

Partnering for Success:
Strategic Plan for
Statewide Implementation of the
1915 (b)/(c) Medicaid Waiver
July 1, 2011 – June 30, 2013

DRAFT

7/27/11

*“Responsible Change to Achieve Easy Access, Better Quality
and Personal Outcomes”*

Table of Contents

Chapter 1. Introduction.....	1
A Managed Care System	1
Background.....	2
Environmental Factors.....	4
The Impact of the Patient Protection and Affordable Care Act (HR 3590) on the MH/DD/SA service system	4
SAMHSA’s Strategic Initiatives and Unified Plan	5
Chapter 2. Overview of the Strategic Plan	7
Goals for North Carolina	7
Purpose of the Strategic Plan.....	7
Timeline.....	7
Implementation Structure and Process	8
Chapter 3. Strategic Objectives and Action Steps.....	10
The Objectives Work Together	10
The Plan Requires Accountability.....	11
Objective 1: Oversee MH/DD/SA service system change	12
Objective 2: Monitor Implementation of LME-MCOs	15
Objective 3: Ensure access and quality of the service system for individuals with mental illness, developmental disabilities or substance abuse.....	16
Objective 4: Strengthen the partnership with stakeholders in advising the State on implementation of the plan.....	19
Objective 5: Increase knowledge and skills throughout the system.....	20
Objective 6: Promote integrated care between mental health, intellectual/developmental disability and substance abuse service providers and primary care providers.....	21
Chapter 4. Evaluation of Progress and Next Steps.....	23
Appendix A. House Bill 916	26
Appendix B. LME-MCO Implementation Plan for IMT Oversight.....	31
LME-MCO Facilities and Organizational Management Tasks.....	31
Contracting and Capitation.....	31
Customer Services	31
Utilization Management/Care Management.....	32
Provider Network Management	32
Quality Management	33
Financial Management/Monitoring	33
Claims and IT Staffing	34
Claims Administration System Development	34
Reporting	37
Merger / Interlocal Agreement Management/Monitoring.....	37
Appendix C. Acronyms and Definitions	39

Chapter 1. Introduction

The North Carolina General Assembly through S.L. 2011-264, House Bill 916,¹ has instructed the Department of Health and Human Services (Department) to proceed with statewide restructuring of the management responsibilities for the delivery of services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders through expansion of the 1915(b)/(c) Medicaid Waiver. It is the intent of the General Assembly that expansion of the 1915(b)/(c) Medicaid Waiver will be completed by July 1, 2013, and will result in the establishment of a system that is capable of managing all public resources that may become available for mental health, intellectual and developmental disabilities and substance abuse services, including federal block grant funds, federal funding for Medicaid and Health Choice, and all other public funding sources.

Further, House Bill 916 instructs the Department in coordination with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS), the Division of Medical Assistance (DMA), local management entities (LMEs), and PBH and with stakeholder input to submit the appropriate Oversight Committee of the General Assembly a strategic plan delineating specific strategies and agency responsibilities for the achievement of the objectives and deadlines set forth in the act.

This document presents the strategic plan and outlines the objectives, action steps and milestones that will be accomplished over the next two years – that is state fiscal year 2012 and state fiscal year 2013.

This strategic plan describes the desirable actions that support progress in the implementation of the 1915 (b)/(c) Medicaid Waiver and marks steps with timeframes to achieve the objectives in specific areas. The Department through DMHDDSAS and DMA will monitor, evaluate and report the status and progress on the strategic plan’s objectives per legislative requirements.

A Managed Care System

Expansion of North Carolina’s 1915 (b)/(c) Medicaid waiver requires approval by the federal Centers of Medicare and Medicaid (CMS). Such approval allows each selected LME to develop a managed care delivery system to serve individuals with mental health, developmental disabilities and substance abuse needs who are eligible for Medicaid. Each LME operating as a managed care organization (MCO) receives from Medicaid a per capita rate based on historical service utilization patterns for these populations. The LME-MCO assumes financial risk for covering required services for each Medicaid eligible individual. The functions of a LME-MCO include development of a provider network comprised of the

¹ The legislation is shown in full in appendix A.



most qualified providers, management of the network, authorization of services, coordination of care for individuals with the highest needs, and reimbursement of approved services. Both improved quality of care and cost effectiveness are brought about as a result of being able to: (1) select the most qualified providers for its network, and (2) coordinate recipient care in a manner that provides timely, appropriate services and prevents the need for more costly and intensive services.

The 1915 (b) authority allows the LME-MCO to limit the provider network to include only the most qualified providers rather than any willing provider as required under the Medicaid fee for service delivery system.

The 1915 (c) waiver authority allows Medicaid recipients who meet the criteria for admission into an Intermediate Care Facility for persons with developmental disabilities (ICF-MR) to receive services in the community if the services can be provided at or below the cost of placement in an institution.

Background

At the local level, DMHDDSAS oversees mental health, developmental disabilities and substance abuse services through a network of 23 area authorities / county programs that cover the state's 100 counties. As a result of system reform undertaken in 2001, the role of area authorities / county programs changed from service provider to service manager as they became local management entities (LMEs). LMEs develop community capacity through service provider contracts, expand partnerships with formal and informal community organizations and engage service recipients and family members in planning and policy implementation. Services are provided through the private sector.

In the process of reform, the Department applied to CMS and was granted approval to establish one LME as a pilot project under authority of both a 1915(b) and a 1915(c) Medicaid waiver to serve individuals with mental health, developmental disabilities and substance abuse needs who are eligible for Medicaid.

PBH (formerly known as Piedmont Behavioral Health) began delivering Medicaid State Plan funded mental health and substance abuse services through the Piedmont Cardinal Health Plan, as a managed care organization using a capitated model known as a prepaid inpatient health plan because it covers inpatient services for acute psychiatric admissions. PBH remained responsible for state allocated funds including federal block grants and for all applicable rules and policies.

PBH also began delivering Home and Community Based Services and supports through the Innovations waiver, a 1915(c) Medicaid waiver for individuals with intellectual or developmental disabilities. The Innovations waiver replaced the State's Comprehensive and Supports waivers in the PBH catchment area. Accordingly, PBH assumed risk for mental health and substance abuse services (including inpatient, clinic option and rehabilitation



option services) through the Piedmont Cardinal Health Plan, and for Home and Community Based Services under the Innovations waiver.

PBH has operated as a managed care organization in Cabarrus, Davidson, Rowan, Stanly and Union counties since April 1, 2005. All Medicaid recipients in those counties that are included in eligibility groups covered under the 1915 (b)/(c) waiver were mandatorily enrolled with PBH on April 1, 2005.

Since the inception of these waiver programs, North Carolina has demonstrated that the State can provide quality mental health, developmental disabilities and substance abuse services through private and public sector cooperation and at a lesser or comparable cost than the fee-for-service program costs for the Medicaid eligible population.

In 2009, the Department initiated a collaborative effort with DMA and DMHDDSAS with the goal of restructuring the delivery system for Medicaid funded mental health, substance abuse and developmental disabilities services. This new delivery system was designed to operate on a capitation basis with the intention to be phased in statewide.

- DMA manages North Carolina’s Medicaid health insurance program for low-income individuals and families including parents, children, seniors, and people with disabilities. The Medicaid program includes coverage of mental health, developmental disabilities and substance abuse services.
- DMH/DD/SAS has specific responsibilities for the provision of publicly funded services for individuals in North Carolina with mental health and substance abuse problems and/or with intellectual or developmental disabilities. Furthermore, DMHDDSAS is responsible for the programmatic oversight of the use of funds allocated by the General Assembly for these purposes, including those provided by federal block grants.

In February 2010, DHHS solicited applications from LMEs to participate in the State’s 1915 (b)/(c) Medicaid Waiver. Four LMEs applied and on the basis of the application process, the Department selected Mecklenburg County Area Mental Health, Developmental Disabilities, and Substance Abuse Authority and Western Highlands Network to be the next LMEs to participate in the State’s Medicaid Waiver for mental health, developmental disabilities and substance abuse services.

In 2011, the General Assembly instructed the Department to expand the 1915 (b)/(c) Medicaid waiver statewide. The Department reissued the request for applications and received seven applications from LMEs. The Department issued plans of correction to the other two LMEs (East Carolina Behavioral Health and Sandhills Center) that originally applied in 2010 and will work with them to begin managed care operations by July 2012.

Based on the review of the LMEs’ applications and on approval by the federal Centers for Medicare and Medicaid (CMS), the Department has selected LMEs to operate Medicaid funded services through a capitated prepaid inpatient health plan. DMA and DMHDDSAS



will each contract with the selected LME-MCOs. LME-MCOs will continue current obligations and commitment to the management of state and federally funded mental health, substance abuse and developmental disabilities services.

LMEs that are selected must be fully operational by January 1, 2013. The Department will assign counties that remain uncommitted at that time to a fully operational LME/MCOs. Full expansion and DHHS assignment is expected to be completed by July 1, 2013.

Environmental Factors

These changes are taking place at a time of nationwide economic uncertainties, health care reform, and challenges in housing, job security, the role of government, political values, additional support for veterans, and scientific and medical developments.

Lanier Cansler, Secretary of DHHS, is leading a department wide strategic planning effort resulting in uniform mission, vision and values and a strategic plan that is applicable to all of its divisions and offices, as well as goals and performance measures applicable to all services.

The Department's strategic plan includes key performance measures and targets to enable continuous monitoring and evaluation of progress toward the goals and objectives. These measures include budgetary information to enable review of costs and wise use of the resources available, especially in this time of economic hardship.

The Impact of the Patient Protection and Affordable Care Act (HR 3590) on the MH/DD/SA service system²

The nation's healthcare reform is another environmental factor that must be understood and taken into consideration as the Department proceeds in the design and development of the public mental health, developmental disabilities and substance abuse services system.

The Accountable Care Act is designed to ensure all Americans have access to quality, affordable health care and to significantly reduce long-term health care costs. Key provisions of this legislation will have significant impact on those who receive services from the mental health, developmental disabilities and substance abuse service system. Overall the legislation addresses key areas intended to:

- Offer quality and affordable health care for all Americans.
- Provide investments in Medicaid and the Children's Health Insurance Program.
- Improve the provision of Medicare services.
- Improve prevention of chronic disease and public health.

