Section 1915(b) Waiver

STATE OF NORTH CAROLINA

PIEDMONT CARDINAL HEALTH PLAN

Renewal

April 1, 2009 – March 31, 2011

Table of Contents

Proposal

Face sheet 3
Section A: Program Description 5
Part I: Program Overview 5
A. Statutory Authority 8
B. Delivery Systems 10
C. Choice of MCOs, PIHPs, PAHPs, and PCCMs 16
D. Geographic Areas Served by the Waiver 18
E. Populations Included in Waiver 19
F. Services 23
Part II: Access 31
A. Timely Access Standards 31
B. Capacity Standards 34
C. Coordination and Continuity of Care Standards 37
Part III: Quality 40
Part IV: Program Operations 44
A. Marketing 44
B. Information to Potential Enrollees and Enrollees 46
C. Enrollment and Disenrollment 50
D. Enrollee Rights 54
E. Grievance System 55
F. Program Integrity 58

Section B: Monitoring Plan 60
Part I: Summary Chart 62
Part II: Monitoring Strategies 65

Section C: Monitoring Results 70

Section D: Cost Effectiveness 93
Part I: State Completion Section 93
Part I: Appendices D1-7 Attachment I

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

Face sheet

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

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

The **name of the waiver program** is **PIEDMONT CARDINAL HEALTH PLAN**. (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:

___ initial request for new waiver

___ amendment request for existing waiver, which modifies Section/Part _

 __ Replacement pages are attached for specific Section/Part being amended

 __ Document is replaced in full, with changes highlighted

X 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) are filled out.

 X 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.

X assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section A has been updated to reflect current waiver renewal and contract renewal periods, the name of the State's new EQRO, State contact information, clarification that the enrollee has 20 days to file an appeal with the PIHP, and an updated 1915(b)(3) services list. The only program changes are the timeframe for filing an appeal and the b3 service list. All changes, including minor changes in wording, are highlighted.

Section B is ___ replaced in full

___ carried over from previous waiver period. The State:

___ assures there are no changes in the Monitoring Plan from the previous waiver period.

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

Section B has been updated as follows. All changes are highlighted.

- Item d: Clarified that the measure reported is denied treatment authorizations rather than denied claims
- Item d: Clarified that when the PIHP identifies issues as a result of a grievance, the PIHP is not required to get the State's approval before implementing a corrective action plan.
- Item m: Now that the PIHP has four performance improvement projects (PIPs) in operation, the language has been changed to the effect that new PIPs will be added as current PIPs are terminated.
- Item h: Requested that the State be relieved of doing an independent assessment during the second renewal period

X __The State has used this waiver format for its previous waiver period. Sections C and D are filled out.

Effective Dates: This waiver/**renewal**/amendment is requested for a period of 2 years; effective **April 1, 2009** and ending **March 31, 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:

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section A: Program Description

Part I: Program Overview

Piedmont Behavioral HealthCare is a public MH/DD/SAS organization serving a five-county region in North Carolina, including Cabarrus, Davidson, Rowan, Stanley and Union counties. The North Carolina public MH/DD/SAS system has traditionally delivered services through local "area authorities," which are political subdivisions of the State. This system underwent reform, which required that the area authorities transition from providers of services to managers of services. Consistent with the philosophy in the President's "New Freedom" Commission Report, the reform required that the State's local area authorities divest themselves of service provision and become Local Management Entities (LMEs) for all publicly funded MH/DD/SA services, including Medicaid funded services. Most services will be provided through the private sector, and LMEs will be responsible for authorizing and overseeing service provision. Piedmont has met the State's requirements and has been certified as a Local Management Entity.

Piedmont has developed an LME plan of operation which will ensure that services are provided in a prompt and efficient manner to those who need them. Piedmont's plan focuses 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. Piedmont has been at the forefront of MH/DD/SAS system reform, and the State of North Carolina proposes that Piedmont be given the authority to manage both services and funding and function for Medicaid purposes as a prepaid inpatient health plan (PIHP). As a prepaid health plan, Piedmont will recruit providers and develop and oversee a comprehensive MH/DD/SAS provider network that assures access to care for all enrollees. Piedmont will be paid per member, per month capitated payments and will be responsible for authorizing payments for services, processing and paying claims, and conducting utilization and quality management functions. As a prepaid health plan, Piedmont will be at financial risk for a discrete set of Mental Health, Developmental Disabilities and Substance Abuse services, including both Medicaid State Plan services and services contained in a new Home and Community Based Services waiver for persons with mental retardation and developmental disabilities. All age groups will be covered. ("Innovations," the new HCBS waiver, is being submitted along with this waiver request and will be a component of the Piedmont initiative.)

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.

The goals of The Piedmont Cardinal 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 Mental Health Recovery Model concepts.**
- **Demonstrate that care can be provided more efficiently with increased local control.**

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. The Piedmont counties included in this project are located in central North Carolina. Please note, however, that a public process with significant opportunity for public comment by individuals of all races and ethnicities was utilized in designing the framework for the Piedmont 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 Piedmont's plan and a feedback link for public comments. Since the waiver was implemented in April 2005, the Piedmont 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 is incorporated for system improvement.

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 timeframe; new populations added; major new features of existing program; new programs added).

The Piedmont Cardinal Health Plan (PCHP), which operates concurrently with a 1915 (c) waiver, Innovations, was implemented in the five Piedmont counties on April 1, 2005. PCHP is operated by Piedmont Behavioral Healthcare (PBH), a local government entity that manages publicly funded mental health, developmental disabilities and substance abuse services. All Medicaid participants in the eligibility groups covered under the waiver were mandatorily enrolled in the single PIHP on April 1.

Implementation of PCHP coincided with two major initiatives: transition of the public MH/DD/SAS area programs into management entities and redesign of the state's Medicaid MH/DD/SAS service package. The State's public MH/DD/SAS system has traditionally delivered services through local "area authorities"; however, the system has been undergoing reform over the past few years to transition the area authorities from providers to managers of services. The Piedmont PIHP divested of services and made the transition to a "local management entity" during the year preceding waiver implementation. The second major system change, implementation of the State's new MH/DD/SAS benefit package, took place in a very short timeframe during the first year of waiver operation, from January through March of 2006. Implementation was a challenge for the entire state but particularly so for PCHP given its new structure as an at-risk managed care entity.

During its first year of operation, it was determined that PCHP had generated savings through care and utilization management strategies, and the state requested and received approval from CMS in December of 2006 to invest the savings in 1915(b)(3) services for PCHP Medicaid recipients. The b3 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 b3 services were implemented after CMS approved the associated waiver and contract amendments.

The Piedmont waiver program exists in a dynamic environment and continues to evolve and grow as a managed care entity. The program has been closely scrutinized during its first four years of operation through mandatory EQRO activities, two Independent Assessments, the Intra-departmental monitoring team and annual on-site reviews of operations. 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.

A. Statutory Authority

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

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

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

c. _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):

a. X **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 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 The PIHP is paid on a risk basis.
___ The PIHP is paid on a non-risk basis.

Piedmont Behavioral Healthcare is a PIHP for Mental Health and Substance Abuse services. A 1915c waiver for the Piedmont MR/DD population operates concurrently with this waiver and Piedmont will deliver these services through the PIHP as well. Therefore, Piedmont will be at risk for mental health and substance abuse services, including inpatient, clinic option and rehabilitation option services, and Home and Community Based Services under the "Innovations" 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 Piedmont

The North Carolina General Assembly, in Session Law 2001-437, (codified at NC Gen. Stat. 122C) mandates that the Department of Health and Human Services 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 mental health 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 Mental Health, Developmental Disabilities and Substance Abuse 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 local management 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, developmental disabilities 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 Mental Health, Developmental Disabilities, and Substance Abuse 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 levels of care, 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 behavioral health 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 managed care organizations, with the necessary capacity, essential localized experience and relationships, and incumbent public behavioral healthcare expertise, are virtually nonexistent in North Carolina. The vast majority of North Carolina's employer

based health care purchasers have chosen not to furnish benefits through managed care organizations. A specialized behavioral health managed care vendor provides limited, paper-transaction-based utilization review of some behavioral health services once an individual's utilization exceeds certain thresholds. DHHS is in the process of re-procuring these services. The State and local Authorities have always held all of the financial risk and public accountability for public behavioral healthcare services in North Carolina. Consumers, local elected officials, State lawmakers and policymakers – none of these groups has determined that a private managed care organization 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 Consumer and Family Advisory Committee), assure that services and supports are being delivered pursuant to the consumer-developed Person Centered Plan, 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 the Division of MH/DD/SAS, which determines if the plan demonstrates that the local Authority has the capacity to perform the administrative functions required of a "Local Management Entity." Local Authorities meeting all of these requirements are then certified by the Department of Health and Human Services as "Local Management Entities" (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. Piedmont Behavioral HealthCare, the five-county local Authority to which this waiver request refers, submitted its approved local business plan, and has been certified as an LME. Piedmont has 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.

Piedmont has been selected by the State to apply this innovative approach to Medicaid services, under this Waiver renewal request. Pursuant to its LME certification, Piedmont Behavioral HealthCare 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 Piedmont LME; accordingly, and in light of the absence of other entities with the requisite capacity and local experience, the State has selected the Piedmont LME as the PIHP for the 1915b waiver. Savings achieved under this waiver will not be used for non-Medicaid consumers, but will be reinvested back into services for Medicaid consumers through an approved reinvestment plan.

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.

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs

1. **<u>Assurances</u>.**

___ 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.

Piedmont Behavioral HealthCare is a local mental health Authority and has provided and coordinated 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 Piedmont is 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. Piedmont has decades of experience locating and developing services for consumers with MH/DD/SAS needs, and over the years, Piedmont has 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 Piedmont, as a public entity, has reinvested in the system. Private managed care organizations with this type of experience and relationships with local human service agencies and facilities are largely nonexistent in North Carolina.

2. **<u>Details</u>**. 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 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, Piedmont 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, Piedmont 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.

___ **Statewide** -- all counties, zip codes, or regions of the State

X **Less than Statewide**

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, PAHP)
Piedmont Region **(Which includes the following counties: Cabarrus, Davidson, Rowan, Stanly and Union)**	**PIHP**	**Piedmont Cardinal Health Plan**

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 SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (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 (SAD) and Special Assistance for the Aged (SAA)
- 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, "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. **<u>Assurances</u>.**

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 behavioral health 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, 2008 to March 31, 2009.

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.

___ The PIHP 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. **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 Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

Treatment for MH/SA Conditions identified in EPSDT screenings will be furnished through the Piedmont PIHP. Agencies conducting the screenings will coordinate with the Piedmont PIHP and service providers.

