North Carolina Medicaid and NC Health Choice Section 1115 Demonstration Waiver Application

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Health & Human Services

Table of Contents

1. Executive Summary

North Carolina, through the Department of Health and Human Services (DHHS), is pleased to submit this Section 1115 demonstration application to the Centers for Medicare & Medicaid Services (CMS). North Carolina's Medicaid Reform Demonstration represents the culmination of three years of stakeholder engagement and planning to accomplish the joint vision of Governor Pat McCrory and the North Carolina General Assembly.

The demonstration represents and builds on the DHHS tradition of successfully developing innovative programs that serve North Carolinians. DHHS requests CMS to invest in and support Medicaid and NC Health Choice system-wide transformation goals through the authority provided under an 1115 demonstration. Support from CMS will help ensure a smooth and seamless transition to prepaid health plans for beneficiaries and providers, build person-centered health communities, systematically integrate behavioral health, and improve access for beneficiaries by investing in the state's health care workforce. This proposal aims to drive future innovation that will lead to better health for North Carolinians and increased budget stability.

Background

In September 2015, the North Carolina General Assembly enacted Session Law (SL) 2015-245 (Appendix A), to transform and reorganize North Carolina's Medicaid and NC Health Choice programs. This legislation directed DHHS to redesign Medicaid and NC Health Choice to achieve the following goals:

1) Ensure budget predictability through shared risk and accountability;

2) Ensure balanced quality, patient satisfaction and financial measures;

3) Ensure efficient and cost-effective administrative systems and structures; and

4) Ensure a sustainable delivery system through the establishment of two types of prepaid health plans: provider-led entities and commercial plans.

The new endeavors reflected in this demonstration are logical next steps in North Carolina's progression since the early 1990s toward a well-coordinated care partnership with providers that leverages and supports community-based health care delivery systems. Going forward under the proposed demonstration, DHHS will further transform the Medicaid and NC Health Choice programs into a high-performing health care system with accountability for value and outcomes.

The Future

The DHHS vision, developed with a diverse and comprehensive group of stakeholders, will set a course for North Carolina to improve health and cost outcomes in Medicaid and NC Health Choice. At its core, this demonstration sets forth a plan to improve health care access, quality and cost efficiency for the growing population of Medicaid and NC Health Choice beneficiaries. Care delivery will use accountable, next generation prepaid health plans. Payments will reward value and outcomes rather than volume. DHHS will continue moving toward meaningful person-centered care that leverages community resources and data analytics.

The demonstration will test and evaluate five broad-based initiatives and their program proposals:

1. Build a System of Accountability for Outcomes
2. Create Person-Centered Health Communities
3. Support Providers through Engagement and Innovations
4. Connect Children and Families in the Child Welfare System to Better Health
5. Implement Capitation and Care Transformation through Payment Alignment

Demonstration Initiative #1: Build a System of Accountability for Outcomes

- **Next generation prepaid health plans in a hybrid model**
  DHHS will contract with two types of prepaid health plans (PHPs): provider-led entities and commercial plans. Contracts will use value-based purchasing principles and require PHPs to reward their network providers for producing favorable health and cost outcomes. DHHS will enter into long-term contracts (4-5 years) with PHPs to encourage ongoing investment in transformation and ensure commitment.

  DHHS also is working with the Eastern Band of Cherokee Indians (EBCI) to develop a sub-regional Tribal managed care entity as an additional PHP choice for members of federally recognized tribes. *This has the potential to become the first Indian Medicaid managed care entity in the country*.

- **Person-centered health communities supported by PHPs**
  DHHS will partner with PHPs to support advancement beyond the current patient-centered medical home functions and create person-centered health communities (PCHCs).

- **Clinically integrated behavioral and physical health**
  North Carolina will address the complex interaction of mind and body by focusing on clinical integration of behavioral health services with primary care.

Next Generation Prepaid Health Plans

Prepaid health plan (PHP)
Risk-based Medicaid MCO

Provider-led entity (PLE)
Local PHP led by North Carolina providers

Commercial plan (CP)
PHP operated by a commercial Medicaid MCO

Tribal prepaid health plan
PHP operated by the Eastern Band of Cherokee Indians

- **Long-term services and supports for Medicaid-only beneficiaries**
  DHHS will implement integrated long-term services and supports (LTSS) for Medicaid-only beneficiaries, consistent with standards for person-centered care and supportive of family caregivers and other natural supports. The new program will work toward delaying or avoiding the need for institutional services.

Demonstration Initiative #2:
Create Person-Centered Health Communities

- **Transform patient-centered medical homes and enhanced primary care case management to person-centered health communities**
  The North Carolina PCHCs will expand primary care and care management activities beyond the state's nationally recognized patient-centered medical home (PCMH) and enhanced primary care case management (ePCCM) models. Conceptually, PCHCs and the engaged medical community will focus on meeting health care needs of the beneficiary and addressing social determinants of health. Over time, aspects of population health and overall community health needs will be incorporated. This will be driven by health assessments that support the person-centered approach to improve individual health outcomes. The PCHC concept will be embedded within PHP contractual requirements and financial incentives.

- **Improve rural health access, outcomes and equity**
  Beneficiaries in rural areas will gain enhanced access to quality services. Rural providers will be able to use tools such as value-based purchasing, telemedicine and robust data analytics to help decrease disparities in rural health care.

Demonstration Initiative #3:
Support Providers through Engagement and Innovations

- **Provider administrative ease in PHP contracts**
  DHHS will work with PHPs and providers to minimize administrative burden. The PHP contract will include provisions designed to lower provider burden, such as uniform credentialing, a standard preferred drug list, a common set of performance measures and requirements for prompt payment.

- **Practice supports for quality improvement**
  DHHS will ensure that supports are available to practices large and small, private and public, to build on the success of the medical home model, including transformation to PCHCs. Practice supports will include population management tools and clinical toolkits, quality measure reporting with peer comparison, provider-facing analytics for use in daily practice, quality improvement coaching, and behavioral health integration.

- **North Carolina Health Transformation Center**
  The North Carolina Health Transformation Center (NCHTC) will help providers and PHPs achieve demonstration goals. NCHTC will perform continuous quality improvement activities as the state's outward-facing center of excellence for clinical and technical improvements. NCHTC will promote continued partnerships with community-based providers and care organizations.
- **Health Information Exchange**
  To support provider transformation, Medicaid providers will be connected to the NC Health Information Exchange (HIE) network by February 2018. Providers involved with other state-funded health programs will be connected by June 2018.
- **Statewide informatics layer**
  North Carolina will use robust population health management tools that combine clinical and administrative claims data to better manage patient care, improve health outcomes and more efficiently direct resources.
- **Strengthening the health care safety net**
  DHHS will designate "essential providers" to secure safety net and rural providers within PHP networks, and will preserve federally qualified health center (FQHC) and rural health center (RHC) payment rates using direct, wrap-around payments from Medicaid. The demonstration proposes to extend this arrangement to certain additional safety net providers, such as local health departments, to recognize their unique role with North Carolina Medicaid.
- **Community residency and health workforce education**
  DHHS will expand crucial health workforce programs that ensure Medicaid beneficiaries will have access to essential services in rural and other underserved areas. DHHS will focus on community-based residency programs and health workforce education that emphasize ambulatory and preventive care to advance the goal to provide higher value health care to reduce long-term costs.

Demonstration Initiative #4:
Connect Children and Families in the Child Welfare System to Better Health

- **DHHS will implement a complementary package of initiatives to enhance health outcomes for children and families in the child welfare system.**
  - **Design a statewide PHP** that meets specialized requirements to care for children in foster care.
  - **Expand Fostering Health NC,** a current pilot program to improve outcomes for children and youth in foster care by strengthening medical homes.
  - **Extend coverage to parents of children in foster care** to increase the likelihood of successfully reuniting children with their families.

Demonstration Initiative #5:
Implement Capitation and Care Transformation through Payment Alignment

- **Capitation payments and incentives**
  DHHS will ensure provider-directed, value-based payments are part of PHP capitation payments to align PHP incentives with incentives for point-of-care providers.

- **Public and private safety net hospital payments**
  The demonstration proposes direct Medicaid uncompensated care payments to maintain supplemental payment funding levels while redirecting funds to transform care.

- **Delivery system reform incentive payment program initiatives**
  DHHS requests funding for delivery system reform incentive payment (DSRIP) program initiatives. Funds available for DSRIP program initiatives will be tied to reform projects for safety net providers, including public hospitals, private hospitals, local health departments and academic medical centers. These providers will be required to meet predetermined milestones to qualify for performance- and outcomes-based incentive payments related to these projects.

- **Workforce initiatives in underserved areas**
  DHHS will expand existing community-based residency programs to create additional and sustainable health care access for Medicaid beneficiaries. The focus will be on rural ambulatory care to advance the goal of higher-value health care to reduce long-term costs.

- **Tribal uncompensated care payments and alternative services**
  The demonstration includes funding to enhance and expand health services to Native Americans. A Tribal uncompensated care pool will be structured to fund payment for uncompensated care and payment to cover costs of nontraditional services for the Eastern Band of Cherokee Indians (EBCI) members, whether they opt to enroll in PHPs or remain in fee-for-service.

In summary, DHHS goals, as further described in this demonstration application, align fully with the Triple Aim: Improve the patient care experience, improve population health and contain per capita health care cost. DHHS will to go one step further by pursuing the Quadruple Aim: Triple Aim + Improved Provider Engagement and Support. By adding this fourth aim, DHHS will continue the tradition of collaboration with the medical community, other providers, beneficiaries and other stakeholders, innovating to meet North Carolina's health care needs.

2. Program Description

2.1. Rationale for the 1115 Demonstration

North Carolina is uniquely situated to serve as a laboratory of comprehensive and innovative health care transformation. The demonstration will advance population health and contain state and federal health care spending over the long term. The new endeavors described in the demonstration application are logical next steps in North Carolina's progression since the early 1990s toward a well-coordinated care partnership that leverages and supports community-based health care delivery systems.

North Carolina's Medicaid and NC Health Choice programs (Medicaid[1]) currently serve more than 1.9 million beneficiaries – covering 380,000 more people since 2013[2] – and engages with more than 80,000 participating providers. DHHS has a history of success with coordinated care models, including enhanced primary care case management and behavioral health managed care. DHHS is now pursuing measures to overcome Medicaid challenges that remain unresolved:

- **Payment for health services today is predominantly fee-for-service.** Medicaid will transition to a model that will reward better health and cost outcomes rather than quantity and intensity of services – value, not volume.
- **Medicaid operates largely according to a medical model.** DHHS must shift the program to a meaningful person-centered model that will emphasize prevention and health promotion with attention to social determinants of health, and coordinate long-term services and supports.
- **Accountability for costs and population health is too thinly distributed and therefore lacking**. DHHS will start partnering with organizations that have the scale, scope and resources to accept risk and be accountable for quality outcomes and costs.

This overhaul includes a transition of approximately $2 billion in annual Medicaid payments, which funds hospitals and physicians, and also local health departments and other providers that play a vital role in the North Carolina Medicaid and safety net health care system. This funding must stay in the system for DHHS to implement PHPs.

The demonstration will allow North Carolina to protect the financial underpinnings of the current Medicaid provider payments as DHHS creates a glide path to a capitated model. Delivery system transformation will be encouraged without unduly disrupting the Medicaid provider community.

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[1] For brevity, "Medicaid" will represent the Medicaid and NC Health Choice programs in this demonstration application, except when NC Health Choice needs to be specifically mentioned.

[2] https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/march-2016-enrollment-report.pdf

DHHS requests CMS to invest in and support Medicaid system-wide transformation goals through the authority provided under an 1115 demonstration. By doing so, CMS will help North Carolina ensure a smooth and seamless transition to prepaid health plans for beneficiaries and providers, to build person-centered health communities, to systematically integrate behavioral health, and to develop additional access for beneficiaries by investing in the state's health care workforce.

In making this transition, North Carolina cannot risk destabilizing provider networks and threatening access for Medicaid beneficiaries. North Carolina has a fiscal and programmatic imperative, plus a legislative mandate, to transform Medicaid into a new model that is sustainable. The demonstration will build on the state's history of innovation, which will lead to improved budget stability and better health for North Carolinians.

SL 2015-245 provides DHHS with 18 months following approval of this demonstration to implement reform. The time allotted demonstrates that Governor McCrory and the General Assembly are committed not to rush but to thoughtfully implement reform and seek ongoing stakeholder input on program design. This will smooth the transition for beneficiaries and providers. For the next few years (until the demonstration is approved by CMS and PHPs begin enrollment), Medicaid beneficiaries will receive services the same way they do now while DHHS invests the necessary resources into a well-planned transition for beneficiaries and providers.

2.2. 1115 Demonstration Overview

> *1) CMS Application Question - Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).*

North Carolina's Medicaid reform demonstration represents the culmination of three years of planning to accomplish the collective vision of Governor McCrory, the North Carolina General Assembly and stakeholders.

The demonstration builds on DHHS' and providers' record of shared success developing innovative programs that serve beneficiaries. A key indicator of effectiveness is that the vast majority of North Carolina primary care providers accept Medicaid and NC Health Choice.

At its core, the demonstration sets forth a plan to improve health care access, quality and cost efficiency for the growing population of Medicaid beneficiaries. Care delivery will be restructured using accountable, next-generation prepaid health plans. Payment will be redesigned to reward value and outcomes rather than volume. DHHS will continue moving toward true person-centered care that leverages community resources and data analytics.

2.2.1. Background and History of Innovation in North Carolina

In September 2015, the North Carolina General Assembly enacted SL 2015-245 (Appendix A) to transform and reorganize North Carolina's Medicaid and NC Health Choice programs. This legislation directed DHHS to redesign Medicaid to achieve four goals:

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

The new undertakings reflected in this demonstration are logical next steps in North Carolina's progression since the early 1990s toward a well-coordinated care partnership with providers that leverages and supports community-based health care delivery systems.

North Carolina has a well-established history of innovation in Medicaid, including:

- Our nationally acclaimed statewide **patient-centered medical home model** began in pilot counties in 1998 and continues to provide crucial support to DHHS programs. Over the years, the Community Care of North Carolina (CCNC) program expanded to 14 networks covering more than 1.4 million Medicaid beneficiaries. Early in the program development, state leaders and providers recognized that creating access to a medical home was important, and that additional community-based care support was needed to truly aid and manage the Medicaid population and set expectations for better health outcomes and cost containment.
- Thanks to North Carolina's successful program, CMS created a new category of PCCM entitled "**Enhanced Primary Care Case Management**" (ePCCM), enabling other states to support the infrastructure needed for population health management. This program design strengthens medical homes by enhancing primary care providers' ability to improve care and outcomes for patients with chronic illnesses through four new program elements: 1) community-based networks, 2) population management tools, 3) care management and clinical support for providers, and 4) data and analytics for providers.
- North Carolina launched several initiatives funded by CMS to improve specialty care and integration among programs and practices. DHHS views this demonstration as an opportunity to continue promoting CMS priorities while enhancing and expanding the medical home delivery model. These initiatives include:
    - **CHIPRA Quality Demonstration Grant Program**. A CMS grant funded through the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 that will improve the quality of care for children.

