Section 1915(b) Waiver

STATE OF NORTH CAROLINA

NC MH/DD/SAS Health Plan

Amendment

October 1, 2011

Table of Contents

Proposal

Face sheet 3
Section A: Program description 5
Part I: Program overview 6
A. Statutory authority 13
B. Delivery systems 15
C. Choice of MCOs, PIHPs, PAHPs and PCCMs 20
D. Geographic areas served by the waiver 22
E. Populations included in waiver 24
F. Services 27
Part II: Access 38
A. Timely access standards 38
B. Capacity standards 41
C. Coordination and continuity of care standards 44
Part III: Quality 47
Part IV: Program operations 51
A. Marketing 51
B. Information to enrollees and potential enrollees 53
C. Enrollment and disenrollment 56
D. Enrollee rights 61
E. Grievance system 62
F. Program integrity 65

Section B: Monitoring plan 67
Part I: Summary chart 69
Part II: Monitoring strategies 71

Section C: Monitoring results 83

Section D: Cost effectiveness 103
Part I: State completion section 103
Part I: Appendices D1-7

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

Face sheet

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

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

The **name of the waiver program** is **NC MH/DD/SAS Health Plan waiver.**. (Please list each program name if the waiver authorizes more than one program.).

This waiver authorizes one MHDDSAS capitated program that currently operates through a single prepaid inpatient health plan (PIHP) in a five-county geographic area of the State. The PIHP, Piedmont Behavioral Healthcare, is a local management entity (LME). LMEs are agencies of local government, also known as area authorities or county programs, and are responsible for managing, coordinating, facilitating and monitoring the provision of mental health, developmental disabilities and substance abuse services in the LME's respective catchment area.

This waiver was amended effective July 1, 2010 to allow for expansion of the capitated program to other areas of the state over time. The State released a request for applications in February 2010, giving all of the State's LMEs the opportunity to apply to participate in the waiver and operate as a PIHP for MHDDSA services.

This waiver operates concurrently with the NC Innovations waiver, a 1915(c) home and community based services waiver which provides services and supports to individuals with intellectual and other developmental disabilites (IDD). As the capitated program expands to other areas of the State, individuals participating in other IDD 1915(c) waivers (NC 0662 and 0663) will transition to the Innovations waiver. NC Innovations is the only 1915(c) waiver operating concurrently with this 1915(b) managed care waiver.

The purpose of this amendment is to designate the phase in schedule for the specific geographic areas of the state indicated. The concurrently operating 1915(b) waiver will incorporate additional counties through additional LMEs operating as PIHPs. The State intends to make the 1915(b)(3) services included in this waiver available in all geographic areas once the waiver is fully rolled-out; however, during the roll-out period, availability of 1915(b)(3) services will vary as the new PIHPs implement the program. The State anticipates that the waiver and the full package of 1915(b)(3) services will be rolled out and operating statewide no later than July 1, 2013. The following counties and their respective LMEs will be phased in as follows:

WAIVER PROGRAM ROLL-OUT SCHEDULE:

1. **October 1, 2011: Alamance and Caswell counties (PBH) – 23,000**
2. **January 1, 2012: Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, and Yancey Counties (Western Highlands) – 68,000**

3. **January 1, 2012: Franklin, Granville, Halifax, Vance and Warren counties (PBH) – 44,000**
4. **April 1, 2012: Orange, Person, Chatham (PBH) – 20,000**
5. **April 1, 2012: Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Gates, Hertford, Hyde, Jones, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrell, and Washington Counties (East Carolina Behavioral Health (ECBH)) – 88,000**
6. **July 1, 2012: Anson, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, and Richmond Counties (Sandhills) – 81,000**
7. **July 1, 2012: Alexander, Allegheny, Ashe, Avery, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, Macon, McDowell, Swain, Watauga and Wilke Counties (Smoky Mountain) – 75,000**
8. **January 1, 2013 Mecklenburg county (Mecklenburg) – 104,000**
9. **January 1, 2013 Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Surry, Yadkin counties (Pathways) – 128,000**
10. **January 1, 2013 Bladen, Columbus, Duplin, Edgecombe, Greene, Nash, Lenoir, Robeson, Sampson, Scotland, Wayne and Wilson counties (Eastpointe) – 163,000**
11. **January 1, 2013 Davie, Forsyth, Rockingham and Stokes counties (Centerpoint) – 69,000**
12. **January 1, 2013 Cumberland, Durham, Johnston and Wake counties (Durham Center) – 168,000**
13. **January 1, 2013 will have Brunswick, Carteret, New Hanover, Onslow and Pender counties (Eastern Coastal Care) – 62,000**
14. **January 1, 2013 Guilford county – 59,000**

Part I.D of Section A has been updated to reflect the statewide expansion effective October 1, 2011. References to "PBH" as the single managed care entity have been deleted throughout to reflect that the waiver now includes multiple PIHPs. Cost effectiveness, Section D, has also been updated.

Type of request. This is a:

___ Initial request for new waiver

_X_ Amendment request

___Replacement pages are attached for specific Section/Part being amended

___X_Document is replaced in full, with changes highlighted.

__Renewal request

__ This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e., Sections A through D) is filled out.

__ The State has used this waiver format for its previous waiver period.

Section A is ___ Replaced in full.

___ Carried over from previous waiver period. The State: Assures there are no changes in the Program Description from the previous waiver period.

__ Assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages. **(Changes are highlighted.)**

Section B is ___ Replaced in full.

___Carried over from previous waiver period. The State:

_X__ Assures there are no changes in the Monitoring Plan from the previous waiver period.

__ Assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages.

__ The State has used this waiver format for its previous waiver period.

Sections D is filled out. There are no changes to Section C.

Effective Dates: The State is requesting an implementation date of the amendment of October 1, 2011

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

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

Judy Walton –Waiver Management
Telephone +1 919 855 4265
Fax +1 919 715 4715
E-mail: judy.walton@dhhs.nc.gov

Christal Kelly, David Martin – Waiver cost effectiveness
Telephone Christal +1 919 647-8178; David +1 919 647-8172
Fax +1 919 715 2209
E-mail: christal.kelly@dhhs.nc.gov; david.martin@dhhs.nc.gov

Section A: Program Description

Part I: Program Overview

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

The goals of this capitated health plan initiative are to:

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

The NC Department of Health and Human Services (DHHS) submitted amendments to both waivers to CMS in December of 2009 requesting approval to expand the program statewide over time in order to standardize care management and service delivery for individuals with MH/DD/SAS.

<u>Public process</u>

The processes described below have continued since the April 1, 2010 amendment was submitted regarding the plan for statewide expansion of managed care for Medicaid covered MH/DD/SA services through local management entities (LMEs) functioning as prepaid inpatient health plans (PIHPs). Updates are provided and feedback obtained through all of the venues listed below.

The State has increased its commitment to expansion of (b)/(c) waiver programs through House Bill 916 which was signed into law by the Governor on June 23, 2011 and requires statewide implementation of managed MH/DD/SAS care by July 1, 2013.
Stakeholder forums have begun with the first area of transition, Alamance and Caswell counties. Stakeholder meetings have been held with participants, providers and community partners to discuss the waiver expansion and transition issues in these two counties. Future meetings are planned with the remaining eight counties. The same processes that were used in the 2005 implementation will be employed in this implementation to ensure stakeholder input and a seamless transition.

A public process with significant opportunity for public comment by individuals of all races and ethnicities was utilized in designing the original framework for the PBH pilot program. A series of local forums to obtain input from all stakeholders was conducted and a consumer family advisory committee was established to ensure consumer input to both the planning process and the ongoing operation of the program. A website was also developed which provided information about PBH's plan and a feedback link for public comments. Since the waiver was implemented in April 2005, the PBH plan has maintained open communication with consumers, providers and other stakeholders through consumer and provider satisfaction surveys, grievance tracking and analysis, and active consumer affairs and community relations offices. Outreach, cultural sensitivity and coordination with community resources for the best possible consumer outcomes are the central focus of the consumer affairs and relations offices. As described in detail in Section C, Monitoring Results, stakeholder feedback from the PBH pilot was incorporated for system improvement in PBH expansion.

For the statewide expansion, the following public process has occurred:

- **Session Law 2009-451 authorizes DHHS to "carry out pilot programs for prepaid health plans, contracting for services, managed care plans, or community-based services programs in accordance with plans approved by the United States DHHS or when DHHS determines that such a waiver will result in a reduction in the total Medicaid costs for the recipient." Based on this authority, the DHHS Secretary instructed DHHS to prepare for an expansion of the concurrent PBH 1915(b)/(c) waivers to other areas of the State. The Secretary provided information on the plan to the Joint Legislative Oversight Committee on MH, DDs and SAS during regularly scheduled meetings in September and October of 2009.**
- **DHHS facilitates meetings quarterly with the directors of the LMEs. DHHS's DMA and DMH directors presented and discussed the expansion plan at the October 21, 2009 meeting. DHHS officials will continue to provide updates and accept input, comments and questions at these meetings.**
- **DMH sponsors an External Advisory Team, a stakeholder group with representation from LMEs, providers, professional organizations and consumers, which advises DMH on statutes, rules, and policies. DMA and DMH directors and officials attend monthly meetings and will be discussing and receiving comments on the waivers at future meetings.**
- **The State Consumer and Family Advisory Committee (SCFAC), which communicates information to the local Consumer and Family Advisory Committees, is a primary means of communicating with consumers. The committee meets monthly and the DMH director provides updates on issues that impact and are of interest to consumers. The waiver expansion plan has been mentioned at these meetings and further discussion will be held in the January 2010 State SCFAC meeting.**

- **DMA will notify providers of the planned changes via monthly Medicaid Bulletins. The first article about the expansion will be in the December Bulletin and subsequent Bulletins will contain updates on progress with the waiver, entities selected for expansion and implementation of the new processes and procedures for service authorization and delivery.**
- **DMA announced the expansion at the November 2009 North Carolina Finance and Reimbursement Organization (NC-FARO) conference. NC-FARO is a non-profit organization that supports all stakeholders in the public MH/DD/SA service sector.**
- **The North Carolina Council of Community Programs is a non-profit organization that supports member LMEs in areas such as policy analysis, educational programs and technical assistance. The DMA and DMH directors provide updates at monthly directors' forums and discussed the waiver expansion at the December 2009 conference.**
- **The county Departments of Social Services (DSSs) assist the State in the local administration of the Medicaid program and are primary contacts for many Medicaid recipients. DMA will provide information regularly on the waiver expansion to the DSSs through formal written communications. In addition, DMA has a team of Medicaid Program Representatives who consult with and provide technical assistance on program changes to their respective counties on a regular basis.**
- **Once entities are selected for waiver participation, DMA will send written communication to all affected consumers with detailed information on how to access services in their respective geographic areas.**
- **The request for applications for waiver participation required applicants to describe in detail their plans for engaging and educating consumers, providers and other stakeholders on the new program. The State included specific requirements around stakeholder activities, such as a minimum number of forums, samples of informational materials, etc.**
- **The State conducted a bidders' conference for all interested PIHPs to clarify expectations.**
- **DHHS has formed a core work group with representatives from DMA and DMH who are working with the State's contracted consultant to develop expertise on waiver development, plan selection criteria and readiness for transition to managed care operations. The work group will be responsible for training and providing information to their colleagues in both agencies to facilitate the transition to managed care. DMH has designated a leadership team for the project and is providing regular updates to staff via their website. This core work group continues to operate and meets on a regular basis and provides technical assistance to the future PIHPs**
- **Comments on the waiver renewal were solicited via the DMA website at least 60 days prior to submission.**

- **The State continues to provide waiver updates and seek input from the following organizations on a regular basis: State CFAC, Children & Family Services Association (CFSA-NC), North Carolina Providers Council, Provider LME Leadership Forum (PLLF), NC Psychiatric Association, NC Psychological Association and the I/DD Consortium.**

Tribal consultation

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

The Eastern Band of Cherokee is the only federally recognized tribe with tribal lands in North Carolina. The tribal lands are located in five counties in the far western part of the State near Tennessee. A letter outlining this waiver amendment was sent to the tribe on November 18, 2009, and comments were solicited. No comments have been received as of this date. The Eastern Band of Cherokee was notified of the waiver renewal and has the continuing opportunity for input. The State formally notified tribal leaders of the plan to expand the waiver in writing on June 30, 2011 and discussed the expansion via conference call in detail on July 6, 2011. In addition, the State had a conference call with tribal leaders on April 20, 2011 to discuss and solicit input on the expansion.

Program history

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

The North Carolina General Assembly, in session law 2001-437, designated the local MH authorities, also known as local management entities (LMEs), as the focus of coordination for the provision of all publicly-funded MH/DD/SAS. This system underwent reform a few years ago, which required that the area authorities transition from providers of services to managers of services. The reform required that the State's local area authorities divest of service provision and become Local Management Entities (LMEs) for all publicly-funded MH/DD/SA services, including Medicaid-funded services. Most services are now provided through the private sector, and LMEs have MH/DD/SAS system management and oversight responsibilities.

Specific LME responsibilities are as follows:

- **Serve as the single portal for HCBS eligibility.**

- **Provide information to HCBS waiver participants about their rights and protections.**
- **Assure family/recipient awareness and choice for all available HCBS waiver services and responsibilities, including the right to change providers**
- **Resolve issues related to participants' health and safety or service delivery that are unresolved by the case manager**
- **Conduct annual health and safety reviews for unlicensed Alternative Family Living residences.**
- **Manage appeals for levels of care**
- **For lead agency billed services, process billing, verify that billing does not exceed cost summary, transmit billing, post remittance advises, research denials and rebilling as indicated, and order/purchase non-service items**
- **Maintain service provider list, recruit providers to address unmet needs, provide training and technical assistance to provider agencies endorsed to provide services in the lead agency catchment area**
- **Assure family/recipient awareness and choice for all available waiver services**
- **Utilize paid claims as warranted by specific situations as needed with follow up on any discrepancies noted.**
- **Provide or arrange for 24/7/365 crisis response system.**
- **Conduct the endorsement (credentialing) process for providers.**
- **Conduct ongoing monitoring of endorsed providers based on a standardized monitoring protocol and scheduled based on a confidence level calculation.**
- **Provide technical assistance to providers.**
- **Oversee and provide follow-up of to ensure implementation of plans of correction.**
- **Implement a quality improvement system that includes an incident review committee, external CFAC, quality improvement committee, and client rights committee.**
- **Receive, track and respond to participant complaints and appeals.**
- **Receive, track and respond to incident reports from providers; prepare incident trend reports for DMH/DD/SAS.**
- **Assess community service needs and develop provider capacity.**
- **Monitor and oversee case managers working with individuals leaving state facilities to ensure they are monitoring health and safety and implementation of the person-centered plan (PCP).**

Piedmont Behavioral Healthcare (PBH), an LME serving five counties, was the initial pilot program for this waiver. PBH has been at the forefront of MH/DD/SAS system reform, and the State of North Carolina created the pilot program giving PBH the authority to manage both services and funding and function for Medicaid purposes as a PIHP. This waiver, which operates concurrently with a 1915(c) waiver, Innovations, was implemented in the

five PBH counties on April 1, 2005. All Medicaid participants in the eligibility groups covered under the waiver and residing in the PBH catchment area were mandatorily enrolled in the single PIHP on April 1, 2005.