6. **<u>1915(b)(3) Services</u>.**

_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	Reimbursement
Respite consistent with the Innovations 1915(c) waiver program definition and limitations. A maximum of sixty-four (64) units (sixteen (16) hours a day) can be provided in a twenty-four (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 (not living in a child residential treatment facility) and adults who are functionally eligible but not enrolled in the Piedmont Innovations 1915(c) waiver program OR children who are not functionally eligible for the Piedmont Innovations Waiver Program but require continuous supervision due to a Mental Health (Axis I or II) diagnosis (CALOCUS level III or greater) or Substance Abuse Diagnosis (ASAM criteria of II.1 or greater), OR Children or Adults with a Developmental Disabilities Diagnosis (adults must have a score of 102 or below on the Supports Intensity Scale).	Providers must meet all Piedmont Innovations waiver provider requirements and be enrolled 1915(c) waiver providers.	Entire Piedmont service area (Cabarrus, Davidson, Rowan, Stanly and Union counties)	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.
Crisis Respite consistent with the Innovations 1915(c) waiver program respite definition and limitations. Crisis Respite is a short-term service that cannot be provided for more than thirty (30) days in a twelve (12) month period. The maximum length of stay is 10 days.	Children (not living in a child residential treatment facility) and adults who are functionally eligible but not enrolled in the Piedmont Innovations 1915(c) waiver program OR 1) Children who have a Mental Health diagnosis (CALOCUS level III or greater) or 2) Children with	Providers must meet all Piedmont Innovations waiver provider requirements and be enrolled 1915(c) waiver providers.	Entire Piedmont service area (Cabarrus, Davidson, Rowan, Stanly and Union counties)	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	Reimbursement
	a Substance Abuse diagnosis and ASAM criteria of II.1 or greater AND who are at imminent risk for PRTF/psychiatric hospitalization if not in receipt of Crisis Respite services.			
Supported Employment consistent with the Innovations 1915(c) waiver program supported employment definition and limitations. Initial job development, training and support: A maximum of 86 hours (344 units) per month for the first 90 days; Intermediate training and support: a maximum of 43 hours (172 units) per month for the second 90 days; Long Term support: 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 Piedmont Innovations 1915(c) waiver program.	Providers must meet all Piedmont Innovations waiver provider requirements and be enrolled 1915(c) waiver providers.	Entire Piedmont service area (Cabarrus, Davidson, Rowan, Stanly and Union counties)	Separate 1915(b)(3) capitation rates certified by the State's actuary.
Integrated medical services as a portion of the Supported Employment program Medical services that enable an individual to function in the workplace. This includes psychiatrist or psychologist treatment, rehabilitation planning, therapy and counseling, and case management activities assisting the enrollee to gain access to needed medical, social, educational and other services. All other aspects of Supported Employment may not be paid for under 1915(b)(3) for State Plan enrollees not eligible for the 1915(c) waiver. The plan may choose to provide to the other populations under 42 CFR 438.6(e) if cost-effective alternatives to State Plan services.	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: meet one of the following: (a) there is an Axis I or II diagnosis present and the person meets Level of Care Criteria for LOCUS Level II or ASAM III; (b) the person has a diagnosed developmental disability as defined in GS 122C-3 (12a) and has significant deficits in one or more functional life areas and, for adults (age 21 and older), a score of 102 or below on the Supports Intensity Scale. Children (age 16 or older but under age 21) who are residing in a Medicaid funded group residential treatment facility are not eligible for this service.	Providers must meet all Piedmont Innovations waiver provider requirements and be enrolled 1915(c) waiver providers.	Entire Piedmont service area (Cabarrus, Davidson, Rowan, Stanly and Union counties)	Separate 1915(b)(3) capitation rates certified by the State's actuary.
Personal Care/Individual Support Personal Care under the current NC State Plan emphasizes the need for assistance with ADLs.	Adults ages 18 and older with a diagnosis of Severe and Persistent Mental Illness and a LOCUS level	Paraprofessional staff employed by the contracted	Entire Piedmont service area (Cabarrus,	Separate 1915(b)(3) capitation rates certified by the

Service	Populations Eligible	Provider Type	Geographic Eligibility	Reimbursement
Some assistance with IADLs is covered but only to the extent linked to ADLs. This service (personal care – individual support) is coverable under the State Plan but NC has not included in its approved State Plan. Personal Care (Individual Support) is not covered under the Innovations waiver and is a "hands-on" service for persons with severe and persistent mental illness, a population that is not covered under the Innovations 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.	of II or greater. Persons between the ages of 18 and 21 may not live in a Medicaid funded child residential treatment facility.	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. Provider may not be a family member	Davidson, Rowan, Stanly and Union counties)	State's actuary. Total expenditures on Personal Care cannot exceed 1915(b)(3) resources available in the waiver.
One Time Transitional Costs consistent with the Innovations 1915(c) waiver program community transition services definition and limitations.	Adults who are functionally eligible but not enrolled in the Piedmont 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 Piedmont Innovations waiver provider requirements and be enrolled 1915(c) waiver providers.	Entire Piedmont service area (Cabarrus, Davidson, Rowan, Stanly and Union counties)	Separate 1915(b)(3) capitation rates certified by the State's actuary.
Psychosocial Rehabilitation/Peer Supports This service (Psychosocial Rehabilitation -- Peer Supports) is coverable under the State Plan but NC has not included in its approved State Plan. This service has been found to be more cost-effective than Community Supports and is a SAMSHA 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.	Adults ages 18 and older with identified needs in life skills, who: (1) have an Axis I or II diagnosis present; and (2) meet Level of Care Criteria for LOCUS Level I or ASAM I. Persons ages 18 to 21 may not live in a child residential treatment facility.	North Carolina Certified Peer Support Specialists and Paraprofessionals, who: (1) possess a high school degree or GED equivalent; and (2) are supervised by a	Entire Piedmont service area (Cabarrus, Davidson, Rowan, Stanly and Union counties)	Separate 1915(b)(3) capitation rates certified by the State's actuary.

Service	Populations Eligible	Provider Type	Geographic Eligibility	Reimbursement
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.		Qualified Professional according to 10A NXCAC 27G .0204; and (3) are not a member of the family of the person receiving Peer Supports services. Paraprofessional level providers must meet requirements in 10 NCAC 27G 0104.		
Innovations Waiver Services consistent with the Innovations 1915(c) waiver program services definition and limitations.	Children (not living in a child residential treatment facility) and adults who are functionally eligible but not enrolled in the Piedmont Innovations 1915(c) waiver program: • exiting ICF-MRs or • currently live in licensed community facilities 6-beds or less designed to support people with developmental disabilities. Services not appropriate to provider owned facilities will not be provided (e.g., one-time transitional costs, respite, home and vehicle modifications, etc).	Providers must meet all Piedmont Innovations waiver provider requirements and be enrolled 1915(c) waiver providers.	Entire Piedmont service area (Cabarrus, Davidson, Rowan, Stanly and Union counties)	Separate 1915(b)(3) capitation rates certified by the State's actuary.
Physician Consultation Communication between a Primary Care Physician and a Psychiatrist for a patient specific	Must be under the care of a primary care physician, and require e consultation between a psychiatrist and	Primary Care Physician or Board Certified in Adult or Child	Entire Piedmont service area (Cabarrus,	Separate 1915(b)(3) capitation rates certified by the

Service	Populations Eligible	Provider Type	Geographic Eligibility	Reimbursement
consultation that is medically necessary for the Medical Management of psychiatric conditions by the Primary Care Physician. 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 Physician. 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 Physician regarding a seriously ill patient, lengthy communication needed to consider lab results, response to treatment, current symptoms, presenting problem. Staffing of case between Psychiatrist and Primary Care Physician to consider evaluation findings and discuss treatment recommendations, including medication regimen.	their primary care practitioner for appropriate medical or mental health treatment Adults ages 18 and older with Severe Mental Illness and a Locus level of 0 (basic level). Children with Serious Emotional Disturbance and a Cal locus level of 0 (basic level).	Psychiatry and holds a current license in the state of North Carolina.	Davidson, Rowan, Stanly and Union counties)	State's actuary.

7. **Self-referrals.**

___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:

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, 2008 to March 31, 2009 .

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. **<u>Assurances for MCO, PIHP, or PAHP programs</u>.**

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, 2008 to March 31, 2009 .

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. **<u>Details for PCCM program</u>**. 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 number 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. **<u>Assurances For MCO, PIHP, or PAHP programs</u>**.

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, 2008 to March 31, 2009.

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

The following items are required.

a. **X** 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 the **PIHP/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.

As a behavioral health carve-out, the services under the waiver are specialty services and are designed for persons with special needs, some more intense than others. The waiver will serve persons with developmental disabilities, severe psychiatric diagnoses such as schizophrenia, and substance abuse disorders, in addition to individuals who have one-time or short-term needs such as psychotherapy due to a personal concern. When an individual requests services, a determination is made as to intensity of need. Treatment plans containing a variety of services and supports are developed for everyone who needs ongoing services. Issues around identification of persons with special needs do not appear to be relevant to this application as all enrollees are considered to have special needs in varying intensities.

b. ___ **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.

c. ___ **Assessment**. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care 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.

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

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

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

e._____**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, 2008 to March 31, 2009(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** 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; Validation of Performance Improvement Projects; On-site review	Encounter data validation/ISCA

Effective May 2, 2008, the Division of Medical Assistance contracted with CCME to perform EQR activities for the Piedmont program.

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).

NOTE: Marketing activities are not applicable due to a sole source to one PIHP.

1. **Assurances**

___ 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.

___ 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.___ 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.___ 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):

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

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

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, 2008 to March 31, 2009.

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 **5** 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.

Piedmont will make interpreter services available to individuals with limited English proficiency through contract with a telephone language line and will also contract with individual providers in the community for on-site interpretation. As a public MH/DD/SAS program, Piedmont is accustomed to making this service available to consumers on an as-needed basis.

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.")**

Under the wavier, the PIHP must inform the beneficiaries in writing of its policies before and at the time of enrollment. Through review of the results of Satisfaction Surveys, the State shall ensure that the enrollee orientation process for the waiver participants is conducted in a manner that is:

- **Respectful**
- **Understandable &**
- **Affords enrollees with necessary support through the process**

Piedmont has a 30 year history of public management of services for people with mental health, developmental disabilities, and substance abuse services in the Piedmont counties. This includes long standing relationships with public agency partners such as the school systems, departments of social services, health departments, and county government, as well as with local Advocacy organizations such as NAMI and the Arc's. Piedmont's Board consists of an elected County Commissioner from each county as well as other local citizens and stakeholders. Piedmont is the manager of local teams that include consumers/family members, providers and community agencies such as Interagency Teams, Child and Family Teams, Substance Abuse advisory boards and Collaboratives for Child Services across the counties. Piedmont has strong relationships with the courts, and law enforcement agencies as well. Piedmont has historically engaged stakeholders at the county level and is extremely knowledgeable of key resources, stakeholders and the nuances of each individual county. Piedmont also has a long standing relationship with state and regional agencies including State Psychiatric Hospitals, Mental Retardation Centers, Juvenile Justice and Criminal Justice Services. New strategies to expand and enhance these activities include the development of a Department of Community Relations and Office of Consumer Affairs.

The Community Relations Department is responsible for coordinating education and outreach across the Piedmont communities, that includes working with agencies that serve special needs clients, advocates for special needs populations, special needs beneficiaries and their families. This office centralizes community planning, education and outreach activities into one department of the LME in order ensure the array of staff specialties needed and for better coordination of activities across the five counties. This office includes a Licensed Adult Mental Health and Substance Abuse Professional, a Licensed Child Mental Health Specialist, an Hispanic Specialist, a Developmental Disabilities Specialist and a Housing

Coordinator. Responsibilities of this department include development of an annual community plan through county level Advisory Committees, community education, promotion of collaboration across agencies affecting the services for people with disabilities, and promotion of increased access to generic community resources for people with disabilities. The Hispanic specialist will focus on outreach to Hispanic populations in order to increase penetration.

Piedmont also has an office of Consumer Affairs, staffed by an openly declared consumer and will work to develop and identify consumer leaders, assist in community education, and will assist in outreach activities. The Director will serve as an ombudsman and advocate for individual cases and assist consumers as requested with appeals and grievances.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

X State
___ contractor (please specify) ________

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

The State considers potential enrollees individuals who are eligible to receive services from the PIHP, by virtue of the fact that they are enrolled in Medicaid in one of the five participating counties, but are not accessing services. Enrollees are eligible individuals who are accessing/receiving services.

