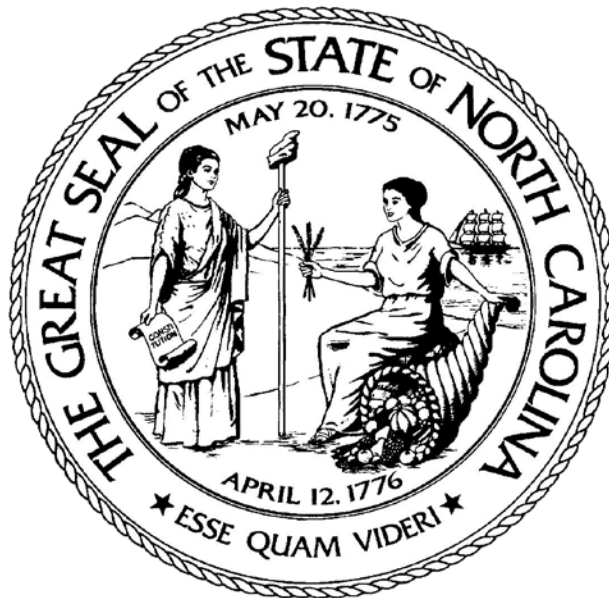


Legislative Report

TRANSFORMATION AND REORGANIZATION OF NORTH CAROLINA MEDICAID AND NC HEALTH CHOICE PROGRAMS

SESSION LAW 2016-121



**State of North Carolina
Department of Health and Human Services
Division of Health Benefits**



Oct. 1, 2016

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I. Background

At the end of the 2015 session, the Governor and General Assembly passed Session Law (S.L.) 2015-245, also known as the Medicaid Reform bill. Subsequently, thanks to continued collaboration among the Governor, General Assembly and Department of Health and Human Services (DHHS), S.L. 2016-121 was passed at the end of the 2016 session, and addressed the administrative and technical changes necessary to facilitate the ongoing implementation of the Medicaid Reform project.

As background, S.L. 2015-245 was enacted to transform and reorganize the North Carolina Medicaid and NC Health Choice programs¹. The legislation directed DHHS to design Medicaid and NC Health Choice programs to:

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

This session law also established the Division of Health Benefits (DHB) within DHHS to begin development of a Section 1115 demonstration waiver application, and other state plan and waiver amendments, to effectuate the goals outlined in the legislation.

After preliminary conversations with stakeholders, including providers, beneficiaries and the Centers for Medicare & Medicaid Services (CMS), DHHS recognized the need for administrative and technical changes necessary to continue moving forward with the transformation process. As such, S.L. 2016-121 accomplished a number of important goals:

- Clarified for CMS the single state agency authority under which the Medicaid transformation project was working, retroactive to June 1, 2016;
- Clarified certain services and populations that would be excluded under the capitated program;
- Provided an administrative change to the number of potential regional PLE contracts from 10 to 12; and
- Clarified the cooling-off period according to G.S. § 143B-139.6C as it applies to DHHS employees who participate in the contract approval process.

¹ For report readability, “Medicaid transformation” will represent “Medicaid and NC Health Choice programs’ transformation,” unless one program needs to specifically identified.

S.L. 2016-121 also directed DHHS to submit this report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice (JLOC) and the Fiscal Research Division by Oct. 1, 2016, that will include:

- **Waiver application status:** The progress of the Section 1115 waiver application submitted to CMS, and any other submissions related to the Medicaid transformation. The report will specifically address timeliness, CMS responses and strategies necessary to ensure approval of the waiver application.
- **Transformation work plan:** A detailed work plan to implement the Medicaid transformation. The work plan will provide sufficient detail to allow the JLOC to monitor progress, and identify challenges and impediments to transformation implementation. The detailed work plan will identify key milestones, tasks and events necessary to Medicaid transformation. For each milestone, task and event, the work plan will specify the expected completion dates and identify the individual assigned responsibility for accomplishing or ensuring the accomplishment of the milestone, task or event.
- **Planning process developments:** A sufficiently detailed description of any developments or changes during the planning process to enable the General Assembly to address any barriers to successful implementation of Medicaid transformation.