² References: NAMI, 2010 , *Provisions in the Senate Passed Health Reform Legislation for Americans Living with Serious Mental Illness and Their Families*; and House Committee on Ways and Means, Energy and Commerce, and Education and Labor, March 23, 2010: *Affordable Health Care for America*, Summary.



- Increase the competency and availability of the healthcare workforce through investments in training doctors, nurses and other health care providers.
- Focus on transparency and program integrity by providing consumers with information about their physicians, hospitals and medical equipment companies.
- Improves access to innovative medical therapies.
- Make long-term support and services more affordable.

The provisions related to preventing the exclusion of individuals with pre-existing conditions from receiving insurance will apply to people with serious mental illness, developmental disabilities and a substance abuse diagnosis. There are also provisions in the legislation that provide for mental health and substance abuse parity and a voluntary public, long term care insurance program to help individuals with serious mental illness and those with functional limitations. Those who qualify would receive assistance to purchase services that will assist in their maintaining personal and financial independence. On the Medicaid front, the legislation calls for an increase in the number of people who will qualify for services when the poverty level calculation changes to 133% of the federal poverty level in January 2014.

With the passage of health care reform, Medicaid coverage will expand to include the health and behavioral health needs of a larger percentage of the population. In addition, the Affordable Care Act (ACA) promotes the integration of behavioral health and primary health care. This integration results in improved access and improved quality of services for those in need of mental health and substance abuse services. The goals for health care reform and North Carolina’s expansion of the 1915 (b)/(c) Medicaid waiver are similar in that they both focus on cost containment while focusing on increased quality, access, and prevention to improve care.

SAMHSA’s Strategic Initiatives and Unified Plan

Another environmental factor affecting the public MH/DD/SA services system is the future use of funds from the federal Mental Health Block Grant (MHBG) and federal Substance Abuse Prevention/Treatment Block Grant (SAPTBG) provided to the State. The Substance Abuse and Mental Health Services Administration (SAMHSA) has committed to eight strategic initiatives in response to health care reform. These initiatives are more prescriptive in the use of MHBG and SAPTBG funds given the planning for the increased number of individuals who will be newly eligible for Medicaid in January 2014. Recognizing that states will play an important role in the design and implementation of health care reform and the need to be more strategic in purchasing services, SAMHSA set its strategic initiatives as:

1. Prevention of Substance Abuse and Mental Illness.
2. Trauma and Justice.
3. Military Families.
4. Recovery Support.
5. Health Reform Implementation.
6. Health Information Technology.
7. Data, Outcomes, and Quality.
8. Public Awareness and Support.



In 2011, SAMHSA required each state to submit a unified block grant plan for SFYs 2012 and 2013 including both mental health and substance abuse funds for (1) individuals who are not eligible for Medicaid, (2) services that Medicaid does not cover, and (3) significant involvement in new data sharing and electronic health information. As required, the DMHDDSAS unified block grant plan includes new strategic priorities that focus on the SAMHSA initiatives and target populations including children and adults with mental or substance abuse disorders who are homeless, who are involved in criminal or juvenile justice systems, who live in rural areas, or who are in an underserved minority or lesbian/gay/bi-sexual/transgendered population, or communities with need for environmental prevention strategies and other prevention interventions, and recovery support services. One of the priorities in North Carolina’s unified block grant plan is the statewide implementation of the 1915 (b)/(c) Medicaid waivers and preparation for the Affordable Care Act (ACA) with designated LMEs operating as managed care organizations (MCOs).

As stated in House Bill 916, the LME operating as a managed care organization (MCO) continues to be responsible for the management of “...all public resources that may become available for mental health, intellectual and developmental disabilities, and substance abuse services, including federal block grant funds, federal funding for Medicaid and Health Choice and all other public funding sources”. One of the contractual requirements for an LME is to “prioritize State and non-Medicaid federal funds allocated for services under this contract for mental health, developmental disabilities and substance abuse services for severely disabled and economically disadvantaged individuals in the catchment area in accordance with DHHS Target Population categories.”

Therefore, DMHDDSAS will continue to work with LMEs to ensure the appropriate use of federal block grant funds by LME-MCOs as required by SAMHSA and the State’s block grant awards.

In summary, these environmental factors may bring considerable changes in the way mental health, developmental disabilities and substance abuse services are delivered, though the details of those changes are not yet known.



Chapter 2. Overview of the Strategic Plan

The strategic plan is organized around a framework encompassing the State's vision for the Waiver initiative and goals that are designed to include and represent all stakeholders. The plan is based on an assessment of strengths and the challenges that lie ahead during the next two years. Included among those strengths is the commitment of the Department's leadership in facilitating the planning process and guiding DMHDDSAS and DMA in the development and implementation of the plan.

Goals for North Carolina

DHHS has four primary goals for the statewide expansion of the 1915 (b)/(c) Medicaid waiver, including:

- Establish a system to manage all public resources.
- Improve access to primary care and behavioral health resources.
- Improve quality of all MH/DD/SA services.
- Improve cost benefit.

The performance of the system will be measured over the long term as LMEs operating as a managed care organization (MCO) are included in the 1915 (b)/(c) Medicaid Waiver to determine how well the strategy meets these primary goals for North Carolina.

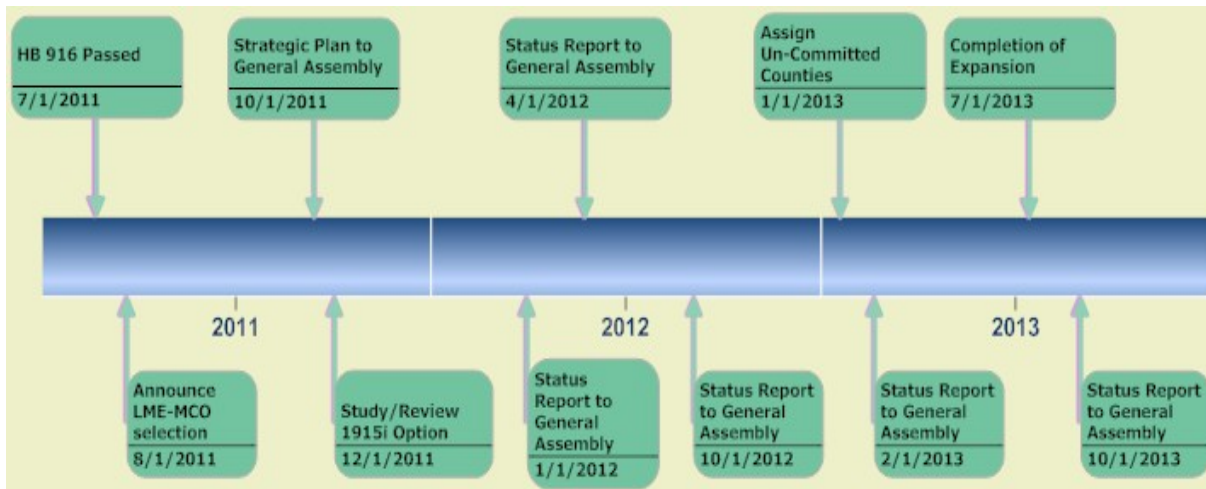
Purpose of the Strategic Plan

In addition to meeting the requirements of the North Carolina General Assembly for a strategic plan that delineates the specific strategies and agency responsibilities for the achievement of the objectives and deadlines as set forth in SL 2011-264 (House Bill 916), this strategic plan and its status reports provide a vehicle for active communication with all stakeholders across the State and for coordinating detailed implementation tasks among the Department, DMA, DMHDDSAS, LMEs, providers and consumers and family members.

Timeline

The strategic plan includes specific strategic objectives to be accomplished within a given timeframe. Implementation of the strategic plan begins July 1st, 2011 and includes specific action steps that will be completed by July 1, 2013. Status reports will be provided to the Legislative Oversight Committee and published for all stakeholders as required by legislation. The following timeline depicts key implementation dates of the 1915 (b)/(c) Medicaid Waiver strategic plan.





Implementation Structure and Process

The Department of Health and Human Services has focused on the importance of clearly identifying priorities and appropriate resources for the statewide implementation of the 1915 (b)/(c) Medicaid Waiver. The leadership of the Department believes that all stakeholders should have a clear and common perception of the State’s priorities and confidence that these priorities are sound, given the state’s changing needs and budget constraints.

Because the strategic plan impacts many, both outside as well as inside the organization, the Department acknowledges that these relationships must be utilized during various planning phases, including the communication of the strategic plan. Therefore, the process of developing this strategic plan has involved several phases.

- ❖ First, DMHDDSAS planning staff worked with Department leadership and waiver project managers from DMHDDSAS and DMA to develop a first organizational draft of the plan with which stakeholders – both individually and as organizations - could provide input and feedback.
- ❖ Secondly, the DMHDDSAS External Advisory Team including representatives from multiple stakeholder groups, the DMHDDSAS State Consumer and Family Advisory Committee (SCFAC) including representatives from all disability groups, and the DMA Advisory Council provided review and feedback.
- ❖ Finally, the initial plan was posted on the web and distributed via a Communication Bulletin inviting all stakeholders to provide their ideas, suggestions, questions, and feedback.

Given the plan’s due date of October 1, 2011, stakeholder input was compiled and incorporated in the final strategic plan prior to the Department’s formal review and approval



process before delivery to the NC General Assembly Legislative Oversight Committee as required by legislation.

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Chapter 3. Strategic Objectives and Action Steps

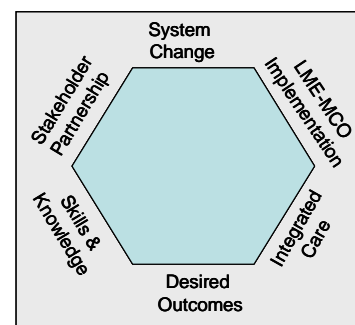
This strategic plan is organized into six strategic objectives. The objectives define the work that the Department is committed to undertake between July 1, 2011 and June 30, 2013. The strategic objectives are:

- ❖ Oversee and manage system changes.
- ❖ Monitor implementation of LME-MCOs.
- ❖ Ensure access and quality of the service system for individuals with mental illness, developmental disabilities or substance abuse.
- ❖ Strengthen the partnership with stakeholders in advising the State on implementation of the plan.
- ❖ Increase knowledge and skills throughout the system.
- ❖ Promote integrated care between mental health, intellectual/developmental disability and substance abuse service providers and primary care providers.