The State mails out written notices to all new Medicaid recipients in the catchment area. The notices contain basic information regarding the provision of all mh/dd/sa services through the PIHP, the process for accessing services, including emergency services, and contact information including access sites and telephone numbers. In addition, the PIHP conducts outreach as described above in B.2. to assure that Medicaid recipients who need and want services are able to receive them.

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 PIHP shall provide each new Enrollee who requests services, within fourteen (14) days of the request for services, written information on the Medicaid waiver program. Written information must be available in the prevalent non-English languages found in the Piedmont 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 PIHP.

C. Enrollment and Disenrollment

1. **Assurances.**

X 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.

___ 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)

_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, 2008 to March 31, 2009.

2. **Details**. Please describe the State's enrollment process for MCOs/PIHPs/PAHP 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 notified 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 Piedmont's Access Unit. The Access unit provides information and referral for benefits assessment as needed.**
- **Piedmont's Community Relations Department coordinates education and outreach activities. This office plans for community education, including Access to Care, Appeals and Grievances, Consumer Rights, etc. As directed by consumers and stakeholders, information regarding access to the system is widely available and in a variety of media.**

Media include advertising in print media, radio/television announcements, brochures, yellow pages, internet web sites and links to / from other sites, translation into other languages must occur to ensure that the information is widely available.

- **Piedmont also has an Office of Consumer Affairs, directed by a primary consumer. This Office has wide participation in community forums in order to provide support for consumers and families.**

b. **Administration of Enrollment Process**.

X State staff conducts the enrollment process.

Since this waiver program is sole-sourced to the Piedmont PIHP, the State uses its Medicaid Eligibility Information System (EIS) to identify and enroll persons covered by the waiver.

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

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

Broker name: __________________

Please list the functions that the contractor will perform:

___ choice counseling

___ enrollment

___ other (please describe):

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

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

___ This is a **new** program. Please describe the **implementation schedule** (e.g. implemented Statewide all at once; phased in by area; phased in by population, etc.):
This is an existing program with no expansion planned.

___ 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.):

___ 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 single PIHP to Medicaid enrollees in the five-county area.**

___ 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, 2008 to March 31, 2009.

X The State assures CMS it will satisfy all 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, 2008 to March 31, 2009.

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

a. **Direct access to 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. **Timeframes**

X The State's timeframe 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 20 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 fair hearing or a PCCM or PAHP enrollee's direct access to a 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 procedures 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. **<u>Assurances</u>.**

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. **<u>Assurances For MCO or PIHP programs</u>**

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, 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, 2008 to March 31, 2009.

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	Marketing	Enroll Disenroll	Program .Integrity	Information	Grievance	Timely Access	PCP/Specialist Capacity	Coordination Continuity	Coverage Authorization	Provider Selection	Quality of Care
Accreditation for Deeming												
Accreditation for Participation												
Consumer Self-Report data	**X**				**X**	**X**	**X**				**X**	**X**
Data Analysis (non-claims)			**X**			**X**	**X**	**X**		**X**		**X**
Enrollee Hotlines	**X**		**X**		**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**									
Network Adequacy	**X**		**X**					**X**			**X**	

Strategy	Program Impact						Access			Quality		
	Choice	Marketing	Enroll Disenroll	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**	**X**	**X**
Performance Improvement Projects				**X**								**X**
Performance Measures			**X**			**X**	**X**	**X**	**X**	**X**		**X**
Periodic Comparison of # of Providers	**X**							**X**			**X**	
Profile Utilization by Provider Caseload												
Provider Self-Report Data					**X**							
Test 24/7 PCP Availability												
Utilization Review			**X**				**X**					**X**

Strategy	Program Impact						Access			Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information	Grievance	Timely Access	PCP/Specialist Capacity	Coordination Continuity	Coverage Authorization	Provider Selection	Quality of Care
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. ____ Accreditation for Deeming (i.e. the State deems compliance with certain access, structure/operation, or quality requirements for entities that are accredited)

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

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

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

c. __X___ Consumer Self-Report data

___ **CAHPS** (please identify which one(s))
X__ State-~~developed~~ approved survey
___ Disenrollment survey
___ Consumer/beneficiary focus groups

The PIHP is required by contract to complete an annual survey or other standardized consumer satisfaction survey approved by the Division for adults and children as part of the 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.

d. **X** Data Analysis (non-claims)
X Denials of referral requests

The PIHP will report to the Division annually the number and percentage of denials of treatment authorization requests.

___ Disenrollment requests by enrollee
____ From plan
____ From PCP within plan
X Grievances and appeals data
___ PCP termination rates and reasons
___ Other (please describe)

The PIHP will maintain records of grievances and appeals within its internal global Continuous Quality Improvement (CQI) program. The PIHP will also submit quarterly reports to the Division 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.

e. X Enrollee Hotlines operated by State **and the PIHP**
Both DMA and the Department of Health and Human Services (DHHS) operate toll free customer hotlines during business hours 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 DMA. The PIHP operates a toll free customer service line 24/7 to address enrollee needs and concerns.

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 performance improvement projects 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

The PIHP will maintain geographic mapping of the provider network for the Division's review during site visits.

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

The State is requesting that the independent assessment requirement be lifted, as assessments of the first two waiver periods have shown that quality and access are better or at least as good as they were prior to implementation, and the program has consistently been cost effective.

i**. X** Measurement of any disparities by racial or ethnic groups **The PIHP will include items on the annual consumer satisfaction survey to assess cultural sensitivity.**

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

Per Section 6.4 Accessibility of Services of the Contract, the PIHP is required to establish and maintain appropriate provider networks. Additional contract mandates require the PIHP to establish policies and procedures to monitor the adequacy, accessibility, and availability of its provider network to meet the needs of Enrollees. The PIHP 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. The analysis will be reviewed by the Division at the beginning of the contract; at any time there has been a significant change in the PIHP's 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 PIHP; and annually thereafter during annual on-site reviews. Whenever network gaps are noted, the PIHP 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.

k. _____ Ombudsman

l. **X** On-site review

The Division of Medical Assistance and the Division of Mental Health/Developmental Disabilities/Substance Abuse Services will conduct annual on-site reviews to evaluate compliance with the terms of the Contract, compliance with State and Federal Medicaid requirements, the PIHP's compliance with NC G.S. 122C-112.1, and implementation of the PIHP's local business plan. The on-site review will consist of both interviews and documentation review. Any compliance issues found on review will require the submission of a corrective action plan. The DMA, the Division of Mental Health Developmental Disabilities and Substance Abuse Services, (DMH/DD/SAS), and the Intra-Departmental Monitoring Team (IMT) will approve and monitor any corrective action plan.

The frequency of on-site reviews may be decreased to every two years at the discretion of DMA; if DMA determines that other required on-site review activities such as the EQRO and Independent Assessment are sufficient to assure the effective operation of the PIHP and compliance with State and Federal requirements.

m. **X** Performance Improvement projects [**Required** for MCO/PIHP]

X Clinical

X Non-clinical

The PIHP has implemented four performance improvement projects (PIPs), as required by DMA, since the waiver was implemented in April 2005. The PIHP reports to the Intradepartmental Monitoring Team quarterly on their progress with the PIPs. DMA in consultation with the PIHP will determine when a project will be terminated. When projects are terminated, the PIHP will implement new projects as approved by DMA. At any given time, the PIHP will be operating at least four performance improvement projects, and at least one of the four shall be clinical and one non-clinical. The project topics will be determined jointly by the Division and the PIHP from the clinical and non-clinical focus areas listed in Attachment N of the contract. Baselines will be established the first year of each project and the PIHP will set benchmarks for each project based on currently accepted standards, past performance data, or available national data.

n**. X** Performance measures [**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

The Division and the PIHP will determine jointly the focus areas for all performance measures. The topics listed above are included in the Contract as choices for focus areas and are listed in Attachment N of the Contract.

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

The Division will compare the PIHP provider network numbers and types on an annual basis using results from the PIHP reported Network Capacity measure as required in Attachment M of the Contract.

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

q. **X** Provider Self-report data

X Survey of providers
___ Focus groups

Included in the annual statistical reporting, the PIHP must conduct an annual Provider Satisfaction Survey to include the provider's self-reported satisfaction with the PIHP's performance in the areas of claims submissions, timeliness of payments, assistance from the PIHP and communication with the PIHP. The survey will be developed by the PIHP and approved for use by the Division. The survey will be reported to the Division annually as required in Appendix V of the contract.

r. **_____** Test 24 hours/7 days a week PCP availability

s**. X** Utilization review (e.g. ER, non-authorized specialist requests)
The PIHP will monitor utilization through its global CQI committee by reviewing data reports on utilization as well as monitoring enrollee calls coming into the service center. The Division requires annual statistical reporting of utilization measures listed in Attachment M of the Contract to include the following: Mental Health Utilization-Inpatient Discharges and Length of Stay; Percentage of Members Receiving Inpatient, Day/Night Care, Ambulatory and Other Support Services; Chemical Dependency Utilization-Inpatient Discharges and Average Length of Stay; Chemical Dependency Utilization-Percentage of Members receiving Inpatient, Day/Night Care, Ambulatory and Support Services, Identification of Alcohol and Other Drug Services; and Utilization Management of the Provision of High Use Services. Each of these measures is described in Attachment M of the contract. The reports will be due no later than June 30th of each contract year. The PIHP will use all applicable HEDIS technical specifications pertaining to the Medicaid population. The measurement year will be January 1st-December 31st of each contract year.

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

The PIHP had a baseline survey conducted in 2005 and contracted with UNC Charlotte Urban Institute to conduct consumer satisfaction surveys in 2006 and 2007. The response rates were 13% (1157 respondents/population of 8586) in 2006 and 15% (1067 respondents/population of 7000) in 2007. The Dillman Total Design method was used for both surveys. Surveys were mailed out in three increments and took into account invalid addresses. In both years, surveys were sent to a random sample of the

PIHP's consumer population, which consists of both Medicaid and non-Medicaid consumers. Sixty-six percent and 83% of the respondents were Medicaid recipients in 2006 and 2007, respectively. Disabilities represented included mental illness, developmental/intellectual disabilities, substance abuse and multiple disabilities.

Confirmation it was conducted as described:

X Yes

___ No. Please explain:

Summary of results:

2006 Survey:

The survey consisted of six questions requiring "yes/no" responses; one question in which the respondent was asked to identify barriers to service provision from a predefined list; and 18 questions regarding satisfaction with services using a four-point Likert scale, with a higher score signifying greater satisfaction.

