Demonstration Benefits and Cost Sharing Requirements

This section should include information on the benefits provided under the Demonstration as well as any cost sharing requirements. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

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

☑ Yes

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

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

☐ Yes

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

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

All services provided under the demonstration are or will be included in North Carolina's Medicaid and NC Health Choice (CHIP) state plans executed through State Plan amendments, except for those listed below as "Demonstration Only Services." Any changes to State Plan services will be executed through a State Plan amendment.

Demonstration Only Services

- **IMD Waiver.** To improve access to services, North Carolina seeks expenditure authority to make payments to IMDs for all Medicaid enrollees, either through PHPs or local management entities-managed care organizations (LME/MCOs),[7] or directly to IMDs for fee-for-service enrollees, regardless of whether enrollees are enrolled in managed care or through other delivery systems. Payments will be limited to individuals receiving acute care for behavioral health or those receiving substance use disorder treatment at an American Society of Addiction Medicine (ASAM) level 3.1 or higher. Considering the public health emergency declared Oct. 26, 2017, North Carolina also seeks a separate and accelerated approval of the IMD waiver for substance use disorder services, as described in section "V. Implementation of Demonstration."
- **Behavioral Health Services to be Covered in IMDs.** Short-term behavioral health crisis services that aim to stabilize beneficiaries experiencing a psychiatric crisis with the expectation of shifting them to less intensive, community-based setting.
- **Substance Use Disorder Services to be Covered in IMDs**
    - Substance abuse halfway house (ASAM 3.1)

[7] Today, LME-MCOs, which are prepaid inpatient health plans (PIHPs), manage behavioral health and I/DD services for the vast majority of North Carolina Medicaid beneficiaries. North Carolina has recently begun covering IMD stays for up to 15 days as an "in lieu of" service in LME-MCO contracts, as permitted under federal rules.

- Social setting detoxification (ASAM 3.2)
- Clinically managed population-specific high intensity residential services (ASAM 3.3)[8]
- Substance abuse non-medical community residential treatment (ASAM 3.5)
- Substance abuse medically monitored community residential treatment (ASAM 3.7)
- Non-hospital medical detoxification (ASAM 3.7)
- Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (ASAM 3.9)
- Medically managed intensive inpatient services (ASAM 4)

- **1915(b)(3) Services.** Services currently authorized under the 1915(b)(3) waiver will be transitioned into and authorized under the 1115 demonstration in Year 3 of managed care.
- **Innovations Waiver Services**. Services currently authorized under the 1915(c) Innovations waiver will be transitioned into and authorized under the 1115 demonstration in Year 3 of managed care.
- **Traumatic Brain Injury Waiver Services.** Services that will be authorized under the 1915(c) Traumatic Brain Injury (TBI) waiver will be transitioned into and authorized under the 1115 demonstration in Year 3 of managed care.

TABLE 4. BENEFIT PACKAGE CHART

POPULATION	BENEFIT PACKAGE
General Medicaid and NC Health Choice Population	State Plan, including those delivered in an IMD
Carolina Cares Enrollees (if enacted)	Alternative Benefit Plan, including those delivered in an IMD
Innovations Waiver Enrollees	State Plan and Innovations Waiver Services
TBI Waiver Enrollees	State Plan and TBI Waiver Services
Individuals receiving services at tribal facilities	State Plan, including those delivered in an IMD and HCBS services as transitioned

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

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

Any benchmark-equivalent coverage would be outlined in an Alternative Benefit Plan State Plan amendment.

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

[8] Today, ASAM levels 3.1, 3.2, and 3.3 are not provided at IMDs; however, the State will submit a State Plan Amendment to expand its substance use disorder service array. The State is requesting that the expenditure authority to make payments to IMDs apply to these services as State Plan covered services.

TABLE 5. BENEFITS CHART

BENEFIT	DESCRIPTION OF AMOUNT, DURATION AND SCOPE	REFERENCE
Short-term behavioral health crisis services that aim to stabilize beneficiaries experiencing a psychiatric crisis with the expectation of shifting them to less intensive, community-based setting	As defined in the State Plan, except that services may be provided in an IMD	State Plan
Substance abuse halfway house	Service will be defined in the State Plan; service may be provided in an IMD	State Plan
Social setting detoxification	Service will be defined in the State Plan; service may be provided in an IMD	State Plan
Clinically managed population-specific high intensity residential services	Service will be defined in the State Plan; service may be provided in an IMD	State Plan
Substance abuse non-medical community residential treatment	As defined in the State Plan, except that services may be provided in an IMD	State Plan
Substance abuse medically monitored community residential treatment	As defined in the State Plan, except that services may be provided in an IMD	State Plan
Non-hospital medical detoxification	As defined in the State Plan, except that services may be provided in an IMD	State Plan
Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization	As defined in the State Plan, except that services may be provided in an IMD	State Plan
Medically managed intensive inpatient services	As defined in the State Plan, except that services may be provided in an IMD	State Plan
Innovations waiver services	As defined in current 1915(c) waiver	1915(c) waiver
1915(b)(3) services	As defined in current 1915(b) waiver	1915(b) waiver
TBI waiver services	As defined in pending 1915(c) waiver	1915(c) waiver

6) Indicate whether Long Term Services and Supports will be provided.

☑ Yes (if yes, please check the services that are being offered)

☐ No

There are no changes to the State Plan or waiver benefits that beneficiaries eligible for long-term services and supports (LTSS) receive today. The demonstration changes only the delivery system to enable these services to be delivered through capitated PHPs for some beneficiaries; therefore, the State does not need to fill out the LTSS forms or checklist below. Further description of the sources of authority for LTSS State Plan and Waiver services that will be covered under the demonstration follows next.

State Plan LTSS

Except for PACE, all State Plan LTSS for the Medicaid-only population will be delivered through the demonstration.

Innovations Services

The State will delay enrollment of 1915(c) Innovations waiver enrollees into the demonstration until the Year 3 of managed care. In the period prior to phase-in, Innovations waiver services will continue to be administered through the concurrent 1915(b)/(c) waivers via LME/MCOs. In Year 3, these enrollees will transition to capitated BH I/DD tailored plans, which will deliver all existing Innovations services.

Traumatic Brain Injury Waiver Services

The State will delay enrollment of 1915(c) TBI waiver enrollees into the demonstration until Year 3 of managed care. In the period prior to phase-in, TBI waiver services will be administered through the concurrent 1915(b)/(c) waivers via the Alliance LME/MCO. In Year 3, these enrollees will transition to capitated BH I/DD tailored plans, which will deliver all TBI waiver services.

In addition, please complete the: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-LTSS-Benefits.pdf , and the: http://www.medicaid.gov/ Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Long-Term-Services-Benefit-Specifications-and-Provider-Qualifications.pdf.

Homemaker
Case Management
Adult Day Health Services Habilitation – Supported Employment Habilitation – Day Habilitation Habilitation – Other Habilitative
Respite
Psychosocial Rehabilitation
Environmental Modifications (Home Accessibility Adaptations) Non-Medical Transportation
Home Delivered Meals Personal Emergency Response Community Transition Services Day Supports (non-habilitative) Supported Living Arrangements
Assisted Living
Home Health Aide
Personal Care Services
Habilitation – Residential Habilitation
Habilitation – Pre-Vocational
Habilitation – Education (non-IDEA Services)
Day Treatment (mental health service) Clinic Services
Vehicle Modifications
Special Medical Equipment (minor assistive devices)
Assistive Technology Nursing Services Adult Foster Care
Supported Employment
Private Duty Nursing
Adult Companion Services
Supports for Consumer Direction/Participant Directed Goods and Services
Other (please describe)

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

☐ Yes (if yes, please address the questions below)
☑ No (if no, please skip this question)

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

b) Include the minimum employer contribution amount

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

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

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

See section "II. Demonstration Eligibility," question 6.

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

There are no changes to cost-sharing provisions already approved in the State Plan.

If the state is proposing to impose cost sharing in the nature of deductions, copayments or similar charges beyond what is permitted under the law, the state should also address in its application, in accordance with section 1916(f) of the Act, that its waiver request:

a) will test a unique and previously untested use of copayments;

b) is limited to a period of not more than two years;

c) will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients;

d) is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area; and

e) is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.

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

Not applicable.

IV. Delivery System and Payment Rates for Services

This section should include information on the means by which benefits will be provided to Demonstration participants. In accordance with 42 CFR 431.412(a)(ii), a description of the proposed healthcare delivery system must be included in a state's application in order to be determined complete. Specifically, this section should:

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

☑ Yes

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

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

North Carolina's Medicaid Managed Care Organizations – Prepaid Health Plans

North Carolina seeks to implement Medicaid managed care in a way that advances high-value care, improves population health, engages and supports providers, and establishes a sustainable program with predictable costs. At the core of these efforts is the goal to improve the health of North Carolinians through an innovative, whole-person centered, well-coordinated system of care, which addresses medical and non-medical drivers of health.

To ensure consumer choice, leverage the experience and commitment of Medicaid providers in North Carolina, and maximize opportunities for innovation, the State will contract with two types of PHPs: commercial plans (CPs) and provider-led entities (PLEs), which are risk-bearing Medicaid managed care plans owned and operated by providers with a history of serving Medicaid beneficiaries. PLEs must cover a region in its entirety, and may offer products in more than one region, provided the regions are contiguous.

Standard Plans, BH I/DD Tailored Plans and Specialized Foster Care Plan

Pending State legislative authorization, North Carolina intends to permit CPs and PLEs to develop and offer two types of products: standard plans and tailored plans.

- **Standard Plans** will serve most Medicaid enrollees, including adults and children. They will provide integrated physical health, behavioral health and pharmacy services at the launch of North Carolina's Medicaid managed care program.
- **BH I/DD Tailored Plans** will be specifically designed to serve special populations with unique health care needs. As described further below, North Carolina plans to launch a BH I/DD tailored plan no later than two years after the launch of Medicaid managed care. The plan will provide integrated physical health, behavioral health, I/DD, TBI and pharmacy services to enrollees with serious mental illness, serious emotional disturbance, substance use disorder, I/DD and/or TBI needs.
- **Specialized Plan for Children in Foster Care** will be a single product for children in county-operated foster care, children in adoptive placements and former foster youth who aged out of care up to age 26. The PHP that offers the specialized plan for children in foster care must meet a set of requirements ensuring robust care management and medication management specifically for this vulnerable population.

Additionally, the subset of State Plan enhanced behavioral health services that will be exclusively available in BH I/DD tailored plans (see below) will be available in the specialized foster care plan.

BH I/DD Tailored Plans

The table below indicates which populations would be eligible for BH I/DD tailored plans as well as the benefits that would be exclusively available in BH I/DD tailored plans. As noted in various places throughout this demonstration, BH and I/DD tailored plans require legislative authority to implement.

TABLE 6. POPULATIONS ELIGIBLE FOR BH I/DD TAILORD PLANS AND BENEFITS EXCLUSIVE TO BH I/DD TAILORED PLANS

POPULATIONS ELIGIBLE FOR BH I/DD TAILORED PLANS	BENEFITS EXCLUSIVELY AVAILABLE IN BH I/DD TAILORED PLANS
• Individuals with a qualifying I/DD diagnosis including those enrolled in or on the waiting list for the Innovations waiver • Individuals enrolled in the TBI waiver, who are on the waiting list for the TBI waiver or have used a State-funded TBI service • Individuals who are enrolled in the Transition to Community Living Initiative (TCLI) • Individuals with a serious mental illness or serious emotional disturbance diagnosis who have used a Medicaid covered enhanced behavioral health service or a state-funded behavioral health service within the past year as identified through quarterly claims/encounter data review • Individuals with a qualifying substance use disorder diagnosis who have used a Medicaid covered enhanced behavioral health service or state funded behavioral health service within the past year • Individuals with a serious mental illness, serious emotional disturbance or substance use disorder diagnosis who have not used an enhanced behavioral health service but have self-identified as being potentially eligible and are screened to meet the BH I/DD tailored plan level of need • Individuals with a serious mental illness, serious emotional disturbance or substance use disorder diagnosis who require a service that is only available through the BH I/DD tailored plan	• A subset of State Plan enhanced behavioral health services[9] • TBI waiver services • Innovations waiver services • 1915(b)(3) services • State-funded behavioral health and I/DD services • State-funded TBI services

Overview of Health Home Care Management for BH I/DD Tailored Plan Enrollees

When BH I/DD tailored plans launch, contingent on legislative authority, they will offer robust, whole-person care management services specifically tailored to the unique physical health, behavioral health and social needs of this clinically complex population. The BH I/DD tailored plan care management model will meet federal standards for health home services. North Carolina will submit a health home State Plan amendment, including behavioral health, I/DD, and TBI diagnoses as eligible diagnoses. Health home funds will flow to BH I/DD tailored plans, and

[9] State Plan enhanced behavioral health services that will be available only in the BH I/DD tailored plans include residential treatment facility services, child and adolescent day treatment services, intensive in-home services, multi-systemic therapy services, psychiatric residential treatment facilities (PRTFs), assertive community treatment (ACT), community support teams (CST), substance abuse non-medical community residential treatment, substance abuse medically monitored residential treatment and intermediate care facilities for individuals with intellectual disabilities (ICF/IID).

BH I/DD tailored plans and care management agencies will deliver health home care management services (described next).

The care management features available in BH I/DD tailored plans are compared below to those available in standard plans:

TABLE 7. CARE MANAGEMENT FEATURES IN STANDARD PLANS AND BH I/DD TAILORED PLANS

CARE MANAGEMENT FEATURES AVAILABLE IN STANDARD PLANS AND BH I/DD TAILORED PLANS	CARE MANAGEMENT FEATURES AVAILABLE ONLY IN BH I/DD TAILORED PLANS
• Providing care coordination across settings • Providing and following up on referrals • Providing linkages to community resources • Providing care management services for enrollees with intensive needs in community settings to the maximum extent possible • Monitoring service utilization and response to treatment	• Providing more frequent intensive care management services that occur face-to-face • Providing navigation across behavioral health, I/DD and TBI settings, while connecting individuals to a primary care provider • Requiring care managers to have specialized expertise, including training in behavioral health, I/DD and/or TBI care, experience managing physical and behavioral health, I/DD or TBI co-morbidities • Providing specialized clinical supervision to support the coordination of care between physical and behavioral health, I/DD or TBI care

Health Home Care Management Roles and Responsibilities

Community-Based Care Management Agencies

- BH I/DD tailored plans must contract with community-based care management agencies to provide health home care management services for the behavioral health, I/DD and TBI populations to the maximum extent possible.
- BH I/DD tailored plans may provide care management through directly employed care managers, only if the community-based care management agencies lack capacity.
- Organizations that act as care management agencies would be subject to standards that incorporate elements of the Substance Abuse and Mental Health Services Administration (SAMHSA) Certified Community Behavioral Health Clinic (CCBHC) model, especially related to providing State-defined targeted case management services for individuals with behavioral health conditions.[10] In addition, the State will deploy research-based standards for I/DD and TBI care management, leveraging the State's definition of targeted case management for individuals with I/DDs.

Care Manager Responsibilities

- BH I/DD tailored plans will be required to designate one care manager (either contracted through a care management agency or directly employed by the tailored plan) for each BH I/DD tailored plan enrollee.
- The care manager will have primary responsibility for navigating across behavioral health, I/DD and TBI settings, and for coordinating with the enrollee's primary care provider/advanced medical home and community-based social support agencies that play important roles in ensuring effective coordinated care for the enrollee.

Table 8 shows proposed roles and responsibilities for North Carolina's Department of Health and Human Services, BH I/DD tailored plans, and entities delivering health home care management services.

[10] *SAMHSA CCBHC Criteria* is available online at samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf

TABLE 8. HEALTH HOME CARE MANAGEMENT ROLES AND RESPONSIBILITIES

ENTITY	RESPONSIBILITIES
North Carolina Department of Health and Human Services	• Contract with BH I/DD tailored plans and pays a capitated rate considering the need for intensive and specialized care management services • Monitor BH I/DD tailored plans' performance, including care management • Establish minimum requirements (e.g., training, education, supervision, oversight) for BH I/DD tailored plan and care management agency personnel • Establish standards of care through evidence-supported protocols for high-risk patients
BH I/DD Tailored Plans (Contingent on Legislative Authority)	• Perform administrative functions, such as financial services and reporting to the State • Conduct risk stratification to identify intensity of enrollees' care management needs and provide care management agencies with information on patient risk • When contracting with care management agencies: o Pay care management agencies a tiered per member per month for care management based on assessment of level of care management services required to assist client in meeting care plan goals o Assign enrollees to care management agencies o Monitor performance of care management agencies, including patient engagement, care plans and services delivered o Provide support to care management agencies as needed to create/maintain the capacity required to meet assigned caseloads and provide advanced education/training for care managers
Entity Delivering Health Home Care Management Services (Either BH I/DD Tailored Plan or Care Management Agency)	• Assign a care manager to each BH I/DD tailored plan enrollee • Conduct outreach to BH I/DD tailored plan enrollees • Engage individuals in care management and promote the development of linkages to primary care providers and advanced medical home care teams • Conduct a comprehensive assessment • Working with the plan enrollee, develop and implement care plans • Identify care team members (e.g., primary care provider, behavioral health provider, I/DD provider, TBI provider, pharmacist) • Manage timely communication across the care team; for example, when the enrollee is hospitalized or seeks care from a hospital emergency department • Monitor and coordinate delivery of physical health, behavioral health, I/DD services, TBI services, and formal and informal other support services • Follow up on referrals • Participate in discharge planning process and coordinate individuals' follow-up care post-discharge from inpatient or residential settings • Institute evidence-based care transitions programs, such as the critical time intervention • Provide peer support services • Develop relationships with the justice system and the North Carolina Division of Social Services • Track beneficiary progress and organize care team case reviews

Financing Capacity Building for Care Management

The State is seeking expenditure authority (up to $150 million) to help BH I/DD tailored plans, contingent on legislative authority, and care management agencies build capacity to implement the health home care management model.[11] While North Carolina's Medicaid program has historically had robust care management capabilities targeted toward populations with chronic physical health conditions, the State recognizes a need to

[11] This expenditure authority request is limited to funding to build capacity to implement the behavioral health home care management model. Ongoing care management will be supported through a forthcoming Health Home SPA, which will comply with all Medicaid regulations, rules and guidance.

improve care management for the populations that will be served by BH I/DD tailored plans. The State intends for BH I/DD tailored plans to provide health home care management services beginning at their launch, meaning that the BH I/DD tailored plans will need to establish this capability prior to BH I/DD tailored plan enrollment. The State will use a competitive procurement process to determine which entities and activities receive funding, and will prioritize funding entities that demonstrate a need to build care management capacity.

The funding will be used to support functions such as:

1. **Building BH I/DD tailored plans, care management agencies and providers' IT capacity to support intensive and specialized care management.**
    - **Care Management Platform.** Each BH I/DD tailored plan will be required to have a care management platform to be deployed across its contracted care management agencies. BH I/DD tailored plans will be responsible for providing technical assistance to care management agencies related to the implementation and use of the care management platform. The platform's functions will include:
        - Documenting the results of screenings and assessments;
        - Creating care plans and sharing them across an enrollee's providers;
        - Monitoring adherence to the enrollee's care plan; and
        - Tracking follow-up on referrals.
    - **Health Information Exchange.** State statute requires BH I/DD tailored plans and behavioral health, I/DD and TBI providers to submit data to the State's health information exchange. BH I/DD tailored plans and providers may seek seed money to strengthen their capacity to leverage the State's health information exchange in the provision of care management.
    - **Risk Stratification and Predictive Modeling.** BH I/DD tailored plans will develop the capacity to perform risk stratification and predictive modeling to identify BH I/DD tailored plan enrollees' specific care management needs.
    - **Population Health Management, Quality Improvement and Reporting.** BH I/DD tailored plans will aggregate encounter and care management data across providers for the purposes of population health management, quality improvement and reporting to the State and care management agencies. In addition, BH I/DD tailored plans will be required to establish linkages with the State's Controlled Substances Reporting System.
    - **Care Management Web Portals.** BH I/DD tailored plans will be required to create a web portal where care management agencies can access encounter data across providers. They will be encouraged to develop enrollee-specific profiles that include information about enrollees' historical utilization, including hospital admissions/readmissions, emergency department visits, pharmacy utilization and primary care relationships. BH I/DD tailored plans will also be required to create a member portal where enrollees can access information on their utilization, unmet resource needs and educational materials.
    - **Evidence-Based Decision-Making Tools.** BH I/DD tailored plans will encourage care management agencies and providers to leverage evidence-based decision-making tools.
2. **Creating a highly skilled care management workforce with competencies in the provision of integrated and coordinated physical and behavioral healthcare.**
    - **Recruiting.** Prior to BH I/DD tailored plan launch, BH I/DD tailored plans will contract with care management agencies. The care management agencies will need to undertake an intensive recruiting effort to ensure that they are able to employ sufficient care managers to meet the State's minimum staffing ratios.

- **Training.** BH I/DD tailored plans will deliver ongoing training to care managers serving the tailored plan population, covering topics such as behavioral health, I/DD and/or TBI care; co-occurring disorders; care management functions; crisis response; person-centered planning; goal setting; peer supports; cultural competency; conflict resolution; interactions with the justice system; and linkages to community resources.

Public-Private Regional Partnership Pilots

As described further in section "I. Program Description," North Carolina plans to provide focused investment to test, scale, strengthen and sustain public-private initiatives in select regions of North Carolina that aim to measurably improve health and lower costs through evidence-based interventions in four domains of social determinants of health: housing, food, transportation and interpersonal safety/toxic stress. Individuals who enroll in a pilot may receive evidence-based intervention services to meet the pilot's defined objectives around improving health care utilization and spending and improving health.

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

Managed care:

- ☑ Managed Care Organization (MCO)
- ☐ Prepaid Inpatient Health Plans (PIHP)
- ☐ Prepaid Ambulatory Health Plans (PAHP)

☑ Fee-for-service (including Integrated Care Models)

☐ Primary Care Case Management (PCCM)

☑ Health Homes

☐ Other (please describe)

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

While most Medicaid and NC Health Choice beneficiaries eligible for managed care will mandatorily enroll in the State's managed care delivery system, some high-need populations will be phased-in over time to ensure that provider relationships and care regimens transition smoothly. During the transition period, to avoid care disruption, special populations will continue to have access to their existing provider networks. The timeline and processes for this phase-in is contingent on State legislative authority.

Table 9 depicts the delivery system that will be used for Medicaid and NC Health Choice populations in the first five years after Medicaid managed care launch. Table 10 depicts each delivery system's authority.

TABLE 9. DELIVERY SYSTEM FOR MEDICAID AND NC HEALTH CHOICE DEMONSTRATION POPULATIONS

POPULATIONS	YEARS 1-2 OF MANAGED CARE IMPLEMENTATION	YEARS 3-4 OF MANAGED CARE IMPLEMENTATION	YEARS 5+ OF MANAGED CARE IMPLEMENTATION
Medicaid and NC Health Choice populations included in the demonstration except populations listed below	Standard plan	Standard plan	Standard plan

POPULATIONS	YEARS 1-2 OF MANAGED CARE IMPLEMENTATION	YEARS 3-4 OF MANAGED CARE IMPLEMENTATION	YEARS 5+ OF MANAGED CARE IMPLEMENTATION
Medicaid enrollees with a serious mental illness, serious emotional disturbance or substance use disorder who have used an enhanced behavioral health service, enrollees with I/DD and TBI waiver enrollees[12]	Medicaid fee-for-service/LME/MCO	BH I/DD tailored plan	BH I/DD tailored plan
NC Health Choice enrollees with a serious mental illness, serious emotional disturbance or substance use disorder who have used an enhanced behavioral health service or who have an I/DD	Medicaid fee-for-service	BH I/DD tailored plan	BH I/DD tailored plan
Legal aliens with a serious mental illness, serious emotional disturbance or substance use disorder who have used an enhanced behavioral health service or who have an I/DD	Medicaid fee-for-service	BH I/DD tailored plan	BH I/DD tailored plan
Children in foster care	Specialized foster care plan	Specialized foster care plan	Specialized foster care plan

TABLE 10. DELIVERY SYSTEMS' AUTHORITY

DELIVERY SYSTEM	AUTHORITY
Medicaid fee-for-service	State Plan
LME/MCO	1915(b) waiver
PHP (standard plan, BH I/DD tailored plan, specialized foster care plan)	Demonstration

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

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

All Medicaid and NC Health Choice populations will be mandatorily enrolled in PHPs except for those who will be excluded or exempt, as described next.

- **Excluded.** The following excluded populations will continue to receive benefits through Medicaid fee-for-service or their existing delivery system:
  - Beneficiaries dually eligible for Medicaid and Medicare, except those eligible to enroll in BH/IDD tailored plans
  - PACE beneficiaries[13]
  - Medically needy beneficiaries except those covered by Innovations or TBI waivers
  - Beneficiaries only eligible for emergency services
  - Presumptively eligible enrollees, during the period of presumptive eligibility
  - Health Insurance Premium Payment (HIPP) beneficiaries

[12] Populations eligible for BH I/DD tailored plans are described in more detail above under Section IV, Behavioral Health and Intellectual/Developmental Disability Tailored Plans.

[13] PACE beneficiaries will be excluded from PHPs and will continue to be enrolled in their current managed care delivery system.

- Family Planning enrollees[14]
- Prison inmates
- CAP/C and CAP/DA waiver enrollees, pending legislative change
- Medicaid-only beneficiaries receiving long stay nursing home services, pending legislative change

- **Exempt:** Members of federally recognized tribes will be included in the demonstration but will not be required to enroll in PHPs. Members may voluntarily enroll in PHPs on an opt-in basis and may disenroll without cause at any time.

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

Managed care will operate statewide.

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

North Carolina intends to phase-in managed care for current enrollees contingent on legislative authority. The State will send notifications to all enrollees in advance of the phase-in clearly detailing their specific guidelines and instructions.

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

Ensuring Choice of Managed Care Organization

Under State law, three commercial plans will offer products statewide. Some managed care enrollees may have more than three choices, depending on how many and in which regions the State procures regional PLEs. The State anticipates that one BH I/DD tailored plan will be available in each region (though regions for behavioral and I/DD services may differ from PHP regions). BH I/DD tailored plan-eligible enrollees will have the choice of enrolling in a BH I/DD tailored plan or standard plan; however, if they elect to enroll in a standard plan rather than a BH I/DD tailored plan, they will not have access to the services exclusively offered by BH I/DD tailored plans.

Ensuring Access to Care and Provider Network Adequacy

North Carolina will comply with all federal regulations to maintain and monitor a network of appropriate providers, including that Indian health/tribal providers will not be required to be part of PHP networks. Members of federally recognized tribes who opt to enroll in PHPs will be able to access Indian health/tribal providers on an out-of-network basis without authorization from the PHP. PHPs' provider networks will be supported by written agreements, and will be sufficient to provide adequate access to all services covered under the contract for all beneficiaries, including those with limited English proficiency or physical or behavioral disabilities.

PHPs must comply with the requirements of section 206 of the Indian Health Care Improvement Act.

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

The State intends to release a request for proposal (RFP) for PHPs mid-April 2018, with PHP responses due to the State mid-June 2018 and PHP contracts awarded no later than Oct. 1, 2018. The State will then commence PHP implementation and readiness reviews.

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

All Medicaid mandatory and optional services and NC Health Choice State Plan services will be provided under the demonstration except for the following excluded services:

[14] Exclusion of family planning enrollees and prison inmates requires legislative action.

- Dental services ("Into Mouths of Babes," a fluoride program for children, will be included in the demonstration);
- Fabrication, fitting and dispensing of eyeglasses;
- Program of All-Inclusive Care for the Elderly (PACE);
- Local education agency (LEA) services;
- Children's Developmental Services Agency (CDSA) services; and
- A subset of State Plan-enhanced behavioral health services that will be excluded from the 1115 waiver until the launch of the BH I/DD tailored plans.

Services authorized under the following waivers will be excluded until they are transitioned into the demonstration:

- Innovations waiver;
- TBI waiver; and
- 1915(b)(3) waiver services.

Dental services, PACE, LEA and CDSA services are excluded from the demonstration as required under Session Law 2015-245 and amended by Session Law 2016-121. Additionally, the fabrication of eyeglasses is excluded from the demonstration as required by Session Law 2017-186. North Carolina is currently working with the General Assembly to also exclude the fitting and dispensing of eyeglasses to ensure a streamlined beneficiary and provider experience in providing eyeglasses.

Additionally, North Carolina seeks to delay the inclusion of services for high-need waiver populations to allow for special care and planning to ensure that provider relationships and care regimens transition smoothly. The State believes that certain targeted populations with complex health care needs require more time to make the transition to Medicaid managed care after the program is fully established.

Populations excluded or exempt from the demonstration will continue to receive services through the delivery system as described in the State Plan.

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

☑ Yes
☐ No

The demonstration will provide LTSS for Medicaid-only beneficiaries, including personal care services. Self-direction and financial management services to support self-direction will be available in the BH I/DD tailored plans for Innovations waiver enrollees.

North Carolina and all PHP contracts will comply with the new requirements finalized in the May 2016 Medicaid managed care final rule for managed LTSS at 42 CFR Part 438, including a transition of care policy; compliance with the Home and Community Based Services (HCBS) final rule; supports for beneficiaries; a person-centered process; a comprehensive, integrated service package; participant protections; network adequacy standards and quality. To adequately plan for the inclusion of LTSS in PHP contracts, DHHS' timeline assumes ongoing stakeholder input into program design and a readiness review process before PHP enrollment begins.

8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology.

Not applicable.

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

The methodology for setting capitation rates is described below, as well as these deviations from those payments: cost-settling essential safety-net providers, tribal uncompensated care pool, public-private regional partnerships pilot payments, the Innovation Workforce Fund, the Telemedicine Alliance and Telemedicine Innovation Fund.

PHP Capitation Rate Setting

North Carolina will ensure that capitation rates are set according to actuarially sound principles and reflect specific program design considerations, covered populations and benefits, and PHP payment requirements including mandated rates (e.g., for physicians and physician extenders in the initial years of managed care)[15] and payments to special provider types (e.g., FQHCs/RHCs). The payments to the PHPs under Medicaid managed care are in the form of prospective per member per month (PMPM) capitation rates. The State, in consultation with its actuary, will develop the capitation rate methodology through a transparent process that solicits information from potential PHPs and other stakeholders. A draft methodology was released in November 2017. The State will make available additional rate documentation and draft PHP rates in the PHP procurement. The PHP payments will use a rate cell structure that will likely differentiate payments for beneficiaries by eligibility group, age and region. Base capitation rates will also be risk adjusted. Initial rates will consider service costs based on historical North Carolina Medicaid utilization and expectations of utilization change under Medicaid managed care. The State will also incorporate reasonable administrative costs and margin into the capitation rates. Actual rates will be set annually and updated, as needed, to reflect programmatic changes.

Cost-Settling Essential Safety-Net Providers

Today in North Carolina, certain public providers receive cost-settlements from the Medicaid program to cover the difference between total Medicaid reimbursement received for services delivered and the providers' allowable costs—including local public health departments, public ambulance providers, and state-owned or -operated skilled nursing facilities. North Carolina seeks expenditure authority to continue making wrap-around payments directly to these providers to cover the difference between PHP reimbursement and providers' costs to ensure beneficiaries have access to these essential providers that have limited ability to offset losses with revenue from other payers.

Proposed Cost Settlement Approach Under Managed Care

- PHPs will negotiate rates with cost-settled providers.
    - North Carolina will require that these negotiated rates be no lower than the rates paid to non-public providers for similar services, similar to requirements related to FQHC contracting.
    - For example, rates for emergency ground transportation for a public ambulance provider can be no less than rates paid to a private ambulance provider for the same level of service intensity

[15] Unless providers and plans agree to a different rate.

- At the end of the year, providers will submit reports on costs and revenue. North Carolina will use the reports to determine the difference between the Medicaid allowable costs for cost-settled providers and payments received from PHPs.
- The State will make payments directly to cost-settled providers to cover the difference between their allowable costs and payments received from PHPs.
    - For public health departments and public ambulance providers, the non-federal share will be funded through Certified Public Expenditures or Intergovernmental Transfers.
    - For state-owned or -operated skilled nursing facilities, the non-federal share will be funded with state general funds.

This approach ensures that PHPs do not have an incentive to steer services away from essential providers, similar to the logic behind providing FQHC wrap-around payments outside of managed care.

Establishing a Tribal Uncompensated Care Pool

North Carolina proposes to increase access to care and expand services for Native Americans by establishing a tribal uncompensated care pool. The tribal uncompensated care pool (up to $86.6 million) will provide payments to the Cherokee Indian Hospital Authority to offset the Authority's uncompensated care costs for services provided directly by or referred through the Authority.[16, 17, 18]

Public-Private Regional Partnership Pilot Payments

As described further in section "I. Program Description," North Carolina plans to provide focused investment to test, scale, strengthen and sustain public-private initiatives in select regions of North Carolina that aim to measurably improve health and lower costs through evidence-based interventions in four domains of social determinants of health: housing, food, transportation and interpersonal safety/toxic stress. Medicaid payments will support the pilots in various ways: 1) Capacity building to develop the programmatic supports necessary to plan, build and operate the project, and 2) interventions consistent with the demonstration's Special Terms and Conditions, and not otherwise covered by Medicaid that are provided to pilot participants to achieve pilot goals.

Innovation Workforce Fund

North Carolina proposes a two-part approach to strategically invest in Medicaid provider recruitment and retention programs:

- **Workforce Evaluation.** North Carolina will commission a rigorous study of the State's health care workforce landscape to:
    - Highlight gaps in the Medicaid workforce that prevent meeting the needs of Medicaid beneficiaries
    - Ensure the State's health workforce is prepared to respond to the transforming health care environment
    - Maintain access to current and future actionable information about emerging workforce needs
- **Establish a New Innovation Workforce Fund.** North Carolina seeks federal expenditure authority (up to $45 million) to establish a new Innovation Workforce Fund to address shortages identified in the workforce evaluation. The State anticipates developing an integrated suite of incentive programs,

[16] Uncompensated care costs include costs associated with all healthcare services provided by or arranged through the Authority, regardless of whether such service is specifically covered under the Medicaid State Plan.

[17] The Eastern Band of Cherokee Indians (EBCI) is the only federally recognized tribe in North Carolina.

[18] Tribal members, including EBCI and members of other federally recognized tribes living in North Carolina, will be exempt from mandatory managed care enrollment, giving them the option to enroll in managed care or fee-for-service. Alternative services will be covered regardless of enrollment in managed care or fee-for-service.

including loan repayment and recruitment bonuses for crucial provider types. This fund would complement existing state loan repayment programs and focus on addressing shortages specific to the Medicaid population.

Based on preliminary research, the State anticipates addressing provider shortages, including:

- General surgeons;
- OB/GYNs;
- Psychiatrists;
- Psychologists;
- Mid-level behavioral health providers; and
- Physical, occupational and speech therapists.

After completion of the workforce evaluation, the State will develop a strategic, data-driven fund distribution approach to address provider shortages statewide. The State intends to incorporate the following features into the Innovation Workforce Fund distribution methodology:

- Use evaluation findings to prioritize awards by geography and provider type;[19]
- Change distribution of awards at regular intervals based on changing workforce needs;
- Scale award size by provider type and debt burden; and
- Use incentive fund dollars to complement community-based residency investments.

The State plans to systematically evaluate the impact of the fund on provider recruitment and retention, and will adjust fund distributions based on evaluation findings.

Telemedicine Alliance

To increase provider awareness, education and training on telemedicine opportunities and best practices, the State aims to support the establishment of an independent, statewide telemedicine alliance**.** Telemedicine alliance activities would include:

- Developing coordinated telemedicine policy priorities;
- Administering and evaluating the Telemedicine Innovation Fund (described under "Telemedicine Innovation Fund");
- Providing a forum for and convening stakeholders to share telemedicine-related best practices related to pilots/Medicaid priorities; and
- Providing technical assistance and education regarding opportunities to use telemedicine, including existing opportunities under the current Medicaid policy, use of telemedicine hardware and software, and integration of telemedicine into practice workflows.

North Carolina plans to select a non-governmental organization to operate the alliance through a competitive procurement. The State seeks federal expenditure authority (up to $5 million) to provide the organization with start-up funding to establish the telemedicine alliance,[20] including:

- Personnel costs;
- Development of the alliance's foundational elements, including mission, vision and strategy; and

[19] The State would also vary awards based on the acuity of the provider shortage. For example, an applicant working in a county with no providers of his/her type (e.g. OB/GYN) would receive a larger award than an applicant working in a county with two providers of the same type.

[20] The alliance would be a new program within an existing organization; the State would not create a new organization to serve this function.

- Provision of key activities through Year 2.

The telemedicine alliance's ongoing operation and implementation of activities after year two must be financed through non-Medicaid sources of funding, including philanthropic contributions and membership dues.

Telemedicine Innovation Fund

North Carolina seeks expenditure authority (up to $80 million) to establish a "Telemedicine Innovation Fund" to support provider-PHP collaborations that test evidence-based telemedicine initiatives aligned with the State's quality strategy goals, such as chronic disease management, wellness promotion and high-value care.[21]

- The telemedicine alliance will solicit proposals, prioritizing those from PHP-provider collaborations, that address quality strategy goals through innovative telemedicine pilots that extend beyond what is currently covered. Pilots will be evaluated on criteria including:
  - Alignment with State quality strategy goals through Medicaid;
  - Existing evidence base to support intervention;
  - Extent to which a portion of pilot costs can be offset through in lieu of services; and
  - Replicability.
- If certain quality strategy goals are not addressed in the first round of proposals, the alliance may issue a second request for proposals that address specific goals.
- In certain circumstances, such as initiatives related to provider education and/or provider needs related to telemedicine hardware and software, the alliance may fund provider-only proposals.
- Awardees will be required to define metrics for success, collect data and measure progress toward defined goals.
- The State will also solicit an independent evaluation of all pilot programs, conducted as part of the regular (non-waiver) activities of the State's Medicaid program.

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

The State is actively considering whether to use the flexibility provided in 42 CFR 438.6(c). If the State proceeds with quality-based payments under that authority, the State will design these payments consistent with all CMS rules and guidance, and the State will request approval for such payments through the appropriate pre-prints.

[21] See State Quality Strategy for a comprehensive list of aims, goals and objectives.

V. Implementation of Demonstration

This section should include the anticipated implementation date, as well as the approach that the State will use to implement the Demonstration. Specifically, this section should:

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

The below timeline assumes and is contingent on CMS approval in February 2018 of the full 1115 waiver application and legislative changes needed to support the program design described herein. However, considering the public health emergency declared Oct. 26, 2017, North Carolina requests that CMS consider approving on a separate, accelerated timeframe the State's request for expenditure authority to make payments to IMDs for individuals receiving substance use disorder treatment.

TABLE 11. DEMONSTRATION IMPLEMENTATION SCHEDULE

MAJOR COMPONENT	TARGET DATE
Submit 1115 waiver application	June 2016
Submit 1115 waiver application amendment	November 2017
CMS approval of IMD waiver for substance use disorder services	As soon as possible after November 2017 submission
CMS full 1115 waiver approval	February 2018
Draft PHP RFP	October 2017-March 2018
RFP for PHP procurement issued	April 2018
PHP proposals due	June 2018
PHP awards	October 2018
Readiness reviews	November 2018-June 2019
Begin launch of managed care	July 2019
Launch of BH I/DD tailored plan	July 2021
Phase-in of Innovations and TBI waivers	July 2021

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

Enrollment into Medicaid Managed Care

As part of the transition to Medicaid managed care and prior to launch in July 2019, North Carolina will establish a 60-day PHP choice period for current Medicaid beneficiaries. Beneficiaries will be sent notices about their PHP options, when they must select a PHP, and contact information for in-person, telephone and online consumer support for selecting a PHP and PCP.

After launch, new Medicaid and NC Health Choice applicants will be given an opportunity to select a PHP as part of the Medicaid application process. Individuals who do not select a PHP at application will be auto-assigned by the State into a PHP. The beneficiary will be sent a notice informing them of the PHP auto-assignment and given 90 days to change their PHP for any reason.

Certain special populations have enrollment processes tailored to their unique needs or circumstances:

- **Tribal Members**. Because all members of a federally recognized tribe are exempt from managed care, the State will ensure that tribal members are educated about their option to either enroll in fee-for-service or

in managed care, and the implications of their selection. Tribal members that elect to enroll in managed care can disenroll without cause at any time.

Additionally, to further improve navigation of the health care system and access to well-coordinated services, the EBCI plans to build on its current strong medical home model through a complementary non-waiver initiative, through which EBCI manages pharmacy and medical care for all tribal members through a network of committed providers. To ensure that its trusted relationship with members is preserved and strengthened in the transition to managed care, EBCI plans to develop a robust care coordination arrangement, potentially including some accountability for the cost of care delivered to Tribal enrollees, and is in close collaboration with the State in its development. Additionally, the State and Tribe are aiming to work together with PHPs to identify culturally competent in lieu of services, including acupuncture, biofeedback, therapeutic massage, healing touch and chiropractic services.

- **Foster Care**. To ensure that children in foster care, children in adoptive placements and former foster youth enroll in the foster care plan that is designed to best meet this unique population's needs, these children will be passively enrolled in the specialized foster care plan, with the option to change at any time during the coverage year for any reason.
- **BH I/DD Tailored Plan Enrollees.** Next is a detailed description of the enrollment process for BH I/DD tailored plan enrollees.

Enrollment Process into BH I/DD Tailored Plans

As described in section "IV. Delivery System and Payment Rates for Services," BH I/DD tailored plans will launch after Year 2 of managed care contingent on legislative authority. Table 12 describes the enrollment processes for individuals enrolling into BH I/DD tailored plans.

TABLE 12. ENROLLMENT PROCESS INTO BH I/DD TAILORED PLANS

ENROLLMENT ACTIVITY	ENROLLMENT PROCESS INTO BH I/DD TAILORED PLANS
Rollout of BH I/DD Tailored Plan Launch	The State will develop a rollout plan that will include outreach and education, consumer noticing and choice counseling. The State intends to employ the enrollment broker and train local district eligibility workers so that consumers will be well-supported and given ample time to transition to BH I/DD tailored plans.
Coverage during "Transition"[22]	• Physical health services through fee-for-service • Behavioral health and I/DD services through LME/MCOs[23] • Choice to voluntarily opt-in to a "standard plan" during the coverage year
Approach to Identification and Coverage during Transition	• **Claims Data Review.** At managed care launch (July 2019), the State will identify individuals eligible for a BH I/DD tailored plan based on diagnosis and enhanced service through use of historical claims and encounter data, Innovations and TBI waiver enrollment, and Innovations and TBI waiver wait list status. • **Noticing.** The State will send these individuals a notice about being exempt, remaining in fee-for-service/LME/MCO enrollment and the opportunity to enroll in a standard plan at any point during the coverage year. • **Transition between Delivery Systems, If Needed.** The State will permit individuals to disenroll from a standard plan and return to fee-for-service/LME/MCO if the enrollee requires services only available through the LME/MCOs, including a subset of State Plan- enhanced behavioral health services, current 1915(b)(3) services, or State-funded behavioral health services; the enrollee joins the Innovations or TBI waiver waiting list;

[22] "Transition" Period is post-launch of managed care but prior to launch of BH I/DD tailored plans.