II. Accomplishments

Since S.L. 2015-245 was enacted, DHHS has completed the following activities:

A. Established the Division of Health Benefits

1. Hired and on-boarded 10 full-time staff and two full-time contractors.
2. Posted job descriptions and started interviewing for an additional 10 positions.
3. Established the DHB Human Resources policy manual and compensation program.
4. Developed an employment agreement applicable to DHB and DMA employees hired after Oct. 1, 2015.
5. Established an accounting structure in the North Carolina Accounting System and closed the books for 2015 / 2016.
6. Executed two contracts for consulting services in late 2015 / early 2016 to support initial DHB activities, including development of the Section 1115 waiver application and JLOC reports.

B. Met all legislative submission and reporting deadlines and requests

1. Submitted a report² March 1, 2016, to the JLOC that included a draft Section 1115 waiver application and other initial program concepts as required by S.L. 2015-245.
2. Submitted a report³ May 1, 2016, outlining the proposed program design for the North Carolina Health Transformation Center as required by S.L. 2015-245.
3. Submitted the Section 1115 waiver application⁴ June 1, 2016, to CMS as required by S.L. 2015-245.
4. Presented Medicaid transformation updates at four JLOC meetings from January through April 2016.
5. Convened first four meetings with the Dual Eligibles Advisory Committee to support development of recommendations for a long-term strategy to transition dual eligible enrollees to managed care. DHB will submit a report Jan. 31, 2017, to the JLOC as required by S.L. 2015-245.

C. Engaged with stakeholders and solicited feedback

1. Held 12 public hearings⁵, 10 more than required by CMS, across the state on the draft Section 1115 waiver application, and used the input from the 1,600 attendees to develop the final waiver submission.
2. Collected 750 written public comments⁶ through the DHHS Medicaid Reform website⁷ and used the input to develop the final waiver submission.
3. Discussed Medicaid transformation during more than 100 scheduled meetings with stakeholder groups.
4. Reviewed and catalogued the nearly 2,000 comments received by CMS⁸ during its public comment period on the final Section 1115 waiver application, and combined with prior input received to inform the design, development and implementation efforts.

² March 1, 2016, JLOC report:

<http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=284&sFolderName=\2015-16 Interim\March 1, 2016\Reports>.

³ May 1, 2016, DHHS NC Health Transformation Center report: <http://www.ncdhhs.gov/document/nc-health-transformation-center-report>.

⁴ Section 1115 demonstration waiver application: <https://ncdhhs.s3.amazonaws.com/s3fs-public/NC-Section-1115-Demonstration-App2016.pdf>.

⁵ Public hearing information: <http://www.ncdhhs.gov/nc-medicaid-reform/public-hearings>.

⁶ Summary of public comments and DHHS responses: <https://www.ncdhhs.gov/document/nc-section-1115-demonstration-application-responses-public-comments-2016-06-01>.

⁷ DHHS North Carolina Medicaid Reform website: <http://www.ncdhhs.gov/nc-medicaid-reform>.

⁸ Public comments received by CMS during its public comment period: <https://public.medicaid.gov/connect.ti/public.comments/view?objectId=1886531>.

D. Defined and initiated process to contract for technical assistance needed to support DHHS in the design, development and implementation of the transformed programs

1. Defined 24 key work areas needed to support program design, development and implementation.
2. Issued a public, competitive Request for Qualifications (RFQ) to identify vendors qualified to provide the expertise needed to support DHHS' design, development and implementation of the transformed programs.
3. Reviewed more than 1,400 qualifications statements from 38 vendors across the work areas.
4. Identified qualified vendors in each of the work areas based on qualification statements.
5. Defined eight task orders for which DHHS will receive technical assistance in one or more of the work areas applicable to the task order project.
6. Issued the first three task orders to prequalified vendors for proposal, covering 11 of 24 work areas:
 - a. **Task Order 1:** Project management and budget development support (2 work areas)
 - b. **Task Order 2:** Program design, CMS engagement and regulatory support (8 work areas)
 - c. **Task Order 3:** Organizational design support (1 work area)
7. To date, reviewed and evaluated three technical assistance vendor proposals for Task Order 1 and two vendor proposals for Task Order 2.
8. Held oral presentations for the three vendors qualifying for Task Order 1.