- **Child Health Accountable Care Collaborative**. A Center for Medicare & Medicaid Innovation (CMMI) grant for a pilot program that will improve the health and life quality of children with complex medical conditions through better care coordination.
- **Community Pharmacy Enhanced Services Network.** A CMMI grant to CCNC to develop a network of pharmacies that will provide enhanced services, such as synchronization of a patient's chronic medication fill dates, adherence monitoring and coaching, compliance packaging, and home delivery.
- **Medicare Shared Savings Program (MSSP)**. Many of North Carolina's MSSP accountable care organizations have specialty management initiatives for conditions that require specialty care, such as cardiovascular services, gastroenterology, and hip and knee replacements.
- **Practice Transformation Network.** A CMMI grant that will help primary and specialty clinicians achieve large-scale health transformation through peer supported comprehensive quality improvement strategies.
- **Independence at Home**. A CMMI initiative for medical practices that will test the effectiveness of delivering comprehensive primary care services at home and whether doing so improves care for Medicare beneficiaries with multiple chronic conditions.

- North Carolina has made advancements in the delivery of behavioral health services, and intellectual and developmental disability (I/DD) supports through the section 1915(b)/(c) concurrent waiver. The waiver authorizes DHHS to contract with quasi-governmental, local **behavioral health managed care organizations** (known as Local Management Entity-Managed Care Organizations (LME-MCOs or PIHPs) to coordinate behavioral health and I/DD services statewide under capitated payments. The LME-MCOs gained expertise in serving this population. At present, the LME-MCOs are enhancing partnerships with primary care and CCNC care managers, and are held accountable for ensuring that beneficiaries are connected to primary care. Some LME-MCOs have invested more of their managed care savings in primary care-behavioral health integration activities and developed new ways to partner with physical health care providers.
- Integrated behavioral health care, as defined by the Agency for Healthcare Research and Quality (AHRQ) Academy for Integrating Behavioral Health and Primary Care, is a high priority for North Carolina. Through state, Medicaid and philanthropic support, some health care practices over the years have **integrated behavioral health providers** into some primary care settings to address mild to moderate behavioral health conditions and to assist patients with lifestyle issues that contribute to physical illness or disease.

- North Carolina's statewide **telemedicine and telepsychiatry** coverage began in 1999. Consultative services are provided to a variety of settings across the state through well-established partnerships with tertiary centers and other specialty providers. Notably, the statewide telepsychiatry program (NC-STeP) serves hospital emergency departments across the state and provides psychiatric assessments and consultations to patients linked using telemedicine technologies in these emergency departments. DHHS efforts have been highlighted most recently at the White House National Convening on Rural Telehealth.
- Through a variety of programs, DHHS makes **rural health** a priority. North Carolina invests significantly in the outpatient safety net system that includes federally qualified health centers (FQHCs), rural health clinics and centers (RHCs), free and charitable clinics, local health departments, and school-based health centers. The DHHS Office of Rural Health assists these sites to ensure people have access to primary care services. In addition, many of the 384 outpatient safety net system sites provide integrated services that include behavioral health, dental care and pharmacy services, and are often the sole source of obstetrics care for pregnant women in rural areas. Conservatively, 1 million vulnerable residents rely on the outpatient safety net system.
- DHHS also has invested heavily in **growing the workforce to serve vulnerable populations**, including a $1.6 million state appropriation for recruitment (includes loan repayment incentives) of crucial provider types, including primary care physicians, nurse practitioners, physician assistants, dentists, psychiatrists and general surgeons, in underserved areas across the state. These providers are required to serve low-income and vulnerable populations in North Carolina, either in person or through telemedicine. Additionally, the NC Area Health Education Center (AHEC) has 18 community-based residencies. It is one of only two AHECs in the country with this program. These residencies have a much higher likelihood of graduating practitioners who will stay in North Carolina.
- DHHS is piloting new and evolving models of **community-based health care**, such as community paramedic pilot projects. In these pilots, paramedics function outside their customary emergency response and transport roles to facilitate more appropriate use of emergency care resources and enhance access to primary care for medically underserved populations.
- North Carolina **local health departments** (LHDs) provide residents of all 100 counties with a breadth of services that is distinctive to North Carolina. Many LHDs deliver comprehensive primary care, obstetrical care and dental services, with some serving as medical homes for Medicaid beneficiaries. LHDs provide prenatal care in 67 counties, 30 of which lack an obstetrician. LHDs play a crucial role in defining and responding to community-specific needs and, in addition to emergency rooms, provide a large portion of ambulatory care to indigent clients.

- DHHS **invests in North Carolina providers** and creates a health care climate that fosters innovation. North Carolina Medicaid has long been a laboratory for innovation and experimentation with new models of care. In addition, the NC Quality Center, a national leader in improving hospital quality of care, actively addresses broad quality issues in North Carolina hospitals. CMS has increased the health systems' and providers' level of sophistication with regard to care management, quality and data through Medicare accountable care organizations (ACOs), readmission penalties, and Medicare transition and chronic condition codes. This has laid the groundwork for the Medicare policy evolution, such as ACO development, which also drives Medicaid innovation.
- Medicaid **providers invest in North Carolinians**. The vast majority of North Carolina primary care providers accept Medicaid and NC Health Choice, and most private and public hospitals in the state now contribute funds through an array of assessments to increase resources available to address health care needs of uninsured and underinsured individuals. Of significance, North Carolina's ePCCM program includes about 1,900 practices with more than 6,500 practitioners. Approximately 90% of primary care providers and more than 90% of OB-GYNs who enroll in Medicaid and NC Health Choice actively participate in the ePCCM.

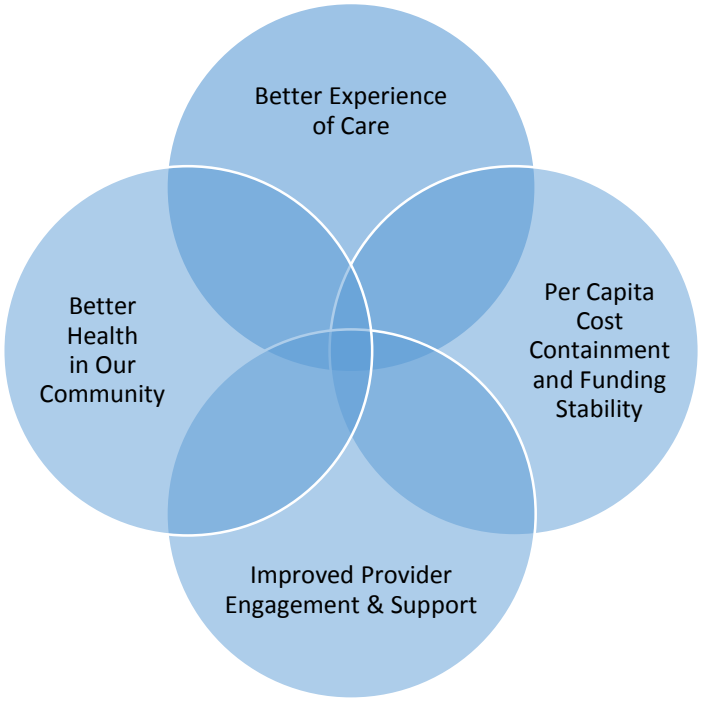
Thanks to these and many more efforts, Medicaid has already achieved a high degree of access and quality of care. North Carolina is proud of its broad-based provider participation, beyond the traditional safety net, in caring for the state's vulnerable populations. Going forward under the demonstration, DHHS plans to further transform Medicaid to a high-performing health care system with accountability for value and outcomes. This demonstration provides the opportunity to strengthen these programs in a coordinated way.

2.2.2. Demonstration Abbreviations and Acronyms

ACO	Accountable Care Organization	HCBS	Home and Community-Based Services
AHEC	Area Health Education Center	HEDIS	Health Effectiveness Data and Information Set
AHRQ	Agency for Healthcare Research and Quality	HIE	Health Information Exchange
APMH	Advanced Pregnancy Medical Home	I/DD	Intellectual/Developmental Disability
BH	Behavioral Health	IDEA	Individuals with Disabilities Education Act
CAP/C	Community Alternatives Program for Children	JLOC	Joint Legislative Oversight Committee on Medicaid and NC Health Choice
CAP/DA	Community Alternatives Program for Disabled Adults	LEA	Local Education Agency
CCNC	Community Care of North Carolina	LHD	Local Health Department
CDSA	Children's Developmental Services Agency	LME-MCO	Local Management Entity-Managed Care Organization
CFR	Code of Federal Regulations	LTSS	Long-Term Services and Supports
CHIP	Children's Health Insurance Program	MCAC	Medical Care Advisory Committee
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009	MCO	Managed Care Organization
CMMI	Center for Medicare and Medicaid Innovation	MSSP	Medicare Shared Savings Program
CMS	Centers for Medicare & Medicaid Services	N3CN	North Carolina Community Care Networks
CP	Commercial Plan	NC	North Carolina
CPESN	Community Pharmacy Enhanced Services Network	NC HIPP	NC Health Insurance Premium Payment Program
CYSHCN	Children and Youth with Special Health Care Needs	NCHTC	North Carolina Health Transformation Center
DHHS	North Carolina Department of Health and Human Services	PACE	Program of All-Inclusive Care for the Elderly
DMA	North Carolina Division of Medical Assistance	PCHC	Person-Centered Health Community
DME	Durable Medical Equipment	PCMH	Patient-Centered Medical Home
DSH	Disproportionate Share Hospital	PMPM	Per Member Per Month
DSRIP	Delivery System Reform Incentive Payment	PCS	Personal Care Services
DSS	Department of Social Services	PDL	Preferred Drug List
DY	Demonstration Year	PHP	Prepaid Health Plan
EBCI	Eastern Band of Cherokee Indians	PIHP	Prepaid Inpatient Health Plan
ED	Emergency Department	PLE	Provider-Led Entity
EG	Eligibility Group	QI	Quality Improvement
EMR	Electronic Medical Record	RFP	Request for Proposal
ePCCM	Enhanced Primary Care Case Management	RHC	Rural Health Center
FFS	Fee for Service	SFY	State Fiscal Year
FMAP	Federal Medical Assistance Percentage	SL	Session Law
FMS	Financial Management Services	SPMI	Severe and Persistent Mental Illness
FQHC	Federally Qualified Health Center	SUD	Substance Use Disorder
GME	Graduate Medical Education	VBP	Value Based Payment

2.3. North Carolina's Demonstration Goal: Achieving the Quadruple Aim

Our goals, as further described in this demonstration application, align fully with the Triple Aim to improve the patient care experience, improve population health and contain per capita health care cost. DHHS will go one step further by pursuing the Quadruple Aim—the Triple Aim + Improved Provider Engagement and Support.



Under the demonstration, DHHS will build on the North Carolina Medicaid tradition of innovation, community-based access and quality. DHHS will restructure care delivery in several ways: Use a hybrid model of risk-based health plans; launch the next generation of the medical home model through the plan for North Carolina PCHCs; and redesign payment to reward value and outcomes. Implementing SL 2015-245 to evolve programs, and improve value and quality outcomes is crucial for a Medicaid program that is currently 23% of the state budget.

This demonstration is organized into five overarching initiatives that create the framework for the demonstration to support the goals of the Quadruple Aim:

- **Demonstration Initiative #1:** Build a System of Accountability for Outcomes
- **Demonstration Initiative #2:** Create Person-Centered Health Communities (PCHCs)
- **Demonstration Initiative #3:** Support Providers through Engagement and Innovations
- **Demonstration Initiative #4:** Connect Children and Families in the Child Welfare System to Better Health
- **Demonstration Initiative #5:** Implement Capitation and Care Transformation through Payment Alignment

Our goals and initiatives are interconnected and mutually reinforcing to provide system-wide innovation for beneficiaries, communities and providers. Our proposed initiatives are designed to protect the stability of our providers for the benefit of our beneficiaries and to prepare for success in the reformed Medicaid model.

Alignment of North Carolina's 1115 Demonstration Initiatives in Support of the Quadruple Aim

	AIM 1: BETTER EXPERIENCE OF CARE	AIM 2: BETTER HEALTH IN OUR COMMUNITY	AIM 3: IMPROVED PROVIDER ENGAGEMENT AND SUPPORT	AIM 4: PER CAPITA COST CONTAINMENT AND FUNDING STABILITY
INITIATIVE 1 Build a System of Accountability for Outcomes	●	●	●	●
INITIATIVE 2 Create Person-Centered Health Communities (PCHCs)	●	●	●	●
INITIATIVE 3 Support Providers through Engagement and Innovations	●	●	●	◒
INITIATIVE 4 Connect Children and Families in the Child Welfare System to Better Health	◒	●	◒	●
INITIATIVE 5 Implement Capitation and Care Transformation through Payment Alignment	●	●	◒	●

● Initiative fully supports the aim

◒ Initiative partially supports the aim

2.3.1. Demonstration Initiative #1: Build a System of Accountability for Outcomes

North Carolina will execute this initiative through the following approaches:

- Next generation PHPs in a hybrid model
- PCHCs supported by PHPs
- Clinically integrated behavioral and physical health
- Providing long-term services and supports (LTSS) for Medicaid-only beneficiaries

2.3.1.1. Next Generation Prepaid Health Plans: A Hybrid Model

DHHS will contract with two types of PHPs (Medicaid managed care organizations under federal rules) on a capitated basis, using value-based purchasing principles to achieve demonstration goals. These PHPs will include PLEs, led by North Carolina providers, and other types of health plans generally operated by commercial managed care companies, referred to as commercial plans (CPs). **DHHS also is working with the Eastern Band of Cherokee Indians (EBCI) to develop a sub-regional Tribal managed care entity as an additional PHP choice for members of federally recognized tribes.**

Next Generation Prepaid Health Plans

Prepaid health plan (PHP)
Risk-based Medicaid MCO

Provider-led entity (PLE)
Local PHP led by North Carolina providers

Commercial plan (CP)
PHP operated by a commercial Medicaid MCO

Tribal prepaid health plan
PHP operated by the Eastern Band of Cherokee Indians

CPs are synonymous with traditional Medicaid managed care organizations (MCOs) that agree to incorporate North Carolina's standards for next-generation medical homes and value-based purchasing initiatives. PLEs are Medicaid MCOs that also incorporate these standards, but are local and provider led. PLEs are currently defined in SL 2015-245 as meeting the following criteria:

- A majority of the entity's ownership is held by an individual or entity that has as its primary business purpose the ownership or operation of one or more Medicaid and NC Health Choice providers.
- A majority of the entity's governing body is composed of physicians, physician assistants, nurse practitioners or psychologists.
- Holds a PHP license issued by the Department of Insurance.