The majority of survey participants (approximately 75% to 91%) responded positively, as follows:

- **They are satisfied or extremely satisfied with the services provided by the PBH (Piedmont Behavioral HealthCare) Network of Providers.**
- **Their service plan definitely meets their needs, or meets their needs most of the time.**
- **They definitely or most of the time participate in the planning of their services.**
- **The services that are available definitely meet their needs or meet them most of the time.**
- **The services they have received over the past year have definitely improved the quality of their lives or have improved it most of the time.**
- **Respondents rated attributes related to the staff of the PBH Network of Providers very high.**
- **The staff is definitely able to address the needs of the consumers' racial and ethnic community or can do so most of the time.**
- **The quality of service when staff changes definitely remains the same or remains the same most of the time.**
- **Staff is definitely available when needed or they are available most of the time.**
- **Appointment times are definitely available when needed or are available most of the time.**
- **If they have scheduled an outpatient appointment, they definitely see the provider within one hour or they do so most of the time.**
- **Treatment options have been explained.**
- **Service locations are convenient.**
- **A handbook was received within 14 days of enrollment.**
- **They are aware of their rights and responsibilities as a PBH network consumer.**

The service attributes that respondents rated with the highest satisfaction were:

- **Respecting privacy, with 95% rating definitely or most of the time.**
- **Ability to meet the needs of consumers' racial/ethnic background, with 93% rating definitely or most of the time.**

Although none of the service attributes were rated low, the service attribute rated lowest was ease of being able to change provider and choice in selecting provider, both with 68% of survey participants rating it definitely easy or easy most of the time. The following items also received lower ratings:

- **Only 66% indicate the denial and appeal process had been explained to them.**
- **More than half of the survey participants (57%) indicate they are aware of the PBH call center toll free number.**
- **Almost half of the respondents (who answered the question) indicate that transportation problems have interfered with receiving services from the PBH Network of Providers (45%).**

2007 Survey:

The 2007 survey used a similar format with "yes/no" questions, items rated on a four point Likert scale, and a list of potential barriers to accessing services. The questions/items were largely unchanged, except that the 2007 survey added items around access to care that were broken down by level of need (emergent, urgent, routine) and awareness of the complaint/grievance filing process. Compared to the previous year, the 2007 survey reflected improvement in most areas. Overall, survey participants seemed satisfied with the level of treatment and services through PBH and the network of providers. Respondents reported being satisfied when asked about their treatment, service options and service location. When asked about their perception of the PBH network of provider services, staff assistance, and appointment times, a majority of respondents indicated being satisfied most of the time or always. When asked if services met their racial/ethnic background and the racial or ethnic background of their community, a majority of respondents indicated services most of the time or always met their needs. With respect to the availability of a translator and educational material available in their native language, respondents reported these two services being available most of the time or always.

Consumers continued to rate "Respecting privacy" very high (97%) always or most of the time. They also rated "Ability to meet the needs of consumers' racial/ethnic background," very high (93%) always or most of the time.

The 2007 survey reflected the following regarding services reflecting lower levels of satisfaction in 2006:

- **The service attributes, "being able to change provider" and "choice in selecting provider," were rated at 73% and 67% (always or most of the time), respectively, in 2007 as opposed to 68% and 68% (definitely or most of the time) in 2006.**
- **Sixty-eight percent as opposed to 66% in 2006 indicate the denial and appeal process has been explained to them.**
- **Sixty-two percent vs. 57% in 2006 indicate they are aware of the PBH call center toll free number.**
- **Only 16.5% indicate that transportation problems have interfered with receiving services from the PBH Network of Providers vs. 45% in 2006.**

New questions in the 2007 survey around access to care and filing complaints yielded the following responses:

- **Eighty-seven and 85 %, respectively, responded that staff and services were available always or most of the time when the respondent was in crisis.**
- **Sixty-nine percent stated they received treatment within two hours in an emergency always or most of the time.**

- **Seventy-one percent indicated they were seen within six hours in a non-life threatening emergency always or most of the time.**
- **Seventy-one percent responded they were seen within 48 hours always or most of the time when urgent (crisis) care was needed.**
- **Sixty-five percent of respondents knew how to access services in a crisis.**
- **Forty-nine percent responded that they did not know how to file a complaint.**

Problems identified:
The surveys show improvement between 2006 and 2007 in the following areas but further improvement is needed:
- **The service attributes, "being able to change provider" and "choice in selecting provider," currently at 73% and 67%, (always or most of the time), respectively**
- **Sixty-eight percent indicate the denial and appeal process has been explained to them.**
- **Sixty-two percent indicate they are aware of the PBH call center toll free number.**

New questions in the 2007 survey indicate that the following areas need to be addressed:
- **Timely access to emergent and urgent care.**
- **Awareness of complaint process.**

Corrective action (plan/provider level):
- **Choice/change of providers/Access to emergent and urgent care: A shortage of substance abuse providers continues to be a statewide problem. The PIHP has a new Network Director and a major focus is network development to assure adequate access and choice. The PIHP is working on opening up additional community based crisis facilities, with one being adjacent to a community hospital in anticipation of cross-referrals. The Plan is also in the process of finalizing contracts with Carolinas Medical Center, a large hospital based health care system in nearby Charlotte, for additional capacity in behavioral health services. The Plan also added a fourth Comprehensive Community Provider (CCP) to its network to address the service access issue. (The CCPs are large community based provider agencies that serve at least two behavioral health/intellectual disability areas. Progress will continue to be monitored via the quarterly intradepartmental monitoring team meetings.)**
- **Denial/Appeal Process: As a result of the 2005 survey, the PIHP developed and distributed a brochure explaining adverse actions and appeal rights under Medicaid and provided toll-free numbers for legal assistance. The State has recently had some changes in the appeals process and procedures and has worked with the PIHP to make notices of adverse action consistent with the State's and assure that the content of the notices contains comprehensive information on the right to appeal and the process for requesting a hearing.**
- **Toll Free Access Number: After the 2005 survey, the PIHP reprinted their consumer materials with emphasis on the toll free number as an access number for the PIHP's services, not just a number to call in case of emergencies. The plan also did newspaper advertisements. The PIHP will continue these efforts and continue to educate the community, including social service agencies, primary care practices, and law enforcement, about the role of the Plan and the services available to Medicaid recipients.**
- **Awareness of Grievance Process: The State has worked with the PIHP during the past year on making sure that all grievances are addressed in a timely manner and that results are used for**

system improvement. The State will continue to work with the PIHP through the intradepartmental monitoring team to assure consumer awareness of the right to file a grievance and when a grievance vs. a request for hearing is appropriate.

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

(d.) Strategy - Data Analysis: The PIHP 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, the PIHP has a very low denial rate. Over the past three waiver years, the rate of denials/reductions in service was only approximately 0.003%.**
- **DMA requires quarterly reports on grievances and has worked with the PIHP 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 the PIHP 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. This analysis covers reporting through June 2008. 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.) There were 110 grievances during the most recent full year reported (July 2007 through June 2008). The number of grievances has trended downward during the past year; there were 74 grievances in the April – June 2007 quarter; during the subsequent four quarters, the number has ranged between 23 and 25 each quarter. Four of the 110 grievances during July 2007 through June 2008 resulted in an investigation and only one was partially substantiated. Grievances resolved within the targeted 30-day timeframe ranged from 66-69% during the past four quarters as opposed to a maximum of 60% at the end of the initial waiver period. Most grievances continue to be about quality/service provision.**
- **Quarterly reports on number, types and disposition of appeals are also submitted. Appeal reports are filed on the same quarterly schedule as grievances. During the past 5 quarters (April 2007 through June 2008), the PIHP had 63 appeals (54 during the most recent 12-month period). In 40 out of 63 of the appeals, the original decision was upheld (63%). The percentage of actions (denials, suspensions, terminations, reductions of service) appealed ranged from 11% to 27% each quarter. The service types most appealed tended to be in the mental health arena and included residential treatment for children and community support services.**

Problems identified:

- **Timeframe for resolving grievances continues to exceed the 30-day limit.**
- **Inadequate access to certain types of behavioral health providers.**

- **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 the PIHP through the intradepartmental monitoring team to identify and resolve obstacles to meeting the timeframe. The PIHP will continue to actively work on this issue via the complaint resolution performance improvement project that was implemented in the first year of the waiver.**
- **PBH added a fourth Comprehensive Community Provider (CCP) to its network to address the service access issue. The CCPs are large community based provider agencies that serve all behavioral health/intellectual disability areas.**

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

(e.) Strategy - Enrollee Hotlines: Both the State and the Plan have hotlines/toll free numbers for consumer grievances, concerns, information and referral.

Confirmation it was conducted as described:

X Yes
__ No. Please explain:

Summary of results: Although DMA has a managed care/customer service hotline available, consumers tend to use the PIHP hotline and issues are resolved at the PIHP level. Both quarterly and annual reports are provided to DMA by the PIHP on numbers and types of calls and response times. The PIHP operates its own hotline and contracts with a vendor for back-up. During the past two calendar years, the PIHP's average answer time was 8.1 and 9 seconds, respectively while the vendor's was 20 and 19 seconds, respectively; the PIHP's average abandonment rate was .3% and 3% while the vendor's was 4% and 4.2% during the respective calendar years. The average length of call for PIHP staff was approximately 6 minutes and 3 minutes, respectively; the vendor's was approximately 6 minutes during each calendar year.

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 the PIHP's network adequacy study. The PIHP 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**

(h.) Strategy - Independent Assessment: **This is the second independent assessment conducted for this waiver. This assessment was completed during calendar year 2008 and focused on the third waiver year, April 2007 through March 2008. Both assessments were conducted by Navigant Consulting, Inc. A complete copy of the assessment report is being forwarded with this waiver renewal request.**

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results: **Improvements were made in some of the areas identified in the first year report. Overall, consumers and most providers are satisfied with the program. Strengths/improvements identified in access to and quality of care are listed below:**

- **Consumers indicated choice of providers for mental health services has continued to improve since waiver implementation**
- **Informational materials are available for Spanish speaking consumers**
- **Consumer and provider hotline access has improved since the first year of the program**
- **Continuity of care and coordination has improved from the first year of the program**
- **Program materials and other educational materials are available through a number of resources**
- **DMA's risk contract meets or exceeds industry best practices for assuring reasonable access to care**
- **The PIHP improved on the first year's difficulties resolving complaints within the 30 calendar days**
- **The PIHP is consistently meeting its prompt payment targets**
- **The PIHP's quality assurance activities have improved and appear to have gained focus since the first year of the program.**
- **The PIHP's Continuous Quality Improvement Plans for 2006-2007 and 2008-2009, appear to be appropriately aligned with helping to ensure continuous quality improvement**
- **The PIHP has implemented and is performing a number of follow-up and ongoing monitoring activities to determine if its QA activities are successful, including the development of reports and committees focused in this area**

- **The PIHP's quality assurance activities are targeting quality concerns identified by consumers, stakeholders, DMA, EQRO and PBH staff**

Navigant reviewed the cost effectiveness section of the waiver and confirmed that the waiver met the cost effectiveness criteria put forth by CMS for 1915(b) waivers.

Problems identified:

- **DMA's risk contract does not specifically address all of the ADA Accessibility Guidelines that apply to medical care facilities, including some requirements for patient bedrooms**
- **There are some areas where PBH does not fully meet DMA's standard, or where PBH could improve access and availability of services or improve communication about available services to consumers**
- **Evidence was found of potential service gaps**
- **The PBH website is difficult to navigate and lacks certain functionality for Spanish speaking consumers**
- **There is some evidence of a shortage of certain types of services and/or providers**
- **While there has been improvement, PBH's rate of resolving complaints within 30 days is still below the goal of resolving 75 percent of complaints within 30 days**
- **DMA's ability to monitor certain areas of the program continues to appear to be limited by data-related issues**
- **Delayed implementation of the State's new MMIS system continues to be problematic for DMA**

Corrective action (plan/provider level):

- **Regarding complaint resolution, the PIHP implemented a performance improvement project (PIP) around resolution of complaints. In the re-measurement year, 68% of complaints were resolved within 30 days. This PIP is continuing.**
- **Regarding access to care issues, the following actions are being taken by the PIHP:**
  - **Opening adult crisis centers for mental health and substance abuse treatment in two of the counties in the PIHP's geographic area. The planned locations are in close proximity to community hospitals in both counties.**
  - **Adding an additional group home for persons with mental health needs who are moving out of a State hospital by working with a local provider.**
  - **Increasing the continuum of residential services for children in lower level residential setting**
  - **Developing and implementing a plan during the current State fiscal year to locate and develop additional Level IV residential options.**
  - **Access to mental health treatment in primary care settings and underserved areas is being increased by partnerships between the PIHP and NC's primary care networks.**
  - **A new Director of Network Management was hired in September 2008. The top priorities for expansion include development of crisis beds and substance abuse treatment beds. The expansion is expected to improve access to urgent care.**
  - **Complaints about the user-friendliness of the website are being analyzed by the PIHP.**

Program change (system-wide level):

- **DMA will review the DMA-PIHP contract and make changes as necessary to meet ADA guidelines**

- **DMA's data issues will be resolved when a new MMIS is implemented. The re-bid process is underway.**

(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 referenced in item (c.) above addresses cultural sensitivity. In the 2006 survey, ninety-three percent of respondents said that providers met their needs related to race/ethnicity definitely or most of the time; ninety-one per cent responded that staff was able to meet the needs of the consumer's racial/ethnic community. In the 2008 survey, ninety-three percent of respondents said that providers met their needs related to race/ethnicity always or most of the time; likewise, ninety-three per cent responded that staff was able to meet the needs of the consumer's racial/ethnic community. Race/ethnicity data are gathered in the surveys, and analysis has not shown any perceived disparity based on race/ethnicity.