By the end of October, two additional task orders will be issued for proposal, and technical assistance vendors will be selected by the end of 2016:

- **Task Order 4:** Technology requirements, strategies and plan (1 work area)
- **Task Order 5:** Actuarial support (1 work area)

As a result of these efforts, **over half** of the work areas (13 of 24) for Medicaid transformation design, development and implementation will be underway by year-end. "Section IV. Work Plan" on page 6 includes detail of the technical assistance procurement process and task orders.

E. Engaged expertise to assist DHHS in establishing the NC Health Care Analytics Task Force

DHHS has engaged the North Carolina Institute of Medicine (NCIOM) to launch and facilitate the NC Health Care Analytics Task Force. The Analytics Task Force will define and prioritize health and health care measures and specifications. Task Force recommendations will support the PHP contract development that will be built on defined measures and goals for risk-adjusted health outcomes, quality of care, patient satisfaction, access and cost.

III. Section 1115 Waiver Application Status

DHHS submissions, activities and anticipated requirements related to CMS since the March 1, 2016, JLOC report are outlined below.

A. Status of Section 1115 Waiver Application

DHHS submitted the Section 1115 waiver application June 1, 2016, to CMS as required by S.L. 2015-245. CMS formally accepted North Carolina's submission June 16, 2016, with a completeness letter acknowledging that all requirements for submission were met (see attachment A).

CMS held its public comment period from June 20 to July 20, 2016. Many comments reflected similar sentiments that stakeholders voiced throughout previous engagement and feedback opportunities held by DHHS.

B. Status of Other Submissions to CMS

Section 1115 waivers often require state plan amendments (SPAs) and Section 1915(b) or 1915(c) waivers to fully implement the program goals. However, it is not until a state is further along in waiver negotiations, and after the state and CMS conceptually agree to the changes that will be needed, that these amendments will be submitted. Based on the proposed transformation approach, DHHS will likely need to submit amendments as follows:

1. **Section 2703 SPA for Medicaid Health Homes** to terminate this state plan authority upon implementation of PHPs.
2. **Section 1932(a) SPA** to terminate the North Carolina Community Care Network SPA pursuant to S.L. 2015-245, Section 7.
3. **Community Alternatives Program for Children and Community Alternatives Program for Disabled Adults** Section 1915(c) home- and community-based services waivers to reflect the capitated PHP delivery system.
4. **Hospital and other provider reimbursement sections** of the Medicaid state plan to sunset current supplemental payments that rely on the fee-for-service upper payment limit (UPL), as has been required by CMS in other Section 1115 waivers that transition UPL funding to other payment pools accompanying managed care implementation.
5. **Amendment to reflect changes from enrollment in CCNC to PHPs** in the NC Health Choice state plan.

C. Responses Received from CMS

The CMS letter of completeness marked the beginning of the CMS Section 1115 waiver application review process. Since then, DHHS and CMS have discussed the question of authority and merit-based employment. It is necessary to address these topics prior to fully engaging in conversations about the Section 1115 waiver application. The first formal discussion with CMS about the waiver application is scheduled for Oct. 6, 2016.

IV. Work Plan

The Medicaid transformation work plan is the baseline for measuring the progress of the Medicaid transformation project and will contain integrated information across the entire program, and internal and external dependencies that could adversely influence the program.