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

The program has been closely scrutinized during its six years of operation through mandatory External Quality Review Organization (EQRO) activities, independent assessments, the Intra-Departmental Monitoring Team (IMT), on-site reviews of operations and NCQA accreditation activities. PBH was fully accredited by NCQA in 2010. As described in Section C, Monitoring Results, feedback from these review and oversight activities have been (and will continue to be) used for system improvements.

Due to the success of the capitated PBH model, the State requested and obtained approval from CMS in February of 2010 to expand the model to other LMEs across the State over time. Regional entities, consisting of one or more LMEs, were given the opportunity to apply to participate in the waiver as a PIHP through a request for applications (RFA) process. Four LMEs, in addition to PBH, were selected and are expected to begin operating in 2012.

Each PIHP will be required to develop a plan of operation which will ensure that services are provided in a prompt and efficient manner to those who need them. The plans submitted by PBH will focus on delivering services of the best quality; serving people in the context of finite resources; and assuring that individuals who want to remain in or return to their communities are able to do so. As PIHPs, the new capitated entities will recruit providers and develop and oversee a comprehensive MHDDSAS provider network that assures access to care for all enrollees. Health plans will be paid per member per month (PMPM) capitated payments and will be responsible for authorizing payments for services, processing and paying claims, and conducting utilization and quality management (QM) functions. As a PIHP, health plans will be at financial risk for a discrete set of MH, DD and SA services, including both Medicaid State Plan services and services contained in the NC Innovations HCBS waiver for persons with MR and DD. All age groups will be covered.

The Division of Medical Assistance (DMA), the State Medicaid Agency, will assure accountability and effective management of the waiver programs. DMA will retain the responsibilities of approving all policies and requirements concerning the waiver. Please note that references to DHHS in this waiver include both the DMA as well as the Division of Mental Health/Developmental Disabilities/Substance Abuse Services DMH/DD/SAS. Oversight of the concurrent waivers is performed by an Intra-Departmental Monitoring Team (IMT) with representation from all divisions within the DHHS involved in the operation of the 1915(b)/(c) waivers. The IMT meets quarterly with DMA leading the team. References to the operating agency in the 1915(c) documentation refer to DMH/DD/SAS even though it is not officially the operating agency – instead it is a sister division with some operational functions. DMA has sole responsibility for operations of the NC Innovations waiver.

A. Statutory Authority

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

a._X__ **1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.

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

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

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

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

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

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

Section 1902(a)(1) - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

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

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

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

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

B. Delivery systems

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

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

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

X PIHPs are paid on a risk basis.
___ PIHPs are paid on a non-risk basis.

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

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

___ The PAHP is paid on a risk basis.
___ The PAHP is paid on a non-risk basis.

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

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

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

___ **Competitive** procurement process (e.g., Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience).
___ **Open** cooperative procurement process (in which any qualifying contractor may participate).
X__ **Sole source** procurement. CMS Regional Office prior approval required.

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

Justification for sole source to capitated PIHP entities

The North Carolina General Assembly, in Session Law 2001-437, (codified at NC Gen. Stat. 122C) mandates that DHHS implement comprehensive reforms to the State's public MH/DD/SA system. The statute, and corresponding "Blueprint for Change" adopted by DHHS, designates the local MH authorities as the "locus of coordination" for the provision of all publicly-funded MH/DD/SA services.

The goal of the North Carolina State Reform is to have one local system manager that manages the complexities of the myriad State, Federal, County and Medicaid funds to ensure access to a seamless system of care for people with MH, DDs and SAS needs. This objective can best be accomplished through a managed system in which the consumer has access, through a single local entity, to all resource streams (Medicaid, State/Federal, and County) that finance services and supports needed by consumers. This LME must bring together multiple policies, programs and payment resources and reconcile differing eligibility requirements in order to achieve optimal outcomes. Consumers with serious mental illness, DDs and addictive disorders need highly specialized assistance, distinctive care management strategies, specialized interventions and highly individualized support arrangements that are not typically available from or covered by other payers and managed care systems. The coordination of these services requires collaboration and cooperative relationships among many agencies, including public health, social services,

housing, education, criminal justice and others. Managing care for these consumers requires a high degree of specificity, organization and integration of its management system, including dedicated programs, transaction-specific facilities and a specialized workforce. There must be a strong, ongoing and collaborative relationship between the purchaser and the providers in order to achieve the necessary investment to support these services at the provider level.

Inherent in North Carolina's model is the assumption that its local public MH/DD/SAS authorities are the only organizations capable of managing the complex service and support needs of the specialty population. These public entities are political subdivisions of the State under North Carolina General Statute 122C and most have been in place over 30 years. The authorities have had the ongoing role of protecting vulnerable populations and supporting full participation and inclusion of these consumers in local communities. This is possible due to the local systems and relationships that they have developed over a long period of time. The infrastructure for managing services and supports for these populations is already in place.

These local public authorities have divested themselves of direct service provision to foster the development of more and varied private providers, increasing access and choice for consumers. The local authority must coordinate with other local agencies and stakeholders to organize resources (specialized and generic) and effectively connect consumers and families with appropriate community services and supports. These efforts achieve greater system efficiency, improve access for consumers, develop a more comprehensive array of provider choices and LOCs, and increase provider-to-provider collaboration and coordination while reducing instances of ineffective, inefficient or wasteful use of limited public resources. The key to achieving these goals involves assigning a "locus of coordination and authority" to a local public entity, charged by State statute, its consumers and the community at large with organizing a system of services and supports that is more responsive and highly accountable to funders, other systems requiring BH services and providers. The local authorities were identified as the "locus of coordination" because of the local authority's decades of experience as the "safety net" for individuals with MH/DD/SA needs, many years of work establishing critical collaborative local relationships and the ability to apply their specialized knowledge to inherently unique characteristics of local communities.

Private MCOs with the necessary capacity, essential localized experience and relationships and incumbent public BH expertise are virtually nonexistent in North Carolina. The vast majority of North Carolina's employer-based healthcare purchasers have chosen not to furnish benefits through MCOs. A specialized BH managed care vendor provides limited, paper-transaction-based utilization review of some BH services once an individual's utilization exceeds certain thresholds in the FFS system. The State and local authorities

have always held all the financial risk and public accountability for public BH services in North Carolina. Consumers, local elected officials, State lawmakers and policymakers – none of these groups has determined that a private MCO can successfully and quickly implement the reform-driven business model in a manner that will be locally responsive and consistent with local, State and federal requirements.

State law redirects the mission of the local authorities from being primarily providers of MH/DD/SA direct services to the role of delivery system manager. Each local authority is required to work with the area's consumers, family members, citizens at large, providers, other community stakeholders and other systems' local authorities to develop a local business plan for the management, delivery and oversight of publicly-funded MH/DD/SA services. The local authorities are required to contract with "qualified public or private providers, agencies, institutions, or resources …" to ensure that core or basic MH/DD/SA services are available locally and that individuals, particularly those considered to have high-needs, are identified and receive the appropriate services. The emphasis is to empower consumers and to provide a choice of providers and services that most significantly impact the person's life, rather than a choice of plan administrators. A single plan administrator within a region will achieve greater administrative efficiencies, and more funding for services to consumers.

The local authority must arrange an accessible screening, triage and referral system, provide for changes in the authority's governance (including the establishment of a CFAC), assure that services and supports are being delivered pursuant to the consumer-developed PCP, monitor providers, encourage the development of coordination/affiliation arrangements among private providers serving consumers with public funds, perform quality improvement activities, incorporate local conditions and needs in plans to purchase services, and provide mechanisms to enable North Carolinians living in institutions to have access to appropriate services necessary to enable them to live in the community, if the consumer so chooses. Local authorities are required to accomplish this system coordination and management by performing a number of identified administrative functions, in a manner that ensures maximum coordination of public MH/DD/SA funds and resources, in ways that are responsive to unique local needs, and to do so while complying with federal and State funding requirements (including 42 USC 1396a, et seq.).

The local business plan sets forth how the authority will meet these responsibilities. Local authorities submit these local business plans to their county commissioners, who by resolution, approve and adopt the plan. In turn, the local authority submits the approved local business plan to DMH, which determines if the plan demonstrates that the local authority has the capacity to perform the administrative functions required of a LME. Local authorities meeting all of these requirements are then certified by DHHS as LMEs.

Developing the fulcrum of LME functionality involves a highly participatory, local and public process involving individuals and agencies throughout the communities served. To be successful, an LME must make significant investments that are directed by that community, through the public governance model, in ways that meet State and Federal requirements. Inherent in this arrangement is the State's determination that local authorities are best situated to perform the roles of an LME.

This model is how North Carolina has chosen to meet the goals. The original pilot, PBH, the five-county local authority, submitted its approved local business plan, and was certified as an LME. PBH entered into a performance agreement with DHHS to assume responsibility for the local management of all State and local public funding for MH/DD/SA services. The agreement requires that a comprehensive array of public resources be coordinated to the greatest extent possible to increase access, improve quality and realize savings by removing barriers to consumers' ability to achieve Resilience, Recovery and/or Self-Determination while living in the community.

Additional capitated PIHPs will be selected by the State to apply this innovative approach to Medicaid services, under this Waiver renewal request. Pursuant to its LME certification, the capitated PIHPs will arrange for the provision of all MH/DD/SA services purchased with public funds on behalf of individuals residing in its five-county area. The State wants to include Medicaid MH/DD/SA services within the array of resources being coordinated by the capitated PIHPs; accordingly, and in light of the absence of other entities with the requisite capacity and local experience, the State will selected the capitated PIHPs as the plans for the 1915(b) waiver. Savings achieved under this waiver will not be used for non-Medicaid consumers, but will be shared through additional services for Medicaid waiver enrollees through approved 1915(b)(3) services.

Throughout the waiver period, the State will continue its efforts to identify any other entities that may come to have developed the capacity to 1) coordinate all of the public resources; 2)address the unique characteristics of North Carolina's diverse local communities through collaboration with community-based stakeholders; 3) adhere to the principles of North Carolina's Blueprint for Change and the goals of the New Freedom Commission; and 4) are found to be acceptable by the local community's Consumer and Family Advisory Committee. If such entities are identified, the State will examine whether

the compelling justification for a sole source continues to exist in subsequent renewal periods.

As noted earlier in this document, the existing 1915(b) and 1915(c) waivers have been modified to reflect that the program will no longer be a pilot with a single capitated provider in a limited geographic area.

C. Choice of MCOs, PIHPs, PAHPs and PCCMs

1. **Assurances.**

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

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

Capitated PIHPs are local MH authorities coordinating publicly-funded MH/DD/SA services for over 30 years. The North Carolina General Assembly, in Session Law 2001-437, designated the local area authorities as the "locus of coordination" for the provision of all publicly-funded MH/DD/SA services. Under these circumstances, the State does not believe that making only one plan available will negatively impact recipients' access to care. On the other hand, the State believes that the capitated PIHPs are in a unique position to bring together the services and supports, both formal and informal, and providers, both professional and paraprofessional, that are needed to meet the complex needs of these populations. The LMEs have decades of experience locating and developing services for consumers with MH/DD/SAS needs, and over the years, have built strong and collaborative working relationships with the providers of these services. These providers support this initiative and consumers have at least as much choice in individual providers as they had in the pre-reform non-managed care environment. By delivering, managing and paying for services through this one public entity with the appropriate experience, the State has streamlined and simplified the delivery system, better identified those in need of services as well as their level of need and achieved a savings which LMEs, as public entities, have reinvested in the system. Private MCOs with this type of experience and relationships with local human service agencies and facilities are largely nonexistent in North Carolina.

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

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

Enrollees will have free choice of providers within the PIHP serving their respective geographic area and may change providers as often as desired. If an individual joins the PIHP and is already established with a provider who is not a member of the network, the PIHP will make every effort to arrange for the consumer to continue with the same provider if the consumer so desires. In this case, the provider would be required to meet the same qualifications as other providers in the network. In addition, if an enrollee needs a specialized service that is not available through the network, the PIHP will arrange for the service to be provided outside the network if a qualified provider is available. Finally, except in certain situations, enrollees will be given the choice between at least two providers. Exceptions would involve institutional services or highly-specialized services which are usually available through only one facility or agency in the geographic area.

3. **Rural exception.**

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

D. Geographic Areas Served by the Waiver

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

X__Statewide – all counties, zip codes or regions of the State.
The program is being expanded statewide under the roll-out plan as included on the face sheet.

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

City/County/Region	Type of program (PCCM, MCO, PIHP or PAHP)	Name of entity (for MCO, PIHP or PAHP)
This waiver currently includes the following counties: Cabarrus, Davidson, Rowan, Stanly, Union. Effective 10-1-11, Alamance, Caswell are added; effective 1-1-12, Franklin, Granville, Halifax, Vance and Warren are added; and effective 4-1-12, Orange, Person, and Chatham are added	**PIHP**	**Piedmont Behavioral Healthcare (PBH)**
Effective 1-1-12: Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, and Yancey Counties	**PIHP**	**Western Highlands**

City/County/Region	Type of program (PCCM, MCO, PIHP or PAHP)	Name of entity (for MCO, PIHP or PAHP)
Effective 4-1-12: Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Gates, Hertford, Hyde, Jones, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrell, and Washington Counties	**PIHP**	**East Carolina Behavioral Health (ECBH)**
Effective 7-1-12: Anson, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, and Richmond Counties.	**PIHP**	**Sandhills**
Effective 7-1-12: Alexander, Allegheny, Ashe, Avery, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, Macon, McDowell, Swain, Watauga and Wilke Countie	**PIHP**	**Smoky Mountain Center**
Effective 1-1-13: Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Surry, and Yadkin Counties	**PIHP**	**Pathways**
Effective 1-1-13: Bladen, Columbus, Duplin, Edgecombe, Greene, Lenoir, Nash, Robeson, Sampson, Scotland, Wayne, and Wilson Counties	**PIHP**	**Eastpointe**
Effective 1-1-13: Mecklenburg County	**PIHP**	**Mecklenburg**
Effective 1-1-13: Durham, Cumberland, Johnston, and Wake Counties	**PIHP**	**Durham Center**
Effective 1-1-13: Davie, Forsyth, Rockingham, and	**PIHP**	**Centerpoint**

City/County/Region	Type of program (PCCM, MCO, PIHP or PAHP)	Name of entity (for MCO, PIHP or PAHP)
Stokes Counties,		
Effective 1-1-13: Brunswick, New Hanover, Pender, Onslow, and Carteret Counties	**PIHP**	**Southeastern Center**
Effective 1-1-13: Guilford	**PIHP**	**Sandhills**

E. Populations Included in Waiver

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

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

X Mandatory enrollment
___ Voluntary enrollment

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

X Mandatory enrollment
___ Voluntary enrollment

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

X Mandatory enrollment
___ Voluntary enrollment

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

X Mandatory enrollment
___ Voluntary enrollment

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

X Mandatory enrollment
___ Voluntary enrollment

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

X Mandatory enrollment
___ Voluntary enrollment

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

___ Mandatory enrollment
___ Voluntary enrollment

The following groups are also included:

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

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

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

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

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

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

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

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

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

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

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

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

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

X_ **Other –** Please define.