DHHS intends to contract with three statewide PHPs and at least one PLE in each defined region of the state. Within each region, DHHS intends that participants will have a choice of PHPs, including a choice of PHP models. The presence of PLEs competing and operating side-by-side with CPs will achieve key goals of consumer choice, provider choice, provider-led innovation and cost containment.

DHHS and the EBCI are also working together to assess the viability of a sub-regional Tribal PHP (an Indian managed care entity under federal definition) as an additional PHP choice for members of federally recognized tribes.

North Carolina providers are leaders in innovation. Just as state provider health systems and physicians led in participation in Medicare's Shared Savings programs and Medicare Advantage, DHHS expects strong participation from the provider community in next generation PHPs. As DHHS works to create a North Carolina solution for Medicaid, it is mindful of opportunities to create greater alignment between Medicaid and Medicare initiatives, including Next Generation ACOs, and potentially position providers to qualify for the CMS Medicare Access & CHIP Reauthorization Act (MACRA) initiative to link quality to payments.

The hybrid approach of PLEs and CPs, coupled with standardized metrics and outcomes that drive improvement, measured by provider, practice, PHP, and regional and statewide, will yield key insights that DHHS needs. DHHS will learn from the models, ensure oversight, and gain an understanding of the best practices that both types of PHPs will use to serve beneficiaries.

PHPs will support and be held accountable for health outcomes and other performance results of North Carolina's advanced, comprehensive medical home model, PCHCs. PCHCs, in turn, will be responsible for community-based comprehensive care management spanning interventions for medical needs, clinical integration of behavioral health and primary care, assessment and appropriate interventions to impact social determinants of health, and supports to beneficiaries using LTSS to ensure all beneficiaries reach and maintain the highest level of health possible. The PCHC model is discussed in greater detail as a part of Initiative #2 in this demonstration.

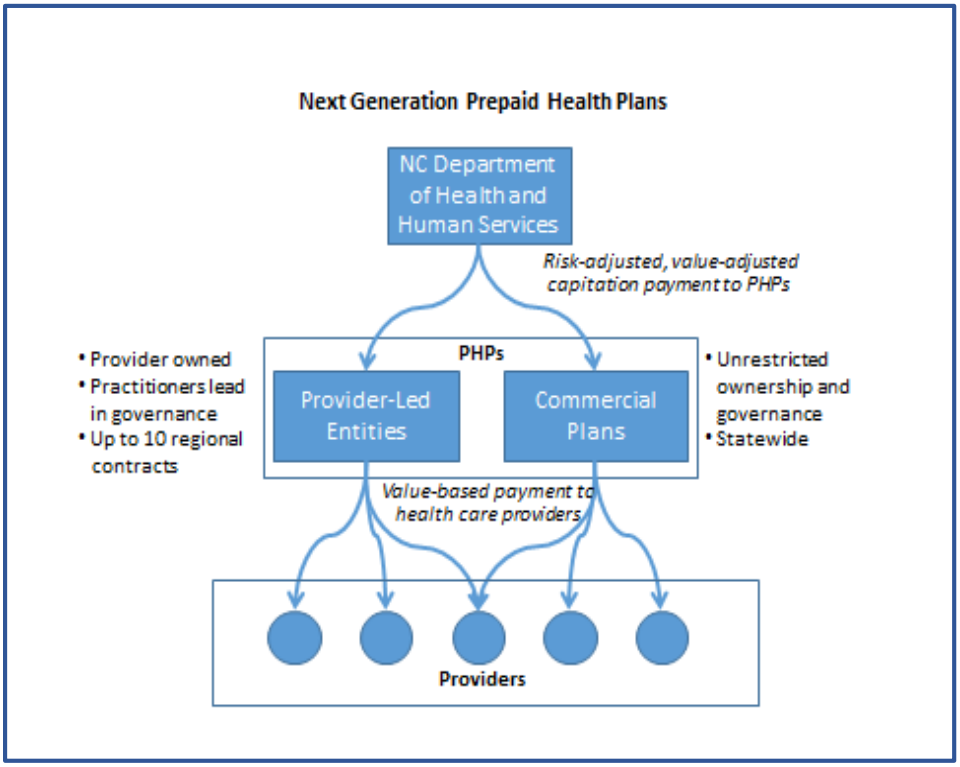
With approximately 71% of PHP members expected to be children, DHHS intends to focus on pediatric outcomes and pediatric-specific standards for accountability, including:

- Pediatric network adequacy standards that recognize family practitioners, pediatricians and pediatric sub-specialties, and the position that providers, such as school-based health centers, hold as important access points for children and teens.
- Network adequacy standards for pediatric primary and specialty care that take into consideration children with special health care needs and children with complex health conditions.
- Pediatric measures for quality that recognize the importance of preventive services.
- Contractual expectations that PHPs engage with communities through effective activities that address social determinants of health (e.g., housing and food insecurity) and improve outcomes for children. Examples of activities may include providing support services to homeless Medicaid beneficiaries to allow for housing stability, nutrition education and support, Reach Out and Read and other evidence-based programs.

DHHS will pay PHPs on a capitation basis. Capitation rates will be set following accepted conventions for actuarial soundness. Capitation rates will vary to take into account population risk factors and, if appropriate, geographic health cost variances. In addition, payments to PHPs may vary according to each plan's performance on quality measures for delivery of appropriate, evidence-based care; health outcomes of the membership and of groups of enrollees having specific chronic conditions; and enrollee and provider satisfaction.

DHHS will drive system change and improve health outcomes by applying performance metrics, and varying PHP and provider payment according to results. DHHS will establish a formal metrics and scoring group with representation of stakeholders and experts. The group will consider pre-existing measure sets, including the one recently issued jointly by CMS and the health plan industry; Medicaid HEDIS measures; and draft North Carolina Medicaid measures prepared during the reform planning phase.

To ease implementation, DHHS will prioritize measures already used by other programs, and will limit the number of measures. The metrics will be dynamic to foster continuous improvement. As PHPs and providers achieve goals, or as new health challenges emerge in the Medicaid population, DHHS will recommend new measures to replace ones no longer needed.



Going further, DHHS will contractually incentivize or require PHPs to incorporate value-based purchasing concepts into their methods for paying participating network providers. **Fundamentally, DHHS will transition to a system that pays not only for services, but rewards PHPs and providers for improving health outcomes while containing costs.**

PHPs will play a key role in implementing value-based payments (VBP) with providers, and using payment to drive down unnecessary and avoidable expenditures while rewarding outcomes. DHHS will require through PHP contracts that, over time, a preponderance of health spending be on a basis other than straight fee-for-service. Acceptable methods may include, but are not limited to, value-modified fee-for-service payments, bundled payments (payments for episodes of care), shared savings (based on total cost of care targets), incentive payments, quality-related payment withholds and sub-capitation. PHPs also will be encouraged to provide cost-effective alternative services, such as community paramedic programs, that may decrease costs and improve outcomes.

DHHS recognizes that changes of this magnitude take time and careful transition, and is committed to future engagement with stakeholders to identify approaches that consider provider and PHP capacity for change and PHP member impact.

2.3.1.2. Person-Centered Health Communities Supported by PHPs

North Carolina is committed to building upon the success garnered with the state's acclaimed ePCCM and PCMH models. Under the demonstration, DHHS will partner with PHPs to support and reward expansion and evolution to communities of care for beneficiaries. PCHCs are anchored on physical health, behavioral health and social determinants of health for beneficiaries.

Continuation and expansion of the medical home model will require ongoing support from DHHS through PHPs to existing patient-centered medical homes (PCMHs), focused on continued practice evolution and recruiting new providers and provider types to the medical home model of care delivery. As part of DHHS' commitment to continued support for PCMHs, DHHS intends to hold PHPs accountable for continuing funding for care management in primary care at levels similar to Medicaid's current investment. Funding will be included as part of actuarially sound capitation rates. PHP contracts will describe DHHS' expectations.

PHPs also will support and be held contractually accountable for quality outcomes of PCHCs. PCHCs, in turn, will drive community-based care transformation with a focus on beneficiary needs and care management. PCHCs will include interventions for beneficiary medical needs, behavioral health integration, appropriate interventions to impact social determinants of health, and supports to beneficiaries using LTSS. These care management interventions will focus on ensuring beneficiaries reach and maintain good health.

2.3.1.3. Clinically Integrated Behavioral and Physical Health

The clinical integration of behavioral health (encompassing mental health and substance use disorders) and primary care services is a priority for North Carolina. Behavioral health disorders contribute significantly to the cost of physical health care. To effectively manage costs and better serve beneficiaries, DHHS must clinically integrate physical and behavioral health in primary care settings for the general population, and clinically integrate primary care and specialty care for beneficiaries with severe and persistent mental illness (SPMI), or chronic or severe substance use disorders. Additionally, special populations, such as those with I/DD, benefit from the integrated delivery of services by providers knowledgeable about their distinct needs. North Carolina is committed to advancing efforts to create a health system that addresses the complex interaction of mind and body.

Enhanced Collaboration between Specialty Behavioral Health Care and Primary Care

DHHS continues to work toward integrating specialty behavioral health with primary care, albeit under separate payment systems. To manage behavioral health and I/DD, North Carolina has operated under section 1915 (b)/(c) concurrent waiver authority since 2005. This program started as a pilot in five counties and has been statewide since 2013. The 1915(b)/(c) program covers treatment and support services for people with mental illness, substance use disorders and I/DD.

LME-MCOs are required by contract to use the National Council on Behavioral Health's Four Quadrant Model to guide their close partnerships with CCNC care managers. LME-MCOs and CCNC care managers have established strong working relationships in every region of the state. In addition, the current combination of LME-MCOs and CCNC encourages local provider engagement, which has led to exploration of pilots and alternative funding models. These experiences will be further developed as part of the demonstration. Several LME-MCOs are reinvesting managed care savings to support the integration of physical health care. For instance, some are supporting primary care-behavioral health integration and others are offering provider training on integration of care.

The demonstration will build on the existing strengths of the LME-MCO system, which include strong clinical management; expertise in mental health, substance use disorders and I/DD; commitment to collaboration; and dedication to integrated care for beneficiaries with SPMI, or chronic or severe substance use disorders.

Primary Care-Behavioral Health Integration

In February 2010, DHHS approved the Behavioral Health Integration initiative under CCNC to support the integration of behavioral health services (mental health and substance use services) in primary care practices across North Carolina.

The program provides supports to primary care practices that become the medical home for those with higher mental health and substance use disorder needs, and coordinate with specialty care providers managed by the LME-MCOs. DHHS is instrumental in promoting a number of related innovations. They include addressing treatment of chronic pain; educating primary care practices related to behavioral health; offering tools for medication management for foster care children; expanding the use of motivational interviewing; demonstrating screening, brief intervention and referral to treatment for substance use; and promoting integrated primary care and behavioral care. However, full integration, described in the AHRQ Academy for Integrated Care's Lexicon for Behavioral Health and Primary Care Integration, is not sustainable for most primary care providers. Efforts have focused on either providing primary care practices with better resources to address behavioral health conditions, or partnering between LME-MCOs and CCNC care managers on care management for a subset of beneficiaries with the highest needs.

The stage is set for North Carolina to move toward more integrated, whole-person health care. With a modest amount of grant funding and support from CCNC and LME-MCOs, providers have shown their ability to increase access to primary care for beneficiaries with SPMI and substance use disorders; to better coordinate physical and behavioral health care; and to provide more comprehensive primary care services that include behavioral health support for the general population. LME-MCOs also have begun to invest in these areas, but have proceeded as far as possible without major realignment of payment systems. LME-MCOs only manage behavioral health and I/DD services, requiring needed flexibility to demonstrate unique solutions to enhance and fund these projects.

Under the demonstration, DHHS will work with PHPs, LME-MCOs, providers and other stakeholders to develop policy and pilot programs that better align services and payment to incentivize integration. For example, LME-MCOs could take on more responsibility for physical health care for beneficiaries with SPMI, chronic or severe substance use disorders, and I/DD. Primary care practices will take more responsibility for beneficiaries with mild-to-moderate behavioral health issues and build capacity to help people with behaviors that affect health. Some examples of potential pilot programs include:

- Promote primary care integration models that support behavioral health screening, inclusion of behavioral health supports in the primary care setting (licensed professional or behavioral health care manager), and coordination with the specialty behavioral health and I/DD system to address care needs of people with SPMI, substance use disorders and I/DD.
- Introduce multiple levels of behavioral health integration by primary care providers, with payment structured to support each level. This spectrum of integrated care services will be appropriate to the size and resources of the primary care provider.

- PHPs and LME-MCOs may partner to provide value-based purchasing arrangements with comprehensive mental health/substance use disorder provider agencies to enhance their capacity to address the physical health needs of beneficiaries with SPMI, or chronic or severe substance use disorders.
- Support I/DD practices to enhance their ability to provide primary care and support for beneficiaries with I/DD and their families, including through PCHCs.
- Enhance community-based behavioral health clinics and other integrated community options by increasing health accountability and outcome measurement.
- Give PHPs incentives and performance-based payments directly linked to behavioral health and I/DD outcomes; add incentives and performance-based payments to existing LME-MCOs that address physical health.
- Require the use of data analytics to improve outcomes for beneficiaries with substance use disorders, mental illness and I/DD.
- Pilot components of a special needs plan for beneficiaries with SPMI, chronic or severe substance use disorders, or I/DD.
- Establish a statewide collaborative through the NCHTC to advance innovation in behavioral health/physical health integration throughout the state.

2.3.1.4. Long-term Services and Supports for Medicaid-only Beneficiaries

DHHS proposes to operate this demonstration concurrently with North Carolina's approved Community Alternatives Program for Children and Disabled Adults (CAP/C and CAP/DA) section 1915(c) waivers to enable PHPs to provide LTSS for Medicaid-only beneficiaries. PHP contracts will include all state plan LTSS services, including institutional care, and the waiver services currently authorized through these two section 1915(c) waivers.

SL 2015-245 directs DHHS to exclude dual eligibles from the demonstration and to form a Dual Eligibles Advisory Committee to help develop a long-term strategy to cover dual eligibles through capitated PHP contracts. While DHHS plans for the implementation of LTSS for Medicaid-only beneficiaries, DHHS also will carefully plan for the potential inclusion of dual eligibles, including coordination with Medicare, consistent with DHHS' vision of person-centered care under the PHP contracts.