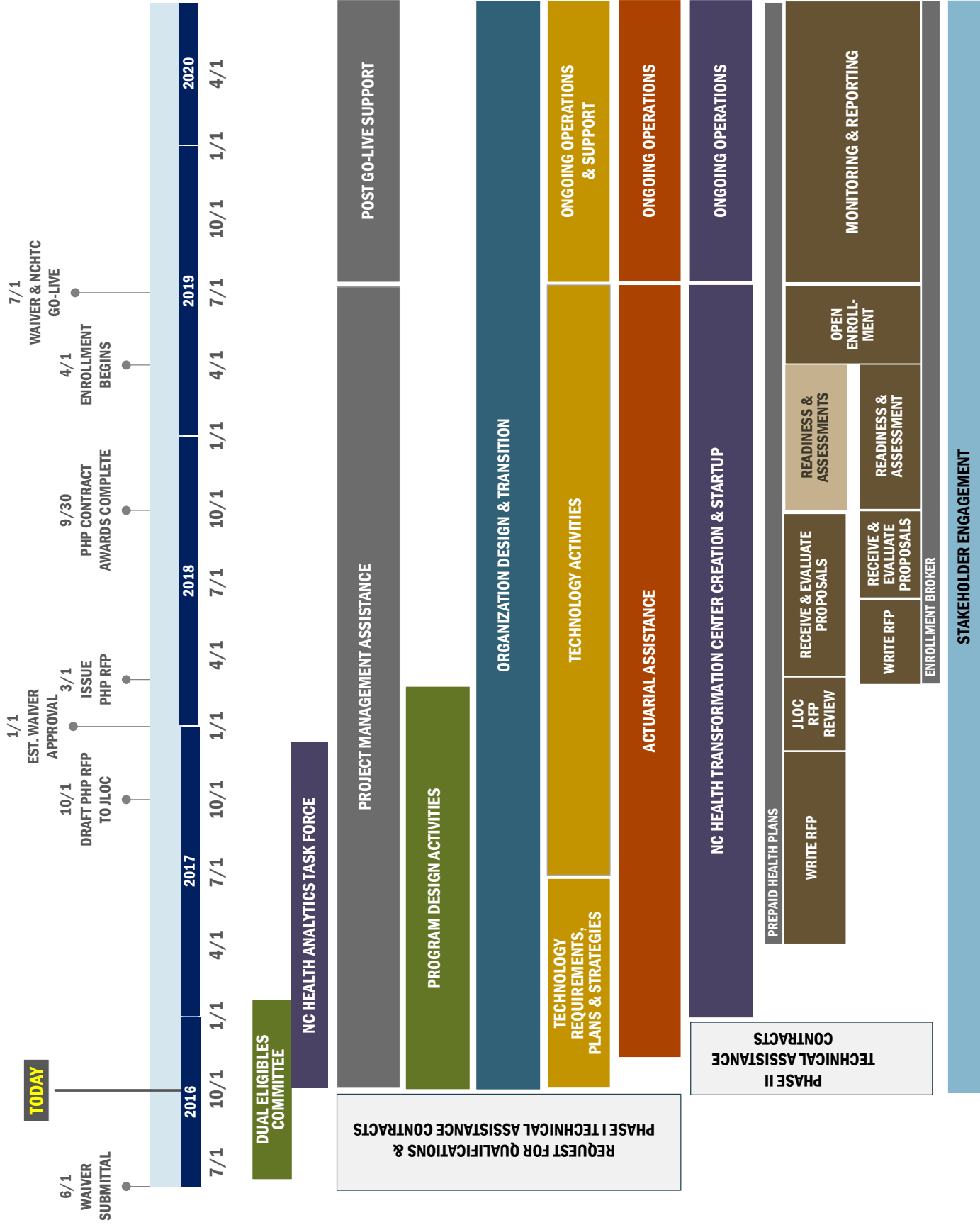
DHHS has established the project's key milestones with associated tasks and completion dates, which are being used to track and risk-manage the project, through July 1, 2019 (assuming CMS waiver approval on Jan. 1, 2018).

DHHS will use technical assistance to build further levels of detail for each milestone. This work will begin early October 2016, with the baselined work plan to be delivered by Dec. 30, 2016. This baselined work plan will include specific completion dates with their corresponding responsible staff, including DHB and technical assistance vendors, and other DHHS divisions such as Information Technology and Medical Assistance.

A. Program Timeline

The diagram on the following page illustrates Medicaid transformation key activities and milestones.