These six objectives and strategies for their accomplishment are described in this chapter. Two or more action steps are identified as important for accomplishing each objective. Each action step has two or more milestones to clarify the activities and deliverables that must be accomplished and by when.

The Objectives Work Together

Successful implementation of North Carolina's 1915 (b)/(c) Medicaid Waiver statewide for the public MH/DD/SA system of services depends upon development of local management entities as managed care organizations with the careful oversight by the State and partnership with all stakeholders. Successful oversight of multiple system changes includes implementation of healthcare reform and changes in funding requirements of federal block grants that call for integrating care for individuals with the primary care system. Integrating with primary care is dependent on increasing knowledge and skills throughout the system using multiple communication strategies and supporting learning communities. Greater knowledge and skills among all stakeholders improves outcomes for all individuals served including individuals with intellectual and/or developmental disabilities.



Therefore, accomplishment of an action step under one objective may be dependent on the completion of other actions steps in the same objective or in another objective. The dates for milestones have been chosen to correspond to a necessary sequencing of related milestones, plus recognition of limited resources for implementation at any one time. In addition, time has been allowed for engaging partners at the state level and at the local level including LMEs, local governments, providers and other community agencies.

The Plan Requires Accountability

Progress will be measured in terms of the timely completion of the deliverables and activities as defined in the action steps and milestones. In addition, the overall effectiveness of these endeavors will be measured in terms of outcomes for consumers and changes in system performance over time. These are described in chapter 4.

Each objective is described in the following sections of this chapter. Each section describes why the specific strategic objective was selected and what it means for consumers and the system. It identifies current issues and barriers, what problems must be overcome and what impedes progress. Such an environmental scan becomes the basis for the action steps.

It is important to recognize that a plan is a dynamic process and neither the Department nor any part of the mental health/developmental disabilities/substance abuse services system can control the many variables - including financial limitations – that affect the outcomes. What is written in statute and rule outlines the specific authority of the Department, DMHDDSAS, DMA, LMEs, county governments, consumer and family advisory committees and providers. Beyond that, it is the Department’s responsibility to provide policy guidance and tools for managing the system through performance and process expectations at State and local levels.

Ultimately, successes and failures rest with all stakeholders, including DMHDDSAS and DMA and the Department. With everyone’s participation and commitment, the definition and accomplishment of the objectives should produce concrete, visible progress and changes for consumers and families within two years. The Department is motivated and accepts the challenges presented by the plan.



Objective 1: Oversee MH/DD/SA service system change

The Department's responsibility is to establish the long term vision and the means for achieving desired outcomes for the delivery of services for individuals with mental illness, substance abuse disorders or intellectual and/or developmental disabilities. The statewide implementation of the 1915 (b)/(c) Medicaid Waiver is the means to accomplish that vision, the desired outcomes and to create quality and stability in the system and predictability in the future. This involves a shift from managing processes to managing outcomes as the State determines how to affect the system change dynamics to accomplish the vision. This objective points to the responsibilities of the State to manage system changes to accomplish the overall goals.

Action Step 1	Publish strategic plan and status reports as required by SL 2011- (HB 916).
Milestones	By 10/01/2011, submit a strategic plan to the NC General Assembly as required by HB 916 that includes stakeholder input.
	By January 1, 2012, April 1, 2012, October 1, 2012, February 1, 2013, and October 1, 2013, provide a status report with progress, outcomes, system performance and trends to the appropriate Oversight Committee of the NC General Assembly.

Action Step 2	Structure DHHS internally to provide statewide oversight of a locally managed system of MH, DD, and SA services through 1915 (b)/(c) Medicaid Waiver.
Milestones	By xx/xx/2011, assess and plan utilization of staff resources for requirements and functions related to the 1915 (b)/(c) Medicaid waiver, federal block grants, state funding, quality measures and related regulations.
	By 10/01/2011, secure a presentation led by PBH for DMHDDSAS and DMA management on their model and operations as an MCO.
	By xx/xx/2011, assign new functions to Division teams and/or existing matrix work groups and/or establish new matrix work groups as issues require while maximizing use of clinically licensed and certified staff.
	By xx/xx/201x, develop DMHDDSAS and DMA work plans including parallel tracks.
	By xx/xx/2011, identify and assign staff for the Intra-departmental Monitoring Teams (see Objective 2).
	By xx/xx/201x, develop individual staff work plans including definitions of quality and success.
	By xx/xx/201x, determine expertise needed in the future and strategies for staff development.

Action	Establish accountability for the development and management of a local
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Step 3	system with selected LMEs as participants in the 1915 (b)/(c) Medicaid Waiver.
Milestones	By 08/01/2011, select and announce the selection of LMEs to participate in the 1915 (b)/(c) Medicaid Waiver.
	As required, finalize and sign appropriate DMHDDSAS and DMA contracts for each LME including (1) those continuing as is, (2) those selected to become LME-MCOs, (3) those who currently operate as a LME-MCO.
	By 01/01/2013, assign responsibility for uncommitted counties to an existing LME-MCO.
	By xx/xx/201x, review and make recommendations for changes in statutes and/or rules pertaining to LME-MCO governance and other topics.
	By 01/01/2013, manage mergers as part of implementation process.
	By 01/01/2013, secure CMS approval of adding selected LMEs as participants in the 1915 (b)/(c) Medicaid Waiver.
	By 07/01/2013, confirm establishment of a statewide system of LME-MCOs participating in the 1915 (b)/(c) Medicaid waiver.

Action Step 4	Oversee implementation process of LME-MCOs and IMT process.
Milestones	By 10/01/2011, establish an Executive Management Team (EMT) to provide detailed oversight of the IMT process.
	Beginning by xx/xx/201x and quarterly thereafter, report by EMT to DHHS, DMHDDSAS and DMA regarding implementation progress made by each selected LME.
	By xx/xx/201x and quarterly thereafter, review progress and make recommendations for changes in operations or monitoring of each LME-MCO.
	By xx/xx/201x, review recommendations for innovative changes in standardization of policies, procedures and/or forms for use by statewide by LME-MCOs.
	By xx/xx/201x, review the trend of costs in the State Medicaid program and design strategies and deploy a system for allocation of resources based on the reliable assessment of intensity of need.
	By 12/01/2011 and quarterly thereafter, manage potential risks and threats.

Action Step 5	Manage the system to achieve specified consumer outcomes, system performance and cost benefits.
Milestones	By xx/xx/2011, define what constitutes success for the system and how measured, including consumers, providers, LME-MCOs, State facilities, and State.
	By xx/xx/2011, secure the means of obtaining needed data from LMEs and providers and processing the data by the State, and resolve any reporting requirements.
	By xx/xx/2011, identify and conduct analysis of consumer outcomes and system performance measures during implementation and set schedule for periodic analysis including trends and pre- and post- comparisons.
	By xx/xx/2011, define and conduct cost benefit analysis of the system during implementation and set schedule for periodic analysis including trends and pre- and post- comparisons and impact on NC's economy.



	By 10/31/11 and every quarter thereafter, report results and trends to management.
	By 12/1/11 and every quarter thereafter, review outcomes, system performance measures and cost benefit analysis and make adjustments in system as needed.

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Objective 2: Monitor Implementation of LME-MCOs

(Add Intro including a brief description of how the IMT operates and role of EMT.)

Action Step 1	Establish the protocols and expectations for Intra-departmental monitoring teams (IMT).
Milestones	By 09/01/2011, set schedule, assign staffing, and establish an IMT for each selected LME-MCO.
	By 10/01/2011, define protocols to assure consistency of operations across IMTs and establish means for communication among IMTs and requirements for reporting to management.
	By 10/01/2011, define procedures for monitoring cross-area service programs (CASPs) and use of block grant funding by LMEs.
	By 10/01/2011, define the consequences for LMEs if not meeting implementation plans, readiness reviews or other requirements for becoming a LME-MCO.
	By 12/1/11 and every quarter thereafter, review outcomes, system performance measures and cost benefit analysis and make adjustments in system as needed.

Action Step 2	Monitor the progress of each LME's implementation and readiness to become a LME-MCO.³
Milestones	By 10/01/2011 and monthly thereafter, review and discuss progress of each LME according to their implementation plan regarding contracting and capitation, facilities management, member services, clinical care management/utilization review, network operations/provider relations, quality assurance and quality improvement, financial management/monitoring, claims and IT staffing, claims administration system development, reporting, and merger/interlocal agreements management/monitoring. ⁴
	As required, prepare with LME-MCO appropriate plan of correction and monitor compliance and progress.
	By 10/01/2011 and monthly thereafter, assess fidelity to the implementation of standardized PBH policies, protocols, and forms and document recommendations for innovation.
	By 10/01/2011 and monthly thereafter, report progress, issues and concerns to the Executive Management Team.
	By 01/01/2013, schedule and hold two readiness reviews six months and three months prior to start date for each LME-MCO.
	By 01/01/2013, apply consequences to LMEs for not meeting implementation plans, readiness reviews or other requirements for becoming a LME-MCO.
	Six months after the start date for an LME-MCO, monitor quality by IMT on a quarterly basis.

³ Utilizing Mercer's monitoring tool.

⁴ See appendix B, LME-MCO Implementation Plan for IMT Oversight.