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

F. Services

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

1. **Assurances.**

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

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

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

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114 and 431.51 (Coverage of Services, Emergency Services and Family Planning) as applicable, and these contracts are effective for the period April 1, 200**9,** to March 31, 200**11**.

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

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

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

___ PBH or PAHP does not cover emergency services.

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

___ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services
___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers
___ The State will pay for all family planning services, whether provided by network or out-of-network providers.
___ Other (please explain):

X Family planning services are not included under the waiver.

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

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

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

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

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

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

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

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

1915(b)(3) Services.

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

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

Service	Populations eligible	Provider type	Geographic eligibility	Reimburse ment
	or greater), OR children ages 3-21 and adults with a DD diagnosis			
Supported employment consistent with the NC Innovations 1915(c) waiver program supported employment definition and limitations. **Supported employment** – initial job development, training and support: A maximum of 86 hours (344 units) per month for the first 90 days; **Supported employment –** intermediate training and support: a maximum of 43 hours (172 units) per month for the second 90 days. Long Term **Vocational s**upport: a maximum of 10 hours (40 units) per month. Specific authorization must be obtained to exceed these limits.	Persons age 16 and older, who are not eligible for this service under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142, and who are eligible but not enrolled in the NC Innovations 1915(c) waiver program.	Providers must meet all NC Innovations waiver provider requirements and be enrolled 1915(c) waiver providers.	Entire capiatated service area.	Separate 1915(b)(3) capitation rates certified by the State's actuary.
Personal Care/Individual Support Personal Care under the current North Carolina State Plan emphasizes the need for assistance with activities of daily living (ADLs). Some assistance with instrumental activities of daily living (IADLs) is covered but only to the extent linked to ADLs. This service (personal care – individual support) is coverable under the State Plan but North Carolina has not included in its approved State Plan. Personal Care (Individual Support) is not covered under the NC Innovations waiver and is a "hands-on" service for persons with severe and persistent mental illness, a population that is not covered under the NC Innovations	Adults ages 18 and older with a diagnosis of Severe and Persistent Mental Illness and a LOCUS level of II or greater. Persons between the ages of 18 and 21 may not live in a Medicaid funded child RTF.	Paraprofessional staff employed by the contracted provider and supervised by that provider's appropriate Qualified Professional. The Paraprofessional must have a high school degree and two years of experience working with adults with mental illness. A minimum of 20 hours of initial training will be required.	Entire capitated service area.	Separate 1915(b)(3) capitation rates certified by the State's actuary. Total expenditures on Personal Care cannot exceed 1915(b)(3) resources available in the waiver.

Service	Populations eligible	Provider type	Geographic eligibility	Reimburse ment
waiver. The intent of the service is to teach and assist individuals in carrying out instrumental activities of daily living, such as preparing meals, managing medicines, grocery shopping, and managing money, so they can live independently in the community. We envision that the need for the service will "fade" or decrease over time as the individual becomes capable of performing some of these activities more independently. Units are provided in 15-minute increments. No more than 240 units per month (60 hours per month) of Individual Support may be provided unless specific authorization for exceeding this limit is approved.				
One-time transitional costs consistent with the NC Innovations 1915(c) waiver program community transition services definition and limitations.	Adults who are functionally eligible but not enrolled in the NC Innovations 1915(c) waiver program . The plan may choose to provide to other populations under 42 CFR 438.6(e) if cost-effective alternatives to State Plan services. Per the May 9, 2002 SMDL #02-008, the individual must be moving out of a licensed facility, their family home, hospital or institution into his or her own home.	Providers must meet all NC Innovations waiver provider requirements and be enrolled 1915(c) waiver providers.	Entire capitated service area.	Separate 1915(b)(3) capitation rates certified by the State's actuary. Transitional costs cannot exceed 1915(b)(3) resources available in the waiver.
Psychosocial rehabilitation/Peer supports This service (psychosocial Rehabilitation/peer supports) is coverable under the State Plan but North Carolina has not included in its approved State Plan. This service has been found to be more cost-effective than Community	Adults ages 18 and older with identified needs in life skills, who: (1) have an Axis I or II diagnosis present; and (2) meet LOC criteria	North Carolina Certified peer support specialists and paraprofessionals, who: (1) possess a high school degree or GED equivalent; and (2) are supervised by a qualified professional according to 10A NXCAC 27G .0204; and	Entire **capitated** service area	Separate 1915(b)(3) capitation rates certified by the State's actuary. Psychosocial rehab/Peer Supports

Service	Populations eligible	Provider type	Geographic eligibility	Reimbursement
Supports and is a Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based practice. Peer support services are structured and scheduled activities for adults age eighteen and older with MH/SA disability. Peer supports are provided by peer support staff. Authorizations will be made as follows: • Initial authorization: First 90 days (or when a person is experiencing a period of instability): No more than 20 hours per week individual and/or group. • Step down to sustaining support: After first 90 days and up to subsequent 90-days no more than 15 hours per week except when necessary to address short-term problems/issues • Intermittent support: After 180 days, no more than 10 hours per week of individual and/or group. A maximum of 20 units of peer support services individual and/or group can be provided in a 24-hour period by any one peer support staff. No more than 80 units per week of services can be provided to an individual. If medical necessity dictates the need for more service hours, consideration should be given to interventions with a more intense clinical component; additional units may be authorized as clinically appropriate.	for LOCUS Level I or ASAM I. Persons ages 18 – 21 may not live in a child RTF.	(3) are not a member of the family of the person receiving peer support services. Paraprofessional level providers must meet requirements in 10 NCAC 27G 0104.		cannot exceed 1915(b)(3) resources available in the waiver.
NC Innovations waiver services – consistent with the NC Innovations 1915(c) waiver program services definition and limitations.	Children ages 3-21 (not living in a child RTF) and adults who are functionally eligible but not enrolled in the NC Innovations 1915(c) waiver program: • exiting ICF-	Providers must meet all NC Innovations waiver provider requirements and be enrolled 1915(c) waiver providers.	Entire capitated service area.	Separate 1915(b)(3) capitation rates certified by the State's actuary. Total expenditures

Service	Populations eligible	Provider type	Geographic eligibility	Reimbursement
	MRs			cannot exceed 1915(b)(3) resources available in the waiver.
Physician consultation Communication between a primary care provider and a Psychiatrist for a patient specific consultation that is medically necessary for the Medical Management of psychiatric conditions by the primary care provider. This service is coverable under the State Plan under physician services. **Brief:** Simple or brief communication to report tests and/or lab results, clarity or alter previous instructions, integration new information into the medical treatment plan or adjust therapy or medication regimen. **Intermediate:** Intermediate level of communication between the Psychiatrist and the primary care provider. Does not require face to face assessment of patient. To coordinate medical management of a new problem in an established patient, evaluate new information and details and/or initiate a new plan of care, therapy or medication regime. **Extensive:** Complex or lengthy communication such as a prolonged discussion between the psychiatrist and the primary care provider regarding a seriously ill patient, lengthy communication needed to consider lab results, response to treatment, current symptoms or presenting problem. Staffing of case between psychiatrist and primary care provider to consider evaluation findings and discuss treatment recommendations, including	Must be under the care of a primary care provider, and require e consultation between a psychiatrist and their primary care practitioner for appropriate medical or MH treatment Adults ages 18 and older with Severe Mental Illness and a Locus level of 0 (basic level). Children ages 3-21 with Serious Emotional Disturbance and a CALOCUS level of 0 (basic level).	Primary care provider or Board Certified in adult or child psychiatry and holds a current license in the state of North Carolina.	Entire capitated service area	Separate 1915(b)(3) capitation rates certified by the State's actuary. Total expenditures cannot exceed 1915(b)(3) resources available in the waiver.

Service	Populations eligible	Provider type	Geographic eligibility	Reimbursement
medication regimen.				
Community Guide Consistent with the NC MH/DD/SAS 1915(c) waiver program Community Guide definition and limitations, as described below. **Community Guide Services provide support to participants and planning teams that assist participants in developing social networks and connections within local communities. The purpose of this service is to promote self-determination, increase independence and enhance the participant's ability to interact with and contribute to his or her local community. Community Guide Services emphasize, promote and coordinate the use of natural and generic supports (unpaid) to address the participant's needs in addition to paid services. These services also support participants, representatives, employers and managing employers who direct their own waiver services by providing direct assistance in their participant direction responsibilities. Community guide services are intermittent and fade as community connections develop and skills increase in participant direction; however, a formal fading plan is not required. Community guides assist and support (rather than direct and manage) the participant throughout the service delivery process. Community Guide services are intended to enhance, not replace, existing natural and community resources. Specific functions are: (1) Assistance in forming and sustaining a full range of relationships with natural and community supports that allows the participant meaningful**	Children ages 3-21 and Adults who are functionally eligible but not enrolled in the NC Innovations 1915(c) waiver program	Providers must meet all NC Innovations waiver provider requirements, as outlined below, and enrolled in the 1915(c) waiver: **Community Guide from provider agencies in a non-self directed arrangement must meet the following requirements:** • **Approved as a provider in PIHP provider network:** • **Are at least 18 years old** • **If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance** • **Criminal background check presents no health or safety risk to participant** • **Not listed in the North Carolina Health Care Abuse Registry** • **Staff that work with participants must be qualified in CPR and First Aid** • **Staff that work with participants must have a high school diploma or high school equivalency (GED)** • **Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP** • **Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline. Associate professionals**	Entire capitated service area	Separate 1915(b)(3) capitation rates certified by the State's actuary. Total expenditures cannot exceed 1915(b)(3) resources available in the waiver.

Service	Populations eligible	Provider type	Geographic eligibility	Reimbursement
community integration and inclusion **(2) Support to develop social networks with community organizations to increase the participant's opportunity to expand valued social relationships and build connections within the participant's local community** **(3) Assistance in locating and accessing non-Medicaid community supports and resources that are related to achieving Individual Support Plan (ISP) goals; this includes social and educational resources, as well as natural supports.** **(4) Instruction and counseling, which guides the participant in problem solving and decision making** **(5) Advocacy and collaborating with other individuals and organizations on behalf of the participant** **(6) Supporting the person in preparing, participating in and implementing plans of any type (IEP, ISP or service plan).** **(7) Provide training on the Individual and Family Directed Supports Option, if the participant is considering directing services and supports** **(8) Guidance with management of the participant directed budget** **(9) Providing information on recruiting, hiring, managing, training, evaluating and changing support staff, if the participant is self-directing services** **(10) Assisting with the development of schedules and outlining staff duties, if the participant is self-directing**		**providing supervision to paraprofessionals on the date of the implementation of this waiver amendment are grandfathered through 3/31/2012** • **Additionally, effective January 1, 2012 or upon enrollment with PBH, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of PBH. This includes national accreditation within the prescribed timeframe** • **Meets community guide competencies specified by PBH** • **Must meet applicable requirements of NC G.S. 122C (the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985)** **Community Guide from provider agencies in a self directed arrangement must meet the following requirements:** • **Recommended by managing employer and approved by Agency with Choice** • **At least 18 years old** • **Able to effectively read, write and communicate verbally in English, understand instructions and perform record keeping** • **If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance**		

Service	Populations eligible	Provider type	Geographic eligibility	Reimbursement
services **(11) Assisting with understanding staff financial forms, qualifications and record keeping requirements, if the participant is self-directing services** **(12) Providing on-going information to assure that participants and their families/representatives understand the responsibilities involved with self-direction, including reporting on expenditures and other relevant information and training** **(13) Coordinating services with the Agency with Choice if the participant is directing services under the Agency with Choice Model** **(14) Informing and coordinating community resources including coordination among, primary, preventative and chronic care providers** **This service does not duplicate care coordination. Care coordination under managed care includes assisting the participant in the development of the ISP, completing or gathering evaluations inclusive of the re-evaluation of the level of care, monitoring the implementation of the ISP, choosing service providers, coordination of benefits and monitoring the health and safety of the participant consistent with 42 CFR 438.208(c).** **The amount of community guide services is subject to the amount of the participant's Support Need Matrix Category Budget as specified in Appendix C-4.**		• **Criminal background checks present no health or safety risk to participant** • **Not listed in the North Carolina Health Care Abuse Registry** • **Qualified in CPR and First Aid and the customized needs of the participant as described in the individual service plan (ISP)** • **High school diploma or equivalency and supervised by the managing employer** • **Clinical oversight by a qualified professional or associate professional under the supervision of a qualified professional in the field of developmental disabilities employed by Agency with Choice** • **Meets community guide competencies as specified by PBH** • **Must meet applicable requirements of NC G.S. 122C (the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985)** **Community Guide services cannot be provided by a legally responsible person or a relative or legal guardian.**		

7. **Self-referrals.**

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

- **Basic benefits (outpatient) – Eight visits per year for adults, 12 visits per year for children**
- **Medically managed detoxification (16 hours/episode)**
- **Mobile crisis – Eight hours per event**
- **Diagnostic assessments – Two per year for adults and children**
- **Medication check – Prior authorization (PA) not required**
- **Medication administration – PA not required**
- **Facility-based crisis – 16 hours per episode**

Section A: Program Description

Part II: Access

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

A. Timely Access Standards

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

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

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

X The CMS Regional Office has reviewed and approved the MCO, PIHP or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206, Availability of Services, and these contracts are effective for the period April 1, 200**9,** to March 31, 20**11**.

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

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

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

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Hospitals (please describe):

6.___ Mental Health (please describe):

7.___ Pharmacies (please describe):

8.___ Substance Abuse Treatment Providers (please describe):

9.___ Other providers (please describe):

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

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Urgent care (please describe):

8.___ Other providers (please describe):

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

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Other providers (please describe):

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

B. Capacity Standards

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

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

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

X The CMS Regional Office has reviewed and approved the MCO, PIHP or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services and these contracts are effective for the period April 1, 200**9,** to March 31, 20**11**.

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

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

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

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

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

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

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

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

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

e.___ The State ensures adequate **geographic distribution** of PCCMs. Please describe the State's standard.

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

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

Statewide Average: (e.g. 1:500 and 1:1,000)	

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

C. Coordination and Continuity of Care Standards

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

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

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

X The CMS Regional Office has reviewed and approved the MCO, PIHP or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208, Coordination and Continuity of Care, and these contracts are effective for the period April 1, 200**9,** to March 31, 20**11**.

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

The following items are required.

a. __ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that PBH/**PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.

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

- **In order to identify enrollees with special needs, PBH is required to identify clients who meet the following criteria:**
  - **Adults who are Severely Persistently Mentally Ill**
  - **Children who are Severely Emotionally Disturbed**
  - **Individuals with Intellectual Developmental Disability (IDD) who are functionally eligible for ICF-MR**
  - **Female Temporary Assistance for Needy Families recipients with SA dependency diagnoses**
  - **Individuals with co-occurring diagnoses**
  - **Individuals who are IV drug or opiate users**

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

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

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

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

2. **X** Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan).

3. **X** In accord with any applicable State quality assurance and utilization review standards.

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

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

N/A

a. ___ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.

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

c. ___ Each enrollee is receives **health education/promotion** information. Please explain.

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

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

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

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

h. ___ **Additional case management** is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).

i. ___ **Referrals**: Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

Section A: Program Description

Part III: Quality

1. **Assurances for MCO or PIHP programs**.