Medicaid Transformation Timeline



B. Technical Assistance Procurement

A public, competitive vendor prequalification for 24 work areas was performed from June through August 2016 to select pre-qualified vendors that can best serve the interests of the state for technical assistance on specific projects. All interested vendors were given the opportunity to submit their qualifications for evaluation using the NC Interactive Procurement System (IPS).

Teams of subject matter specialists were assembled from throughout DHHS to create an RFQ and perform vendor evaluations.

1. An RFQ was issued and posted on IPS from June 15 to July 13, 2016, to identify vendors qualified to perform work in specific areas to assist DHHS with the design, development and implementation of the Medicaid transformation.
2. DHHS reviewed and evaluated the vendor responses for prequalification using the criteria outlined in the RFQ. A list of vendors that met the prequalification criteria for each of the work areas was created, and those vendors were notified of their eligibility to bid on task orders to be issued by DHHS.

C. Technical Assistance Task Orders

A competitive process continues to be used to select vendors that can best serve the interests of the state for technical assistance. Below is an overview of the current procurement status and targeted start dates for technical assistance:

Task Order	To Assist DHB & DMA With:	Status	Targeted Start Date
1	Project management and DHB biennium budget development	Issued; vendor proposals evaluated; vendor presentations under evaluation	Oct. 2016
2	Program design and associated support	Issued; vendor proposals under evaluation	Oct. 2016
3	Organizational design and DMA transition	Issued; vendor proposals to be received Oct. 7	Nov. 2016
4	Technology requirements, strategies and plans	In development	Dec. 2016
5	Actuarial support	In development	Dec. 2016
6	NC Health Transformation Center development	To be drafted	Feb. 2017
7	PHP procurement, contracting and monitoring	To be drafted	TBD 2017
8	PHP readiness assessment	To be drafted	TBD 2018

D. Proposed Timeline for Issuance of PHP Request for Proposal (RFP)

S.L. 2015-245 requires that capitation begin and beneficiary enrollment be completed within 18 months following CMS approval. Assuming that CMS approves the Section 1115 waiver application Jan. 1, 2018, below are the proposed PHP RFP dates to go live July 1, 2019:

Key Activity	Estimated Date*
Section 1115 waiver application submission	June 1, 2016
CMS approval of Section 1115 waiver application (assumed)	Jan. 1, 2018
Draft PHP RFP (including contract)	Jan. 2018
Consult with JLOC on RFP terms and conditions	Feb. 2018
PHP RFP issued	March 2018
PHP proposals due	June 2018
PHP awards complete	Sept. 2018
PHP readiness reviews by DHHS	Oct. 2018 through June 2019
Open enrollment for current eligible beneficiaries	April 2019 – June 2019
PHP go-live	July 1, 2019
* Assumes CMS approves Section 1115 waiver application Jan. 1, 2018	

The process for PHP solicitation and contracting will rely on input from a wide variety of stakeholders, including CMS.

V. Planning Process Development: Medicaid Managed Care Final Rule

The CMS release of the Medicaid and CHIP Managed Care Rules (Final Rule) May 6, 2016, includes substantial revisions to the proposed rule released a year earlier. Although the General Assembly and DHHS anticipated many Final Rule provisions in S.L. 2015-245 and the Section 1115 waiver application, additional impacts are described below.

- A. Medical loss ratio (MLR).** The Final Rule requires an 85 percent minimum MLR, but allows DHHS to set a higher MLR and determine whether to recoup funds from plans that fail to meet the MLR.
- B. Enrollment support.** DHHS will be required to have a “beneficiary support system” that provides assistance in understanding managed care, choice counseling, and provides other additional functions for beneficiaries who receive LTSS.
- C. Network adequacy standards.** DHHS is required to develop time and distance standards for specific provider types for adult and pediatric populations. The Final Rule also requires DHHS to establish additional network adequacy standards specifically for beneficiaries who receive LTSS.

- D. Provider payments outside of capitation.** In the Final Rule, CMS recognizes the challenge of states like North Carolina to transition supplemental payment funding from fee-for-service to managed care, and provides permanent and phased-down payment options that do not require a Section 1115 waiver.