Objective 3: Ensure access and quality of the service system for individuals with mental illness, developmental disabilities or substance abuse

(Add Introduction)

Action Step 1	Ensure access and quality of the service system for consumers of mental health services and their families.
Milestones	On an ongoing basis, get feedback and input from stakeholders.
	By xx/xx/201x, design and promote best practices and strategies that identify, engage and retain individuals with mental health disorders in services.
	By 01/01/2013, develop protocols to encourage eligible individuals with mental health disorders to enroll in Medicaid.
	By xx/xx/201x, develop capacity for serving all eligible individuals with mental health disorders either through Medicaid or through services funded by State and federal dollars.
	By 07/01/2013, develop and implement strategies of mental health promotion.
	By 07/01/2013, develop and implement a plan for strengthening recovery oriented systems of care (ROSC) for individuals with mental health disorders, families, and communities through Cross-Area Service Programs (CASPs) and Critical Access Behavioral Health Agencies (CABHAs) for the continued statewide development, support, and effective utilization of evidence-based treatment, recovery, and quality management practices.
	By 07/01/2013, continue to strengthen the quality of CABHAs through review of performance and compliance with certification requirements.

Action Step 2	Ensure access and quality of the service system for consumers of substance abuse services and their families.
Milestones	On an ongoing basis, get feedback and input from stakeholders.
	By xx/xx/201x, design and promote best practices and strategies that identify, engage and retain individuals with substance abuse in services.
	By xx/xx/201x, develop capacity for serving all eligible individuals with substance abuse disorders either through Medicaid or through services funded by State and federal dollars.
	By xx/xx/201x, enhance prevention programs and environmental strategies to reduce the effects of substance abuse on adults and youth.
	By 01/01/2013, develop protocols to encourage eligible individuals with substance abuse disorders to enroll in Medicaid.
	By xx/xx/201x, secure the use of Screening, Brief Intervention, Referral and Treatment (SBIRT) and other tools for the prevention and early intervention in cases of substance abuse by primary care physicians.
	By xx/xx/2013, develop and implement a plan for strengthening recovery oriented systems of care (ROSC) for individuals with substance abuse disorders, families, and communities through Cross-Area Service Programs (CASPs) and Critical Access Behavioral Health Agencies (CABHAs) for the continued statewide development,



	support, and effective utilization of evidence-based treatment, recovery, and quality management practices.
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Action Step 3	Increase appropriate and timely access to community crisis services.
Milestones	By xx/xx/201x, increase access to crisis or emergency services to individuals with MH, SA or I/DD and co-occurring primary care needs.
	By xx/xx/201x, develop measures to analyze and evaluate correlation in reductions of behaviors, incidents and ED visits.

Action Step 4	Structure DMHDDSAS and DMA internally to provide statewide oversight/guidance of a locally managed system of Intellectual/developmental disability (I/DD) services and supports.
Milestones	By xx/xx/2011, redefine DMHDDSAS' and DMA's roles in providing guidance and oversight of Innovations Waiver to serve maximum number of individuals with IDD.
	By xx/xx/201x, identify and promote community services and supports for individuals with I/DD to ensure self-determination.
	By xx/xx/201x, ensure LME-MCOs contract with provider(s) for service known as Community Guide.
	By xx/xx/201x, monitor the provision of fundamental services to individuals with I/DD as required of G.S.131E-176 and G.S. 131E-178.

Action Step 5	DMHDDSAS and DMA to oversee process of transitioning from the CAP-MR/DD Tiered Waiver to the Innovations Waiver.
Milestones	By xx/xx/2011, prepare and submit amended CAP Waiver by 10/1/11.
	By xx/xx/2011, secure CMS approval of amended waiver.
	By xx/xx/2011, re-write CAP waiver policy manual.
	By xx/xx/201x, ensure that providers discontinue the administration of the Supports Intensity Scale (SIS) in non-Waiver LMEs.
	By xx/xx/201x, establish and implement resource allocation plan and supports needs matrix along with the SIS.

Action Step 6	DMHDDSAS and DMA to oversee outcomes, trends, and analysis of the Innovations Waiver.
Milestones	By xx/xx/201x, DMHDDSAS and DMA to collect and monitor performance measures as identified in the waiver review by the IMT and report to CMS.
	By xx/xx/201x, develop and establish standardized protocols for clinical monitoring and data analysis tools.
	By xx/xx/201x, develop protocol/guidance to identify community stakeholders for clinical monitoring.
	By xx/xx/201x, develop criteria to establish protocols for clinical monitoring of incidents.
	By xx/xx/201x, develop measures to correlate and verify waitlist, services offered and



	state dollars spent.
	By xx/xx/201x, verify that individual service improvements are implemented and monitored.
	By xx/xx/201x, identify gap in service availability according to state plans and goals.
	By xx/xx/201x, identify populations that are underserved.

Action Step 7	Manage the 1915(c) Innovations Waiver to achieve specified service outcomes, consumer outcomes, system performance and cost benefits.
Milestones	By xx/xx/201x, ensure that individuals with I/DD and co-occurring diagnosis have access to and receive appropriate comprehensive, person-centered services in their community.
	By xx/xx/201x, ensure individuals with I/DD and co-occurring diagnosis have access to and receive appropriate comprehensive, person-centered services in inpatient and facility-based settings.
	By xx/xx/201x, develop and provide standardized core competency and other training.
	By xx/xx/201x, conduct analysis of Core Indicators to evaluate improvement in satisfaction.
	By xx/xx/201x, establish statewide protocols to ensure equability of service delivery and ensure that all those that identified on waitlist has participated in STR and waitlist process.
	By xx/xx/201x, develop and establish protocols for peer reviews.



Objective 4: Strengthen the partnership with stakeholders in advising the State on implementation of the plan.

[Add introduction]

Action Step 1	Establish the roles and responsibilities for other stakeholders in the system.
Milestones	By xx/xx/201x, receive stakeholder feedback and input on elements of an effective consumer affairs office for each LME-MCO.
	By xx/xx/201x, receive stakeholder feedback and input on elements of an effective care coordination office for each LME-MCO

Action Step 2	Seek input regarding the understanding and satisfaction of consumers and families, advocates and providers with the implementation of LMEs becoming LME-MCOs.
Milestones	By 12/1/11 and every quarter thereafter, review the questions, concerns, understanding, comments and satisfaction of all stakeholders.

Action Step 3	Establish and maintain systems for consistent communication.
Milestones	By xx/xx/201x, engage stakeholders in establishing and maintaining systems for ongoing, effective communication and coordination (regarding DSS, DMA, DPH, CCNC, hospitals, schools, academic centers, Dept. of Juvenile Justice, providers, and other state and community agencies).



Objective 5: Increase knowledge and skills throughout the system

(Add Intro)

Action Step 1	Establish and maintain systems for consistent communication.
Milestones	By xx/xx/201x, engage stakeholders in establishing and maintaining systems for ongoing, effective communication and coordination with state and local agencies and organizations including DSS, DMA, DPH, CCNC, hospitals, schools, academic centers, Juvenile Justice, providers, and other state and community agencies.
	By xx/xx/201x, schedule and provide weekly interviews with the Director, and subsequently publish weekly updates.
	By xx/xx/201x, seek stakeholder input about what they want to know regarding system changes.
	By xx/xx/201x, publish successes of the 1915 (b)/(c) Waiver on an on-going basis.
	By xx/xx/210x, prepare materials on the waiver for the general public.
	By xx/xx/201x, communicate system successes noting global impact on NC economy and personal impacts on individuals.
	By xx/xx/201x, enhance DMH/DD/SA, DMA, and DHHS websites to enable stakeholders, LME-MCOs, providers, and consumers easy access to a full range of information regarding state and national health resources and initiatives.
	By xx/xx/201x, develop a mechanism to monitor website utilization and seek feedback on the ease of the website's use as well as ideas on additional information or links that would enhance the website's utility.
	By xx/xx/201x, facilitate the on-going exchange of information with employees of all supports and services, including all types of licensed or certified clinicians, behavioral health providers, IT, QM, etc, in order to maximize the clinical and organizational knowledge and expertise available across the Divisions.

Action Step 2	Ensure on-going learning and application of skills and knowledge.
Milestones	By xx/xx/201x, develop model of a learning community and establish statewide networks to support learning and development opportunities for all stakeholders.
	By xx/xx/201x, define and clarify role of Division, AHECs, BHRP, DDTI, NC Council, LME-MCOs, CABHAs regarding training.
	By xx/xx/201x, develop a Consumer/Family Learning Academy.
	By xx/xx/201x, develop an improved staff recruitment, retention, and development plan, including statewide work force development initiatives to ensure that the state has a well trained, highly qualified workforce and consumers can readily access the high quality provision of services and supports.
	By xx/xx/201x, development of knowledge and skills of risk reserve management.



Objective 6: Promote integrated care between mental health, intellectual/developmental disability and substance abuse service providers and primary care providers.

[Add intro]

Action Step 1	Provide outreach, support and services to individuals and families identified as being at risk of compromised health and safety to eliminate or reduce those risks.
Milestones	By xx/xx/201x, establish written policies ensuring alignment of objectives and operational coordination in the care of individuals with MI, IDD, and SA disorders with other organized systems.
	By xx/xx/201x, ensure that consumers have access to healthcare and behavioral health care treatment integrating effective care management and care coordination.
	By xx/xx/201x, develop processes and procedures for participation in Community of Care of North Carolina (CCNC) and coordination of generic health issues, hospital utilization, etc. for MH/DD/SAS consumers.
	By xx/xx/201x, determine impact of ACA and adjust as needed such as the development of Health Homes, an option allowed with ACA focusing on chronic conditions outlined in Quadrant IV, and referenced in Quadrant II and III.
	By xx/xx/201x, ensure that all CCNCs and LMEs-MCOs performance contracts include state performance measures and goals pertaining to the four quadrant integration of care model.

Action Step 2	Develop strategies and materials to educate/inform LMEs-MCOs, providers, consumers and family members, and other stakeholders of the four quadrant integration of care model in North Carolina.
Milestones	By xx/xx/201x, develop supporting documents and forms, such as standard procedures, flow charts, tool kits, and other education materials with stakeholder input.
	By xx/xx/201x, provide training to LMEs-MCOs and providers regarding the Four Quadrant Integration of Care Model.
	By xx/xx/201x, provide educational and materials opportunities to empower consumers/family members regarding integrated care.