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

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

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii) – (iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240 and 438.242, and these contracts are effective for the period April 1, 200**9,** to March 31, 200**11**(with an option for a one year extension).

X Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this **quality strategy** was submitted to the CMS Regional Office on **the date of submission of this waiver request.**

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

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

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

2. **Assurances For PAHP program.**

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

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

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

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

N/A

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

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

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

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

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

4.___ Refer to program staff for further investigation;

5.___ Send warning letters to PCCMs;

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

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

8.___ Change an enrollee's PCCM;

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

10.___ Further limit the number of assignments;

11.___ Ban new assignments;

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

13.___ Suspend or terminate PCCM agreement;

14.___ Suspend or terminate as Medicaid providers; and

15.___ Other (explain):

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

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

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

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

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

   A. ___ Initial credentialing

   B. ___ Performance measures, including those obtained through the following (check all that apply):

      ___ The utilization management system.
      ___ The complaint and appeals system.
      ___ Enrollee surveys.
      ___ Other (Please describe).

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

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

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

7. __ Other (please describe).

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

Section A: Program Description

Part IV: Program Operations

A. Marketing

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

1. **Assurances**

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

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

_X__ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities and these contracts are effective for the period ___ to ___.

2. **Details**

a. **Scope of Marketing**

1.__X_The State does not permit direct or indirect MCO/PIHP/PAHP or PCCM marketing.

2.___ The State permits indirect MCO/PIHP/PAHP or PCCM marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

3.___ The State permits direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

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

1.___ The State prohibits or limits MCOs/PIHPs/PAHPs from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

2.___ The State permits MCOs/PIHPs/PAHPs and PCCMs to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3.__X_The State requires MCO/PIHP/PAHP and PCCM to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

Spanish

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

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

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

ii.__ The languages comprise all languages in the MCO/PIHP/PAHP/PCCM service area spoken by approximately ___ percent or more of the population.

iii.__ Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. **Assurances.**

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

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

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10, Information requirements, and these contracts are effective for the period April 1, 200**9,** to March 31, 20**11**.

2. **Details.**

a. **Non-English Languages**

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

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

1.__ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."

2. **X** The languages spoken by approximately **five** percent or more of the potential enrollee/ enrollee population.

3.__ Other (please explain).

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

The PIHPs make available to participants with limited English proficiency (LEP) and their legally responsible representative's materials that are translated into the prevalent non-English languages of the State. The PIHPs make interpreter services available to individuals with LEP through a contracts with telephone language lines and contracts with

individual providers in the community.. The PIHPs comply with the DHHS Title VI Language Access Policy.

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

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

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

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

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

___ State

___ contractor (please specify) _____

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

c. Enrollee Information

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

(i) ___ the State

(ii) ___ State contractor (please specify):_____

(ii) **X** the MCO/PIHP/PAHP/PCCM

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

C. Enrollment and Disenrollment

1. **Assurances.**

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

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

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

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

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56, Disenrollment requirements, and these contracts are effective for the period April 1, 200**9**, to March 31, 200**11**.

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

a. **X** **Outreach.** The State conducts outreach to inform potential enrollees, providers and other interested parties of the managed care program. Please describe the outreach process and specify any special efforts made to reach and provide information to special populations included in the waiver program:

- **The State officially notifies all potential enrollees by sending written communication to each Medicaid participant enrolled in Medicaid in one of the counties participating in the waiver.**
- **The State Medicaid agency notifies providers prior to program implementation and periodically thereafter through Medicaid Bulletins.**
- **Consumers with questions on eligibility and enrollment directed to a toll free number for the capitated PIHP member services unit. The unit provides information and referral for benefits assessment as needed.**

b. Administration of Enrollment Process.

X **State staff conducts the enrollment process.**

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

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

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

Broker name: _____

Please list the functions that the contractor will perform:

___ choice counseling
___ enrollment
___ other (please describe):

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

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

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

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

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

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

N/A

i. ___ Potential enrollees will have ___ days/month(s) to choose a plan.

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

X The State **automatically enrolls** beneficiaries

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

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

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

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

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

The State does not exempt any enrollees from enrolling in the plan. All Medicaid MH/DD/SA services are provided through the PIHP to Medicaid enrollees in the 15-county area.

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

d. **Disenrollment:**

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

i.___ Enrollee submits request to State.

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

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

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

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

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

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

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

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

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

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

D. Enrollee rights.

1. **Assurances.**

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

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

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections, and these contracts are effective for the period April 1, 200**9** to March 31, 200**11**.

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

E. Grievance System

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

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

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

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

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

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

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

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

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

X The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438, Subpart F, Grievance System, and these contracts are effective for the period April 1, 200**9,** to March 31, 200**11**.

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

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

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

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

b. **Time frames**

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

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

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

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

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

___ The grievance procedure is operated by:

- ___ the State
- ___ the State's contractor. Please identify: _____
- ___ the PCCM
- ___ the PAHP.

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

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

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

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

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

___ Establishes and maintains an expedited grievance review process for the following reasons:_____ . Specify the time frame set by the State for this process____

___ Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the grievance.

___ Notifies the enrollee in writing of the grievance decision and further opportunities for appeal, as well as the procedures available to challenge or appeal the decision.

___ Other (please explain):

F. Program Integrity

1. **Assurances.**

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

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

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

The prohibited relationships are:

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

(2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;

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

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

1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3) Employs or contracts directly or indirectly with an individual or entity that is
   a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
   b. could be excluded under 1128(b)(8) as being controlled by a sanctioned individual.

2. **Assurances For MCO or PIHP programs**

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

X State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604,

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

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

X The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604, Data that must be Certified; 438.606, Source, Content , Timing of Certification; and 438.608, Program Integrity Requirements. These contracts are effective for the period April 1, 200**9,** to March 31, 200**11**.

Section B: Monitoring Plan

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

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

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

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

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

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

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

I. Summary chart

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

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

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

II. Monitoring Strategies

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

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

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

a. **_X___** Accreditation for ~~Deeming~~ EQRO Non-duplication (i.e. the State's EQR ~~deems~~ will use information from accreditation reviews to assess compliance with certain access, structure/operation, or quality requirements for entities that are accredited)

___ National Committee for Quality Assurance (NCQA)
___ Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
___ Accreditation Association for Ambulatory Health Care (AAAHC)
_X_ Other (please describe) **Within three years of contracting, the PIHP must be accredited by NCQA, Utilization Review Accreditation Commission or other accreditation agencies recognized by CMS for non-duplication of EQR activities under 42 CFR 438.360 and 42 CFR 422.158, and approved by the State, so that the State may ensure that it is able to not duplicate EQR review activity requirements in the future to the extent possible.**

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

___ NCQA
___ JCAHO
___ AAAHC
___ Other (please describe)

c. **__X___** Consumer self-report data

___ **Consumer assessment of healthcare providers and systems (**CAHPS) (please identify which one(s))
X_State-approved survey
___ Disenrollment survey
___ Consumer/beneficiary focus groups

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

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

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

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

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

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

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

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

e. X Enrollee hotlines operated by State

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

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

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

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

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

g. **X** Geographic mapping of provider network

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

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

State annually and is reported to the QM committee and IMT. The Committee members discuss the findings to identify opportunities for improvement. If deficiencies are noted the contractor must perform corrective action until compliance is met.

h. Independent assessment of program impact, access, quality and cost-effectiveness

i. **X** Measurement of any disparities by racial or ethnic groups.

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

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

j. **X** Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]

- **Applicable programs: PIHP**
- **Personnel responsible, (e.g., state Medicaid, other state agency, delegated to plan, EQR, other contractor), PIHP**
- **Detailed description of activity: Per Accessibility of Services Section of the contract, The PIHPs are required to establish and maintain appropriate provider networks. Additional contract mandates require the PIHPs to establish policies and procedures to monitor the adequacy, accessibility and availability of its provider network to meet the needs of enrollees.The PIHPs shall conduct an analysis of its provider network to demonstrate an appropriate number, mix and geographic distribution of providers, including geographic access of its members to practitioners and facilities.**

- **Frequency of use: Documentation was submitted at the time of contracting and is submitted any time there is a significant change that would affect adequate capacity and services or at enrollment of a new population. Certain network reports are submitted annually.**
- **How it yields information about the area(s) being monitored: Network reports provide information on:**
    - **Primary care provider/Specialist capacity**
    - **Provider selection**

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

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

k. ____Ombudsman

l. **X** On-site review

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

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

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

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

On-site review – EQR

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

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

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

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

X Clinical

X Non-clinical

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

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

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

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

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

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

n. **X** PMs [**Required** for MCO/PIHP]

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

Beneficiary characteristics

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

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

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

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

- **Provider selection**

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

p. ____Profile utilization by provider caseload (looking for outliers)

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

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

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

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

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

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

utilization review are reported in the State QI statistical report and are reviewed by the State IMT on an annual basis.

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

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

t. Other (please describe).

Section C: Monitoring Results

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

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

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

X This is a renewal request.

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

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

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

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

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

NOTE: Since there is currently only one PIHP operating under this waiver, program change at the system level as a result of monitoring activities is included in the Plan level corrective action section.

(c.) Strategy - Consumer Self-Report Data

PBH continued to contract with UNC Charlotte Urban Institute to conduct consumer satisfaction surveys in 2009 and 2010. As in previous years, the Dillman Total Design method was used. A total of 10,000 surveys were mailed out each year in three increments. In both years, surveys were sent to a random sample of PBH's consumer population, which consists of both Medicaid and non-Medicaid consumers. The response rate was 14% in 2009 and 9% in 2010, which is similar to previous years' rates of response. Seventy-eight percent and 76% of the respondents in 2009 and 2010, respectively, were Medicaid recipients. Forty-six percent of respondents in 2009 (45% in 2010) were the consumers themselves; the

remainder were consumers' caregivers/or significant others. In 2009 and 2010, respectively, individuals self-identified their disability as follows: mental illness, 37%, 37%; multiple disabilities, 36%, 34%; developmental disabilities, 19%, 19%; and the remainder identified as substance abuse or unknown disability.

Confirmation it was conducted as described:

X Yes

___ No. Please explain:

Summary of results:

Please see the chart below which summarizes survey results over the past four years.

Question	Goal	2007	2008	2009	2010
Q1 Have your treatment and service options been explained to you?	80%	87%	91%	90%	90%
Q2 Are service locations convenient?	80%	86%	90%	89%	89%
Q3 Did you receive a PBH handbook in the mail within 14 days of enrollment?	80%	74%	47%	88%	80%
Q4 Are you aware of your rights & responsibilities?	80%	79%	81%	87%	83%
Q5 Has the denial & appeal (reduction, suspension termination of services) processes been explained to you?	80%	66%	68%	70%	66%
Q6 If you filed an appeal, was the process satisfactory?	80%	NA	NA	63%	50%
Q7 Have authorization for treatment been timely?	80%	NA	84%	83%	80%
Q8 Are you aware of the PBH call center toll free number?	80%	57%	62%	71%	67%
Q9 Do you know how to file a complaint?	80%	NA	51%	59%	64%
Q10 Do you know how to access services in a crisis?	80%	NA	65%	69%	70%
Q11. Does your service plan meet your needs?	80%	88%	92%	91%	87%
Q12. Do you participate in planning your services?	80%	85%	88%	87%	85%
Q13. Does your quality of service remain the same even if staff changes?	80%	84%	85%	87%	83%
Q14.Does your stability and/or well being remain the same even if staff changes?	80%	NA	87%	87%	84%
Q15. Are staff available when you need services?	80%	86%	90%	90%	88%
Q16. Are services available to meet your needs?	80%	86%	90%	90%	87%
Q17. Are staff available when you are in a crisis?	80%	NA	87%	89%	85%

Question	Goal	2007	2008	2009	2010
Q18. Are services available to meet your needs in a crisis?	80%	NA	85%	87%	82%
Q19. If you needed an appointment for an emergency, were you seen within 2 hours?	80%	NA	69%	74%	69%
Q20. If you requested an appointment while in a crisis (not an emergency), were you seen within 48 hours?	80%	NA	71%	78%	73%
Q21. If you needed an appointment for an emergency but your life wasn't in immediate danger, were you seen within 6 hours?	80%	NA	71%	77%	71%
Q22. If you have a scheduled outpatient appointment, do you see the provider within one hour of arriving?	80%	91%	91%	94%	89%
Q23. Do you have a choice in selecting your provider?	80%	68%	72%	75%	69%
Q24. Is it easy to change your provider?	80%	68%	67%	71%	67%
Q25. Do the services you receive help you to be as independent as possible?	80%	88%	89%	91%	89%
Q26. Is your privacy respected?	80%	95%	97%	97%	95%
Q27. Do you feel free to complain?	80%	87%	86%	88%	85%
Q28. Are services available to meet your racial and ethnic background?	80%	93%	93%	95%	93%
Q29.Are staff able to address the needs of your racial and ethnic community?	80%	91%	93%	94%	91%
Q30. Are translators available if you need them?	80%	84%	87%	92%	89%
Q31. Is educational material translated for your language?	80%	87%	89%	94%	89%
Q32. Within the past year, have your services improved your quality of life?	80%	89%	85%	86%	83%
Q33. Please rate your overall level of satisfaction with the services you receive from providers in the PBH network.	80%	84%	88%	89%	83%

Overall, results from PBH's 2009 and 2010 Consumer Surveys reflected satisfaction in most areas. While some respondents expressed dissatisfaction, results suggest that the majority of those surveyed were satisfied with PBH. This is evidenced in the last question in which respondents were asked about their overall level of satisfaction with services provided by providers in the PBH network. Eighty-nine percent in 2009 and 83 percent of respondents in 2010 reported being satisfied or extremely satisfied with the services they received from these providers. Furthermore, when respondents were asked if these services improved their quality of life within the past year, a majority of the respondents indicated this had occurred most of the time or always (86% - 2009, 83% - 2010). Results also indicated that respondents

were satisfied with the staff and services provided by PBH's network of providers. A large majority of consumers reported that treatment and service options were explained to them; service locations were convenient; the PBH Handbook had been received within two weeks of enrollment; and they were aware of their rights and responsibilities.

With regard to the frequency that PBH services met the consumers' needs, results showed that, in general, this occurred most of the time or always. Over 80 percent of those surveyed indicated that most of the time or always the service plan met their needs; they had participated in planning their services; the quality of service remained the same during periods of staff transitions; and their well-being remained the same when staff changed. A majority of consumers reported that staff was available when services were needed, that the services themselves were available in times of need, and that when in a crisis both staff and services were available to assist them.