DHHS is working with stakeholders and other experts to determine whether the payment options are advantageous relative to the approach outlined in the June 1, 2016, Section 1115 waiver application.

DHHS will work with stakeholders and technical assistance vendors to continue assessing the Final Rule for its effect on transformation efforts.

VI. 2017 Legislative Session Requests

DHHS continues to collaborate with stakeholders to identify legislative changes needed to support Medicaid transformation. Below are anticipated or potential changes that may be considered as part of the program design process.

A. PHP Licensure

Section 6 of S.L. 2015-245 added a new scope of responsibility to the North Carolina Department of Insurance (DOI):

“The transformed Medicaid and NC Health Choice system shall include the licensing of PHPs based on solvency requirements established and implemented by the Department of Insurance. The Commissioner of Insurance, in consultation with the Director of the Division of Health Benefits, shall develop recommended solvency requirements that are similar to the solvency requirements for similarly situated regulated entities and recommended licensing procedures that include an annual review by the Commissioner and reporting of changes in licensure to the Division of Health Benefits....”

DHHS provided recommendations in its March 1, 2016, report to the JLOC related to the solvency and licensure requirements for PHPs. DHHS will continue to collaborate with DOI and stakeholders to finalize requested legislative changes related to PHP licensure by early 2017.

B. Provider Protection Language from Chapter 58 of the NC General Statutes

Section 4 of S.L. 2015-245 requires that Medicaid and NC Health Choice programs be organized according to certain principles. Section 4(6a) specifies that:

“To the extent allowed by Medicaid federal law and regulations and consistent with the requirements of this act, PHPs shall comply with the requirements of Chapter 58 of the General Statutes. The Department of Health and Human Services, Division of Health Benefits, and the Department of Insurance shall jointly review the applicability of provisions of Chapter 58 of the General Statutes to PHPs, and report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2016, on the following:

1. *Proposed exceptions to the applicability of Chapter 58 of the General Statutes for PHPs.*
2. *Recommendations for resolving conflicts between Chapter 58 of the General Statutes and the requirements of Medicaid federal law and regulations.*
3. *Proposed statutory changes necessary to implement this subdivision.”*

The March 1, 2016, JLOC report included an overview of DHHS and DOL’s review of the applicability of Chapter 58 provisions to Medicaid PHPs. The findings indicated that many Chapter 58 provisions are not applicable to the Medicaid program because they are controlled by federal Medicaid laws and regulations.

The provisions identified in Chapter 58 that are not controlled by federal Medicaid law (e.g., notice of claim denied, selection of a specialist as a primary care provider, identification card requirements) are being evaluated by DHHS to determine whether they are best incorporated into PHP contracts, Medicaid statutes or regulations.

DHHS will continue to collaborate with stakeholders to define the best approach by early 2017 to incorporate these provisions.

C. Clarification of Medical Loss Ratio Requirements

Session Law 2015-245, Section 5(6)(c) states:

“Until final federal regulations are promulgated governing medical loss ratio, a minimum medical loss ratio of eighty-eight percent (88%) for health care services, with the components of the numerator and denominator to be defined by DHHS, through the Division of Health Benefits.”

In the Final Rule, federal regulations governing MLR were codified in 42 C.F.R. § 438.8. The Final Rule includes the following MLR provisions:

“If a State elects to mandate a minimum MLR for its MCOs, PIHPs, or PAHPs, that minimum MLR must be equal to or higher than 85 percent (the standard used for projecting actuarial soundness under §438.4(b)) and the MLR must be calculated and reported for each MLR reporting year by the MCO, PIHP, or PAHP, consistent with this section.” 42 C.F.R. § 438.8(c) (2016).

In 42 C.F.R. § 438.4, the Final Rule also requires that to be approved by CMS, capitation rates for MCOs, PIHPs and PAHPs must (among other things):

“Be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under § 438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.” 42 C.F.R. § 438.4(b)(9) (2016).

Given the newly codified federal regulations on MLRs, DHHS requests that the General Assembly clarify whether the applicable minimum MLR should be 88 percent as initially defined, or the 85 percent floor defined by CMS.