Action Step 3	Implement system-wide outcome and performance measures, and conduct on-going analysis of outcome and performance data to assure the quality, effectiveness and accountability of the Four Quadrant Integration of Care Model.
Milestones	By xx/xx/201x, establish a system for monitoring indicators.
	By xx/xx/201x, define how outcomes and performance measures will be used to effectively manage care of individual lives.
	By xx/xx/201x, define how outcomes and performance measures will be used to increase cost effectiveness.
	By xx/xx/201x, conduct frequent monitoring in the initial stages of implementation to



	evaluate improvements in process and client outcomes.
	By xx/xx/201x, analyze the current process of integrated care and modify it as necessary so that it is evidence-based such as SBIRT.
	By xx/xx/201x, evaluate and revise annually to reflect new evidence and best practices of integrated care.
	By xx/xx/201x, identify system limitations and facilitate quality of care reporting.
	By xx/xx/201x, analyze the current process of care and modify it as necessary so that it is evidence-based and supported by the multidisciplinary team actually providing care, other service providers, clients, and families involved.

Action Step 4	Enhance existing provider information system – CCNC’s Provider Portal.
Milestones	By xx/xx/201x, clarify procedures and legalities for sharing data (HIPAA, HIT and electronic health records) on mental health, developmental disabilities, and substance abuse consumers.
	By xx/xx/201x, refine information that can be accessed (via CCNC or the LMEs) from the Provider Portal/Informatics Center that includes a patient care team summary, visit history, medication regimen, and any applicable care alerts.
	By xx/xx/201x, clarify qualification for access to Provider Portal/Informatics Center.



Chapter 4. Evaluation of Progress and Next Steps

An important component of the Strategic Plan is the development of an evaluation process. The Department is presently engaged in several processes to ensure the appropriate evaluation of the system as the Medicaid waiver is implemented. As stated in chapter 2, the system goals are to establish a system to manage all public resources, improve access to primary care and behavioral health resources, improve quality of all MHDDSA services, and improve cost benefit. Specifically, priorities for the evaluation process include ensuring appropriate access to services for those who are Medicaid-eligible, as well as those who are indigent, ensuring that high quality services are provided to those who are served and ensuring that fiscal resources are used appropriately.

The main mechanism that DMHDDAS in partnership with DMA will utilize to evaluate the progress of LMEs as they assume the roles and responsibilities of managed care organizations is a standardized performance dashboard. These dashboards will contain a standard set of data elements that the State analyzes to assist in decision-making at the State level. These dashboard measures will assist in monitoring managed care functions, as well as functions required of LMEs to appropriately provide state and federally-funded services.

The measures in the dashboard, including annual expectations for performance, will be specified in the LME contracts with DHHS. The DMHDDAS, DMA and the LME address areas of underperformance through the LME's IMT to ensure that improvements are made.

LME/MCOs will begin reporting on these elements prior to becoming LME/MCOs so that baseline data is available. Then, service trends and fiscal viability can be monitored on an on-going basis, during managed care implementation and thereafter. This will allow the State to monitor implementation as well as evaluate the impact of managed care on the existing service system.

The anticipated domains and types of measures that will be found in the LME-MCO Performance Dashboard can be found in the table below.

Domain	Example Measures
Access	Penetration rates
Consumer Experience	Grievances Perceptions of Care Service Outcomes
Clinical Management	Inpatient Utilization Crisis Services ED visits

Domain	Example Measures
System Performance & Financial Management	Adherence to expected expenditures Financial Health Claims processing
Integrated Care	Annual Preventive Care Visits of consumers with MH/DD/SA
Provider Networks	Qualified providers-providers with issues with appropriate remediation
Stakeholder perceptions	Provider and other stakeholder agency satisfaction
Health and Safety	Critical Incidents and Unexpected Deaths
SAMHSA Initiatives	Appropriate adherence to block grant requirements Services to target populations Coordination with justice system & other partners
Prevention	Appropriate adherence to block grant requirements
Innovations	Qualified Providers Appropriate level of care Resource allocation Waiting list

As these data are collected and analyzed, the State will share results with providers, LMEs, partner agencies, and consumers and families. DMHDDSAS will also actively seek stakeholder input on an on-going basis as a vital component of the evaluation process.

Also, as data are collected, the State will use it to actively manage and monitor the waiver implementation process. Some measures will be used as “early warning signals” to alert the State of potential problems and assist LMEs and the State in determining strategies to appropriately modify the implementation process.

There are additional mechanisms that will be utilized to evaluate Waiver implementation progress which include the following:

- Intra-departmental Monitoring Teams-** These teams comprised of DMHDDSAS and DMA staff are charged with meeting with assigned LMEs on a regular basis to assess their progress in adopting managed care functions, continuing their LME responsibilities, and meeting a set of prescribed milestones prior to Waiver implementation. DMHDDSAS and DMA are currently working together to develop a cross-training and communication process for all staff assigned to the IMTs in order to ensure adherence to industry standards, identify and implement best practices and to effectuate an internal quality improvement culture. The IMTs will be the primary

locus for reviewing trends on the LME Performance Dashboards, making recommendations for improvements in each LME's operations, and monitoring their progress.

- **Executive Management Team** – The Executive Management Team (EMT) will provide global oversight for waiver implementation and will be responsible for approving any needed policy changes. [To be defined further.]
- **External Quality Review Organization** - Many of the Medicaid performance measures that will be used for the LME-MCO performance dashboard are required by the Centers for Medicaid and Medicare Services (CMS). CMS requires contracts with Medicaid managed care organizations (MCO) to provide for an external independent review with an external quality review organization (EQRO). CMS specifically requires that EQRO to provide the following functions for every MCO:
 - annual validation of performance improvement projects required by the State;
 - annual validation of plan performance measures required by the State and reported by the MCO; and
 - a review, conducted in the previous three-year period, to determine the plan's compliance with State standards for access to care, structure and operations, and quality measurement and improvement.
- **Quality of Care Committee** - This committee, comprised of DMHDDSAS and DMA staff, reviews quality of care concerns such as unresolved complex clinical concerns or health and safety issues raised by Medicaid services utilization review vendors. It is anticipated that this committee will continue to work with LMEs in identifying statewide trends in quality of care concerns as LMEs become waiver sites.
- **Global Continuous Quality Improvement** – This committee, comprised of DMHDDSAS and DMA staff, review QMS activities and provides direction, feedback and support for strategic quality issues. These ongoing communications create a continuous feedback loop that impacts quality of care improvements for Medicaid participants.
- **DMHDDSAS Quality Improvement Steering Committee** – This committee acts as a clearinghouse for all above efforts. It is responsible for evaluating the performance of the service system as a whole, reviewing issues identified by the above groups and other committees, develop plans for improvements, overseeing implementation of performance improvement projects, and evaluating the impact of improvement efforts.

In conjunction with the committees and processes listed above, there are also on-going mechanisms to provide global oversight for the Medicaid waiver implementation. Annual on-site reviews of the LMEs will serve to verify data reported to DMHDDSAS and DMA by the LME-MCOs. Finally, periodic reports will be provided to the Legislature to describe the status of LME-MCOs and waiver implementation.

Appendix A. House Bill 916

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2011

SESSION LAW 2011-264 HOUSE BILL 916

H916-v-5

AN ACT TO ESTABLISH REQUIREMENTS FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND LOCAL MANAGEMENT ENTITIES WITH RESPECT TO STATEWIDE EXPANSION OF THE 1915(B)/(C) MEDICAID WAIVER.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services (Department) shall proceed with statewide restructuring of the management responsibilities for the delivery of services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders through expansion of the 1915(b)/(c) Medicaid Waiver. It is the intent of the General Assembly that expansion of the 1915(b)/(c) Medicaid Waiver will be completed by July 1, 2013, and will result in the establishment of a system that is capable of managing all public resources that may become available for mental health, intellectual and developmental disabilities, and substance abuse services, including federal block grant funds, federal funding for Medicaid and Health Choice, and all other public funding sources. In implementing the restructuring and expansion authorized in this section, the Department shall do all of the following:

- (1) Establish accountability for the development and management of a local system that ensures easy access to care, the availability and delivery of necessary services, and continuity of care for consumers in need of mental health, intellectual and developmental disabilities, and substance abuse services.
- (2) Maintain fidelity to the Piedmont Behavioral Health (PBH) demonstration model, a proven system for the operation of all public resources for mental health, developmental disabilities, and substance abuse services.
- (3) Designate a single entity to assume responsibility for all aspects of Waiver management. The following operational models are acceptable options for Local Management Entity (LME) applicants:
 - a. Merger model: A single larger LME is formed from the merger of two or more LMEs.
 - b. Interlocal agreement among LMEs: A single LME is identified as the leader for all Waiver operations, financial management, and accountability for performance measures.
- (4) Use managed care strategies, including care coordination and utilization management, to reduce the trend of escalating costs in the State Medicaid program while ensuring medically necessary care and deploy a system for the allocation of resources based on the reliable assessment of intensity of need. The Department

shall design these strategies to efficiently direct consumers to appropriate services and to ensure that consumers receive no more and no less than the amount of services determined to be medically necessary and at the appropriate funding level.

- (5) As the 1915(b)/(c) Medicaid Waiver expands statewide, phase out the current CAP-MR/DD Waiver as well as the utilization management functions currently performed by public and private contractors.
- (6) Design the Innovations Waiver in such a way as to serve the maximum number of individuals with intellectual and developmental disabilities within aggregate funding.
- (7) Require LMEs approved to operate a 1915(b)/(c) Medicaid Waiver of the following:
 - a. Maintain a local presence in order to respond to the unique needs and priorities of localities.
 - b. Implement a process for feedback and exchange of information and ideas to ensure communication with consumers, families, providers, and stakeholders regarding disability-specific and general Waiver operations.
 - c. Establish and maintain systems for ongoing communication and coordination regarding the care of individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders with other organized systems such as local departments of social services, Community Care of North Carolina, hospitals, school systems, the Department of Juvenile Justice, and other community agencies.
 - d. Comply with the following operational requirements:
 1. Maintain disability specific infrastructure and competency to address the clinical, treatment, rehabilitative, habilitative, and support needs of all disabilities covered by the 1915(b)/(c) Medicaid Waiver.
 2. Maintain administrative and clinical functions, including requirements for customer service, quality management, due process, provider network development, information systems, financial reporting, and staffing.
 3. Maintain full accountability for all aspects of Waiver operations and for meeting all contract requirements specified by the Department. The Department shall not require LMEs to subcontract any managed care functions or nonservice activities to other entities. However, LMEs that choose to subcontract managed care functions to other entities will be limited to the following:
 - I. Information systems.
 - II. Customer service (including call center) operations.
 - III. Claims processing.
 - IV. Provider, enrollment, credentialing, and monitoring.
 - V. Professional services.
 - VI. Treatment Plan development.
 - VII. Referral to services.