In addition, the PIHP has conducted provider training and education on cultural diversity, and ninety-eight percent of respondents to the 2008 provider survey either agreed or strongly agreed that the PIHP's cultural competency initiative 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:

The PIHP operates in a five county area and covers a total of 2500 square milest. The counties are primarily rural with some moderate to large urban areas. The total population of the PIHP catchment area is approximately 700,000. Twenty-eight percent of the population are between the ages of 0 and 18 and 72% are 19 and older. The PIHP 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.

The PIHP conducts network adequacy studies annually using data from multiple sources including the US Census Bureau, SAMHSA Office of Applied Studies, the Division of Mental Health and the Division of Medical Assistance within the NC DHHS, the State Medical Facilities Plan, the Cecil G. Sheps Center for Health Services Research and the PIHP's internal database. The PIHP also does geographic mapping to support the network adequacy analysis.

<u>Confirmation it was conducted as described:</u>

X Yes

___ No. Please explain:

<u>Summary of results:</u> The PIHP has approximately 167,000 enrollees (individuals eligible to access services through the PIHP if needed); about 88,000 are Medicaid recipients. At any given time, about 15% to 17% (25,000 to 29,000) of enrollees are actively receiving services through the PIHP. The PIHP currently has 232 contracted providers in multiple sites within or bordering the PIHP catchment area. 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. The capacity and mix of providers appear to be adequate to meet consumers' needs and all services, with the exception of highly specialized or recently implemented services (such as facility based crisis units) are accessible within the contractual access standards. The PIHP has, however, identified areas that need to be addressed to assure continued adequate capacity and appropriate treatment alternatives in the future.

(Potential) 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**

<u>Corrective action (plan/provider level):</u>

- **The number of inpatient hospital beds across the State is controlled by the NC State Health Coordinating Council. The PIHP 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. The PIHP 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. The PIHP is working toward opening adult crisis centers for mental health and substance abuse treatment in two of the counties in the PIHP'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, the PIHP is taking the following actions:**
    - **Increasing the continuum of residential services for children in lower level residential setting**

    - **Developing and implementing a plan during the current State fiscal year to locate and develop additional Level IV residential options.**
- **The PIHP 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. The PIHP 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. The PIHP 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.**
    - **The PIHP 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.**

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

(l.) Strategy - On-Site Review: **Administrative and clinical operations of the PIHP were reviewed by members of the Piedmont intradepartmental monitoring team (IMT) with assistance from Mercer Government Human Services in 2007 and 2008. The annual reviews consist of a preliminary review of key documents and onsite review of administrative operations (financial, information system, reporting and claims management) and clinical operations (care and utilization management, network management and quality improvement). The 2007 administrative and clinical onsite review components were conducted on July 10-11 and August 9-10, 2007, respectively. The 2008 administrative and clinical onsite components were conducted on September 24 and October 8-9, 2008, respectively.**

Confirmation it was conducted as described:
X Yes
___ No. Please explain:

Summary of Results (2007):
Mercer and the State conducted three readiness reviews of the PIHP in 2004 and 2005, and this review was the second annual review conducted since the PIHP began operating under the waiver in April 2005. All members of the team agreed that the 2007 review findings confirmed that the PIHP had made a successful transition from being a provider of services to a fully functional managed care entity operating in a capitated environment. The strengths identified include:
- **Well defined processes for medical oversight of clinical quality and stable leadership**

- **Increased supervision of clinical staff with a new position, Director of Utilization Management. Access, utilization/care management and outreach staff are monitored through inter-reliability testing, blind call monitoring and auditing of call documentation.**
- **Staffing, process reconfigurations and IS enhancements in clinical operations have resulted in significant improvement in call responsiveness and staff efficiency.**
- **Transition to a matrix model of operations with cross-functional teams, resulting in more efficient management and execution of operational tasks.**
- **Effective monitoring and tracking of grievances through a "no wrong door" process that ensures the review of each grievance by the appropriate department.**
- **Development of a risk management plan to monitor Plan performance**
- **Development and implementation of policies and procedures for consumer directed care and implementation of a contract with a financial agent to process payments and conduct other administrative activities under this model.**

Summary of Results (2008):
The PIHP continues to improve its administrative and clinical operations, relying on the feedback from the annual reviews, the IMT, the External Quality Review (EQRO), Performance Improvement Projects and its own internal quality management program to take corrective actions and improve operations. A summary of findings is provided below.
Administrative Operations:

- **The overall financial management of the PIPH has continued to improve each year since the start of the IMT process. The financial solvency of the PIHP has continued to strengthen as indicated by the current ratio and solvency ratios as reported on the June 30, 2007, Audited Financial Statements (AFS). The methodology and process used by the PIHP to develop the State required quarterly financial reports have improved and reports appear reasonable, accurate and consistent with other reported information to the State.**
- **The PIHP has developed a solid core information system, Cardinal Innovations (CI) for processing membership, provider and claims data. The system is integrated and largely automated for the processes that receive claims, perform edits, link authorizations, determine benefits, and calculate provider payments. In conjunction with the Great Plains finance system and interfaces built by the PIHP developers, the financial processes finalize payments to providers with a detailed remittance advice.**
- **Significant improvement has been achieved in reporting on clinical and administrative performance indicators through establishing cross functional teams responsible for documenting existing reports and prioritizing new report requests for the organization.**

Clinical Operations:

- **The role differentiation between the Medical Director and Associate Medical Director has helped in managing the workload and improving overall medical management.**
- **The care management and utilization management practices continue to significantly improve. The policies and procedures for UM have been updated to meet NCQA standards and are comprehensive. The UM process has become more standardized, due in part to role differentiation between the Medical Director and Associate Medical Director.**
- **QM improvements are significant. Progress has occurred in pursuit of NCQA accreditation. There is increased efficiency through focused monitoring activities related to access and availability, performance improvement and continuous quality improvement projects. The**

reorganization of QM into three teams (data management, billing audit, quality management) and the transition of provider endorsement and training activities to the Network Operations department resulted in the transfer of two QM staff to the UM department, demonstrating responsiveness to IMT recommendations.
- **A new Director of Network Management was hired in September 2008. The top priorities for expansion include development of crisis beds (two new centers are under development) and substance abuse treatment beds. The expansion is expected to improve access to urgent care. Provider training and coaching is also planned, including training in the areas of family focused care that can offset the use of PRTFs (psychiatric residential treatment facilities).**

Care Management Record (CMR) Review:
- **The CMRs reviewed for individuals with developmental disabilities are comprehensive and well documented. The care management documentation reviewed for other levels of care needs improvement.**

Problems Identified (2007):
- **Additional management reports, requested but not yet designed, are needed to better guide internal operations**
- **Paper EOPs (explanation of payments) are not given to service providers. Providers may not be aware of claim denials if they do not view or download information from the on-line system, resulting in slow resolution of issues. In addition, out of network providers may be impacted adversely because they have to call the PIHP to request an EOP.**
- **Additional claims audits are needed in PIHP payment system.**
- **Risk management plan needs to be enhanced.**
- **QM activities currently focus on routine, onsite provider evaluations rather than monitoring quality through reporting and outcomes.**
- **Quality of services provided to the PIHP outside its geographic area of operation is inadequately monitored.**

Problems Identified (2008):
- **Claims edits that are performed during adjudication are missing a critical step that validates eligibility.**
- **The electronic care management record system does not have adequate space to document care management issues, decisions, supervisory and medical staff involvement, and the clinical rationale for authorization and care management decisions.**
- **Access to emergent care is consistent with State standards and contract requirements, while wait times for urgent and routine care exceed these standards.**
- **Care management documentation for adults with co-occurring disorders of mental health and substance abuse and for children and adolescents residing in PRTFs needs improvement.**

Corrective action (plan/provider level):
2007 CAP:
- **Develop a prioritized list of reports to support and inform day to day operations and have the list presented to and approved by the PIHP executive cabinet monthly.**

- 2008 Status: Significant improvement has been noted; the PIHP has established cross-functional teams responsible for documenting existing reports and prioritizing new report requests.

- **Automatically generate paper explanations of payments (EOPs) when needed.**
  - **2008 Status: The PIHP now provides hard copy remittance advice to out-of-network providers.**
- **Expand risk management plan to include acceptable thresholds for each indicator and to implement processes/steps to be taken when performance falls outside these thresholds.**
  - **2008 Status: The PIHP has developed risk management/dashboard indicators and measures to monitor accessibility, acceptability, clinical management, risk and system performance.**
- **The PIHP, with active involvement of the CEO and Medical Director, should assess the level of QM staffing and the onsite provider monitoring activities conducted by the QM and Network departments. The assessment should consider:**
  - **The value of onsite visits currently conducted in light of network maturity;**
  - **Daily provider interaction through the UM department;**
  - **Impact of these tasks on QM's ability to focus on monitoring through reports/outcomes;**
  - **Industry standards and the outcome of departmental process mapping;**
    - **2008 Status: Assessment has occurred and changes have been made in roles, responsibilities and QM focus, as described in the 2008 report of findings.**
- **Work with other local management entities to monitor the quality of services delivered to PIHP enrollees outside the PIHP geographic area.**
  - **2008 Status: The PIHP has processes in place to assure that out of area providers meet the same criteria as network providers.**

Corrective Action Plan (2008):

- **Create an additional edit to assure claims paid are adjudicated for eligible members and associated with payments from the correct funding source.**
- **Expand electronic care management system to fully support clinical care management tasks.**
- **Develop and improve management of the network to decrease wait times for urgent and routine care.**
- **Develop and provide didactic training and ongoing monitoring to care managers to improve their use of more clinically focused care management techniques and to clarify minimum documentation standards.**

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

(m) Strategy - Performance Improvement Projects (PIPs): DMA requires the following PIPs. The first year of the contract, the PIHP implemented one non-clinical and one clinical PIP. The non-clinical project for the first year was "Improving resolution of complaints within established guidelines", and the clinical topic was "Improving coordination of care and reducing recidivism rates in State facilities through Screening, Triage and Referral (STR)." During year two of the contract, the PIHP implemented an additional performance improvement project, "Prone restraints as a restrictive intervention" for a total of three PIPs. In year three of the contract, the PIHP implemented a fourth PIP, "Effectiveness of

technical assistance for providers to manage claim denials." The project topics were determined jointly by DMA and the PIHP.
<u>Complaints:</u> Study indicators are:

- **Complaints resolved within 30 days - the goal is to increase the percentage resolved in 30 days to 75%.**
- **Average number of days to resolve complaints - The goal is a 10% decrease in the number of days to resolve in both the measurement and re- measurement years.**

<u>Reducing Recidivism in State Hospitals through STR:</u> The study focuses on decreasing admissions to State hospitals and preventing re-admittance through aggressive STR and outreach. The goal is to remain below the current NC readmission rates to State hospitals. Study indicators include:

- **Readmissions to state hospitals within 30 days**
- **# of consumers who received/did not receive STR intervention**
- **Readmission rate among consumers who did/did not receive STR intervention**

<u>Prone Restraints as a Restrictive Intervention:</u> 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 the PIHP's contracted providers report prone restraints as restrictive interventions.
<u>Technical Assistance to Manage Claims Denials:</u> This PIP was implemented in 2007. When the PIHP began operations in April 2005, the percentage of claims denied was approximately 9%. As the program grew, however, the denials increased and it was clear that the PIHP's claims processing system was not adequate. This led to replacement of the system and technical assistance from DMA through DMA's contractor, Mercer, with claims processing. The purpose of this project was to determine whether technical assistance and support to providers by the PIHP were effective in maintaining the denial rate at below 20%. Twenty percent was selected as it reflects the DMA standard for claims denied.