[23] LME-MCOs are quasi-governmental entities and prepaid inpatient health plans (PIHPs) that contract with the Department of Health and Human Services to manage Medicaid and State-funded BH and I/DD services.

ENROLLMENT ACTIVITY	ENROLLMENT PROCESS INTO BH I/DD TAILORED PLANS
	or a TBI or Innovations waiver slot becomes available.[24] Individuals may also voluntarily transition from fee-for-service/LME/MCO to a standard plan at any time during the coverage year.
Approach to Identification, Coverage and Enrollment Post BH I/DD Tailored Plan-Launch	**Transition from Fee-for-Service/LME/MCOs to BH I/DD Tailored Plans When Tailored Plans are Launched** • **Data Review.** The State will conduct a claims data analysis to identify current Medicaid enrollees who are eligible for BH I/DD tailored plans, and will also flag individuals enrolled in the Innovations and TBI waivers, and those on Innovations and TBI waiver waitlists • **Enrollment Process.** The State will enroll these individual into the one BH I/DD tailored plan available in their region consistent with 42 CFR 438.54. The enrollee will be notified of their enrollment into the BH I/DD tailored plan. Enrollees will be given an active choice period of 90 days to elect to switch into a standard plan.[25] • **Choice of BH I/DD Tailored Plan or Standard Plan.** Individuals who need services that are only available through the BH I/DD tailored plans may elect to enroll in a standard plan rather than a BH I/DD tailored plan, but they will not have access to the services exclusively offered in the BH I/DD tailored plan. **New Medicaid Applicants** • **Claims Data Review.** The State will review claims data history for every new Medicaid applicant to identify previous enrollment in Medicaid (within an established period) and potential BH I/DD tailored plan eligibility. The State will passively enroll eligible individuals into a BH I/DD tailored plan. The enrollee will be notified of their enrollment into the BH I/DD tailored plan and be given 90 days to elect to enroll in a standard plan.[26] • **Self-Identification and Verification.** Individuals can self-identify as potentially BH I/DD tailored plan eligible on the Medicaid application as part of the opportunity to select a plan. Individuals who do not self-identify on the application may self-identify by contacting the enrollment broker by phone, online, by mail or in-person. • **Enrollment Process.** The State will default Medicaid applicants who self-identify as potentially BH I/DD tailored plan-eligible into standard plans. Upon enrollee contact, the enrollment broker will initiate the eligibility verification process by sending a BH I/DD tailored plan assessment form[27] to be completed. Applicants will then be responsible for submitting the assessment form to the enrollment broker. The State will review the paperwork and transition the individual from the standard plan to the BH I/DD tailored plan in the individual's region, if appropriate. Denial of a request to enroll in a BH I/DD tailored plan will trigger appeal rights. • **Choice Counseling.** The State will ensure that Medicaid applicants are informed of their PHP choices and understand the eligibility criteria and benefits unique to the BH I/DD tailored plans. The State will send consumer notices that include information about BH I/DD tailored plans and encourage applicants to contact the enrollment broker for choice counseling and additional information. The State will provide training to the enrollment broker to support applicants and deploy targeted training to behavioral health and I/DD providers to ensure they are sufficiently equipped to identify and counsel patients who may be eligible for BH I/DD tailored plans.

[24] The State plans to incorporate the current set of 1915(b)(3) waiver services in the 1115 waiver.

[25] After the 90-day period, enrollees will only be able to transfer to a standard plan during the coverage year for cause.

[26] Individuals who move outside of their region will also be allowed to change PHPs outside of the 90-day period.

[27] The BH I/DD tailored plan assessment form will be a short clinical assessment form to determine whether the applicant's health care needs meet the BH I/DD tailored plan's eligibility criteria (i.e., the individual has a qualifying serious mental illness, serious emotional disturbance, SUD, I/DD). Medicaid-enrolled behavioral health clinicians (e.g., psychiatrists, therapists and registered nurses) will have the authority to complete the assessment form.

ENROLLMENT ACTIVITY	ENROLLMENT PROCESS INTO BH I/DD TAILORED PLANS
Transition Across Standard Plans and BH I/DD Tailored Plans Mid-Coverage Year	The State recognizes the importance of ensuring that enrollees can transfer across standard plans and BH I/DD tailored plans mid-coverage year, and that those requiring the BH I/DD tailored plan level of need or covered service are transitioned as quickly and smoothly as possible. The State intends to establish the following standard and expedited review timeline and criteria for these mid-coverage year PHP transitions: • **Standard**. The State will review and approve or deny a PHP transfers requests within seven calendar days of receipt of the enrollee request to the enrollment broker. • **Expedited.** The State will review and approve or deny an expedited PHP transfer for urgent medical needs in fewer than three calendar days from the date the assessment is received from the enrollee to the enrollment broker. Requests for urgent medical need will be defined as a case where continued enrollment in the PHP could jeopardize the enrollee's life, physical or behavioral health, or ability to attain, maintain or regain maximum function. **Scenarios When Enrollees May Transition Across Standard Plans and BH I/DD Tailored Plans Mid-Coverage Year** • A standard plan enrollee requires a State Plan, 1915(b)(3) or State-funded service that is available only through the BH I/DD tailored plan; • A standard plan enrollee joins the Innovations or TBI waiver or waiting list; • A standard plan enrollee self-identifies as BH I/DD tailored plan eligible (e.g., the enrollee has a qualifying serious mental illness, serious emotional disturbance, substance use disorder or I/DD that makes them potentially eligible); • A standard plan enrollee is identified through claims data review as BH I/DD tailored plan eligible; or • A BH I/DD tailored plan enrollee wants to enroll in a standard plan with cause.

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

The State intends to release an RFP for PHPs in mid-April 2018, with PHP responses due back to the State mid-June and PHP contracts awarded no later than Oct. 1, 2018. The State will then commence PHP implementation and readiness reviews.

VI. Demonstration Financing and Budget Neutrality

This section should include a narrative of how the Demonstration will be financed as well as the expenditure data that accompanies this application. The State must include 5 years of historical data, as well as projections on member month enrollment. In accordance with 42 CFR 431.412(a)(iii) and (iv), historical and projected expenditures as well as projected enrollment for the proposed demonstration project must be included in a state's application in order to be determined complete. The additional information requested will be needed before the application can be acted upon.

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

Financing

North Carolina currently uses a combination of financing sources for the State share of Medicaid payments, including the State General Fund, intergovernmental transfers, certified public expenditures and provider assessment revenues. The State anticipates using a combination of State General Fund, provider assessment revenues and intergovernmental transfers to finance the demonstration costs.

North Carolina is not proposing to use a reduction in Disproportionate Share Hospital (DSH) to offset demonstration costs in the calculation of budget neutrality. DSH payments will continue outside of the demonstration and thus are not reflected in budget neutrality calculations.

Demonstration Financing Form

Please complete this form to accompany Section VI of the application in order to describe the financing of the Demonstration.

The State proposes to finance the non-federal share of expenditures under the Demonstration using the following (please check all that are applicable):

- ☑ State General Funds
- ☑ Voluntary intergovernmental transfers from governmental entities. (Please specify and provide a funding diagram in the narrative section – section "VI. Demonstration Financing and Budget Neutrality.")
- ☐ Voluntary certified public expenditures from governmental entities. (Please specify and provide a funding diagram in the narrative section – section "VI. Demonstration Financing and Budget Neutrality.")
- ☑ Provider taxes. (Provide description the narrative section – section "VI. Demonstration Financing and Budget Neutrality.")
- ☐ Other (If the State is interested in other funding or financing arrangements, please describe. Some examples could include, but are not limited to, safety net care pools, designated state health programs, Accountable Care Organization-like structures, bundled payments, etc.)

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking States to confirm to CMS that providers retain 100 per cent of the payments for services rendered or coverage provided.

Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)?

☑ Yes ☐ No

If no, provide an explanation of the provider payment arrangement.

Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of payments are returned to the State, local governmental entity, or other intermediary organizations?

☑ Yes ☐ No

If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount of percentage of payments that are returned, and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).

Please indicate the period that the following data is from.

Section 1902(a) (2) provides that the lack of adequate funds from other sources will not result in the lowering of the amount, duration, scope or quality of care and services available under the plan.

Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global, supplemental, enhanced payments, capitation payments, other) is funded.

Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment. Please indicate the period that the following data is from:

If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b).

For any payment funded by CPEs or IGTs, please provide the following, and indicate the period that the data is from:

Name of Entity Transferring/ Certifying Funds	Type of Entity (State, County, City)	Amount Transferred or Certified	Does the entity have taxing authority?	Did the entity receive appropriations?	Amount of appropriations

Section 1902(a) (30)(A) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a) (1) and 2105(a)(1) provide for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type, and indicate the time period that that the data is from.

Provider Type	Supplemental or Enhance Payment Amount

Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, and other) that, in the aggregate, exceed its reasonable costs of providing services?

☐ Yes ☑ No

If yes, provide an explanation.

In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)

☑ Yes ☐ No ☐ Not Applicable

If so, how do these arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations?

If payments exceed the cost of services (as defined above), does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

☐ Yes ☑ No

Use of other Federal Funds
Are other federal funds, from CMS or another federal agency, being used for the Demonstration program?

☐ Yes ☑ No

If yes, provide a list below of grants the State is receiving from CMS or other federal agencies. CMS must ensure these funds are not being used as a source of the non-federal share, unless such use is permitted under federal law. In addition, this will help to identify potential areas of duplicative efforts and highlight that this demonstration is building off of an existing grant or program.

Source of Federal Funds	Amount of Federal Funds	Period of Funding

Funding the Non-Federal Share of Demonstration Payments

- **Capitation payments** will be funded using a combination of state general revenue appropriations to the Medicaid agency, hospital assessment revenue, intergovernmental transfers (IGTs) from public hospitals (in lieu of assessments), and managed care plan tax revenue (if approved by the legislature).
- **Other demonstration payments** will be funded using a combination of managed care plan tax revenue (if approved by the legislature) and state general revenue appropriations to the Medicaid agency.

Total Expenditures and Non-Federal Share Amounts

Please see "Demonstration Budget Neutrality and Allotment Neutrality" for details related to total expenditures.

The State's estimates of what portion of the non-federal share will be funded by each source depends on legislative approval to extend the State's existing managed care tax to prepaid health plans serving the Medicaid population.

Use of IGTs to Fund the Demonstration

- The State currently receives IGTs from public hospitals to cover the non-federal share of certain supplemental payments made under the State Plan.
- The State expects to continue receiving from public hospitals a similar amount of funding, potentially through IGTs. (There is some possibility that the public hospitals instead would be subject to a provider assessment.)
- In the event IGTs continue, the public hospitals would make IGTs on a regular basis, which would be used to fund a portion of the non-federal share for capitation payments. PHPs would pay hospitals' claims in the ordinary course of business.
- Hospitals retain the full value of all payments made to them.
- A list of public hospitals making IGTs can be provided at a later date once the State has finalized the total amount of IGTs anticipated.

Supplemental Payments

Supplemental payments will not be made through the demonstration. The State will continue to make disproportionate share hospital payments consistent with the State plan, but those payments will be made outside of the demonstration.

Upper Payment Limits

The demonstration implements managed care, and the upper payment limit does not apply to managed care. The State will continue to submit UPL demonstrations for its fee-for-service program that exists outside of the demonstration using the process currently in place.

Actual or Potential Payments That Exceed the Amount Certified as Actuarially Sound

The State is contemplating a risk corridor for the Carolina Cares population, if authorized by the Legislature. Additionally, the State may consider establishing incentive arrangements. In the event the State decides to implement incentive arrangements or risk corridors, such arrangements would be documented in the contracts with the PHPs and incorporated in rate setting materials, subject to CMS approval as required by federal rules.

Payments in Excess of Reasonable Costs

Payments to prepaid health plans would be limited to actuarially sound capitation rates, plus any incentive arrangements or risk corridors that the State implements consistent with the requirements in 42 C.F.R. Part 438.

Demonstration Budget Neutrality and Allotment Neutrality

This section presents evidence and calculations supporting Medicaid budget neutrality for Title XIX expenditures and CHIP allotment neutrality for Title XXI expenditures. The documentation describes base data selection and underlying assumptions included in evaluating historical trends, and development of the cost and caseload estimates.

The State is proposing a demonstration that encompasses most services and most eligible populations to provide broad flexibility to more effectively manage its programs while pursuing innovations to enhance access to quality care in Medicaid and NC Health Choice programs.

Budget Neutrality Overview

The five-year demonstration is proposed to start July 1, 2019, and end June 30, 2024.

TABLE 13. FIVE-YEAR DEMONSTRATION PERIODS

DEMONSTRATION YEAR (DY)				
DY 1	**DY 2**	**DY 3**	**DY 4**	**DY 5**
7/1/2019 – 6/30/2020	7/1/2020 – 6/30/2021	7/1/2021 – 6/30/2022	7/1/2022 – 6/30/2023	7/1/2023 – 6/30/2024

The budget neutrality projections include “Without Waiver” and “With Waiver” costs and caseloads for the populations included in the demonstration (see section “III. Demonstration Benefits and Cost Sharing Requirements” through section “VI. Demonstration Financing and Budget Neutrality”). These projections are based on five years of historical eligibility and expenditure data from the State’s Medicaid Management Information System (MMIS) between Jan. 1, 2011 and Dec. 31, 2015. The calendar year 2015 base year provides the most complete picture of historical costs, including the historical provider payments that occur outside of the claims system. The components of budget neutrality are outlined in the following sections:

- Populations and Expenditures;
- Per Member Per Month (PMPM) Projections for Eligibility Groups (EGs);
- Without Waiver Projections;
- With Waiver Projections; and
- Budget Neutrality Summary.

Title XXI allotment neutrality is described in this section under “Title XXI (CHIP) Allotment Neutrality.”

Populations and Expenditures

Populations. Standards for eligibility are set forth under the Medicaid and NC Health Choice programs. There are no changes to Medicaid and NC Health Choice eligibility under the demonstration, except that the State proposes to extend eligibility to childless adults and parents with low incomes up to 138% of FPL who meet certain work requirements. Participation in the demonstration will be mandatory for all Medicaid eligibility categories, excluding certain populations such as:

- Individuals meeting nursing facility level of care criteria;
- Individuals enrolled in either the CAP/C or CAP/DA 1915(c) waivers;
- Beneficiaries eligible for Medicare including individuals in those categories limited to Medicare cost sharing programs. As noted below, dual eligibles meeting BH I/DD tailored plan criteria are included in the demonstration;
- Beneficiaries enrolled in the Program of All-Inclusive Care for the Elderly (PACE);
- Individuals enrolled in North Carolina's Health Insurance Premium Program;
- Individuals enrolled in Medicaid for emergency services only;
- Medically needy beneficiaries;
- Individuals eligible for family planning services only;
- Expenditures for periods of presumptive eligibility; and
- Members of federally recognized tribes will be included in the demonstration but will not be required to enroll in PHPs. Members may voluntarily enroll in PHPs on an opt-in basis and may disenroll without cause at any time.

Section "II. Demonstration Eligibility" provides additional details of the included and excluded populations. The table below summarizes how each included population is categorized into the eligibility groups for budget neutrality.

TABLE 14: ELIGIBLE POPULATIONS BY BUDGET NEUTRALITY GROUP

BUDGET NEUTRALITY ELIGIBILITY GROUP	ELIGIBILITY GROUP NAME
Aged, Blind and Disabled	• Blind or disabled individuals eligible in 1973 • Disabled adult children • Disabled widows and widowers ineligible for SSI due to early receipt of Social Security • Disabled widows and widowers ineligible for SSI due to Increase in OASDI • Individuals receiving SSI • Individuals who are essential spouses • Individuals who lost eligibility for SSI/SSP due to an increase in OASDI benefits in 1972 • Individuals who would be eligible for SSI/SSP but for OASDI COLA increases since April 1977 • Institutionalized individuals continuously eligible since 1973 • Poverty-level aged or disabled Working disabled under 1619(b)
TANF and Related Adults (Ages 21 and over)	• Low income families (parents/caretaker relatives) • Certain women needing treatment for breast or cervical cancer • Extended Medicaid due to child or spousal support collections • Families who would qualify for cash if requirements were more broad • Individuals eligible for but not receiving cash • Mandatory poverty level-related pregnant women • Optional poverty level-related pregnant women and infants • Qualified pregnant women and children • Ticket to work basic group • Ticket to work medical improvements group • Transitional medical assistance

BUDGET NEUTRALITY ELIGIBILITY GROUP	ELIGIBILITY GROUP NAME
TANF and Related Children (Under Age 21)	• Children under 21 not receiving cash • Children with non-IV-E adoption assistance • Children with Title IV-E adoption assistance, foster care or guardianship care • Deemed newborns • Former foster care children up to Age 26 • Independent foster care adolescents • Mandatory poverty level-related children aged 1-5 • Mandatory poverty level-related children aged 6-18 • Mandatory poverty level-related infants • Optional poverty level-related pregnant women and infants • Qualified pregnant women and children
Innovations / TBI	• Innovations waiver • TBI waiver
Carolina Cares	New adult group

North Carolina's proposed managed care program includes two managed care products designed to meet the specific needs of their diverse Medicaid population. Most populations will enroll in standard plans at the start of the demonstration on the launch of the managed care program. The State has proposed enrolling certain targeted populations with complex and unique health care needs in Year 3 of managed care. Under the proposal, beneficiaries with serious behavioral health and I/DD needs would not generally enroll in standard plans. Instead, these beneficiaries would be covered by BH I/DD tailored plans—separate integrated managed care products targeted toward this population.

For budget neutrality, the State includes all non-dual individuals not otherwise excluded above and not anticipated to be eligible for BH I/DD tailored plans, in Year 1 of managed care. BH I/DD tailored plans are scheduled to be implemented beginning in Year 3 of managed care, at which time all BH I/DD tailored plan enrollees, dual and non-dual, will be enrolled under the waiver.

Services. All Medicaid mandatory and optional services and NC Health Choice State Plan services will be provided under the demonstration with certain exclusions, including:

- Dental services (fluoride varnish provided by non-dental providers is included in the demonstration);
- Program of All-Inclusive Care for the Elderly (PACE);
- Local education agency (LEA) services;
- Children's Developmental Services Agency (CDSA) services; and
- Eyeglasses and fittings.

Note that beneficiaries eligible for BH I/DD tailored plans include those dually eligible Medicare and full Medicaid benefits. The dual eligibles will only receive behavioral health services under the waiver. Other physical health, pharmacy, and long-term services and supports will be provided outside of the waiver.

Section "II. Demonstration Eligibility" provides details of included and excluded services.

In addition to these inclusions and exclusions, the State will continue to pay graduate medical education and DSH amounts outside of the waiver.

PMPM Caps for Eligibility Groups

The budget neutrality PMPM caps are defined for five eligibility groups (EGs) outlined in "Table 14: Eligible Populations by Budget Neutrality Group." The first four EGs were developed based on the evaluation of historical

data for the included populations outlined in section "II. Demonstration Eligibility." The last EG is a new population not captured in historical Medicaid data and, thus, alternative available information was required to develop the PMPM cap for this EG.

The State proposes per capita cost limits for each of these EGs. However, the State would not be at risk for conditions (economic or other) that may impact caseload levels in each of the groups for the years of managed care. The State proposes that budget neutrality would not be limited to each individual EG, but rather would span across all EGs for the entire five-years of managed care. PMPM savings in one EG may offset PMPM costs in another EG within a single managed care year or over the five years.

TABLE 15: ELIGIBILITY GROUPS/PROGRAM GROUPS - HISTORICAL COST AND CASELOAD ANALYSIS

ELIGIBILITY GROUP	DESCRIPTION
01	Aged, blind and disabled
02	TANF and related children (under age 21)
03	TANF and related adults (age 21 and older)
04	Innovations/TBI (duals and non-duals)
05	Carolina Cares

Cost and caseload data were available for the Medicaid populations in this waiver application for the five-year historical period for calendar years 2011 through 2015 (Jan. 1, 2011 through Dec. 31, 2015). The data were aggregated on an incurred basis with paid run out through June 30, 2017. Fully completed data for calendar years 2016 and 2017 are not yet available. Calendar year 2015 was used as the base year to develop each managed care year cost and caseload estimate.

The populations and expenditures analyzed during the historical period were influenced by one-time events, which distorted PMPM costs and historical trends. These include:

- Implementation of the Affordable Care Act (ACA);
- Reductions in provider reimbursement due to economic conditions in the State; and
- Implementation of managed care for behavioral health services.

As part of the historical trend evaluation, the State took steps to normalize the five-year historical data period for each of these issues.

- **ACA Impact.** The ACA impacted the historical analysis of caseload and PMPM cost trends for the EGs. Evaluation of historical EG PMPM trends considered the following ACA impacts:
    - **Increases in Pharmacy Rebates.** The ACA reformed Medicaid payments for prescription drugs, increasing rebates and setting limits on federal reimbursements. The historical trend analysis measures the PMPM trends pre- and post-ACA (CY 2011–CY 2015), which were impacted by the increases in rebates, thus decreasing the observed trend factors. To address this situation for all EGs, the historical data were not reduced for pharmacy rebates to calculate the PMPM trend factors. Without this adjustment, these impacts would negatively distort the historical trend and inappropriately consider this one-time event as a trend throughout the projection for each demonstration year.
    - **Changes to Eligibility and Enrollment.** Implementation of streamlined enrollment, increased outreach efforts, changes to renewal processes, and income standards impacted the TANF and Related Children, and TANF and Related Adult EGs. Between CY 2013 and CY 2015 enrollment increased for the TANF and Related Children EG and the TANF and Related Adult EG related to new enrollees previously eligible but not enrolled in Medicaid.

Data analysis indicates that individuals enrolled after Jan. 1, 2014, generally have lower per capita cost compared to other individuals within the TANF and related adult EG. Also, when beneficiaries shifted between aid categories, like those who moved from NC Health Choice to MCHIP (Medicaid expansion CHIP), the beneficiary also may have experienced a change in benefit package, which reduced the PMPM cost between pre- and post-ACA periods. To address these situations, the historical trends for the TANF and related children EG and the TANF and related adult EG, were measured for the five years while assuming a cost-per-member distribution consistent with the pre-ACA enrollment. This normalized for the acuity of the population and provided a consistent historical cost base for evaluating trend. Without this adjustment, these one-time impacts would negatively distort the historical trend and would inappropriately consider these changes as trend throughout the projection for each managed care year.

- **Reductions in Provider Reimbursement Due to Economic Conditions.** During the historical period, North Carolina faced significant budget challenges and the General Assembly took steps to ameliorate the state's financial situation. In a number of cases, the Legislature directed the State to implement cost containment initiatives in the Medicaid program. These one-time reductions, outlined in "Table 16: Historical Cost Containment," had an impact on the measured historical PMPM trends for all EGs. These reductions and their influence on the PMPM trend were addressed by reversing their impacts on the historical data to produce a longer-term view of utilization and cost changes.

TABLE 16: HISTORICAL COST CONTAINMENT

SERVICE IMPACTED	SFY2011	SFY2012	SFY2013	SFY2014	SFY2015	SFY2016
Ambulatory Surgical Centers		-2.67%				
Behavioral Health Enhanced		-2.65%				
Chiropractor, Podiatry, and Optometry		-2.67%		-3.00%		
Dialysis		-2.67%				
Durable Medical Equipment (DME)		-2.66%				
Extended Services for Pregnant Women		-2.67%				
Geropsychiatric, Head Injury and Ventilator Nursing Beds		-2.67%				
Hearing Aids		-2.67%		-3.00%		
HIV Case Management		-2.67%				
Home Health		-2.67%				
Home Infusion Therapy		-2.67%				
Hospital Inpatient		-9.80%		-3.00%		
Hospital Outpatient				-10.00%		
Independent Practitioner Services		-2.66%				
Labs & X-Rays		-2.66%				
Nurse Midwives, R.N. Anesthesiologist, Anesthesiology Assist.		-2.67%				
Nursing Facilities	-2.15%		-2.17%	-3.00%		
Optical Supplies		-2.66%		-3.00%		
Orthotics and Prosthetics		-2.67%				
Other Licensed Practitioner Services		-2.66%				
Personal Care Services				-3.00%		
Prescribed Drugs						-3.07%
Physician Services				-3.00%		

SERVICE IMPACTED	SFY2011	SFY2012	SFY2013	SFY2014	SFY2015	SFY2016
Private Duty Nursing		-2.67%				
Transportation		-2.66%				

- **Implementation of Managed Care for Behavioral Health Services.** In March 2013, the State completed implementation of managed care for behavioral health services statewide. The managed care program has managed utilization of behavioral health services and mitigated the five-year trends for these services. As this managed care impact on behavioral health was a one-time event, the behavioral health capitation payments were excluded from the per capita cost for trend evaluation.

Historical Trend Evaluation

The prior sections discussed how the historical data were adjusted to remove distortions associated with the implementation of ACA and cost containment initiatives. These distortions and the corresponding adjustments made by the State are important in the evaluation of historical data for purposes of trend. Under budget neutrality, the lower of the historical trend factors or the President's budget trends are used to project the base period PMPM into each managed care period.

Consistent with the "2016 Actuarial Report on the Financial Outlook for Medicaid,"[28] the State expects trends during the managed care period to be higher than the raw historical trends from the five-year lookback period. The adjustments to remove distortions yield the most appropriate measurement of trend in the historical period for use in the projections of costs under managed care.

Exhibits 1 and 2 show the historical caseload, adjusted PMPMs and annualized trend measured for a five-year period for each EG. These exhibits support the trends used to develop the Without Waiver projections discussed next.

Without Waiver Development

- **EG PMPM Projection.** The Without Waiver budget neutrality PMPM projections were prepared using calendar year 2015 as the base period. Note that the base period used to develop demonstration year projections reflects the actual costs for each EG, including reductions for pharmacy rebates. The base period does not include adjustments considered in trend development, described in "PMPM Caps for Eligibility Groups." The result is that the calendar year 2015 base period PMPM for each EG used for the demonstration Without Waiver PMPM projections represents actual cost and differs from the normalized data evaluated in the historical cost trend analysis.

  Once the base data were established, they were trended forward to the waiver effective date based on measured cost and enrollment trends outlined in "Table 17: Without Waiver and With Waiver Annual Medical Cost Trends." Trend was applied from the end of 2015 through the bridge period of January 2016 through June 2019 into the managed care period using annual trend factors. Additionally, costs for State programmatic changes and other items were considered in the projection of costs.

- **Cost Trend.** Historical trends were evaluated as described in "PMPM Caps for Eligibility Groups" and used to project from the base period to each demonstration year. Consistent with previous CMS policy for budget neutrality, the trend used is the lower of the actual historical PMPM trend by EG or the President's Budget trend rates from the 2016 Actuarial Report published by the CMS Office of the Actuary. The PMPM cost trend for each EG is illustrated in "Table 17: Without Waiver and With Waiver Annual Medical Cost Trends."

[28] "2016 Actuarial Report on the Financial Outlook for Medicaid." Department of Health & Human Services. Available at cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf.

TABLE 17: WITHOUT WAIVER AND WITH WAIVER ANNUAL MEDICAL COST TRENDS

MEDICAID ELIGIBILITY GROUP	BASE YEAR TO DY1	DY1 TO DY2	DY2 TO DY3	DY3 TO DY4	DY4 TO DY5
Aged, Blind and Disabled	4.6%	4.6%	4.6%	4.6%	4.6%
TANF and Related Children (under 21 years)	3.3%	3.3%	3.3%	3.3%	3.3%
TANF and Related Adults (older than 20 years)	4.1%	4.1%	4.1%	4.1%	4.1%
Innovations	4.4%	4.4%	4.4%	4.4%	4.4%
Carolina Cares		4.0%	4.0%	4.0%	4.0%

* The annual PMPM trend is applied to the base year (CY 2015) PMPMs.

- **Enrollment Trend.** Enrollment estimates for demonstration Years 1–5 use actual caseloads from calendar year 2015 and are projected using emerging actual enrollment for the bridge period and estimates for enrollment growth rates for all EGs based on historical enrollment trends within the State for these populations adjusted for one-time impacts of ACA.
- **BH I/DD Tailored Plan Considerations.** As described earlier, the State plans to implement BH I/DD tailored plans beginning in demonstration Year 3. The historical cost and trend analysis described above included all eligible populations to evaluate the historical trends. To develop the Without Waiver projections, enrollment and per capita cost adjustments were developed to project demonstration Year 1 and Year 2 for the standard plan populations. Based on actuarial analysis, the population exhibits higher historical costs compared to the standard plan population. As such, a caseload reduction was applied to the historical enrollment and a per capita cost reduction was included in the projection of the Without Waiver PMPM for demonstration Year 1 and Year 2. As the Innovations EG consists solely of BH I/DD tailored plan eligibles, this results in no enrollment or per capita cost projection for demonstration Year 1 and Year 2. The Carolina Cares population was assumed to enroll in the standard plan and, as such, no adjustment was made for the BH I/DD tailored plan considerations.

  The adjustment factors below were applied to the projection of the historical base year data, which included the BH I/DD tailored plan individuals. For example, in demonstration Year 1, 82% of the projected enrollment for aged, blind and disabled was included, as 18% are anticipated meet the eligibility criteria for BH I/DD tailored plans. Similarly, for this same Medicaid EG and demonstration Year 1, a 0.97 factor was applied to the per capita projection as the non-BH I/DD tailored plan individuals are anticipated to be 3% less costly than the average inclusive of anticipated BH I/DD tailored plan enrollees.

TABLE 18: BH I/DD TAILORED PLAN ENROLLMENT ADJUSTMENT FACTORS

	DEMONSTRATION YEARS 1-5				
MEDICAID ELIGIBILITY GROUP	DY1	DY2	DY3	DY4	DY5
Aged, Blind and Disabled	0.82	1.00	1.34	1.00	1.00
TANF and Related Children (under 21 years)	0.97	1.00	1.03	1.00	1.00
TANF and Related Adults (older than 20 years)	0.96	1.00	1.04	1.00	1.00
Innovations/TBI	0.0	0.0	1.00	1.00	1.00
Carolina Cares	N/A	N/A	N/A	N/A	N/A

TABLE 19: BH I/DD TAILORED PLAN PER CAPITA ADJUSTMENT FACTORS

MEDICAID ELIGIBILITY GROUP	DEMONSTRATION YEARS 1-5				
	DY1	DY2	DY3	DY4	DY5
Aged, Blind and Disabled	0.97	1.00	1.03	1.00	1.00
TANF and Related Children (under 21 years)	0.96	1.00	1.05	1.00	1.00
TANF and Related Adults (older than 20 years)	0.96	1.00	1.04	1.00	1.00
Innovations/TBI	0.0	0.0	1.00	1.00	1.00
Carolina Cares	N/A	N/A	N/A	N/A	N/A

For demonstration Year 3, the enrollment and per capita adjustments were reversed for each impacted EG. In addition, a positive case load adjustment was applied to the aged, blind and disabled group as consideration for dual eligible BH I/DD tailored plan individuals. These beneficiaries have similar cost structure as other aged, blind, and disabled eligibles. Year 3 also represents the starts of the Innovations/TBI eligibility group under the waiver.

- **New Populations and Hypothetical Services.** The demonstration and budget neutrality appraisal includes the following proposed new eligibility groups and hypothetical service expenditures. The costs for hypothetical services in the Without Waiver and With Waiver are projected to be the same. The costs for the Carolina Cares population are anticipated to be lower under the demonstration compared to the anticipated cost of serving this population under a Medicaid fee-for-service system.
- **Carolina Cares.** Discussed in section "II. Demonstration Eligibility," the Legislature is currently considering the proposed Carolina Cares program, which would make childless adults and parents with low incomes up to 138% of FPL who meet certain work and other requirements eligible for Medicaid.

  These Carolina Cares individuals are identified under the separate EG "Carolina Cares." Because a subset of the potentially eligible population currently receives coverage through the Marketplace, Marketplace premiums, with adjustments, were used as a proxy for the baseline cost of this population. Specifically, the demonstration Year 1 PMPM costs are based on available calendar year 2017 North Carolina silver level premium information from the Marketplace, modified to reflect Medicaid provider reimbursement values, a higher actuarial value due to lower cost-sharing requirements in Medicaid, and enrollment considerations. For projections for demonstration Years 2–5, the PMPM trend from the TANF and related adult EG is applied to the demonstration Year 1 PMPM.
- **Hypothetical Service Considerations.** In projecting the Without Waiver costs, the State included expenditures for additional initiatives and programmatic changes that could have been covered in the current program. These adjustments are applied in addition to the annual trend rate as they are related to changes that have occurred or will occur after the 2015 historical base year.
  - **Advanced Medical Homes (AMH).** The State proposes to build from its existing enhanced primary care case management program to enhance payments to physician AMH certified practices for care management at the practice level.
  - **Health Home Care Management for BH I/DD Tailored Plan Enrollees.** When BH I/DD tailored plans launch, they will offer robust, whole-person care management services specifically tailored to the unique physical health, behavioral health and social needs of this clinically complex population.
  - **Substance Use Disorder Service Array Changes.** The State proposes to expand the substance use disorder service array to include the full ASAM continuum of services.
  - **Pain Management Array Changes.** The State proposes to expand therapy services for adults and add acupuncture services as an alternative to prescription pain medications.
  - **IMD Service Costs.** For the Without Waiver projection, the State included consideration for all acute IMD stays for psychiatric treatment for adults. These stays are critical to the continuum of

care in the State. substance use disorder stays are excluded from the per capita calculations in this Budget Neutrality analysis and addressed separately in a unique eligibility group through the CMS substance use disorder toolkit template.

- **Changes to Private Duty Nursing Service Offering.** The State made recent fee schedule changes to Private Duty Nursing services, and expanded its offering under the State Plan between the historical and waiver periods. An adjustment was included as consideration for these changes.

Without Waiver projections on a total computable and federal share basis are illustrated in Exhibits 3 and 4.

With Waiver Development

Per Member Per Month Projections

Under the demonstration, the State will contract with PHPs to provide care for North Carolina's Medicaid beneficiaries. As a result, the State is anticipating savings through improving health care access, quality and cost efficiency for the growing population of Medicaid and NC Health Choice beneficiaries.

With Waiver estimates were calculated for each EG based on the implementation of managed care July 1, 2019, which coincides with the start of the proposed demonstration. Savings are projected to begin in Year 1 of the demonstration and to scale up through demonstration Year 5.

Transformation Initiatives and Annual, Aggregate Expenditure Projections

As described in section "IV. Delivery System and Payment Rates for Services," the State will implement Medicaid payment reforms using risk-based payments paid as a part of the managed care rates that consider various reimbursement reforms including the rebasing of hospital rates to recognize historical supplemental payments, investments in public-private regional partnerships, increased behavioral health care management capacity investments and telemedicine initiatives. The State requests expenditure authority and annual expenditure limits for each year of managed care for the following direct payments.

For each item below, the State proposes the use of savings, as calculated by the difference between the Without Waiver and With Waiver projections (PMPM x member months) to fund these expenditures. Expenditure projections for these payments are reflected in the With Waiver projection only. Additional information on each of these initiatives is included in section "IV. Delivery System and Payment Rates for Services."

- **Workforce Initiatives.** North Carolina seeks federal expenditure authority to establish a new "Innovations Workforce Fund" to address shortages identified in the workforce evaluation. The State anticipates developing an integrated suite of incentive programs, including loan repayment and recruitment bonuses for critical provider types.
- **Public-Private Regional Partnerships.** North Carolina plans to provide focused investment to test, scale, strengthen and sustain public-private initiatives in select regions of North Carolina that aim to measurably improve health and lower costs through evidence-based interventions in four domains of social determinants of health: housing, food, transportation and interpersonal safety/toxic stress.
- **Tribal Uncompensated Care Payments.** North Carolina proposes to increase access to care and expand services for Native Americans by establishing a tribal uncompensated care pool. The tribal uncompensated care pool payments will provide payments to offset the cost of uncompensated care provided by or arranged through the Cherokee Indian Hospital Authority.
- **Building of Behavioral Health Care Management Capacity.** Specific to behavioral health care management, North Carolina proposes to provide support to care management agencies and tailored plans as needed to create and maintain the capacity required to meet assigned caseloads, and provide advanced education and training for care managers. This will include building capacity prior to the launch of tailored plans in demonstration Year 3, and intensive recruiting and training of care management staff.

- **Telemedicine Initiatives.** To increase provider awareness, education and training on telemedicine opportunities and best practices, North Carolina aims to support the establishment of an independent, statewide telemedicine alliance. The State seeks federal expenditure authority to provide the organization with start-up funding.

  In addition, the State proposes to establish the "Telemedicine Innovation Fund," which will support pilot projects and may include financing the purchase of hardware and software.

With Waiver projections on a total computable and federal share basis are illustrated in Exhibits 5 and 6.

Substance Use Disorder Residential Services

In addition to expenditure authority, the State requests waiver of the 15-day managed care final rule limitation related to IMD utilization. The State seeks to provide the full-continuum of substance use disorder treatment including, when necessary, treatment in residential settings that may exceed 16 beds. The State has developed PMPM cost projections for months when Medicaid eligibles receive substance use disorder treatment in IMD settings based on recent guidance issued by CMS.

The State has limited Medicaid experience for these type services, and thus has relied on historical data from North Carolina and other states to develop historical and projected per capita costs for a single substance use disorder Medicaid EG. Note that these per capita costs are developed based on experience across the entire substance use disorder residential service continuum.

The substance use disorder projections are separately illustrated in the substance use disorder budget neutrality templates provided by CMS. The template includes With Waiver and Without Waiver projections that are identical based on the State's intent to consider these costs hypothetical as instructed. The projections have been prepared based on the State's understanding of the CMS substance use disorder guidance.

The substance use disorder projections for the residential service array are presented in Exhibit 7. As the costs for these services were excluded from the other EGs, the per capita estimates for the other EGs included in the Exhibits 1 through 6 are mutually exclusive from these estimates.

Budget Neutrality Summary

The federal share of the combined Medicaid expenditures for the populations included in this waiver, excluding those covered under the Title XXI Allotment Neutrality, will not exceed what the federal share of Medicaid expenditures would have been without the waiver.

The State makes the following assumptions regarding budget neutrality:

- Nothing in this waiver application precludes the State from applying for enhanced Medicaid funding.
- Administrative costs for management of this waiver are not subject to budget neutrality and have been excluded from the budget neutrality calculations.
- The projected savings is the difference between the Without Waiver and With Waiver PMPM projections. The State is proposing to reinvest a majority of these savings into the North Carolina health care system as described in section "I. Program Description."
- The annual budget neutrality expenditure limit for the demonstration includes the products of the PMPM expenditure limits and actual member months (PMPM x member months) for each EG plus the annual expenditure limits for the workforce initiatives, public-private regional partnerships, tribal uncompensated care payments, behavioral health care management capacity investment costs, and telemedicine initiatives.
- The budget neutrality summary includes the Without Waiver and With Waiver projections from the substance use disorder budget neutrality summary.

- The final budget neutrality agreement will be expressed in terms of total computable, so the State's Medicaid budget would not be obligated by future changes to the FMAP rate on services.

The aggregate five-year summary for Without Waiver, With Waiver and Estimated Savings are illustrated in Table 20, next.

TABLE 20: TOTAL WITHOUT WAIVER, WITH WAIVER AND ESTIMATED SAVINGS

FUNDING SOURCE	WITHOUT WAIVER	WITH WAIVER	ESTIMATED SAVINGS
Total Computable	$81,751,424,693	$80,520,067,719	$1,231,356,975
Federal Share*	$61,403,520,972	$60,101,866,371	$1,301,654,600

* FMAP rate 67.61% for all included populations, 90.00% was assumed for behavioral health home expenditures in demonstration Year 3 and Year 4 (to the extent permitted under federal rules and guidance), 90.75% for Carolina Cares in demonstration Year 1, 90.00% for Carolina Cares in demonstration Years 2-5, 100% for tribal uncompensated care payments, and 50% for the other transformation initiatives.

EXHIBIT 1: HISTORICAL EG CASELOAD, PMPM AND ANNUALIZED TREND | TOTAL COMPUTABLE

Illustrates the historical caseload, adjusted PMPMs and annualized trend measured for a five-year period for each EG as outlined in "PMPM Caps for Eligibility Groups."