SECTION 1.(b) By August 1, 2011, the Department shall select LMEs that have been assessed to meet minimum criteria for Waiver operations according to the requirements of RFA #2011-261 issued on April 1, 2011.

SECTION 1.(c) The Department shall require LMEs that have not been approved by the Department to operate a 1915(b)/(c) Medicaid Waiver by January 1, 2013, to merge with or be aligned through an interlocal agreement with an LME that has been approved by the Department to operate a 1915(b)/(c) Medicaid Waiver. If any LME fails to comply with this requirement, the Department shall assign responsibility for management of the 1915(b)/(c) Medicaid Waiver on behalf of the noncompliant LME to an LME that is successfully operating the Waiver and successfully meeting performance requirements of the contract with the Department. Those LMEs approved to operate the 1915(b)/(c) Medicaid Waiver under an interlocal agreement must have a single LME entity designated as responsible for all aspects of Waiver operations and solely responsible for meeting contract requirements.

SECTION 1.(d) County governments are not financially liable for overspending or cost overruns associated with an area authority's operation of a 1915(b)/(c) Medicaid Waiver. County governments are not financially liable for overspending or cost overruns of Medicaid services associated with a county program or multicounty program's operation of a 1915(b)/(c) Medicaid Waiver beyond the county program or multicounty program's Medicaid risk reserve and Medicaid fund balance amounts.

SECTION 1.(e) Providers of targeted case management under the CAP-MR/DD Waiver are qualified to provide the 1915(c) service known as Community Guide under the Innovations Waiver. During the first year of assuming responsibility for Waiver operations, LMEs shall offer to contract with providers that were previously approved to provide targeted case management to individuals with intellectual and developmental disabilities under the CAP-MR/DD Waiver, for the provision of Community Guide services.

SECTION 1.(f) By December 31, 2011, the Department shall determine the feasibility of adding habilitation services to the State Medicaid Plan through the 1915(i) Option as a strategy to address the needs of Medicaid enrollees with IDD who are not enrolled in the Innovations Waiver and are not residing in an intermediate care facility for the mentally retarded (ICF-MR facility).

SECTION 1.(g) The Department shall consider the impact on ICF-MR facilities included in the 1915(b)/(c) Medicaid Waiver to determine and, to the extent possible, minimize potential inconsistencies with the requirements of G.S. 131E-176 and G.S. 131E-178 without negatively impacting the viability and success of the 1915(b)/(c) Medicaid Waiver programs.

SECTION 1.(h) The Department shall discontinue the pilot program to administer the Supports Intensity Scale to people with intellectual and developmental disabilities in non-Waiver LMEs.

SECTION 1.(i) The Department shall establish written policies ensuring alignment of objectives and operational coordination of the 1915(b)/(c) Medicaid Waiver and the care of individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders with other organized systems under the auspices of the Department, including Community Care of North Carolina.

SECTION 1.(j) In the development of the budget for the 2013-2015 fiscal biennium and subsequent biennia, the General Assembly shall consider a reinvestment of at least fifteen percent (15%) of the total projected State savings for that biennium from the operation of the 1915(b)/(c) Waiver, for the purpose of expanding the number of consumers served by the Innovations 1915(c) Medicaid Waiver, or for the purpose of expanding other services that are designed to meet the needs of individuals with intellectual and developmental disabilities.

SECTION 1.(k) By October 1, 2011, the Department, in coordination with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the Division of Medical Assistance, LMEs, PBH, and with stakeholder input, shall submit to the appropriate Oversight Committee of the General Assembly a strategic plan delineating specific strategies and agency responsibilities for the achievement of the objectives and deadlines set forth in this Act.

SECTION 1.(l) The Department shall submit status reports to the General Assembly on the restructuring and expansion authorized in this section on January 1, 2012, April 1, 2012, October 1, 2012, February 1, 2013, and October 1, 2013.

SECTION 2. G.S. 122C-115(a) reads as rewritten:

"(a) A county shall provide mental health, developmental disabilities, and substance abuse services through an area authority or through a county program established pursuant to G.S. 122C-115.1. The catchment area of an area authority or a county program shall contain either a minimum population of at least 200,000 or a minimum of six counties. Beginning July 1, 2012, the catchment area of an area authority or a county program shall contain a minimum population of at least 300,000. Beginning July 1, 2013, the catchment area of an area authority or a county program shall contain a minimum population of at least 500,000. To the extent this section conflicts with G.S. 153A-77(a), the provisions of G.S. 153A-77(a) control.

(a1) Effective July 1, 2007, the Department of Health and Human Services shall reduce by ten percent (10%) annually the administrative funding for LMEs that do not comply with the catchment area requirements of subsection (a) of this section. However, an LME that does not comply with the catchment area requirements because of a change in county membership shall have 12 months from the effective date of the change to comply with subsection (a) of this section. Effective July 1, 2012, the Department shall reduce the administrative funding for LMEs that do not comply with the minimum population requirement of 300,000 to a rate consistent with the funding rate provided to LMEs with a population of 300,000.

(a2) Effective July 1, 2013, the Department shall reassign management responsibilities for Medicaid funds and State funds away from LMEs that are not in compliance with the minimum population requirement of 500,000 to LMEs that are fully compliant with all catchment area requirements, including the minimum population requirements specified in this section.

(b) Counties shall and cities may appropriate funds for the support of programs that serve the catchment area, whether the programs are physically located within a single county or whether any facility housing a program is owned and operated by the city or county. Counties and cities may make appropriations for the purposes of this Chapter and may allocate for these purposes other revenues not restricted by law, and counties may fund them by levy of property taxes pursuant to G.S. 153A-149(c)(22).

(c) Except as authorized in G.S. 122C-115.1, within a catchment area designated in the business plan pursuant to G.S. 122C-115.2, a board of county commissioners or two or more boards of county commissioners jointly shall establish an area authority with the approval of the Secretary.

(d) Except as otherwise provided in this subsection, counties shall not reduce county appropriations and expenditures for current operations and ongoing programs and services of area authorities or county programs because of the availability of State-allocated funds, fees, capitation amounts, or fund balance to the area authority or county program. Counties may reduce county appropriations by the amount previously appropriated by the county for one-time, nonrecurring special needs of the area authority or county program."

SECTION 3. G.S. 122C-115.3(a) reads as rewritten:

"(a) Whenever the board of commissioners of each county constituting an area authority determines that the area authority is not operating in the best interests of consumers, it may direct that the area authority be dissolved. In addition, whenever a board of commissioners of a county that is a member of an area authority determines that the area authority is not operating in the best interests of consumers of that county, it may withdraw from the area authority. An area authority that does not meet the minimum population requirements specified in G.S. 122C-115 may dissolve at any time during a fiscal year. Dissolution of an area authority or withdrawal from the area authority by a county for other reasons shall be effective only at the end of the fiscal year in which the action of dissolution or withdrawal transpired."

SECTION 4. G.S. 150B-1(d) is amended by adding a new subdivision to read:

"(20) The Department of Health and Human Services in implementing, operating, or overseeing new 1915(b)/(c) Medicaid Waiver programs or amendments to existing 1915(b)/(c) Medicaid Waiver programs."

SECTION 5. This act is effective when it becomes law.

In the General Assembly read three times and ratified this the 13th day of June, 2011.

Walter H. Dalton
President of the Senate

Dale R. Folwell
Speaker Pro Tempore of the House of Representatives

Beverly E. Perdue
Governor

Approved 4:52 p.m. this 23rd day of June, 2011

Appendix B. LME-MCO Implementation Plan for IMT Oversight

As described in Objective 2, an Intra-departmental Monitoring Team (IMT) is assigned to oversee the implementation of an LME-MCO. Each LME develops its implementation plan and reports to the IMT on a monthly basis. The following describes the major tasks involved in establishing the functions that must be in place to operate as a managed care organization. Each implementation plan specifies target dates for these tasks based on a “go live” date upon DHHS and CMS approval.

LME-MCO Facilities and Organizational Management Tasks

- Implementation kick-off meeting with DMA and DMHDDSAS.
- Implementation team and workgroups identified/assigned for all departments.
- Communication plan (stakeholders, advocacy groups, consumers, providers).
- Review standardization requirements.
- Initiate issues log.
- Develop Board and Committee structure - agency wide.
- Develop initial implementation plan.
- Produce integrated manual of all policy and procedures.
- Select claims processing system.
- Select financial management system.
- Develop LME-MCO organizational structure.
- Implementation planning.
- Build-out, equipment, furniture.
- Building/space layout - floor plan/staff locations.
- Readiness review of Member Services, Provider Operations, Medical/Clinical operations system.

Contracting and Capitation

- Implementation planning.
- Review of services and expectations.
- Finalize performance metrics and reporting requirements.
- Negotiate contracts.

Customer Services

- Implementation planning.
- Develop and finalize job descriptions for member services.
- Staffing needs assessment.
- Member Service training module development.
- Member Service training for new and tenured staff.
- Develop website content for LME-MCO.
- Develop business requirements for member services reports.

- Develop specifications for member services reports.
- Develop departmental policies and procedures such as member R&R, call documentation protocols, clinical triage/inquiry protocol, call transfer protocol/crisis calls, claims inquiry protocol, grievance/appeal protocol).
- Develop member communication materials including grievance/appeal process, member rights and responsibilities.
- Prepare hard copies of member communication materials.
- Develop draft member handbook.
- Prepare hard copies of member handbook.
- Identify stakeholder groups to assist with forums, schedule and hold community forums.
- Hold community forums.