<u>EQR validation of PIPs:</u> The 2008 EQRO validation reported high confidence in PBH's complaint resolution PIP results and all critical elements of the PIP. The reducing recidivism PIP contained all of the essential elements for a solid study design that produced a level of high confidence in the reported results. Both of these PIPs have been validated as part of the EQRO process since 2005. The 2008 EQRO validation of the restrictive intervention PIP reported high confidence in the results. The evaluation recommended additional work with two specific providers that have higher rates of use of restraints as well as education of new providers. The fourth PIP validated in 2008 was Technical Assistance for Providers to Manage Claim Denials. The EQRO reported high confidence in the results for this non-clinical PIP as well, with only two minor suggestions for improved documentation.

<u>Confirmation that the performance improvement projects were implemented and validated as described:</u>

<u>X</u> Yes
___ No. Please explain:

<u>Summary of results:</u>
<u>Complaints:</u> Percentage of complaints resolved within 30 days increased from 43.12% at baseline to 67.65% in the re-measurement year. The average number of days to resolve a complaint steadily decreased from 44.86 days in the baseline year to 35.48 days (21% reduction) in the initial measurement year and to 27.81 days (22% reduction) in the re-measurement year.
<u>Reducing Recidivism in State Hospitals through STR:</u> The utilization rate at State hospitals decreased by 7.39% between baseline and measurement year and decreased 20.9% between the measurement and re-

measurement year. The readmission rate within 30 days for consumers with the STR intervention was 4.35% in the measurement year and 3.37% in the re-measurement year. The readmission rate within 30 days for consumers without the STR intervention was 7.38% in the measurement year and 8.72% in the re-measurement year. The PIHP's readmission rate to State hospitals within 30 days remained below both the national and State rates. (2006 national and State rates were 9.1% and 12%, respectively. The PIHP's 2006-2007 rate was 6.96%.)
Prone Restraints as a Restrictive Intervention: The number of restrictive interventions decreased from baseline to measurement year but the use of prone restraints shows an upward trend. Two providers of the 14 reporting comprised 74% of all prone restraints reported. The providers include a psychiatric residential treatment facility (PRTF) and a day treatment provider serving consumers whose behavior is too disruptive to attend public school. If the use of prone restraints reported by these providers is factored out, the percentage of prone restraints compared to all restrictive interventions drops to 13.2% in the measurement year and 16.7% in the re-measurement year.
Technical Assistance to Manage Claims Denials: Both the dollar amount of claims denied and the number of line items denied were under the 20% standard, at 13.4% and 15.2%, respectively, at baseline; in measurement year one, denial rates for both measures were 13.9% and 14.3% respectively; and, in the re-measurement year, they were at 14% and 11.3%, respectively. For both measures and all three measurement years, the top denial reason was duplicate claims.

Problems identified:
Complaints:
- **Duplicate complaints entered by multiple staff**
- **Inadequate tracking of complaint resolution**
- **Staff understanding of what constitutes a complaint**

Reducing Recidivism in State Hospitals through STR:
- **Increasing State hospital admissions**
- **Lack of data to track consumers through the State hospital system**
- **Lack of discharge planning to assure appropriate level of care**
- **State hospital frequently does not involve PIHP's hospital liaison in discharge planning**

Prone Restraints as a Restrictive Intervention: Two providers of the 14 reporting comprised 74% of all prone restraints reported.
Technical Assistance to Manage Claims Denials:
- **Limitations of eCura claims processing software**
- **Communication barrier between the PIHP and providers**
- **Level of system knowledge of PIHP claims adjudicators**
- **Providers needed tools for analyzing denials**

Corrective action (plan/provider level):
Complaints: As a result of the PIP, the following corrective actions were taken:
- **Increased QM Department monitoring of complaints by developing a schedule for reviewing the complaints before transfer and sending standardized reminder emails to staff members to resolve their complaints.**
- **All supporting documentation related to a complaint is to be housed in a secure place within the QM department.**

- **Complaint Intake specialist position was created to monitor the complaint module and ensure complaint information is being documented as well as resolved in a timely manner.**
- **Emails are sent 7 to 10 days prior to the 30 day state requirement for resolution.**
- **Complaint trainings were held for individuals and departments and are now included in Employee Orientation for all new employees. Quarterly complaint training has also been implemented.**
- **Modified the transfer process for complaints so that all complaints are now transferred to QM. QM staff reviews for completeness of data, severity of complaint, and concise entry of complaint description. This effort improves resolution times through the appropriate and timely assignment of complaints.**
- **The PIHP's complaint procedure was revised for clarity.**
- **Revised complaint reports according to feedback from the Client Rights Committee (CRC) to track complaints by service and type and identify provider specific trends. CRC provides recommendations for additional interventions based on these reports.**
- **Complaint categories were revised to meet NCQA standards and clearly define complaint types.**

Reducing Recidivism in State Hospitals through STR:

- **Local facility based crisis center was created as an alternative to State hospitals**
- **Developed manual process 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 the PIHP 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 and follow-up processes.**

Prone Restraints as a Restrictive Intervention:

- **The PIHP required a corrective action plan of the day treatment program, and the use of restrictive interventions for that particular provider has decreased significantly.**
- **The PIHP is working with the PRTF provider to identify issues that will decrease the use of prone restraints.**
- **An intake position was created to streamline and monitor the restrictive intervention reporting process.**
- **Encouraged/facilitated collaboration among residential and day treatment providers to share alternative methods to prone restraints that some providers have implemented**
- **Revised restrictive intervention reporting process based on feedback from the Client Rights Committee (CRC) to identify specific providers.**
- **The QM Department developed a new process to review all prone restraints. Identified issues are taken to Global CQI for discussion in order to encourage collaboration among residential and day treatment providers. This will provide an opportunity for all providers to share alternative methods to prone restraints.**

Technical Assistance to Manage Claims Denials:

- **Replaced ECura system**
- **Increased training and informational sessions at Network Council and routine provider meetings**
- **Created reports for claims adjudicators: on-demand claims denial reports by provider; process-mapped claims processing system**

- **Created reports for providers: claims status reports; authorization status reports; client enrollment report**

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

(n) Strategy - Performance Measures: DMA in conjunction with the PIHP (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:

Summary of results: The following table demonstrates selected PBH performance measures that are directed at achieving waiver goals. Examples of additional performance measures that are monitored and have been validated by the EQRO are:

- **Crisis plan – The percent of Enrollees who are in need of a crisis plan and for whom a crisis plan has been developed.**
- **Chemical dependency utilization – The number and percentage of Medicaid Enrollees receiving mental health services by category (any service, inpatient, intermediate, ambulatory).**
- **Provision of high-use services – The number and percentage of C waiver Enrollees with the following services (personal care services – periodic, habilitation services – periodic, habilitation services – residential, respite services – periodic).**
- **Complaints/Grievances/Appeals – The total number of complaints resolved within 30 days.**

PBH performance indicator	PBH 2006	PBH 2007	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%	74.4	90	HEDIS
Protocall	82.50%	83.30%	74.4	90	
Call answer abandonment Percentage of call abandoned by the caller before answered by a live voice					
PBH	0.30%	3.00%	5.8	5%	HEDIS
Protocall	4.00%	4.20%	5.8	5%	
Denied claims Number and percentage of claims for services that were denied by PBH					
Percentage denied	21.89%	18.55%	N/A	20%	DMA
Inpatient discharges and ALOS (Inpatient Only)					

PBH performance indicator	PBH 2006	PBH 2007	Quality Compass national average	PBH benchmark	Specifications
Inpatient discharges per 1,000 member months	1.39	1.28	1.1	1.1	HEDIS
ALOS	9.71	8.71	7.4	8	HEDIS
Readmittance to inpatient MH facility within 30 days					
Percentage of Readmits	7.79%	8.60%	N/A	11%	DMA
Readmittance to Inpatient SA facility within 30 days					
Percentage of Readmits	9.80%	3.49%	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%	39.1%	70%	HEDIS
30 day	38.46%	24.25%	57.7%	58%	HEDIS
Follow up after hospitalization for SA Percent who had follow-up visit after discharge					
7 day	22.20%	27.12%	N/A	70%	HEDIS-like
30 day	35.99%	37.01%	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	N/A	N/A	HEDIS
Percentage of Members receiving services	11.53%	11.46%	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	N/A	N/A	HEDIS
Percentage of Members receiving services	1.72%	1.81%	2.5		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%	43.3	71%	HEDIS
Percentage who initiated treatment and had two additional services within 30 days of initiation	34.37%	30.00%	11.7	50%	HEDIS
Inpatient discharges and ALOS for SA					
Inpatient discharges per 1,000 member months	0.16%	0.49%	0.3	0.3	HEDIS
ALOS	6.65	4.39	4.9	4.9	HEDIS
Member months of enrollment by age and sex					
Total Medicaid	757,312	768,688	N/A	N/A	DMA
Diversity of membership – language					
Asian/Pacific Island	0.03%	0.03%	N/A		
English	96.17%	95.76%			
Other Indo-European	0.03%	0.03%			

PBH performance indicator	PBH 2006	PBH 2007	Quality Compass national average	PBH benchmark	Specifications
Spanish	3.69%	4.08%			
Other	0.07%	0.06%			
Unknown	0.00%	0.01%			
Diversity of membership – race/ethnicity					
American Indian/Alaskan Native	0.20%	0.19%			
Asian/Pacific Islander	1.05%	1.07%			
Black/African American	27.35%	26.96%			
White	61.74%	61.29%			
Other	0.00%	10.49%	N/A		

<u>Problems identified:</u> Follow-up after hospitalization for mental illness is below the PIHP's benchmark and the quality compass; in addition, follow-up decreased between 2006 and 2007. Follow-up after hospitalization for substance abuse is below the PIHP's benchmark but increased between 2006 and 2007.

<u>Corrective action (plan/provider level):</u>
The PIHP implemented 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 the PIHP 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.**

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

<u>(o) Strategy - Periodic Comparison of # of Providers:</u> Please see item (j) above regarding the network adequacy study process. The PIHP 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.

<u>Confirmation it was conducted as described:</u>

X Yes
___ No. Please explain:

<u>Summary of results:</u> See item (j) above.

<u>Problems identified:</u> See item (j) above.