DHHS has greatly benefited from more than two years of stakeholder input that has helped shape our goals for the inclusion of state plan and waiver LTSS in PHPs, which include:

- Support and build a system that promotes consumer choice.
- Build upon the current system by ensuring continued access to facility-based services when necessary, and expanding the continuum of services and variety of settings in which to receive them.

- Promote use of enabling technology.
- Invest in service strategies that prevent, delay or avert the need for Medicaid-funded LTSS through appropriate upstream interventions.
- Recognize and bolster the key role family caregivers and other natural supports play in supporting beneficiaries with long-term care needs to delay or divert use of institutional services.
- Ensure that LTSS beneficiaries have access to, as needed, hands-on streamlined service coordination that is responsive to their clinical and social needs.
- Focus on care transitions and opportunities for early interventions related to transition planning.

All I/DD services currently provided through North Carolina's LME-MCOs will continue to be delivered through the LME-MCOs. However, as described in Section 2.3.1.3, DHHS will work with PHPs, LME-MCOs, providers and other stakeholders to develop pilot programs that incentivize primary care integration for beneficiaries with I/DD.

2.3.2. Demonstration Initiative #2: Create Person-Centered Health Communities

North Carolina seeks reforms through the following strategic initiatives:

- Transformation of Patient-Centered Medical Homes (PCMHs) and enhanced Primary Care Case Management (ePCCM) to Person-Centered Health Communities (PCHCs)
- Improve rural health access, outcomes, and equity

2.3.2.1. Transformation of Patient-Centered Medical Homes and Enhanced Primary Care Case Management to Person-Centered Health Communities

DHHS' future medical home model, the North Carolina PCHC, will build on the current infrastructure of well-documented population management, care management and transitional care performance to extend care management activities beyond the current PCMH and pregnancy medical home. The model will expand upon successful care management programs and include provider and PHP financial incentives through value-based payment.

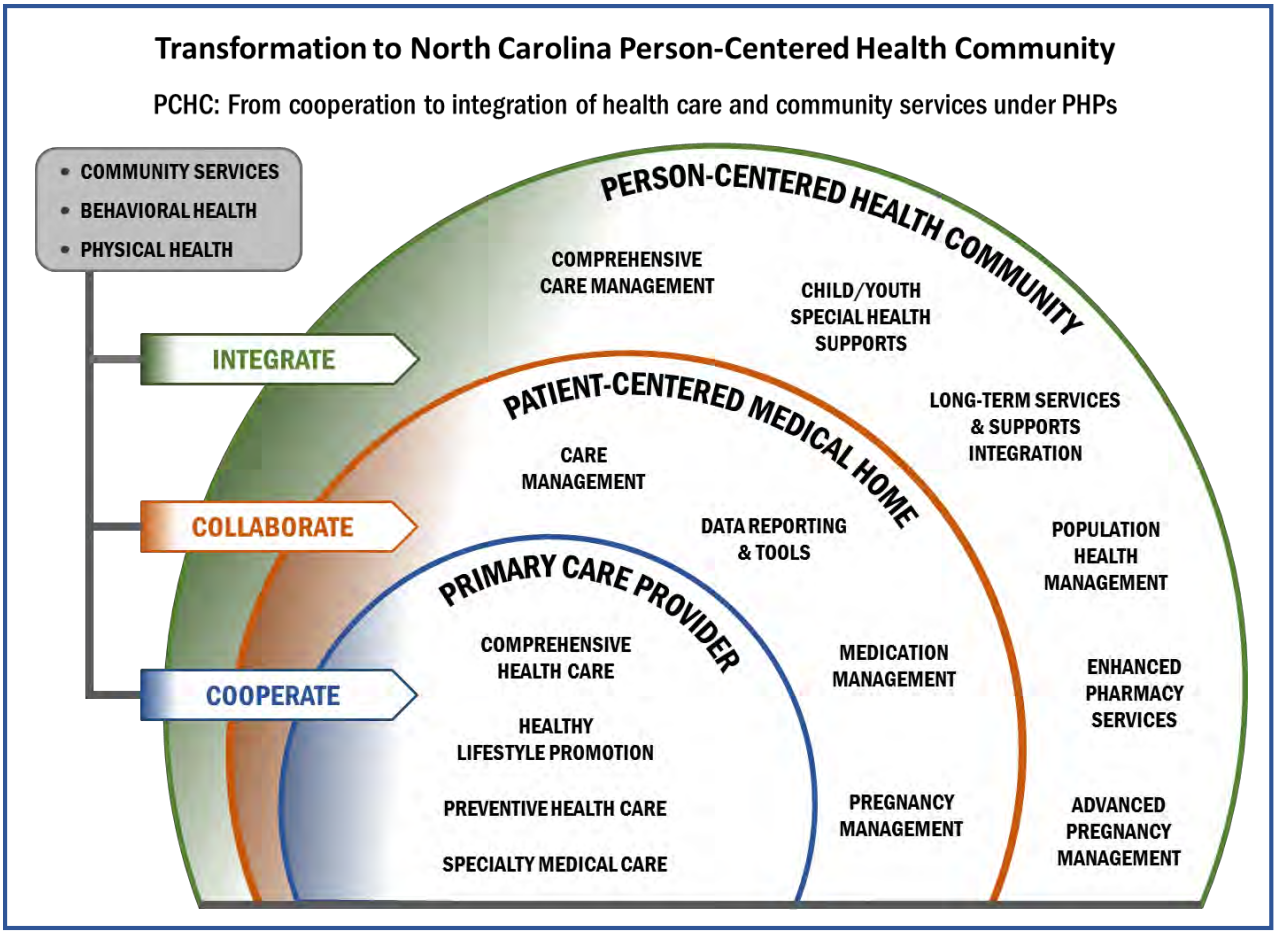
PCHC closely aligns with medical neighborhood concepts found in the AHRQ White Paper entitled "Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms."[3] The paper "conceptualizes the medical neighborhood as a PCMH and the constellation of other clinicians providing health care services to patients within it, along with

[3] Taylor EF, Lake T, Nysenbaum J, Peterson G, Meyers D. Coordinating care in the medical neighborhood: critical components and available mechanisms. White Paper (Prepared by Mathematica Policy Research under Contract No. HHSA290200900019I TO2). AHRQ Publication No. 11-0064. Rockville, MD: Agency for Healthcare Research and Quality. June 2011.

community and social service organizations and state and local public health agencies. Defined in this way, the PCMH and the surrounding medical neighborhood can focus on meeting the needs of the individual patient but also incorporate aspects of population health and overall community health needs in its objectives."

North Carolina PCHCs will leverage current ePCCM and PCMH programmatic features that are successful in North Carolina. PCHCs will expand and improve current programs. As part of PHP implementation, DHHS will ensure that similar payment levels for care management will be available to providers. Providing a medical home and health community for all beneficiaries along with coordinated care for those with complex conditions will allow intervention-based programs to promote the goal of maximizing health outcomes.

As the transition to PHPs evolves, DHHS will collaborate with stakeholders to develop PCHCs. In addition to working on the care management redesign, collaboration will focus on how to balance the need for standardization, similar to the current program, while allowing flexibility in innovation for PHPs and providers. Through these efforts, DHHS will encourage continued innovation and continuous quality improvement while planning, implementing and operationalizing PCHCs. The following illustration represents the transformation to PCHCs.



Key Features of PCHCs

DHHS will consider including the following PCHC features in PHP contracts:

Person-Centered Care

- Concentrated effort to ensure that beneficiaries are provided with appropriate support regarding their social determinants of health, coordinated linkages to needed public services, primary and specialty care; along with follow-up and ongoing planning.
- Beneficiaries will receive a health assessment, which may include an assessment of physical health, behavioral health, need for LTSS and social determinants of health.
- Beneficiaries with more complex or complicated needs will have a care plan and person-centered goals that are visible to care team members.
- Care plans will be exchanged electronically among the beneficiary's appropriate providers.
- The use of non-face-to-face encounters, such as telemedicine, will be incentivized as appropriate, when it improves access, outcomes and efficiency of care.
- Beneficiaries will have a choice of primary care provider.
- Beneficiary experience is measured annually.
- Case management is performed at the local community level.

Population Health Management

- Population health management will be embedded within the PCHC and will leverage health care data to help manage the health care of the demonstration populations.
- Provider's electronic medical record will be connected to the state's HIE/informatics platform.
- Health assessment data will feed the population management platform. Comprehensive health assessment includes social determinants of health data, which will support the person-centered approach to ensure that beneficiary needs are identified and connections are made.
- Quality measures will be reported through provider-facing population management reporting tools.

Provider, PHP and Community Driven

- Recognize variation in providers' readiness to perform the array of PCHC functions and to assume accountability for outcomes and cost through VBP arrangements.

- Enable providers lacking the internal capabilities to engage in the evolution of the current model to perform PCHC functions in a variety of ways with PHPs or other supportive arrangements.
- Engage the community to drive PCHC objectives.
- Provide the opportunity for certain specialty providers to assume primary care responsibilities for specialized cases, as appropriate.

The PCHC model will support beneficiary access to care, interdisciplinary team-based care, special population needs, continuous quality improvement and population health management to better serve Medicaid beneficiaries in their communities. Active management and coordination of specialty services will be enhanced, particularly for children with complex medical diagnoses and children in foster care. Other innovations may be developed, including the use of community health workers and home nursing visitation during pregnancy.

Through contracts, DHHS will require that PCHCs, PHPs, and LME-MCOs work together to ensure integration of medical care needs for beneficiaries participating in the 1915(b)/(c) behavioral health waiver.

Key Specialty Person-Centered Programs in the PCHC

Advanced Pregnancy Medical Home (APMH)

- APMH will be embedded in PCHCs and will provide obstetrical supports for pregnant women including risk screening (physical health and behavioral health), pregnancy care management for high-risk patients, and advancing evidenced-based practices to obstetric providers.
- APMH aims to improve infant mortality, perinatal costs, low birth weight rate, C-section rates, breast feeding rate at 6 months and post-partum visit rates.

Enhanced LTSS Integration

- Provide PCHC supports for all CAP/C and CAP/DA beneficiaries.
- Perform targeted annual LTSS screenings to capture pre-LTSS populations.
- Support use of enabling technologies.
- Each LTSS beneficiary will receive an annual LTSS comprehensive evaluation and coordination for therapies, durable medical equipment, personal care services and non-medical LTSS supports for non-waiver recipients.

Independence at Home

- Providers within PCHCs that meet Independence at Home practice requirements will provide home-based primary care to targeted chronically ill beneficiaries with the goal of continued living at home.
- Beneficiary's care will be monitored using appropriate quality and outcome measures.

Supports for Children and Youth with Special Health Care Needs

- Enhance the medical home for children and youth with special health care needs.
- Support practices to enhance their ability to provide primary care and support for all children and youth with special health care needs.

Community Pharmacy Enhanced Services Network (CPESN)

- CPESN pharmacies provide enhanced pharmacy services that go beyond conventional prescription dispensing and basic patient education, including interventions such as synchronization of patient's chronic medication fill dates, adherence monitoring and coaching, compliance packaging, and home delivery.
- Pharmacies also will offer community pharmacy care management services in close collaboration with the medical homes and their care management supports to engage in continuous care plan development and reinforcement.

Clinically Integrated Behavioral and Physical Health

- Integrate physical and behavioral health into the primary care settings for Medicaid beneficiaries.
- Clinically integrate primary care and specialty care for beneficiaries with SPMI and/or chronic or severe substance use disorders.
- Implement primary care integration models that support routine behavioral health screening, integration of behavioral health supports in the primary care setting (licensed professional or behavioral health care manager), and coordinate with specialty behavioral health and I/DD system to address care needs of beneficiaries with SPMI, SUD and I/DD.

Improved Specialty Care for Complex Beneficiaries

- Focuses on joint comprehensive care management with PCP, transitional care, community living, LTSS, targeted disease/population health initiatives and interventions.
- Identifies and assists in providing needs-based beneficiary supports; e.g. collaborative care plans for the family, community supports and assistive technology supports.

2.3.3.2. Improve Rural Health Access, Outcomes and Equity

DHHS strives to address the needs of beneficiaries and other vulnerable populations to access primary care, behavioral health, specialist care, emergency and public health services. Healthy People 2020[4] provides that access to health care is important for an individual's overall physical, social and mental health status, in particular to prevent and slow disease progression,

[4] https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services

detect and treat illnesses, avoid preventable death and increase life expectancy. Health disparities or inequities occur when individuals are prevented from attaining optimal health and are often a result of socio-economic differences, impacts of social determinants of health, and limited access to necessary health care services.

Of the 100 counties in North Carolina, 70 are rural. DHHS has long been instrumental in expanding the availability and accessibility of health care capacity in rural areas. Through these programs, DHHS promotes greater health equity for rural citizens. DHHS developed rural health programs that continue to thrive today and are successful in recruiting primary care and other crucial workforce providers to rural areas.

DHHS will use the demonstration as an opportunity to enhance rural health programs through collaborative partnerships among DHHS, PHPs and providers, and continued development of the PCHC model of health care delivery. These partnerships will build on the successes of existing DHHS programs and will use tools such as value-based payment structures, telemedicine/ telepsychiatry and robust data analytics to expand upon the existing primary and specialty care rural infrastructure. They will provide disruptive technologies to improve access and delivery of health care services. DHHS will improve the exchange of necessary member health information to reduce redundant care, enhance timeliness of care, and improve overall coordination of care. Through these strategies, DHHS will successfully deliver on the Quadruple Aim.

- PCHC structures will include pregnancy medical homes that focus on improving outcomes related to infant mortality, which is higher in rural areas. Incentivizing and improving access to pregnancy medical homes will address the health of women before, during and after pregnancy. Appropriate prenatal care and inter-conception care – care that addresses a woman's health care choices between pregnancies – will directly influence the health and well-being of infants. Additionally, programs that support new parents or single mothers work to create supportive communities that can welcome children into healthy families.
- Broadening telemedicine can improve access to behavioral health care and will support primary care providers who often must render specialty services beyond their means.

As the PCHC model spreads, rural primary care providers will benefit from improved connections with specialists for patient referrals and from streamlined exchange of requisite member health information that will improve overall care coordination across the system.