Utilization Management/Care Management

- Implementation planning.
- Develop and finalize job descriptions for LME-MCO clinical operations.
- Staffing needs assessment.
- Hire staff.
- Develop clinical training module.
- UM/CM training for new and tenured staff.
- Develop clinical care management/UR policies and procedures and workflows including out-of-network, authorization process, CM interface with member services/ICM/peer support specialists, disclosure of protected health information, mixed services protocol, protocol for authorization extensions.
- Develop and finalize job descriptions for LME-MCO clinical care management including medical management, managers/supervisors, MH/SA/DD specialists per State regulations.
- Develop business requirements for clinical management reports.
- Develop specifications for clinical management reports.
- Develop utilization management plan.
- Finalize medical necessity criteria for DMA approval.
- Finalize level of care guidelines.
- Select and draft clinical guidelines.
- Develop member appeals process.
- Develop provider appeals process.

Provider Network Management

- Implementation planning.
- Draft job descriptions for LME-MCO network operations.
- Staffing needs assessment.
- Hire staff.
- Network access/needs assessment for all populations and specialties.
- Develop detailed network development/re-contracting plan.
- Network Operations training program documentation.
- Network Operations training for new and tenured staff.
- Develop business requirements for network management reports.
- Develop specifications for network management reports.

- Development of provider manual with State and claims staff.
- Finalize provider manual.
- Plan and schedule provider forums.
- Hold provider forums.

Quality Management

- Implementation planning.
- Draft job descriptions for LME-MCO operations.
- Staffing needs assessment.
- Hire staff.
- Claims training program documentation.
- Claims training for new staff.
- Develop and finalize Quality Assurance/Quality Improvement policies and procedures.
- Finalize Quality Management Program Description and obtain leadership approval.
- Develop business requirements for QM reports,
- Develop specifications for QM reports.

Financial Management/Monitoring

- Implementation planning.
 - Draft job descriptions for LME-MCO financial operations.
 - Staffing needs assessment.
 - Hire staff.
- Budget - proforma for next three years:
 - Financial Solvency.
 - Plan for Medical Loss Ratio requirements.
- Insurance and State contractual requirements are in place.
- Category of Expense configuration in claims system (contingent on claims paying system implementation).
- G/L setup for category of aid and expense.
- Accounting/financial/risk management.
- Develop policies and procedures to ensure timely payment.
- Accounts payable.
 - 835 transaction set and EFT payments to providers as well as paper option capabilities developed.
- Develop procedures for claims for both IBNR and RBUCs estimation.
- Month-end procedures.
- Financial statements – GAAP.
- Include IBNR estimates and footnote disclosures related to claim payment and estimation techniques in financial statement presentation.
- Ensure all State reporting and financial solvency requirements are in place.
- Establish independent departments for internal control.
- Auditors are aware of new requirements and can adapt to a 90 day audit completion after period end.
- Provider contracting.
- Capitation reconciliation.

- Develop process to reconcile state 835 capitation roster to internal eligibility system.
- Monitoring of minimum requirements.
 - Develop monitoring process for MLR requirements and adjustments to MLR for rebate requirement provisions.
 - Develop monitoring tool for trending analysis of financial and utilization data.
- Training.
 - Finance training program documentation.
 - Finance training for new staff.
- Readiness review.
- Third Party Liability.
 - Ability to identify from State enrollment any third party resources with policies in place to cost avoid claims.
 - Accident/Injury detection is in place and procedures are developed to subrogate on behalf of or in coordination with the State.
- Fraud and abuse.
 - Develop program integrity monitoring.
 - Establish claims audit department and staffing.
 - Develop process for fraud and abuse detection.
- Readiness review.

Claims and IT Staffing

- Implementation planning.
- Claims processing operations.
- Staffing needs assessment.
- Hire staff.
- Claims training program documentation.
- Claims training for new staff.
- IT staffing including help desk, programmers, infrastructure.
- Staffing needs assessment.
- Hire IT staff.
- Train appropriately.

Claims Administration System Development

- Implementation planning.
- Claims receipt – electronic.
 - EDI policies and procedures developed, including steps for error handling and reporting.
 - EDI claims processes (incoming claims) - coding, testing and implementation.
- Claims receipt – paper.
 - Paper claims policies and procedures developed, including error handling and reporting.
 - Claims imaging and routing processes.
 - Paper claims processes - coding, testing and implementation.
- Claims portal for providers (optional).
 - Policies and procedures developed.

- Requirements gathering.
 - Portal development.
 - External communication and training.
- Claims edits.
 - Policies and procedures developed.
 - System configuration.
 - System edit configuration with disposition.
 - System testing and implementation.
- Eligibility and enrollment.
 - Eligibility policies and procedures documented.
 - Mapping from State eligibility format (834 format) for waiver recipients.
 - Eligibility load test.
 - Eligibility reconciliation including exception handling, balancing and reporting.
- Benefit plan.
 - System configuration.
 - Test benefit plan and implement in production environment.
- Provider contract setup for claims payment.
 - Requirements identified, i.e. provider demographics.
 - Provider contract fee schedules.
 - Provider contract - system configuration.
 - Provider match to incoming claims.
- System data code sets.
 - Code set requirements gathered.
 - Place of service.
 - Diagnosis table ICD-9 and preparation for ICD-10.
 - Procedure code table (HIPAA CPT/HCPCS standard and state allowed procedures).
 - UB standard codes (i.e., type of bill, revenue code).
 - System coding, testing and implementation.
- Coordination of Benefits (COB).
 - Policies and procedures developed for collection and processing.
 - Systematic identification of Other Insurance.
 - System configuration and programming for claims payment.
 - COB process implementation.
- Claims adjustments.
 - Policies and procedures developed.
 - System configuration to handle all adjustment types including retaining original claims paid information.
 - Testing and implementation.
- Provider appeals.
 - Claims policies and procedures developed.
- Claim Voids.
 - Policies and procedures developed.

- System configuration to handle all adjustment types including retaining original claims paid information.
 - Testing and implementation.
- Out of Area (non-network) provider claims.
 - Policies and procedures developed.
- Claims audit for both system and manual adjudication.
 - Policies and procedures developed.
 - Training.
- Authorizations, service table match with provider allowed services (set up Clinical authorization system).
 - Requirements documented.
 - System configuration and programming.
 - System testing and implementation.
- Authorizations - system integration.
 - System matching claim to authorization information.
 - Capability to manually match authorization.
 - Authorization accumulators and counters for maximum allowed.
- Auto adjudication (system automatic pay/denial).
 - System requirements and analysis.
 - Auto pay - coding, testing and implementation.
 - Auto deny - coding, testing and implementation.
- Reimbursement (link of provider to payment).
 - Requirements documented.
 - System configuration.
 - System testing and implementation.
- HIPAA transactions.
 - 270/271 Eligibility Inquiry and Response.
 - 276/277 Claims Inquiry and Response.
 - 278 Authorization.
 - 820 Premium (Capitation Payment).
 - Mapping from State payment format (820 format) for waiver recipients.
 - Payment process and reconciliation analysis and design.
 - Payment and reconciliation coding, testing and implementation.
 - Eligibility reconciliation, exception handling and balancing reports.
 - 834 Eligibility and Enrollment.
 - Mapping from State eligibility format (834 format) for waiver recipients.
 - Eligibility and enrollment process and reconciliation analysis and design.
 - Eligibility and enrollment process coding, testing and implementation.
 - Eligibility and enrollment reconciliation, exception handling and balancing reports.
 - 835 Remittance (in addition to paper).
 - Remittance advice analysis, design and analysis to generate paper and EDI remittance advice.

- Remittance advice process coding, testing and implementation.
 - 837 Claims (837I - Institutional, 837P - Professional).
 - ANSI X12 transactions coding, testing and implementation.
 - External trading partner communication.
 - ANSI X12 5010 - Federal mandated implementation by 1/1/12.
- Security Requirements.
 - Physical office and computer security.
 - PC/Laptop configuration if necessary.
 - Disaster planning and recovery.
 - System and data backups.
 - Policies and procedures developed for all security requirements.
 - Recovery testing.
 - Hot site planning.
- Help Desk.
 - Policies and procedures developed.

Reporting

- Implementation planning.
- Internal reporting - reporting defined, developed and tested.
- Operational reporting.
- Out of area reporting defined and developed.
- Provider reporting.
- Daily operational reporting.
- Financial reporting.
- Clinical reporting.
- Claims audit reporting.
- Development testing.
- End user testing.
- External reporting - reporting defined, developed and tested.
- State reporting.
- Board of Directors.
- Development testing.
- User testing by internal staff.
- Ad-hoc reporting.
- Analysis and design for ad-hoc reporting.
- Creation of reporting repositories and ad-hoc tools.
- Report specifications developed.
- Reports production ready.
- Encounter data.
- State requirements documented.
- Program configuration.

Merger / Interlocal Agreement Management/Monitoring

- Implementation planning.
- Legal Due Diligence.

- Financial Due Diligence.
- Program Due Diligence.
- Business Management Agreement.
- Board of Directors Discussions.
- Transfer of Personal Property Assets.
- Disposition of Leased Property.
- General Liability Insurance.
- Directors and Officers' Insurance.
- Employment of Employees.
- No transfer of Liability.
- Dissolving of LME / Unreserved Fund Balance, Liabilities/Indemnifications, Merged LME Indemification, Covenant of Merged LME, Pending Litigation and Claims, Financial Disclosure, Employment Practices, Severability, Applicable Law, Execution dates,
- Communication Plans.
- Stakeholder Meetings.
- Involvement with DHHS.
- Maintain a local presence in order to respond to the unique needs and priorities of localities.
- Public Hearings per 122C.
- Interlocal agreement among LMEs including a single LME identified as the leader for all waiver operations, financial management, and accountability for performance measures.