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

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

<u>(q) Strategy -</u> <u>Provider Self-Report Data:</u> A Provider satisfaction survey is conducted annually by the PIHP. In 2007, the PIHP contracted with Marketwise, and in 2008 with the UNC-Charlotte Urban Institute. The survey is developed by the PIHP and approved for use by DMA. The purpose of the survey is to solicit input from providers regarding levels of satisfaction with program areas such as claims submission and payment, assistance from the PIHP, and communication. In both years, surveys were mailed to all providers. The response rate was 23% in 2007 (64 respondents) and 44% in 2008 (104 respondents).

<u>Confirmation it was conducted as described:</u>

X Yes

___ No. Please explain:

<u>Summary of results: 2007 Survey Findings:</u>

Ratings on the integrity and competence of PBH and its staff were positive. Thirty-four percent of respondents did not rate PBH on improvements in service availability since the development of the Local Business Plan in their community. In general, many ratings cluster around the midpoint of the scale. A rating of 3 (the midpoint) represents a provider that is neither satisfied nor dissatisfied. More than half indicate they are satisfied overall (40). An additional 20% are neutral, and about 25% are dissatisfied

<u>Findings by PIHP department/functional area:</u>

- **<u>Access</u>**
  The item with the highest score is "PBH Access Staff have a good understanding of services." Fifty-two percent agree with this item.
  More than 1 in 4 (28%) did not rate PBH on making equitable, appropriate referrals.
- **<u>Company Relations</u>**
  One-fourth to 1/3 of respondents did not rate PBH on items in this section. However, among respondents who did rate PBH on this item, perceptions are positive.
  The item with the most positive scores is "PBH places emphasis on the importance of culturally competent services."
- **<u>Consumer Affairs</u>**
  Over 40% of respondents did not rate these items.
  Thirty-eight to 41% agree with the two items in this section.
- **<u>Finance</u>**
  Fifty-eight percent agree that claims are processed in a timely manner.
  Fifty-one percent agree that finance trainings meet their needs.
- **<u>Information Systems</u>**
  Many respondents (19%-28%) did not rate PBH on these items. However, perceptions are positive among respondents who did rate these items.
- **<u>Network Management and Provider Relations</u>**

Ratings in this section are largely positive.
The item with the lowest rating is "Providers are active participants in the development of the Contract" with 41% agreeing and 25% disagreeing.

- **Quality Management**
  Many respondents (28%-36%) did not rate PBH on these items. However, perceptions are positive among respondents who are able to rate.
- **Utilization Management**
  Although ratings are generally positive, agreement on items in this section is lower than in other sections.

Summary of results: 2008 Survey Findings:
Breakdown of respondents is as follows:

- **13% provide community based services only**
- **41% provide outpatient services only**
- **25% provide residential services only**
- **21% provide multiple services**
- **59% serve more than one priority population**
- **36% provide services in more than one county**

Findings:

- **Overall, responses mostly favored strongly agree/agree for each of the statements.**
- **77% are extremely satisfied/satisfied with their interactions with PBH**
- **98% strongly agreed/agreed that PBH's cultural compentency initiative has provided valuable training to help them become culturally competent**
- **93% strongly agreed/agreed that PBH's staff treat their agencies with courtesy and respect.**
- **92% strongly agreed/agreed that the monthly provider meetings are helpful and informative.**

Problems identified: **The PIHP made many improvements in operations between 2007 and 2008. The claims processing department improved their remittance advice documents, became more proficient in processing inpatient hospital claims (DRG based) and worked closely with providers to resolve issues with denied claims. The PIHP's philosophy is that once a service has been authorized, it is the goal of the claims processing department to see that the claim is paid as quickly as possible. They also provide regular training to providers. It should also be noted that the survey instrument was redesigned in 2008 to be much more streamlined and user friendly. The following problems/opportunities for improvement were identified based on the 2008 survey:**

- **1/3 of the respondents said they were not as satisfied with the PIHP when compared to other local management entities (regional area management entities for publicly funded behavioral health services).**
- **About ¼ of respondents said that the PIHP's website was not easy to navigate.**
- **About ¼ of providers said that the PIHP did not respond quickly enough to providers' needs.**

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Corrective action (plan/provider level
The PIHP has taken the following actions:

- **The 2008 findings were presented to the PIHP's cross-functional Network team whose members have been charged with having their respective departments review the report and make suggestions for improvement.**
- **The findings were reported to the Network Council and resulted in a request for further analysis of the statement, "Compared to other LMEs, I am more satisfied with PBH."**
- **The PIHP is considering changes to their website.**

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

(s) Strategy - Utilization Review

The PIHP reports on several utilization/performance measures annually as described in item (n) above and uses findings as a basis for continuous quality improvement. In addition, the PIHP's medical director, who is a board-certified adult psychiatrist, focuses on utilization patterns with particular emphasis on adult individuals who are not doing well, inpatient utilization, and special studies identified through review of UM/UR trends (e.g., Community Support Services in comparison to ACT). He also tracks with care managers those individuals who do not engage for treatment after being released from inpatient care in order to increase engagement of these individuals and provide follow up upon their release. The PIHP's associate medical director, who is board certified in child and adolescent psychiatry, focuses on concurrent review with heavy emphasis on PRTF for children and adolescents. Utilization of these services by the court system and county social services agencies occurs without notification or pre-planning with the PIHP. Two areas are being addressed by the PIHP to rectify these issues: 1) providing outreach to the social service agencies and the Courts to provide joint case planning/referrals to alternative services; and 2) enhancing the network with more family-based services, such as Multi-systemic Family Therapy (an evidence-based practice).

Confirmation it was conducted as described:

X Yes

___ No. Please explain:

Summary of results: See item (n) for findings and quality improvement activities based on performance measures. Regarding the utilization review/management activities described above, the medical directors' leadership has resulted in identifying problems and taking actions to address them as described throughout this narrative on monitoring results.

Problems identified: See item (n) for findings and quality improvement activities based on performance measures.

Corrective action (plan/provider level): See item (n) for findings and quality improvement activities based on performance measures.

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

Section D – Cost-Effectiveness

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

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

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

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

Part I: State Completion Section

A. Assurances

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

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

b. Name of Medicaid Financial Officer making these assurances: _Aydlett Hunike

c. Telephone Number:__919 855 4208_________

d. E-mail:_ aydlett.hunike@ncmail.net ___

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 based on recent economic conditions. The changes in enrollment are primarily due to changes in economic conditions 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.

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 CAP-MR	Total
P1 Qtrly Trends	1.6%	0.9%	0.6%	7.0%	1.4%
P2 Qtrly Trends	1.6%	0.9%	0.6%	1.0%	1.3%

d. _X_ [Required] Explain any other variance in eligible member months from BY/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, 2007 through March 31, 2008. R2 is April 1, 2008 through March 31, 2009 (data currently available for R2 is for April 1, 2008 through September 30, 2008).

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 versus Appendix D5. 1915(b)(3) costs reported on Appendix D3 are summarized from the adhoc quarterly reports submitted to CMS because of the inability of the MBES system to track 1915(b)(3) costs.

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 Piedmont (b)(c) concurrent waiver all costs for individuals are reported on either the Piedmont (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,	*$54,264 savings*	*9.97% or*	*$59,675 or .03 PMPM P1*

Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)	*or .03 PMPM*	*$5,411*	*$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 Piedmont waiver reflect the approved allocation methodology for administrative expenses. General State administrative expenses excluding EQRO are allocated to the Piedmont waiver based on the actual Piedmont 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 1.2-1.3%.

In addition, the State has determined that 25% of the EQRO/MPRO Medicaid expenditures are attributable to the Piedmont waiver.

The administrative costs reflected on Appendix D3 are pulled directly from the Piedmont 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 projected	Amount projected to be spent in Prospective Period
Respite	*$133,440 or $0.17 PMPM R1* *$420,694 or $1.03 PMPM R2*	5.0% or $61,538 Adj: 172.8% or $1,454,131	$2,357,057 or 2.90 PMPM in P1 $2,515,572 or 3.09 PMPM in P2

1915(b)(3) Service	Amount Spent in Retrospective Period (R2 dollars reflective of 6 months of services)	Inflation projected	Amount projected to be spent in Prospective Period
Crisis Respite	*$0 or $0.00 PMPM R1* *$0 or $0.00 PMPM R2*	5.0% or $0 Adj: $40,657	$40,657 or 0.05 PMPM in P1 $43,392 or 0.05 PMPM in P2
Supported Employment	*$112,942 or $0.15 PMPM R1* *$183,726 or $0.45 PMPM R2*	5.0% or $26,875 Adj: 172.8% or $635,048	$1,029,374 or 1.27 PMPM in P1 $1,098,601 or 1.35 PMPM in P2
Integrated Medical Services as a Portion of Supported Employment	*$0 or $0.00 PMPM R1* *$0 or $0.00 PMPM R2*	5.0% or $0 Adj: $40,657	$40,657 or 0.05 PMPM in P1 $43,392 or 0.05 PMPM in P2
Personal Care (Individual Support)	*$0 or $0.00 PMPM R1* *$519 or $0.00 PMPM R2*	5.0% or $76 Adj: 172.8% or $1,795	$2,910 or 0.00 PMPM in P1 $3,106 or 0.00 PMPM in P2
One-Time Transitional Costs	*$0 or $0.00 PMPM R1* *$5,416 or $0.01 PMPM R2*	5.0% or $792 Adj: 172.8% or $18,719	$30,343 or 0.04 PMPM in P1 $32,383 or 0.04 PMPM in P2
Psychosocial Rehab (Peer Supports)	*$0 or $0.00 PMPM R1* *$14,383 or $0.04 PMPM R2*	5.0% or $2,104 Adj: 172.8% or $49,716	$80,587 or 0.10 PMPM in P1 $86,007 or 0.11 PMPM in P2
Innovations Waiver Services	*$87,030 or $0.11 PMPM R1* *$71,765 or $0.18 PMPM R2*	5.0% or $10,498 Adj: 172.8% or $248,057	$402,085 or 0.49 PMPM in P1 $429,125 or 0.53 PMPM in P2
Physician Consultation	*$0 or $0.00 PMPM R1* *$0 or $0.00 PMPM R2*	5.0% or $0 Adj: $81,315	$81,315 or 0.10 PMPM in P1 $86,783 or 0.11 PMPM in P2

1915(b)(3) Service	Amount Spent in Retrospective Period (R2 dollars reflective of 6 months of services)	Inflation projected	Amount projected to be spent in Prospective Period
Total	*$333,412 or $0.43 PMPM R1* *$696,503 or $1.71 PMPM R2*	**5.0% or $101,883** **Adj: 184.5% or $2,570,096**	**$4,064,985 or 5.00 PMPM in P1** **$4,338,361 or 5.34 PMPM in P2** **(PMPM in Appendix D5 Column Z x annualized R2 member months should correspond)**

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 contract with Piedmont contains a requirement for a risk and contingency 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: **_1.6% from 9/30/2008 to 3/31/2009_**. Please document how that trend was calculated:

This is the actual trend rate experienced by the State from R1 to R2 and reflects the capitation payments and anticipated pharmacy spending for the October 2008 through March 2009 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___**2006, 2007, 2008**__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 base periods R1 and R2, 18 months of experience for the managed care program has been reported. The annualized service trend level contained in Appendix D.3 shows an annualized growth rate of 1.6% using R1 and R2 reported waiver expenditures. This waiver cost trend has been managed to a very low rate of growth over the past two years through the utilization management of services. 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.

Mercer developed trend by Category of Service (COS) and Medicaid Eligibility Group. Trend is set in total, considering both unit cost inflation and utilization. The trend projections in the cost effectiveness spreadsheets are consistent with the trend assumptions that will be used to develop the future rates.