D. Resources for Fee-for-Service Claims Run-Out

Initial post-implementation program costs will exceed the usual run rate. Because fee-for-service claims are received and paid *after* services are rendered, lagged fee-for-service payments will be made at the same time PHP *upfront* capitation payments are made.

DHHS is developing estimates of the initial cost of simultaneous fee-for-service and capitation payments so that the General Assembly can establish reserves to cover those costs. These estimates will be delivered early 2017.

E. Resources to Support Implementation

DHHS is committed to implementing Medicaid transformation in a thoughtful and collaborative way that accounts for the needs of beneficiaries, providers, taxpayers and other stakeholders. Given the extent and complexity of the reforms, there are activities necessary to support a smooth transition. These include:

1. Beneficiary education and support
2. Provider education and support
3. Local department of social services education and support
4. Thorough testing of changes to DHHS systems, including NCTracks, NC FAST and analytics capabilities
5. Implementation of centralized or standardized systems to mitigate provider burden; including statewide informatics and uniform credentialing

DHHS is developing estimates of the cost to support these design and implementation activities, which will result in a more sustainable and efficient program post-implementation. These estimates will be delivered early 2017.

F. Technical Correction to Carve-out Language

Session Law 2016-121 included provisions to carve out certain services and populations based on recommendations in the DHHS March 1, 2016, JLOC report. DHHS is proposing changes to the Local Education Agency and Children's Developmental Services Agency carve-out language underlined below:

"(4) Services covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice services, including physical health services, prescription drugs, long-term services and supports, and behavioral health services for NC Health Choice recipients, except as otherwise provided in this subdivision. The capitated contracts required by this subdivision shall not cover:

"d. Audiology, speech therapy, occupational therapy, physical therapy, nursing, and psychological services prescribed in an Individualized Education Program (IEP) and performed by schools or individuals contracted with Local Education Agencies.

"e. Services provided directly by a Children's Developmental Services Agency (CDSA) or by a provider under contract with a CDSA if the service is authorized through the CDSA and is included on the child's Individualized Family Service Plan."

To better align with Medicaid and NC Health Choice payment policies, DHHS requests a technical correction that changes (4)(d) and (4)(e) to:

“d. Services documented on an Individualized Education Program (IEP) and provided or billed by a Local Education Agency.”

“e. Services provided by a Children’s Developmental Services Agency (CDSA) that are documented on the child’s Individualized Family Service Plan.”

G. Other Potential Statutory Changes

In the March 1, 2016, JLOC report, DHHS identified 21 existing statutes in Chapters 108A and 108C that may need clarifying language to reflect the system changes made by S.L. 2015-245: G.S. §§ 108A-55, 108A-57, 108A-59, 108A-64.1, 108A-65, 108A-68, 108A-70, 108A-70.5, 108A-70.9A, 108A-70.9B, 108A-70.9C, 108A-70.11, 108A-70.12, 108A-70.18, 108A-70.21, 108A-70.27, 108A-70.29, 108C-2, 108C-3, 108C-4 and 108C-14.

As an example, G.S. § 108A-55 refers to provider reimbursement, and states that the *“Department shall establish the methods by which reimbursement amounts are determined in accordance with Chapter 150B of the General Statutes.”* While this would still be true for rates for services in the remaining fee-for-service programs, the reimbursement framework will change under the PHP structure.

Other potential changes could include clarity to G.S. § 108A-57, which sets out the state’s subrogation rights. While DHHS will remain the single state agency and collection of third-party resources could, in theory, be dealt with in contracts, it may be beneficial to revise certain language within the statute to facilitate collection of third-party resources by PHPs. As currently written, § 108A-57 sets out notification requirements and payment requirements solely related to DHHS, with no reference to DHHS’ vendors, contractors or agents. A revision clarifying the rights of PHPs to pursue third-party resources in the transformed system would be helpful to ensure maximum recovery.

In addition, statutory changes may be required to implement the recommendation in Section XV of the March 1, 2016, JLOC report to allow parents to retain Medicaid eligibility while their children are being served temporarily by the foster care program. While S.L. 2016-121 provided DHHS the authority to seek approval for this change through the Section 1115 waiver application, the General Assembly will need to take further action to enact this change.