	2011 (01/11 - 12/11)	2012 (01/12 - 12/12)	2013 (01/13 - 12/13)	2014 (01/14 - 12/14)	2015 (01/15 - 12/15)	5-YEARS CY11-CY15
EG-01 - Aged, Blind, and Disabled						
TOTAL EXPENDITURES						
Eligible Member Months	1,894,908	1,960,614	2,010,118	2,043,763	2,109,018	10,018,421
Cost per Eligible	$ 1,076.32	$ 1,110.16	$ 1,179.20	$ 1,258.53	$ 1,323.09	$ 1,192.70
Expenditures	$ 2,039,527,071	$ 2,176,602,239	$ 2,370,331,548	$ 2,572,126,891	$ 2,790,426,330	$ 11,949,014,079
TREND RATES			Annual Change			5 Year Average
Eligible Member Months		3.5%	2.5%	1.7%	3.2%	2.7%
Cost per Eligible		3.1%	6.2%	6.7%	5.1%	5.3%
Expenditures		6.7%	8.9%	8.5%	8.5%	8.2%
					President's Budget Trend - Disabled	*4.6%*
EG-02 - TANF & Related Children						
TOTAL EXPENDITURES						
Eligible Member Months	10,065,693	10,650,724	10,916,872	11,561,691	11,965,976	55,160,956
Cost per Eligible	$ 169.39	$ 173.74	$ 175.35	$ 181.66	$ 192.79	$ 179.06
Expenditures	$ 1,705,068,711	$ 1,850,462,164	$ 1,914,288,494	$ 2,100,268,833	$ 2,306,965,998	$ 9,877,054,199
TREND RATES			Annual Change			5 Year Average
Eligible Member Months		5.8%	2.5%	5.9%	3.5%	4.4%
Cost per Eligible		2.6%	0.9%	3.6%	6.1%	3.3%
Expenditures		8.5%	3.4%	9.7%	9.8%	7.9%
					President's Budget Trend - Children	*4.5%*
EG-03 - TANF & Related Adults						
TOTAL EXPENDITURES						
Eligible Member Months	2,248,911	2,215,191	2,193,895	2,640,190	3,032,789	12,330,976
Cost per Eligible	$ 516.18	$ 546.38	$ 565.16	$ 583.72	$ 605.21	$ 566.68
Expenditures	$ 1,160,842,203	$ 1,210,334,874	$ 1,239,894,224	$ 1,541,134,315	$ 1,835,470,773	$ 6,987,676,389
TREND RATES			Annual Change			5 Year Average
Eligible Member Months		-1.5%	-1.0%	20.3%	14.9%	7.8%
Cost per Eligible		5.9%	3.4%	3.3%	3.7%	4.1%
Expenditures		4.3%	2.4%	24.3%	19.1%	12.1%
					President's Budget Trend - Adults	*5.1%*
EG-04 - Innovations/TBI						
TOTAL EXPENDITURES						
Eligible Member Months	90,809	86,780	84,028	85,776	86,321	433,714
Cost per Eligible	$ 902.08	$ 917.46	$ 939.14	$ 985.77	$ 1,071.05	$ 962.52
Expenditures	$ 81,916,645	$ 79,617,074	$ 78,914,396	$ 84,555,233	$ 92,453,885	$ 417,457,232
TREND RATES			Annual Change			5 Year Average
Eligible Member Months		-4.4%	-3.2%	2.1%	0.6%	-1.3%
Cost per Eligible		1.7%	2.4%	5.0%	8.7%	4.4%
Expenditures		-2.8%	-0.9%	7.1%	9.3%	3.1%
					President's Budget Trend - Disabled	*4.6%*
All Included Populations						
TOTAL EXPENDITURES						
Eligible Member Months	14,300,321	14,913,309	15,204,913	16,331,420	17,194,104	77,944,067
Cost per Eligible	$ 348.76	$ 356.53	$ 368.53	$ 385.64	$ 408.59	$ 375.03
Expenditures	$ 4,987,354,630	$ 5,317,016,350	$ 5,603,428,661	$ 6,298,085,272	$ 7,025,316,986	$ 29,231,201,900
TREND RATES			Annual Change			5 Year Average
Eligible Member Months		4.3%	2.0%	7.4%	5.3%	4.7%
Cost per Eligible		2.2%	3.4%	4.6%	6.0%	4.0%
Expenditures		6.6%	5.4%	12.4%	11.5%	8.9%
					President's Budget Trend	*4.7%*

EXHIBIT 2: HISTORICAL EG CASELOAD, PMPM AND ANNUALIZED TREND | FEDERAL SHARE

Illustrates the historical caseload, adjusted PMPMs and annualized trend measured for a five-year period for each EG as outlined in "PMPM Caps for Eligibility Groups."

	2011 (01/11 - 12/11)	2012 (01/12 - 12/12)	2013 (01/13 - 12/13)	2014 (01/14 - 12/14)	2015 (01/15 - 12/15)	5-YEARS CY11-CY15
EG-01 - Aged, Blind, and Disabled						
TOTAL EXPENDITURES						
Eligible Member Months	1,894,908	1,960,614	2,010,118	2,043,763	2,109,018	10,018,421
Cost per Eligible	$ 698.01	$ 725.36	$ 773.32	$ 828.18	$ 872.85	$ 781.83
Expenditures	$ 1,322,665,411	$ 1,422,142,982	$ 1,554,462,640	$ 1,692,610,669	$ 1,840,847,368	$ 7,832,729,069
TREND RATES			Annual Change			5 Year Average
Eligible Member Months		3.5%	2.5%	1.7%	3.2%	2.7%
Cost per Eligible		3.9%	6.6%	7.1%	5.4%	5.7%
Expenditures		7.5%	9.3%	8.9%	8.8%	8.6%
					President's Budget Trend - Disabled	*4.6%*
EG-02 - TANF & Related Children						
TOTAL EXPENDITURES						
Eligible Member Months	10,065,693	10,650,724	10,916,872	11,561,691	11,965,976	55,160,956
Cost per Eligible	$ 109.85	$ 113.52	$ 115.00	$ 119.54	$ 127.19	$ 117.37
Expenditures	$ 1,105,763,900	$ 1,209,050,387	$ 1,255,389,756	$ 1,382,100,333	$ 1,521,908,047	$ 6,474,212,423
TREND RATES			Annual Change			5 Year Average
Eligible Member Months		5.8%	2.5%	5.9%	3.5%	4.4%
Cost per Eligible		3.3%	1.3%	4.0%	6.4%	3.7%
Expenditures		9.3%	3.8%	10.1%	10.1%	8.3%
					President's Budget Trend - Children	*4.5%*
EG-03 - TANF & Related Adults						
TOTAL EXPENDITURES						
Eligible Member Months	2,248,911	2,215,191	2,193,895	2,640,190	3,032,789	12,330,976
Cost per Eligible	$ 334.75	$ 356.99	$ 370.63	$ 384.12	$ 399.26	$ 371.57
Expenditures	$ 752,824,442	$ 790,805,603	$ 813,122,219	$ 1,014,156,958	$ 1,210,862,120	$ 4,581,771,343
TREND RATES			Annual Change			5 Year Average
Eligible Member Months		-1.5%	-1.0%	20.3%	14.9%	7.8%
Cost per Eligible		6.6%	3.8%	3.6%	3.9%	4.5%
Expenditures		5.0%	2.8%	24.7%	19.4%	12.6%
					President's Budget Trend - Adults	*5.1%*
EG-04 - Innovations/TBI						
TOTAL EXPENDITURES						
Eligible Member Months	90,809	86,780	84,028	85,776	86,321	433,714
Cost per Eligible	$ 585.01	$ 599.45	$ 615.89	$ 648.69	$ 706.57	$ 630.67
Expenditures	$ 53,124,234	$ 52,020,007	$ 51,752,035	$ 55,642,313	$ 60,991,931	$ 273,530,519
TREND RATES			Annual Change			5 Year Average
Eligible Member Months		-4.4%	-3.2%	2.1%	0.6%	-1.3%
Cost per Eligible		2.5%	2.7%	5.3%	8.9%	4.8%
Expenditures		-2.1%	-0.5%	7.5%	9.6%	3.5%
					President's Budget Trend - Disabled	*4.6%*
All Included Populations						
TOTAL EXPENDITURES						
Eligible Member Months	14,300,321	14,913,309	15,204,913	16,331,420	17,194,104	77,944,067
Cost per Eligible	$ 226.18	$ 232.95	$ 241.68	$ 253.78	$ 269.55	$ 245.85
Expenditures	$ 3,234,377,987	$ 3,474,018,979	$ 3,674,726,649	$ 4,144,510,273	$ 4,634,609,465	$ 19,162,243,354
TREND RATES			Annual Change			5 Year Average
Eligible Member Months		4.3%	2.0%	7.4%	5.3%	4.7%
Cost per Eligible		3.0%	3.7%	5.0%	6.2%	4.5%
Expenditures		7.4%	5.8%	12.8%	11.8%	9.4%
					President's Budget Trend	*4.7%*

EXHIBIT 3: WITHOUT WAIVER PROJECTIONS | TOTAL COMPUTABLE

Eligibility Group	Annual Trend Rate	Demonstration Years (DY) DY 01 (07/19 - 06/20)	DY 02 (07/20 - 06/21)	DY 03 (07/21 - 06/22)	DY 04 (07/22 - 06/23)	DY 05 (07/23 - 06/24)	Total
Aged, Blind, and Disabled							
Eligible Member Months	10.0%	1,844,530	1,884,832	2,587,191	2,643,720	2,701,485	
Without Waiver Cost Per Eligible	4.6%	$ 1,698.39	$ 1,776.72	$ 1,933.48	$ 2,022.37	$ 2,115.34	
Without Waiver Expenditures	16.2%	$ 3,132,731,219	$ 3,348,818,591	$ 5,002,279,712	$ 5,346,571,094	$ 5,714,558,984	$ 22,544,959,600
TANF & Related Children							
Eligible Member Months	3.0%	12,503,211	12,796,635	13,440,274	13,755,688	14,078,505	
Without Waiver Cost Per Eligible	3.3%	$ 233.67	$ 241.60	$ 263.90	$ 272.58	$ 281.54	
Without Waiver Expenditures	7.9%	$ 2,921,652,166	$ 3,091,726,433	$ 3,546,934,435	$ 3,749,523,599	$ 3,963,683,985	$ 17,273,520,617
TANF & Related Adults							
Eligible Member Months	4.0%	3,123,979	3,216,470	3,444,614	3,546,598	3,651,601	
Without Waiver Cost Per Eligible	4.1%	$ 571.27	$ 594.71	$ 649.14	$ 675.48	$ 702.90	
Without Waiver Expenditures	9.5%	$ 1,784,643,012	$ 1,912,852,227	$ 2,236,041,057	$ 2,395,671,317	$ 2,566,697,531	$ 10,895,905,145
Innovations/TBI							
Eligible Member Months	2.2%			162,692	166,224	169,832	
Without Waiver Cost Per Eligible	4.4%			$ 7,490.24	$ 7,818.74	$ 8,161.66	
Without Waiver Expenditures	6.7%			$ 1,218,605,181	$ 1,299,663,050	$ 1,386,112,639	$ 3,904,380,871
All Included Populations							
Eligible Member Months	4.2%	17,471,719	17,897,937	19,634,771	20,112,231	20,601,424	
Without Waiver Cost Per Eligible	10.2%	$ 448.67	$ 466.72	$ 611.36	$ 636.00	$ 661.66	
Without Waiver Expenditures	14.8%	$ 7,839,026,397	$ 8,353,397,251	$ 12,003,860,385	$ 12,791,429,061	$ 13,631,053,139	$ 54,618,766,233
Hypothetical Groups							
Carolina Cares							
Eligible Member Months	5.7%	3,765,600	3,981,075	4,208,880	4,449,721	4,704,342	
Without Waiver Cost Per Eligible	4.1%	$ 1,177.56	$ 1,225.34	$ 1,278.99	$ 1,330.89	$ 1,384.90	
Without Waiver Expenditures	10.1%	$ 4,434,210,414	$ 4,878,188,416	$ 5,383,110,536	$ 5,922,097,737	$ 6,515,051,358	$ 27,132,658,460
Transformation Initiatives							
Workforce Initiatives		$ -	$ -	$ -	$ -	$ -	$ -
Public-Private Regional Pilots		$ -	$ -	$ -	$ -	$ -	$ -
Tribal Uncompensated Care		$ -	$ -	$ -	$ -	$ -	$ -
Building BH I/DD Care Mgmt Capacity		$ -	$ -	$ -	$ -	$ -	$ -
Telemedicine Alliance		$ -	$ -	$ -	$ -	$ -	$ -
Telemedicine Innovation Fund		$ -	$ -	$ -	$ -	$ -	$ -
Total Transformation Initiative Expenditures		$ -	$ -	$ -	$ -	$ -	$ -
Without Waiver Total Expenditures	**13.2%**	**$ 12,273,236,810**	**$ 13,231,585,666**	**$ 17,386,970,921**	**$ 18,713,526,798**	**$ 20,146,104,498**	**$ 81,751,424,693**

Excluded Expenditures:		
-Graduate Medical Expense	-PACE Capitation	-All services associated with excluded populations
-Disproportionate Share Hospital	-Local Education Agency (LEA) services	-Dental services (excluding dental varnish applied by non-dental practitioners)
-Children's Developmental Service Agencies	-Eyeglasses and fittings	

EXHIBIT 4: WITHOUT WAIVER PROJECTIONS | FEDERAL SHARE

Eligibility Group	Annual Trend Rate	Demonstration Years (DY) DY 01 (07/19 - 06/20)	DY 02 (07/20 - 06/21)	DY 03 (07/21 - 06/22)	DY 04 (07/22 - 06/23)	DY 05 (07/23 - 06/24)	Total
Aged, Blind, and Disabled							
Eligible Member Months	10.0%	1,844,530	1,884,832	2,587,191	2,643,720	2,701,485	
Without Waiver Cost Per Eligible	4.6%	$ 1,148.28	$ 1,201.24	$ 1,309.03	$ 1,369.21	$ 1,430.18	
Without Waiver Expenditures	16.2%	$ 2,118,039,577	$ 2,264,136,249	$ 3,386,706,407	$ 3,619,802,895	$ 3,863,613,329	$ 15,252,298,458
TANF & Related Children							
Eligible Member Months	3.0%	12,503,211	12,796,635	13,440,274	13,755,688	14,078,505	
Without Waiver Cost Per Eligible	3.3%	$ 157.99	$ 163.35	$ 178.67	$ 184.55	$ 190.35	
Without Waiver Expenditures	7.9%	$ 1,975,329,029	$ 2,090,316,241	$ 2,401,390,220	$ 2,538,549,687	$ 2,679,846,742	$ 11,685,431,920
TANF & Related Adults							
Eligible Member Months	4.0%	3,123,979	3,216,470	3,444,614	3,546,598	3,651,601	
Without Waiver Cost Per Eligible	4.1%	$ 386.24	$ 402.08	$ 439.49	$ 457.32	$ 475.23	
Without Waiver Expenditures	9.5%	$ 1,206,597,141	$ 1,293,279,391	$ 1,513,872,676	$ 1,621,947,566	$ 1,735,344,201	$ 7,371,040,974
Innovations/TBI							
Eligible Member Months	2.2%			162,692	166,224	169,832	
Without Waiver Cost Per Eligible	4.4%			$ 5,071.14	$ 5,293.54	$ 5,518.10	
Without Waiver Expenditures	6.6%			$ 825,035,426	$ 879,914,246	$ 937,150,755	$ 2,642,100,428
All Included Populations							
Eligible Member Months	4.2%	17,471,719	17,897,937	19,634,771	20,112,231	20,601,424	
Without Waiver Cost Per Eligible	10.2%	$ 303.35	$ 315.55	$ 413.91	$ 430.59	$ 447.35	
Without Waiver Expenditures	14.8%	$ 5,299,965,747	$ 5,647,731,881	$ 8,127,004,730	$ 8,660,214,393	$ 9,215,955,027	$ 36,950,871,779
Hypothetical Groups							
Carolina Cares							
Eligible Member Months	5.7%	3,765,600	3,981,075	4,208,880	4,449,721	4,704,342	
Without Waiver Cost Per Eligible	4.1%	$ 1,068.63	$ 1,102.81	$ 1,151.09	$ 1,197.80	$ 1,246.41	
Without Waiver Expenditures	9.9%	$ 4,024,045,950	$ 4,390,369,574	$ 4,844,799,482	$ 5,329,887,963	$ 5,863,546,223	$ 24,452,649,192
Transformation Initiatives							
Workforce Initiatives		$ -	$ -	$ -	$ -	$ -	$ -
Public-Private Regional Pilots		$ -	$ -	$ -	$ -	$ -	$ -
Tribal Uncompensated Care		$ -	$ -	$ -	$ -	$ -	$ -
Building BH I/DD Care Mgmt Capacity		$ -	$ -	$ -	$ -	$ -	$ -
Telemedicine Alliance		$ -	$ -	$ -	$ -	$ -	$ -
Telemedicine Innovation Fund		$ -	$ -	$ -	$ -	$ -	$ -
Total Transformation Initiative Expenditures		$ -	$ -	$ -	$ -	$ -	$ -
Without Waiver Total Expenditures	**12.8%**	**$ 9,324,011,697**	**$ 10,038,101,455**	**$ 12,971,804,212**	**$ 13,990,102,357**	**$ 15,079,501,250**	**$ 61,403,520,972**

Excluded Expenditures		
-Graduate Medical Expense	-PACE Capitation	-All services associated with excluded populations
-Disproportionate Share Hospital	-Local Education Agency (LEA) services	-Dental services (excluding dental varnish applied by non-dental practitioners)
-Children's Developmental Service Agencies	-Eyeglasses and fittings	

EXHIBIT 5: WITH WAIVER PROJECTIONS | TOTAL COMPUTABLE

Eligibility Group	Annual Trend Rate	Demonstration Years (DY) DY 01 (07/19 - 06/20)	DY 02 (07/20 - 06/21)	DY 03 (07/21 - 06/22)	DY 04 (07/22 - 06/23)	DY 05 (07/23 - 06/24)	Total
Aged, Blind, and Disabled							
Eligible Member Months	10.0%	1,844,530	1,884,832	2,587,191	2,643,720	2,701,485	
With Waiver Cost per Eligible	4.5%	$ 1,674.09	$ 1,694.48	$ 1,838.14	$ 1,908.57	$ 1,994.18	
With Waiver Expenditures	14.9%	$ 3,087,904,256	$ 3,193,817,492	$ 4,755,629,355	$ 5,045,725,123	$ 5,387,236,769	$ 21,470,312,994
Estimated Costs (Savings)		$ (44,826,963)	$ (155,001,099)	$ (246,650,357)	$ (300,845,972)	$ (327,322,215)	$ (1,074,646,605)
TANF & Related Children							
Eligible Member Months	3.0%	12,503,211	$ 12,796,635	$ 13,440,274	$ 13,755,688	14,078,505	
With Waiver Cost per Eligible	4.4%	$ 237.51	$ 245.16	$ 264.93	$ 272.83	$ 281.75	
With Waiver Expenditures	7.5%	$ 2,969,695,684	$ 3,137,275,315	$ 3,560,692,974	$ 3,752,958,658	$ 3,966,598,905	$ 17,387,221,536
Estimated Costs (Savings)		$ 48,043,518	$ 45,548,882	$ 13,758,539	$ 3,435,059	$ 2,914,920	$ 113,700,919
TANF & Related Adults							
Eligible Member Months	4.0%	3,123,979	3,216,470	3,444,614	3,546,598	3,651,601	
With Waiver Cost per Eligible	4.7%	$ 578.55	$ 597.98	$ 644.80	$ 667.96	$ 694.78	
With Waiver Expenditures	8.8%	$ 1,807,363,923	$ 1,923,397,846	$ 2,221,103,731	$ 2,369,001,736	$ 2,537,068,382	$ 10,857,935,618
Estimated Costs (Savings)		$ 22,720,910	$ 10,545,619	$ (14,937,326)	$ (26,669,582)	$ (29,629,149)	$ (37,969,528)
Innovations/TBI							
Eligible Member Months	2.2%			$ 162,692	$ 166,224	169,832	
With Waiver Cost per Eligible	4.0%			$ 7,461.57	$ 7,741.95	$ 8,069.26	
With Waiver Expenditures	6.2%			$ 1,213,940,892	$ 1,286,897,648	$ 1,370,420,852	$ 3,871,259,392
Estimated Costs (Savings)				$ (4,664,289)	$ (12,765,402)	$ (15,691,788)	$ (33,121,479)
All Included Populations							
Eligible Member Months	4.2%	17,471,719	17,897,937	19,634,771	20,112,231	20,601,424	
With Waiver Cost per Eligible	9.4%	$ 450.15	$ 461.20	$ 598.50	$ 619.25	$ 643.71	
With Waiver Expenditures	14.0%	$ 7,864,963,863	$ 8,254,490,653	$ 11,751,366,952	$ 12,454,583,165	$ 13,261,324,907	$ 53,586,729,541
Estimated Costs (Savings)		$ 25,937,466	$ (98,906,597)	$ (252,493,433)	$ (336,845,896)	$ (369,728,232)	$ (1,032,036,692)
Cost (Savings %)		*0.3%*	*-1.2%*	*-2.1%*	*-2.6%*	*-2.7%*	*-1.9%*
Hypothetical Groups							
Carolina Cares							
Eligible Member Months	5.7%	3,765,600	3,981,075	4,208,880	4,449,721	4,704,342	
With Waiver Cost per Eligible	4.0%	$ 1,155.82	$ 1,163.69	$ 1,204.45	$ 1,253.33	$ 1,304.19	
With Waiver Expenditures	9.0%	$ 4,352,339,822	$ 4,632,733,496	$ 5,069,381,921	$ 5,576,956,855	$ 6,135,353,036	$ 25,766,765,129
Estimated Costs (Savings)		$ (81,870,592)	$ (245,454,920)	$ (313,728,615)	$ (345,140,882)	$ (379,698,322)	$ (1,365,893,331)
Targeted Investments							
Workforce Initiatives		$ 9,000,000	$ 9,000,000	$ 9,000,000	$ 9,000,000	$ 9,000,000	$ 45,000,000
Public-Private Regional Pilots		$ 160,000,000	$ 160,000,000	$ 160,000,000	$ 160,000,000	$ 160,000,000	$ 800,000,000
Tribal Uncompensated Care	3.9%	$ 16,000,000	$ 16,631,856	$ 17,288,664	$ 17,971,410	$ 18,681,119	$ 86,573,048
Building BH I/DD Care Mgmt Capacity		$ -	$ 150,000,000	$ -	$ -	$ -	$ 150,000,000
Telemedicine Alliance		$ 2,500,000	$ 2,500,000	$ -	$ -	$ -	$ 5,000,000
Telemedicine Innovation Fund		$ 16,000,000	$ 16,000,000	$ 16,000,000	$ 16,000,000	$ 16,000,000	$ 80,000,000
Total Transformation Initiative Expenditures		$ 203,500,000	$ 354,131,856	$ 202,288,664	$ 202,971,410	$ 203,681,119	$ 1,166,573,048
With Waiver Total Expenditures	**12.1%**	**$ 12,420,803,685**	**$ 13,241,356,005**	**$ 17,023,037,537**	**$ 18,234,511,429**	**$ 19,600,359,062**	**$ 80,520,067,719**
Estimated Costs (Savings)		**$ 147,566,874**	**$ 9,770,338**	**$ (363,933,384)**	**$ (479,015,368)**	**$ (545,745,435)**	**$ (1,231,356,975)**

Excluded Expenditures:		
-Graduate Medical Expense	-PACE Capitation	-All services associated with excluded populations
-Disproportionate Share Hospital	-Local Education Agency (LEA) services	-Dental services (excluding dental varnish applied by non-dental practitioners)
-Children's Developmental Service Agencies	-Eyeglasses and fittings	

EXHIBIT 6: WITH WAIVER PROJECTIONS | FEDERAL SHARE

Eligibility Group	Annual Trend Rate	Demonstration Years (DY) DY 01 (07/19 - 06/20)	DY 02 (07/20 - 06/21)	DY 03 (07/21 - 06/22)	DY 04 (07/22 - 06/23)	DY 05 (07/23 - 06/24)	Total
Aged, Blind, and Disabled							
Eligible Member Months	10.0%	1,844,530	1,884,832	2,587,191	2,643,720	2,701,485	
With Waiver Cost per Eligible	4.5%	$ 1,131.85	$ 1,145.64	$ 1,244.48	$ 1,292.16	$ 1,348.26	
With Waiver Expenditures	14.9%	$ 2,087,732,068	$ 2,159,340,006	$ 3,219,716,076	$ 3,416,120,367	$ 3,642,310,779	$ 14,525,219,296
Estimated Costs (Savings)		$ (30,307,509)	$ (104,796,243)	$ (166,990,331)	$ (203,682,528)	$ (221,302,550)	$ (727,079,161)
TANF & Related Children							
Eligible Member Months	3.0%	12,503,211	$ 12,796,635	$ 13,440,274	$ 13,755,688	14,078,505	
With Waiver Cost per Eligible	4.4%	$ 160.58	$ 165.76	$ 179.36	$ 184.71	$ 190.49	
With Waiver Expenditures	7.5%	$ 2,007,811,252	$ 2,121,111,840	$ 2,410,705,199	$ 2,540,875,334	$ 2,681,817,520	$ 11,762,321,146
Estimated Costs (Savings)		$ 32,482,223	$ 30,795,599	$ 9,314,979	$ 2,325,647	$ 1,970,777	$ 76,889,226
TANF & Related Adults							
Eligible Member Months	4.0%	3,123,979	3,216,470	3,444,614	3,546,598	3,651,601	
With Waiver Cost per Eligible	4.7%	$ 391.15	$ 404.30	$ 436.55	$ 452.23	$ 469.74	
With Waiver Expenditures	8.8%	$ 1,221,958,748	$ 1,300,409,284	$ 1,503,759,620	$ 1,603,891,389	$ 1,715,311,933	$ 7,345,330,974
Estimated Costs (Savings)		$ 15,361,607	$ 7,129,893	$ (10,113,057)	$ (18,056,176)	$ (20,032,268)	$ (25,710,000)
Innovations/TBI							
Eligible Member Months	2.2%			162,692	$ 166,224	169,832	
With Waiver Cost per Eligible	3.9%			$ 5,051.73	$ 5,241.55	$ 5,455.63	
With Waiver Expenditures	6.2%			$ 821,877,551	$ 871,271,653	$ 926,541,538	$ 2,619,690,741
Estimated Costs (Savings)				$ (3,157,876)	$ (8,642,593)	$ (10,609,218)	$ (22,409,686)
All Included Populations							
Eligible Member Months	4.2%	17,471,719	17,897,937	19,634,771	20,112,231	20,601,424	
With Waiver Cost per Eligible	9.4%	$ 304.35	$ 311.82	$ 405.20	$ 419.26	$ 435.21	
With Waiver Expenditures	14.0%	$ 5,317,502,068	$ 5,580,861,131	$ 7,956,058,447	$ 8,432,158,743	$ 8,965,981,770	$ 36,252,562,158
Estimated Costs (Savings)		$ 17,536,321	$ (66,870,751)	$ (170,946,284)	$ (228,055,651)	$ (249,973,258)	$ (698,309,622)
Cost (Savings %)		*0.3%*	*-1.2%*	*-2.1%*	*-2.6%*	*-2.7%*	*-1.9%*
Hypothetical Groups							
Carolina Cares							
Eligible Member Months	5.7%	3,765,600	3,981,075	4,208,880	4,449,721	4,704,342	
With Waiver Cost per Eligible	3.9%	$ 1,048.90	$ 1,047.32	$ 1,084.00	$ 1,127.99	$ 1,173.77	
With Waiver Expenditures	8.7%	$ 3,949,748,388	$ 4,169,460,146	$ 4,562,443,729	$ 5,019,261,169	$ 5,521,817,733	$ 23,222,731,165
Estimated Costs (Savings)		$ (74,297,562)	$ (220,909,428)	$ (282,355,753)	$ (310,626,794)	$ (341,728,490)	$ (1,229,918,027)
Transformation Initiatives							
Workforce Initiatives		$ 4,500,000	$ 4,500,000	$ 4,500,000	$ 4,500,000	$ 4,500,000	$ 22,500,000
Public-Private Regional Pilots		$ 80,000,000	$ 80,000,000	$ 80,000,000	$ 80,000,000	$ 80,000,000	$ 400,000,000
Tribal Uncompensated Care	3.9%	$ 16,000,000	$ 16,631,856	$ 17,288,664	$ 17,971,410	$ 18,681,119	$ 86,573,048
Building BH I/DD Care Mgmt Capacity		$ -	$ 75,000,000	$ -	$ -	$ -	$ 75,000,000
Telemedicine Alliance		$ 1,250,000	$ 1,250,000	$ -	$ -	$ -	$ 2,500,000
Telemedicine Innovation Fund		$ 8,000,000	$ 8,000,000	$ 8,000,000	$ 8,000,000	$ 8,000,000	$ 40,000,000
Total Transformation Initiative Expenditures		$ 109,750,000	$ 185,381,856	$ 109,788,664	$ 110,471,410	$ 111,181,119	$ 626,573,048
With Waiver Total Expenditures	**11.7%**	**$ 9,377,000,456**	**$ 9,935,703,133**	**$ 12,628,290,839**	**$ 13,561,891,322**	**$ 14,598,980,621**	**$ 60,101,866,371**
Estimated Costs (Savings)		**$ 52,988,759**	**$ (102,398,323)**	**$ (343,513,373)**	**$ (428,211,035)**	**$ (480,520,629)**	**$ (1,301,654,600)**

Excluded Expenditures:		
-Graduate Medical Expense	-PACE Capitation	-All services associated with excluded populations
-Disproportionate Share Hospital	-Local Education Agency (LEA) services	-Dental services (excluding dental varnish applied by non-dental practitioners)
-Children's Developmental Service Agencies	-Eyeglasses and fittings	

EXHIBIT 7: SUBSTANCE USE DISORDER RESIDENTIAL SERVICE PROJECTIONS

Without Waiver Projections

	DEMONSTRATION YEARS (DY)					
	DY 01	DY 02	DY 03	DY 04	DY 05	5-Year Total
Eligible Member Months	15,985	16,736	17,523	18,346	19,208	87,798
PMPM Cost	$7,243	$7,612	$8,000	$8,408	$8,837	
Total Expenditures	$115,774,339	$127,397,655	$140,187,941	$154,262,344	$169,749,793	$707,372,072

With Waiver Projections

	DEMONSTRATION YEARS (DY)					
	DY 01	DY 02	DY 03	DY 04	DY 05	5-Year Total
Eligible Member Months	15,985	16,736	17,523	18,346	19,208	87,798
PMPM Cost	$7,243	$7,612	$8,000	$8,408	$8,837	
Total Expenditures	$115,774,339	$127,397,655	$140,187,941	$154,262,344	$169,749,793	$707,372,072

Notes:

- Expenditures from 2014, 2015 and 2016 are sourced from CMS21.
- MCHIP administration is included under SCHIP, on line 25.
- FFY17 member months include actual enrollment through December 2016 and projections through September 2017.
- Annual fee-for-service medical trends from FFY15 to FFY17 include President's Budget trend as of 2014, which is 4.4% per year for Low-Income Family populations.
- Trend projections from FFY15 to FFY17 are based on the annual rate of change reflected in the 1915(b) waiver for the MCHIP population, which is 3.05% per year.
- CHIP authority expires at the end of FFY19.

Title XXI (CHIP) Allotment Neutrality

This section presents the State's approach for CHIP allotment neutrality, and the data and assumptions used in the development of the cost and caseload estimates supporting this request. The State has projected that the CHIP allotment will be neutral using the CMS allotment neutrality in "Exhibit 7: Substance Use Disorder Residential Service Protections."

- **Population Overview.** The CHIP allotment neutrality includes two populations: Medicaid expansion CHIP (MCHIP) and North Carolina's separate CHIP program, NC Health Choice. Each population receives health care services differently, which is reflected in the allotment neutrality projections. The MCHIP population (over age 3) is currently enrolled in LME/MCOs for behavioral health and substance abuse services, but accesses all other health services through fee-for-service. Note that MCHIP beneficiaries between age 0 and 3 receive all services through fee-for-service, as does the NC Health Choice population.
- **Historical Expenditures.** CHIP allotment and expenditures were sourced from CMS 21 for federal fiscal year (FFY) 2014 through FFY 2016 and projected for FFY 2017 through FFY 2019. Under current law, CHIP funding expired on Sept. 30, 2017; however, legislation exists to extend the program through FFY 2019.

  FFY 2016 is the base year for FFY 2017 through FFY 2019 projections. In FFY 2016, the State received $448,150,621 in CHIP allotment plus $289,505,894 carried over from prior years.

Non-administrative expenditures for FFY 2016 totaled $426,041,248, with $174,604,228 being expended for NC Health Choice and $251,437,020 for MCHIP. Note, as discussed above, NC Health Choice furnishes all health services through fee-for-service and MCHIP furnishes services under a combination of managed care and fee-for-service.

The administrative component for FFY 2016 totaled $10,873,599. Total non-administrative and administrative expenditures totaled $436,914,847, which resulted in a carryover amount for FFY 2017 equal to $302,802,923.

- **Cost and Caseload Projections.** FFY 2017 through FFY 2019 projections are based on FFY 2016 non-administrative caseloads and PMPMs. Caseload projections are based on projected State enrollment for NC Health Choice and MCHIP.
- PMPM expenditures for NC Health Choice and MCHIP (non-LME/MCO) are trended at 4.44%, based on the President's Budget for Children. PMPM expenditures for MCHIP associated with the LME/MCO are trended at 3.05% annually, consistent with the annual rate of change reflected in the LME/MCO 1915(b) waiver.

For this waiver, the federal share of combined MCHIP and NC Health Choice expenditures for all population groups covered under the CHIP portion of the waiver will not exceed the federal CHIP allotment. "Exhibit 7: Substance Use Disorder Residential Service Protections" summarizes the allotment neutrality estimates for the base year and over the five-year period.

EXHIBIT 8: TITLE XXI ALLOTMENT NEUTRALITY BUDGET TEMPLATE FOR SECTION 1115 DEMONSTRATIONS (FFY 2013 – FFY 2017)

Title XXI Allotment Neutrality Budget Template for Section 1115 Demonstrations (FFY - Federal Fiscal Year is 10/1 through 9/30)								
		Actual			Projected			
Line	Line Description	FFY 2014 [1,2]	FFY 2015 [1,2]	FFY 2016 [1,2]	FFY 2017 [2,3,4,5]	FFY 2018 [2,4,5,6]	FFY 2019 [2,4,5,6]
01.	State's Allotment	$ 323,738,478	$ 395,016,255	$ 448,150,621	$ 448,150,621	$ 448,150,621	$ 448,150,621
02.	Funds Carried Over From Prior Year(s)	$ 220,188,974	$ 222,055,491	$ 289,505,894	$ 302,802,923	$ 252,976,115	$ 160,910,789
03.	SUBTOTAL (Allotment + Funds Carried Over)	$ 543,927,452	$ 617,071,746	$ 737,656,515	$ 750,953,544	$ 701,126,736	$ 609,061,410
04.	Reallocated Funds (Redistributed or Retained that are Currently Available)	$ -	$ -	$ -	$ -	$ -	$ -
05.	TOTAL (Subtotal + Reallocated funds)	$ 543,927,452	$ 617,071,746	$ 737,656,515	$ 750,953,544	$ 701,126,736	$ 609,061,410
06.	State's Enhanced FMAP Rate (Quarterly Blend)	76.05%	76.12%	99.68%	99.82%	100.00%	100.00%
07.	**COST PROJECTIONS OF APPROVED SCHIP PLAN: Health Choice**						
08.	**Benefit Costs**						
09.	Insurance payments						
10.	Total Managed Care						
11.	per member/per month rate						
12.	# of eligible (MM)						
13.	Total Fee for Service	$ 227,536,061	$ 168,400,634	$ 174,604,228	$ 196,895,053	$ 212,122,096	$ 228,451,782
14.	per member/per month rate	$ 184.57	$ 165.08	$ 155.66	$ 162.57	$ 169.78	$ 177.31
15.	# of eligible (MM)	1,232,807	1,020,113	1,121,706	1,211,171	1,249,404	1,288,421
16.	Total Benefit Costs (Managed Care + Fee for Service)	$ 227,536,061	$ 168,400,634	$ 174,604,228	$ 196,895,053	$ 212,122,096	$ 228,451,782
17.							
18.	**Administration Costs**						
19.	Personnel						
20.	General administration	$ 11,023,697	$ 8,308,119	$ 10,873,599	$ 11,100,000	$ 11,100,000	$ 11,100,000
21.	Contractors/Brokers						
22.	Claims Processing						
23.	Outreach/marketing costs						
24.	Other (specify)						
25.	**Total Administration Costs**	$ 11,023,697	$ 8,308,119	$ 10,873,599	$ 11,100,000	$ 11,100,000	$ 11,100,000
26.	10% Administrative Cap	4.6%	4.7%	5.9%	5.3%	5.0%	4.6%
27.							
28.	Federal Title XXI Share	$ 181,424,849	$ 134,511,169	$ 184,886,814	$ 207,620,662	$ 223,222,096	$ 239,551,782
29.	State Share	$ 57,134,909	$ 42,197,584	$ 591,013	$ 374,391	$ -	$ -
30.	**TOTAL COSTS OF APPROVED SCHIP PLAN**	$ 238,559,758	$ 176,708,753	$ 185,477,827	$ 207,995,053	$ 223,222,096	$ 239,551,782
31.	**COST PROJECTIONS FOR DEMONSTRATION PROPOSAL: MCHIP - Medicaid**						
32.	**Benefit Costs**						
33.	Insurance payments						
34.	Total Managed Care	$ 44,606,566	$ 53,675,096	$ 47,563,704	$ 54,424,364	$ 58,664,859	$ 62,433,452
35.	per member/per month rate	$ 43.31	$ 41.99	$ 38.61	$ 39.79	$ 41.00	$ 42.25
36.	# of eligible (MM)	1,029,953	1,278,420	1,231,803	1,367,764	1,430,698	1,477,541
37.	Total Fee for Service	$ 140,070,559	$ 199,943,749	$ 203,873,316	$ 236,455,988	$ 258,328,992	$ 278,626,025
38.	per member/per month rate	$ 120.39	$ 139.83	$ 146.82	$ 153.33	$ 160.14	$ 167.24
39.	# of eligible (MM)	1,163,519	1,429,873	1,388,592	1,542,094	1,613,170	1,666,000
40.	Total Benefit Costs (Managed Care + Fee for Service)	$ 184,677,125	$ 253,618,845	$ 251,437,020	$ 290,880,352	$ 316,993,851	$ 341,059,476
41.							
42.	**Administration Costs**						
43.	Personnel						
44.	General administration	$ -	$ -	$ -	$ -	$ -	$ -
45.	Contractors/Brokers						
46.	Claims Processing						
47.	Outreach/marketing costs						
48.	Other (specify)						
49.	**Total Administration Costs**	$ -	$ -	$ -	$ -	$ -	$ -
50.	10% Administrative Cap	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
51.							
52.	Federal Title XXI Share	$ 140,447,112	$ 193,054,683	$ 249,966,778	$ 290,356,767	$ 316,993,851	$ 341,059,476
53.	State Title XXI Share	$ 44,230,013	$ 60,564,162	$ 1,470,242	$ 523,585	$ -	$ -
54.	**TOTAL COSTS FOR DEMONSTRATION**	$ 184,677,125	$ 253,618,845	$ 251,437,020	$ 290,880,352	$ 316,993,851	$ 341,059,476
55.	**TOTAL TITLE XXI PROGRAM COSTS (State Plan + Demonstration)**	$ 423,236,883	$ 430,327,598	$ 436,914,847	$ 498,875,405	$ 540,215,947	$ 580,611,259
56.	Federal Title XXI Share	$ 321,871,961	$ 327,565,852	$ 434,853,592	$ 497,977,429	$ 540,215,947	$ 580,611,259
57.	State Title XXI Share	$ 101,364,922	$ 102,761,746	$ 2,061,255	$ 897,976	$ -	$ -
58.	**Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)**	$ 543,927,452	$ 617,071,746	$ 737,656,515	$ 750,953,544	$ 701,126,736	$ 609,061,410
59.	**Total Federal Title XXI Program Costs (State Plan + Demonstration)**	$ 321,871,961	$ 327,565,852	$ 434,853,592	$ 497,977,429	$ 540,215,947	$ 580,611,259
60.	**Unused Title XXI Funds Expiring (Allotment or Reallocated)**	$ -	$ -	$ -	$ -	$ -	$ -
61.	**Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)**	$ 222,055,491	$ 289,505,894	$ 302,802,923	$ 252,976,115	$ 160,910,789	$ 28,450,152

Notes:

1. Expenditures from 2014, 2015 and 2016 are sourced from CMS21.
2. MCHIP administration is included under SCHIP, on line 25.
3. Based on current legislation, CHIP authority expires at the end of FFY2017 and funding is anticipated to end in FFY19.
4. The State Allotment in projection years is assumed to have no increase from FFY 2016.
5. Projected SCHIP and MCHIP FFS PMPMs are trended based on a the Presidents Budget Trend for child populations.
6. Projected MCHIP managed care PMPMs are trended based on the most recently available NC BH capitated claims trends.

VII. List of Proposed Waivers and Expenditure Authorities

This section should include a preliminary list of waivers and expenditures authorities related to title XIX and XXI authority that the State believes it will need to operate its Demonstration. In accordance with 42 CFR 431.412(a)(vi), this section must be included in a state's application in order to be determined complete. Specifically, this section should:

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

See Table 21 below for all proposed waivers and expenditure authorities, and reasons for their request.

2) Describe why the state is requesting the waiver or expenditure authority, and how it will be used. Please refer to the list of title XIX and XXI waivers and expenditure authorities: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/ 1115 /Downloads/List-of-Waivers-and-Expenditure-Authorities.pdf that the state can reference to help complete this section. CMS will work with the State during the review process to determine the appropriate waivers and expenditures needed to ensure proper administration of the Demonstration.

TABLE 21. WAIVER AND EXPENDITURE AUTHORITY REQUESTED

WAIVER/EXPENDITURE AUTHORITY	USE FOR WAIVER/EXPENDITURE AUTHORITY	REASON FOR WAIVER/EXPENDITURE AUTHORITY REQUEST
WAIVERS		
§ 1902(a)(10)(B) and § 1902(a)(17)	To permit North Carolina to implement tailored plans offering certain benefits not available to enrollees who either do not qualify for or decline to enroll in tailored plans.	This waiver authority will allow the State to offer tailored plans to an eligible subset of the demonstration population with a benefit package that is more expansive than that of standard plans.
§ 1902(a)(10)(B) and § 1902(a)(17)	To permit North Carolina to implement specialized foster care plans offering certain benefits not available to enrollees who either do not qualify for or decline to enroll in the specialized foster care plan.	This waiver authority will allow the State to offer a specialized foster care plan to an eligible subset of the demonstration population with a benefit package that is more expansive than that of the standard plans.
§ 1902(a)(23)	To permit North Carolina to implement mandatory managed care through selective contracting with PHPs for demonstration participants.	This waiver authority will allow the State to competitively procure PHPs and mandatorily enroll individuals in the PHPs who are not exempt or excluded from the demonstration.
§ 1902(a)(1)	To permit North Carolina to implement statewide mandatory managed care through PHPs for demonstration enrollees on a phased-in basis as necessary and contingent on legislative authority.	This waiver authority will allow the State to phase in mandatory managed care for current enrollees rather than convert to managed care statewide on one specific date.
§ 1902(a)(14) and § 1916	To permit North Carolina to impose premiums of 2% of income for Carolina Cares enrollees with incomes >50% of FPL.	This waiver authority will allow North Carolina to impose and collect premiums from Carolina Cares enrollees with incomes >50% of FPL.
§ 1902(a)(8)	To permit North Carolina to prohibit reenrollment of Carolina Cares enrollees disenrolled for failure to pay premiums until payment of back due premiums.	This waiver authority will allow North Carolina to not allow Carolina Cares enrollees to re-enroll into the program if they were disenrolled for failure to pay premiums until all premium amounts owed are paid.