Problems identified:

One area of concern is the lack of awareness of and dissatisfaction with certain aspects of various processes, as described below:

- **Thirty percent of consumers in 2009 and 34 % in 2010 reported that the denial and appeal process had not been explained to them. In addition, for those who had filed an appeal, only 63% in 2009 and 50% in 2010 reported that the process had been satisfactory. With regard to knowing how to file a complaint, 39% in 2009 and 36% in 2010 indicated that they did not possess this knowledge.**
- **Another area that merits attention is the ability to be seen when in a crisis or an emergency. Twenty-six percent of respondents in 2009 and nearly one-third of responding clients in 2010 reported never or rarely being seen within a two-hour timeframe when they needed to schedule an emergency appointment. Twenty-two percent in 2009 and 27% of respondents in 2010 indicated they were not seen with 48 hours when requesting an appointment when in a crisis. In addition, 23% of survey respondents in 2009 and 29% in 2010 said that they were never or rarely able to get an appointment for a non-life threatening emergency within six hours of attempting to do so.**
- **Two final issues to be noted concern the opportunity to have a choice in the selection of a provider and also the ease of changing providers if so desired. Twenty-five percent of respondents in 2009 and 30% in 2010 said they never or rarely had a choice in selecting a provider. Twenty-nine percent of respondents in 2009 and 34% percent in 2010 reported it was never or rarely easy to change a provider.**

Corrective action (plan/provider level):

The problems identified above are being incorporated in the corrective action plan which is monitored by waiver program's intradepartmental monitoring team (IMT). As of this date, PBH has taken the following actions to address these issues:

- **Awareness of the appeals process – PBH took this issue to the Global CQI Committee which includes representatives from the provider network. Since providers are a primary point of contact for consumers, PBH posted the appeals process to the provider link on PBH's website so providers could make it readily available to consumers.**
- **Timeliness of appointments and choice of provider – PBH is working with the four comprehensive community providers (CCPs) to better educate them on expectations and responsibilities around timeliness of appointments and choice of provider. The CCPs are large providers that serve multiple disabilities and function as access points to services for enrollees. PBH is also doing "mystery shopping" within their network to identify access problems. One finding thus far is that providers need education on the responsibilities of being a "first responder."**

- **All PIHP departments, including Access, Human Resources, Community Relations, QM, UM and Network are now required to implement performance improvement projects. PIPs must be improved internally by the CQI Committee.**

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

(d.) Strategy - Data Analysis: PBH tracks and reports to DMA on unauthorized treatment requests, grievances and denials/appeals of service requests.

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results:

Regarding treatment authorization requests, PBH has a very low denial rate.

- **The full year reporting period July 2008 through June 2009 saw a total of 51,048 treatment authorization requests, 216 denials and 89 reduction of services; for a denial rate of 0.06%**
- **The reporting period July 2009 through June 2010 saw a total of 45,259 treatment authorization requests, 269 denials and 124 reductions in services and 2 terminations; for a denial rate of 0.009%.**

DMA requires quarterly reports on grievances and has worked with PBH to provide meaningful detail in the reports along with more in-depth tracking and trending in order to better identify areas for improvement. In order to prevent duplication, DMA adopted the complaint/grievance reporting tool already in use by PBH for required reporting to the NC DHHS Division of Mental Health. The report was revised to include Medicaid only consumers and was implemented beginning with the July-September 2007 quarter. The reports are filed with DMA after a four-month lag period to more fully capture grievance resolution. The reports provide data on who is filing the grievance (consumer, consumer's representative, anonymous, etc.), consumer's area of disability (MI, substance abuse, MR/DD or multi-disability), detailed information on the nature of the grievance, steps taken to resolve it, and whether the grievance warranted an investigation. (An investigation is conducted if the consumer's health and/or safety is jeopardized.)

Results of full year reporting period July 2008 through June 2009:

- **There were a total of 123 grievances received, representing a 10% increase over the prior period. It was noted that the first two quarters remained steady at 26 grievances apiece but increased by approximately 10 grievances per quarter in the later part of the year.**
- **Twenty-one of the 123 grievances (17%) during the review period resulted in an investigation, a significant increase from the prior year and driven mainly by grievances received from consumers with Developmental Disabilities. Ten of the investigations were substantiated, nine were partially substantiated, 1 was referred to DSS for follow up and 1 was not substantiated. All substantiated and partially substantiated investigations required the submission of a corrective action plan. In one instance a provider did receive a Type B violation from DHSR (the Division of Health Services Regulation, the State's licensing authority) and all referrals were frozen.**

- **Grievances resolved within the targeted 30-day timeframe ranged from 65-77% during the past four quarters and averaged 73.2% for the year. Quarter-over-quarter improvement in resolution timeframes is noted and PBH met the measurement standard for the year.**

Results of full year reporting period July 2009 through June 2010:

- **There were a total of 114 grievances received, representing an approximately 8% decrease over the prior period. It was noted that the first two quarters remained steady with the last two quarters of the prior period, at about 35 grievances a piece, but decreased by more then 10 grievances per quarter in the later part of the year.**
- **Fifteen of the 114 grievances (13%) during the review period resulted in an investigation, a decrease from the prior year. Six of the investigations were substantiated, three were partially substantiated, and six were not substantiated. Corrective action plans were requested for eight of the providers, two received recommendations and five required no further action.**
- **Grievances resolved within the targeted 30-day timeframe ranged from 62% - 85% during the past four quarters and averaged 75.4% for the year. Overall improvement in the resolution timeframes year-over-year is noted and PBH met the measurement standard for the year.**

Quarterly reports on number, types and disposition of appeals are also submitted. Appeal reports are filed on the same quarterly schedule as grievances. Results of full year reporting period July 2008 through June 2009:

- **56 appeals were received during the review period**
- **28 out of 56 of the appeals, the original decision was upheld (50%)**
- **The percentage of actions (denials, suspensions, terminations, reductions of service) appealed averaged 18.4% for the full year reporting period**
- **Community and Home support services remain the top drivers of appeals; however residential level III services, previously one of the top categories, has showed a significant decline over the last 3 quarters of the reporting year. Denials for Day Supports became one of the top three appeal categories in the last quarter of the period and will continue to be monitored for trends in the next year.**

Results of full year reporting period July 2009 through June 2010:

- **104 appeals were received during the review period**
- **74 out of 104 of the appeals, the original decision was upheld (71%)**
- **The percentage of actions (denials, suspensions, terminations, reductions of service) appealed averaged 18% for the reporting period.**
- **Day, Community and Home support services remain the top three appeal categories during this period. These are 1915(c) HCBS waiver services. Level III residential which had consistently been in the top three in previous reporting years, has not been an appeal driver. Level II residential did appear in the second quarter as one of the top categories, with 6 appeals or 11% of the volume for the quarter; however, this does not appear to be an ongoing appeal driver.**
- **Increases in the denial rates and greater consistency in upholding appeals is considered a result of PBH internal process improvements related to application of utilization management guidelines and benchmarking.**

Problems identified:

- **Timeframe for resolving grievances continues to exceed the 30-day limit.**
- **Inadequate access to certain types of behavioral health providers.**
- **Lack of consistency in appeal decisions and utilization management guideline application.**

Corrective action (plan/provider level): As stated above, the grievance resolution timeframe has improved since the waiver was initiated. However, DMA will continue to work with PBH through the Intradepartmental Monitoring Team to identify and resolve obstacles to meeting the timeframe. PBH will continue to actively work on this issue via the complaint resolution performance improvement project (PIP) that was implemented in the first year of the waiver.

During the first quarter of the 2009/2010 fiscal year, PBH analyzed utilization management department practices and consumer outcomes. The findings of the review resulted in improved application of utilization management guidelines and consistency in medical necessity decision making.

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

(e.) Strategy - Enrollee Hotlines:

Both the State and PBH operate toll free hotlines for consumer grievances, concerns, information and referral.

Confirmation it was conducted as described:

X Yes
__ No. Please explain:

Summary of results:

The State's hotline, Care-Line, is a customer service line available to all individuals interested in or receiving services through any of the divisions or offices of the NC DHHS. When PIHP enrollees contact the Care-Line with issues related to PBH, a referral is made directly to PBH program manager at the Medicaid agency. The DHHS tracks all referrals to ensure timely responses. PBH continues to operate a toll free access line 24/7. Calls are answered and addressed in a timely manner. During CY 2008, 99% of all calls to PBH were answered by a live voice within 30 seconds (85% of calls to PBH's after-hours contractor were responded to within 30 seconds by a live voice). During CY 2009, PBH and the contractor, respectively, responded to 96% and 90% of calls within 30 seconds. In 2008 and 2009, respectively, the abandonment rate of calls received directly by PBH was 2.5% and 1.6%; the abandonment rate for the contractor during the respective calendar years was 5.4% and 3.4%. All statistics exceed the National Quality Compass benchmark.

Problems identified:
None.

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

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

(g.) Strategy - Geographic Mapping:
Please see item (j) regarding PBH's network adequacy study. PBH uses geographic mapping software to support network adequacy studies.

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results: **See item (j).**

Problems identified: **See item (j).**

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

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

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

Confirmation it was conducted as described:

X Yes
___ No Please explain:

Summary of results:
The consumer satisfaction survey discussed in item (c) above addresses cultural sensitivity and perception of any service disparities due to race/ethnicity. In 2009 and 2010, the surveys indicated that 95% and 93% of respondents, respectively, believed that providers met their needs related to race/ethnicity all or most of the time; the surveys indicated that 94% in 2009 and 91% in 2010 believed that PBH's staff were able to meet the needs of the consumer's racial/ethnic community.

PBH's provider satisfaction survey also addresses cultural sensitivity. In 2009 and 2010, 87% and 95% of respondents, respectively, stated that PBH's cultural competency initiative "has provided valuable training to help providers and their services become more culturally competent."

Problems identified: **None**

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

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

(j.) Strategy - Network Adequacy Study:

PBH operates in a five county area and covers a total of 2500 square miles. The counties are primarily rural with some moderate to large urban areas. The total population of PBH catchment area is approximately 700,000 which has remained relatively unchanged from the last assessment. Twenty-eight percent of the population is between the ages of 0 and 18 and 72% are 19 and older. PBH is responsible for providing MH/DD/SA services to Medicaid recipients and individuals eligible for services through other public (State and Federal grants) funding sources.

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results:

- **As of the 2010 Network Accessibility study PBH has approximately 102,000 enrollees (individuals eligible to access services through PBH if needed); about 88,000 are Medicaid recipients. At any given time, about 19% to 24% (20,000 to 25,000) of enrollees are actively receiving services through PBH. This represents a decrease of 39% or 65,000 enrollees from the previous study period; however, penetration has increased by seven percentage points during the same period. PBH currently has 258 contracted providers in multiple sites within or bordering PBH catchment area; this represents the addition of 36 new providers, or a 10% increase from the 2008 study. The provider network consists of Comprehensive Community Providers (CCPs), which are large provider organizations serving at least two disability groups; single and multi-service agencies, which provide services such as home and community based services, residential treatment, and substance abuse and day treatment services; group and individual practices (psychiatrists, licensed psychologists, social workers and other licensed behavioral health practitioners); and hospitals, providing both inpatient and outpatient services.**
- **As of the 2010 Network Accessibility study there were no psychiatrists or other providers reporting they are closed to new referrals. Additionally, PBH has not received enrollee complaints that referrals are being refused. Consistent with the previous review, PBH continues to meet the access and availability ratios and distance standards defined within the contract. Highly specialized services and other recently implemented services (such as facility based crisis units) remain the exception. PBH actively reviews network adequacy information and continues to identify areas that need to be addressed to assure continued adequate capacity and appropriate treatment alternatives in the future.**

Problems Identified:

- **High demand for adult inpatient psychiatric beds and inpatient substance abuse beds in PIHP area**
- **High demand for level IV or PRTF (psychiatric residential treatment facility) beds.**
- **Shortage of psychiatrists**
- **Shortage of Community Support Services providers**

Corrective action (plan/provider level):

PBH continues to work toward implementing the corrective action plan described in the 2009 waiver renewal.

- **The number of inpatient hospital beds across the State is controlled by the NC State Health Coordinating Council. PBH is therefore taking actions to reduce the need for hospitalization for both mental illness and substance abuse when feasible by:**
    - **decreasing re-hospitalization due to consumers not getting services and treatment in a timely manner after discharge. PBH is working with the Mental Health Association to implement Bridger programs which use peer specialists to link consumers to the needed services and provide support to the consumer**
    - **increasing crisis alternatives. PBH is working toward opening adult crisis centers for mental health and substance abuse treatment in two of the counties in PBH's geographic area. The planned locations are in close proximity to community hospitals in both counties. (Neither of these counties has an acute psychiatric unit in their general hospitals.)**
    - **working with a local provider to add an additional group home for persons with mental health needs who are moving out of a State hospital.**
- **Regarding level IV and PRTF treatment for children, PBH is taking the following actions:**
    - **Increasing the continuum of residential services for children in lower level residential setting**
    - **Developed Intensive In-Home Team in Davidson County**
    - **Developing a plan for a system of residential services for children that is more focused and includes wrap around specialty supports based on clinical indications which is intended to provide a more intensive clinical milieu.**
    - **Developing and implementing a plan during the current State fiscal year to locate and develop additional Level IV residential options.**
- **PBH is working with Community Care of North Carolina (CCNC) to increase access to psychiatrists and behavioral health services. (CCNC is NC's statewide PCCM program in which organized provider networks deliver and coordinate services to Medicaid recipients; the focus is on quality and cost effective care through evidence based practices, disease management, and care management practices. CCNC has recently started focusing on the aged, blind and disabled population and has recognized the need to coordinate closely with MH/DD/SAS providers who also work closely with this population.) The following actions are being taken.**
    - **Access to mental health treatment in primary care settings is being increased. PBH has partnered with a local CCNC network on a co-location project and has facilitated the placement of licensed behavioral health clinicians in three pediatric offices. PBH and CCNC network are planning to create a pilot program to locate behavioral health services in family practices. The program will offer outpatient behavioral health services to patients served in primary care settings and bring in consumers with substance abuse/mental health issues for primary care treatment. Physician consultation (1915b3 service) will be provided to primary care providers who are treating people with mental health conditions.**
    - **PBH is in the process of locating a licensed clinician and nurse who will be supported by psychiatric telemedicine in a CCNC federally qualified health center in an underserved area.**
    - **Worked with a contracted provider to expand service offerings to meet the need for additional Community Support Services; this became fully operational in the third quarter of 2008.**

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

(l.) Strategy - On-Site Review: Confirmation it was conducted as described: **Members of the intradepartmental monitoring team from the DHHS Division of Medical Assistance (Medicaid) and the Division of MHDDSAS, along with Mercer Government Human Services conducted an on-site review of PBH in December 2010. Care management records and documentation of clinical and administrative operations were reviewed prior to the visit. During the visit, additional care management records were reviewed; key staff were interviewed; and, updates on overall PIHP operations were presented by PIHP staff and management. An onsite review was not conducted in 2009. The waiver and contract provide for waiving the annual visit if DMA believes monitoring activities during the year are sufficient to assure quality. DMA waived the 2009 review as PBH was undergoing NCQA accreditation. PBH is now fully accredited.**

X Yes
___ No. Please explain:

Summary of Results: **PBH has resolved all financial and IT issues identified during the 2008 review. Recommended claims edits have been added. PBH has implemented appropriate processes and procedures for payment reconciliations. A full-time report developer has been hired and detailed dashboards have been designed for internal management and external reporting. The reports are being moved to a system that will allow for drill-down to the client specific level which will enhance data driven decision making and management. The average time to produce ad hoc reports (clinical, financial, etc.) is now only about a week.**

PBH is implementing and piloting for the State a cost matrix for budget development for participants in the concurrent 1915(c) waiver, Innovations. HSRI has assisted PBH in the development of this Supports Intensity Scale (SIS) based tool. Age and living arrangement were identified as two major drivers of need. The tool consists of four matrices (adult/living at home; adult/living in a licensed non-ICF-MR residential setting; child/living at home; and child/living in a licensed non-ICF-MR residential setting). There are seven funding levels for each matrix. An eighth level is available for extraordinary needs. The cost matrix is being used for all new waiver participants and phased in for existing participants.