DHHS will collaborate with stakeholders to prepare by early 2017 suggested changes to applicable statutes.

VII. Next Steps

DHHS will continue to focus significant time and energy to bring in staff and technical assistance with the expertise needed to support the design, development and implementation of the Medicaid transformation. Key milestones through the end of this calendar year include:

A. Increasing DHB staff from 10 to 28 FTEs

B. Contracting with technical assistance on the first five task orders:

1. Project management and budgeting support
2. Program design, CMS engagement, regulatory support
3. Organizational design
4. Technology requirements development
5. Actuarial support

C. Continuing to support the Dual Eligibles Advisory Committee as it develops recommendations to transition the dual eligibles population into managed care

D. Developing the following deliverables:

1. Draft biennium budget with the administrative costs of program transformation
2. Baselined work plan by Dec. 30, 2016
3. Plan for engaging stakeholders on outstanding program design decisions
4. First annual report with enrollment and budget forecasts, as required by S.L. 2015-245 and due to the JLOC and OSBM by Jan. 1, 2017
5. Report with recommended plan to transition the dual eligibles population to managed care, as required by S.L. 2015-245 and due to the JLOC by Jan. 31, 2017

E. Launch the NC Health Care Analytics Task Force with NCIOM

Planning activities, including identifying Analytics Task Force participants and steering committee, scheduling meetings and setting agendas, are underway. The first monthly Task Force meeting will be scheduled for early November.

Attachment A: CMS Completeness Letter

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850



State Demonstrations Group

JUN 16 2016

Rick Brajer, Secretary
North Carolina Department of Health and Human Services
1985 Umstead Drive
Raleigh, North Carolina 27603-2001

Dear Mr. Brajer:

Thank you for your recent section 1115(a) demonstration application titled, North Carolina's Medicaid Reform Demonstration. The Centers for Medicare & Medicaid Services (CMS) has completed a preliminary review of the application and have determined that the state's application has met the requirements for a complete application as specified under section 42 CFR 431.412(a).

In accordance with section 42 CFR 431.416(a), CMS acknowledges receipt of the state's application. The documents will be posted on Medicaid.gov and the comment period will last 30 days, as required by 42 CFR 431.416(b). The state's application will be available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html.

We look forward to working with you and your staff to extend the state's demonstration. If you have additional questions or concerns, please contact your project officer Ms. Erica Dimes, at (410) 786-5913, or at erica.dimes@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink that reads 'Kim Howell'. The signature is written in a cursive, flowing style.

Kim Howell
Director
Division of State Demonstrations and Waivers

cc: Jackie Glaze, Associate Regional Administrator, Atlanta Regional Office
Teresa J. Smith, State Lead

Attachment B: Abbreviations

Below are abbreviations used in this report.

CCNC	Community Care of North Carolina
CDSA	Children’s Developmental Services Agency
C.F.R.....	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CP.....	Commercial Plan
DHB	North Carolina Division of Health Benefits
DHHS	North Carolina Department of Health and Human Services
DMA	North Carolina Division of Medical Assistance (Medicaid)
DOI.....	North Carolina Department of Insurance
DSRIP.....	Delivery system reform incentive payment
G.S.....	North Carolina General Statute
IEP.....	Individualized education program
IPS.....	North Carolina Interactive Procurement System
JLOC.....	Joint Legislative Oversight Committee on Medicaid and NC Health Choice
LME/MCO	Local management entity/managed care organization
LTSS.....	Long-term services and supports
MCO	Managed care organization
MLR	Medical loss ratio
PAHP	Prepaid ambulatory health plan
PHP.....	Prepaid health plan
PIHP.....	Prepaid inpatient health plan
PLE	Provider-led entity
PMP	Project management plan
RFP	Request for proposal
RFQ	Request for qualifications
S.L.	North Carolina Session Law
SPA.....	State plan amendment
SFY	State fiscal year (e.g., “SFY 2018” is July 1, 2017 – June 30, 2018)
UPL.....	Federal upper payment limit