WAIVER/EXPENDITURE AUTHORITY	USE FOR WAIVER/EXPENDITURE AUTHORITY	REASON FOR WAIVER/EXPENDITURE AUTHORITY REQUEST
§ 1902(a)(10)(A)	To permit North Carolina to require Carolina Cares enrollees to engage in work or work-related activities to remain enrolled in coverage.	This waiver authority will allow the State to assess Carolina Cares enrollees' work or work-related activity status as a condition of program eligibility.
EXPENDITURE AUTHORITIES		
Tribal Uncompensated Care Pool	Expenditures for uncompensated care provided by or arranged through the Cherokee Indian Hospital Authority of up to $86.6M over five years.	This expenditure authority will allow the State to establish a tribal uncompensated care pool and make payments to the Cherokee Indian Hospital Authority for uncompensated costs.
Cost-Settling Essential Safety-Net Providers	To make wrap-around payments outside of managed care to selected providers currently reimbursed on a cost-settled basis (local public health departments, public ambulance providers and state-owned or -operated skilled nursing facilities).	This expenditure authority will allow the State to continue making wrap-around payment to essential safety-net providers, thereby preserving beneficiaries' access to them.
Innovation Workforce Fund	To expand the Medicaid provider workforce in underserved areas of the State through new loan repayment and incentive programs of up to $45M over five years.	This expenditure authority will allow the State to invest in new loan repayment and incentive programs focused on enhancing the Medicaid workforce based on findings from a workforce evaluation.
Health Home Care Management	To provide up to $150M over five years seed money to help tailored plans and care management agencies build capacity to implement the health home care management model.	This expenditure authority will allow the State to support tailored plans and care management agencies to build capacity to implement the health home care management model.
IMD Waiver	To make payments to IMDs for individuals receiving acute care for either behavioral health or substance use disorder treatment.	This expenditure authority will allow the State to expand access to IMD services by paying for acute care for either behavioral health or substance use disorder treatment.
Public-Private Regional Partnership Pilots	To fund up to $800M over five years for public-private regional partnership pilots aimed at addressing the social determinants of health through evidence-based interventions.	This expenditure authority will allow the State to support pilots to test, scale, strengthen and sustain public-private initiatives in select regions of North Carolina that aim to measurably improve health and lower costs through evidence-based interventions addressing targeted health-related needs.
Telemedicine Alliance	To provide an organization with up to $5M in start-up funding to establish a statewide telemedicine alliance.	This expenditure authority will allow the State to support an existing organization to establish an independent, statewide telemedicine alliance.
Telemedicine Innovation Fund	To fund up to $80M over five years pilots aimed at testing evidence-based telemedicine initiatives.	This expenditure authority will allow the State to establish a Telemedicine Innovation Fund to test evidence-based telemedicine initiatives aligned with the State's quality strategy goals.

VIII. Public Notice

This section should include information on how the state solicited public comment during the development of the application in accordance with the requirements under 42 CFR 431.408. For specific information regarding

the provision of state public notice and comment process, please click on the following link to view the section 1115 Transparency final rule and corresponding State Health Official Letter: http://medicaid.gov/Medicaid-CHIP-Program-Information/By- Topics/Waivers/1115/Section-1115-Demonstrations.html. Please include the following elements as provided for in 42 CFR 431.408 when developing this section:

1) Start and end dates of the state's public comment period.

Below are descriptions of the State's public comment period and stakeholder activity conducted in advance of the June 2016 original waiver submission, followed by activities conducted after June 2016 and in advance of the waiver amendment submission.

Stakeholder input helped build the foundation for the draft demonstration waiver application, and the additional information and refinements described in the waiver amendment.

Draft Waiver Application: Public Comment Period March 7, 2016 through 11:59 p.m. April 18, 2016. The draft waiver application was released to the public March 1, 2016, for additional input and consideration by stakeholders and, more broadly, the residents of North Carolina. The public comment period, outlined in greater detail next, yielded a better understanding of the grassroots impact of the proposal. Importantly, the public comment process also provided a resource to further refine the draft waiver application to better reflect the needs and concerns of those whom it will impact.

The following summarizes North Carolina's public notice activities in advance of the submission of the original waiver application and since the original submission:

Public Notice Activities in Advance of June 2016 Submission of Original Waiver Application

Public Hearings

- Draft 1115 demonstration waiver application was posted on the General Assembly website March 1, 2016, as part of the materials for presentation to the Joint Legislative Oversight Committee (JLOC) on Medicaid and NC Health Choice. The website is: http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=284&sFolderName=\2015-16%20Interim\March%201,%202016\Reports
- The State staff provided a summary of the draft demonstration waiver application to the JLOC during a public meeting March 1, 2016.
- Governor McCrory issued a press release March 1, 2016.
- Draft 1115 demonstration waiver application was published on the North Carolina Medicaid reform website, http://www.ncdhhs.gov/nc-medicaid-reform, March 7, 2016.
- Detailed public notice was published on the Medicaid reform website March 7, 2016 (see "Appendix B. Public Notices"). The detailed public notice included:
    - Summary of the demonstration.
    - Location and website address where copies of the demonstration waiver application were available.
        - Hard copies of the draft demonstration waiver application were provided on request at the Department of Health and Human Services, 101 Blair Drive, Raleigh, North Carolina.
        - An electronic copy of the demonstration application was available at http://www.ncdhhs.gov/nc-medicaid-reform.
    - Postal and internet email addresses where written comments could be sent:

    - Postal mail to Department of Health and Human Services, Division of Health Benefits, 2501 Mail Service Center, Raleigh, NC 27699-2501.
    - Emails to MedicaidReform@dhhs.nc.gov.
  - Period comments would be accepted was March 7, 2016, through 11:59 p.m. April 18, 2016.
  - Location, date and time of the three March public hearings, including the dial-in number for one of the hearings, a note that a complete list of hearings was available on the Medicaid Reform website, and a link to the website.
  - Additional modes for submitting comments include:
    - An online comment submission form at http://www.ncdhhs.gov/nc-medicaid-reform/medicaid-reform-comment-submission-form (see "Appendix A. Public Comments and State Responses").
    - In-person at the Department of Health and Human Services, 101 Blair Drive in Raleigh, North Carolina.

- As required by 42 CFR 431.408(a)(2)(i), the Medicaid Reform website included information on the public notice process, public input process, public hearings, draft demonstration waiver application and a link to the CMS website.
- The State certifies that an abbreviated public notice (see "Appendix B. Public Notices") was published in 11 newspapers (including the newspapers of the widest circulation in each of the seven cities with a population of 100,000 or more) as of March 16, 2016, which is more than 30 days prior to submitting this application to CMS. The State republished the public notice in seven of these newspapers (newspapers with the widest circulation in each of the seven cities with a population of 100,000 or more) to include information on the second dial-in option. See "Appendix B. Public Notices" for the newspaper public notices.
  - The State certifies that, as required by 42 CFR 431.408(a)(2)(ii), the abbreviated public notice included a summary of the demonstration; the location, date and time of the three March public hearings and the dial-in number for one of the hearings, and a note that a complete list of hearings was available on the Medicaid Reform website, and a link to the website.
  - Newspapers and public notice publication dates are outlined below:

TABLE 22. PUBLIC NOTICE PUBLICATIONS, AREAS SERVED AND LOCATIONS

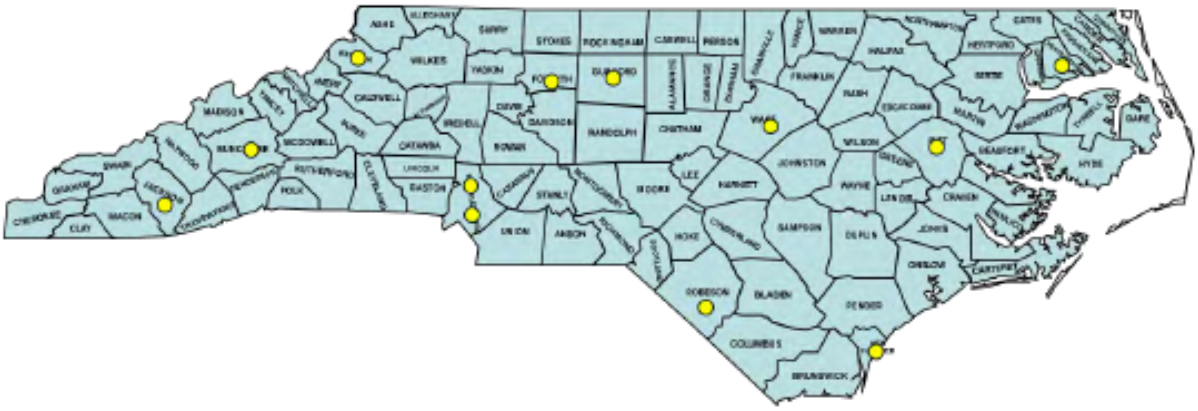
GEOGRAPHIC AREA	NC CITIES WITH 100,000 RESIDENTS[29]	PUBLIC HEARING LOCATION[30]	NEWSPAPER
Western		Asheville, Boone, Sylva	Asheville Citizen-Times
Charlotte	Charlotte	Monroe, Huntersville	• Charlotte Observer • Gaston Gazette
Greensboro	Greensboro	Greensboro	Greensboro News and Record
Greenville		Greenville	The Daily Reflector
High Point	High Point		High Point Enterprise
Raleigh-Durham-Fayetteville	Cary, Raleigh, Durham, Faye	Raleigh	• News & Observer • The Herald Sun • The Fayetteville Observer

[29] Source: United Census Bureau

[30] The newspapers covering public hearings in Elizabeth City (The Daily Advance) and Pembroke (The Robesonian) did not respond to repeated requests to publish he abbreviated notice.

GEOGRAPHIC AREA	NC CITIES WITH 100,000 RESIDENTS[29]	PUBLIC HEARING LOCATION[30]	NEWSPAPER
Wilmington	Wilmington	Wilmington	Wilmington StarNews
Winston-Salem	Winston-Salem	Winston-Salem	Winston-Salem Journal

- The State certifies that it used electronic mailing lists to notify the public. This included a "stakeholders" listserv with over 90,000 email addresses, email notices to 75 North Carolina health-related associations, and media advisories to the local media listservs before each public hearing.
- The State certifies that it hosted a total of 12 public hearings, two of which included teleconferencing ability, more than 20 days prior to submitting this application to CMS. The public hearings were held at geographically diverse locations around the state March 30, 2016 through April 18, 2016. The public hearings accessible by phone were held March 31 in Monroe, North Carolina, and April 18 in Pembroke, North Carolina. Notification regarding the dial-in number was provided on the Medicaid Reform website, in the public notice, and in the abbreviated public notice published in the 11 newspapers. See below for a map of the public hearing locations.



March 30 – Raleigh, 6–8 p.m.
March 31 – Monroe, 2–4 p.m.*
March 31 – Huntersville, 6:30–8:30 p.m.
April 5 – Sylva, 4–6 p.m.
April 6 – Boone, 12–2 p.m.
April 6 – Asheville, 6:30–8:30 p.m.
April 7 – Greensboro, 6:30–8:30 p.m.
April 8 – Winston-Salem, 2–4 p.m.
April 13 – Wilmington, 6–8 p.m.
April 14 – Greenville, 2–4 p.m.
April 16 – Elizabeth City, 10–12 p.m.
April 18 – Pembroke, 3:30–5:30 p.m.*

* Dial-in option available.

The public hearings provided an opportunity for the State to present information on the demonstration waiver application and for the public to provide input through spoken and written comments. In total, 1,590 individuals attended the various public hearings. Of those who attended, 323 spoke. To ensure that all comments were documented, two note takers from the State attended each public hearing and documented the remarks offered by each commenter. The hearings were also recorded.

Table 23 outlines the public hearing schedule, the number of attendees at each public hearing, and the number of speakers:

TABLE 23. PUBLIC HEARING SCHEDULE, ATTENDEES AND SPEAKERS

PUBLIC HEARING	ATTENDANCE AND SPEAKERS	
	TOTAL ATTENDEES	SPEAKERS
March 30, 2016: Raleigh; 6:00 PM – 8:00 PM McKimmon Center Room 6 1101 Gorman Street Raleigh, NC 27606	213	33
March 31, 2016: Monroe (Charlotte Area); 2:00 PM – 4:00 PM Union County Dept. of Social Services Auditorium 1212 W. Roosevelt Boulevard Monroe, NC 28110	231 157 (dial-in)	41 20 (dial-in)
March 31, 2016: Huntersville (Charlotte Area); 6:30 PM – 8:30 PM Central Piedmont Community College, Merancas Campus Auditorium 11930 Verhoeff Drive Huntersville, NC 28078	70	27
April 5, 2016: Sylva; 4:00 PM – 6:00 PM Southwestern Community College Auditorium 447 College Drive Sylva, NC 28779	23	3
April 6, 2016: Boone; 12:00 PM – 2:00 PM Holiday Inn Express 1943 Blowing Rock Road Boone, NC 28607	72	7
April 6, 2016: Asheville; 6:30 PM – 8:30 PM Asheville-Buncombe Technical Community College Mission Health / A-B Tech Conference Center 340 Victoria Road Asheville, NC 28801	138	40
April 7, 2016: Greensboro; 6:30 PM – 8:30 PM Guilford County Health & Human Services 1203 Maple Street Greensboro, NC 27405	121	30
April 8, 2016: Winston-Salem; 2:00 PM – 4:00 PM Forsyth County Department of Public Health Meeting Room 1 & 2 799 North Highland Avenue Winston-Salem, NC 27102	100	24
April 13, 2016: Wilmington; 6:00 PM – 800 PM University of North Carolina-Wilmington McNeill Hall Lecture Hall 601 S. College Road Wilmington NC 28403	114	27
April 14, 2016: Greenville; 2:00 PM – 4:00 PM Greenville Convention Center Emerald Ballroom 303 SW Greenville Boulevard Greenville, NC 27834	183	38
April 14, 2016: Elizabeth City; 10:00 AM – 12:00 PM College of The Albemarle AE 208 1208 N. Road Street Elizabeth City, NC 27909	31	11
April 18, 2016: Pembroke (Lumberton); 3:30 PM – 5:30 PM UNC-Pembroke Moore Hall Auditorium 1 University Drive Pembroke, NC 28372-1510	84 (53 dial-in)	22 (0 dial-in)
TOTAL	**1,590**	**323**

In addition to public hearings, two Medical Care Advisory Committee (MCAC) meetings, which are public meetings, included a presentation on the demonstration waiver and an opportunity for MCAC members and the public to comment. At the March 23, 2016, meeting, 10 people provided spoken comments. At the April 15, 2016, meeting two people provided spoken comments.

Tribal Consultation

The State certifies that it conducted Tribal consultation according to the consultation process outlined in North Carolina's approved State Plan. State staff met with staff from the Eastern Band of the Cherokee Indians (EBCI), Division of Public Health and Human Services and the Cherokee Indian Hospital Authority Feb. 16-17, 2016, to solicit input on the development of the demonstration waiver and other Medicaid issues. The visit and initial consultation were documented in a Feb. 21, 2016, letter to the State from the Cherokee Indian Hospital Authority.

The State sent a letter Feb. 29, 2016, and a copy of the draft demonstration waiver application by certified mail and email to Vicki Bradley, Secretary of the EBCI Public Health & Human Services Administration and Casey Cooper, Chief Executive Officer of the Cherokee Indian Hospital Authority notifying the EBCI of the draft demonstration waiver application and requesting comments. The State received a response April 1, 2016, with comments on the draft demonstration waiver application. The State met with EBCI representatives April 28, 2016, to discuss EBCI feedback and desired initiatives related to the demonstration waiver. On April 29, 2016, the State sent a letter to EBCI summarizing the EBCI comments and the State's response. The State revised the draft demonstration waiver application as reflected in the letter. In summary, these changes included:

- Clarifying that PHPs may include a Tribal/Indian managed care entity.
- Confirming the State's position that identified members of federally recognized tribes will be excluded from mandatory enrollment in PHPs and can opt to enroll in PHPs.
- Inclusion of new proposals for supplemental Medicaid uncompensated care payments to EBCI hospital providers.
- Providing assurance for compliance with 42 CFR Part 438, which includes provisions for Indians and Indian health care providers.
- Additional assurances listed in "Appendix C. Tribal Consultation and Assurances" as requested by EBCI.

Public Notice Activities After Submission of the Original Waiver Application

Public notice and stakeholder activities after the June 2016 submission of the original waiver application were targeted to gather input on more specific topics or populations, although all feedback was—and continues to be—welcomed and encouraged. In addition to formalized activities, ad hoc comments were received through the dedicated waiver email address, Medicaid.Transformation@dhhs.nc.gov, and during other Medicaid-related stakeholder meetings.

Public Comment or Response Requests

North Carolina Medicaid and NC Health Choice Requests for Public Input: Public Comment Period April 25, 2017 through May 25, 2017. The State published the "North Carolina Medicaid and NC Health Choice Transformation Request for Public Input" April 28, 2017, on the Medicaid Transformation website at https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/Medicaid_and_NC_Health_Choice_Request_for_Public_Input_20170425.pdf. The request solicited feedback on several topics raised by stakeholders as the State continued to listen to and talk with North Carolinians about how to make the state healthier. Although all input was welcome and encouraged, these topics were particularly important to the design of a successful Medicaid managed care program:

- Physical and behavioral health service delivery;
- Supporting provider transformation;

- Care management and population health;
- Addressing social determinants of health;
- Improving quality of care; and
- Increasing access to care and treating substance use disorder.

Public input was received during four public hearings:

- May 1, 5:30-7:30 p.m., Greensboro;
- May 10, 3:00-5:00 p.m., Greenville;
- May 12, 2:00-4:00 p.m., Asheville; and
- May 16, 6:00-8:00 p.m., Raleigh.

Written input was received through:

- Email: MedicaidReform@dhhs.nc.gov;
- U.S. Mail: Department of Health and Human Services, Division of Health Benefits, 1950 Mail Service Center, Raleigh NC 27699-1950; and
- Drop-off: Department of Health and Human Services, Dorothea Dix Campus, Adams Building, 101 Blair Dr., Raleigh NC.

The State received over 700 comments related to improving Medicaid. A summary of public input received is in "Appendix A. Public Comments and State Responses" and on the Medicaid Transformation website at https://files.nc.gov/ncdhhs/PublicCommentsSummary_Medicaid_April-May_2017.pdf.

North Carolina's Proposed Program Design for Medicaid Managed Care: Public Comment Period August 8, 2017 through Sept. 8, 2017. The State published the "North Carolina's Proposed Program Design for Medicaid Managed Care" August 8, 2017, on the Medicaid Transformation website at https://files.nc.gov/ncdhhs/documents/files/MedicaidManagedCare_ProposedProgramDesign_REVFINAL_20170808.pdf.

The proposed program design was published to provide more detailed information on the State's vision for Medicaid managed care and to solicit comments from all stakeholders; and to encourage input from health plans on technical and operational aspects of managed care program design. More than 200 written comments were received through email, U.S. Mail or dropped off at the Department of Health and Human Services. A summary of public input received is in "Appendix A. Public Comments and State Responses" and on the Medicaid Transformation website at https://files.nc.gov/ncdhhs/documents/files/20171102_Public_Comment_Summary_FINAL.pdf?nQgWfLp4hlGPe0j.yIKET4CLdrBNqFam.

Requests for Information: Response Period Nov. 2, 2017 through Dec. 15, 2017. Two requests for information were issued in November 2017:

- **Managed Care Operations RFI.** Addresses managed care operations, including a request for statement of interest from prospective PHPs.
- **Managed Care Program Actuarial RFI.** Addresses financial aspects of managed care, including information on the proposed capitation rate setting methodology.

The RFIs represent the next step in refining the design of the Medicaid managed care program and in transitioning into the procurement process needed to implement the program. The State will use input on the Medicaid managed care RFI to inform an RFP from entities that want to participate as PHPs.

Concept Paper

Behavioral Health I/DD Tailored Plan Concept Paper, issued Nov. 9, 2017. The first in a series of concept papers that will provide details on specific components of the managed care program design. The State invites stakeholders to share input by sending an email to Medicaid.Transformation@dhhs.nc.gov. The papers are posted on the Medicaid Transformation website at https://files.nc.gov/ncdhhs/documents/files/BH-IDD-TailoredPlan_ConceptPaper_20181109.pdf?CkZhWxchGeNGBa2wXQSrSwWPrqi41aVP.

Work Groups and Committees

Medical Care Advisory Committee. With the release of the "North Carolina's Proposed Program Design for Medicaid Managed Care," the State engaged the Medical Care Advisory Committee (MCAC), which is open to the public, as the formal stakeholder engagement body charged with providing feedback and comment on the wide range of transformation efforts including the draft 1115 demonstration waiver application. The diverse membership of the MCAC, including beneficiaries, advocates, urban and rural physicians, and hospitals with representation from each region, will help ensure the State is sharing information with and receiving feedback from a wide-range of perspectives. The State has hosted in-person and conference calls to ensure accessibility for individuals with disabilities to participate in stakeholder engagement wherever possible.

MCAC in-person and telephone meetings were held as follows:

- **August 31, 2017 –** MCAC meeting (telephone) regarding proposed design for Medicaid transformation with question and answer session. Several members of the MCAC spoke during the Q&A session.
- **September 22, 2017 –** MCAC meeting (in-person) regarding program design details, comments received on proposed design and procurement timelines. Several members of the public spoke during this face-to-face meeting.
- **October 26, 2017 –** MCAC meeting (telephone) regarding draft Managed Care Quality Strategy.
- **November 15, 2017 –** MCAC meeting (telephone) reviewed amended draft 1115 demonstration waiver application and subcommittees of the MCAC to address managed care program design topics. One member of the public spoke during the public comment period.

Dual Eligibles Advisory Committee Work Group. The Dual Eligibles Advisory Committee was formed August 2016 to meet the requirements of S.L. 2015-245. This Committee, which was comprised of 32 individuals throughout North Carolina who are recognized as experts in a wide range issues pertaining to dual eligible health care delivery and coverage. The group provided input that the State used to prepare "The Managed Care Strategy for North Carolina Medicare-Medicaid Dual Eligible Beneficiaries," a legislatively required report recommending the approach to transitioning dual eligibles into managed care. This report was released to the General Assembly Jan. 23, 2017, and can be found on the Medicaid Transformation website at files.nc.gov/ncdhhs/documents/files/20161207%20NC%20Duals%20Legislative%20Report.pdf?5GahGl5.MYoBvDWLL_RRp6mScaWFGdhe.

Tribal Consultation

The State has also continued to pursue ongoing, meaningful engagement with EBCI through telephone and in-person meetings. See "Appendix C. Tribal Consultation and Assurances."

Planned Public Comment Period

The State plans to conduct a supplemental 30-day public comment period directly after submitting the application amendment to CMS to align with the federal public comment period.

2) Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.

See answer to Question 1.

3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.

See answer to Question 1.

4) Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used).

See answer to Question 1.

5) Comments received by the state during the 30-day public notice period.

See summaries of public comments received through 2016 and 2017 in "Appendix A. Public Comments and State Responses."

6) Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.

See summaries of North Carolina's responses to the submitted comments in "Appendix A. Public Comments and State Responses."

7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.

See "Appendix C. Tribal Consultation and Assurances."

If this application is an emergency application in which a public health emergency or a natural disaster has been declared, the State may be exempt from public comment and tribal consultation requirements as outlined in 42 CFR 431.416(g). If this situation is applicable, please explain the basis for the proposed emergency classification and public comment/tribal consultation exemption.

Not applicable.

IX. Demonstration Administration

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

Name and Title: Jay Ludlam, Assistant Secretary for Medicaid Transformation, Division of Health Benefits, North Carolina Department of Health and Human Services

Telephone Number: (919) 527-7033

Email Address: jay.ludlam@dhhs.nc.gov

Appendix A

Summaries of Public Comments and State Responses

A.1. North Carolina's Proposed Program Design for Medicaid Managed Care: August-September 2017

A.2. Request for Public Input on Medicaid Managed Care

A.3. Draft Section 1115 Demonstration Waiver Application: March/April 2016

A.1. Public Input Summary on North Carolina's Proposed Program Design for Medicaid Managed Care: August-September 2017

Public Input Summary

This document summarizes themes from more than 200 comments the North Carolina Department of Health and Human Services (the Department) received from Aug. 8 through Sept. 8, 2017, on "North Carolina's Proposed Program Design for Medicaid Managed Care." The Department sincerely appreciates the thoughtful comments received, and looks forward to continuing this collaborative process to build a strong Medicaid managed care program.

Introduction

In September 2015, the North Carolina General Assembly enacted Session Law 2015-245, directing the transition of Medicaid and NC Health Choice programs from a primarily fee-for-service structure to a primarily managed care structure. As the Department prepares to launch managed care in 2019, it will work with stakeholders to refine program details.

As described in "North Carolina's Proposed Program Design for Medicaid Managed Care," the Department seeks to implement Medicaid managed care in a way that advances high-value care, improves population health, engages and supports providers, and establishes a sustainable program with predictable costs. The Department's goal is to improve the health of North Carolinians through an innovative, whole-person centered and well-coordinated system of care that addresses medical and non-medical drivers of health.

In managed care, the Department will remain responsible for all aspects of the Medicaid and NC Health Choice programs. As directed by the North Carolina General Assembly, the Department will delegate the direct management of health services and financial risks to Prepaid Health Plans (PHPs). PHPs will receive a capitated payment and will contract with providers to deliver health services to their members. PHPs will be subject to rigorous monitoring and oversight by the Department across many metrics to ensure strong provider networks, high program quality and other aspects of a successful Medicaid program.

About This Summary

Each comment received during the input period was reviewed by the Medicaid transformation team and used to identify recurring themes. In addition to the comments on specific topics that are summarized in this document, the Department received many general comments (e.g., commenters expressed approval or disapproval for the transition to managed care, or commenters requested more detail on parts of program design), and several specific or technical comments that may not be mentioned in this document but have been read and reviewed by subject matter experts.

No names of individuals or organizations are identified in this summary.

To provide transparency through the transition to managed care, and as the Department continues to refine and finalize program design, additional information will be provided to beneficiaries, providers and other stakeholders. In coming months, the Department will release white papers or requests for information (RFIs) on specific program design topics that will address many of the questions raised by commenters.

Please send questions or comments to Medicaid.Tranformation@dhhs.nc.gov.

For more information, visit ncdhhs.gov/nc-medicaid-transformation on the Medicaid website.

A couple commenters sought more detail on how the Department's strategy to address social determinants would interact with other areas of the proposed program design, particularly with value-based purchasing (VBP) and the advanced medical home (AMH) model.

Department Response: *In designing its Medicaid transformation, the Department is committed to optimizing health and well-being for all beneficiaries by effectively stewarding our collective resources to unite communities and the health care system. Given the compelling body of evidence linking social determinants to health and well-being, the Department views addressing unmet social needs as central to this vision. The Department agrees that implementing a standard screening for unmet social needs and mapping available resources in communities are important, and seeks to leverage and build upon existing investments and efforts. The Department is seeking federal funding to support this effort.*

1.1 Strengthen and support care management

Several commenters agreed with the proposal to strengthen and support North Carolina's care management infrastructure and were supportive of the proposed AMH model. Some commenters also noted the importance of maintaining or replicating North Carolina's existing care management infrastructure.

Several commenters also requested additional detail or clarity on the Department's vision for care management in general and AMH in particular. Some commenters wanted to know whether there would be specialized AMH models for specific populations (such as a pregnancy health home) or wanted to better understand how AMHs would interact with other entities, particularly tailored plans.

A few commenters stressed the importance of care management in the community or at the site of care. A few also stressed the importance of flexibility in the AMH model (e.g., flexibility for plans and providers to design their own financial arrangements; and flexibility for practices that are ready to move more quickly toward higher tiers of the AMH model).

Department Response: *North Carolina Medicaid has long been known for its successful primary care case management (PCCM) program, including a strong care management infrastructure for beneficiaries, transitional care populations, high-risk/high-cost patients, and supports for pregnancy care and other programs. The Department is considering how to maintain and strengthen the best elements of today's programs while establishing appropriate flexibility to allow for PHPs innovation. The Department also wants to maintain strong provider participation in Medicaid through medical homes. Additional work is underway on the development of the care management infrastructure, and stakeholders will continue to be engaged throughout the development process. the Department intends to provide additional detail for public feedback in the near future.*

2. Supporting providers and beneficiaries during the transition

2.1 Support providers through the transition

Several commenters supported the proposed creation of Regional Provider Support Centers (RSPCs), although some requested more detail about their role and scope of activities. A few commenters noted that providers would need significant training and education with the transition to managed care. Some noted that small, independent or rural providers, and Medicaid providers without experience in commercial insurance (e.g., local health departments) might particularly need this support.

Several commenters also stressed reducing administrative burden as an important central focus for provider support. Commenters suggested several ways to accomplish this, with most recommendations focusing on

standardizing or centralizing processes to avoid duplication, and refraining from changing existing systems (such as NCTracks) unless necessary.

Many commenters supported the Department's proposal to adopt a centralized credentialing process with a single electronic application. Several commenters asked for additional detail on the credentialing process, including clarity on how long credentialing would take, and what the process would look like for certain types of providers (e.g., I/DD specialists or out-of-state providers).

Department Response: *Providers are crucial partners in ensuring a long-term, successful Medicaid managed care program. The Department will continue to partner with providers to work toward easing administrative burdens during and after the transition. To ensure providers are prepared to adapt their practices and support their patients throughout the transition, the Department will establish a provider support infrastructure through the RSPCs, which will include managed care education and training, practice transformation and education, and advanced medical home certification. The Department intends to provide additional detail for public feedback in the near future.*

1.1 Streamline beneficiary eligibility and enrollment processes

Several commenters commended the Department's goal of moving toward a "one-stop shop" eligibility and enrollment process in which beneficiaries could apply for Medicaid, receive a determination, and select a PHP and primary care provider in one visit. Other aspects of the proposal in this area also received generally positive feedback from several commenters, including the emphasis on preserving existing beneficiary-provider relationships in auto-assignment algorithms and the proposal to use an enrollment broker.

A few commenters expressed concerns about the Department's vision for eligibility and enrollment, including concerns about the burden on county Department of Social Services (DSS) case workers.

A few commenters emphasized the need for education and choice counseling to ensure that beneficiaries make informed decisions in plan selection, with one commenter cautioning that county DSS staff may not be well positioned to provide such counseling.

Department Response: *The Department wants Medicaid applicants to experience a simple, timely, and user-friendly eligibility and enrollment process, which will be available online, by telephone, by mail or in-person. Over time, the Department seeks an eligibility and enrollment process that can be completed in a single visit. The Department is also committed to providing beneficiaries with the tools and supports necessary to successfully select the PHP best-suited to their needs.*

At Medicaid managed care launch, the Department will contract with an enrollment broker. With the future upgraded eligibility and enrollment system, applicants will move seamlessly from the application process to the PHP/primary care provider selection process. The Department will ensure that county DSS caseworkers, the enrollment broker and PHPs receive extensive training and education to enable them to seamlessly support beneficiaries through the eligibility and enrollment process. The Department intends to provide additional detail for public feedback in the near future.

1.2 Focus on member services, education and choice

A few commenters noted the importance of giving beneficiaries a choice of plans or a choice of primary care providers. Some of these commenters recommended allowing beneficiaries to switch between plans for cause

but otherwise suggested limiting the ability to switch. One commenter noted that beneficiaries who would be in behavioral health and I/DD tailored plans should also have a choice of plans.

A few commenters commended the Department's emphasis on member services, education and the ombudsman program with one commenter recommending that the Department establish PHP requirements to ensure adequate beneficiary education (e.g., on selecting a primary care provider).

Department Response: *At Medicaid managed care launch, applicants and beneficiaries will receive support and educational materials to make a well-informed PHP selection. This includes explanation of the Medicaid managed care program, services covered through Medicaid managed care, a list of PHPs available to that individual, and instructions on how and by what deadline to select a plan.*

The Department envisions that the enrollment broker, PHP member services, and the ombudsman program will jointly serve as the beneficiary support system. Further details around the functions of the ombudsman program and the enrollment process (including primary care provider selection) will be released in the future. The Department intends to provide additional detail for public feedback in the near future.

1.1 Stakeholder Engagement

Several commenters addressed the Department's engagement of the standing Medical Care Advisory Committee (MCAC) as the formal stakeholder engagement body charged with providing feedback and input on a wide range of transformation efforts. One commenter expressed concerned that using the MCAC quarterly meetings to receive public input was inadequate. Others suggested that the MCAC needed behavioral health representation, including family and youth advocates and a consumer advocate. One commenter suggested use of a webinar format for MCAC. A few commenters noted a need for clear communication, more public hearings about payment strategies, and collaboration with associations to develop provider communications. A few commenters recommended the creation of a behavioral health workgroup.

One commenter requested that the Department allow for public comment on its final quality strategy. A few suggested that the Department hold regular ongoing meetings with diverse consumer advocates and consider establishing a consumer advisory group for Medicaid transformation.

Department Response: *The Department agrees that ongoing stakeholder engagement is crucial for a successful Medicaid transformation. Stakeholders, such as individuals and family members with personal experiences, advocates, diverse provider organizations/associations, and social service agencies including faith based groups, are essential to the successful implementation of managed care. The Department will continue to engage with beneficiaries, providers, plans, elected officials, local agencies, communities and other stakeholders throughout the health care and social services systems to refine Medicaid managed care program details, and implement and monitor program changes. The Department will seek public comments on its quality strategy, support MCAC in filling committee vacancies and development of subcommittees, and supplement invitations for further written comments on white papers with targeted outreach to specific stakeholders and groups.*

2. Promoting Access to Care

2.1 Support provider workforce initiatives

Several commenters supported provider workforce initiatives such as loan repayment and residency programs as an important component of promoting access to care, noting that these initiatives are crucial to increasing

the number of clinicians in rural and underserved areas. Workforce initiatives allow for North Carolina to target gaps in its state health care delivery system, and better align and develop practitioners to fill those gaps. In particular, commenters praised or advocated using loan repayment programs, Area Health Education Centers' (AHEC) residency programs, and the Community Health Worker (CHW) model.

A few commenters recommended several improvement opportunities, such as making modifications to Graduate Medical Education (GME) payments, doing more to attract subspecialists to rural or underserved areas, increasing the number of residency slots and offering loan repayment to social workers.

Department Response: *North Carolina has long been focused on building health care capacity in rural and underserved areas. The Department proposes to expand, and is seeking federal funding to support, community-based residency programs that promote essential workforce training with a primary focus on ambulatory and preventive care.*

Recruitment and retention of a well-trained, multi-disciplinary workforce will be crucial to ensuring adequate access to services in rural and underserved communities. This effort will include continuation of existing loan repayment, community grant and AHEC residency programs, and may also include new community-based graduate medical education and fellowship programs.

The Department will also examine the feasibility of introducing a community health worker model to assist in addressing social determinants of health.

1.1 Support telehealth initiatives

Several commenters supported the Department's plan to leverage telehealth and telemedicine initiatives to ensure that rural enrollees have access to quality health services. A few commenters also recommended specific actions that the Department could take toward achieving this end, such as removing originating site requirements, helping to bring high-speed internet access to rural areas or expanding the availability of telehealth for the I/DD population.

One commenter expressed concern that telehealth would be used as more than just supplemental care in rural areas or as a replacement for in-person care.

Department Response: *PHPs will be encouraged to support the use of telemedicine as a tool for ensuring access to needed services. When a PHP enrollee requires a medically necessary service that is not available within the PHP network, the PHP would be permitted to provide access to the service through telemedicine. Accordingly, PHPs will be permitted to leverage telemedicine in their Request for Exception to the Department's network adequacy standards. The Department will also encourage PHPs to implement pilots that test additional telemedicine strategies and will invite PHPs to propose innovative pilots related to telemedicine in their responses to the Department's Medicaid managed care procurement.*

The Department is also working with CMS to explore strategies to increase provider awareness, education and training on telemedicine opportunities and best practices. These strategies involve telehealth alliances and innovation funds that support provider-PHP collaborations that test evidence-based telemedicine initiatives aligned with the Department's quality strategy goals, such as chronic disease management, wellness promotion and high-value care.

1.1 Increase access to Medicaid

Many commenters supported increasing access to Medicaid, including several commenters who praised "Carolina Cares," the proposed legislation in the NC General Assembly that would allow low-income individuals to enroll in Medicaid if they meet work and personal responsibility requirements, and paid a required premium. Commenters noted that such legislation would be beneficial to many individuals with behavioral health and substance use disorder needs and would particularly help combat North Carolina's opioid epidemic.

A few commenters suggested potential changes to the proposed legislation. A few commenters expressed concerns about mandatory employment activities included in the legislation, including one commenter who recommended removing these requirements. Another commenter recommended that hospital assessments fund only a portion of the non-federal share for this program.

Department Response: *Proposed legislation in the North Carolina General Assembly (NCGA) aims to increase access to affordable health care under Medicaid by requiring the Department to design the Carolina Cares program. If passed, this program will begin at the same time as the launch of the Medicaid managed care program. This aspect of the proposed program design will only be implemented with additional legislative authority from the NCGA.*

1.2 Combat the opioid epidemic

Many commenters agreed that combatting the opioid crisis is a crucial public health priority in North Carolina and offered several recommendations for the Department as it continues these efforts. Several commenters would like increased access to Medication Assisted Treatment (MAT) for opioid use disorder, including elimination of prior authorization for the use of MAT and increased resources dedicated to MAT. A few commenters also supported expanding access to low-intensity residential SUD services. A few commenters also noted the importance of provider education on opioids (e.g., training on safe prescribing).

One commenter expressed concern that Suboxone® was too often prescribed without concurrent treatment services. One commenter also recommended that provider-led entity governance should be required to have a substance use specialist on staff. A commenter also stressed that tailored plans would need additional resources to adequately serve the SUD service needs of many of their enrollees.

Department Response: *Independent of the Medicaid managed care transformation, doing everything possible to combat the opioid epidemic is among the Department's highest priorities. As part of a comprehensive Department-wide effort to combat the opioid epidemic, the Department developed a multi-pronged Medicaid strategy to reduce the number of North Carolinians who develop SUDs and better treat those who have those disorders. Implementation of numerous initiatives is underway, including reducing the permitted maximum daily dosage of opioids, requiring prior approval for certain prescriptions or supply sizes, and working toward Medicaid matching funds for SUD treatment in institutions of mental disease.*

The Medicaid managed care program will be another tool that the Department can use to deliver needed services. The Department is exploring additional strategies to prevent new cases of SUDs (e.g., training physicians and pharmacists on best practices in prescribing) and treat existing SUDs (e.g., adding low intensity residential services as covered benefits). The Department is always interested in receiving feedback and comments as it continues to address this crisis.

1. Promoting Quality and Value

1.1 Implement a statewide quality strategy

Many commenters made recommendations regarding the use of quality measures, with several recommending using a standard set of measures across all PHPs that leverages existing quality programs or measures used by other payers, and focuses on a narrow set of measures selected with significant stakeholder feedback and engagement. A few commenters recommended quality measures for specific populations (e.g., children, behavioral health or I/DD population), and several commenters recommended specific measures (e.g., HIV viral load suppression or contraceptive care/counseling).

A few commenters commended the Department's proposal to implement a statewide quality strategy generally, with two commenters recommending leveraging CMS's Quality Payment Program. A few commenters also supported having PHPs accreditation done by a single accrediting body to maintain consistency across multiple health plans. A few commenters also requested that the Department publish its quality strategy.

Department Response: *If North Carolina is to realize its transformation goals, it is crucial that a cross-cutting quality strategy for Medicaid aligns efforts by PHPs, providers and the Department to measure and achieve value with a set of clear priorities for quality improvement and innovation. North Carolina's quality strategy must identify a single set of statewide quality priorities, tie those priorities to a streamlined set of measures and metrics, and use those measures and metrics to assess performance and drive progress on Department transformation efforts. The Department will publish a quality strategy document and will solicit public comment on this document.*

Key quality priorities and initiatives will be derived from existing performance on quality measures and outcomes in North Carolina and build on the work of the North Carolina Institute of Medicine (NCIOM). The Department will also leverage existing quality efforts underway today to develop these metrics.

1.2 Encourage value-based payment

Several commenters agreed with the Department's proposal to move toward VBP arrangements between PHPs and providers. Some commenters advocated for specific payment frameworks or strategies (e.g., HCP-LAN framework or CPC+ program). A few commenters noted that providers are at varying levels of readiness to adopt VBP arrangements and cautioned that the Department's approach must recognize and account for these variations.

A few commenters noted potential barriers to the adoption of VBP, such as the need to change culture and behaviors, and the need for timely and transparent data. Some commenters also recommended giving PHPs and providers flexibility in designing their VBP arrangements, as well as continuing to engage stakeholders through the process (e.g., for determining pay-for-performance measures).

Department Response: *VBP offers an opportunity to move away from volume-based reimbursement and, instead, more closely align the quality of services delivered with payment. For that reason, the Department plans to encourage accelerated adoption of VBP arrangements between PHPs and providers in Medicaid that tie to quality strategy priorities. The goal of pursuing VBP is to ensure that payments to providers are increasingly focused on population health, appropriateness of care and other measures of value, rather than on a fee-for-service basis.*

PHPs will be encouraged to develop and lead innovative strategies to increase the use of VBP arrangements over time, and to submit their VBP strategies to the Department and report on their use of VBP contracting arrangements each year. Over time, PHPs will be rewarded for having a strong VBP baseline and making measurable improvements against their baseline from year to year. The Department will create a VBP roadmap to engage stakeholders on this topic and will develop clear goals for moving toward VBP.

1.1 Enhance data collection and sharing capabilities

Multiple commenters noted the importance of continuing North Carolina's investment in data collection, analysis, and sharing among plans and providers as an integral component of promoting quality and value. Several commenters stressed the need to minimize the administrative burden of data collection and analysis on providers. A few commenters highlighted the need for data to be timely and actionable, and others noted the importance of building on or leveraging existing data systems and capabilities.

A few commenters sought more detail or clarity on how the Health Information Exchange ties into the data infrastructure envisioned by the Department.

Department Response: *Data will play a crucial role in North Carolina's Medicaid transformation. The Department will facilitate the development of the infrastructure and processes to support timely data collection, and to produce and disseminate data and information. Such data are needed to ensure appropriate program oversight and operations, and to support its quality, VBP, care management and population health strategies.*

2. Setting up Relationships for Success

2.1 Ensure transparent and fair payments for PHPs

A few commenters addressed the need for transparent and fair payments to PHPs. One commenter stressed that rates must be actuarially sound, and another noted the need for sufficiently sized risk pools for each plan. One commenter felt that risk adjustment was not necessary for capitated payments for all Medicaid populations. Another commenter asked that the Department's data book be released at least 90 days prior to procurement.