Findings regarding clinical operations showed better coordination among UM, access and network departments. Effective utilization review and management processes which make use of the increased reporting capabilities are now in place. The medical director has begun co-chairing the CQI committee along with the director of the QM department, which has strengthened the clinical component of quality improvement efforts. This has also led to better coordination between primary care and behavioral health.

Problems Identified:

- **Care management records for the MH/SA population have improved but need to be enhanced to better document medical necessity and track consumers.**
- **Additional claims processing edits need to be added to enhance the integrity of the claims processing system.**
- **Claim system changes need to be made to support identifying and pursuing 3rd party liability.**

Corrective action (plan/provider level):

- **PBH understands the need for better documentation in care management records and this will be a top priority during the coming year and will be tracked by the intradepartmental monitoring team (IMT). Reviewers suggested implementing inter-rater reliability for care management record documentation.**
- **Implementation of additional claims edits and changes regarding TPL will also be tracked by the IMT.**

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

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

As of the previous waiver renewal, PBH had implemented four PIPs: improving resolution of complaints within established guidelines; improving coordination of care and reducing recidivism rates in State facilities through Screening, Triage and Referral (STR); prone restraints as a restrictive intervention; and effectiveness of technical assistance for providers to manage claim denials.

Three additional projects were implemented since the previous renewal; the non-clinical project is" Finance Department COB/ Sliding Fee Schedule" and the two clinical topics are "Improve Community Tenure for Enrollees with Multi Systemic Therapy (MST) and In-Home Services (IIHS) paired with Respite Services" and "Decrease Admission Rate to PRTF and/or Inpatient for Consumers Discharged from Residential Level III Placement". A new project was agreed upon, "Incident Reporting and IRIS Implementation;" however, measurement will not occur until the end of 2011. The project topics were determined jointly by DMA and PBH.

The EQRO reviewed the following PIPs in 2009:
- **Decreasing Prone Restraints as a Restrictive Intervention**
- **Effectiveness of Technical Assistance for Providers to Manage their Claims Denials**
- **Decreasing Admission Rate of PRTF and/or Inpatient Stays for Consumers Discharged for Residential Level III Placement**
- **Improving Community Tenure for Enrollees with Multi Systemic Therapy (MST) and In-Home Services (IIHS) Paired with Respite Service**

All four were evaluated and judged to have sound study designs that do not introduce bias. The first two projects were previously rated as high confidence but received a confidence rating in 2009; changes were around minor documentation issues. The last two projects scored in the high confidence range, although it should be noted that the last project was relatively new so certain sections of the PIP could not be assessed.

The EQRO reviewed the following PIPs in 2010:
- **Improve community tenure for enrollees with multi systemic therapy (MST) and in-home services (IIHS).**
- **Decrease admission rate to Psychiatric Residential Treatment Facilities (PRTF) and/or inpatient for consumers discharged from residential level III placement.**
- **Improve provider incident reporting through the State's Incident Reporting Improvement System (IRIS).**
- **Improve provider compliance with Coordination of Benefits (COB) and sliding fee schedules**

Only the first project received a high confidence rating, the remaining three projects received the confidence rating. The EQR did recommend that the COB and sliding fee schedule project discard the initial baseline measurement and utilize the next measurement period as the baseline; this was due concerns around valid sampling size and subsequent ability to draw conclusions about the results.

Confirmation that the performance improvement projects were implemented and validated as described:

X Yes
___ No. Please explain:

The results, problems identified and corrective action plans are described below for the PIPs reviewed by the EQRO in 2009 and 2010 with the exception of the TA to Providers to Manage Claims Denials, which has been retired.

PIP #1: Prone Restraints as a Restrictive Intervention:
The purpose of this PIP is to reduce or maintain the number of prone restrictive interventions utilized and ensure the safety of consumers. The goal is 20% or fewer of PBH's contracted providers report prone restraints as restrictive interventions.
Summary of Results: The second re-measurement year shows a continuing downward trend where use of prone restraints dropped from 32% to 20% and the rate of prone restraints per 1000 members dropped from 3.76 to 1.78. The established goals were met for both of these measures.
Problems Identified:

- **Provider unaware of their utilization of prone restraints or any restrictive interventions**
- **Providers are unaware of how they compare with utilization of prone restraints in comparison to same type of provider in the network**
- **Providers are unaware of contractual compliance for application and documentation of restrictive devices**
- **Staff lack knowledge on non-restrictive intervention measures and consistency with implementation of members care plan**
- **Lack a policy and procedure for transferring enrollees that are no longer appropriate for setting**
- **Member specific alternative methods for deescalating behavior not identified and/or not communicated in care plan**
- **Program philosophy, processes and policies do not support appropriate restraint use**
- **Providers need assistance with creating adequate systems to document and report incidents**

Corrective Action Plan:

- **Provider and staff education**
- **Utilization Management will now approve the use of prone restraints in the consumer's treatment plan.**

PIP #2: Finance Department COB/ Sliding Fee Schedule: This PIP was implemented in 2009. PBH contracts with Comprehensive Community Providers (CCPs), agency-based entities providing a number of different services, including assessment, enrollment, Community Support, Outpatient and Psychiatric Services and provide service to approximately 75% of the total population served. Review of provider billing practices related to Coordination of Benefits (COB) and Sliding Fee Schedule (SFS) contractual requirements demonstrated opportunities for improvement. This is an important project as, to maximize funding for Medicaid and State eligible consumers all other funding sources are to be used first to pay for

services. The purpose of this project was to determine if continuous monitoring of claims and providing technical assistance after audits will result in improvements to providers' compliance with COB and SFS requirements. The goal of this project is to ensure 100% compliance with provider documentation of COB and utilization of the SFS.

Summary of Results: Documentation of COB and SFS should be present 100% of the time on all claims. Baseline measurement demonstrated 29% and 22% compliance for COB and SFS respectively. During the EQR validation there was concern regarding the sampling methodology for this project, it was recommended that the methodology be re-structured and a new baseline measurement performed.

Problems Identified:

- **Difficulty in obtaining consumer income or dependent data;**
- **Financial intake process is lengthy**
- **Providers need assistance in understanding contractual requirements**
- **PIHP needs a formalized and consistent process to monitor contractual compliance of COB and SFS.**

Corrective Action Plan:

- **Revise Sampling Process to be more representative of the population served**
- **Notify (remind) Providers of the Audit process and the existing contractual requirements and preliminary audit dates.**
- **Share results of the audits with the CCPs**
- **Require Corrective Action plans and paybacks for those CCPs who do not meet the compliance goal**
- **Revise the PBH procedures to specifically detail how to conduct the audits and analyze the results**

PIP #3: Decrease Admission Rate to PRTF and/or Inpatient for Consumers Discharged from Residential Level III Placement: PBH's goal is to remain consistent with the System of Care philosophy of providing care in the least restrictive, most normative environment. Specifically, PBH is interested in determining whether reduction in length of stay in Residential Level III and admission to community based services with an intensified Care Management focus decreases the likelihood of admission to Psychiatric Residential treatment Facilities (PRTF) or Inpatient Hospitalizations. The sole measure for this project is the percent of consumers who were admitted to a PRTF or hospital inpatient setting who were discharged from a Residential level III facility during the measurement period.

Summary of results: The baseline measurement period had an admission rate of 32% against a baseline goal of 22%. The first re-measurement period showed a decline of 17 percentage points to 15%. A new goal was established for the next measurement period of 12%.

Problems Identified:

- **Lack of discharge planning and poor information exchange between providers**
- **Lack of knowledge by consumers and families about Community Support and intensive Care Management service and the importance of community based services**
- **Limited Provider availability in intensive community based services**

Corrective Action Plan:

- **Intensified the Care Management process and increasing clinical staffing of high risk cases and consumers ready for step down from Residential III**
- **Trained Community partners on the High Risk care management process**
- **Increased capacity in IIHS through Provider Network Department**
- **Designed and implemented a structured High Risk Consumer process involving UM, Access, and Access Outreach departments.**

PIP #4: Improve Community Tenure for Enrollees with Multi Systemic Therapy (MST) and In-Home Services (IIHS) paired with Respite Services: This clinical project, implemented in 2009 seeks to determine if pairing of MST and IIHS with Respite would lead to a decrease in the use of higher level, more restrictive services by children receiving both services. The sole measure is the admission rate for consumers age 6-18 with MST and IIHS services paired with Respite Services admitted to Residential III, IV, PRTF or Hospital during the measurement period.

Summary of Results: The initial baseline measurement reviewed data for 2008 and found the admission rate was 16% against the baseline goal of 11%.

Problems Identified:

- **Lack of education regarding respite services**
- **Lack of referrals to respite services for those consumers receiving MST and IIHS**

Corrective Action Plan:

- **Reinforced the need to increase referrals to respite when referring consumers to MST and IIHS with PBH Utilization Management staff and managers**
- **Educated a subgroup of 14 providers about the need to pair respite services with MST and IIHS.**

PIP #5: Reporting and IRIS Implementation: The Incident Response Improvement System (IRIS) is a state operated online application to which providers are required to electronically submit Level II and III Incident Reports. PBH is required to monitor IRIS on a daily basis to ensure the timely submission of consumer incident reports. All incidents are reviewed by PIHP staff for accuracy to ensure needed elements are provided and entered into the IRIS system. As this is a new system implemented in 2010, this project seeks to determine if technical assistance and daily monitoring of IRIS by PBH's Quality Management Department will improve the timely submission of provider incident reports. The sole measure of this project is the percent of Level II and III incidents not submitted within 72 hours of the provider learning of the incident through IRIS during the measurement year. Baseline measurement will occur at the end of 2011.

Summary of Results: Measurement results are not yet available due to system implementation issues.

Problems Identified:

- **Multiple system implementation issues affecting providers and local management entities around data extraction, reporting printing, system navigation, data security.**
- **Lack of training and education on the IRIS system**

Corrective Action Plan:

- **IRIS systems training for staff and providers**
- **Ongoing conference calls and forums for information dissemination, discuss ongoing issues and provide education on reporting, HIPPA and other system requirements.**

(n) Strategy - Performance Measures: DMA in conjunction with PBH (PBH) identified several performance measures that address a range of priority issues for the Medicaid population. These measures were identified through a process of data analysis and evaluation of trends within the Medicaid population and involved consumer, advocate, and provider input with final approval of the measures being the responsibility of DMA. The performance measure results are submitted to DMA annually by June 30 and cover the preceding calendar year. A subset of the performance measures is validated annually by the EQRO.

Confirmation it was conducted as described:

X Yes

___ No. Please explain:

<u>Summary of results:</u> The following table demonstrates selected PBH performance measures that are directed at achieving waiver goals. Additionally, a rotating set of performance measures are validated by the EQRO on an annual basis. Details of the annual performance measure validations can be found in the EQRO reports.

PBH performance indicator	PBH 2006	PBH 2007	PBH 2008	PBH 2009	Quality Compass national average	PBH benchmark	Specifications
Call answer timeliness Percent of calls answered by a live voice within 30 seconds							
PBH	94.10%	98.00%	98.70%	95.80%	74.4	90	HEDIS
Protocall	82.50%	83.30%	85.00%	89.8%	74.4	90	
Call answer abandonment Percentage of call abandoned by the caller before answered by a live voice							
PBH	0.30%	3.00%	2.50%	1.60%	5.8	5%	HEDIS
Protocall	4.00%	4.20%	5.40%	4.30%	5.8	5%	
Denied claims Number and percentage of claims for services that were denied by PBH							
Percentage denied	21.89%	18.55%	16.43%	15.23%	N/A	20%	DMA
Inpatient discharges and ALOS (Inpatient Only)							
Inpatient discharges per 1,000 member months	1.39	1.28	1.20	1.26	1.1	1.1	HEDIS
ALOS	9.71	8.71	8.76	8.77	7.4	8	HEDIS
Readmittance to inpatient MH facility within 30 days							
Percentage of Readmits	7.79%	8.60%	10.71%	7.35%	N/A	11%	DMA
Readmittance to Inpatient SA facility within 30 days							
Percentage of Readmits	9.80%	3.49%	4.35%	2.31%	N/A	11%	DMA
Follow up after hospitalization for mental illness Percentage who had an outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner							
7 day	26.47%	18.16%	21.16%	24.03%	39.1%	70%	HEDIS
30 day	38.46%	24.25%	28.26%	31.55%	57.7%	58%	HEDIS
Follow up after hospitalization for SA Percent who had follow-up visit after discharge							
7 day	22.20%	27.12%	30.99%	35.14%	N/A	70%	HEDIS-like
30 day	35.99%	37.01%	48.54%	45.78%	N/A	58%	HEDIS-like
MH utilization The number and percentage receiving any mental health services							
Number of Members receiving service	10,211	10,381	9,499	10,143	N/A	N/A	HEDIS

PBH performance indicator	PBH 2006	PBH 2007	PBH 2008	PBH 2009	Quality Compass national average	PBH benchmark	Specifications
Percentage of Members receiving services	11.53%	11.46%	9.95%	9.83%	9.1%	30%	HEDIS
Identification of alcohol and other drug dependence The number and percentage with an alcohol and other drug claim who received chemical dependency services							
Number of members receiving service	1,521	1,637	1,593	1,853	N/A	N/A	HEDIS
Percentage of Members receiving services	1.72%	1.81%	1.67%	1.80%	2.5	N/A	HEDIS
Initiation and engagement of alcohol and other drug dependence treatment Percentage with a new episode of alcohol or other drug dependence who initiate treatment and engage in two or more services within 30 days of initiation visit							
Percentage who initiate treatment within 14 days of diagnosis	47.85%	36.61%	37.37%	40.55%	43.3	71%	HEDIS
Percentage who initiated treatment and had two additional services within 30 days of initiation	34.37%	30.00%	32.55%	35.63%	11.7	50%	HEDIS
Inpatient discharges and ALOS for SA							
Inpatient discharges per 1,000 member months	0.16%	0.49%	0.32%	0.30%	0.3	0.3	HEDIS
ALOS	6.65	4.39	4.73	4.58	4.9	4.9	HEDIS
Member months of enrollment by age and sex							
Total Medicaid	757,312	768,688	810,329	875,445	N/A	N/A	DMA
Diversity of membership – language							
Asian/Pacific Island	0.03%	0.03%	0.04%	0.04%	N/A	N/A	N/A
English	96.17%	95.76%	95.23%	94.51%	N/A	N/A	
Other Indo-European	0.03%	0.03%	0.03%	0.04%	N/A	N/A	
Spanish	3.69%	4.08%	4.58%	5.28%	N/A	N/A	
Other	0.07%	0.06%	0.08%	0.08%	N/A	N/A	
Unknown	0.00%	0.01%					

PBH performance indicator	PBH 2006	PBH 2007	PBH 2008	PBH 2009	Quality Compass national average	PBH benchmark	Specifications
			0.02%	0.03%	N/A	N/A	
Diversity of membership – race/ethnicity							
American Indian/Alaskan Native	0.20%	0.19%	0.23%	0.23%	N/A	N/A	N/A
Asian/Pacific Islander	1.05%	1.07%	1.02%	1.07%	N/A	N/A	
Black/African American	27.35%	26.96%	26.07%	25.22%	N/A	N/A	
White	61.74%	61.29%	61.78%	61.99%	N/A	N/A	
Other	0.00%	10.49%	10.90%	11.47%	N/A	N/A	

Problems identified: Follow-up after hospitalization for mental illness is below PBH's benchmark and the quality compass. However, with the exception of the 2007 reporting year, this measure has showed steady improvement but has not reached the initial baseline established in 2006 for either the 7 or 30 day follow up. Follow-up after hospitalization for substance abuse is below PBH's benchmark but has shown steady year-over-year improvement for the past three measurement years.