2.3.3. Demonstration Initiative #3: Support Providers through Engagement and Innovations

Historically, DHHS brought together the best in health care and innovation to create a partnership between the health care community and beneficiaries in medical homes. With this demonstration, DHHS will pioneer the development of person-centered health communities to once again lead the nation in caring for North Carolina's neediest population. This initiative will include:

- Provider administrative ease in PHP contracts
- Practice supports for quality improvement
- NC Health Transformation Center
- Health Information Exchange
- Statewide informatics layer
- Strengthening the safety net
- Community residency and health workforce education

2.3.3.1. Provider Administrative Ease in PHP Contracts

North Carolina recognizes the provider community as a vital partner in driving the success of Medicaid transformation efforts. One of the guiding principles in development of PHP contracts is to minimize administrative burden and disruption to providers. PHPs also must offer supports needed to drive the success of the new delivery system. For example:

- Consistent with SL 2015-245, all PHPs will be required to use the DHHS preferred drug list.
- DHHS prompt pay requirements for PHPs will be consistent with the standards for commercial insurers. DHHS proposes to require PHPs to process clean claims within 30 calendar days and, after an initial transition period, pay 18% interest if they do not meet that timeframe.
- DHHS will adopt a uniform credentialing process, including a standardized application and a centralized verification process.
- DHHS will develop a comprehensive set of performance measures to evaluate the system, PHPs and providers. Providers will be held accountable for meeting a common set of performance measures, when appropriate. These measures should be the same across PHPs and aligned with other payers, as applicable.

- DHHS will work with PHPs to standardize the approach to provide practice supports (for example, population management tools, clinical toolkits and quality improvement coaching) to be consistent across PHPs and minimize disruption to provider practices.
- DHHS supports an approach to care management that will create consistency across PHPs and practices, support innovation and excellence at the PHP and practice levels, and minimize burden on providers.

DHHS will work with stakeholders to enhance HIE capacity, connectivity and functionality, and provide consistent statewide informatics functions.

2.3.3.2. Practice Supports for Quality Improvement

To support the evolution of PCMHs to PCHCs, emphasis on practice supports is essential. Minimizing disruption to individual providers and practices is a strategic focus for DHHS in the transition to PHPs. Physical health providers currently interact with one Medicaid entity, CCNC, for practice supports, care management and data/reporting. DHHS recognizes current ePCCM activities as crucial to the success of existing medical homes and intends for them to continue under the new program as part of the responsibilities of the PHPs or DHHS (e.g., through the NCHTC). DHHS' philosophy is to standardize the approach to providing practice supports when needed while supporting innovation and excellence at the provider and PHP level.

To ensure continued high provider engagement – which translates to access for beneficiaries – minimized administrative burden and standardized processes are key objectives during and after transition to PHPs.

Practice support will help accelerate implementation of a next generation medical home, the PCHC model of care. To date, providers have received supports including help with gaining PCMH recognition from the National Committee for Quality Assurance; development, distribution and use of population management tools and clinical toolkits; quality measure reporting with peer comparison; quality improvement coaching; behavioral health integration; electronic medical record implementation; and workflow analysis. As noted above, DHHS intends for these supports to continue under the new program.

Ongoing Quality Improvement and Performance Assessment

The following provides an initial framework for activities focused on provider supports to ensure ongoing quality improvement (QI) and performance assessment:

- PCHCs will engage in ongoing QI, moving through five stages of practice transformation set by CMS and achieving the Quadruple Aim.

- The PCHC model will include a common quality measure data set aligned with Health Effectiveness Data and Information Set (HEDIS), Medicaid Adult and Child Core Measures, and Physician Quality Reporting System (PQRS). The measures will be selected based on specific clinical priorities for North Carolina.
- PCHCs will report on measures encompassing acute care, chronic disease care, specialty care and preventive care across pediatric, adult and obstetric populations.

In addition to these activities, DHHS will include the planning of additional HIE and practice support programs into the work that will be done through the collaboration between stakeholders and the NCHTC.

2.3.3.3. North Carolina Health Transformation Center

SL 2015-245 directed DHHS to form a transformation innovations center – the North Carolina Health Transformation Center (NCHTC) – to assist providers and PHPs to achieve the ultimate goals of better health and better care for North Carolinians, better provider and clinician engagement, and predictable costs for the state. The General Assembly instructed DHHS to use the Oregon Health Authority's Transformation Center as a design model for NCHTC and to consider certain features. In addition to Oregon's center, DHHS reviewed transformation organizations in Arkansas, Delaware, Oklahoma and Pennsylvania.

DHHS proposes the following preliminary NCHTC roles and capabilities. These features are based on lessons from the states reviewed and an assessment of the current innovations structure and initiatives across North Carolina, goals for successful Medicaid reform, and an analysis of technology impacts and considerations related to Medicaid reform:

- Performance and analytics measurement (for example, to identify leading practices and measure PHP performance).
- Stakeholder engagement to spread innovations and system improvements.
- Support center capabilities, such as provider and PHP access to collaborations and technical assistance as they transition to value-based payments; PCHC development assistance; and provider and PHP liaison services with the community, patient advocacy groups and other agencies.
- Center of excellence capabilities on strategic program development and oversight, which may include workforce development, innovation pilots, financial resources, best practices for providers, and learning and sharing conferences for providers.
- Tools for use with providers, PHPs and the community to nurture and drive innovations and systems improvement (e.g., data analytics tools, stakeholder engagement tools and clinical data sharing mechanisms).

DHHS' legislative report on the NCHTC is included in Appendix D.

2.3.3.4. Health Information Exchange (HIE)

Robust HIE development is a crucial component of the DHHS Medicaid reform strategy. The North Carolina General Assembly, in SL 2015-241, Section 12.5(a)-(g), established a state-managed Health Information Exchange Authority to oversee and administer the NC Health Information Exchange Network. The Authority, as of Feb. 29, 2016, assumed operation of the NC HIE, a secure, standardized electronic system where providers share and view real-time patient health information.

By February 2018, all Medicaid providers are to be connected to the NC HIE network. No later than June 2018, providers involved with other state-funded health programs must be connected. This broad connectivity across North Carolina will greatly facilitate efforts to support coordination of care and lead to improved health outcomes for Medicaid beneficiaries and other patients across the state.

The Authority will have an advisory board, whose members include representation from the North Carolina provider community and health care data experts, the Secretary of Health and Human Services and Secretary of the Department of Information Technology, and the Director of the North Carolina Government Data Analytics Center. The advisory board will help guide the vision, mission and direction of NC HIE as the state looks to increase its utility to the provider community and those responsible for the management of health programs, such as Medicaid.

The Authority will work with public and private stakeholders to enhance the capacity of NC HIE. The initial focus will be expanding the connectivity of providers and, therefore, the statewide availability of medical records, including allergies, laboratory results, medications, vitals and encounter data; and a bidirectional connection to the statewide immunization registry across all care entities. Future plans include chronic and specialized disease registries and analytics, and developing connections to behavioral health providers, nursing homes and pharmacies.

2.3.3.5. Statewide Informatics Layer

With a standardized set of broad health care data developed, DHHS will be well positioned to enhance data analytics capacities for the total person. Collaborating with private and public partners, North Carolina envisions using comprehensive population health management tools to combine clinical and administrative claims data to better manage patient care, improve health outcomes and more efficiently direct resources to meet health care needs of its citizens. Efforts under this sub-initiative include:

- All providers cooperate in sharing data and care plans to optimize coordination and continuity of care for beneficiaries across geographies and over time.
- Consistent infrastructure for coordinated care team management of beneficiaries with complex needs.

- Statewide, provider-facing utility for data exchange and population health analytic services.
- Provider-facing tools to incorporate clinical data from NC HIE, claims data from PHPs, public health data such as immunizations, and data on social determinants of health.
- Mechanisms for engaging and supporting providers in underserved areas to succeed under value-based payments.
- Common performance metrics for LME-MCOs and PHPs for specified populations, aligning incentives for cooperative innovations.
- Explore integrating performance on broader measures of public health and social determinants of health (e.g., education, housing, food insecurity and corrections) to align incentives for innovative collaboration across key health and social determinants sectors.

2.3.3.6. Strengthening the Health Care Safety Net

Strengthening the outpatient safety net, which includes FQHCs, RHCs, LHDs, and free and charitable clinics, will improve access to essential high quality and cost-effective primary medical care and preventive services in rural and underserved communities. DHHS' goal is to maintain and enhance the current safety net infrastructure that serves the state's most vulnerable populations. Pivotal to this is high quality, cost-effective primary care that, in many settings, also may include integrated behavioral health, dental health, pharmacy, care management and other enabling services. The safety net system is crucial to North Carolina's vulnerable and underserved populations:

- **Safety net infrastructure serves over 1 million North Carolinians, representing 10% of the population.** Of the 1 million residents who depend on these providers for primary and secondary care, approximately 32% are Medicaid beneficiaries.
- **One in five North Carolinians, including over a half million Medicaid beneficiaries, live in a rural county.** Rural populations are more likely to live in poverty, and have co-occurring chronic diseases and lower life expectancy than individuals living in non-rural areas.

Designated by DHHS as an "essential provider," safety net providers, including FQHCs, RHCs, LHDs, free clinics (per SL 2015-245) and veterans' homes (which DHHS proposes to designate as an essential provider), will negotiate in good faith with PHPs. DHHS will use the Medicaid essential provider designation to secure a place for safety net and rural health community providers in the PHP networks and will preserve FQHC/RHC payment rates through direct, wrap-around payments from Medicaid. DHHS also is seeking to extend direct, wrap-around payments to limited types of additional safety net providers, including local health departments, public ambulance providers and state facilities through the demonstration.

This will allow North Carolina to engage in system redesign necessary to migrate Medicaid payments to risk-based capitation. This approach builds on current federal Medicaid safeguards for FQHCs and RHCs by extending payment methodology to these additional providers to support their transition into PHP networks.

2.3.3.7. Community-Based Residency and Health Workforce Education

DHHS will work to expand programs that will reduce long-standing health workforce shortages in North Carolina's rural and underserved communities. The state has made sizeable state-only financial investments to support increased access through recruitment, loan repayment, community grants, AHEC residency and new community-based graduate medical education. In addition, DHHS wants to expand the Health Resources and Services Administration (HRSA) investment in several Teaching Health Centers' Graduate Medical Education payment programs and pediatric/family medicine residencies in North Carolina.

Evidence shows that community-based education programs, built on best practices, expand the vital health care workforce, which ensures Medicaid beneficiaries will have greater access to essential services. North Carolina is investing to redesign the health system to ensure the state has the appropriate team-based workforce needed to succeed in the changing health care environment. These investments will be enhanced through this demonstration. DHHS will support and create community-based residency programs that promote essential workforce training with a primary focus on ambulatory and preventive care that advance the goals of higher-value health care that reduces long-term costs.

To expand these existing programs, DHHS is requesting federal match for state-only funds that may be appropriated to support and build community-based residency programs. With federal funds though the demonstration, these community-based residency programs may offer an opportunity to develop team-based training to create the future workforce to integrate into PCHCs. Future advanced training programs for workforce growth might include fellowships for nurse practitioners, physician assistants, therapists, substance use counselors, care managers and other members of the health care workforce.

In addition, DHHS is requesting federal match for existing state-only funded community-based AHEC, Teaching Health Centers Graduate Medical Education and new community-based residencies to receive additional payments for the services they provide to Medicaid beneficiaries, much like Graduate Medical Education payments to academic centers.

2.3.4. Demonstration Initiative #4: Connect Children and Families in the Child Welfare System to Better Health

In partnership with county Departments of Social Services (DSS), DHHS has identified several opportunities for enhancing outcomes for the children and families served by the child welfare system. North Carolina plans to implement the following strategic initiatives to improve outcomes for those children and families:

- Designate a statewide PHP for children in foster care
- Expand Fostering Health NC
- Extend coverage to parents of children in foster care

2.3.4.1. Designate a Statewide PHP for Children in Foster Care

DHHS will choose one statewide PHP to provide specialized services to foster care children, but will continue to offer a choice of PHPs to this population. Under this option, DHHS will:

- Develop requirements for a PHP for children served by the foster care program;
- Select the statewide PHP (of the three statewide PHPs) that is most qualified to provide services to children and youth in foster care;
- Require the selected PHP to comply with specialized requirements for this population, including provider network and training requirements; and
- Hold that PHP accountable for providing high-quality, coordinated care specifically tailored to these children.

Parents (or the county DSS) will select from among all PHPs serving the applicable region, but there will be one plan tailored to this population. Thus, a county DSS could choose the designated plan for all or most of the children in its custody, which would reduce the county DSS' administrative burden. Additionally, children and youth enrolled in the designated plan will not need to change PHPs when they move across regions. This will greatly enhance the continuity of their care.

DHHS is considering whether to also include children in adoptive placement and children receiving in-home services as part of this option.

2.3.4.2. Expand Fostering Health NC

Fostering Health NC began as one pilot under a CMS Children's Health Insurance Program Reauthorization Act (CHIPRA) grant awarded to DMA. Fostering Health NC is focused on building and strengthening medical homes for children and youth in foster care through integrated communications and coordination of care through a partnership among the county DSS office, primary care practice's team, care manager, school, child and the child's family.

Fostering Health NC is transitioning to a statewide program and is currently jointly funded by DHHS and the Duke Endowment. It is focused on improving health outcomes for children and youth in foster care. This effort, which is led by the North Carolina Pediatric Society, is working to ensure every child in foster care has a medical home and that services meet standards recommended by the American Academy of Pediatrics and the Child Welfare League of America for health care for children in foster care, and standards developed by Fostering Health NC such as "Best Practice for Medication Management."

A medical home is particularly important to foster and adopted youth because the health care provided prior to and during their time in care is often fragmented, which exacerbates their already high health care needs. Frequent check-ups help identify and treat issues early, mitigating the negative effects of their trauma. A medical home also is important when these children and youth experience a change in placement as it can further help caregivers to act to prevent a medical or behavioral health crisis. DHHS will work with Fostering Health NC and its partners to identify methods to maintain and expand this program with PHPs and PCHCs.

An important component of Fostering Health NC is the ability of county DSS directors to access Medicaid beneficiary information through the CCNC Informatics Center provider portal. DHHS, across multiple divisions, addressed privacy laws to facilitate the exchange of information, which is operationalized using the Technology Enabled Care Coordination Agreement (TECCA). This gives the care team contact information, office visit and hospital stay histories, current and past medications (along with information on whether/where prescriptions were filled), and immunization records. County DSS use this information to fill information gaps, coordinate care and identify potential problems early. DHHS will maintain county DSS access to these types of data and will address this feature as part of the transition.

2.3.4.3. Extend Coverage to Parents of Children in Foster Care

When child maltreatment has been identified, but does not necessitate the removal of the child from the home, Medicaid services are provided to the family to improve behaviors and conditions that may have led to the maltreatment. Often this includes the provision of comprehensive health services. When efforts to prevent removal are unsuccessful or unsafe, the child may require foster care services, and parents may lose Medicaid eligibility. Foster care is a temporary living arrangement and, in most cases, the plan is to reunify the child to preserve the family unit. DHHS strives to ensure that parents are provided with appropriate and effective comprehensive health services, including behavioral health and substance use disorder services, to increase the likelihood of successful reunification of the child and family.