Department Response: *The Department will ensure that capitation rates are set according to actuarially sound principles and will reflect specific program design considerations, covered populations and benefits, and PHP provider payment requirements including rate floors and payments to special provider types (e.g., FQHCs/RHCs). The payments to the PHPs under Medicaid managed care are in the form of prospective per member per month (PMPM) capitation rates. The Department, in consultation with its actuary, will develop the capitation rate methodology through a transparent process that solicits information from potential PHPs and other stakeholders. Through the medical loss ratio, the Department will monitor the expenditure of the capitation payments to ensure that funds are spent primarily on medical services.*

2.2 Ensure transparent and fair payments for providers

Many commenters stressed the need for fair payments for providers. Many commenters recommended increasing Medicaid provider payments, including general recommendations of payment increases and specific recommendations to set payments at particular levels (such as matching Medicare rates). Several commenters also noted the need for timely payments to providers in managed care.

A few commenters commended the Department's proposal to set a rate floor at 100 percent of the current fee-for-service rate, with one commenter also suggesting a rate ceiling. One commenter asked that the Department state that all parties, not just providers, must negotiate in good faith.

A small number of commenters also mentioned the Department's proposal to migrate the current supplemental payment structure to an alternative arrangement, either offering general advocacy of the proposed approach or making technical recommendations for the new payment structure.

Department Response: *The Department wants to maintain beneficiary access to care and strong provider participation in Medicaid managed care. As a part of those objectives, the Department seeks to balance flexibility and prescriptiveness in its proposed approach to provider reimbursement by requiring PHPs maintain a certain level of payment, including a rate floor of 100 percent fee-for-service for physicians and physician extenders. The Department looks forward to continued work with hospitals and other stakeholders in developing an approach for supplemental payments. The Department intends to provide additional detail for public feedback in the near future.*

1.1 Ensure provider access

Several commenters noted the importance of maintaining an adequate provider network in managed care and supported networks that would ensure timely access to care. Many commenters supported the "any willing provider" rules in North Carolina statute, but some expressed concerns. A few commenters noted that if the Department requires the plans to demonstrate network adequacy within their RFP responses, that this requirement should be in the form of Letters of Intent rather than signed contracts.

A few commenters opposed the proposed 90 percent of fee-for-service rate for out-of-network providers who have declined a PHP contract. A few commenters also recommended specific changes or additions to the network adequacy standards enumerated in the proposed program design (e.g., more stringent standards for prenatal care).

Department Response: *North Carolina's Medicaid program enjoys strong participation from a range of providers. Moving to Medicaid managed care, it is crucial to ensure continued participation and to monitor access, while balancing the PHPs' ability to manage their networks and patient care. States with Medicaid managed care are required to ensure that PHPs maintain a network of appropriate providers that is "sufficient to provide adequate access" to all services covered under the contract for all enrollees. North Carolina's Medicaid managed care legislation also requires PHPs to "not exclude providers from their networks" except for the inability to negotiate rates or quality concerns. The Department intends to provide additional detail for public feedback in the near future.*

1.2 Take a thoughtful approach to pharmacy policies

Several commenters responded to the Department's proposal for pharmacy policies. Some commenters supported the legislation mandating a single statewide formulary, while others recommending instead that PHPs be given more flexibility to adopt their own preferred drug list (PDL). Other comments included consulting plans as a part of the formulary design process and making the PDL available with the data book as part of the managed care procurement process.

A few commenters also expressed concerns about the potential administrative burden on providers if PHPs were to have unique clinical coverage policies or suggested that current policies be maintained.

Department Response: *North Carolina's Medicaid pharmacy program has a history of effective program management, using drug rebates and careful selection of drugs on a PDL to acquire the correct mix of drugs at the most advantageous cost. The Department wants to continue providing the best overall value to beneficiaries, providers and North Carolina. The proposed approach will assist the Department in meeting the statutory requirement that PHP spending for prescribed drugs, net of rebates, ensures that the Department realizes a net savings on spending for prescribed drugs. This approach will also help the Department meet statutory requirements mandating a single statewide formulary and rate floors for dispensing fees. The Department will provide additional detail for public feedback in the near future.*

1.1 Ensure compliance and program integrity

A few commenters made recommendations regarding actions the Department could take to ensure compliance and program integrity after the launch of managed care. A few commenters recommended that the Department conduct audits of commercial plans and provider-led entities. Others suggested that the PHPs use their special investigation units to combat fraud, waste and abuse. Multiple commenters highlighted the need for clear guidelines and expectations, and frequent communication among plans, providers and the Department as important components of maintaining program integrity.

Department Response: *While some of the Department's operations will change with the transition to Medicaid managed care, the Department remains responsible for all aspects of North Carolina's Medicaid program. To ensure that PHPs comply with Medicaid managed care requirements and align with Department-defined program goals, the Department is designing rigorous requirements and oversight protocols for the Medicaid managed care program.*

1.2 Build a fair grievance and appeals process

A few commenters made recommendations or expressed concerns about the proposed provider grievance and appeals process. For example, one commenter felt that providers needed access to a state hearing that was not run by a PHP and another advocated for the implementation of an ombudsman program for providers.

Department Response: *The Department will ensure that Medicaid beneficiaries and providers will have a transparent and predictable mechanism to complain, grieve or appeal issues involving PHPs. The Department is committed to honoring and supporting the right of beneficiaries to pursue a formal appeal of an adverse benefit determination through their Medicaid managed care plan or, upon exhaustion of the Medicaid managed care plan appeal process, through timely access to a North Carolina fair hearing. PHPs will be required to establish a provider appeals process through which providers can appeal PHP actions related to termination or non-renewal of contract for quality reasons or violation of terms between the PHP and provider (e.g., prompt pay or denial of claims). In designing these processes, the Department seeks to strike a balance between the protection of provider rights and respecting the contractual relationship between providers and PHPs.*

Public Input Summary

Introduction

The Department of Health and Human Services is dedicated to improving the health and well-being of all North Carolinians. Medicaid and NC Health Choice programs, which cover more than two million people (about 20 percent of the state's population), hold crucial roles in the Department's efforts to build a healthier North Carolina. These two programs cover over half of births in the state, long-term care for vulnerable seniors and services for those in our communities with disabilities.

The Department is in the process of shifting administration for most Medicaid enrollees to a managed care system. In June 2016, a proposal was submitted to the federal government related to transitioning Medicaid to managed care. Since then, the Department has continued to listen to and talk with North Carolinians about how to make the state healthier.

Through these ongoing conversations, several topics were identified as particularly important to the design of a successful Medicaid managed care program. Recently, the Department asked for comments through a series of public input sessions across the state, and in writing or by phone message.

From April 25 through May 25, 2017, the Department received approximately 700 comments related to improving Medicaid. This Public Input Summary provides the major themes from those comments, organized by the questions covering the seven topics in the Medicaid and NC Health Choice Request for Public Input document. At the end of the summary, feedback on other subjects is included. Senior leaders in the Department and Medicaid will use the public input as they consider whether modifications are needed to the proposal submitted in June 2016.

The Department sincerely appreciates the valuable, thoughtful comments received and is committed to continuing this open and collaborative process to build a strong, efficient Medicaid program. Thank you for sharing your ideas, thoughts and recommendations.

About This Summary

Each comment received during a public input session, in writing or by phone was reviewed by the Medicaid transformation team and used to identify overall major themes. To ensure the privacy and confidentiality of those who submitted comments, no names are listed in this summary. A list of abbreviations and acronyms used in this summary is included at the end.

Additional feedback is always welcome. Please send written input to:

Email: Medicaid.Transformation@dhhs.nc.gov

U.S. Mail: Department of Health and Human Services, Division of Health Benefits,
1950 Mail Service Center, Raleigh NC 27699-1950

Drop-off: Department of Health and Human Services, Dorothea Dix Campus, Adams Building,
101 Blair Dr., Raleigh NC

Send questions about North Carolina Medicaid transformation to Medicaid.Transformation@dhhs.nc.gov. For more information, visit ncdhhs.gov/nc-medicaid-transformation.

1. Physical and Behavioral Health Service Delivery

1.1 What are the opportunities and risks associated with integrating behavioral health services with physical health services? Should North Carolina pursue an approach of integrating physical and mental health services earlier than four years after the managed care transition?

Many commenters recommended that the Department integrate physical and behavioral health services, with several requesting that this integration occur earlier than four years after the managed care transition and/or as soon as possible. Most commenters who voiced an opinion on integration timing recommended accelerating the currently proposed timeline. Commenters noted that such integration would reduce fragmentation in care and create a single point of accountability for the outcomes of patients with behavioral health needs. A few noted that this integration would benefit from Department support, particularly technical support (e.g., integrating information technology infrastructure), training/education programs, and support to create a collaborative environment among providers (e.g., co-locating behavioral health and primary care services).

Department Response. *The Department seeks to integrate physical and behavioral health services as quickly as possible while minimizing care disruption. The Department appreciates the comments and concerns regarding how such an integration could be accomplished.*

1.2 How can the Department best integrate care delivery for individuals with lower intensity, lower frequency behavioral health needs? Should these individuals be enrolled in a traditional prepaid health plan with the expectation that both physical health and behavioral health services be covered?

Several commenters indicated support for a design where lower intensity or lower frequency behavioral health needs would be covered in an integrated manner within the context of a traditional pre-paid health plan (PHP) that also would cover physical health services. A few commenters recommended integrating additional services into these traditional PHPs for patients with greater needs, including a robust set of substance use disorder services. Many stressed a need for increased funding and improved access to behavioral health services and resources for these populations, particularly for children and adolescents. A few also recommended that the Department take steps to reduce the administrative burden on health professionals for integrated behavioral health (e.g., streamlined processes).

Department Response. *The Department is committed to ensuring quality care delivery for beneficiaries with lower intensity and/or lower frequency behavioral health needs. The Department appreciates the comments and concerns received on this subject.*

1.3 Should North Carolina use Special Needs Plans (SNPs) to cover the physical and behavioral health services for individuals with serious mental illness, intellectual and developmental disabilities (I/DD) or moderate to severe substance use disorder? If so, how should these plans be structured, and what requirements or protections should be included to ensure access to crucial benefits and specialized care management? Are there any special considerations for the delivery of I/DD services, including the Innovations Waiver, through SNPs?

Many commenters recommended that individuals with serious mental illness, I/DD, or moderate to severe substance use disorder receive integrated behavioral and physical health services though SNPs, particularly if those plans would provide an enriched benefit package that included care management and support services

tailored to the unique needs of their populations. A variety of recommendations regarding potential SNPs were proposed, including rigorous requirements for access and network capacity, quality requirements, physician leadership, need for oversight, and the inclusion of social determinants of health. A few commenters felt that certain populations should have the choice to be in a traditional PHP or SNP, such as patients with low acuity behavioral health needs or those with disabilities. One commenter indicated a preference for a statewide or multi-region SNP. Several advocated for a whole person care approach in addressing behavioral health and I/DD needs.

Department Response. *The Department is committed to ensuring quality care delivery for beneficiaries with serious mental illness, I/DD and moderate to severe substance use disorders. The Department appreciates the comments and concerns received on this subject.*

14 How can Medicaid assist LME/MCOs (local management entities/managed care organizations) in transitioning to an integrated managed care system (e.g., helping LME/MCOs prepare to offer SNPs?) How can the Department best design an appropriate governance model for integrated managed care and how can Medicaid facilitate the implementation of that model?

Several commenters recommended ways that Medicaid can assist LME/MCOs with this transition and recommended an appropriate governance model. Recommendations included collaborating with LME/MCOs to develop minimum requirements for LME/MCO participation in SNPs; giving LME/MCOs standard guidelines and quality metrics; allowing PHPs to subcontract with LME/MCOs; ensuring provider and community participation in plan governance; covering enriched benefits for special populations; and outlining care coordination and data-sharing requirements. One commenter recommended that LME/MCOs be given the opportunity to lead whole person care for the SNP population, while another recommended that LME/MCOs not take on this role.

Department Response. *The Department acknowledges that LME/MCOs will require support in transitioning to an integrated managed care system, and looks forward to working with LME/MCOs and other stakeholders throughout any transition to ensure seamless access to care for beneficiaries. The Department also understands the importance of an appropriate governance model for integrated managed care, and is committed to designing and implementing such a model with care and deliberation. The Department appreciates the comments and concerns received on this subject.*

15 If not through Special Needs Plans, how should North Carolina ensure delivery of integrated physical and behavioral health for individuals with serious mental illness, I/DD, or moderate to severe substance use disorder?

A few commenters felt that SNPs were not necessary and/or proposed alternative approaches to ensuring integrated care delivery for these populations. One commenter suggested that these populations could be managed by traditional PHPs with a special capitation rate. Another recommended that qualified experienced health plans manage care for these populations within a traditional PHP. A few recommended carving out I/DD populations from managed care and maintaining a fee-for-service structure for this population.

Department Response. *The Department is committed to ensuring quality care delivery for beneficiaries with serious mental illness, I/DD and moderate to severe substance use disorders. The Department appreciates the comments and concerns received on this subject.*

Other themes

Several commenters advocated for maintaining or expanding the Innovations waiver program for I/DD beneficiaries. A few recommended that the Department require a whole person care approach from practices and clinics and/or screen providers for an ability to provide whole person care. A few recommended expanding the availability of community-based services for behavioral health and providing a consolidated list of all such services covered by the Medicaid and NC Health Choice programs.

Department Response. *The Department appreciates the comments and concerns received on this subject.*

2. Supporting Provider Transformation

2.1 How can the State minimize administrative burdens on providers as Medicaid transitions to managed care (e.g., standardized provider notifications, standardized data-sharing requirements)?

Many commenters underscored the importance of minimizing administrative burdens on providers as Medicaid transitions to managed care. Recurring suggestions to accomplish this included standard processes and protocols (e.g., standard fee schedules, contract terms, claims requirements, data-sharing requirements and prescription drug list); centralized credentialing; create a single portal for all claims processing; automatic enrollment of newborns; and expanded presumptive eligibility. In addition, some commenters mentioned simplifying or shortening existing processes (e.g., enrollment, verification, credentialing) or increasing automation (e.g., reconciliation for federally qualified health center reimbursement) as ways to reduce administrative burden on providers.

Department Response. *The Department understands it is important to minimize administrative burdens on providers whenever possible and is committed to continuously exploring ways to do so. The Department is investigating centralized credentialing and other administrative simplification techniques, building on best practices in other states, and appreciates the comments and concerns received on this subject.*

2.2 What support will be necessary to assist in the transition to managed care for small providers and providers in rural or underserved communities?

Many commenters highlighted that small and/or rural providers will have unique support needs as Medicaid transitions to managed care, in part due to the disproportionate impact that administrative requirements can have on these providers. Recurring themes included the need for significant implementation support (particularly technology and data), upfront and ongoing provider engagement (including coaching/training for clinical and non-clinical staff, particularly on adhering to claims/billing requirements, performance standards and managing referrals/coordination), and assistance with developing telehealth capabilities. A few recommended modifying certain guidelines (e.g., criteria to qualify as an advanced medical home, ability to engage in community-level care coordination) for small and/or rural providers to encourage participation.

Department Response. *The Department acknowledges that smaller providers and providers in rural or underserved areas may face additional barriers to undergo the transition to managed care. The Department looks forward to working with these providers to support their needs, and appreciates the comments and concerns received on this subject.*

2.3 What are the primary opportunities and barriers for providers interested in establishing provider-led entities (PLEs)? What, if any, support or special accommodations should be made to facilitate the creation of PLEs?

Some commenters noted the importance of maintaining parity between PLEs and traditional PHPs, recommending that the Department take steps such as prohibiting exclusive provider contracts, requiring PLEs to contract with all health plans, and holding PLEs to the same requirements as traditional PHPs (e.g., licensure and solvency standards). Other commenters recommended that the Department encourage the formation of PLEs by, for example, maintaining flexibility for PLE minimum capital requirements or developing processes to equitably distribute members across all PHPs and PLEs. Commenters also highlighted the importance of fostering competition in the managed care market to increase stability and member choice while maintaining rigorous standards for qualifying as a PHP to ensure that that all PHPs meet the needs of enrollees and providers.

Department Response. *The Department acknowledges that there are both opportunities and barriers for providers interested in establishing PLEs. The Department looks forward to continuing to engage our stakeholder community to understand what, if any, support or special accommodations should be made to facilitate the creation of PLEs, and expects to engage in a more formal solicitation of interest later in 2017. The Department appreciates the comments and concerns received on this subject.*

Other themes

Many commenters recommended preserving the Community Care of North Carolina (CCNC) care management infrastructure. Many commenters recommended that the Department increase Medicaid provider reimbursement (e.g., reimbursing at par with Medicare rates), including general increases and targeted increases for specific services or specialties. A few recommended that the Department help expand responsibilities for services provided by non-physician providers (e.g., nurses) as one mechanism to address workforce shortages. A few commenters advocated for a variety of supports, including an ombudsman program, increased continuing medical education support, and maintained PMPM (per member per month) payment and information technology support for medical homes.

Department Response. *The Department appreciates the comments and concerns received on this subject.*

3. Care Management and Population Health

3.1 Should North Carolina consider developing standardized, statewide criteria and a certification process for providers to qualify as advanced medical homes under Medicaid?

Many commenters expressed support for the medical home model and the need for standardized criteria. Most commenters recommended North Carolina institute a certification process in alignment with existing national standards (e.g., the National Committee for Quality Assurance (NCQA) patient centered medical home (PCMH) standards or the Centers for Medicare & Medicaid Services (CMS) standards under the Quality Payment Program). Several commenters suggested national criteria would be sufficient for accreditation, while a few recommended the Department incorporate additional elements, such as standards used by other major payers in the state. A few commenters recommended that the Department not designate specific functions to be included in health plan contracts with medical home providers. Some commenters also highlighted the importance of enhanced financial resources within the medical home model.

Department Response. *The Department believes that supporting the medical home model is an important component in the achievement of North Carolina's health care goals. The Department appreciates the comments and concerns received on this subject.*

3.2 If North Carolina adopts a qualification or certification process for advanced medical homes, please comment on possible guiding principles or factors that should be considered to ensure success (e.g., alignment with other payer programs, specific infrastructure requirements, performance measures).

Several commenters recommended guiding principles for North Carolina's advanced medical home model, with recurring themes including quality/outcomes improvement, patient experience, continuity of care, incentives for innovation, and alignment or collaboration with existing efforts across the state (e.g., PHM efforts). Some commenters recommended specific demonstrated capacities that a qualifying advanced medical home should possess, including the ability to coordinate behavioral health and substance use services, provide comprehensive care management, provide chronic disease management, leverage data analytics, link with community and social supports, and provide high-quality services informed by evidence-based clinical practices. A few commenters also advocated for building on the strong foundations of North Carolina's existing primary care case management (PCCM) and PCMH models.

Department Response. *The Department appreciates the comments and concerns received on this subject.*

3.3 Should the Department contractually mandate that prepaid health plans provide an enhanced care management fee to support delivery of care coordination and care management services to advanced medical homes practices?

Several commenters agreed that the capabilities and infrastructure required for care management and advanced medical home capabilities require investment that should be appropriately compensated. Several recommended that the Department mandate an enhanced care management fee, with recurring themes on payment structure including a flat or acuity-adjusted PMPM add-on payment. A few recommended flexibility and creativity in compensation structures for these payments, such as tying payments to incentive programs or otherwise aligning provider incentives with driving innovation in care delivery.

Department Response. *The Department appreciates the comments and concerns received on this subject.*

3.4 What strategies should the Department consider for providers who may face barriers to meeting the care management criteria, such as small and rural providers?

Several commenters proposed strategies for the Department to take to support small and/or rural providers to implement effective care management. These strategies included ensuring the existence of regional care management organizations that can provide care management services for small providers that lack the scale to provide these services independently (or allowing small providers to develop community-level or multi-provider strategies for care management), requiring PHPs to demonstrate plans to support small/rural providers with care management and population health management during the RFP process, allowing small providers to develop community-level or multi-providers strategies for care management, and providing standard quality data to practices.

Department Response. *The Department acknowledges that smaller providers and providers in rural or underserved areas may face additional barriers to meet care management criteria, and looks forward to*

working with these providers to support their needs. The Department appreciates the comments and concerns received on this subject.

3.5 What types of population health management support should prepaid health plans provide to providers that would assist them in effectively managing care for beneficiaries, particularly those with the most complex needs?

A few commenters made recommendations regarding support that prepaid health plans should offer to providers for population health management. Commenters highlighted the important role that PHPs play in collaborating with providers to coordinate care and (particularly with providers with the most limited capabilities) to identify and implement successful strategies. A few commenters noted that PHPs should provide regular, standardized quality data to providers, and support management of data and service utilization. Two commenters recommended that PHPs be required to demonstrate their population health or care management support plans in their RFP responses. Other recommendations related to PHP population health management support included employing hotspotting techniques to identify high-risk patients, integrating community pharmacies into the medical home infrastructure, and providing monthly patient assignment lists. One commenter noted that services such as medication reconciliation, home visits and transportation intervention are not likely to be supported by MCOs unless required.

Department Response. *The Department is committed to facilitating effective population health management in North Carolina. The Department appreciates the comments and concerns received on this subject.*

3.6 Please comment on the types of services and supports that are best managed at the local provider/practice level and that can best be supported at the prepaid health plan level.

A few commenters noted that, given their scale and experience, PHPs are best-suited to activities such as data and utilization management, population health strategies, technology support, and reporting. Commenters noted that providers/practices are best suited to activities such as care management, care coordination, promoting healthy behaviors, providing follow up care, educating patients and making referrals (including referrals to social supports).

Department Response. *The Department acknowledges that PHPs and providers bring valuable experiences and capabilities that can complement one another in a managed care environment, and is committed to aligning roles and responsibilities with owners who are best-positioned for success. The Department appreciates the comments and concerns received on this subject.*

Other themes

Many commenters emphasized the support providers receive from case managers as important for local care management and population health. Multiple commenters recommended the following actions to improve care management: increase funding/focus on preventive care, embed case managers in practices, create health education programs and improve care coordination throughout the system.

Department Response. *The Department appreciates the comments and concerns received on this subject.*

4. Addressing Social Determinants of Health

4.1 How can the State help providers, community-based organizations and prepaid health plans further integrate and coordinate health care delivery, social support services and targeted interventions regarding social and environmental determinants of health?

Many commenters acknowledged the crucial role of addressing social determinants of health in providing care for North Carolina's Medicaid population, and expressed support for the Department and other stakeholders to do more to integrate health care delivery with social service supports through targeted interventions. Commenters highlighted ways to achieve such integration, including pursue CMS support to establish programs that address social determinants of health within Medicaid; lead development of standardized screening and assessment tools; leverage health technology and data to help identify effective interventions; establish formal referral protocols between PHPs and social services; provide community health worker certification and reimbursement; work with local partners to raise and address unmet resource needs; encourage co-location of health care providers and social services; and allocate flexible funding to pay for emergent unmet resource needs.

Department Response. *The Department understands the importance of addressing social determinants of health in serving North Carolina's Medicaid population, and is committed to supporting our stakeholders to identify and address unmet resource needs, and to identify and encourage the most effective interventions. The Department appreciates the comments and concerns received on this subject.*

4.2 What types of strategic investments in infrastructure to address unmet resource needs (e.g., housing, nutrition, utilities, safety) would have the most significant positive impact on the health of North Carolina communities?

Commenters recommended a wide variety of potential strategic investments to address unmet resource needs. The most commonly cited investments included supportive housing (particularly for beneficiaries with complex chronic conditions), and nutrition and food insecurity interventions (such as identifying and addressing food deserts). Other recommended areas on which to focus included health insurance coverage, utility assistance, transportation, child care, job supports, education support, economic development, legal assistance, safety initiatives and public health initiatives.

Department Response. *The Department acknowledges that there are a wide variety of potential interventions and infrastructure investments that can play an important role in addressing the unmet resource needs of many of our beneficiaries. The Department looks forward to ongoing stakeholder engagement to continuously identify and support the interventions that have the largest positive impact on our communities, and appreciates the comments and concerns received on this subject.*

4.3 Please comment on the types of investments that would be best managed at the local provider/practice level and those that can best be supported at the state level.

Several commenters noted that certain types of investments and activities would best be managed at the Department or plan level, including securing flexible funds; building data-sharing capacity; making benefit package changes;, developing certification and training processes; streamlining or expanding eligibility and enrollment entry points; developing financial incentives to address social determinants of health; and compiling a comprehensive social determinants of health resource inventory. Several commenters noted that other types of investments and activities would be best managed at the local/provider level, including

collecting social determinants of health data (e.g., through screening and assessment tools), distributing funds and allocating temporary assistance for crucial unmet resource needs, and performing on-the-ground care management and care coordination activities. Several commenters requested flexibility to use funds at the local level given the diversity and context-dependence of social needs.

Department Response. *The Department acknowledges that prepaid health plans and providers bring valuable experiences and capabilities that can complement one another in a managed care environment, and is committed to aligning roles and responsibilities with owners best-positioned for success. The Department appreciates the comments and concerns received on this subject.*

4.4 What actions can be taken by the State to help providers integrate social and environmental determinants of health into their care for patients and communities? What are the biggest capacity or infrastructure gaps?

Commenters recommended several actions that the Department could take to support providers in their integration of social determinants of health into care delivery. Several stressed the importance of facilitating communication and collaboration among providers, patients, plans and community organizations. A few noted the importance of ensuring adequate financial resources are in place for investment in local infrastructure, data-sharing capabilities and effective interventions. Other commenters highlighted the need for financial incentives to support these efforts (e.g., global capitated payments to providers) and for a clear measure set and assessment process to define and track success. One commenter noted the important role that pilots and demonstration programs could play in addressing social determinants of health.

Department Response. *The Department acknowledges that it holds an important role in helping providers integrate social and environmental determinants of health into standard care processes, and is committed to delivering on that role to the greatest extent possible. The Department appreciates the comments and concerns received on this subject.*

Other themes

One commenter recommended the Department ensure appropriate supports are in place to support small and/or rural providers as they build the capabilities and infrastructure necessary to address social determinants of health. A few recommended creating or strengthening linkages between Medicaid and specific other entities, including Social Security, public schools, behavioral health resources and substance use disorder services. Commenters noted that it is important to create culturally tailored protocols, focus on early childhood and prenatal interventions, and expand the number of entry points into Medicaid as important aspects of a comprehensive social determinants of health strategy.

Department Response. *The Department appreciates the comments and concerns received on this subject.*

5. Improving Quality of Care

5.1 What quality measures should be used? What quality measures will improve outcomes while rewarding value? How can the unique needs of special populations best be considered when creating quality measures?

Many commenters recommended guiding principles for the selection of quality measures, emphasizing a standardized set of quality metrics across PHPs that is consistent with other payers and with common national metrics such as Healthcare Effectiveness Data and Information Set (HEDIS), Physician Quality Reporting System

(PQRS) and NCQA. Commenters recommended using measures from across the continuum of care, with specific quality measures recommended for chronic respiratory conditions (particularly asthma and COPD), diabetes, HIV management, social determinants, inpatient and emergency department utilization, readmission, immunization, and care coordination and management (e.g., medication adherence). A few commenters recommended adopting specific measures for certain special populations (e.g., individuals with I/DD, pregnant mothers, newborns); and measures tailored to unique settings, such as schools or skilled nursing facilities. Recommendations included measures based on process, outcomes, cost and experience.

Department Response. *The Department understands the importance of selecting the right quality measures that will improve outcomes while also rewarding value. The Department appreciates the comments and concerns received on this subject.*

5.2 What types of quality programs should prepaid health plans deploy to advance quality goals? How should prepaid health plans be rewarded to reach quality goals?

A few commenters made recommendations about the types of quality programs that PHPs should deploy to advance quality goals. These recommendations encouraged PHPs to create financial incentives for providers that reward value (particularly for improving outcomes for high-risk populations), and some highlighted a desire for standard measures and processes for quality programs across PHPs. Some commenters recommended that PHPs should be rewarded for achieving quality goals, with reward mechanisms typically focused on either financial incentives or preferred member assignment models.

Department Response. *The Department believes that finding and implementing the right quality programs is key to advancing North Carolina's quality goals, and believes in appropriately rewarding successful achievement of these goals. The Department appreciates the comments and concerns received on this subject.*

5.3 What types of support do providers need to accurately collect and report quality data?

Several commenters recommended forms of support that would be helpful to accurately collect and report quality data. Recurring themes in these recommendations included clarity regarding data metrics and input process (e.g., fields, frequency); financial and technical support; provider-specific dashboards; access to claims data; statewide registries and benchmarks; standardized metrics and processes across PHPs; and specialized support for small or safety-net providers.

Department Response. *The Department acknowledges that many providers will require support to accurately collect and report quality data, and is committed to finding ways to make that support available. The Department appreciates the comments and concerns received on this subject.*

5.4 What strategies should the Department consider to ensure prepaid health plans effectively communicate to providers about quality of care provided to their patients?

Commenters recommended several strategies to ensure effective communication between plans and providers. These included recommendations that the Department require plans to regularly provide data, reporting, peer benchmarks and performance assessments to providers. Several commenters recommended that PHPs demonstrate the capacity to effectively communicate such information (e.g., have a dedicated provider liaison or show the ability to share data and reports at required frequency).

Department Response. *The Department acknowledges the crucial role that regular, effective communication holds in maximizing quality of care, and is committed to facilitating such communication. The Department appreciates the comments and concerns received on this subject.*

5.5 How can providers be supported in quality improvement and rewarded for high-quality care?

Several commenters recommended ways for providers to be supported in quality improvement and rewarded for high-quality care, including financially incentivizing quality care, incorporating provider quality performance into PHP evaluations, establishing clear expectations for data-sharing and reporting from PHPs, creating metrics that are well-suited to provider interventions, and sharing regular feedback to providers on their quality performance.

Department Response. *The Department is committed to supporting providers in quality improvement and finding the most effective ways to reward providers for delivering high quality care. The Department appreciates the comments and concerns received on this subject.*

5.6 How can providers be supported in maximizing patient satisfaction and creating a positive patient experience?

Several commenters recommended methods to maximize patient satisfaction, including reduce administrative burdens, ensure adequate payment to support high-quality care, support team-based care approaches, develop provider training programs (including programs based on patient satisfaction) and develop beneficiary training (e.g., benefit design).

Department Response. *The Department believes that creating a positive patient experience is an integral part of quality care delivery, and is committed to maximizing patient satisfaction whenever possible. The Department appreciates the comments and concerns received on this subject.*

Other themes

A few commenters recommended developing quality metrics with a broad base of stakeholders, including beneficiaries, physicians with diverse and representative backgrounds and specialties (e.g., safety-net providers), and hospital executives. One commenter recommended that the Department refer to accountable care organizations (ACOs) as the standard for quality metrics. Some recommended that the Department adopt the measures of specific organizations to assess quality for specific specialties or health events, such as NCQA standards for pediatrics and the American Heart Association/American Stroke Association's "Get with the Guidelines" standards for heart failure and stroke.

Department Response. *The Department appreciates the comments and concerns received on this subject.*

6. Paying for Value

6.1 How can Medicaid best support hospitals' delivery of high value care? To what extent can redirecting supplemental payments into significantly enhanced base rates help to achieve this goal?

Many commenters expressed support for the transition to value-based care. Several commenters recommended that the Department create financial incentives that reward high-quality, high-value care, with a focus on alternative payments models such as bundled or episode-based payments, global payments or global budgets, and bonus/enhanced payment structures for meeting specific goals or milestones. One

commenter recommended using the Health Care Payments Learning and Action Network (HCP LAN) framework as a starting point. Some supported redirecting supplemental payments into enhanced base rates, while others recommended against it. A few who recommended maintaining the supplemental payment structure also recommended modifying the current structure.

Department Response. *The Department is committed to transitioning from a fee-for-service model to a model that rewards value, and to ensure that any changes made to supplemental payment structures support the delivery of high-quality care and the overall goals of the Medicaid program. The Department appreciates the comments and concerns received on this subject.*

6.2 How can alignment with transformation goals best be achieved without destabilizing hospitals or disrupting access to care? Should North Carolina use a portion of funds to help transition hospitals to a managed care system? What types of supports would help smooth this transition?

Several commenters offered recommendations to minimize destabilization or disruption during alignment with transformation goals. Many commenters noted that financial supports would be helpful or crucial in transitioning to a value-based environment, particularly funding for safety-net providers and sufficient reimbursement levels to support access to care. Several recommended that the Department provide support in getting clear and standard information to providers, including timely data (e.g., discharge information), consistent metrics, standard clinical pathways, clear and achievable value goals, and a reasonable timeline for implementing changes. A few commenters recommended that the Department take a collaborative approach that includes flexibility to providers to acknowledge local circumstances or flexibility to plans to identify mechanisms to minimize disruption and destabilization. Commenters suggested that the Department require that plans provide evidence of, and/or strategies for offering support to providers during the transition.

Department Response. *The Department is committed to ensuring that any changes made to align payments with transformation goals would be accomplished while minimizing destabilization and disruption of access to care. The Department wants to provide necessary supports to smooth such a transition, and looks forward to working with stakeholders to identify the best ways to achieve that. The Department appreciates the comments and concerns received on this subject.*

6.3 What are the opportunities and risks associated with redirecting supplemental payments, including implications on different types of hospitals?

Several commenters supported redirecting supplemental payments into base rates and recommended an incremental approach to minimize disruption, with some requesting additional payments outside of enhanced base rates to lessen payment volatility or incentivize value. A few commenters recommended clear expectations and a transparent process to minimize provider uncertainty in the event of such a transition. Several commenters recommended maintaining a level of reimbursement that supports access to care and creates flexibility to account for local circumstance, particularly for rural providers.

Department Response. *The Department acknowledges that there are opportunities and risks associated with redirecting supplemental payments, and is committed to capitalizing on opportunities while working to minimize risks. The Department appreciates the comments and concerns received on this subject.*

6.4 Are there things the state should consider in this area that are specific to supporting smaller and rural hospital systems?

Several commenters noted that providers have significantly different degrees of capability and readiness to transition to a value-based environment. A few commenters shared that small and/or rural providers would need either additional support from the Department or plans (particularly financial and technical support to make necessary process changes and infrastructure investment) or additional flexibility (e.g., flexible timing to transition to a value-based environment and value-based payment calculations that account for the smaller populations of many rural providers).

Department Response. *The Department agrees that providers across North Carolina have different capabilities and degrees of readiness to make changes, and acknowledges that smaller providers and providers in rural or underserved areas may face additional barriers. The Department looks forward to working with these providers to support their needs, and appreciates the comments and concerns received on this subject.*

6.5 How should North Carolina encourage prepaid health plans to develop value-based purchasing arrangements with their downstream provider networks that align with statewide quality goals and measures?

Several commenters recommended a variety of actions that the Department could take to encourage PHPs to develop value-based purchasing arrangements with providers. A few commenters recommended that the Department create conditions for successful value-based purchasing agreements by establishing clear goals and expectations, including a set of performance metrics consistent with national metrics. A few commenters recommended that the Department require PHPs to demonstrate their experience with value-based purchasing arrangements, and provide flexibility and/or incentives for plans to pursue such arrangements with providers (e.g., incentives tied to graduated numeric targets).

Department Response. *The Department seeks for PHPs to develop value-based purchasing arrangements with provider networks and seeks for these arrangements to align with statewide goals and measures. The Department appreciates the comments and concerns received on this subject.*

6.6 What support would providers need to participate in value-based purchasing agreements?

Several commenters noted that providers would need or desire support to enter value-based payment arrangements, with a focus on financial support to facilitate infrastructure investment or necessary process changes; technical support to ensure availability of timely and actionable data; training and education support on these arrangements; and support to clarify and standardize expectations (e.g., clear standard performance measures).

Department Response. *The Department recognizes that different providers may be at different stages of readiness and is committed to finding ways to provide appropriate support to providers who need it. The Department appreciates the comments and concerns received on this subject.*

Other themes

One commenter recommended that the Department tie growth in rates and payments to provider performance and progress.

Department Responses. *The Department appreciates the comments and concerns received on this subject.*

7. Increasing Access to Care and Treating Substance Use Disorder

7.1 What are the opportunities and risks of increasing care access to North Carolinians under Medicaid? What will be the impact on individuals and families? On providers and communities? State and local government?

More than 200 commenters across provider, payer and patient groups requested that the Department increase access to care through Medicaid, with several commenters specifically mentioning support for North Carolina House Bill 662. The group highlighted positive outcomes of increased access to coverage, including increased access to primary care, preventive care and behavioral health services for many North Carolinians. Commenters noted additional benefits, which included creating 43,000 new jobs and $5.6 billion in increased economic activity in rural areas, improved health outcomes of hundreds of thousands of North Carolinians, and significant return on investment by using enhanced federal matching funds to treat substance use disorders.

Department Response. *The Department is interested in ways to increase care access to North Carolina individuals and families, and believes in the critical importance of access to affordable to health care. The Department appreciates the comments and concerns received on this subject.*

7.2 What health benefits should be covered to meet the health care needs of this population? How should the benefits align or differ from coverage currently available under Medicaid?

Commenters recommended a variety of specific benefits that should be covered to meet the needs of the newly eligible population, including pharmaceutical interventions for opioids (e.g., SUBOXONE®, methadone and VIVITROL®), HIV case management, addiction prevention, medication-assisted treatment, screening and diagnostics, non-opioid treatments for pain, social supports, robust prenatal and infant care, family planning, telehealth services, and behavioral health services.

Department Response. *The Department appreciates the comments and concerns received on this subject.*

7.3 What additional steps can the Department take to ensure that we are doing everything possible to meet the coverage and access needs of North Carolinians addicted to opioids and other substances? How would Medicaid coverage be used for prevention, treatment and ongoing recovery efforts?

Many commenters recommended steps that the Department could take to further meet the needs of North Carolinians with substance use disorders. Recurring themes from these comments include expand the behavioral health and substance use disorder workforce; cover all types of medication assisted treatment (MAT) and allow non-physician providers to prescribe MAT; cover residential and recovery housing services; offer transition programs for North Carolinians exiting the prison system; increase connectivity between providers and community organizations; increase provider education on substance use disorder prevention and treatment; identify predeterminants of substance use disorder (e.g., genetic predisposition); increase entry points into Medicaid; and ensure continuity of care.

Department Response. *The Department believes that addressing the opioid crisis is one of the most important challenges facing our state, and that access to care is critical. The Department is committed to doing everything possible to meet the coverage and access needs of North Carolinians addicted to opioids and other substances, and to maximize the effectiveness of Medicaid in prevention, treatment and recovery efforts. The Department appreciates the comments and concerns received on this subject.*

7.4 What special programmatic features or strategies should North Carolina consider for the newly eligible population to facilitate enrollment, engage patients in their care and ensure continuity of coverage?

Several commenters recommended specific program features that North Carolina should consider, including a streamlined eligibility and enrollment process; increased Medicaid entry points; in-person enrollment assistance; materials available in multiple languages and for all levels of health literacy; an expanded health care workforce (particularly for primary care and low-paying specialties in rural and underserved areas); expanded Graduate Medical Education payments (particularly for non-physician providers); coverage and access for formerly incarcerated individuals; and reduced barriers to telehealth use (e.g., reimbursement parity, removing the originating site requirement).

Department Response. *The Department acknowledges the importance of facilitating enrollment, engagement and continuous coverage in serving the newly eligible population. The Department appreciates the comments and concerns received on this subject.*

Other themes

A few commenters emphasized the benefit of expanding access to care through Medicaid to specific populations and communities, including rural communities, adolescents and low-income employed individuals. A few commenters requested extending post-partum coverage. Several requested that the Department expand access and pursue an integrated approach to behavioral health and substance use disorder services.

Department Response. *The Department appreciates the comments and concerns received on this subject.*

8. Other Recurring Themes in Public Comment

Transition to managed care

Many commenters recommended against North Carolina Medicaid transitioning to a managed care model, with several commenters expressing concern about the potential negative impact of managed care on patients. Several commenters recommended that the Department carve out child beneficiaries from managed care, leaving this population in a fee-for-service model.

Department Response. *The Department is committed to design and implement a managed care program that minimizes disruption to care, preserves care access, and ensures that all beneficiaries receive the services they need to live healthy and fulfilling lives. The Department appreciates the comments and concerns received on this subject.*

Dental carve-outs

Several commenters recommended the Department preserve the current carve-out for dental care.

Department Response. *Current state statute exempts dental services from managed care. The Department appreciates the comments and concerns received on this subject.*

Covered benefits

Many commenters recommended that North Carolina Medicaid add specific services to its current benefit package (e.g., eyeglasses and routine eye exams, fundus photography, Spinraza treatment, applied behavioral analysis, denture replacement, and smoking cessation services). Several commenters recommended the Department establish Young Adult Peer Support services for behavioral health as a covered benefit under

Medicaid. Several commenters recommended that the Department ensure that the current benefit package for children is maintained during and after the transition to managed care. Commenters also recommended that the Department ensure children can still access specialty services outside their region.

Department Response. *The Department is committed to ensuring that Medicaid beneficiaries have access to the covered services and supports that they need. The Department appreciates the comments and concerns received on this subject.*

Importance of Medicaid

Several commenters noted the importance of North Carolina's Medicaid program to the health and well-being of more than two million citizens, with multiple commenters offering personal anecdotes of the importance of Medicaid to the lives of their families and loved ones. A few commenters recommended against cuts to funding or coverage for North Carolina's Medicaid program.