Corrective action (plan/provider level):
PBH continues to operate a performance improvement project (PIP)"Reducing Recidivism in State Hospitals through Screening, Triage and Referral" which resulted in the following actions, also described in item (m):

- **Local facility based crisis center was created as an alternative to State hospitals**
- **Manual process was developed to monitor, track and analyze STR data and the impact of these interventions on continuity of care and readmissions.**
- **The STR department was created by PBH to increase consumer use of appropriate community supports vs. higher levels of care; improve tracking of consumers through the continuum of care; and increase consumer access to care.**
- **State Hospital Clinical Care Coordinator position was created and housed at Broughton State hospital to better coordinate the discharge process.**

This performance measure is tracked by the intradepartmental monitoring team (IMT) on a regular basis.

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

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

(o) Strategy - Periodic Comparison of # of Providers: Please see item (j) above regarding the network adequacy study process. PBH conducts adequacy studies annually at minimum to determine whether the

network contains the appropriate mix and number of providers to ensure timely access to care by an appropriate provider type.

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results: **See item (j) above.**

Problems identified: **See item (j) above.**

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

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

(q) Strategy - Provider Self-Report Data:

PBH contracted with the UNC-Charlotte Urban Institute to conduct provider surveys in 2009 and 2010. The survey was developed by PBH and approved by DMA. The purpose of the survey is to solicit input from providers about their levels of satisfaction with PIHP operations, including claims processing and payment, assistance from PBH and communication. Surveys were mailed to all providers in both years. The survey questions were grouped by PIHP department with the exception of the last group of questions which was directed toward overall customer service. All were given a Likert scale response. The response rate was 42% in 2009 (102 respondents) and 41% in 2010 (93 respondents).

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results:

During the last waiver renewal period, the following problems were identified. Based on the most recent survey (2010), the following change was noted:

- **1/3 of providers were not as satisfied with PBH as with other local management entities – the number dissatisfied has increased to 51% in 2010.**
- **1/4 of providers said PBH website was not easy to navigate – the number has decreased to 20%.**
- **1/4 of providers said PBH did not respond quickly enough to providers' needs – the number has decreased to about 20%.**

Items with the highest positive responses during 2010 compared to 2009 are as follows:

- **"PBH staff treats my agency and staff with courtesy and respect," (88% in 2009; 96% in 2010),**
- **"PBH's Cultural Competency initiative has provided valuable training to help providers and their services become more culturally competent," (87% in 2009; 95% in 2010),**
- **"QM trainings are informative and meet our needs as a provider/agency," (87% in 2009 and 93% in 2010), and**
- **"Technical assistance and information provided is accurate and helpful," (84% in 2009 and 92% 2010).**

Items with the least positive responses during 2010 compared to 2009 are as follows:

- **"Compared to other LMEs, I am more satisfied with PBH," (62% in 2009; 51% in 2010),**
- **"I am satisfied with the appeals process for denial, reduction, or suspension of service authorizations," (70% in 2009 and 73% 2010),**
- **"PBH Access refers consumers whose clinical needs match the service(s) my practice/agency provides," (84% in 2009 and 77% in 2010), and**
- **"PBH Access staff responds quickly to provider needs," (82% in 2009 and 78% in 2010).**

Providers rated overall satisfaction with PBH at 83% in 2009 and 92% in 2010.

`

Corrective action (plan/provider level):

- **Determine why the providers are less satisfied with PBH than with other local management entities (LMEs) for MH/DD/SA services. (PBH is the only LME that operates as a managed care entity in the State at this time.)**
- **Continue to monitor providers' perception of responsiveness to provider needs.**
- **Obtain more detail from providers regarding mis-match between clinical needs of client and referrals.**

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

(s) Strategy - Utilization Review

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results:

PBH's utilization review processes and procedures have been formalized, are data driven and operate in tandem with QM provider reviews. PBH has identified "red flags" such as: one provider seeing multiple family members; more than one outpatient visit per week; more than one year of treatment for a consumer; consumers receiving multiple services; inpatient readmissions; and current utilization vs. baseline utilization. Reviews are ongoing and have strong support of the medical director.

Problems identified:
Reviews are ongoing and may involve provider education, provider sanctions such as pay-backs, or provider termination.

Corrective action (plan/provider level):
On a case-by-case basis by PBH.

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

NOT PEER REVIEWED

Section D – Cost-Effectiveness

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

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

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

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

Part I: State Completion Section

A. Assurances

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

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

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

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

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

c. Telephone Number:__*919 647 8178*_____

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a.___ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
1.___ First Year: $____ per member per month fee
2.___ Second Year: $____ per member per month fee
3.___ Third Year: $____ per member per month fee
4.___ Fourth Year: $____ per member per month fee

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

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

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

a.___ Population in the base year data

1.___ Base year data is from the same population as to be included in the waiver.

2. __ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b.___ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

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

d. ___ [Required] Explain any other variance in eligible member months from BY to P2: _____

e.____ [Required] List the year(s) being used by the State as a base year:____. If multiple years are being used, please explain:_____

f.____ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.

g.____ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:
_____

For Conversion or Renewal Waivers:

a._X_ [Required] Population in the base year and R1 and R2 data is the population under the waiver.
The R1 and R2 member months were reported quarterly to CMS for the prior waiver period. These member months reflect the enrollment of the population covered under the waiver.

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

c._X_ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
Enrollment projections are based on historical enrollment trends and expectations for enrollment changes. The changes

in enrollment are primarily due to changes in economic conditions and general increases in the population.

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

Year/Quarter	MEG 01 AFDC	MEG 02 Blind/Disabled and Foster Children	MEG 03 Aged	MEG 04 Innovations CAP-MR	Total
P1 Qtrly Trends	2.1%	0.3%	0.3%	1.6%	1.3%
P2 Qtrly Trends	2.1%	0.3%	0.3%	1.6%	1.3%

This waiver amendment incorporates expansion of the managed care program to other prepaid inpatient health plans operating in other areas of North Carolina in addition to the expansion operated by PBH. The specific effective dates and counties are outlined in the bullets below.

- **October 1, 2011, PBH will expand their managed care operations into Alamance and Caswell Counties.**

- **January 1, 2012, PBH will expand their managed care operations into the Five-County LME consisting of Franklin, Granville, Halifax, Vance, and Warren Counties.**

- **January 1, 2012, Western Highlands will consist of Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, and Yancey Counties.**

- **April 1, 2012, PBH will expand their managed care operations into the Orange, Person, and Chatham Counties.**

- **April 1, 2012 East Carolina Behavioral Health (ECBH) will have Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Gates, Hertford, Hyde, Jones, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrell, and Washington Counties.**

- **July 1, 2012 Sandhills will have Anson, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, and Richmond Counties.**

- **July 1, 2012 Smoky Mountain will have Alexander, Allegheny, Ashe, Avery, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, Macon, McDowell, Swain, Watauga and Wilkes Counties.**

- **January 1, 2013 Mecklenburg county**

- **January 1, 2013 Pathways will have Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Surry, Yadkin counties.**

- **January 1, 2013 Eastpointe will have Bladen, Columbus, Duplin, Edgecombe, Greene, Nash, Lenoir, Robeson, Sampson, Scotland, Wayne and Wilson counties.**

- **January 1, 2013 Centerpoint will have Davie, Forsyth, Rockingham and Stokes counties.**

- **January 1, 2013 Durham Center will have Cumberland, Johnston and Wake counties.**

- **January 1, 2013 Eastern Coastal Care will have Brunswick, Carteret, New Hanover, Onslow and Pender counties.**

- **January 1, 2013 Guilford county.**

Year/Quarter	MEG 01 AFDC	MEG 02 Blind/Disabled and Foster Children	MEG 03 Aged	MEG 04 Innovations CAP-MR	Total
Adjustment made to Qtr beginning 10/1/2011 for statewide expansion	**1381%**	**1728%**	**1596%**	**1821%**	**1470%**

d. _X_ [Required] Explain any other variance in eligible member months from R1 to P2:
There are no other variances in the enrollment projections.

e._X__[Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:
R1 is April 1, 2009 through March 31, 2010. R2 is April 1, 2010 through March 31, 2011 (data currently available for R2 is for April 1, 2010 through September 30, 2010).

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

For Initial Waivers:

a.___ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single

beneficiary, please document how all costs for waiver covered individuals taken into account.

For Conversion or Renewal Waivers:

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

No differences in services included on Appendix D3. 1915(b)(3) costs reported on Appendix D3 are summarized from the separately certified 1915(b)(3) service rates multiplied by the actual member months under the waiver.

The waiver expenses for the are summarized directly from the waiver reporting, specifically Schedule F (supplemented by the adhoc calculations for 1915(b)(3) services). For R1, a prior period adjustment was captured on Schedule E for the Innovations/CAP-MR MEG for quarter ending March 2010 although no changes to the historical waiver expenses were made. The quarterly expenses captured in the prior period adjustment had been previously reported against the waiver. Therefore, the expenses were reallocated to the respective quarters to avoid undue impact on this waiver renewal.

During this waiver period, the State had amended the 1915(b) waiver to include the FFS areas of the State to help facilitate expansion of BH managed care to other areas and simplify future amendments. While the State is still moving forward with implementing managed care in the future, the State has chosen to remove the FFS MEGs from the waiver due to complications with reporting all of the BH services on the waiver pages. The State will submit future amendments to the capitated MEGs to obtain the necessary authority to implement managed care in other areas of the states when the implementation dates are finalized.

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

NC used audited CMS 64 reports for the basis of the cost effectiveness analysis. All services covered under the waiver are included in the cost-effectiveness analysis including services impacted by the PIHP (BH pharmacy). Costs for services in the Innovations Program are included in the analysis. Acute care services under the 1932 SPA other than

BH pharmacy are excluded from the cost-effectiveness. The State has documented that for a single beneficiary under the 1932 SPA and the (b)(c) concurrent waiver all costs for individuals are reported on either the (b)(c) CMS 64.9 waiver form or on the base CMS 64.9 form with other 1932 SPA costs.

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

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

For Initial Waivers:

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

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

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

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

b._X_ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the

percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*

The CMS 64.10 reports for the 1915(b) waiver reflect the approved allocation methodology for administrative expenses. General State administrative expenses are allocated to the waiver based on the actual waiver program cost as a percentage of the total Medicaid program cost in each quarter. During the past waiver period, this quarterly percentage has ranged from 1.1-1.4%.

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

c.___ Other (Please explain).

H. Appendix D3 – Actual Waiver Cost

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

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

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

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

			member months should correspond)

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

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

1915(b)(3) Service	Amount Spent in Retrospective Period (R2 dollars reflective of 6 months of services)	Inflation and Adjustment projected	Amount projected to be spent in Prospective Period
Respite	$1,442,771 or $1.50 PMPM in R1	4.6% inflation and 110.9% adjustment equate to $3.47 increase in P1	$4.67 PMPM in P1
	$564,389 or $1.20 PMPM in R2	5.4% inflation and 1.9% adjustment equate to $0.38 increase in P2	$5.05 PMPM in P2
Supported Employment	$193,037 or $0.20 PMPM in R1	4.6% inflation and 110.9% adjustment equate to $-0.22 decrease in P1	$0.05 PMPM in P1
	$124,192 or $0.26 PMPM in R2	5.4% inflation and 1.9% adjustment equate to $0.00 decrease in P2	$0.04 PMPM in P2
Integrated Medical Services as a Portion of Supported Employment	$0 or $0.00 PMPM in R1	4.6% inflation and 110.9% adjustment equate to $0.00 increase in P1	$0.00 PMPM in P1
	$0 or $0.00 PMPM in R2	5.4% inflation and 1.9% adjustment equate to $0.00 increase in P2	$0.00 PMPM in P2
Personal Care (Individual Support)	$92,131 or $0.10 PMPM in R1	4.6% inflation and 110.9% adjustment equate to $-0.18 decrease in P1	$0.04 PMPM in P1
	$103,567 or $0.22 PMPM in R2	5.4% inflation and 1.9% adjustment equate to $0.00 decrease in P2	$0.03 PMPM in P2
One-Time Transitional Costs	$8,816 or $0.01 PMPM in R1	4.6% inflation and 110.9% adjustment equate to $-0.01 decrease in P1	$0.00 PMPM in P1
	$4,087 or $0.01 PMPM in R2	5.4% inflation and 1.9% adjustment equate to $0.00 decrease in P2	$0.00 PMPM in P2
Psychosocial Rehab (Peer Supports)	$35,395 or $0.04 PMPM in R1	4.6% inflation and 110.9% adjustment equate to $0.86 increase in P1	$1.07 PMPM in P1
	$95,018 or $0.20 PMPM in R2	5.4% inflation and 1.9% adjustment equate to $0.09 increase in P2	$1.15 PMPM in P2

Innovations Waiver Services	$518,095 or $0.54 PMPM in R1	4.6% inflation and 110.9% adjustment equate to $-1.29 decrease in P1	$0.27 PMPM in P1
	$734,152 or $1.56 PMPM in R2	5.4% inflation and 1.9% adjustment equate to $-0.02 decrease in P2	$0.24 PMPM in P2
Physician Consultation	$0 or $0.00 PMPM in R1	4.6% inflation and 110.9% adjustment equate to $0.00 increase in P1	$0.00 PMPM in P1
	$0 or $0.00 PMPM in R2	5.4% inflation and 1.9% adjustment equate to $0.00 increase in P2	$0.00 PMPM in P2
Community Guide	$0 or $0.00 PMPM in R1	4.6% inflation and 110.9% adjustment equate to $1.44 increase in P1	$1.44 PMPM in P1
	$0 or $0.00 PMPM in R2	5.4% inflation and 1.9% adjustment equate to $0.12 increase in P2	$1.56 PMPM in P2
Total	$2,290,244 or $2.38 PMPM in R1	**4.6% inflation and 110.9% adjustment equate to $4.07 increase in P1**	**$7.53 PMPM in P1**
	$1,625,404 or $3.46 PMPM in R2	**5.4% inflation and 1.9% adjustment equate to $0.55 increase in P2**	**$8.08 PMPM in P2**

The P1 and P2 projections have been updated to incorporate the expansion of 1915(b)(3) services into the new managed care areas. The numbers are presented on a PMPM basis to allow for comparison to the base year given the expansion of managed care to include new areas. As the State expects to achieve greater savings in the initial years of the managed care program (as was experienced in PBH), the State has adjusted the 1915(b)(3) PMPM upward to account for the initial higher savings of managed care and additional spending authority under 1915(b)(3). Further discussion of the adjustment is provided Section D.I.d.2 of this preprint. As you will note when comparing to the prior PBH waiver amendment, the changes in projected spending on a PMPM basis are mixed due to the initial 1915(b)(3) service limitations of respite, peer support, and community guide services available in the non-PBH areas of this waiver. This causes some of the PMPMs in the chart above to drop as these services are not available in those other areas of the state at this time. As the State and CMS have discussed, the State plans to expand the full array of 1915(b)(3) services into the non-PBH waiver in the future.