Thus, DHHS is proposing to the NC General Assembly and CMS to allow parents to retain their Medicaid eligibility while their children are being served temporarily by the foster care program. This will promote the overall health of children, families and communities, and potentially avert long-term costs to Medicaid.

2.3.5. Demonstration Initiative #5: Implement Capitation and Care Transformation through Payment Alignment

DHHS must gradually, and carefully, evaluate the historical state, public and private provider investment in Medicaid through base payments, assessments, intergovernmental transfers and certified public expenditures, and transition this financing to a new model centered on value-based capitation payments to PHPs. This overhaul includes a transition of approximately $2 billion in annual Medicaid payments—funding not just for hospitals and physicians but also for local health departments and other providers that play a vital role in North Carolina's Medicaid and safety net health care system. This is funding that must stay in the system for DHHS to implement PHPs. The demonstration will allow North Carolina to protect the financial underpinnings of the current Medicaid provider payments as DHHS paves a path to a capitated model. Delivery system transformation will be encouraged without unduly disrupting the Medicaid provider community.

To ensure a smooth and seamless transition for beneficiaries and providers to PHPs, build PCHCs, systematically integrate behavioral health, and improve access for beneficiaries by investing in the state's health care workforce, DHHS is asking CMS to invest in and support system-wide transformation goals through the authority provided under an 1115 demonstration. In making this transition, North Carolina cannot risk destabilizing provider networks and threatening access for Medicaid and NC Health Choice beneficiaries.

North Carolina proposes a solution that includes direct Medicaid uncompensated care payments[5], the creation of delivery system reform incentive payment (DSRIP) programs, and direct or directed value-based payments to providers. This strategic set of funding streams will:

- Drive care improvements and functional reforms to advance the Quadruple Aim.
- Ensure vital funding for Medicaid beneficiaries and other purposes remains intact.
- Provide a smooth transition to ensure system and provider stability.

Our Care Transformation through Payment Alignment proposal (also described under Payments in Section 6) includes:

- **Capitation payments and incentives**
  DHHS will call for provider-directed, value-based payments to be made as part of the PHP capitation payments, so that PHP incentives are aligned with incentives for point-of-care providers.
- **Public and private safety net hospital payments**
  The demonstration proposes direct Medicaid uncompensated care payments to maintain supplemental payment funding levels while redirecting funds to transform care.

[5] Medicaid uncompensated care payments in this context include both payments for Medicaid uncompensated care and uninsured uncompensated care payments.

- **Delivery system reform incentive payment (DSRIP) program initiatives**
  DHHS is requesting funding for DSRIP program initiatives. Funds available for DSRIP program initiatives will be tied to reform projects for safety net providers including public hospitals, private hospitals, local health departments and academic medical centers. These providers will be required to meet predetermined milestones to qualify for performance and outcomes-based incentive payments related to these projects.
- **Workforce initiatives in underserved areas**
  DHHS will expand the existing community-based residency programs with the goal of creating additional and sustainable health care access for Medicaid beneficiaries. The focus will be on rural ambulatory care to advance the goals of higher-value health care to reduce long-term costs.
- **Tribal uncompensated care payments and alternative services**
  This proposal includes funding to enhance and expand health services to Native Americans. A tribal uncompensated care pool (100% FMAP) will be structured to provide payment for uncompensated care and payment to cover costs of nontraditional services for EBCI members, regardless of whether they opt to enroll in PHPs or remain in fee-for-service.

The state's DSH funding and hospital graduate medical education funding will remain outside of the demonstration.

2.4. Demonstration Hypotheses and Evaluation Plan

North Carolina will assess the implementation and impact of Medicaid transformation by evaluating the system transformation as a whole using the Quadruple Aim as the foundation of the evaluation. The evaluation will be supported by the DHHS plan to use standardized metrics including performance measures, quality improvement, access to care, value-based payments, population health outcomes and informatics infrastructure including the HIE. The experience and engagement of beneficiaries and providers will be included as key components of the evaluation.

North Carolina expects that the proposed changes in financing and delivery will lead to improvements in population health and in the quality of care provided to Medicaid beneficiaries. In the demonstration, DHHS will focus on a core set of outcomes, incentivize providers in a meaningful way, and continually introduce new initiatives and incentives when existing goals are achieved. DHHS will drive significant and broad-based improvements to the health care of North Carolina beneficiaries. DHHS will work with an evaluator to refine hypotheses and evaluation plan as program design evolves.

2.4.1. The Hypotheses

The state will develop an evaluation design for the demonstration to test the following research hypotheses through the demonstration:

1. Our hybrid model of PLEs and CPs (including a Tribal PHP) will create a diverse proving ground where lessons can be evaluated against the Quadruple Aim.
2. Building on North Carolina's current system of PCMHs and ePCCM, PCHCs will drive the primary care integration model by: supporting coordinated access to specialty care; providing routine behavioral health screening, diagnosis and management; coordinating social and home-based services; and coordinating with the DHHS specialty behavioral health system to achieve integrated health goals.
3. By requiring outcome and performance measures, and tying measures to meaningful financial incentives for PHPs and providers, DHHS will improve health care quality and improve beneficiary and provider experience and satisfaction.
4. Improved supports for children in foster care – statewide expansion of Fostering Health NC and designating a PHP for children in foster care – will ensure continuity of care and reduce unnecessary health care expenditures through dedicated and coordinated care management during the child welfare experience for children in foster care and their families. In addition, continuation of Medicaid eligibility (especially to provide behavioral health services) for parents of children temporarily removed from the home will result in shorter length of foster care episodes. Shorter length of out-of-home placement will reduce Medicaid expenditures for services during foster care service provision and Medicaid eligibility for the former foster children after reaching age 18, up to age 26.

2.4.2. Draft Evaluation Questions

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

- Which of the measures of outcomes or performance show the most improvement and are there any meaningful differences in the performance of commercial plans to provider-led entities?
    - Access to primary care
    - Access to specialist care
    - Equity of rural health care
    - Population health
    - Experience of beneficiaries
    - Experience and engagement of providers
- Which of the following components of the North Carolina PCHC demonstrate a direct correlation to improved health outcomes for Medicaid and NC Health Choice beneficiaries?
    - Advanced pregnancy medical home
    - Integrated LTSS for Medicaid-only individuals
    - Physical and behavioral health screening
    - Children and youth with special health care needs (CYSHCN)
    - Community pharmacy enhanced services network (CPESN)
    - Interventions to impact social determinants
    - Ongoing quality improvement and performance assessment at PHP and/or provider levels
    - Value-based payment and primary care incentives
    - Supports and services to providers
- Which demonstration value-based models show a correlation to better health outcomes for beneficiaries and/or practice transformation success?
- Does continuity of Medicaid eligibility for parents of children placed in foster care reduce length of stay in foster care, and avert long-term costs to Medicaid?

2.4.3. Data Sources

To support the evaluation, DHHS will leverage existing data collection and informatics assets (including baseline access reviews required by CMS for Medicaid fee-for-service) and use HIE to gather additional data to begin integrating clinical data with administrative claims data. Further, DHHS intends to incorporate external sources of data, as needed, to gain insight into system performance. Clinical information from HIE will be integrated with administrative claims data from the PHPs and DHHS' fiscal agent. Specialized information sources (e.g., national research or niche sources) will augment that data to support the creation, monitoring and dissemination of performance and quality metrics and measures.

The creation of integrated data and a comprehensive set of analytics tools will be used to support the operational aspect of managing the delivery of Medicaid for the state (e.g., provider supports, performance and quality metrics and measures) and a platform for identifying trends, forming and testing hypotheses, and modeling and monitoring innovation.

2.5. Demonstration Location and Timeframe

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

The demonstration will operate statewide.

> *5) Include the proposed timeframe for the Demonstration*

Jan. 1, 2018 through Dec. 31, 2022.

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

No. The demonstration will not modify the state's current Medicaid and CHIP programs outside of eligibility, benefits, cost-sharing, or delivery systems.

3. Demonstration Eligibility

1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration:

Except for parents of children in foster care, all affected groups derive their eligibility through the Medicaid state plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan. All Medicaid eligibility standards and methodologies for these eligibility groups remain applicable.

Exhibit 1 - State Plan Eligibility Groups Enrolled in the Demonstration

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Mandatory State Plan Groups		
Low Income Families (Parents/Caretaker Relatives)	1931 42 CFR 435.110	45% of FPL
Transitional Medical Assistance	408(a)(11)(A) 1931(c)(2) 1925 1902(a)(52)	185% of FPL
Extended Medicaid due to Child or Spousal Support Collections	408(a)(11)(B) 42 CFR 435.115 1931(c)(1)	No income test
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care	1902(a)(10)(A)(i)(I) 473(b)(3) 42 CFR 435.145	No income test
Former Foster Care Children up to Age 26	1902(a)(10(A)(i)(IX)	No income test
Qualified Pregnant Women and Children	42 CFR 435.116 1902(a)(10)(A)(i)(III) 1905(n)	45% of FPL
Mandatory Poverty Level Related Pregnant Women	1902(a)(10)(A)(i)(IV) 1902(l)(1)(A)	196% of FPL
Mandatory Poverty Level Related Infants	1902(a)(10)(A)(i)(IV) 1902(l)(1)(B)	210% of FPL
Mandatory Poverty Level Related Children Aged 1-5	1902(a)(10)(A)(i)(VI) 1902(l)(1)(C)	210% of FPL
Mandatory Poverty Level Related Children Aged 6-18	1902(a)(10)(A)(i)(VII) 1902(l)(1)(D)	133% of FPL
Deemed Newborns	1902(e)(4) 42 CFR 435.117	Automatically eligible
Individuals Receiving SSI	1902(a)(10)(A)(i)(II)(aa) 42 CFR 435.120	Automatically eligible
Individuals Who Are Essential Spouses	42 CFR 435.131 1905(a)	SSI standard (Closed to new enrollment)

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Institutionalized Individuals Continuously Eligible Since 1973	42 CFR 435.132	SSI standard (Closed to new enrollment)
Blind or Disabled Individuals Eligible in 1973	42 CFR 435.133	SSI standard (Closed to new enrollment)
Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972	42 CFR 435.134	SSI standard (Closed to new enrollment)
Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April, 1977	1939(a)(5)(E) 42 CFR 435.135 Section 503 of P.L. 94-566	SSI standard
Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI	1634(b) 42 CFR 435.137	100% of FPL
Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	42 CFR 435.138 1634(d)	100% of FPL
Working Disabled under 1619(b)	1902(a)(10)(A)(i)(II) 1905(q) 1619(b)	200% of FPL
Disabled Adult Children	1634(c)	SSI standard
Optional State Plan Groups		
Children with Non-IV-E Adoption Assistance	1902(a)(10)(A)(ii)(VIII) 42 CFR 435.227	Applicable children's group
Independent Foster Care Adolescents	1902(a)(10)(A)(ii)(XVII) 1905(w)	No income test
Children under 21 Not Receiving Cash	1902(a)(10)(A)(ii)(I) – (IV) 1905(a)(i) 42 CFR 435.222	45% of FPL
Families Who Would Qualify for Cash if Requirements Were More Broad	1902(a)(10)(A)(ii)(III) 42 CFR 435.223 1905(a)	45% of FPL
Optional Poverty Level Related Pregnant Women and Infants	1902(a)(10)(A)(ii)(IX) 1902(l)(2)	196% of FPL
Individuals Eligible for but not Receiving Cash	42 CFR 435.210 1902(a)(10)(A)(ii)(I) 1905(a) 1902(v)(1)	Applicable cash group
Poverty Level Aged or Disabled	1902(a)(10)(A)(ii)(X) 1902(m)(1)	100% of FPL
Certain Women Needing Treatment for Breast or Cervical Cancer	1902(a)(10)(A)(ii)(XVIII) 1902(aa)	250% of FPL

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Ticket to Work Basic Group	1902(a)(10)(A)(ii)(XV)	150% of FPL for unearned income Enrollment fee if countable income above 150% of FPL Enrollment fee plus premium if income above 200% of FPL Full buy-in if income above 450% of FPL
Ticket to Work Medical Improvements Group	1902(a)(10)(A)(ii)(XVI)	150% of FPL for unearned income Enrollment fee if above 150% of FPL Enrollment fee plus premium if income above 200% of FPL Full buy-in if income above 450% of FPL
Individuals Eligible for Family Planning Services	1902(a)(10)(A)(ii)(XXI) 42 CFR 435.214	195% of FPL
Added Population		
Parents of foster care children	NA	45% of FPL

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

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

Exhibit 2: Groups Excluded from Enrollment in PHPs and the Demonstration

Group Name	**Social Security Act and CFR Citations**
Qualified Medicare Beneficiaries	1902(a)(10)(E)(i) 1905(p)
Qualified Disabled and Working Individuals	1902(a)(10)(E)(ii) 1905(s) 1905(p)(3)(A)(i)
Specified Low Income Medicare Beneficiaries	1902(a)(10)(E)(iii) 1905(p)(3)(A)(ii)
Qualifying Individuals	1902(a)(10)(E)(iv) 1905(p)(3)(A)(ii)
Medically Needy Pregnant Women	1902(a)(10)(C)(ii)(I) 42 CFR 435.301(b)(1)(i) and (iv)
Medically Needy Children under 18	1902(a)(10)(C)(ii)(I) 42 CFR 435.301(b)(1)(ii)
Medically Needy Children Age 18 through 20	42 CFR 435.308 1902(a)(10)(C)
Medically Needy Parents and Other Caretaker Relatives	1902(a)(10)(C) 42 CFR 435.310

Group Name	**Social Security Act and CFR Citations**
Medically Needy Aged	1902(a)(10)(C) 42 CFR 435.320 and 435.330
Medically Needy Blind	1902(a)(10)(C) 42 CFR 435.322 and 435.330
Medically Needy Disabled	1902(a)(10)(C) 42 CFR 435.324 and 435.330
Medically Needy Blind or Disabled Individuals Eligible in 1973	42 CFR 435.340 (Closed to new enrollment)
Presumptively Eligible Pregnant Women	1902(a)(47) 1920
Individuals dually eligible for Medicare and Medicaid	Various
Individuals participating in the Program of All-Inclusive Care for the Elderly (PACE)	Various
Individuals receiving Refugee Medical Assistance	45 CFR Part 400
Individuals participating in the NC Health Insurance Premium Payment (HIPP) program	Various
Individuals with limited or no Medicaid coverage (e.g., eligible for emergency services, or individuals receiving presumptive eligibility)	Various

2) Describe the populations that will participate in the Demonstration.