Department Response. *The Department agrees that Medicaid is a crucial program to maintain affordable health care access for more than two million North Carolinians, including children, seniors and people with disabilities. The Department strongly agrees that cuts to Medicaid funding or coverage would be harmful to Medicaid's ability to continue providing access to affordable health care. The Department does everything possible to ensure access to quality care for beneficiaries, and appreciates the comments and concerns received on this subject.*

Acronyms and Abbreviations

ACO ..... Accountable Care Organization
CMS ..... Centers for Medicare & Medicaid Services
COPD ..... Chronic Obstructive Pulmonary Disease
DSRIP..... Delivery System Reform Incentive Payment
I/DD..... Intellectual and Developmental Disabilities
FQHC ..... Federally Qualified Health Center
HCP-LAN..... Health Care Payment Learning and Action Network
HEDIS..... Healthcare Effectiveness Data and Information Set
HIV..... Human Immunodeficiency Virus
LME/MCO..... Local Management Entity/Managed Care Organization
LTSS ..... Long-term Services and Supports
MAT..... Medication Assisted Treatment
NCQA..... National Committee for Quality Assurance
PCCM..... Primary Care Case Management
PCMH ..... Patient Centered Medical Home
PHP ..... Prepaid Health Plan
PLE ..... Provider-led Entity
PMPM ..... Per Member Per Month
PQRS..... Physician Quality Reporting System
SMI ..... Serious Mental Illness
SNP ..... Special Needs Plan

A.3. Draft Section 1115 Demonstration Waiver Application Public Input Summary

The public comment topics and themes outlined in each table are listed below:

1. Rationale for the 1115 and the Quadruple Aim
2. Prepaid Health Plans (PHPs)
3. Person-Centered Health Communities (PCHCs)
4. Integrating Behavioral and Physical Health
5. Long-term Services and Supports
6. Rural Health and Community-Based Residency and Health Workforce Training
7. Provider Administrative Ease
8. Provider Practice Supports, HIE, and Informatics
9. Child Welfare Initiatives
10. Payments and Budget Neutrality
11. Eligibility and Enrollment
12. Pharmacy
13. Other Benefits
14. Additional Comments

    Innovations Center (renamed the North Carolina Health Transformation Center)

    Demonstration Hypotheses and Evaluation Plan

    Implementation Timeline

    Procurement

    Proposed Waivers and Expenditure Authorities

    Essential Providers

    Stakeholder Engagement

    Other

1. Rationale for the 1115 and the Quadruple Aim

	Summary of Comments	Response
1. Reason for system change	Several commenters asked why DHHS is changing the current system.	DHHS revised the demonstration application to better describe the rationale for the demonstration.
2. Support for the current system	Many commenters expressed support for the current system and concern about changing it.	DHHS recognizes the strengths of the current system, and plans to build on these strengths in the new system while also addressing some of the limitations of the current system.
3. Concern about capitated managed care	Many commenters expressed concern about capitated managed care, including the possibility of reduced access and lower quality of care.	DHHS acknowledges these concerns and will consider ways to prevent these outcomes in the development, implementation, and operation of the program.
4. Quadruple Aim	A few commenters expressed general support of the Quadruple Aim. A couple of commenters raised skepticism about the ability to maintain, much less improve, provider engagement and support.	DHHS acknowledges these comments and appreciates support for the Quadruple Aim. DHHS will focus on provider engagement and support in the development, implementation, and operation of the program.

2. Prepaid Health Plans (PHPs)

	Summary of Comments	Response
1. Network adequacy standards	Several commenters requested more detail on network adequacy standards.	DHHS revised the demonstration application to include more detail on network adequacy standards, including reference to the final Medicaid managed care rule. DHHS will include additional detail on network adequacy standards in the PHP contract, and will monitor compliance with those standards on an ongoing basis.
2. Regions and access to specialists	Many commenters expressed concern about how specialist referrals will work within the regional structure.	PHPs will be required to develop networks that meet the needs of their enrollees, which, for regional PHPs, is likely to include contracting with providers outside of the applicable region. DHHS will include detailed network adequacy standards, including those required by the final Medicaid managed care rule, in the PHP contract, and will monitor compliance with those standards on an ongoing basis.
3. Out-of-network providers	Many commenters expressed concern about access to out-of-network providers.	Per federal Medicaid regulations, if a PHP is not able to provide necessary services to a particular enrollee, the PHP must adequately and timely cover these services out of network for the enrollee, for as long as the PHP is unable to provide them. DHHS intends to include requirements regarding out-of-area and out-of-network providers in the PHP contract.
4. Intent to contract with three statewide PHPs	One commenter asked DHHS to confirm that it intends to contract with three statewide PHPs.	DHHS revised the demonstration application to clarify its intent to contract with three statewide PHPs.
5. Support for provider-led entities (PLEs)	Several commenters expressed support for including PLEs, though one commenter expressed concern about PLEs.	DHHS acknowledges these comments and appreciates the support for PLEs.
6. PLE governing body	A couple of commenters requested that DHHS retain the requirement that a majority of a PLE's governing body be composed of physicians. One commenter suggested changes to this requirement.	This requirement is in Section 4(2)(b) of SL 2015-245, and DHHS does not anticipate requesting a change to this requirement.
7. One statewide PLE	A couple of commenters requested that there be at least one statewide PLE. Another commenter requested that DHHS confirm that it will only award statewide contracts to commercial plans (CPs).	DHHS does not interpret Section 4(6)(b) of SL 2015-245 as prohibiting DHHS from contracting with a PLE as a statewide plan. Therefore, DHHS could award a statewide contract to a PLE.

2. Prepaid Health Plans (PHPs)

	Summary of Comments	Response
8. Number of PHPs	Many commenters expressed concern about the number of PHPs, and one commenter suggested that DHHS limit the number of PHPs in a region to three.	DHHS recognizes these concerns and will consider ways to address these concerns in the development, implementation, and operation of the program. Section 4(6) of SL 2015-245 requires DHHS to have three statewide contracts and up to 10 regional contracts, and DHHS supports having a choice of models in each region.
9. Specialty pediatric PHP	A couple of commenters recommended DHHS establish a statewide, pediatric-specific PHP so that the unique needs of pediatric patients can be accommodated efficiently.	DHHS acknowledges this comment. However, given the number of beneficiaries who are children, all PHPs must be qualified to serve this population. Also, if a large percentage of children enrolled in a specialty PHP, the other PHPs would not be financially viable. DHHS did modify the demonstration application to clarify that DHHS will focus on pediatric requirements for PHPs, including pediatric network adequacy requirements and quality measures.
10. Provider education prior to implementation	A couple of commenters recommended that DHHS learn from the experience from other states and provide appropriate education to providers before the implementation of PHPs.	DHHS agrees and intends to provide appropriate education to all stakeholders, including providers and beneficiaries, prior to the implementation of PHPs.
11. PLEs as Managed Care Organizations (MCOs)	One commenter asked whether PLEs would be MCOs, as defined in 42 CFR 438.2.	The application has been revised to more clearly state that PHPs, whether PLEs or CPs, will be MCOs, as defined in 42 CFR 438.2.
12. Same requirements for PLEs and CPs	A couple of commenters asked whether the requirements for PLEs will be the same as for CPs.	DHHS intends to have one standard contract for PHPs, with the same requirements for both PLEs and CPs.
13. Medicaid requirements	One commenter expressed concern that the draft demonstration application did not reference applicable federal Medicaid requirements.	Unless DHHS has requested authority to not comply with a Medicaid requirement (see Section 9 of the demonstration application), all Medicaid requirements will apply to this program.
14. Grievances and Appeals	A couple of commenters expressed concern that the draft demonstration application did not discuss grievance and appeals.	While the demonstration application does not describe the grievance and appeals process, it includes an assurance that PHP contracts will comply with all requirements in 42 CFR Part 438, which includes requirements for grievance and appeals.

2. Prepaid Health Plans (PHPs)

	Summary of Comments	Response
15. Consumer protections	A few commenters recommended that the demonstration application include language about consumer protections.	DHHS acknowledges this comment and notes that while the demonstration application does not include language about consumer protections, DHHS intends to incorporate consumer protections, including all federal and state requirements, into regulation and/or the PHP contract, and will monitor the PHPs for compliance with those requirements.
16. Profit motive	Several commenters expressed concern about the profit motive of PHPs, particularly the financial incentive for PHPs to limit access to care.	DHHS acknowledges this concern and will have safeguards, including a medical loss ratio (MLR), robust contract requirements, and monitoring mechanisms, to protect against excessive profit and inappropriate limitations on care. DHHS also believes that PHPs will have an incentive to develop innovative ways to provide services to enrollees in a more cost-effective manner while ensuring access and quality.

3. Person-Centered Health Communities (PCHCs)

	Summary of Comments	Response
1. Building on medical homes	Several commenters expressed support for building on what is currently working with medical homes.	DHHS appreciates the support and revised the demonstration application to clarify that ePCCM and PCMH models are the foundation of PCHCs.
2. Pregnancy medical home	Several commenters expressed support for preserving and strengthening the pregnancy medical home program as part of Medicaid reform.	DHHS appreciates the support and intends to preserve and strengthen the pregnancy medical home program, specifically through the advanced pregnancy programs in PCHCs.
3. PCHC details	Several commenters requested additional detail about PCHCs, including functions and activities, how they will be organized and structured, and how they will meet the needs of various communities and populations. Individual commenters also recommended that PCHCs include certain features and services.	It is not DHHS' intent to have a "one size fits all" approach to PCHCs. However, DHHS revised the demonstration application to include additional detail regarding PCHCs. As part of program development, DHHS will continue to work with stakeholders to further define PCHCs.
4. Role of PHPs	A couple of commenters asked about the role of PHPs with respect to PCHCs, and a couple of other commenters expressed concern about requiring PHPs to delegate functions such as care coordination to a PCHC.	Details regarding the role of the PHP and what functions will be provided by the PHP versus the PCHC will be addressed during development of the program.
5. Comprehensive Primary Care Plus Initiative	One commenter requested that DHHS implement a Comprehensive Primary Care Plus (CPC+) initiative in North Carolina.	DHHS appreciates this comment and intends to evaluate the possibility of implementing CPC+ in North Carolina. The PCHC model may be aligned with CPC+, but it will be a North Carolina-specific model.

4. Integrating Behavioral and Physical Health

	Summary of Comments	Response
1. State law and integration	Two commenters noted that language in the draft demonstration application incorrectly stated that SL 2015-245 requires integration of behavioral health services within a single capitated system after the four-year carve out of LME/MCO services.	DHHS revised the demonstration application to remove the incorrect statement.
2. Coordination between PHPs and LME/MCOs	Several commenters noted the importance of clarifying the responsibilities of PHPs and LME/MCOs, and ensuring coordination between PHPs and LME/MCOs.	DHHS agrees that clarifying responsibility and ensuring coordination between the PHPs and LME/MCOs is critical. DHHS will work with stakeholders to develop the contract requirements for PHPs and LME-MCOs and establish a process to monitor compliance with those requirements.
3. Fee-for-service payments for integrated services by Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)	Two commenters recommended the demonstration application clarify that integrated behavioral health/primary health services provided by FQHCs/RHCs will continue to be paid by the State outside of the PHP and LME/MCO contracts.	Integrated behavioral health/primary care services by FQHCs/RHCs will continue to be reimbursed by Medicaid, but the specific payment mechanism will be determined as part of program development. Therefore, DHHS did not revise the demonstration application.
4. Intellectual/ Developmental Disability (I/DD) health home	Two commenters asked for additional detail about the proposed I/DD health home.	DHHS revised the application to remove the term I/DD health home. However, DHHS intends to support I/DD providers to enhance their ability to provide primary care for individuals with I/DD and to increase the capacity of primary care providers to provide care to individuals with I/DD. DHHS will work with stakeholders to develop the requirements for these conceptual I/DD health homes as part of program development.

4. Integrating Behavioral and Physical Health

	Summary of Comments	Response
5. Behavioral health supports and models of care	Several commenters suggested including specific behavioral health supports or models of care in the demonstration, including: • Co-location of behavioral health and primary care • Collaborative care models • Case management expertise • Tools such as telemedicine and tele psychiatry • Medical homes, intense case management, and clinical pharmacy care • Social supports and safety nets for individuals with SPMI • Incorporating principles of recovery-based care	DHHS appreciates these suggestions. Some of these are part of the current LME/MCO system, some are included in the demonstration application, and DHHS will consider including the others as part of program development.
6. Long-term plan for physical and behavioral integration	Several commenters asked what happens after the four years during which the LME/MCOs continue to manage behavioral health services. Some suggested that behavioral health services be carved in; some recommended that the PHP carve-out continue; and a couple of commenters recommended the development of a specialty plan to provide integrated services to individuals with behavioral health needs.	SL 2015-245 does not specify whether or how physical and behavioral health will be integrated after the four years that LME/MCOs continue to manage behavioral health services. The decision on whether or how physical health and behavioral health services will be integrated after the four years will be determined by the North Carolina General Assembly and the Governor with input from key stakeholders.

5. Long-Term Services and Supports (LTSS)

	Summary of Comments	Response
1. Inclusion of LTSS in the new system	A couple commenters expressed confusion about which LTSS will be included in the demonstration, and how these services will be administered.	All LTSS, other than PACE and services provided by LME/MCOs, will be provided by PHPs to their enrollees. Dually eligible beneficiaries – beneficiaries who also are eligible for Medicare – will not be included. LTSS provided by PHPs will include both state plan services (such as nursing facility services, personal care, private duty nursing, and home health) and services included in the CAP/C and CAP/DA 1915(c) waivers. Unlike some other states with managed LTSS, DHHS will operate 1915(c) waivers concurrently with the 1115 demonstration, so coverage for these services will continue to be authorized through the 1915(c) waiver, not the demonstration. The demonstration will provide authority for the 1915(c) services to be delivered through the PHPs. DHHS revised the application to clarify that the demonstration changes the delivery system for state plan and 1915(c) LTSS, not the coverage of those services.
2. Additional LTSS services	A couple of commenters suggested adding a specific home and community-based service (structured family caregiving) to the demonstration.	DHHS appreciates the suggestion and may consider covering this service in the future.
3. LTSS network development	One commenter suggested that DHHS provide data on providers currently serving the potential LTSS member population so that prospective PHPs can identify care patterns and target providers for contracting.	DHHS thanks the commenter and will consider providing this information as part of the PHP procurement.
4. Outcomes	A couple commenters noted that a stakeholder group reached consensus about five outcomes that are important to individuals and families from all disability groups for a managed care system: (1) more independent; (2) no waiting lists; (3) jobs in integrated employment settings; (4) individuals live inclusively in their communities, where people with disabilities have the ability to develop assets; and (5) system is accountable for meaningful outcomes.	DHHS appreciates the comments and supports these outcomes for individuals with all types of disabilities.

5. Long-Term Services and Supports (LTSS)

	Summary of Comments	Response
5. Financial management services (FMS)	A commenter encouraged DHHS to procure a single FMS administrator with which each PHP must contract.	DHHS will consider this suggestion in the development of the PHP requirements.

6. Rural Health and Community-Based Residency and Health Workforce Training

	Summary of Comments	Response
1. Rural access	A few commenters expressed the need to increase access and expand services to beneficiaries residing in rural areas.	DHHS agrees and reiterates that one of the key goals of the demonstration is to expand the availability and accessibility of services to beneficiaries residing in rural areas. Specifically, this will be facilitated by value-based payments, PCHCs, expanded telemedicine/telepsychiatry, community-based residency and health workforce training, and DSRIP projects.
2. Telemedicine	Several commenters recommended expanding telemedicine, though a couple of commenters cautioned that telehealth should not be a substitute for the doctor/patient relationship.	DHHS supports the appropriate use of telemedicine and anticipates that the demonstration, particularly through value-based payments, will allow and encourage expanded use of telemedicine.
3. Community-based residency and health workforce training	A few commenters expressed support for the initiatives around community-based residency and workforce training included in the draft demonstration application. A couple of other commenters suggested additional ways to increase the workforce.	DHHS thanks the commenters for their support and input and will consider the suggestions as part of program development.

7. Provider Administrative Ease

	Summary of Comments	Response
1. Multiple PHPs	A large number of commenters expressed concern about the administrative burden of moving from a single payer to multiple PHPs and the potential impact on providers and beneficiaries.	DHHS understands these concerns and will work with stakeholders to minimize the administrative burden. This will include working with stakeholders to maximize standardization, centralize functions where feasible, and reduce unnecessary requirements (also see responses to comments below).
2. Standardization	A number of commenters recommended standardization of policies and procedures, forms, coverage requirements, prior authorization, billing, credentialing, quality measures, reimbursement, provider contracts, reporting, and/or monitoring.	DHHS understands the potential burden on providers of having to comply with multiple different sets of requirements. DHHS proposes to organize a collaborative effort among providers and PHPs to create and embed standardization to the greatest extent possible.
3. Centralization	Several commenters suggested that certain functions, such as credentialing, billing, prior authorization, quality, care management, shared savings, and informatics, be centralized.	DHHS has proposed that certain credentialing functions be conducted by DHHS. DHHS will work with stakeholders to determine the feasibility of centralizing other functions.
4. Ombudsman for PHP/provider disputes	Several commenters requested that DHHS establish a state-operated ombudsman to settle disputes between providers and PHPs.	DHHS will consider this request as part of program development.

8. Provider Practice Supports, HIE and Statewide Informatics Layer

	Summary of Comments	Response
1. Preserve and enhance current provider supports	Several commenters requested that DHHS preserve and enhance current provider supports, both direct (per member per month payments) and indirect (care management, quality initiatives, and informatics).	DHHS agrees with the commenters and intends to preserve and enhance provider supports as part of the demonstration.
2. Additional detail on how supports will be provided	A few commenters requested additional detail about how provider supports will be provided, including who will be providing them (e.g., PHP, State, or other entity) and who will be paying for them (e.g., PHP, State, or provider).	DHHS plans to identify additional detail on how provider supports will be delivered as part of program development, which will reflect additional input from stakeholders.
3. Health Information Exchange (HIE)	Many commenters expressed support for the State's health information exchange (HIE). However, several of these same commenters expressed concern about participation rates, cost, data blocking, timeliness, and privacy.	DHHS appreciates the support and input and will work to address these concerns as part of program development.
4. Statewide informatics layer	Several commenters expressed general support for collecting quality measures and having centralized, robust, real-time informatics, at low or no cost to providers.	DHHS appreciates the support and is committed to working with stakeholders to develop the specifications for the statewide informatics layer.
5. Quality of care information for beneficiaries	One commenter asked if beneficiaries will have access to quality of care information for PHPs and providers and, if so, how the information will be made available.	DHHS intends to provide the public with information on the performance of PHPs. This will include, at a minimum, adopting a managed care quality rating system as required by the final Medicaid managed care rule. At this time, DHHS does not anticipate providing beneficiaries or the public with quality of care information for individual providers. However, PHPs may provide this information as part of their provider directory.
6. Role of Community Care of North Carolina (CCNC)	Many commenters asked about the role of CCNC in the new system.	As required by Section 7 of SL 2015-245, DHHS is working with CCNC to develop a transition plan.

9. Child Welfare Initiatives

	Summary of Comments	Response
1. Three child welfare care initiatives	A few commenters expressed support for all three of the child welfare initiatives.	DHHS appreciates the commenters' support of these initiatives.
2. Single statewide PHP for foster care children	A couple of commenters asked for additional detail about the proposal to designate a single statewide PHP for children in foster care, including whether the procurement for this plan would be conducted as part of the PHP procurement. One commenter suggested that all statewide PHPs serve foster care children, and other commenters suggested that LME-MCOs manage specialized care for foster care children.	DHHS is not proposing any changes to its proposal to designate a single statewide PHP for foster care children while not restricting choice of other PHPs. Additional details will be defined as part of program development. DHHS intends to procure this plan as part of the PHP procurement (not a separate procurement).
3. Coverage of parents of kids in foster care	Several commenters expressed support of extending coverage to parents whose children are placed in foster care. One commenter was not supportive.	DHHS appreciates this input.

10. Payments and Budget Neutrality

	Summary of Comments	Response
1. Capitation rates	Several commenters asked for additional detail or made suggestions about the capitation rates, including risk adjustment, blended LTSS rates, inclusion of provider incentives, individual stop loss, and risk sharing.	Additional detail regarding capitation rates will be defined during program development, and DHHS will consider commenters' suggestions and additional stakeholder input as part of rate development.
2. PHP performance-based payment	One commenter supported and applauded DHHS' plan to vary payments to PHPs according to the PHP's performance on quality measures.	DHHS appreciates the support and believes that this will be an important tool for incentivizing PHP performance.
3. Support for value based payment (VBP)	Several commenters expressed support for VBP and incentive payments, while a couple of commenters expressed concern about being accountable for outcomes that were outside the provider's control.	DHHS appreciates this input and will consider these concerns as DHHS works with stakeholders to develop VBP and incentive payment methodologies.
4. VBP design	Several commenters requested additional detail and/or provided suggestions regarding the design of VBP. For example, the commenters offered the following suggestions: VBP should be specialty-specific; VBP should not apply to certain providers; VBP should "meet providers where they are;" VBP should include a limited number of measures; VBP should be the same across PHPs; PHPs should have flexibility to design their own VBP approaches; VBPs should include social determinants of health; and VBPs should be piloted or phased in.	Additional detail regarding VBP will be defined during program development. DHHS will consider commenters' suggestions and additional stakeholder input during development of the VBP requirements. DHHS will include requirements regarding VBP in the PHP contract.
5. Flexible funding	A few commenters recommended that DHHS ensure that payments to practices include funding flexibility to enable practices to provide services that are not otherwise Medicaid reimbursable such as phone nurse consults and Reach Out and Read.	DHHS supports reimbursement methodologies that allow for the flexibility to provide these types of supports, and expects that VBP will provide this type of flexibility. In addition, DHHS will encourage PHPs to provide cost-effective alternative services that may decrease costs and improve outcomes.
6. Clarifying FQHC/RHC "wrap around" payment language	One commenter noted that the draft demonstration application states that DHHS will continue the current FQHC/RHC wraparound payments; however, under the current fee-for-service system FQHCs and RHCs do not receive a wraparound payment. Rather, they receive the prospective payment system (PPS) rate or alternate payment methodology (APM).	DHHS revised the demonstration application to clarify that "wrap around" payments will be part of the future capitated PHP system, when DHHS will pay an FQHC/RHC the difference between the FQHC/RHC contracted rate with the PHP and the FQHC/RHC PPS/APM rate.

10. Payments and Budget Neutrality

	Summary of Comments	Response
7. Automated payment of FQHC/RHC "wrap around" payment	Two commenters recommended that DHHS familiarize itself with Kentucky's automated Medicaid reconciliation process for FQHC/RHC PPS/APM reimbursement.	DHHS will consider this option as part of program development.
8. Out-of-network FQHCs/RHCs	Two commenters requested the following: if DHHS establishes rate ceilings that apply when non-participating essential providers deliver services to PHP enrollees after declining a good faith offer, DHHS should exempt FQHCs/RHCs with established PPS/APM rates from the rate ceiling and ensure they are reimbursed directly by the State at their PPS/APM rate.	DHHS will consider this comment as it works with stakeholders to further develop the requirements for contracting with essential providers. DHHS intends to include requirements regarding out-of-network providers in the PHP contract.
9. Cost settlement for EMS agencies	Many commenters requested that DHHS continue to provide cost settlement payments to municipal EMS agencies for the provision of ambulance services to Medicaid beneficiaries.	DHHS has revised the demonstration application to request authority for DHHS to provide "wrap around" payments to EMS agencies to preserve cost-settlements.
10. Cost settlement for free and charitable clinics	One commenter requested that free and charitable clinics that serve Medicaid receive a "wrap around" payment to cost.	DHHS is considering this request but did not amend the demonstration application to include these clinics as receiving "wrap around" payments.
11. Cost-based reimbursement for other providers	A couple of commenters requested that reimbursement for all or certain providers (e.g., personal care) be based on cost.	PHPs will determine the reimbursement rates for covered services, and DHHS will only provide "wrap around" payments to cost for FQHCs/RHCs (as required by federal law) and a limited number of other safety-net providers.
12. Preserving supplemental payments	A few commenters supported the preservation of supplemental payment funding.	DHHS thanks the commenters for their feedback.
13. Supplemental payments	A couple of commenters requested more information on how supplemental payments would be made under the demonstration.	DHHS revised the demonstration application to include more information on its Care Transformation through Payment Alignment proposal, and additional detail will be developed, with stakeholder input, as part of DHHS' negotiations with CMS.
14. DSRIP	A few commenters offered suggestions on DSRIP, specifically that DHHS should: include stakeholders in the design; include a broad spectrum of providers; invest DSRIP funding in infrastructure; align measures with the program's defined quality goals; and develop a reasonable implementation schedule.	DHHS revised the demonstration application to include a sample list of DSRIP projects, but additional details will be developed with stakeholder input as part of DHHS' negotiations with CMS.

10. Payments and Budget Neutrality

	Summary of Comments	Response
15. Impact on other funding streams	A couple of commenters asked whether all Medicaid funding would be included in the PHP capitation rates and how that would impact other programs that address social determinants of health, such as public health. The same commenters recommended that the demonstration application identify programs that will lose funding and the potential impact on services for North Carolina children and others. Another commenter recommended that DHHS explore innovative and flexible options to pay for non-medical services outside of PHPs' capitated rates, in order to ensure that appropriate and adequate revenue streams are available to support the Medicaid population's needs.	DHHS appreciates this input and reiterates that one of the key goals of the Care Transformation through Payment Alignment proposal is to ensure that funding continues to be available for programs that support Medicaid beneficiaries.
16. Missing graphic	Two commenters noted that the draft demonstration application (p. 34) referenced a graphic that is not included.	DHHS revised the demonstration application to delete this reference.
17. Physician rate floor	Many commenters expressed support for establishing Medicare reimbursement rates as the rate floor for primary care and specialty physicians.	Section 5(5)(b) of SL 2015-245 requires DHHS to establish "appropriate rate floors" for network primary care physicians and specialist physicians. As noted in its March 1 report to the JLOC on Medicaid and NC Health Choice, DHHS expects to establish these rate floors as a percentage of the effective Medicaid fee schedule.
18. Hospice rate floor	One commenter recommended that DHHS establish a rate floor for hospice services consistent with rates set by CMS.	At this time, DHHS does not anticipate establishing rate floors for providers other than those currently itemized in SL 2015-245.
19. Reimbursement of Clinical Laboratory Improvement Amendments (CLIA) certified labs	One commenter requested that DHHS require PHPs to negotiate fair and acceptable reimbursements for CLIA certified labs.	DHHS understands the concern, but PHPs will be responsible for establishing reimbursement rates for covered services.
20. Reimbursement rates	Many commenters expressed concern about the current Medicaid provider reimbursement rates and requested that these rates be increased.	DHHS understands this concern but notes that current provider rates are outside the scope of the demonstration application. The PHP capitation rates will be based on current expenditures, but PHPs will have some flexibility to adjust provider rates and will be expected to develop VBP methodologies within their capitation payments.

10. Payments and Budget Neutrality

	Summary of Comments	Response
21. PHP rates 2% below national spending growth	Two commenters asked about the requirement in Section 5(6) of SL 2015-245 that the PHP contract include that risk-adjusted cost growth for "enrollees must be at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for non - expansion states." One commenter recommended that DHHS clearly outline the actual formula to achieve this savings in the demonstration application. The commenter also suggested that national Medicaid spending growth be based on the increase in spending on a per beneficiary basis and that the measurement occur retrospectively using actual, not projected, growth in spending. Further, the commenter requested that statute be modified as required to reflect the demonstration. Another commenter noted that this provision, as written, could cause significant problems for the long-term viability of the Medicaid program.	DHHS appreciates the input. The respective components of the calculation will be defined with additional input with stakeholders.
22. Budget neutrality	Two commenters asked about the enrollment and expenditures chart on page 58 of the draft demonstration application. The commenters calculated the cost per member for the historical five-year total and the five-year total for the demonstration period and noted that the five-year total cost per member for the demonstration period was higher than the historical five-year total cost per member.	The five-year total cost per member for the demonstration period was higher than the historical five-year total cost per member due to projected enrollment growth and expenditure cost trend. Note that the final demonstration application includes the completed budget neutrality forms, and DHHS projects savings as a result of the demonstration.

11. Eligibility and Enrollment

	Summary of Comments	Response
1. Medicaid expansion	Many commenters requested that the State expand Medicaid under the Affordable Care Act.	DHHS appreciates these comments. The decision to expand Medicaid in North Carolina is outside of the demonstration proposal. SL 2013-5 does not give DHHS authority to expand Medicaid.
2. North Carolina Health Insurance Premium Payment program (NC HIPP)	Many commenters expressed concern that DHHS is proposing to discontinue the NC HIPP.	DHHS apologizes for the misunderstanding and has revised the demonstration application to clarify that NC HIPP will continue as it is currently administered under fee-for-service and that beneficiaries enrolled in NC HIPP will be excluded from PHP enrollment.
3. Individuals dually eligible for Medicaid and Medicare ("dual eligibles")	A couple of commenters requested clarification on whether dual eligibles will be part of the demonstration. A couple of other commenters stated that carving out dual eligibles was a mistake and encouraged DHHS to accelerate the inclusion of this population in the demonstration.	As specified in SL 2015-245, dual eligibles will not be part of the demonstration at this time. DHHS defers to the Dual Eligibles Advisory Committee, which will develop a strategy to cover dual eligibles through capitated PHP contracts.
4. Children	Several commenters proposed that children be left out of the demonstration and remain in fee-for-service Medicaid.	SL 2015-245 requires inclusion of children other than dual eligibles.
5. Retroactive coverage	One commenter asked how providers will be paid for retroactive eligibility situations, when a beneficiary has received services and later it is determined he/she qualified for Medicaid.	DHHS intends to pay claims incurred during a retroactive coverage period on a fee-for-service basis.
6. Unify enrollment in Medicaid and PHPs	Several commenters recommended that DHHS unify Medicaid eligibility and PHP enrollment, and some of these commenters suggested that this could be done by local departments of social services (DSS) or FQHCs.	DHHS recognizes the potential benefits of having a unified Medicaid eligibility and PHP enrollment process. However, since capitated managed care will be new to North Carolina beneficiaries and other stakeholders, DHHS plans to keep these processes separate for at least the first year or two of the new program. DHHS notes that given the "independence" requirement for enrollment brokers, providers, such as FQHCs, could not perform choice counseling or enrollment activities.

7. Information for beneficiaries	One commenter noted that beneficiaries must have the information they need to make an informed decision about enrollment, including information about formularies, providers, and plan performance.	DHHS agrees and intends, through the enrollment broker, to provide information and support to beneficiaries to help them make an informed choice of PHP.

11. Eligibility and Enrollment

	Summary of Comments	Response
8. Enrollment broker	One commenter expressed concerns with the plan to use an enrollment broker, particularly the potential for poor matches between beneficiaries and PCPs/PHPs.	DHHS appreciates the commenter's concerns but has determined that the advantages of having an enrollment broker outweigh the potential disadvantages. DHHS will seek to address the commenter's concerns through requirements in the enrollment broker contract.
9. Enrollment broker activities	One commenter stated that it is ineffective to use enrollment brokers to assist in the selection of a PCP because many PCPs will be participating in a number of PHPs.	While DHHS understands the comment, given the importance of the PCP-patient relationship, DHHS intends to use every opportunity to help beneficiaries select an appropriate PCP.
10. Enrollment broker and the Program of All-Inclusive Care for the Elderly (PACE)	One commenter recommended that DHHS ensure that the enrollment broker is fully informed about PACE and actively refer potentially eligible beneficiaries to PACE.	DHHS will consider including requirements regarding PACE information and referral in the enrollment broker contract.
11. Current PCP as factor in the auto-assignment algorithm	Several commenters noted that consideration of a patient's current PCP is crucial in any auto-assignment.	DHHS agrees and, as noted in the demonstration application, will consider continuity of care in the auto-assignment process.
12. PCPs should include nurse practitioners and physician assistants	A few commenters requested that DHHS broaden primary care assignment to include nurse practitioners and physician assistants.	DHHS intends to continue the current practice, which allows beneficiaries to be assigned to nurse practitioners or physician assistants.
13. Assignment to FQHCs	One commenter requested that beneficiaries be assigned to the FQHC organization, rather than to a specific provider.	DHHS understands and intends to continue the current practice of assigning beneficiaries to the FQHC organization, rather than to a specific provider within the FQHC.
14. Protecting providers against adverse risk	Two commenters encouraged DHHS to present mechanisms to protect network providers from having a disproportionate number of high-risk patients attributed to them by a PHP.	DHHS understands the concern and will address this as part of program development, which will include input from stakeholders.
15. Assignment of LTSS members	One commenter suggested that DHHS design an LTSS auto-assignment algorithm to ensure that each of the selected PHPs will serve a balanced mix of LTSS members in both institutional and community settings.	DHHS understands the need to balance enrollment of LTSS members and will consider including this in the auto-assignment algorithm.

11. Eligibility and Enrollment

	Summary of Comments	Response
16. Assignment of new beneficiaries	A couple of commenters asked how new beneficiaries will be assigned to a PHP if DHHS does not have claims data.	DHHS will develop details on beneficiary assignment as part of program development, but the general approach is as follows: 1) If a new Medicaid beneficiary selects a PCP but not a PHP, he/she will be assigned to a PHP that includes the PCP and serves the beneficiary's region consistent with DHHS's program goals (e.g., balanced enrollment among PHPs the first year) or PHP performance (if implemented). If a beneficiary is new to Medicaid and does not select a PCP or PHP, he/she will be assigned to a PHP in his/her region consistent with DHHS's program goals (e.g., balanced enrollment the first year) or PHP performance (if implemented); or 2) If DHHS does not have a program goal and has not incorporated PHP performance into the auto-assignment algorithm, new beneficiaries who did not select a PCP would be assigned to a PHP serving their region on a random basis.
17. Assignment based on PHP performance	A couple of commenters encourage DHHS to develop an auto-assignment process that rewards quality performance.	DHHS agrees that high-quality PHPs should be rewarded for high performance, and, as noted in the demonstration application, intends to review the assignment process after the first year to determine whether the assignment process should consider PHP quality performance.
18. Choice period before auto-assignment	One commenter recommended that beneficiaries have 90 days to enroll in a PHP before being auto-assigned.	DHHS appreciates the comment and will determine the choice period as part of program development, which will include additional stakeholder input.
19. Enrollment lock-in	A couple of commenters asked whether DHHS will limit disenrollment/require enrollment lock-in.	DHHS intends to limit disenrollment/require lock-in for all mandatory enrollees in order to maximize continuous enrollment, consistent with federal Medicaid managed care regulations. The details will be identified as part of program development, which will reflect additional stakeholder input.

12. Pharmacy

	Summary of Comments	Response
1. Pharmacy carve-in	One commenter asked whether pharmacy will be separate from medical benefits or carved into the PHPs.	The pharmacy benefit will be provided by the PHPs, but a PHP may subcontract with a pharmacy benefit manager (PBM) to manage the pharmacy benefit.
2. Responsibility for behavioral health drugs	One commenter requested that DHHS require PHPs to accept full risk for all pharmacy costs and administer the pharmacy benefit for both physical and behavioral health drugs.	In accordance with DHHS' interpretation of SL 2015-245, PHPs will be responsible for both physical and behavioral health drugs.
3. Prompt pay	One commenter noted that extending the time to receive payment will create cash flow issues for some pharmacies, since pharmacies generally must pay wholesalers within 14 days.	DHHS will consider specifying a shorter timeframe for payment of pharmacy claims in the PHP contract and/or program regulations.
4. Standard formulary/ Preferred Drug List (PDL)	One commenter asked whether PHPs will be able have their own formulary or if it will be mandated by DHHS. Another commenter stated that DHHS should maintain its fee-for-service formulary and designate it as the required, uniform formulary for all PHPs. Two other commenters urged DHHS to allow PHPs to develop their own PDLs.	As specified in Section 5(6)(b) of SL 2015-245, PHPs will be required to use the same drug formulary, which shall be established by DHHS.
5. Development of a standard PDL	One commenter recommended that DHHS include PHPs with multi-region or statewide coverage and practicing providers in the committee developing a statewide formulary. The commenter also requested that DHHS limit committee participation of entities whose incentives are misaligned with containing the rate of growth in prescription drug spending. Another commenter raised concern with the required use of the State's PDL and requested clarification and transparency on who determines what drugs are included.	DHHS acknowledges these comments and will consider including PHP and provider representatives in the committee that provides clinical recommendations for the State PDL. DHHS intends to require conflict of interest forms for each member of the committee. DHHS makes the final determination on what drugs are included on the State's PDL. Currently, there are three committees that provide clinical review and recommendations on the drug determinations for the PDL. Meetings of the final committee review will continue to be held in a public venue in order to receive comments from the general public.

12. Pharmacy

	Summary of Comments	Response
6. PHP utilization management	A few commenters recommended that the PHP contract specify that PHP prior authorization criteria be no more restrictive than the State's prior authorization criteria. One commenter recommended that DHHS specify that PHP utilization management requirements be no more restrictive than the State's. A couple of other commenters raised concern with the use of utilization management tools, and one commenter requested a "medically necessary" exception process.	DHHS intends to specify in the PHP contract that the PHP's utilization management requirements can be no more restrictive than the State's requirements unless the State has provided prior approval of the PHP's UM requirements.
7. Dispensing fee rate floor amount	One commenter noted that given DHHS' new reimbursement methodology, the dispensing fee rate floor (required by Section 5(5) of SL 2015-255) should be no less than a weighted average of $10.24. Another commenter recommended that DHHS allow PHPs to negotiate appropriate pricing methodologies and dispensing fees for the pharmacy benefit.	DHHS intends to determine the dispensing fee rate floor based on a cost of dispensing survey.
8. Protecting the 340B program	A couple of commenters requested that DHHS protect the 340B program by restricting PHPs from the following: • Prohibiting 340B providers from using 340B drugs for their patients; • Requiring providers to agree to not use 340B drugs for their patients as a condition of network participation; • Paying lower rates for drugs purchased by 340B covered entities than for the same drugs when purchased by other PHP network providers; • Requiring 340B providers to use a method for identifying 340B claims that makes it difficult or impossible for providers and their contract pharmacies to use 340B for PHP members; and • Using billing information from 340B claims to reduce reimbursements for 340B commercial claims.	DHHS will consider including these provisions in the PHP contract. DHHS intends to require PHPs to use the State's methodology for identifying 340B claims.

9. Lock-in program	One commenter requested that DHHS require PHP participation in the Medicaid pharmacy/prescriber lock-in program for high-risk beneficiaries.	DHHS will consider requiring PHPs to have a pharmacy/prescriber lock-in program for high-risk beneficiaries.

12. Pharmacy

	Summary of Comments	Response
10. Medication review	One commenter recommended that every enrollee who meets certain criteria (e.g., number of medications, disease state, age, surgical procedure) have access to a licensed pharmacist for a full medication review.	DHHS thanks the commenter for the suggestion and will consider including medication therapy management (MTM) in the PHP contract.
11. Enhanced pharmacy services	One commenter expressed support for the inclusion of Community Pharmacy Enhanced Services Network (CPESN) in the demonstration and encouraged DHHS to consider recognizing enhanced services provided by pharmacists. Another commenter was pleased to see DHHS' commitment to continue to develop a network of pharmacies that provide enhanced services.	DHHS appreciates the commenters' support and will determine how to include enhanced pharmacy services in the PHP contract.
12. Role of PBMs	Two commenters asked whether PBMs would be bidding on the demonstration.	Pharmacy will be part of the benefit package provided by the PHPs, so DHHS will be contracting with the PHPs for the pharmacy benefit. However, a PHP could contract with a PBM to manage the pharmacy benefit.
13. Access to local pharmacists	One commenter requested that DHHS apply the "pharmacy of choice" provisions in Chapter 58 to Medicaid.	DHHS appreciates the commenter's input and will consider applying the "pharmacy of choice" provisions in Chapter 58 to Medicaid, consistent with the requirements in Section 5(6)(d) of SL 2015-245 regarding objective quality standards.
14. Mail order pharmacy	One commenter requested that PHPs be allowed to utilize mail order pharmacy programs without restriction.	DHHS appreciates the comment and will consider allowing mail order pharmacy programs consistent with pharmacy of choice requirements.

13. Other Benefits

	Summary of Comments	Response
1. Local education agencies (LEA) services	Two commenters asked that DHHS allow LEAs to continue billing for the following school-based services: speech, occupational and physician therapy, and audiology.	As noted in the demonstration application, LEAs are carved out of the PHP benefit package. DHHS will continue to pay LEAs on a fee-for-service basis.
2. Dental carve-out and fluoride varnish treatment	A few commenters raised concerns that the current oral health program, which includes coverage of fluoride varnish treatments by medical providers, will not be covered since it was not addressed in the draft demonstration application.	While this program is not described in the demonstration application, DHHS intends to require PHPs to reimburse medical providers for the application of fluoride varnish for children.
3. School-based health center services	A couple of commenters either assumed or requested that school-based health centers be carved out of PHPs.	DHHS considered the request but will not carve out school-based health centers. As part of the PHP contract DHHS will encourage PHPs to contract with these centers. DHHS also notes that in order to meet network adequacy standards PHPs may need to contract with school-based health centers.
4. Non-emergency medical transportation (NEMT)	One commenter asked how DHHS is handling NEMT in the demonstration.	PHPs will be required to cover NEMT as a service.
5. Preventive services	A couple of commenters requested that DHHS include U.S. Preventive Services Task Force (USPSTF) recommended preventive services as covered benefits. The commenters also noted that if DHHS provides these services without cost-sharing, the State is eligible for a 1% increase in the Federal Medical Assistance Percentage (FMAP) on preventive services.	DHHS thanks the commenters for the recommendations. DHHS is conducting a policy assessment to evaluate its options regarding coverage of the preventive services recommended by the USPSTF.
6. Chiropractic care	One commenter requested that DHHS consider that chiropractors are an underutilized part of treating the Medicaid population.	DHHS thanks the commenter for the suggestion.
7. Services for persons with HIV/AIDS	A few commenters requested that DHHS support services for persons with HIV/AIDS.	DHHS supports services for persons with HIV/AIDS and plans to include requirements specific to persons with HIV/AIDS in the PHP contract.
8. Paramedic services	A few commenters requested that DHHS cover community paramedic programs.	DHHS revised the demonstration application to note that DHHS supports the use of cost-effective alternative services by PHPs and includes community paramedic services as an example. DHHS will consider covering this service under the State plan based on the results of the current pilots.

13. Other Benefits

	Summary of Comments	Response
9. Coverage of other services	A couple of commenters requested that DHHS include services in the demonstration that are not currently covered by NC Medicaid (e.g., home visitation services, alternative therapies).	DHHS appreciates these suggestions. DHHS is not proposing to cover any "new" services as part of the demonstration except those that PHPs may provide as "in lieu of" or "value-added services."
10. Additional carve-outs	A couple of commenters requested that certain services (e.g., personal care, pediatric therapies) be excluded from the PHPs.	DHHS acknowledges the requests but does not intend to request exceptions to SL 2015-245 (which requires PHPs to cover all Medicaid services except LME/MCO and dental services) other than those specified in the 3/1 draft of the demonstration application.
11. Waitlists	Two commenters raised concerns that individuals will be put on a waitlist for physical health services and asked whether PHPs will have the ability to "close" certain services as they do for HCBS waiver services.	PHPs will not be able to "close" any state plan services. However, PHPs will be able to limit or close the CAP 1915(c) waiver services (covered by the PHPs for Medicaid only beneficiaries) since the enrollment limit/registration lists for those waivers will remain intact.