Mercer considers historical year over year trends, as well as rolling averages in making these estimates. In addition to North Carolina-specific data sources, Mercer also considers national indices (Consumer Price Index, Producer Price Index and Data Resource, Inc.). No adjustments for programmatic, policy, or pricing changes were necessary; therefore, trend estimates do not duplicate the effect of any changes.

The following chart illustrates the weighted averages of the Capitated PIHP services and Wraparound Pharmacy trends. These trends were primarily based on Mercer's actuarial trend analysis.

Chart: Weighted Average Trend Assumptions

Service Grouping	Trend Assumption
BH services covered by PIHP	6.0%
CAP-MR services covered by PIHP	9.0%
Pharmacy (FFS wraparound)	5.5%
Weighted Average Prospective Trend Rates	6.7%

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)	*1.6%*
P1 (4/1/09-3/31/10)	*6.7%*
Annualized Trend From End of R2 to End of P1	5.0%
P2 Trend Rate	6.7%

ii. _X__ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used ______________. **In addition to North Carolina-specific data sources, Mercer also considers national**

indices (Consumer Price Index, Producer Price Index and Data Resource, Inc.). 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._X_ 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.___ An adjustment was necessary and is listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _______
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _______
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _______
D.____Determine adjustment for Medicare Part D dual eligibles.
E.____Other (please describe):

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

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

iv.__ Changes brought about by legal action (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _______
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _______
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _______
D.____Other (please describe):

v.__ Changes in legislation (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _______
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _______
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _______
D.____Other (please describe):

vi.__ Other (please describe):
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _______
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _______

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

D.____Other (please describe):

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: base years_R1 and R2_2005, 2006, 2007 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 is 13.2%. Going back to the initial waiver year, the administrative costs from April 2005 through March 2006 were $7.11 PMPM. The administrative costs from April 2008 through September 2008 are

$8.54 as reflected on Appendix D.3. This amounts to a 6.9% annualized administrative trend factor.

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 _5.0% for P1 and 6.7% 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 13.2% in cost changes from R1 to R2. While the historical admin trend was 6.9%, the trend used in the projection was limited to the lower State Plan service trend rate of 5.0% for P1 and 6.7% for P2 as required.

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: __1.6%_____. Please provide documentation.

This is the historical State Plan Service trend for October 2008 through March 2009.

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 2008____________**

Spending on 1915(b)(3) services began in July 2007. As reflected in the CMS quarterly adhoc reporting, the spending on these services has increased drastically in the last two years. The raw trend exhibited on Appendix D.3 reflects an annualized trend of over 400% from $0.43 PMPM in R1 to $1.71 for the first six months of R2.

2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _5.0% for P1 and 6.7% for P2 _.

Given the 1915(b)(3) services trend has exceeded the State Plan service trend due to recent expansions, the 1915(b)(3) service trend will be limited to the State Plan trend rate. Additional expansions of 1915(b)(3) spending are reflected in an adjustment in Column W on Appendix D.5.

The State received 1915(b)(3) authority through a waiver amendment approved December 6, 2006. Actual spending on (b)(3) services began in July 2007 initially financed out of the community reinvestment fund. In July 2008, (b)(3) services were funded through an upfront capitation rate. In the future, all (b)(3) funding will be made through an upfront capitation rate from the State to the MCO.

Per the terms and conditions of the prior waiver renewal, the State has submitted quarterly reports on 1915(b)(3) service expenditures. These reports are adhoc reports outside of the CMS-64 reporting and reflect actual payments for 1915(b)(3) services in each respective quarter. Appendix D3 reflects the summarization of these expenses for R1 and R2 and (b)(3) expenses. As mentioned above, effective July 2008 the 1915(b)(3) services were funded through a separate upfront 1915(b)(3) capitation rate. North Carolina accounted for this upfront 1915(b)(3) capitation payment as well as any additional expenses for 1915(b)(3) services in Column H of Appendix D3. Appendix D3 is limited to the actual spending on services as documented in the quarterly 1915(b)(3) services report.

In the last waiver, the State received approval for 1915(b)(3) spending of $20.16 PMPM for P2. The actual 1915(b)(3) spending has amounted to $1.71 PMPM for the first two quarters of R2. Spending on (b)(3) services has increased over the last few quarters.

The State is requesting authority to support additional increases in (b)(3) service spending. This expansion is justified through State savings generated on lower payments to the plan for State Plan services. The following exhibit compares the State Plan service expenses with the projections for P1 and P2. The overall savings through September 2008 on State Plan services is $12.16 PMPM or approximately $14.4M

The State's waiver program required PIHP utilization management efforts that led to reductions in utilization of two major State Plan service categories as documented in the data at the bottom of the exhibit. The documented utilization savings on just two State Plan services is $4.35. $4.35 of that $12.16 PMPM in savings is demonstrated through decreases in the actual rates paid to the PIHP for just two services – Inpatient hospital/RTF and Community Based Services.

The State is requesting authority to expand (b)(3) services from the historical R2 PMPM of $1.71 up $5.00 PMPM in P1 after consideration for inflation. This would share a portion of the additional savings generated by the waiver program with waiver participants. This expansion is reflected in Appendix D.5 through an adjustment of 184.5% to the current (b)(3) expenses of $1.71 PMPM in column W.

North Carolina Piedmont Waiver
2009-2011 Renewal

1915(b)(3) Service Analysis

	Member Months	R1 - Actual	Aggregate	P1 - Former	Aggregate
MEG 1	519,070	$0.01	$7,144	$3.82	$1,982,824
MEG 2	163,990	$1.92	$315,446	$63.53	$10,417,784
MEG 3	89,415	$0.12	$10,807	$2.68	$239,252
MEG 4	6,389	$0.00	$0	$342.87	$2,190,570
	778,864	**$0.43**	**$333,397**	**$19.04**	**$14,830,430**
		R2 - Actual		**P2 - Former**	
MEG 1	274,190	$0.22	$59,376	$4.10	$1,124,528
MEG 2	84,055	$7.55	$634,437	$68.21	$5,732,997
MEG 3	45,041	$0.06	$2,690	$2.87	$129,394
MEG 4	3,287	$0.00	$0	$368.12	$1,209,996
	406,573	**$1.71**	**$696,503**	**$20.16**	**$8,196,915**

The State was approved to spend $20.16 in R2 for (b)(3) services. Only $1.71 PMPM was spent during R2. However, because of the increase in trend in 1915(b)(3) utilization for R1 and R2 documented in the quarterly reports sent to CMS, there is actually higher ending utilization than documented in the average R2 utilization.

Did the State realize enough State Plan savings to justify additional 1915(b)(3) authority?

State Plan Service Analysis - Excluding State Administration and 1915(b)(3) costs

	Member Months	R1 - Actual	Aggregate	P1 - Former	Aggregate
MEG 1	519,070	$41.37	$21,474,726	$43.58	$22,619,324
MEG 2	163,990	$373.76	$61,293,088	$393.88	$64,592,964
MEG 3	89,415	$30.97	$2,769,084	$31.37	$2,804,636
MEG 4	6,389	$4,770.50	$30,478,705	$5,205.75	$33,259,546
	778,864	**$148.95**	**$116,015,603**	**$158.28**	**$123,276,470**
		R2 - Actual		**P2 - Former**	
MEG 1	274,190	$43.70	$11,983,339	$47.76	$13,095,312
MEG 2	84,055	$381.88	$32,098,949	$425.00	$35,723,405
MEG 3	45,041	$31.98	$1,440,553	$34.50	$1,554,057
MEG 4	3,287	$4,717.61	$15,506,798	$5,419.19	$17,812,869
	406,573	**$150.11**	**$61,029,639**	**$167.71**	**$68,185,642**
	State Plan Savings		**$14,416,871**	**$12.16**	

The State's operation and oversight of the waiver program has led to savings on State Plan services of $12.16 PMPM in R1 and the first part of R2.

Did the State realize savings through the utilization management efforts the State required?

Utilization Analysis Based on Encounters*

	Contract Period 1		**Contract Period 3**	
Service	Util/1,000	PMPM	Util/1,000	PMPM
Inpatient/RTF	1,114	$20.57	950	$19.24
Community Based Services	26,777	$17.54	12,597	$14.52
	State Plan Utilization Savings			**$4.35**

*Encounter data was used as the basis for rate-setting.

The State has realized savings through the utilization management of State Plan services to justify expansion of 1915(b)(3) spending authority for the upcoming waiver period.

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 BY/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 based on recent economic conditions. The changes in enrollment are primarily due to changes in economic conditions 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.

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, 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 spreadsheets.

State of North Carolina **Appendix D1. Member Months** .

Row # / Column Letter	B	C	D	E	F	G	H	I	J	K	L	M	N	
2							**Renewal Waiver**							
3							**Estimated Member Month Calculations**							
4					State:	**North Carolina**								
5	Actual Enrollment for the Time Period -	R1 =	4/1/07	through	3/31/08	R2 =	4/1/08	through	9/30/08	**R1 and R2 include actual data and dates used in conversion - no estimates				
6	Enrollment Projections for the Time Period -	P1 =	4/1/09	through	3/31/10	P2 =	4/1/10	through	3/31/11	*Projections start on Quarter and include data for requested waiver period				
7	**Medicaid Eligibility Group (MEG)**	**Retrospective Year 1 (R1)**	**Retrospective Year 2 (R2)**	**Projected Quarter 1**	**Projected Quarter 2**	**Projected Quarter 3**	**Projected Quarter 4**	**Projected Year 1**	**Projected Quarter 5**	**Projected Quarter 6**	**Projected Quarter 7**	**Projected Quarter 8**	**Projected Year 2**	**Total Projected**
8		**4/1/07**	**4/1/08**	**4/1/09**	**7/1/09**	**10/1/09**	**1/1/10**	**(P1)**	**4/1/10**	**7/1/10**	**10/1/10**	**1/1/11**	**(P2)**	**(H+M)**
9	AFDC	519,070	274,190	139,330	141,601	143,909	146,255	571,094	148,638	151,061	153,524	156,026	609,249	1,180,343
10	Blind/Disabled and Foster Children	163,990	84,055	42,284	42,542	42,801	43,062	170,689	43,325	43,589	43,855	44,123	174,892	345,582
11	Aged	89,415	45,041	22,721	22,923	23,127	23,333	92,104	23,541	23,750	23,962	24,175	95,427	187,531
12	CAP-MR	6,389	3,287	1,759	1,882	2,013	2,154	7,808	2,176	2,199	2,222	2,244	8,841	16,649
13	**Total Member Months**	**778,864**	**406,573**	**206,093**	**208,947**	**211,851**	**214,804**	**841,695**	**217,681**	**220,600**	**223,562**	**226,568**	**888,410**	**1,730,106**
14	**Quarterly % Increase**				**1.4%**	**1.4%**	**1.4%**		**1.3%**	**1.3%**	**1.3%**	**1.3%**		
15	**Annualized % Increase R1 to R2 to P1 to P2**		**4.4%**					**3.5%**					**5.6%**	
16														
17														
18														
19														
20	Modify Line items as necessary to fit the MEGs of the program.													
21	State Completion Sections													

To modify the formulas as necessary to fit the length of the program complete this section. The formulas will automatically update given this data.

Use Quarter Starting Dates on Appendix D1. Appendix D6 will automatically become Quarter Ending Dates to sync with CMS-64.

NUMBER OF DAYS OF DATA	
R2	182.00
Gap (end of R2 to P1)	183.00
P1	364.00
P2	364.00
TOTAL R2 to P2	1093
(Days-365)	728
TOTAL R2 to P1	729
(Days-364)	364