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

c._X_ Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of

coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

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

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

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

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

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

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

2._NA For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs **(Column G of Appendix D3 Actual Waiver Cost).** For PCCM

providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program **(See D.I.I.e and D.I.J.e)**

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

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

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

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

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

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

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

1999 to present) The actual trend rate used is: **_4.0% from 9/30/2010 to 3/31/2011**_. Please document how that trend was calculated:

This is the actual trend rate experienced by the State from 2008 through the second quarter of R2 and reflects the capitation payments and anticipated pharmacy spending for the October 2010 through March 2011 time period.

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

i. __X__ State historical cost increases. Please indicate the years on which the rates are based: base years___**2008, 2009, 2010**__In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). **Mercer considers historical year over year trends, as well as rolling averages in making these estimates.** Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

For the prospective trend analysis, three years of waiver reported data was available to assist in the development of the trend assumptions. As noted above, this amounted to approximately 4.0% trend from 2008. This waiver cost trend has been managed to a low rate of growth over the waiver period through the utilization management of services. To assist in the projection of future trends, Mercer also performed an actuarial analysis of trend consistent with the capitated rate-setting process. The actuarial analysis focused on trends in the actual encounter data which should be more indicative of future rate-setting trends. Mercer also reviewed FFS data for the counties in North Carolina that are not in managed care. This data provided a supplemental source for the waiver and rate-setting trend review, specifically for the pharmacy wraparound services.

In the analysis of waiver and rate-setting trends, Mercer considers historical year over year trends, as well as rolling averages in making these estimates. No

adjustments for programmatic, policy, or pricing changes were necessary; therefore, trend estimates do not duplicate the effect of any changes.

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

Time Period	Trend Assumption
End of R2 (9/30/2008) to Start of P1 (4/1/09)	*4.0%*
P1 (4/1/09-3/31/10)	*4.8%*
Annualized Trend From End of R2 to End of P1	4.5%
P2 Trend Rate	4.9%

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

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

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

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

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

These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

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

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

2._X__An adjustment was necessary and is listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

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

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Determine adjustment for Medicare Part D dual eligibles.

E.____ Other (please describe):

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

iii.__ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv.__ Changes brought about by legal action (please describe):
For each change, please report the following:

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

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

v.__ Changes in legislation (please describe):
For each change, please report the following:

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

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

vi.__ X Other (please describe):

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

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____X Other (please describe):

Expansion of waiver to additional counties

With this waiver amendment, the State is requesting authority to expand the PBH 1915(b) waiver pilot program to include additional counties as indicated in the roll-out schedule. , Mercer summarized the

historical fee-for-service costs for waiver covered services in the FFS program for the time period of R1. This allows for the comparison of a complete historical year of data with the data from PBH for R1.

We reviewed the FFS data and the Section D preprint for initial waivers to determine whether adjustments were necessary to the raw FFS data for the expansion counties. The following list addresses the adjustments required in Section D for consideration in Initial Waivers.

- **Graduate Medical Education – The State assures CMS that GME payments are reflected in the base data.**
- **Payments/Recoupments not processed through MMIS Adjustment – Payments/recoupments outside the MMIS were made for the ICF-MR and outpatient cost settlement process. Mercer summarized this cost-settlement impact for R1 and incorporated into the base data considered for the program change.**
- **Copayments – The State collects minimal copayments for the services covered under the waiver. Based on a review, the impact was determined to be immaterial so no upward adjustment was made for the waiver cost projections.**
- **TPL – No adjustment was necessary for TPL as the base year costs were cut with post-pay recoveries already deducted from the database.**
- **Pharmacy Rebates – The State has applied this adjustment based on the average rebate percentage received for all pharmaceuticals during R1 and incorporated into the base data considered for the program change.**
- **DSH – The State assures CMS that DSH payments are excluded from the base year data.**

- **Population Biased Selection Adjustment – This adjustment is not necessary as the entire eligible population is required to enroll in the waiver.**

Using this adjusted base data, Mercer calculated MEG-specific adjustments to the P1 and P2 projections based on the effective dates of the managed care expansions. The first table below illustrates the R1 PMPMs for each of the effective dates for the waiver expansion including PBH. The second and third tables illustrate the P1 and P2 adjustment by MEG respectively based on the October 1, 2011 waiver expansion date.

R1 Data - April 2009 through March 2010

Medicaid Eligibility Group	PBH		Waiver Expansion - A&C		5-Cty + WHN Expansion		ECBH + OPC Expansion		Sandhills+Smoky		Centerpoint+Durham+Eastern Coastal Care+Eastpointe+Mecklenburg+Pathways+Guilford	
Effective Date	Current Waiver		October 1, 2011		January 1, 2012		April 1, 2012		July 1, 2012		January 1, 2013	
	MMs	PMPM	MMs	PMPM	MMs	PMPM	MMs	PMPM	MMs	PMPM	MMs	PMPM
AFDC	670,323	$ 44.72	176,767	$52.35	817,968	$57.42	784,357	$95.57	1,199,386	$54.64	5,869,652	$67.49
Blind/Disabled and Foster Children	188,610	$365.91	56,366	$399.15	324,806	$383.81	323,301	$510.97	399,293	$324.55	1,942,282	$434.32
Aged	95,517	$31.96	31,206	$69.75	165,354	$40.89	160,551	$63.52	214,042	$43.38	829,520	$46.63
Innovations CAP-MR	7,387	$4,380.70	2,019	$4,135.90	13,472	$4,702.77	12,845	$3,973.63	13,615	$4,373.46	78,635	$4,459.80
Total	961,837	$139.74	266,357	$158.73	1,321,600	$182.92	1,281,053	$235.27	1,826,337	$144.52	8,720,089	$186.82

P1 Adjustment - MMs based on October 1, 2011 waiver expansion date

Medicaid Eligibility Group	PBH		Waiver Expansion - A&C		5-Cty + WHN Expansion		ECBH + OPC Expansion		Sandhills+Smoky		Centerpoint+Durham+Eastern Coastal Care+Eastpointe+Mecklenburg+Pathways+Guilford		Combined P1		
Effective Date	Current Waiver		October 1, 2011		January 1, 2012		April 1, 2012		July 1, 2012		January 1, 2013				
	MMs	PMPM	MMs	PMPM	MMs	PMPM	MMs	PMPM	MMs	PMPM	MMs	PMPM	MMs	PMPM	Adjustment
AFDC	670,323	$44.72	88,141	$52.35	407,863	$57.42	391,104	$95.57	598,050	$54.64	2,926,785	$67.49	5,082,267	$64.06	43.3%
Blind/Disabled and Foster Children	188,610	$365.91	28,106	$399.15	161,958	$383.81	161,207	$510.97	199,100	$324.55	968,480	$434.32	1,707,461	$415.83	13.6%
Aged	95,517	$31.96	15,560	$69.75	82,450	$40.89	80,056	$63.52	106,728	$43.38	413,624	$46.63	793,935	$45.99	43.9%
Innovations CAP-MR	7,387	$4,380.70	1,007	$4,135.90	6,718	$4,702.77	6,405	$3,973.63	6,789	$4,373.46	39,210	$4,459.80	67,515	$4,415.69	0.8%
Total	961,837	$139.74	132,814	$158.73	658,989	$182.92	638,772	$235.27	910,666	$144.52	4,348,099	$186.82	7,651,178	$179.09	28.2%

P2 Adjustment - Additional MMs based on October 1, 2011 waiver expansion date

Medicaid Eligibility Group	Combined P1 from Prior		Waiver Expansion - A&C		5-Cty + WHN Expansion		ECBH + OPC Expansion		Sandhills+Smoky		Centerpoint+Durham+Eastern Coastal Care+Eastpointe+Mecklenburg+Pathways+Guilford		Combined P2		
Effective Date	Current Waiver		October 1, 2011		January 1, 2012		April 1, 2012		July 1, 2012		January 1, 2013				
	MMs	PMPM	MMs	PMPM	MMs	PMPM	MMs	PMPM	MMs	PMPM	MMs	PMPM	MMs	PMPM	Adjustment
AFDC	5,082,267	$64.06	88,626	$52.35	410,104	$57.42	393,253	$95.57	601,336	$54.64	2,942,867	$67.49	9,518,453	$65.43	2.1%
Blind/Disabled and Foster Children	1,707,461	$415.83	28,260	$399.15	162,848	$383.81	162,093	$510.97	200,194	$324.55	973,802	$434.32	3,234,658	$418.76	0.7%
Aged	793,935	$45.99	15,646	$69.75	82,904	$40.89	80,495	$63.52	107,314	$43.38	415,896	$46.63	1,496,190	$46.89	2.0%
Innovations CAP-MR	67,515	$4,415.69	1,012	$4,135.90	6,754	$4,702.77	6,440	$3,973.63	6,826	$4,373.46	39,425	$4,459.80	127,973	$4,417.72	0.0%
Total	7,651,178	$179.09	133,544	$158.73	662,610	$182.92	642,281	$235.27	915,670	$144.52	4,371,990	$186.82	14,377,273	$181.74	1.5%

These adjustments are applied as a percentage adjustment in the P1 and P2 projection in column L of Appendix D.5.

c.___ X **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the

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

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

2._X_ An administrative adjustment was made.

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

ii.___ Cost increases were accounted for.

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

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

C.____State Historical State Administrative Inflation. The actual trend rate used is: _____. Please document how that trend was calculated:

D.____Other (please describe):

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

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: **2008, 2009, 2010** In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). **Mercer considers historical year over year trends, as well as rolling averages in making these estimates.** Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

The annualized administrative cost trend rate contained in Appendix D.3 from R1 to R2 is 10.5%.

This is largely driven by a lower PMPM in Q1 of R1. Ignoring this quarter would suggest administrative trends on a go-forward basis in the 3-4% range. Based on this data and state expectation of administrative trends, the administrative costs have been projected using a 3.0% annualized administrative trend factor.

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

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above **_4.5% for P1 and 4.8% for P2**.

The quarterly CMS 64 reports have exhibited a general upward trend in state administrative costs over this waiver period as indicated by the 10.5% in cost changes from R1 to R2. As discussed above, the administrative costs have been trended using a 3% inflation factor.

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

1._X_ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: **__45% per Appendix D3_____.** Please provide documentation.

The actual 1915(b)(3) capitation rate trends have exceeded in the most recent waiver year continuing significant growth since their introduction to the waiver in July 2007. In recent data, the service utilization for 1915(b)(3) services have began to stabilize after this period of ramp-up. The R2 PMPM is viewed as a good baseline for projecting future 1915(b)(3) spending.

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

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

1. Please indicate the years on which the rates are based: base years. **July 2007 through September 2010**

   Spending on 1915(b)(3) services began in July 2007. As reflected in the 1915(b)(3) capitation rate, the State spending on these services has increased in R2 of this waiver period much faster than the State Plan services. For future waiver periods, the 1915(b)(3) utilization is anticipated to increase at levels consistent with the State Plan trends and has been set accordingly. The 1915(b)(3) trends have been set equal to the State Plan service trend for each MEG as this is lower than the actual trend for 1915(b)(3) services.

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

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above **_4.5% for P1 and 4.8% for P2 _**.

Justification of State Plan Savings

In the managed care expansion areas of this waiver, mental health and substance abuse systems are unfettered fee-for-service delivery systems. The introduction of the PIHP model to manage care is anticipated to result in a dramatic change in utilization and management of the services included in this waiver. For example, the State anticipates that there will be fewer inpatient hospitalizations and residential placements and more effective community-based treatment and outpatient services. This expectation is based on the experience with the implementation of the waiver in PBH.

Specifically, the State has made the following estimates of managed care savings in the development of the waiver projections. These assumptions are developed based on the State's actuary (Mercer's) experience in assisting States in their implementation of behavioral health managed care. Typically, inpatient and residential utilization is reduced through better case management and diversion to outpatient settings, generating an overall savings to the State. The following assumptions and the associated savings will also be incorporated into the rates. The aggregate adjustment for managed care savings is reflected on Appendix D5 column N. and takes into account the effective date of the waiver implementation in each area.

Since the State currently has 1915(b)(3) spending authority in PBH, the managed care savings first cover the current 1915(b)(3) PMPM of $3.70 for P1 and then the additional savings support the adjustment in the P1 projection.

Inpatient Psychiatric and Other Residential Services: The State assumed 10 -15% savings on inpatient and other residential care. This generated $3.37 PMPM in savings for the waiver program in these expansion areas.

More cost-effective utilization of mental health services: The State assumed 5% savings based on utilization management of (non-inpatient) State Plan services. This generated $5.00 PMPM in savings for the waiver program in the expansion areas.

Together these adjustments total savings of $8.37 PMPM and cover the 1915(b)(3) spending authority of $3.70 in PBH, while providing the support for the $3.83 PMPM expansion adjustment in P1 and the $0.55 PMPM expansion adjustment in P2. The overall 1915(b)(3) spending authority justified by this managed care savings is $7.53 PMPM in P1 and $8.08 PMPM in P2. These calculations take into account the effective dates of the managed care implementation as well as the current approved spending authority of the PBH 1915(b) waiver of $3.70 for P1 and $3.88 for P2.

This amount of savings is consistent with savings achieved in PBH upon managed care implementation and other similar programs. For example, in its initial implementation, the Iowa Plan program achieved an upfront savings of 15% through the introduction of lower cost services and has achieved

approximately 18% in additional savings through the use of cost-effective management techniques. That 18% has been translated into additional 1915(b)(3) services in the Iowa Plan program. Similarly, the State of Kansas achieved savings of over 20% with the introduction of their 1915(b) waiver using a similar non-risk model for managed care.

The adjustments are reflected in column Y of Appendix D.5.

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

1. List the State Plan trend rate by MEG from **Section D.I.J.a _____**
2. List the Incentive trend rate by MEG if different from **Section D.I.J.a**. _____
3. Explain any differences:

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

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

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same

proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.

3.___ Other (please describe):

1.___ _X_ No adjustment was made.

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

J. Appendix D5 – Waiver Cost Projection

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

K. Appendix D6 – RO Targets

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

L. Appendix D7 - Summary

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

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

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

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

Mercer did not estimate cost changes separate from the utilization changes. No adjustments for programmatic, policy,

or pricing changes were necessary; therefore, trend estimates do not duplicate the effect of any changes.

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

   In developing trend for the time periods from R2 to P1 and from P1 to P2, estimates were based primarily on historical managed care encounter data and historical trends of the waiver expenses, with consideration for other data sources such as CPI and DRI. Changes in utilization and unit cost were considered together in developing trend. The trends used are consistent with historical changes in cost and utilization in North Carolina's Medicaid program.

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

Part II: Appendices D.1-7

Please see attached Excel spreadsheet