14. Additional Comments

	Summary of Comments	Response
14.1. Innovations Center (renamed the North Carolina Health Transformation Center)	One commenter endorsed the creation of the center as a means for providers and PHPs to achieve the Quadruple Aim and recommended the center as the vehicle through which PHPs collaborate to ease provider administrative burdens through process standardization. A couple of commenters asked which stakeholders (e.g., physicians, beneficiaries, family members advocacy groups) would be engaged in the process and how, and two commenters asked how I/DD will be integrated into the program. Another commenter recommended that the center create common set of pregnancy medical home 2.0 measures and work on connecting physicians and practices with social supports already in place in the community such as faith-based groups, YMCAs, etc.	DHHS appreciates the input. DHHS' legislative report on the North Carolina Health Transformation Center (dated May 1, 2016) provides additional information on the center, including capabilities related to performance measurement and analysis, stakeholder engagement, liaison center, and center of excellence. DHHS will develop additional details regarding the center over the next couple of years.
14.2. Demonstration Hypotheses, Evaluation, and Related Data Sources	One commenter encouraged DHHS to measure and reduce health disparities. Another commenter noted that more detail was needed about how outcomes will be measured and monitored.	DHHS appreciates the input and notes that the final Medicaid managed care rule requires a State's quality strategy to include the State's plan to identify, evaluate, and reduce health disparities. DHHS will develop measures and data sources as part of program development, which will include stakeholder input. DHHS will submit to CMS a more comprehensive evaluation design as required by CMS after approval of the demonstration.
14.3. Implementation Timeline		
1. Allow 90 days from JLOC consultation to PHP RFP release	A couple of commenters requested that the 30-day timeframe from JLOC consultation to the release of the PHP RFP be extended to 90 days.	DHHS did not revise the timeline but intends to include stakeholders throughout the development of the program, including PHP contract requirements.
2. Start RFP development based on draft demonstration application	Two commenters suggested that DHHS begin development of the RFP based on the draft demonstration application.	DHHS thanks the commenters for the suggestion. DHHS has included RFP development in its workplan.

14. Additional Comments

	Summary of Comments	Response
3. Program implementation 18 months from demonstration approval	One commenter expressed strong support for the full 18-months from the demonstration approval to the contract effective date to provide adequate time to successfully launch program.	DHHS agrees and appreciates the support.
14.4. Procurement		
1. Request for application (RFA) instead of an RFP	One commenter suggested procuring PHPs bids through a competitive RFA, which is data-driven and uses yes/no questions and attestations to gather historical actual performance, instead of an RFP.	DHHS thanks the commenter for the suggestion and will discuss this approach with DHHS procurement staff.
2. Lowest cost bidder	One commenter requested that DHHS not choose the PHPs with the lowest bid.	DHHS agrees with the commenter and intends to select the PHPs that provide the best value to the State, considering all factors, not just price.
3. Suggested language for PHP contracts	A few commenters suggested topics and language to include in the PHP contracts (e.g., provider directories, third party liability, program integrity network adequacy standards, readability standards, grievance and appeals).	DHHS thanks the commenters for their input and will consider these suggestions for inclusion in the PHP contract.
14.5. Proposed Waivers and Expenditure Authorities	A couple of commenters requested that DHHS clarify that there is an error on pg. 59 of the draft application, which states that DHHS will "restrict choice," as this conflicts with what is proposed throughout the rest of the application.	While DHHS will encourage and support beneficiary choice of PHPs and providers, this language is requesting authority from CMS for DHHS to require beneficiaries to enroll in PHPs. Thus, DHHS did not change this language.
14.6. Essential Providers		
1. Ryan White providers as essential providers	A few commenters encouraged DHHS to include Ryan White providers as essential providers.	While DHHS values these providers, Section 5(3) of SL 2015-245 prohibits DHHS from classifying physicians and other practitioners as essential providers. However, DHHS intends to include requirements specific to enrollees with HIV/AIDS in the PHP contract, including network requirements that encourage PHPs to contract with Ryan White providers.

14. Additional Comments

	Summary of Comments	Response
2. School-based health centers (SBHCs) as essential providers	One commenter requested that SBHCs be designated as essential providers.	As noted above, Section 5(3) of SL 2015-245 prohibits DHHS from classifying physicians and other practitioners as essential providers. Thus, a SBHC run by an essential provider (e.g., FQHC or local health department) will be designated as an essential provider, but a SBHC run by a physician or other practitioner will not. However, DHHS intends to include requirements in the PHP contract that encourage PHPs to contract with SBHCs, regardless of whether they are designated as an essential provider.
3. Critical access hospitals (CAHS) as essential providers	One commenter recommended that CAHs should be designated as essential providers.	DHHS considered this suggestion but has decided not to designate any hospitals, including CAHs, as essential providers. However, DHHS expects that PHPs will likely need to contract with CAHs in order to meet network adequacy requirements.
4. Psychiatrists as essential providers	A few commenters recommended designating psychiatrists as essential providers.	DHHS considered this recommendation but, as noted above, section 5(13) of SL 2015-245 prohibits DHHS from classifying physicians as essential providers.
5. Good faith negotiations	One commenter recommended that the demonstration application include the requirement from the JLOC report that PHPs make at least a "good faith effort" to contract with essential providers. Another commenter encouraged DHHS to formulate a plan to monitor these negotiations to ensure that essential providers are able to negotiate fair and reasonable contracts with PHPs.	DHHS revised the demonstration application to include the referenced language from the JLOC report. DHHS will consider developing a plan for ensuring that essential providers are able to participate in the PHP networks on fair and reasonable terms.
6. Additional protections for essential providers	A couple of commenters requested that DHHS provide additional protections to essential providers, such as requiring PHPs to give essential providers priority for inclusion in the network and ensuring that essential providers are given preferential assignment for beneficiaries who do not choose a primary care provider (PCP).	DHHS acknowledges these comments and will consider including the suggestions as part of program development.

14. Additional Comments

	Summary of Comments	Response
14.7. Stakeholder Engagement		
1. Stakeholder involvement in development of the demonstration application	A few commenters expressed concern about not being involved in the development of the demonstration application.	As noted in Section 10 of the application, since the passage of SL 2015-245, DHHS has proactively sought input from stakeholders across the State, including physicians, beneficiaries, beneficiary advocates, hospitals, potential PHPs, etc. DHHS looks forward to ongoing stakeholder engagement on the development, implementation, and operation of the program.
2. Public notice and comment period	A couple of commenters thanked DHHS for allowing stakeholders the opportunity to provide feedback on the proposed program. A few other commenters expressed concern that more beneficiaries and self-advocates were not at the public hearings.	DHHS thanks the commenters for their participation in the process. DHHS received comments from almost 100 commenters who identified themselves as beneficiaries, family members, and caregivers. DHHS will continue to engage stakeholders, including beneficiaries and self-advocates, as part of program development, implementation, and operations.
3. Stakeholder engagement in later phases of the demonstration	Several commenters offered to work with DHHS on developing, implementing, and monitoring the new program and suggested various structures for ongoing stakeholder engagement (e.g., a formal advisory committee, focus groups, or a body like the physician advisory group).	DHHS appreciates the input and will consider these suggestions as DHHS creates a robust stakeholder engagement process for providing ongoing input into the development, implementation, operation, and oversight of the new program.
4. Limited English proficiency	One commenter asked whether the presentation from the public hearing will be available in other languages.	Translation of the public hearing slides into Spanish is available upon request.
5. Public record	A couple of commenters requested that DHHS make the record of comments public, along with how these comments were addressed.	A summary of the comments and DHHS' responses are included in this section of the demonstration application. In addition, DHHS will post to its website this summary as well as a summary of comments collected on other Medicaid reform topics (e.g., regions) that are not included in this document.
14.8. Other		
1. Social determinants	A couple of commenters expressed support for addressing social determinants including food insecurity and housing.	DHHS appreciates the comment and agrees that addressing social determinants is key to improving health.

14. Additional Comments

	Summary of Comments	Response
2. Children and Youth with Special Health Care Needs (CYSHCN)	One commenter expressed concern that the definition of CYSHCN was under-inclusive.	DHHS appreciates the comment. DHHS does not intend to limit CYSHCN to the populations listed in the referenced language and has removed that language from the final demonstration application.
3. Veterans	A few commenters expressed concerns about the treatment of veterans, particularly access to mental health services. One commenter noted that veterans were not addressed in the demonstration application. Another commenter encouraged all reforms to consider the mental health needs of our veterans.	DHHS values and supports our veterans, and DHHS will continue to work to improve services to veterans. DHHS notes that while there are not initiatives in the application specific to veterans, DHHS has designated veterans' homes as essential providers. DHHS anticipates that veterans will benefit from the reformed system, particularly from PCHCs and initiatives to integrate physical and behavioral health.
4. Public health	Many commenters raised the valuable role of public health in North Carolina's Medicaid system. Several commenters noted that public health has a strong network of services in all 100 counties and provides quality, low-cost care, with a population health focus.	DHHS appreciates the input and agrees that public health departments have and will continue to have a critical and valuable role in North Carolina's Medicaid system. As written in the demonstration application, DHHS has designated all local health departments as essential providers and has requested authority to provide "wrap around" payments to local health departments.
5. Definition of safety-net provider	A couple of commenters expressed concern about the definition of "safety-net provider" and asked that it be expanded. The commenter noted that the safety-net providers listed in the draft demonstration application do not provide services 24 hours a day, seven days a week.	DHHS thanks the commenter for the input. While the safety-net providers listed in the demonstration application may not be available 24 hours a day, seven day a week, they do provide after-hours coverage.
6. Quality metrics	Several commenters provided suggestions regarding quality measures, including the process for selecting measures, the importance of including selecting measures relevant to the provider type/population, sources of measures, particular measures, and the need to standardize measures across PHPs.	DHHS appreciates the input and will consider these suggestions and part of program development.

14. Additional Comments

	Summary of Comments	Response
Frequency of PCP assignment	A couple of commenters suggested that DHHS limit the frequency of PCP assignments and changes. One commenter who is a physician shared personal experience from another state where PCP assignment occurs monthly, which made it impossible to plan and manage care.	DHHS appreciates the comment and will consider this during the development of the program. DHHS intends to establish a PCP assignment methodology that honors current relationships and fosters the development of long-term PCP-patient relationships.
Medical loss ratio (MLR)	A few commenters expressed support for the 88% MLR in SL 2015-245 or a higher standard. A couple of these commenters requested that DHHS adopt applicable CMS guidelines. Another commenter requested that DHHS consider directing funds from MLR rebates to DSRIP or a provider quality incentive program.	DHHS appreciates this input and is reviewing the language in SL 2015-245 in light of the final Medicaid managed care rule and will consider these suggestions as it develops the MLR requirements.
Chapter 58 protections	Several commenters requested that DHHS ensure that the provider and patient protections in Chapter 58 (NC's insurance statute) are maintained in the demonstration.	When not superseded by federal Medicaid managed care requirements, DHHS intends to incorporate the provider and patient protections in Chapter 58 in the PHP contract, program regulations, and/or NC Medicaid statute.
Conditioning provider participation in commercial network	A few commenters requested that DHHS prohibit PHPs from requiring that providers participate in the PHP's Medicaid network as a condition of participating in the PHP's commercial network.	DHHS acknowledges the concern and will consider whether to include this requirement in the PHP contracts.

14. Additional Comments

	Summary of Comments	Response
Preventing double dipping	A couple of commenters requested that in order to maximize choice and competition, DHHS prohibit "double dipping." This would mean that an entity that is awarded one of the three statewide contracts would not be eligible to also participate in the regional awards either as a PLE or as a significant partner to a PLE. Both commenters strongly recommended that DHHS consider requirements similar to those in the most recent Florida Medicaid managed care procurement. Florida required bidding entities to disclose any business relationships with any other responding health plans and prohibited the Medicaid agency from selecting health plans within the same region if a business relationship existed. One of the commenters also referenced language in Arizona's MCO contract.	DHHS acknowledges the comments and will consider requirements that address this concern.

Appendix B. Public Notices

B.1. 2017 Full and Abbreviated Public Notices

B.2. 2016 Full and Abbreviated Public Notices

B.1. 2017 Public Notices

2017 Full Public Notice

PUBLIC NOTICE

The North Carolina Department of Health and Human Services (DHHS), Division of Health Benefits (DHB) is providing public notice of its submission to the Centers of Medicare and Medicaid Services (CMS) of a written request to amend its Section 1115 Waiver application and to solicit public input to receive comments on the amendments to the Application.

The State submitted a Section 1115 Demonstration Waiver to CMS in June 2016 outlining plans to transition to a Medicaid managed care program. The State now seeks to amend the June 2016 Section 1115 Demonstration Waiver Application to strengthen the design of its managed care program to ensure the State's ability to: 1) measurably improve health, 2) maximize value to ensure the sustainability of the program, and 3) increase access to care.

Programmatic features of the amendments to the application have been refined through multiple rounds of robust stakeholder engagement since the original public comment period and waiver submission in June 2016. In 2017, the State released a "Request for Public Input" and a "Proposed Program Design for Medicaid Managed Care," each of which described the State's approach to managed care and highlighted features to strengthen managed care implementation. The State accepted public comments on each of these documents for at least 30 days after their release. Additionally, the State released a summary of public comments on the Proposed Program Design document on the North Carolina Medicaid Transformation website.(https://files.nc.gov/ncdhhs/documents/files/20171102_Public_Comment_Summary_FINAL.pdf?nQgWfLp4hlGPe0j.yIKET4CLdrBNqFam). A list of additional public notice activities since the submission of the original waiver application is included at the end of this notice.

A summary of the amended application follows. We highlight for stakeholders the financial information related to the amended application, which was still under development at the time the Proposed Program Design was released.

- The purpose of the waiver application is to transition the Medicaid program from predominantly fee-for-serve to managed care in a way that advances high-value care, improves population health, engages and supports providers and establishes a sustainable program with predictable costs. As described in the Proposed Program Design, North Carolina is proposing initiatives to achieve those goals, including designing managed care products tailored for enrollees with high behavioral health needs, strengthening the provider workforce through new initiatives specially designed to address the needs of the Medicaid population, and testing and strengthening public-private initatives in select regions of North Carolina that aim to measurably improve health and lower costs through evidence-based interventions addressing targeted health-related needs.
- Approximately 1.5 million of the current 2 million Medicaid beneficiaries will be mandatorily enrolled in managed care under the proposed demonstration. All members of a federally recognized tribe will be permitted to opt-in to managed care and to disenroll at any time without cause. A subset of beneficiaries will be excluded from managed care and will continue to receive benefits through their current delivery system. There will be no changes to cost-sharing obligations for current enrollees. As described in the Proposed Program Design Document, the State now seeks to establish the "Carolina Cares" program, if proposed State legislation is enacted. "Carolina Cares" would expand access to

Medicaid for certain low-income adults, most of whom would be subject to premium payments and employment activity requirements.

- Estimated Impact on Expenditures and Enrollment
  - The following projections use calendar year 2015, historical aggregate per capita cost trend, and enrollment trend data based on the populations expected to be enrolled in the demonstration.
  - The increase in costs beginning in DY03 includes consideration for the enrollment of additional individuals with I/DD, TBI and/or significant behavioral health needs.
  - Please refer to Section VI of the Section 1115 Demonstration Waiver application amendment for complete details.

	Historical Enrollment and Budgetary Data					
	2011 (01/11 - 12/11)	2012 (01/12 - 12/12)	2013 (01/13 - 12/13)	2014 (01/14 - 12/14)	2015 (01/15 - 12/15)	5 Year Total
Members	1,304,030	1,359,884	1,386,625	1,489,365	1,568,181	7,108,085
Historical Aggregate Expenditures	$ 6,222,934,113	$ 6,612,096,825	$ 6,954,086,394	$ 7,211,615,017	$ 7,594,611,753	$ 34,595,344,101

Excluding Carolina Cares

	Demonstration Years (DY)					
	DY 01 (07/19 - 06/20)	DY 02 (07/20 - 06/21)	DY 03 (07/21 - 06/22)	DY 04 (07/22 - 06/23)	DY 05 (07/23 - 06/24)	5 Year Total
Members	1,588,338	1,627,085	1,784,979	1,828,385	1,872,857	8,701,644
Estimated Aggregate Expenditures	$ 7,839,026,397	$ 8,353,397,251	$ 12,003,860,385	$ 12,791,429,061	$ 13,631,053,139	$ 54,618,766,233

Including Carolina Cares

	Demonstration Years (DY)					
	DY 01 (07/19 - 06/20)	DY 02 (07/20 - 06/21)	DY 03 (07/21 - 06/22)	DY 04 (07/22 - 06/23)	DY 05 (07/23 - 06/24)	5 Year Total
Members	1,930,665	1,989,001	2,167,605	2,232,905	2,300,524	10,620,700
Estimated Aggregate Expenditures	$ 12,273,236,810	$ 13,231,585,666	$ 17,386,970,921	$ 18,713,526,798	$ 20,146,104,498	$ 81,751,424,693

- The hypotheses North Carolina will use to evaluate the effectiveness of the Demonstration test the State's goals. Examples include:
  - To test whether the demonstration measurably improves health, the State hypothesizes that the implementation of tailored plans and the specialized foster care plan will increase the quality of care for individuals with serious mental illness, serious emotional disturbance, substance use disorder and I/DD, and for children in foster care.
  - To test whether the demonstration maximizes high-value care to ensure the sustainability of the program, the State hypothesizes that the implementation of Medicaid managed care will decrease the use of emergency departments for non-urgent use and hospital admissions for ambulatory sensitive conditions.
  - To test whether the demonstration increases access to care, the State hypothesizes that the implementation of Medicaid managed care and the proposed provider support initiatives will increase the numbers of primary care, obstetric, mental health and specialty providers in

underserved areas, improve provider satisfaction, and maintain the same level of providers' participation in Medicaid.

The State will request the following waivers and expenditure authorities to effectively execute its proposed Section 1115 Demonstration Waiver:

Waivers

- § 1902(a)(10)(B) and § 1902(a)(17): To permit North Carolina to implement tailored plans offering certain benefits not available to enrollees who either do not qualify for or decline to enroll in tailored plans (contingent on legislative authority).
- § 1902(a)(10)(B) and § 1902(a)(17): To permit North Carolina to implement specialized foster care plans offering certain benefits not available to enrollees who either do not qualify for or decline to enroll in the specialized foster care plan.
- § 1902(a)(23): To permit North Carolina to implement mandatory managed care through selective contracting with PHPs for demonstration participants.
- § 1902(a)(1): To permit North Carolina to implement statewide mandatory managed care through PHPs for demonstration enrollees on a phased-in basis as necessary (contingent on legislative authority).
- § 1902(a)(14) and § 1916: To permit North Carolina to impose premiums of 2% of income for Carolina Cares enrollees with incomes > 50% of the FPL (if proposed legislation is enacted).
- § 1902(a)(8): To permit North Carolina to prohibit reenrollment of Carolina Cares enrollees disenrolled for failure to pay premiums until payment of back due premiums (if proposed legislation is enacted).
- § 1902(a)(10)(A): To permit North Carolina to require Carolina Cares enrollees to engage in work or work-related activities to remain enrolled in coverage (if proposed legislation is enacted).

Expenditure Authorities

- Tribal Uncompensated Care Pool: Expenditures for uncompensated care provided by or arranged through the Cherokee Indian Hospital Authority of up to $86.6 million over five years.
- Cost-Settling Essential Safety-Net Providers: To make wrap-around payments outside of managed care to selected providers currently reimbursed on a cost-settled basis (local public health departments, public ambulance providers, and state-owned or -operated skilled nursing facilities).
- Innovation Workforce Fund: To expand the Medicaid provider workforce in underserved areas of the State through new loan repayment and incentive programs of up to $45 M over five years.
- Health Home Care Management: To provide up to $150 M over five years seed money to help tailored plans and care management agencies build capacity to implement the health home care management model.
- Institutions of Mental Disease (IMD) Waiver: To make payments to IMDs for individuals receiving acute care for either mental health or substance use disorder treatment. The State will seek approval of the expenditure authority to pay for substance use disorder services in an IMD as quickly as possible for immediate implementation.
- Public–Private Regional Pilots: To fund up to $800 M over five years for public–private regional pilots aimed at addressing the social determinants of health through evidence-based interventions.

- Telemedicine Alliance: To provide an organization with up to $5 M in start-up funding to establish a statewide telemedicine alliance.
- Telemedicine Innovation Fund: To fund up to $80 M over five years pilots aimed at testing evidence-based telemedicine initiatives.

The complete version of the current draft of the Demonstration application will be available for public comment as of 5 p.m. Nov. 20, 2017, at ncdhhs.gov/nc-medicaid-transformation.
Public comments on any part of the Section 1115 Demonstration Waiver application amendment, including previously released sections or concepts, may be submitted until 11:59 pm on Friday, Dec. 29, 2017. Comments may be submitted by email to Medicaid.Transformation@dhhs.nc.gov or by regular mail to: Division of Health Benefits, North Carolina Department of Health and Human Services, 1950 Mail Service Center, Raleigh NC 27699-1950.
For additional information or a hard copy of the Section 1115 Demonstration Waiver application amendment, please contact Debra Farrington, Department of Health and Human Services, Division of Health Benefits, 1950 Mail Service Center, Raleigh NC 27699-1950 or debra.farrington@dhhs.nc.gov.

Public Notice Activities After Submission of the Original Waiver Application

Public notice and stakeholder activities after the submission in June 2016 of the original waiver application were targeted to gather input on more specific topics or populations, although all feedback was – and continues to be -- welcomed and encouraged. In addition to formalized activities, ad hoc comments were received through the dedicated waiver email, Medicaid.Transformation@dhhs.nc.gov and within other Medicaid-related stakeholder meetings.

Public Comment or Response Requests

North Carolina Medicaid and NC Health Choice Requests for Public Input: Public Comment Period April 25, 2017 through May 25, 2017. DHHS published the "North Carolina Medicaid and NC Health Choice Transformation Request for Public Input" April 28, 2017, on the Medicaid Transformation website at https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/Medicaid_and_NC_Health_Choice Request_for_Public_Input_20170425.pdf. The request solicited feedback on several topics raised by stakeholders as the Department continued to listen to and talk with North Carolinians about how to make the state healthier. Although all input was welcome and encouraged, these topics were particularly important to the design of a successful Medicaid managed care program:

- Physical and behavioral health service delivery
- Supporting provider transformation
- Care management and population health
- Addressing social determinants of health
- Improving quality of care
- Increasing access to care and treating substance use disorder

Public input was received during four public hearings:

- May 1, 5:30-7:30 p.m., Greensboro
- May 10, 3:00-5:00 p.m., Greenville
- May 12, 2:00-4:00 p.m., Asheville
- May 16, 6:00-8:00 p.m., Raleigh

Written input was received through:

- Email: MedicaidReform@dhhs.nc.gov
- U.S. Mail: Department of Health and Human Services, Division of Health Benefits, 1950 Mail Service Center, Raleigh NC 27699-1950
- Drop-off: Department of Health and Human Services, Dorothea Dix Campus, Adams Building, 101 Blair Dr., Raleigh NC

The Department received over 700 comments related to improving Medicaid. A summary of public input received is on the Medicaid Transformation website at https://files.nc.gov/ncdhhs/PublicCommentsSummary_Medicaid_April-May_2017.pdf.

North Carolina's Proposed Program Design for Medicaid Managed Care: Public Comment Period August 8, 2017 through Sept. 8, 2017. DHHS published the "North Carolina's Proposed Program Design for Medicaid Managed Care" August 8, 2017, on the Medicaid Transformation website at https://files.nc.gov/ncdhhs/documents/files/MedicaidManagedCare_ProposedProgramDesign_REVFINAL_20170808.pdf.

The proposed program design was published to provide more detailed information on the Department's vision for Medicaid managed care, and solicit comments from all stakeholders, but also to encourage input from health plans on technical and operational aspects of managed care program design. More than 200 written comments were received through email, U.S. Mail or dropped off at DHHS. A summary of public input received is on the Medicaid Transformation website at https://files.nc.gov/ncdhhs/documents/files/20171102_Public_Comment_Summary_FINAL.pdf?nQgWfLp4hlGPe0j.yIKET4CLdrBNqFam.

Requests for Information: Response Period Nov. 2, 2017 through Dec. 15, 2017. Two requests for information were issued in November 2017:

- **Managed Care Operations RFI.** Addresses managed care operations, including a request for statement of interest from prospective prepaid health plans.
- **Managed Care Program Actuarial RFI.** Addresses financial aspects of managed care, including information on the proposed capitation rate setting methodology.

The RFIs represent the next step in refining the design of the Medicaid managed care program and in transitioning into the procurement process needed to implement the program. DHHS will use input on the Medicaid managed care RFI to inform a Request for Proposal (RFP) from entities that want to participate as Prepaid Health Plans.

Concept Paper

Behavioral Health I/DD Tailored Plan Concept Paper, issued Nov. 9, 2017. The first in a series of concept papers that will provide details on specific components of the managed care program design. DHHS invites stakeholders to share input by sending an email to Medicaid.Transformation@dhhs.nc.gov. The papers are posted on the Medicaid Transformation website at https://files.nc.gov/ncdhhs/documents/files/BH-IDD-TailoredPlan_ConceptPaper_20181109.pdf?CkZhWxchGeNGBa2wXQSrSwWPrqi41aVP..

Work Groups and Committees

Medical Care Advisory Committee. With the release of the "North Carolina's Proposed Program Design for Medicaid Managed Care," the State engaged the Medical Care Advisory Committee (MCAC) which is open to

the public, as the formal stakeholder engagement body charged with providing feedback and comment on the wide range of transformation efforts including the Draft 1115 demonstration application. The diverse membership of the MCAC, including beneficiaries, advocates, urban and rural physicians and hospitals with representation from each region, will help ensure DHHS is sharing information with and receiving feedback from a wide-range of perspectives. DHHS has hosted in person and conference calls to ensure accessibility for individuals with disabilities to participate in stakeholder engagement wherever possible.

MCAC in person and telephonic meetings were held as follows:

- August 31, 2017 – MCAC meeting (telephonic) regarding proposed design for Medicaid transformation with Question and Answer session. Several members of the MCAC spoke during the Q&A session
- September 22, 2017 – MCAC meeting (in person) regarding program design details, comments received on proposed design and procurement timelines, several members of the public spoke during this face to face meeting
- October 26, 2017 – MCAC meeting (telephonic) regarding draft Managed Care Quality Strategy
- November 15, 2017 – MCAC meeting (telephonic) reviewed Amended Draft 1115 demonstration application and subcommittees of the MCAC to address managed care program design topics. One member of the public spoke during the public comment period.

Dual Eligibles Advisory Committee Work Group. The Dual Eligibles Advisory Committee was formed August 2016 to meet the requirements of S.L. 2015-245. This Committee, which was comprised of XX individuals throughout North Carolina who are recognized as experts in a wide range of issues pertaining to dual eligible health care delivery and coverage. The group provided input that DHHS used to prepare "The Managed Care Strategy for North Carolina Medicare-Medicaid Dual Eligible Beneficiaries," a legislatively required report recommending the approach to transitioning dual eligibles into managed care. This report was released to the General Assembly Jan. 23, 2017, and can be found on the Medicaid Transformation website at https://www.ncdhhs.gov/divisions/medical-assistance/nc-medicaid-reform/dual-eligibles-advisory-committee.

Tribal Consultation

The State has also continued to pursue ongoing, meaningful engagement with EBCI through telephonic and in-person meetings as follows:

- February 10, 2017 – Meeting with EBCI representatives regarding tribal priorities for Medicaid managed care transformation
- June 12-13, 2017 – Meeting with EBCI representatives regarding program design
- August 17, 2017 – Meeting with EBCI representatives and NC DHHS Secretary Cohen on program design
- September 6, 2017 – Meeting with EBCI representatives regarding enrollment broker activities
- September 27, 2017 – Meeting with EBCI representatives regarding foster care design
- October 18, 2017 – Meeting with EBCI representatives to discuss enrollment broker approach, 100% FMAP/referral pass through options, and quality strategy development
- October 25, 2017 – Meeting with EBCI representatives to discuss 100% FMAP/referral pass through updates
- November 7, 2017 – Meeting with EBCI representatives to discuss updates related to the uncompensated care pool and care management PMPM estimates; discussion of quality strategy, RFI, and proposed design topics of interest to the Tribe to be discussed in future meetings

- November 13, 2017 – Meeting with EBCI representatives to discuss uncompensated care pool questions
- November 15, 2017 – Meeting with EBCI representatives regarding Carolina Cares, social determinants of health, care management/advanced medical homes, the institutions for mental disease waiver, and in lieu of services design policies
- November 20, 2017 – Meeting with EBCI representatives regarding pharmacy/utilization management, clinical coverage, network adequacy, and credentialing design policies

2017 Abbreviated Public Notice

PUBLIC NOTICE

The North Carolina Department of Health and Human Services (DHHS), Division of Health Benefits (DHB) is providing public notice of its submission to the Centers of Medicare and Medicaid Services (CMS) of a written request to amend its Section 1115 Waiver application and to solicit public input to receive comments on the amendments to the Application.

The State submitted a Section 1115 Demonstration Waiver to CMS in June 2016 outlining plans to transition to a Medicaid managed care program. The State now seeks to amend the June 2016 Section 1115 Demonstration Waiver Application to strengthen the design of its managed care program to ensure the State's ability to: 1) measurably improve health, 2) maximize value to ensure the sustainability of the program, and 3) increase access to care.

Programmatic features of the amendments to the application have been refined through multiple rounds of robust stakeholder engagement since the original public comment period and waiver submission in June 2016. In 2017, the State released a "Request for Public Input" and a "Proposed Program Design for Medicaid Managed Care," each of which described the State's approach to managed care and highlighted features to strengthen managed care implementation. The State released a summary of public comments on the Proposed Program Design document on the North Carolina Medicaid Transformation website.

The purpose of the waiver application is to transition the Medicaid program from predominantly fee-for-service to managed care in a way that advances high-value care, improves population health, engages and supports providers and establishes a sustainable program with predictable costs. As described in the Proposed Program Design, North Carolina is proposing initiatives to achieve those goals, including designing managed care products tailored for enrollees with high behavioral health needs, strengthening the provider workforce and piloting public-private regional partnerships in select regions of North Carolina that aim to measurably improve health and lower costs. Additionally, the State now seeks to establish the "Carolina Cares" program, if proposed State legislation is enacted. "Carolina Cares" would expand access to Medicaid for certain low-income adults, most of whom would be subject to premium payments and employment activity requirements.

We highlight for stakeholders that financial information related to the amended application was added since the release of the Proposed Program Design. Please refer to Section VI of the Section 1115 Demonstration Waiver application amendment for complete details.

The complete version of the current draft of the Demonstration application will be available for public comment by 5 p.m. Nov. 20, 2017, at ncdhhs.gov/nc-medicaid-transformation.

Public comments on any part of the Section 1115 Demonstration Waiver application amendment, including previously released sections or concepts, may be submitted until 11:59 pm on Friday, Dec. 29, 2017. Comments may be submitted by email to Medicaid.Transformation@dhhs.nc.gov or by regular mail to: Division of Health Benefits, North Carolina Department of Health and Human Services, 1950 Mail Service Center, Raleigh NC 27699-1950.

The full version of this public notice document may be found at ncdhhs.gov/nc-medicaid-transformation. For additional information or a hard copy of the Section 1115 Demonstration Waiver application amendment, please contact Debra Farrington, Department of Health and Human Services, Division of Health Benefits, 1950 Mail Service Center, Raleigh NC 27699-1950 or debra.farrington@dhhs.nc.gov.

B.2. 2016 Public Notice

2016 Full Public Notice

PUBLIC NOTICE

North Carolina Department of Health and Human Services
Notice of Intent to Submit Social Security Act Section 1115 Demonstration Proposal
(Medicaid Reform Waiver Application)

March 7, 2016

Pursuant to 42 C.F.R. §431.408, the North Carolina Department of Health and Human Services (DHHS) is giving public notice of its intent to submit a Section 1115 demonstration proposal to the Centers for Medicare & Medicaid Services.

Description, Goals and Objectives

North Carolina's Demonstration Goal: Achieving the Quadruple Aim

The North Carolina Department of Health and Human Services' (DHHS') proposed Social Security Act Section 1115 demonstration application to the federal Centers for Medicare & Medicaid Services (CMS) sets forth a plan to improve the access to, and quality and cost effectiveness of health care for our growing population of Medicaid and NC Health Choice beneficiaries by restructuring care delivery using accountable, next-generation prepaid health plans, redesigning payment to reward value rather than volume, and planning toward true "person-centered" care grounded in increasingly robust patient-centered medical homes and wrap-around community support and informatics services.

Under the demonstration, DHHS will build upon the North Carolina Medicaid and NC Health Choice programs' tradition of innovation, community-based access and quality. DHHS will restructure care delivery in several ways: using a hybrid model of risk-based health plans; launching the next generation of the patient-centered medical home care model via our plan for North Carolina person-centered health communities; and redesigning payment to reward value and outcomes. This hybrid model will offer a combination of regional and statewide provider networks.

The North Carolina General Assembly enacted Session Law 2015-245 to transform and reorganize North Carolina's Medicaid and NC Health Choice programs. This law directs DHHS to redesign Medicaid and NC Health Choice to achieve the following goals:

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

These goals align fully with the Triple Aim of 1) improving the patient experience of care; 2) improving the health of populations; and 3) containing the per capita cost of health care; and go one step further by pursuing the Quadruple Aim—the Triple Aim + 4) Improved Provider Engagement and Support.
Implementation will be through four broad-based initiatives and the corresponding program proposals:

Demonstration Initiative #1: Creating Systems of Accountability for Outcomes

- Next generation prepaid health plans in a hybrid model
- Transformation of patient-centered medical homes to person-centered health communities
- Progress toward integrated behavioral and physical health service coordination
- Long-term services and supports (LTSS) for Medicaid-only individuals

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

- Person-centered health communities to participate in prepaid health plan provider networks
- Improve rural health access, outcomes and equity
- Enhancing outcomes for children and families in the child welfare system

Demonstration Initiative #3: Supporting Providers through Engagement and Innovations

- Practice supports for quality improvement
- Innovations Center
- Health information exchange (HIE)
- Statewide informatics layer
- Strengthening the safety net of hospitals
- Community residency and health workforce training
- Provider administrative ease in prepaid health plan contracts

Demonstration Initiative #4: Care Transformation through Payment Alignment

- Safety net hospital payments
- Delivery System Reform Incentive Payment (DSRIP) initiatives
- Incentives in capitated payments
- Rural and public provider payments

DHHS will submit the demonstration application to CMS on June 1, 2016, and is requesting approval from CMS no later than January 1, 2018.

Eligibility

Except for parents of children in foster care, there are no changes to Medicaid and NC Health Choice (CHIP) statutory program eligibility criteria under the demonstration. DHHS is proposing to allow parents to retain their Medicaid eligibility while their children are being served temporarily by the foster care program.

Except as provided below, participation in the demonstration will be mandatory for all Medicaid eligibility categories, including the aged, blind and disabled, as well as individuals enrolled in NC Health Choice (CHIP). The following individuals will not be enrolled in the demonstration:

- Medicaid and Medicare “dual eligibles.”
- Individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE).
- Individuals enrolled in Medicaid for emergency services only.
- Individuals eligible for Medicaid as “medically needy.”
- Individuals eligible for periods of presumptive eligibility.

Members of federally recognized tribes may participate in the demonstration and prepaid health plans if they elect, or “opt-into,” enrollment. Indian health/tribal providers will not be required to be part of prepaid health plan networks.

Benefits and Cost Sharing

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

- Services currently provided through Local Management Entities/Managed Care Organizations (LME/MCOs) under fully capitated payments (applies to Medicaid, not NC Health Choice beneficiaries)
- Dental services
- Program of All-Inclusive Care for the Elderly
- Local education agency services
- Children's Developmental Services Agency services

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

- Community Alternatives Program for Children (CAP/C)
- Community Alternatives Program for Disabled Adults (CAP/DA)

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

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

There are no changes to cost sharing for either Medicaid or NC Health Choice program beneficiaries under the demonstration.

Delivery System and Payment Rates for Services

Under this demonstration, DHHS will transition from the fee-for-service enhanced primary care case management program operated today to a full-risk capitation model. DHHS will contract with prepaid health plans on a capitated basis, using actuarially sound capitation rates and value-based purchasing principles to achieve our desired goals in the Quadruple Aim. These prepaid health plans will include entities known as provider-led entities, led by North Carolina providers, and commercial plans. This hybrid model will offer a combination of regional and statewide provider networks.

DHHS will simultaneously address the financial underpinnings of the current Medicaid provider payments to provide a glide path to a capitated model in which provider innovation is encouraged, but disruption to the Medicaid safety net is minimized. DHHS will implement Medicaid payment reforms using a blended approach that includes direct payments to Medicaid safety-net hospitals for Medicaid uncompensated care, DSRIP programs, risk-based incentive payments paid as a part of the prepaid health plan rates, and rural/safety-net provider payments. These initiatives are designed to ensure stability within our safety-net providers and prepare for success in delivery system reforms.

Except for members of a federally recognized tribe, North Carolina 1115 demonstration participants will mandatorily enroll in a capitated prepaid health plan.

Demonstration Hypotheses and Evaluation Plan

DHHS will develop an evaluation design for the demonstration to test the following hypotheses:

1) Building on North Carolina's current system of primary care and enhanced care management, the person-centered health communities will drive the primary care integration model by supporting coordinated access to specialty care, providing routine behavioral health screening, diagnosis and

management, coordinating social and home-based services, and coordinating with the state's specialty behavioral health system to achieve integrated health goals.

2) By requiring outcome and performance measures, and tying measures to meaningful financial incentives for prepaid health plans and providers, the state will improve health care quality and improve beneficiary and provider experience and satisfaction.

3) Our hybrid model of PLEs and CPs will create a diverse proving ground where lessons learned can be evaluated against the Quadruple Aim.

4) Improved supports for children in foster care: a) statewide expansion of "Fostering Health NC"; b) designating a prepaid health plan for children in foster care will provide continuity of care for the children regardless of their place of residence, and reduce unnecessary health care expenditures through dedicated and coordinated care management during the child welfare experience for children in foster care and their families; and c) continuation of Medicaid eligibility (especially to provide behavioral health services) for parent(s) of children temporarily removed from the home, will result in shorter length of foster care placement. Shorter length of out-of-home placement will reduce Medicaid expenditures for services during the foster care service provision, as well as Medicaid eligibility for the former foster children after reaching age 18, up to age 26.

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

- Which of the components of the North Carolina person-centered health community (the next generation patient-centered medical home), demonstrate a direct correlation to improved health outcomes for Medicaid and NC Health Choice beneficiaries?
- Which of the measures of outcomes or performance show the most improvement and are there any meaningful differences in the performance of PLEs compared to commercial plans?
- Which value-based models in the demonstration that incentivize and pay for performance show a correlation to better health outcomes for beneficiaries and/or practice transformation success?
- Does continuity of Medicaid eligibility for parents of children placed in foster care reduce length of stay in foster care and avert long-term costs to Medicaid?

Estimated Impact on Expenditures and Enrollment

The following projections use state fiscal year 2015, historical aggregate per capita cost trend, and enrollment trend data based on the populations expected to be enrolled in the demonstration.

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

	DEMONSTRATION YEARS (DY)					
	DY 1 (1/1/2018 - 12/31/2018)	**DY 2 (1/1/2019 - 12/31/2019)**	**DY 3 (1/1/2020 - 12/31/2020)**	**DY 4 (1/1/2021 - 12/31/2021)**	**DY 5 (1/1/2022 - 12/31/2022)**	**5 Year Total**
Members	1,984,907	2,025,613	2,068,287	2,113,033	2,159,974	10,351,814

Historical Aggregate Expenditures	$9,617,763,981	$10,269,342,336	$10,972,001,556	$11,730,218,374	$12,548,984,673	$55,138,310,920

Waiver and Expenditure Authorities

The table below describes the authorities requested under the demonstration. DHHS will review this request considering the final Medicaid managed care regulations once those rules are finalized.

Waiver/Expenditure Authority Section Citation	Type	Proposed Waiver/Expenditure Authority Language	Descriptive Reason for Waiver/Expenditure Authority Request
1. Amount, Duration, and Scope of Services Section 1902(a)(10)(B) and 1902(a)(17)	Waiver Authority	To the extent necessary to permit North Carolina to offer coverage through prepaid health plans that provide additional or different benefits to enrollees, than those otherwise available to other eligible individuals.	To permit North Carolina to implement mandatory managed care through prepaid health plans for demonstration participants. Prepaid health plans may offer additional benefits, such as health education and value-added services not available to other Medicaid beneficiaries not participating in the demonstration.
2. Freedom of Choice Section 1902(a)(23)(A)	Waiver Authority	To the extent necessary to enable North Carolina to restrict freedom of choice of provider using mandatory enrollment into MCOs for demonstration participants.	To permit North Carolina to implement mandatory managed care through prepaid health plans and their network providers for demonstration participants.
3. Statewideness Section 1902(a)(1)	Waiver Authority	To the extent necessary to allow North Carolina to implement managed care statewide on a phase-in basis if part of final program design.	To permit North Carolina to implement statewide mandatory managed care through prepaid health plans for demonstration enrollees on a phased-in basis as necessary.
4. Expenditures for Targeted Provider Medicaid Uncompensated Care Costs (Safety-Net Hospital Payments)	Expenditure Authority	Expenditures for care and services that meet the definition of "medical assistance" contained in section 1905(a) of the Act that are incurred by eligible providers for uncompensated Medicaid medical care costs of medical services provided to Medicaid eligible or uninsured individuals.	Expenditures to providers to stabilize and invest in safety-net providers to ensure access to care as North Carolina transforms Medicaid payments from fee-for-service to capitation under prepaid health plans.

Waiver/Expenditure Authority Section Citation	Type	Proposed Waiver/Expenditure Authority Language	Descriptive Reason for Waiver/Expenditure Authority Request
5. Expenditures for DSRIP	Expenditure Authority	Expenditures for incentive payments under a DSRIP program.	Expenditures to eligible providers to stabilize and invest in safety-net providers and enable North Carolina to transform to a system of value-based payment (VBP) as the State transitions from fee-for-service to capitation under prepaid health plans.
6. Expenditures for Non-Hospital Clinic and Local Health Department Expenditures that Support Rural Health	Expenditure Authority	Expenditures for Rural and Public Provider Initiatives.	Expenditures to eligible federally qualified health centers (FQHCs) and rural health center (RHC)-like clinics and local health departments to preserve funding levels through "wrap-around" payments.
7. Expenditures for Community-Based Residency and Enhanced Training Programs	Expenditure Authority	Expenditures for outpatient community-based residency and enhanced training programs.	Expenditures to support rural health access through funding for outpatient community-based residency and enhanced team-based training programs. Graduate medical education (GME) - like payments for eligible Area Health Education Centers (AHECs), Teaching Health Centers Graduate Medical Education (THCGME) programs, and community-based residency program for services provided to a Medicaid recipient.
8. Expenditures for VBP Methodologies within Capitated Prepaid health plans	Expenditure Authority	Expenditure for capitation payments to incent managed care plans to engage in activities that promote performance targets and identify strategies for VBP models for provider reimbursement.	To enable North Carolina to incent capitated prepaid health plans to adopt VBP models for provider reimbursement.