Except as noted below for parents of children in foster care, there are no changes to Medicaid and NC Health Choice (CHIP) eligibility under the demonstration. Standards for eligibility are set forth under the Medicaid and CHIP state plans. Except as provided below, participation in the demonstration will be mandatory for all Medicaid eligibility categories, including the aged, blind and disabled, and beneficiaries enrolled in NC Health Choice (CHIP). The Medicaid and CHIP state plan and 1915(c) waiver populations will be affected by the demonstration through the proposal to require enrollment in capitated prepaid health plans (PHPs) to receive most Medicaid, CHIP and section 1915(c) waiver services.

Beneficiaries dually eligible for Medicare and Medicaid, including those in categories limited to Medicare cost sharing programs will not be enrolled in the demonstration. As directed by SL 2015-245, DHHS will form a Dual Eligibles Advisory Committee to develop a long-term strategy to cover dual eligibles through capitated PHP contracts.

Beneficiaries enrolled in PACE, North Carolina's Health Insurance Premium Program (HIPP), and individuals enrolled in Medicaid for emergency services only will not be included in the demonstration. Medically needy beneficiaries and expenditures for periods of presumptive eligibility also will be excluded from the demonstration.

Beneficiaries enrolled in LME-MCOs under North Carolina's existing section 1915(b)/(c) waivers will be included in the demonstration and enrolled in PHPs. The demonstration does not impact eligibility or enrollment in LME-MCOs. See question 4 in this section for more details.

DHHS consulted with EBCI, North Carolina's only federally recognized tribe, and supports its request that members of federally recognized tribes will be included in the demonstration but will not be required to enroll in PHPs. Members may voluntarily enroll in PHPs on an opt-in basis and may disenroll without cause at any time.

Medicaid Eligibility for Parents of Children in Foster Care

DHHS seeks to ensure that certain parents, who otherwise would have been eligible for Medicaid under existing rules if their children had not been placed in foster care, get appropriate health coverage, including for mental health and substance use disorder services. The goal is to increase the likelihood of successful reunification of the children and family. Thus, DHHS proposes to allow parents to retain their Medicaid eligibility while their children are being served temporarily by the foster care program. This will promote the overall health of children and families, and communities. DHHS will request guidance from CMS to determine whether waiver or expenditure authority is required under the demonstration.

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

When determining whether an individual is eligible, North Carolina will apply the same eligibility standards and methods as those articulated in the Medicaid and CHIP state plans, with no changes. As noted above, North Carolina will seek technical assistance from CMS to determine whether continuation of Medicaid eligibility for parents of children in foster care (up to the existing parent caretaker income limit) will be determined to be a change to eligibility under the demonstration.

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

With the exception of parents of children in foster care, DHHS is not proposing any population expansions in this application. As noted above, North Carolina will seek guidance from CMS to determine whether continuation of Medicaid eligibility for parents of children in foster care will be determined to be a change to eligibility under the demonstration. If so, DHHS is not proposing any enrollment limits.

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

Assuming approval by Jan. 1, 2018, DHHS projects approximately two million beneficiaries will be eligible for the demonstration. These projections are based on current state programs, including beneficiaries enrolled in NC Health Choice and North Carolina's section 1915(c) waivers. Beneficiaries with section 1915(c) waiver services to be included in the demonstration (excluding dual eligibles) are described below:

- Community Alternatives Program for Children (CAP/C) and Community Alternatives Program for Disabled Adults (CAP/DA): Approximately 3,600 Medicaid-only beneficiaries. These beneficiaries will be included in the demonstration to receive their state plan and section 1915(c) CAP waiver services through mandatory enrollment in PHPs.
- Beneficiaries enrolled in the North Carolina section 1915(b)/(c) concurrent waivers also will be included in the demonstration for the purpose of mandatory enrollment in PHPs. Per SL 2015-245, all 1915(b)/(c) waiver services provided through North Carolina's LME-MCOs will continue to be delivered through the LME-MCOs. The demonstration will promote clinical integration of behavioral health services and physical health care.

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

The demonstration does not impact post-eligibility treatment of income. North Carolina will continue to operate its section 1915(c) waivers. Please see Appendix B in the approved section 1915(c) waiver applications.

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

Not applicable. DHHS is not proposing any such changes in eligibility procedures.

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

Not applicable.

4. Demonstration Benefits and Cost Sharing Requirements

4.1. Benefits and Cost Sharing

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

____ Yes __X__ No (if no, please skip questions 3 – 7)

All services provided under the demonstration derive their coverage from North Carolina's Medicaid and CHIP state plans and existing section 1915(c) waivers.

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

- LME-MCO (prepaid inpatient health plan) services (applies to Medicaid, not NC Health Choice beneficiaries)
- Dental services (fluoride varnish provided by non-dental providers is included in the demonstration)
- Program of All-Inclusive Care for the Elderly (PACE)
- Local education agency (LEA) services
- Children's Developmental Services Agency (CDSA) services

Indian health/tribal providers will not be required to be part of PHP networks. Members of federally recognized tribes who opt to enroll in PHPs will be able to access Indian health/tribal providers on an out-of-network basis without authorization from the PHP.

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

- CAP/C
- CAP/DA

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

Beneficiaries enrolled in the North Carolina 1915(b)/(c) concurrent waivers will be included in the demonstration to receive non-waiver Medicaid state plan services through the PHPs. As required by SL 2015-245, all 1915 (b)/(c) concurrent waiver services currently provided through North Carolina's LME-MCOs will continue to be delivered through the LME-MCOs. The demonstration will focus on clinical integration of LME-MCO services and physical health care.

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

____ Yes _X_ No (if no, please skip questions 8 - 11)

Cost-sharing requirements will be the same regardless of whether the benefits are delivered under the state plan or the demonstration.

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

Not applicable.

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

___ Federal Employees Health Benefit Package

___ State Employee Coverage

___ Commercial Health Maintenance Organization

___ Secretary Approved

Not applicable.

5) In addition to the Benefit Specifications and Qualifications form, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan.

No chart completed. Benefits are the same under the demonstration and the state plan and approved 1915(c) waivers.

4.2. Long-Term Services and Supports

6) Indicate whether long-term services and supports will be provided.

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

___ No

Except for PACE, all state plan LTSS for the Medicaid-only population will be delivered through the demonstration. 1915(b)/(c) concurrent waiver services will not be included under the demonstration, as those services will continue to be delivered by North Carolina's LME-MCOs.

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

- CAP/C
- CAP/DA

For demonstration participants, all services approved under these CAP waivers will be delivered through the demonstration and coverage authority for these home- and community-based waiver services will continue to be derived from the section 1915(c) waivers. The 1115 demonstration will provide the authority for these services to be delivered through capitated PHPs. **There are no changes in the demonstration to the state plan or waiver benefits that beneficiaries eligible for LTSS, including the CAP/C and CAP/DA waivers, receive today. The demonstration changes only the delivery system to enable these services to be delivered through capitated PHPs.**

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

Not applicable as authority for LTSS services will be derived from the state plan and section 1915(c) waivers, not the 1115 demonstration.

- ☐ Homemaker
- ☐ Case Management
- ☐ Adult Day Health Services
- ☐ Habilitation – Supported Employment
- ☐ Habilitation – Day Habilitation
- ☐ Habilitation – Other Habilitative
- ☐ Respite
- ☐ Psychosocial Rehabilitation
- ☐ Environmental Modifications (Home Accessibility Adaptations)
- ☐ Non-Medical Transportation
- ☐ Home Delivered Meals Personal
- ☐ Emergency Response
- ☐ Community Transition Services
- ☐ Day Supports (non-habilitative)
- ☐ Supported Living Arrangements
- ☐ Assisted Living
- ☐ Home Health Aide
- ☐ Personal Care Services
- ☐ Habilitation – Residential Habilitation

- ☐ Habilitation – Pre-Vocational
- ☐ Habilitation – Education (non-Individuals with Disabilities Education Act of 2004 Services)
- ☐ Day Treatment (mental health service)
- ☐ Clinic Services
- ☐ Vehicle Modifications
- ☐ Special Medical Equipment (minor assistive devices)
- ☐ Assistive Technology
- ☐ Nursing Services
- ☐ Adult Foster Care
- ☐ Supported Employment
- ☐ Private Duty Nursing
- ☐ Adult Companion Services
- ☐ Supports for Consumer Direction/Participant Directed Goods and Services
- ☐ Other (please describe)

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

___ Yes (if yes, please address the questions below)

_X_ No (if no, please skip this question)

Premium assistance through NC HIPP will continue outside the demonstration.

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

b) Include the minimum employer contribution amount.

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

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

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

There are no changes to cost-sharing provisions already approved in the state plan.

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

Not applicable.

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

Not applicable.

5. Delivery System and Payment Rates for Services

5.1. Prepaid Health Plans

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

_X_ Yes

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

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

DHHS will contract with prepaid health plans (PHPs) on a capitated basis, utilizing value-based purchasing principles to achieve desired goals in the Quadruple Aim. These PHPs will include entities known as provider-led entities (PLEs), led by North Carolina providers, and commercial managed care companies, or commercial plans (CPs). **All PHPs, including PLEs and CPs, will be Medicaid managed care organizations as defined by the federal government in 42 CFR 438.2. All PHP members will be afforded the protections provided under the federal rules for Medicaid MCOs at 42 CFR 438, including (but not limited to) information requirements, grievance and appeals, and access to family planning services.**

When successful, the presence of PLEs existing side by side with CPs will achieve key goals for consumer choice, provider choice, and provider-led innovation. Currently, North Carolina has several successful ACOs developed throughout the state in partnership with the CMS Center for Medicare & Medicaid Innovation. We expect the provider community will continue to innovate in Medicaid as the PHP models are established.

Introducing new models of choice for both beneficiaries and providers in Medicaid and NC Health Choice is one of DHHS' top priorities. This hybrid approach, coupled with standardized metrics and outcomes designed for North Carolina's program – measured on a provider, PHP, regional, and statewide basis – will yield the insight DHHS needs to compare the models, ensure oversight, and understand how both types of PHPs are serving beneficiaries.

At the same time, DHHS will address the financial underpinnings of the current Medicaid provider payments to provide a glide path to a capitated model in which provider innovation is encouraged, but disruption to the Medicaid safety net is minimized.

The state expects the proposed delivery system and financing reforms will lead to improvements in health status and in the quality of care provided to Medicaid and NC Health Choice beneficiaries, while containing costs and achieving high levels of provider satisfaction.

North Carolina will implement the reforms statewide. Please see responses #4-6 below and Sections 3 and 4 for populations affected by the demonstration.

DHHS is working with EBCI to develop a sub-regional Tribal managed care entity as an additional PHP choice for members of federally recognized tribes, as well as supplemental payments for uncompensated care and for alternative services for tribal members who opt to enroll in PHPs or remain in fee-for-service Medicaid. DHHS supports these proposals and will continue to work with the EBCI to explore these options. See DHHS' response to EBCI in Appendix C.

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

_X_ Managed care

_X_ Managed Care Organization (MCO)

- ☐ Prepaid Inpatient Health Plans (PIHP)
- ☐ Prepaid Ambulatory Health Plans (PAHP)

☐ Fee-for-service (FFS) (including Integrated Care Models) Primary Care Case Management (PCCM)

☐ Health Homes

Other (please describe)

With the exception of members of a federally recognized tribe, North Carolina 1115 demonstration participants will mandatorily enroll in capitated PHPs (MCOs as defined in 42 CFR 438.2). Within each region, DHHS' intent is that participants will have a choice of PHPs, including a choice of PHP models.

CPs are synonymous with traditional Medicaid MCOs that agree to incorporate North Carolina's standards for next-generation medical homes and value-based purchasing initiatives. PLEs are Medicaid MCOs that also incorporate these standards, but are local and provider led. PLEs are currently defined in SL 2015-245 as meeting the following criteria:

- A majority of the entity's ownership is held by an individual or entity that has as its primary business purpose the ownership or operation of one or more Medicaid and NC Health Choice providers.
- A majority of the entity's governing body is composed of physicians, physician assistants, nurse practitioners, or psychologists.
- Holds a PHP license issued by the Department of Insurance.

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

All demonstration enrollees will receive services included in the demonstration through a single delivery system that uses capitated PHPs (federal MCOs). Demonstration enrollees who are enrolled in LMEs/MCOs for behavioral health, substance use, and intellectual and developmental disability (I/DD) services will continue to receive those services through the existing capitated section 1915(b)/(c) concurrent waiver program administered by LME-MCOs. LME-MCO services are not included in the demonstration, but a focus of the demonstration will be coordination between the LME-MCOs and the PHPs, and integration of LME-MCO services and physical health services.

DHHS intends to set specifications for one of the statewide PHPs to serve foster care children, so that a single statewide PHP is available to coordinate the complex needs of these children. All PHPs in a region will be available for enrollment, but one statewide PHP will be designated as being the most qualified to serve this population.

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

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

Except as noted below, enrollment in PHPs will be mandatory for all Medicaid eligibility categories, including the aged, blind and disabled, and beneficiaries enrolled in NC Health Choice (CHIP). Beneficiaries dually eligible for Medicare and Medicaid, including those in categories limited to Medicare cost sharing programs, will be excluded from PHPs and not enrolled in the demonstration. As directed by the authorizing legislation, SL 2015-245, DHHS will form a Dual Eligibles Advisory Committee to devise a long-term strategy to cover dual eligibles through capitated PHP contracts.

Beneficiaries enrolled in PACE, the NC Health Insurance Premium Payment Program (NC HIPP) and those enrolled in Medicaid for only emergency services will not be enrolled in PHPs and will not be included in the demonstration. Medically needy beneficiaries also will be excluded from PHPs and the demonstration. Individuals in a period of presumptive eligibility will be excluded from the demonstration. All periods of retroactive eligibility for beneficiaries included in the demonstration will be excluded from the PHP contracts, but included in the demonstration.

DHHS consulted with EBCI, North Carolina's only federally recognized tribe, and supports its request that members of federally recognized tribes will be included in the demonstration but will not be required to enroll in PHPs. Members may voluntarily enroll in PHPs on an opt-in basis and may disenroll without cause at any time.

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

Managed care through PHPs will be statewide.

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

DHHS is planning statewide implementation of PHPs within 18 months of CMS approval of the demonstration, as required by SL 2015-245. This ample lead time for implementation will obviate the need for a phased rollout.

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

As noted above, it is DHHS' goal that demonstration participants will have a choice of PHP models, including at least three statewide PHPs and at least one regional PLE. It is DHHS' intent to contract with no fewer than four PHPs in each region (where membership is sufficient), thus ensuring choice of PHPs (MCOs) in each region. Moreover, choice will be ensured even if one or two PHPs in a region should cease operations.