Appendix C. Acronyms and Definitions

[Limit these to the ones actually used in this document when finished]

Acronyms

CABHA	Critical Access Behavioral Health Agency
CFR	Code of Federal Regulations
CMS	The federal Centers for Medicare and Medicaid Services http://www.cms.hhs.gov/
DD or I/DD	Developmental disabilities or intellectual and/or developmental disabilities
DHHS	Department of Health and Human Services
DMA	Division of Medical Assistance, a division of DHHS and North Carolina's State Medicaid Agency
DMH/DD/SAS	Division of Mental Health, Developmental Disabilities and Substance Abuse Services, a division of DHHS
HCBS	Home and Community Based Services
HIPAA	<i>Health Insurance Portability and Accountability Act</i> enacted by U.S. Congress in 1996
ICF-MR	Intermediate Care Facility for the Mentally Retarded
MCO	Managed care organization
PBH	The LME formerly named Piedmont Behavioral HealthCare
PIHP	Prepaid Inpatient Health Plan – see below
PMPM	Per member per month
UM/UR	Utilization management / utilization review – see below

Definitions

Action	<p>The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure of the LME to act within the timeframes provided in 42 C.F.R. 438.408(b). For a rural area resident with only one LME, the denial of a Medicaid Enrollee's request to obtain services outside the Provider Network:</p> <ol style="list-style-type: none"> a. From any other provider in terms of training, experience, and specialization) not available in the network. b. From a provider not part of the network that is the main source of a service to the recipient—provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the Enrollee is given a choice of participating providers and is transitioned to a participating provider within 60 days. c. Because the only plan or provider available does not provide the service because of moral or religious objections. d. Because the Enrollee's provider determines that the
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	recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network.
Appeal	A request for administrative review of an Action as defined above.
Grievance and Appeal Procedure	The written procedures pursuant to which Enrollees may express dissatisfaction with the provision of services by the LME and the methods for resolution of Enrollee grievances and appeals by the LME.
Critical Access Behavioral Health Agency	Critical Access Behavioral Health Agency (CABHA) is a new category of provider agency, approved by DHHS and CMS. CABHAs are designed to ensure that critical services are delivered by a clinically competent organization with appropriate medical, clinical, and quality management oversight and the ability to deliver a continuum of services.
Capitation Payment	A fixed payment remitted at regular intervals by DMA to the LME(s) operating a PIHP. The LME determines whether their providers are paid fee for service or on a capitated basis.
Care Management	A multidisciplinary, disease centered approach to managing medical care using outcome measures to identify best practices. The purpose of care management is to identify level of risk, stratify of services according to risk, and prioritize recipients for services. The approach utilizes collaboration of services, systematic measurement and reporting and resource management.
Clean Claim	A clean claim is a claim that can be processed without obtaining additional information from the provider of the services or from a third party. It does not include a claim under review for medical necessity, or a claim that is from a provider that is under investigation by a governmental agency for fraud or abuse.
Complaint	See grievance.
Covered Services	The services identified in the waiver application and in the contract that the LME agrees to manage pursuant to the terms of the contract.
Cultural Competency	The understanding of the social, linguistic, ethnic, and behavioral characteristics of a community or population and the ability to translate systematically that knowledge into practices in the delivery of mental health, developmental disabilities and substance abuse services. Such understanding may be reflected, for example, in the ability to: identify and value differences; acknowledge the interactive dynamics of cultural differences; continuously expand cultural knowledge and resources with regard to populations served; collaborate with the community regarding service provisions and delivery; and commit to cross-cultural training of staff and develop policies to provide relevant, effective programs for the diversity of people served.
Days	Unless otherwise noted, refers to calendar days. "Working day" or "business day" means day on which DHHS is officially open to conduct its affairs.
Department	The North Carolina Department of Health and Human Services

Enrollee	A person who is on Medicaid and in one of the mandatory eligibility groups included in the waiver is automatically enrolled in the PIHP regardless of whether s/he ever accesses services.
Evidence based	A program or practice that has had multiple site random controlled trials demonstrating that the program or practice is effective for the population served.
Fee-for-service	A method of making payment directly to health care providers enrolled in the Medicaid program for the provision of health care services to Recipients based on the payment methods set forth in the State Plan and the applicable policies and procedures of DMA.
Grievance	An expression of dissatisfaction by or on behalf of an Enrollee about any matter other than an action, as “action” is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the LME level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Enrollee’s rights).
Hearing	A formal proceeding before an Office of Administrative Hearing Law Judge in which parties affected by an action or an intended action of DHHS shall be allowed to present testimony, documentary evidence and argument as to why such action should or should not be taken.
Innovations Waiver	The current NC 1915 C home and community based services waiver (HCBS) currently operated by PBH and for which application has been made for statewide implementation. The Innovations Waiver replaces the Community Alternatives Program for Persons with Mental Retardation and Developmental Disabilities (CAP-MR/DD) in the Piedmont counties.
Insolvency	The inability of the LME to pay its obligations.
Managed Care Organization (MCO)	An umbrella term for health plans that provide health care in return for a predetermined monthly fee and coordinate care through a defined network of providers, physicians and hospitals.
Medical Necessity	Treatment that is <ul style="list-style-type: none"> a. Necessary and appropriate for the prevention, diagnosis, palliative, curative, or restorative treatment of a mental health or substance abuse condition; b. Consistent with Medicaid policies and National or evidence based standards, North Carolina Department of Health and Human Services defined standards, or verified by independent clinical experts at the time the procedures, products and the services are provided; c. Provided in the most cost effective, least restrictive environment that is consistent with clinical standards of care; d. Not provided solely for the convenience of the recipient, recipient’s family, custodian or provider;

	<p>e. Not for experimental, investigational, unproven or solely cosmetic purposes;</p> <p>f. Furnished by or under the supervision of a practitioner licensed (as relevant) under State law in the specialty for which they are providing service and in accordance with Title 42 of the Code of Federal Regulations, the Medicaid State Plan, the North Carolina Administrative Code, Medicaid medical coverage policies, and other applicable Federal and state directives;</p> <p>g. Sufficient in amount, duration and scope to reasonably achieve their purpose, and</p> <p>h. Reasonably related to the diagnosis for which they are prescribed regarding type, intensity, duration of service and setting of treatment.</p> <p>Within the scope of the above guidelines, medically necessary treatment shall be designed to:</p> <p>a. Be provided in accordance with a person centered service plan which is based upon a comprehensive assessment, and developed in partnership with the individual (or in the case of a child, the child and the child’s family or legal guardian) and the community team;</p> <p>b. Conform with any advanced medical directive the individual has prepared;</p> <p>c. Respond to the unique needs of linguistic and cultural minorities and furnished in a culturally relevant manner; and</p> <p>d. Prevent the need for involuntary treatment or institutionalization.</p>
Network Provider	A provider of mental health, developmental disabilities and substance abuse services that meets the LME’s criteria for enrollment, credentialing and/or accreditation requirements and has signed a written agreement to provide services
Prepaid Inpatient Health Plan (PIHP)	An entity that 1) provides medical services to Enrollees under contract with the State Medicaid agency; 2) on the basis of prepaid capitation payments or other payment arrangements does not use State plan payment rates; 3) provides arranges for or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its Enrollees; and 4) does not have a comprehensive risk contract.
Prior authorization	The act of authorizing specific services before they are rendered.
Provider	Any person, agency or entity providing mental health, developmental disabilities, or substance abuse services.
Provider Network	The agencies, professional groups, or professionals under contract to the LME that meet LME standards and that provide authorized Covered Services to eligible and enrolled persons
Recipient	An Enrollee who is receiving services.
Reconsideration	An enrollee’s first step in the appeal process after an adverse

	organization determination; the LME-PIHP shall have procedures to reevaluate an adverse organization determination, findings upon which it was based, and any other evidence submitted or obtained.
Recovery	The processes by which people are able to live, work, learn and participate fully in their communities.
Resilience	The personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses and to live productive lives.
Risk Contract	A contract under which the contractor: 1) assumes risk for the cost of the services covered under the contract; and 2) incurs loss if the cost of furnishing the services exceeds the payments under the contract. This contract is a risk contract because the LME assumes that risk that the cost of providing Covered Services to Enrollees may exceed the capitation rate paid by DHHS.
Risk Reserve	A restricted reserve account maintained by the LME to fund payments for outstanding obligations, such as cost overruns related to Medicaid program services.
Self-determination	Self-determination refers to the right of individuals to have full power over their own lives, regardless of presence of illness or disability. Self-determination in the mental health system refers to individuals' rights to direct their own services, to make the decisions concerning their health and well-being (with help from others of their choice, if desired), to be free from involuntary treatment, and to have meaningful leadership roles in the design, delivery, and evaluation of services and supports.
Service Management Record	A record of Enrollee demographics, authorizations, referrals, actions and services billed by Network Providers
State	The State of North Carolina
State Plan	The "State Plan" submitted under Title XIX of the Social Security Act, Medical Assistance Program for the State of North Carolina and approved by CMS
Subcontract	An agreement which is entered into by the LME in accordance with Section 11
Subcontractor	Any person or entity which has entered into a contract with the LME.
Third Party Resource	Any resource available to a Member for payment of expenses associated with the provision of Covered Services (other than those which are exempt under Title XIX of the Act), including but not limited to, insurers, tort-feasors, and worker's compensation plans
Utilization Management (UM)	A system's overall strategy for managing service utilization by individual clients and by the system as a whole. UM is implemented through a plan that combines care management, resource management, UR, and uses financial data to determine trends and service use patterns
Utilization Review (UR)	The process used to evaluate requested health care services and determine whether they are medically necessary

<p>Waiver</p>	<p>The document by which DHHS, DMA, requests sections of the Social Security Act (SSA) be waived, in order to operate a capitated managed care system to provide services to enrolled recipients.</p> <p>Section 1915 (b) of the SSA authorized the Secretary to waive the requirements of sections 1902 of the SSA to the extent he or she finds proposed improvements or specified practices in the provision of services under Medicaid to be cost-effective, efficient, and consistent with the objectives of the Medicaid program.</p> <p>Section 1915 (c) of the SSA provides the Secretary authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings as the Medicaid alternative to providing comprehensive long-term services in institutional settings. Initial waivers are approved for three years. Renewed waivers are granted for five years.</p>
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