Waiver/Expenditure Authority Section Citation	Type	Proposed Waiver/Expenditure Authority Language	Descriptive Reason for Waiver/Expenditure Authority Request
9. Expenditures for Parents of Foster Care Children Who Would Otherwise be Medicaid Eligible Except for the Placement of Their Child(ren) into the Child Welfare System	Expenditure Authority	Expenditures for parents of foster care children who would otherwise be Medicaid eligible except for the placement of their children into the child welfare system.	To continue Medicaid eligibility for parents of children placed temporarily in foster care to address the comprehensive health care needs of the parents and increase the likelihood of successful reunification of the children with the family.

Public Notice Period and Comments

Stakeholders interested in reviewing the draft demonstration application, commenting on the draft application and receiving more information on the public notice period can visit the DHHS Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform. A copy of the application is available at:

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

The draft demonstration application is available for review and public comment from March 7, 2016, through 11:59 p.m. April 18, 2016. Along with the regularly scheduled Medical Care Advisory Committee (MCAC) meeting where the public can learn more about the 1115 waiver, DHHS will hold 12 public hearings to seek input on the draft demonstration application. Those who cannot attend in person will have the opportunity to dial into the Charlotte South public hearing, and also may view the presentation and provide comments through the Medicaid Reform website. Date, time and location of the public hearings for the demonstration are posted on the DHHS Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform.

The following table lists the public hearing schedule as of March 7, 2016:

Geographic Area	Location	Date	Start Time	End Time
Raleigh	McKimmon Center	3/30/2016	6:00 PM	8:00 PM
Charlotte (South)[1]	Union County Dept. of Social Services	3/31/2016	2:00 PM	4:00 PM
Charlotte (North)	CPCC Merancas Campus	3/31/2016	6:30 PM	8:30 PM
Western NC	*To be determined*			
Western NC - Boone	Holiday Inn Express	4/6/2016	12:00 PM	2:00 PM
Western NC - Asheville	Asheville-Buncombe Tech Community College	4/6/2016	6:30 PM	8:30 PM
Greensboro	Guilford County Health & Human Services	4/7/2016	6:30 PM	8:30 PM
Winston-Salem	Forsyth County Department of Public Health	4/8/2016	2:00 PM	4:00 PM
Wilmington	UNC-Wilmington	4/13/2016	6:00 PM	8:00 PM
Greenville	*To be determined*			
Elizabeth City	College of Albemarle	4/16/2016	10:00 AM	12:00 PM
Lumberton	UNC-Pembroke	4/18/2016	3:30 PM	5:30 PM
[1]This hearing will also provide dial-in access for those who cannot participate in person.				

This schedule is subject to change. The most current schedule is available on the DHHS Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform.

In addition to providing comments through the Medicaid Reform website or during a public hearing, written comments may be emailed, sent by postal mail or delivered in person:

Email: MedicaidReform@dhhs.nc.gov

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

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

2016 Abbreviated Public Notice

PUBLIC NOTICE
North Carolina Department of Health and Human Services
Notice of Intent to Submit Social Security Act Section 1115 Demonstration
(Medicaid Reform Waiver Application)

Pursuant to 42 C.F.R. 431.408, the North Carolina Department of Health and Human Services is providing notice of intent to submit a Social Security Act Section 1115 Demonstration for the Medicaid and N.C. Health Choice plans (Medicaid reform waiver application), and requests public comment on the draft demonstration.

The North Carolina Department of Health and Human Services' (DHHS') proposed Section 1115 Demonstration sets forth a plan to improve the access to, and quality and cost effectiveness of health care for our growing population of Medicaid and N.C. Health Choice beneficiaries. The demonstration will restructure Medicaid care delivery using accountable, next-generation prepaid health plans; redesign payment to reward value rather than volume; and plan toward true person-centered care grounded on the foundation of the current patient-centered medical homes, community support and informatics services.

Medicaid Reform will enable North Carolina to meet four goals defined by the North Carolina General Assembly:

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

The draft Section 1115 Demonstration documents are available for review on the N.C. Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform and include:

- Complete public notice with summary of the Section 1115 Demonstration
- Draft Section 1115 Demonstration proposal

A hard copy of the draft Section 1115 Demonstration is available at the Department of Health and Human Services, 101 Blair Drive, Raleigh NC, 27603.

Public comments are being accepted during the federally required comment period from March 7 through 11:59 p.m. on April 18, 2016. Input will be reviewed and considered by DHHS to help finalize the waiver application for submission to the Centers for Medicare & Medicaid Services by June 1, 2016. Comments can be submitted:

- **Online** at the N.C. Medicaid Reform website at http://www.ncdhhs.gov/nc-medicaid-reform/medicaid-reform-comment-submission-form
- **By email** to MedicaidReform@dhhs.nc.gov
- **By mail** to Division of Health Benefits, North Carolina Department of Health and Human Services, 2501 Mail Service Center, Raleigh, NC 27699-2501
- **In person** at North Carolina Department of Health and Human Services, 101 Blair Drive, Raleigh, NC 27603

Twelve public hearings will be held throughout the state during March and April 2016. Below are the hearings scheduled for March:

March 30, 2016; 6 p.m. – 8 p.m.
McKimmon Center, 1101 Gorman Street, Raleigh, NC 27606

March 31, 2016; 2 p.m. – 4 p.m.
Union County Dept. of Social Services, Auditorium, 1212 W. Roosevelt Boulevard, Monroe, NC 28110
Dial-in access available is available for this session: 1-888-585-9008; conference room number 780073319#.

March 31, 2016; 6:30 p.m. – 8:30 p.m.
CPCC Merancas Campus, Auditorium, 11930 Verhoeff Drive, Huntersville, NC 28078

A complete list of public hearings is available on the N.C. Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform. Dial-in instructions for the March 31 Union County session also will be posted when available to the website.

Visit the N.C. Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform to review the draft Section 1115 Demonstration application, detailed public notice and other documents; submit comments on the Medicaid Reform plan, including the draft application; and learn more about N.C. Medicaid Reform.

Appendix C. Tribal Consultation and Assurances

2017 Consultation

C.1. DHHS Meetings with EBCI Representations – Through November 2017

2016 Consultation

C.2. Cherokee Indian Hospital Authority Memorandum – Feb. 21, 2016
C.3. Division of Medical Assistance Letter – Feb. 29, 2016
C.4. Cherokee Indian Hospital Authority Memorandum – April 1, 2016
C.5. Division of Medical Assistance Memorandum – April 29, 2016

C.6. DHHS Assurances

C.1. DHHS Meetings with EBCI Representations – Through November 2017

2017 DHHS MEETINGS WITH EBCI REPRESENTATIVES	
Date	**Topic**
February 10	Tribal priorities for Medicaid managed care transformation
June 12-13	Program design
August 17	Program design; with NC DHHS Secretary Cohen
September 6	Enrollment broker activities
September 27	Foster care design
October 18	Enrollment broker approach, 100% FMAP/referral pass through options, and quality strategy development
October 25	100% FMAP/referral pass through updates
November 7	Uncompensated care pool and care management PMPM estimates; quality strategy, RFI, and proposed design topics of interest to the Tribe to be discussed in future meetings
November 13	Uncompensated care pool questions
November 15	Carolina Cares, social determinants of health, care management/advanced medical homes, the institutions for mental disease waiver, and in lieu of services design policies
November 20	Pharmacy/UM, clinical coverage, network adequacy, and credentialing design policies

C.2. Cherokee Indian Hospital Authority Memorandum – Feb. 21, 2016

An independent Component Unit of the Eastern Band of Cherokee Indians

Cherokee Indian Hospital Authority
Caller Box C-268
Cherokee, NC 28719
Phone: (828) 497-9163
Fax: (828) 497-5343

MEMORANDUM

TO: Mr. Dave Richards, Deputy Secretary DMA
Ms. Dee Jones, Chief Operating Officer, DHB

FROM: Casey Cooper, CEO

DATE: February 21, 2016

RE: **Initial Consultation with the Eastern Band of the Cherokee Indians (EBCI)**

Background

Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters likely to have a direct effect on Indians, Indian health programs and Urban Indian organizations. North Carolina Session Law 2015-245 (HB 372), "AN ACT TO TRANSFORM AND REORGANIZE NORTH CAROLINA'S MEDICAID AND NC HEALTH CHOICE PROGRAMS" meets the above conditions for the required consultation.

In accordance with the consultation procedures outlined in the approved January 1, 2011 Tribal consultation section of the NC Medicaid State Plan, pages 9-I through 9-IV, staff from NC Department of Health and Human Services (DHHS) met with staff from the Eastern Band of the Cherokee (EBCI) Division of Public Health and Human Services (PHHS) and the Cherokee Indian Hospital Authority (CHIA) on February 16-17, 2016 to solicit input on the development of the Medicaid 1115 Waiver, other Medicaid related issues and policies and State Plan Amendments (SPAs) as required to meet NC Session Law 2014-100, Section 12C.3(a)-(d) and subsequent versions. Once the draft 1115 waiver is released for public review, the sixty (60) day clock will begin for comments from EBCI. Anticipated release date is March 1, 2016.

Solicitation of Input

In attendance for the consultation visit were:

NC DHHS: Dave Richards, Roger Barnes, James Teske
EBCI PHHS: Aneva Turtle-Hagberg, Tate McCoy, Trina Owle, Darlene Creech
CIHA: Casey Cooper, Dr. Michael Toedt, Doug Trantham
Consultants with EBCI: Tara Larson, Lanier Cansler, Melanie Bush, Beth Nelson

Prior to the discussion of the pending Medicaid issues, EBCI staff gave presentations on the mission/vision of health and human service initiatives of the EBCI and of the Cherokee Indian Hospital. These presentations included a discussion of the EBCI Tribal Health Assessment, a tour of the new Cherokee Hospital, the health disparities prevalent within Indian Country, and an in depth discussion of how the initiatives pursued through the realignment of social service functions within EBCI address the overall health of the Cherokee people. Utilizing a medical home model, employing population health analytics, adapting services that embrace the culture of the Cherokee, realigning financial incentives, and addressing social determinants of health must be viewed in the gestalt rather than in isolated, fragmented solutions in order to address the health and well-being of the Cherokee people.

The CIHA's approach to care is founded on a commitment to greater patient and family involvement each step of the way, on prevention and management of chronic disease, and on processes to ensure proper use of specialty care and medications. Care is truly integrated. Patients are assigned a team of providers that includes a case manager, doctor, behavioral health specialist, nutritionist and pharmacist who all work together in one suite. Consultation rooms are adjacent to exam rooms. The restructuring of child and adult protective services to PHHS from the traditional county managed division of social services requires the assignment of a medical home and integrated assessments of child or adult vulnerabilities as part of protective services.

Understanding the principle of Indian self-determination and the vision for addressing the health and lives of the Cherokee is important to the development of the 1115 waiver. Also critical is enhancing eligibility to Medicaid and increasing access to Medicaid covered services. As such, EBCI PHHS and DHHS/DMA must continue in a timely and expeditious manner to seek the approval of the Medicaid/Health Choice eligibility determination SPA and other waivers/SPAs in which EBCI is a manager of the program or provider of services. Also essential is the completion of all other action steps associated with implementation of the SPAs or waivers.

Since EBCI has not seen a draft of the waiver to date, the following comments are offered to assist DHHS/DMA in the development and drafting of the wavier or to implement prior to the approval of the 1115 if other Medicaid authority is in place.

- The NC 1115 Waiver must not infringe on the rights of Tribal members or Tribal providers outlined in ACA, IHCA, or any other Federal laws.
- EBCI enrolled members and providers *shall not be required* to participate in the 1115 Waiver, and can continue to access Medicaid services through fee for service.
- EBCI enrolled members and providers *shall be permitted* to participate in the 1115 Waiver.

- There *shall not* be mandatory enrollment for tribal members or tribal providers into the general MCO/PLE arrangement as outlined in the session law.
- EBCI will serve as a state approved/contracted enrollment broker for educating Tribal members and other Native Americans *prior to* voluntary enrollment into managed care.
- CIHA shall be designated as a Health Home as allowed under Section 2703 for the EBCI community.
- CIHA *may* not meet the definition for a Provider Lead Entity (PLE) under the session law, such as being the PLE for one of the six (6) regions. The unique status, infrastructure, services, and treatment models provided by EBCI and CIHA may provide an opportunity to develop a specialty MCO/PLE for the Cherokee community in North Carolina. CIHA is interested in exploring a tribal MCO/PLE as allowed and outlined under Section 1932 of the Social Security Act.
- The waiver should address complementary medicine and social determinants of health.
- Funding of alternative or complementary services should be based upon outcomes.
- The waiver should accept the metrics currently used by CIHA which are nationally recognized and required by other funders for performance measures. Metrics should build off existing metrics within the healthcare system.
- CIHA and EBCI request to be eligible for any funding opportunities that are provided to other health entities or managed care entities as part of NC Medicaid reform.
- The waiver should explore alternative financial models that will serve to realign Medicaid service dollars and the use of Tribal funds to support services to Medicaid beneficiaries as well as the Tribe's under- or uninsured Members. CMS is currently considering expanding its 100 percent FMAP reimbursement policy for services "received through" Indian health facilities to cover non-IHS providers, which may incentivize the creation of such financial models. Potential options include cost sharing models with the State (Oklahoma), compensation for uncompensated care (Arizona, California, Oregon), and the Arkansas model using the revenue to fund expansion via the certified public expenditure (CPE) process and the use of federal dollars to purchase private health plan participation for recipients as alternative to Medicaid enrollment.
- We understand that NC legislation forbids the expansion of Medicaid at this point and as such, the 1115 may not be used to expand Medicaid eligibility as many other states have, but we would like to document our support for expansion.
- Copies of the relevant citations for the approved Oregon 1115 waiver were distributed.

As part of the discussion, DHHS and EBCI/CIHA agreed that while several of the above bullets required additional discussion over the next several months, immediately the following three (3) areas were agreed upon.

We have included **Recommended Language for Inclusion in NC 1115 Waiver:**

1. **ELIGIBILITY AND ENROLLMENT OF INDIVIDUALS IN COMMERCIAL PLANS OR PROVIDER LEAD ENTITIES (CPs/PLEs)**

   Individuals identified as American Indian or Alaskan Native enrolled in a federally recognized tribe (AI/AN) are excluded from this demonstration unless an individual chooses to opt into

the demonstration and access coverage pursuant to all the terms and conditions of this demonstration.

Individuals who are AI/AN, and who have not opted in to this demonstration will receive the benefit plan generally available to individuals enrolled in the demonstration through a fee for service (FFS) system.

An AI/AN individual, whether receiving direct coverage or coverage through the demonstration will be able to access covered benefits through tribal programs.

Auto-assignment will not apply to AI/ANs unless they have opted in to participate in the demonstration. Prior to opting in, EBCI shall serve as an enrollment broker. The CP/PLE agrees that any Indian otherwise eligible to receive services from the Indian Health Care Provider may be allowed to choose the Indian Health Care Provider as the Indian's primary health care provider if the Indian Health Care Provider has the capacity to provide primary care services to such Indian, and any referral from such IHCP shall be deemed to satisfy any coordination of care or referral requirement of the CP/PLE. 42 U.S.C. §1396u-2(h).

2. ELIGIBILITY AND ENROLLMENT OF INDIAN HEALTH CARE PROVIDERS IN CPs/PLEs

Indian health care providers (IHCPs) – Indian Health Services, tribally operated facilities/programs, and urban Indian clinics (I/T/Us) – are excluded from participation in CPs or PLEs and shall continue to be reimbursed on a fee for service basis in accordance with the requirements set out in Sec. 1932(h) of the Social Security Act. 42 U.S.C. 1396u-2(h).

AI/AN individuals who receive services directly by an IHCP or through referral under Purchased/Referred Care services shall not be imposed any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing or similar charges, and payments to an IHCP or a health care provider through referral under Purchased/Referred care services for services provided to an eligible AI/AN shall not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing or similar charges. 42 U.S.C. § 1396o(j).

Under Section 206 of the Indian Health Care Improvement Act, (IHCIA), IHCPs are entitled to payment notwithstanding network restrictions.

The State acknowledges that eligibility for services at the IHCP's facilities is determined by federal law, including the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136. Nothing in this waiver shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs.

3. SUPPLEMENTAL PAYMENTS FOR UNCOMPENSATED CARE

The state shall make supplemental payments to Indian Health Service (IHS) and tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority:

- To pay for uncompensated care costs from medically necessary "in lieu of"-type services and services to address the social determinants of health that are not covered by the Medicaid State Plan but may be provided under a capitated arrangement by CPs and PLEs. CIHA and EBCI shall be reimbursed on a fee for service arrangement, and

- To pay for uncompensated care costs resulting from services provided to individuals not enrolled in Medicaid, Medicare, CHIP or other coverage. Supplemental payments shall be made according to fee for service as if covered under the Medicaid State Plan or to protocols to be negotiated with the Centers for Medicare and Medicaid Services (CMS).

4. APPLICABILITY OF OTHER LAWS

Nothing in this Demonstration precludes IHCPs from forming a provider-led entity (PLE) as defined in North Carolina Session Law 2015-245, Section 4(2)(b) or from incorporating as an Indian Managed Care Entity (IMCE) as defined in Sections 1932(h) and 2107(e)(1)(J) of the Social Security Act.

Nothing in this Demonstration shall waive the applicability of other federal laws and regulations affecting IHCPs, including but not limited to, the following:

(a) The IHS as a Provider:

(1) Anti-Deficiency Act, 31 U.S.C. § 1341;
(2) ISDEAA, 25 U.S.C. § 450 et seq.;
(3) Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 2671-2680;
(4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
(5) Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
(6) Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2;
(7) Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164; and
(8) IHCIA, 25 U.S.C. § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is a Provider:

(1) ISDEAA, 25 U.S.C. § 450 et seq.;
(2) IHCIA, 25 U.S.C. § 1601 et seq.;
(3) FTCA, 28 U.S.C. §§ 2671-2680;
(4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
(5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; and
(6) HIPAA, 45 C.F.R. Parts 160 and 164.

(c) An urban Indian organization that is a Provider:

(1) IHCIA, 25 U.S.C. § 1601 et seq. (including without limitation pursuant to the IHCIA Section 206(e)(3), 25 U.S.C. § 1621e(e)(3), regarding recovery from tortfeasors);
(2) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; and
(3) HIPAA, 45 C.F.R. Parts 160 and 164.

On behalf of the Tribe, we appreciate your willingness to make an onsite visit and to engage with the Cherokee on this important change in the Medicaid program. If we are able to model programs to the degree we discussed during the visit, I am sure the health and human services programs

offered to the Eastern Band of the Cherokee will address the needs of our community and people. Thank you for your support. We look forward to working with DHHS on the continued evolution of the program.

Cc: Vickie Bradley, Secretary EBCI PHHS

C.3. Division of Medical Assistance Letter – Feb. 29, 2016

North Carolina Department of Health and Human Services
Division of Medical Assistance

Pat McCrory
Governor

Richard O. Brajer
Secretary

Dave Richard
Deputy Secretary for Medical Assistance

February 29, 2016

Ms. Vickie L. Bradley, RN, MPH
Secretary
Public Health & Human Services Administration
Eastern Band of Cherokee Indians
43 John Crowe Hill Road
Cherokee, NC 28719

Mr. Casey Cooper, BSN, MBA, FACHE
Chief Executive Officer
Cherokee Indian Hospital Authority
188 Hospital Road
Cherokee, NC 28719

RE: Consultation on the North Carolina 1115 Waiver Application Authorized by Session Law 2015 – 245

Dear Vickie and Casey:

Attached is a copy of our most current draft of our 1115 Waiver Application for Medicaid Reform as authorized by the General Assembly. I am inviting your comments as we develop our application prior to submission to the Centers for Medicare and Medicaid (CMS).

The purpose of this application is to transform the current Medicaid services currently under fee for service to a managed care health plan in compliance with 42 CFR 438. All of our current Medicaid and Health Choice State Plan services will become part of this waiver application except for dental services and services provided to dual eligible Medicaid enrollees.

Our intent is to submit this waiver application to CMS not later than June 1, 2016. This letter serves as our notice to the Eastern Band of Cherokee Indians of our waiver application and begins the sixty (60) day comment period.

I look forward to receiving your comments concerning this waiver application. Should you have any questions, please do not hesitate to contact us.

Sincerely,

Dave Richard

Attachment

cc: Richard Brajer
Dee Jones
Teresa Smith

www.ncdhhs.gov
Tel 919-855-4100 • Fax 919-733-6608
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Mailing Address: 2501 Mail Service Center • Raleigh, NC 27699-2501
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C.4. Cherokee Indian Hospital Authority Memorandum – April 1, 2016

An independent Component Unit of the Eastern Band of Cherokee Indians

Cherokee Indian Hospital Authority
Caller Box C-268
Cherokee, NC 28719
Phone: (828) 497-9163
Fax: (828) 497-5343

MEMORANDUM

TO: **Dee Jones, COO DHB**
Dave Richard, DHHS Deputy Secretary

FROM: **Casey Cooper, CEO** CC

DATE: **April 01, 2016**

RE: EASTERN BAND OF CHEROKEE INDIANS COMMENTS ON NORTH CAROLINA's DRAFT 1115 WAIVER

The Eastern Band of Cherokee Indians, North Carolina's only federally-recognized tribe, officially submits the following comments for response on the March 1st version of North Carolina's Department of Health and Human Services' "North Carolina Medicaid and Health Choice Draft Section 1115 Application" We are appreciative of the recognition in the waiver of the uniqueness and disparities of health care for Native Americans and for your willingness to continue to have dialogue about the possible development of a Tribal managed care entity.

GENERAL WAIVER COMMENTS

PERSON-CENTERED HEALTH COMMUNITIES

The Eastern Band of Cherokee Indians (EBCI) is supportive of the person-centered health community (PCHC) concept proposed by the North Carolina Department of Health and Human Services in its 1115 application. It is a much-needed step in the right direction towards whole-person care, and is the concept we have worked to implement over the last several years on the Qualla Boundary. We would encourage more details about the minimum requirements and desired outcomes of the model and ensure that financial arrangements support the model.

The re-organization of social and support service functions within the EBCI Department of Public Health and Human Services (PHHS) address the health disparities of the Cherokee community and focus on promoting safe, stable, and nurturing families. The waiver recognizes the role of social determinants in the overall health of people. The success of the new system is dependent upon a partnership between PHHS and the medical home, Cherokee Indian Hospital Authority (CIHA), creating a paradigm shift from traditional, siloed care to an integrated, holistic approach. This design provides a multi-system team that supports the family. The draft waiver outlines the concept of multi-system approach, but is not clear on the requirements or infrastructure the Department is requiring.

1

The CIHA's approach to care is founded on a commitment to greater patient and family involvement each step of the way. A focus on prevention, management of chronic disease, appropriate use of specialty care, and medication formulary control are priorities in this system. CIHA is Level 3 Certified Patient Centered Medical Home and provides services to the majority of Tribal members. The organization is a truly integrated model. Patients are empaneled to a team of providers that includes a case manager, physician, behavioral health specialist, nutritionist and pharmacist who are co-located to provide care. The Cherokee Indian Hospital Authority (CIHA) operates the tribal Behavioral Health Services and Recovery Center, ensuring whole person care in a truly integrated health system.

We feel the approach referenced above is a strong model, maximizing best practices, driven by data and supports the entire family in a comprehensive model. We encourage the use of this approach across NC. In order to implement the model, change is incremental, requires system and knowledge enhancements and also financial support during the change process. Current reimbursement models don't support the change in terms of addressing sustainability as well as supporting the transition process. We encourage the Department to provide resources for Medicaid transformation at the provider and the recipient level.

ELIGIBILITY

We are supportive of the statement on page 38 excluding Eastern Band of the Cherokee (EBCI) from mandatory enrollment and the Department's commitment to continue to work with EBCI on a Tribal Managed Care entity. We agree that EBCI is NC's only federally recognized Tribe; however, there are many other federally recognized Tribes whose members live across North Carolina. The exclusion should be for any enrolled federal Tribal member, not those enrolled members of just EBCI.

As discussed during our consultation conversation, EBCI is interested in exploring ways in which they may serve as an outreach, eligibility broker for Native Americans.

ENHANCING OUTCOMES FOR CHILDREN AND FAMILIES IN THE CHILD WELFARE SYSTEM

We are supportive of DHHS' focus on providing comprehensive health care and interventions for the most vulnerable children at risk of or experiencing abuse and neglect and their families. We are very supportive of maintaining eligibility for parents if their children are placed in foster care. The literature is very explicit about the need for the biological families of children in foster care to receive treatment and support if there will be successful family reunification.

CIHA Behavioral Health and PHHS' Family Safety Division implemented the Integrated Family Safety Team, bridging the gap between medical/behavioral health care and human services. This team is a combination of behavioral health staff and child/adult protective services staff working together to support families through integrated, comprehensive services utilizing a single family plan.

EBCI children may not necessarily participate in the statewide PHP proposed in the 1115 waiver, but stand to benefit from the expansion of Fostering Health NC, and any learnings or best practices that are disseminated through the program's expansion. Children of Indian heritage across North Carolina, especially those in the social services systems, deserve to be served in the manner respectful of their culture. We encourage submission of unique services that are unique to populations such as such as those approved in the New Mexico waiver for Native Americans only. Similarly, the EBCI request access, like the county directors of social services, to Medicaid claims data to fill information gaps, coordinate care, and identify potential problems early. Trauma informed care is critical for serving children. We also support allowing families of children placed in foster care to maintain Medicaid

eligibility while the child is placed outside the home. We hope that DHHS remains committed to improving the health outcomes of EBCI and Native American children and families in the child welfare system that may be outside the PHP health delivery system.

SOCIAL DETERMINANTS OF HEALTH

We are also supportive of the inclusion of screening for social determinants of health by PCHCs and inclusion of this data in electronic health records. To build truly healthy communities, health systems need to look outside of the traditional doctors' offices to understand the factors that may be influencing health where people live and work and learn. Moving treatment upstream towards prevention rather than intervention will have longer term effects on overall health than downstream treatment. We are pleased that it appears North Carolina is moving in this direction as well. We encourage a more detailed explanation of the allowable use of funds to support addressing social determinants. Does the state intend to go with a model of "buckets" of flexible funding such as the Oregon model or leave the flexibility up to the managed care entity such as the Utah approach?

CULTURAL COMPENTENCY

Finally, we would like to underline the importance of creating a culturally competent health care delivery system. We support and are encouraged by your designation as EBCI as one of the eligibility brokers to assist Native Americans in making informed choices. We also offer to DHHS assistance in developing education materials for the use by all county of social services in educating all Medicaid recipients in choosing culturally appropriate managed care entities. While most EBCI members may not choose a PHP for health care delivery, some may choose that option and we feel it is important for members to have access to culturally appropriate care, including traditional healing methods that could be paid for as "in lieu of" services. The Tribe's interest is supporting all aspects of cultural diversity and competencies unique to the various populations across the State, not just for the Eastern Band of Cherokee. We encourage DHHS to write into the waiver, the need for culturally appropriate services. We understand that this could be addressed during the RFP process; however, we feel that there is significant importance to culturally competent education and services that this issue should be addressed in the actual waiver application.

LANGUAGE PREVIOUSLY SUBMITTED BY THE EASTERN BAND OF CHEROKEE INDIANS FOR INCLUSION IN NORTH CAROLINA'S 1115 WAIVER

The following language was submitted in the previous submission of February, 2016 of comments to Secretary Brajer for inclusion in North Carolina's 1115 waiver. The Eastern Band of Cherokee Indians is pleased that the language exempting Indian Health Care Providers and Eastern Band of Cherokee enrolled members from mandatory participation in the 1115 waiver is captured in the draft version of the waiver, language leaving open the option for EBCI to create a sub-regional PLE, and acknowledgement of our desire for uncompensated care payments. However, the language submitted below has either not been explicitly addressed in the draft language and so we resubmit for consideration and inclusion.

ELIGIBILITY AND ENROLLMENT OF INDIVIDUALS IN CPs/PLEs

The CP/PLE agrees that any Indian otherwise eligible to receive services from the Indian Health Care Provider may be allowed to choose the Indian Health Care Provider as the Indian's primary health care provider if the Indian Health Care Provider has the capacity to provide primary care services to such Indian, and any referral from such

IHCP shall be deemed to satisfy any coordination of care or referral requirement of the CP/PLE. 42 U.S.C. §1396u-2(h).

ELIGIBILITY AND ENROLLMENT OF INDIAN HEALTH CARE PROVIDERS IN CPs/PLEs

AI/AN individuals who receive services directly by an IHCP or through referral under Purchased/Referred Care services shall not be imposed any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing or similar charges, and payments to an IHCP or a health care provider through referral under Purchased/Referred care services for services provided to an eligible AI/AN shall not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing or similar charges. 42 U.S.C. § 1396o(j).

The State acknowledges that eligibility for services at the IHCP's facilities is determined by federal law, including the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136. Nothing in this waiver shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs.

SUPPLEMENTAL PAYMENTS FOR UNCOMPENSATED CARE

The state shall make supplemental payments to Indian Health Service (IHS) and tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority:

1) to pay for uncompensated care costs from medically necessary "in lieu of"-type services and services to address the social determinants of health that are not covered by the Medicaid State Plan but may be provided under a capitated arrangement by CPs and PLEs; and
2) to pay for uncompensated care costs resulting from services provided to individuals not enrolled in Medicaid, Medicare, CHIP or other coverage who have incomes up to 138 percent of the Federal Poverty Level (FPL).

Supplemental payments shall be made according to protocols to be negotiated with the Centers for Medicare and Medicaid Services (CMS).

APPLICABILITY OF OTHER LAWS

Nothing in this Demonstration precludes IHCPs from forming a provider-led entity (PLE) as defined in North Carolina Session Law 2015-245, Section 4(2)(b) or from incorporating as an Indian Managed Care Entity (IMCE) as defined in Sections 1932(h) and 2107(e)(1)(J) of the Social Security Act.

Nothing in this Demonstration shall waive the applicability of other federal laws and regulations affecting IHCPs, including but not limited to, the following:

(a) The IHS as a Provider:

1) Anti-Deficiency Act, 31 U.S.C. § 1341;
2) ISDEAA, 25 U.S.C. § 450 et seq.;
3) Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 2671-2680;
4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
5) Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
6) Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2;
7) Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164; and
8) IHCIA, 25 U.S.C. § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is a Provider:

1) ISDEAA, 25 U.S.C. § 450 et seq.;
2) IHCIA, 25 U.S.C. § 1601 et seq.;
3) FTCA, 28 U.S.C. §§ 2671-2680;
4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; and
6) HIPAA, 45 C.F.R. Parts 160 and 164.

(c) An urban Indian organization that is a Provider:

1) IHCIA, 25 U.S.C. § 1601 et seq. (including without limitation pursuant to the IHCIA Section 206(e)(3), 25 U.S.C. § 1621e(e)(3), regarding recovery from tortfeasors);
2) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; and
3) HIPAA, 45 C.F.R. Parts 160 and 164.

Since the initial consultation between EBCI and DHHS and the release of the draft 1115 waiver application, CMS has issued guidance for expanding the availability of 100% FMAP for services offered by non-IHS, compact or tribal facilities if coordinated by Tribal facilities. We have made the initial contact with DHHS regarding implementation of this critical aspect of health care for federal recognized Tribes. We feel this is a critical element for today's health care market but will be more important as the state moves forward with managed care for all federally recognized tribal members, not just EBCI.

We are also very interested in continuing the conversation about the formation of a Tribal MCO, other covered services and initiatives as written in our original draft 1115 waiver submitted to DHHS in 2014. We are pleased with the enhanced collaboration and the recognition by DHHS in addressing the needs of the Cherokee and all Native Americans in NC. We stand ready and willing to assist the Department in implementing solutions.

Cc: Principal Chief Patrick Lambert, EBCI
Secretary Vickie Bradley, EBCI PHHS

C.5. Division of Medical Assistance Memorandum – April 29, 2016

North Carolina Department of Health and Human Services
Division of Medical Assistance

Pat McCrory
Governor

Richard O. Brajer
Secretary

Dave Richard
Deputy Secretary for Medical Assistance

To: Casey Cooper, CEO
Secretary Vickie Bradley, EBCI PHHS

From: Dave Richard, DHHS Deputy Secretary
Dee Jones, COO DHB

Date: April 29, 2016

RE: DHHS'S RESPONSE TO COMMENTS FROM THE EASTERN BAND OF CHEROKEE INDIANS (EBCI) ON NORTH CAROLINA'S DRAFT 1115 WAIVER

The North Carolina Department of Health and Human Services (DHHS) acknowledges the formal feedback submitted in response to the March 1st version of the "North Carolina Medicaid and Health Choice Draft Section 1115 Application." DHHS appreciates the willingness of EBCI to thoughtfully respond and discuss many of the concepts outlined in the 1115 demonstration (waiver) proposal. Through our multiple discussions with representatives of the Tribe and Tribal leadership prior to the initiation of our formal public notice, as well as our meeting yesterday with your designees to discuss the specific EBCI feedback and desired initiatives related to the waiver, we remain committed to working together to achieve our common goal of improving the health of all of North Carolina's Native American population. We look forward to ongoing collaboration with EBCI throughout the period prior to approval while DHHS negotiates these and the many other components of the waiver proposal.

DHHS appreciates EBCI's support of many of the concepts outlined in the waiver and looks forward to continuing our work together. Attached is a summary of our discussion on April 28, 2016.

EBCI Comments	DHHS Response
Person-Centered Health Communities (PCHC)	
• We (EBCI) encourage more details about the minimum requirements (of PCHC), desired outcomes and financial arrangements to support the PCHC model (Page 1). • The draft waiver outlines the concept of multi-system approach but is not clear on the requirements or infrastructure the Department is requiring (Page 1).	• Many of the details determining how DHHS will operationalize PCHC and integrated care concepts under Medicaid Reform have yet to be determined. DHHS will continue to work with all stakeholders to develop many of the concepts discussed in the waiver.

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EBCI Comments	DHHS Response
Eligibility	
• The exclusion (of all tribe members from mandatory enrollment) should be for any enrolled federal Tribal member, not just those enrolled members of EBCI (Page 2). The EBCI prefer that members of federally recognized tribes have the opportunity to "opt in" enrollment into a PHP rather than an "opt out" (as stated in the 3/1 draft waiver).	• DHHS supports the EBCI's position and will adjust the waiver and/or future enrollment/eligibility determination processes to reflect this agreement regarding opting into managed care through PHPs. Operationalization will require agreement on how DHHS can identify members of federally recognized tribes at the time of enrollment as well as the capacity to track these members.
• Any Indian otherwise eligible to receive services from the Indian Health Care Provider may be allowed to choose the Indian Health Care Provider as the Indian's primary health provider if the Indian Health Care provider has the capacity to provide primary care services to such Indian, and any referral from such IHCP shall be deemed to satisfy any coordination of care or referral requirement of the CP/PLE (Pages 3-4). • EBCI prefers that if a Native American chooses to participate in a PHP, the individual will be assigned to an IHCP primary care provider (assuming the IHCP can be reasonably accessed by the member and/or meet appropriate network adequacy requirements). Similarly an Indian Health Provider will have the right to refer to other Indian Health Providers without pre-authorization from PHPs.	• DHHS supports the EBCI's position and will adjust the waiver and/or future enrollment/eligibility determination processes (and contract provisions) to reflect this provision. As noted above, operationalization in PHPs will require continued collaboration to identify these members.
• AI/AN individuals who receive services directly by an IHCP or through referral under Purchased/Referred Care Services shall not be imposed any enrollment fee, premium... (Page 4).	• Co-pays and premiums are not and will not be charged to NC Health Choice and Medicaid Native American beneficiaries. In addition, they are not part of the charges to ICHP. DHHS will continue to work with the EBCI to ensure that these protections will not be part of any future state and/or part of future PHP contracts.
• EBCI requests that the State acknowledge that nothing in the waiver shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through IHCP's programs.	• DHHS agrees to include this language in the waiver submission to CMS.
Enhancing Outcomes for Children and Families in the Child welfare system	
• We (EBCI) encourages submission of unique services that are unique to populations such as those approved in the New Mexico waiver for Native Americans (Page 2).	• DHHS agrees to continue to work with the EBCI to address this important issue. DHHS requests that EBCI provide a list of the services that are considered unique and will work with CMS to add allowable services to the waiver.

EBCI Comments	DHHS Response
• The EBCI requests that AI/AN children in the foster care system receive culturally appropriate services and care management.	• DHHS strongly agrees with the EBCI and commits to continue working with the EBCI to address this important issue currently and in the future.
• The EBCI requests access (like county directors of social services) to Medicaid claims data to fill information gaps, coordinate care, and identify potential problems early (Page 2).	• DHHS appreciates the Tribe's position. DHHS will need to review internal State protocols in order to better understand and work to resolve any barriers in order to satisfy this request. DHHS will continue to work with the Tribe outside of the scope of the waiver.
Social Determinants of Health	
• EBCI supports the inclusion of screening for social determinants of health by PCHCs and inclusion of this data in electronic health records (Page 3).	• DHHS appreciates the EBCI's support.
• EBCI encourages a more detailed explanation of the allowable use of funds to support addressing social determinants (Page 3).	• DHHS appreciates EBCI's comment and agrees to work with EBCI and other stakeholders to determine the allowable use of funds to support addressing social determinants as part of program implementation.
Cultural Competency	
• EBCI offers its expertise and will assist in developing culturally appropriate education materials for use by county of social services to educate all Medicaid recipients (Page 3).	• Many of the details determining how DHHS will operationalize Medicaid reform have yet to be determined. DHHS appreciates this offer and will seek EBCI's expertise as we plan and operationalize the program.
• EBCI encourages DHHS to write into the waiver the need for culturally appropriate services. EBCI believes it should be addressed in the actual waiver application and during the RFP process (Page 3).	• DHHS appreciates EBCI's position and agrees to consider how to write into the waiver and future PHP contracts the need for coverage of culturally appropriate services.
Supplemental Payments for Uncompensated Care	
• The state shall pay for uncompensated care costs resulting from services provided to individuals not enrolled in Medicaid, Medicare, CHIP, or other coverage, who have incomes up to 138 percent of the Federal Poverty Level (FPL) (Page 4).	• DHHS interprets Session Law 2013-5 (SL 2013-5) to not allow consideration of Medicaid coverage expansions up to this federal poverty level under Medicaid Reform.

EBCI Comments	DHHS Response
• The state shall make supplemental payments to pay for uncompensated care costs from medically necessary "in lieu of" type services and to address the social determinants of health that are not covered by the Medicaid State Plan but may be provided under a capitated arrangement by CPs and PLEs (Page 4).	• DHHS appreciates the EBCI's position and agrees to adjust the waiver to include a supplemental payment pool. As stated during our call, DHHS is unable to seek authorization for Medicaid coverage expansion in this waiver proposal. • DHHS commits to continuing to work with the Tribe to identify benefits and/or wrap payments available for supplemental payments, and develop a CMS allowable payment program that assures that IHCP providers can receive payments equivalent to existing statewide supplemental payment programs (many of the existing supplemental programs are designed to equate payments to 100% of Medicare). Any ability of DHHS to make supplemental payments will depend on CMS approval and be fully supported by federal tribal expenditure matching funds. • DHHS asks that the EBCI provide additional detail on a proposed supplemental payment program design. This includes but is not limited to: the total or total estimated amount of uncompensated care dollars – both historical and projected, how these are currently tracked, services covered, and/or any additional information available to assist in development of the budget neutrality for the waiver proposal.
Applicability of Other Laws	
• CMS has issued guidance for expanding the availability of 100% FMAP for services offered by non-IHS compact or tribal facilities if coordinated by Tribal facilities (Page 5).	• DHHS strongly supports the EBCI's interest in expanding the availability of the 100% FMAP. DHHS believes the opportunity to expand the availability of 100% FMAP can be pursued outside of the waiver and is likely to be implemented before the waiver is approved. DHHS requests that the EBCI continue to work with DHHS to continue to pursue this outside of the scope of the waiver.
• EBCI expressed an interest in continuing the conversation about the formation of a Tribal MCO (Page 5).	• DHHS strongly supports the EBCI's interest in the formation of a Tribal PHP and is committed to working with the EBCI to meet the Tribe's goals. DHHS will analyze whether this initiative requires a change to SL 2015-245 and will follow up accordingly. In addition, as agreed to on our call, the interest in becoming a PLE will be presented to CMS in the waiver proposal.

EBCI Comments	DHHS Response
• EBCI requests that nothing in the demonstration shall waive the applicability of other federal laws and regulations affecting IHCPs (Page 4).	• DHHS agrees to include this language in the waiver submission to CMS.

cc: Principal Chief Patrick Lambert, EBCI

C.6. DHHS Assurances

DHHS assures that PHP contracts will address the need for culturally appropriate services.

DHHS acknowledges that eligibility for services at Indian Health Care Provider (IHCP) facilities is determined by federal law, including the IHCIA, 25 U.S.C. 1601, et seq. and/or 42 CFR Part 136. Nothing in this waiver shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through IHCP's programs.

DHHS assures that nothing in this waiver application waives the applicability of other federal laws and regulations affecting IHCPs, including but not limited to the following:

(a) The IHS as a Provider:

1) Anti-Deficiency Act, 31 U.S.C.§1341;
2) ISDEAA, 25 U.S.C. § 450 et seq;
3) Federal Tort Claims Act ("FTCA), 28 U.S.C. §§ 2671-2680;
4) Federal Medical Care Recovery Act, 42 U.S.C §§ 2651-2653;
5) Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552c, 45 C.F.R. Part 5b;
6) Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2; Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164;
and
7) IHCIA, 25 U.S.C § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is a Provider:

1) ISDEAA, 25 U.S.C. § 450 et seq;
2) IHCIA, 25 U.S.C. § 1601 et seq; 3) FTCA, 28 U.S.C. §§ 2671-2680;
4) Federal Medical Care Recovery Act, 42 U.S.C §§ 2651-2653;
5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; and
6) HIPAA, 45 C.F.R. Parts 160 and 164.

(c) An urban Indian organization that is a Provider:

1) IHCIA, 25 U.S.C. § 1601 et seq. (including without limitation pursuant to the IHCIA Section 206(e)(3), 25 U.S.C. § 1621e(e)(3), regarding recovery from tortfeasors);
2) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R Part 5b; and
3) HIPAA, 45 C.F.R. Parts 160 and 164.