Development of access and availability standards is a key design component of the PHP program, and the ability of a PHP to meet those access standards will be a crucial milestone in DHHS' determination that a PHP is ready to enroll beneficiaries. DHHS will carefully consider model network requirements, and requirements from other states and stakeholder input when finalizing North Carolina's standards according to the 2016 final Medicaid managed care rule. DHHS will continually monitor and evaluate access and availability, and will revise the standards as necessary to ensure beneficiaries have timely access to covered services.

The access and availability standards may vary for rural versus metropolitan/urban areas, and will be informed, in part, by the baseline access reviews required by the federal Medicaid FFS access rule, which became effective Jan. 4, 2016. Given the rural nature of a large portion of the state, North Carolina has already implemented telemedicine and telepsychiatry solutions to address unmet needs. DHHS is interested in exploring the continued role of telemedicine and telepsychiatry in meeting access gaps and availability in geographic regions where results of the FFS access monitoring review plans determine certain provider types or specialty capacity are not as robust as they could be.

DHHS also will designate certain providers as "essential providers" for PHP networks, including FQHCs, RHCs, LHDs, free and charitable clinics and veterans' homes. PHPs must make a good faith effort to contract with all essential providers.

Importantly, DHHS will comply fully with the May 2016 final Medicaid managed care rules to *develop, monitor and enforce* network adequacy standards for services including primary care, specialty care, OB/GYN, behavioral health, hospital, pharmacy and LTSS. Many of these services will have separate adult and pediatric standards established in the PHP contracts. While these standards have not yet been set, DHHS has begun discussion about the important role that essential providers and other providers – such as pediatric primary and specialty care providers, school-based health centers, Ryan White providers, critical access hospitals and others – will have in PHP networks to begin informing these standards. DHHS also will perform network adequacy readiness reviews prior to beneficiary enrollment in PHPs.

DHHS also may incorporate additional standards such as appointment availability and office waiting time.

In formulating the standards, DHHS will take into consideration potential competition between PLEs and CPs to ensure all PHPs are appropriately incented when it comes to developing networks that are viable and aligned with DHHS' transformational goals. Some of these related standards include rate floors, antitrust protections and good faith negotiations.

Regardless of whether a beneficiary selects a statewide PHP or a regional PLE, all PHP enrollees will have access to adequate provider networks. Regional plans and statewide plans will have networks adequate to meet the needs of their enrollees, even if some providers, of necessity, are located outside of regional boundaries.

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

DHHS will select PHPs through a competitive solicitation. As noted above, it is DHHS' goal that demonstration participants will have a choice of PHP models. It is DHHS' intent to contract with no fewer than four PHPs in each region (where membership is sufficient), thus ensuring choice of PHPs (MCOs) in each region.

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

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

- **LME-MCO services.** LME-MCO (PIHP) services covered under the concurrent 1915(b)/(c) waivers were excluded from PHP contracts in the authorizing legislation until four years after the date capitated PHP contracts begin.

- **Dental services.** Dental services were excluded from the PHP contracts in the authorizing legislation. (Fluoride varnish applied by non-dental providers will be provided under the demonstration.)
- **PACE.** PACE is a separate, capitated delivery system from the PHP model and will remain an option for qualifying individuals.
- **LEA services.** LEA services for Medicaid beneficiaries are provided according to Part B of the Individuals with Disabilities Education Act (IDEA) and funded via certified public expenditures, making a transition to capitated PHPs difficult and potentially disruptive to the delivery of these services.
- **CDSA services.** CDSA services for Medicaid beneficiaries are provided according to Part C of IDEA and funded by certified public expenditures, making a transition to capitated PHPs difficult and potentially disruptive to the delivery of these services.
- **NC HIPP.** Premium assistance through NC HIPP will continue outside the demonstration.

Indian health/tribal providers will not be required to be part of PHP networks. Members of federally recognized tribes who opt to enroll in PHPs will be able to access Indian health/tribal providers on an out-of-network basis without authorization from the PHP.

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

- CAP/C
- CAP/DA

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

5.2. Long-Term Services and Supports

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

_X_ Yes
___ No

The demonstration will provide LTSS for Medicaid-only beneficiaries, including personal care services, and will provide continued opportunities for self-direction of the same services described in CAP/C and CAP/DA section 1915(c) waivers for individuals enrolled in PHPs. Financial management services to support self-direction will be available to PHP enrollees and DHHS is exploring contractual options for these services.

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

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

Not applicable.

6. Payments

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

Capitation Payments

DHHS will develop actuarially sound capitation rates for payments to PHPs and expects PHPs to apply value-based payment methodologies within these capitated rates. Within the current FFS system, providers are reimbursed based on volume, regardless of whether the services result in quality outcomes. Our goal is to use PHP capitation and other contract elements to push change to the provider level through payment that is based on value rather than volume. North Carolina expects value-based purchasing by PHPs to add momentum to the shift occurring in the state across payers focusing on value and quality. Value-based care, and the emerging delivery systems and provider reimbursement methodologies that support it, can drive significant improvements to help North Carolina achieve its goal of the Quadruple Aim.

At the same time, DHHS recognizes that the transition from FFS to payment for value-based care within capitation takes time and requires stakeholder feedback to design and support. DHHS is committed to this stakeholder process as it moves further into payment model design. Pediatric measures will be carefully addressed in any incentive or value-based payment arrangements given that most children are healthy and the focus should be on prevention.

DHHS is encouraged by CMS' support for value-based payment in the preamble to the June 2015 proposed Medicaid managed care rule, and is evaluating the May 2016 final rule to determine whether any exceptions to these rules will be requested for VBP as part of the demonstration. DHHS is exploring options for providing financial incentives and provider-directed payments in PHP capitation payments under a VBP initiative.

DHHS also will support and encourage PHPs to offer cost-effective, alternative or "in lieu of" services and additional services when these investments align with North Carolina's aims and complement other initiatives under this demonstration. An example of such services could include community paramedic programs as described under Section 2.2.1 - Background and History of Innovation in North Carolina.

Wrap-around Payments

FQHCs and RHCs will receive their federally mandated reimbursement rates through a combination of payments from the PHPs and wrap around payments from DHHS.
North Carolina also seeks authority under the demonstration to allow DHHS to continue supplemental wrap around payments to limited provider types – LHDs and RHC-like rural clinics, public ambulance providers and state facilities including veterans' homes – once payment for these services have been included in PHP contracts. In North Carolina, these local health

departments and RHC-like rural clinics are a vital part of the fabric of the state's fragile rural health safety net system and will help ensure DHHS' ability to improve rural health access, outcomes and equity.

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

North Carolina Care Transformation through Payment Alignment Initiative

As discussed in demonstration initiative #5, DHHS will implement Medicaid payment reforms throughout North Carolina using a blended approach that includes direct payments to Medicaid safety net hospitals for Medicaid uncompensated care, DSRIP programs, risk-based payments paid as a part of the managed care rates and rural/safety net provider payments. These initiatives are designed to ensure that safety net providers are stable and prepared for success in delivery system reforms.

The Care Transformation through Payment Alignment proposal has several components and initiatives that will prepare providers for delivery system changes and support them once reform is fully operational.

Program features include planning and development of four components of the funding programs to support safety net providers as the Medicaid and NC Health Choice programs transition to risk-based managed care:

1. **Safety Net Hospital Medicaid Uncompensated Care Payments.** The funding for this program (approximately $11.9 billion over five years) will be designated for Medicaid uncompensated care to ensure ongoing stability of safety net hospitals through the transition to risk-based managed care.
2. **Delivery System Reform Incentive Payment (DSRIP) Program Initiatives.** To support programs, funds available for DSRIP initiatives (approximately $262 million over five years, not to exceed $425 million when combined with amounts for the Workforce Initiatives) will be tied to reform projects for safety net providers including public hospitals, private hospitals, LHDs and academic medical centers. These providers will be required to meet predetermined milestones to qualify for performance and outcomes-based incentive payments related to these projects. The next section provides representative projects that could be funded as part of the DSRIP program.
3. **Workforce Initiatives for Underserved Areas.** Funds in this program (approximately $163 million over five years, not to exceed $425 million when combined with amounts for DSRIP) will be used to expand health workforce education initiatives to create additional health care access for Medicaid beneficiaries. This program will focus on rural ambulatory preventive care to advance the goals of higher-value health care to promote long-term practitioner retention and reduce long-term costs.

4. **Tribal uncompensated care payments and alternative services**. This proposal includes $65.4 million funding over five years to enhance and expand health services to Native Americans. A tribal uncompensated care pool (100% FMAP) will be structured to provide two specific types of payment. The first component will provide funding for Medicaid hospital uncompensated care in the form of supplemental payments specific to the Cherokee Indian Hospital Authority. The second component will be to cover alternative nontraditional services for EBCI members, regardless of whether they opt to enroll in PHPs or choose to remain in FFS.

   Below are a few examples of the alternative services that would be included:

   - Acupuncture
   - Biofeedback
   - Therapeutic massage
   - Healing touch and other therapies
   - Unique tribal activities supporting healing and recovery

DHHS will collaborate with our stakeholders on more detailed design features within this initiative. In addition, Disproportionate Share Hospital (DSH) and Graduate Medical Education (GME) payments will not be included in the demonstration. Those payments will continue as provided for under the Medicaid state plan authority.

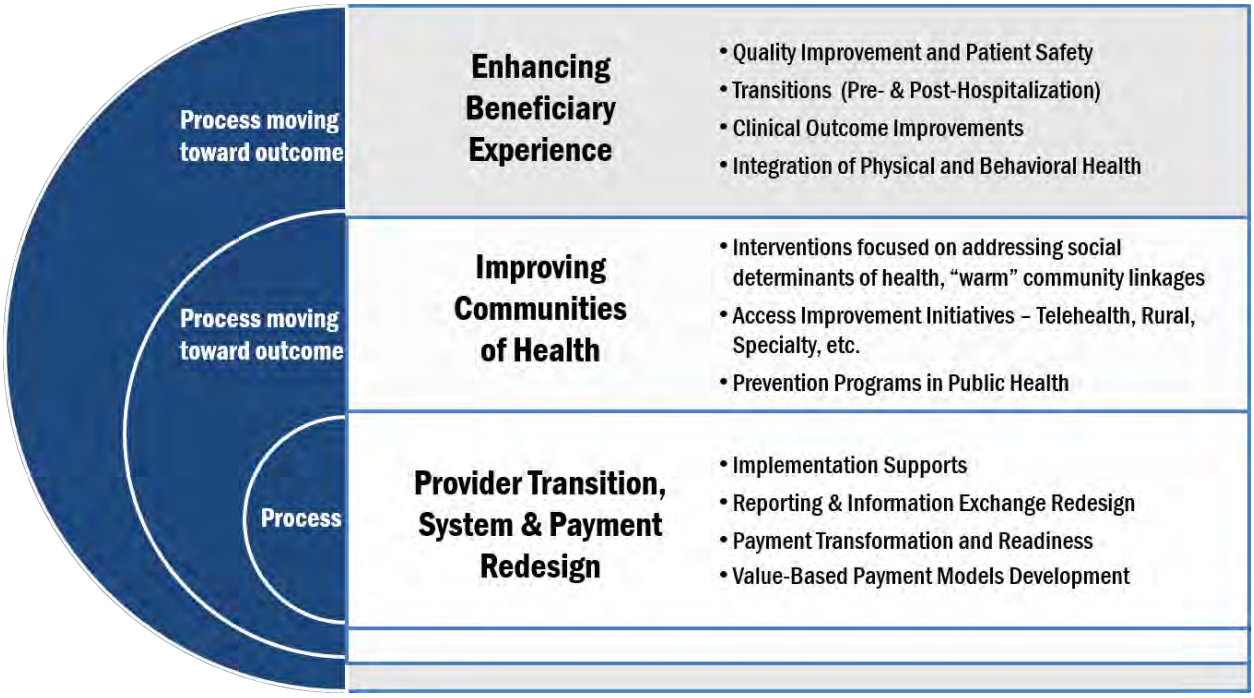
DSRIP Program Initiatives

The North Carolina DSRIP program will focus on initiatives that foster statewide preparation for the delivery system changes. DHHS will collaborate with stakeholders on more detailed design and protocol features to define and determine the greatest need for projects and those aligned with the desired state outcomes.

Planning and development of three specific DSRIP funding programs will support public and private safety net providers as the Medicaid and NC Health Choice programs transition to managed care provided by PHPs:

DSRIP Funding Program	Approximate Funds Over Five Years	Description
Hospital Based Incentive Payment Program	$65 million	Funds available to public and private hospitals in this program will be tied to DSRIP projects, defined milestone achievements and payments for performance as measured by success in meeting project milestones.
Local Health Department Incentive Payment Program	$99 million	Funds will be designated to implement and expand LHD initiatives that support the Quadruple Aim and the community-based approach of PCHCs.
Academic Health System Initiatives	$98 million	Funds will be designated to projects that focus specifically on the role of the academic health systems in relationship to development of programs to support access improvements, provide for low-income and the uninsured, and preparation for the transition to PHPs.

Projects for the three DSRIP program initiatives will be focused on domains that support the initiatives outlined in this proposal. In each of the domains, DHHS will explore specific categories of projects and ultimately design the specific projects that will be available to each of the DSRIP participants. The following diagram displays the proposed domains and the project categories that were developed for the DSRIP initiative.



Standardized Performance Metrics for DSRIP Projects

The performance process and outcome measures will be made suitable to the specific projects. Initiatives will include, but will not be limited to:

- Measures of infrastructure development and participation
- Systems redesign
- Measurement of targeted project milestones
- Clinical outcome improvement of chronic conditions
- Population health improvement

Achievement of Performance Payments in DSRIP Projects

Incentive payment methodologies will be established based on the milestones of the projects and initiatives established under the program.

1. Performance payments will be tied to achievement of specific required milestones and/or project specific measures.
2. Performance payments also will be tied to achievement of population and/or community-based measures.

Examples of Projects Planned for the DSRIP Program

DHHS has engaged with stakeholders regarding the development of a DSRIP program as part of the demonstration preparation. The following projects are examples of the performance-based initiatives that will be included in the DSRIP to align with DHHS' priorities:

1. **Decreasing hospital readmissions.** This project will be **hospital based**, and will greatly support beneficiaries as well as the providers of non-hospital care. The project would be designed by the project participant, approved by DHHS or its contractor, and seek to reduce the hospital readmissions/1,000 enrollees at the facility and overall in the state. Providers would be required to address the following as a minimum in their project design:
    - Ensuring expedited specialty follow-up appointments post-discharge
    - Defined specialty to primary care linkages for children with complex health needs. This work would further the work begun under the Child Health Care Accountable Collaborative CMMI grant.
    - Medication management pre- and post-discharge.
2. **Decreasing emergency department (ED) visits.** This project will be **hospital based**, and will be designed to conduct beneficiary interventions primarily focused on mental health and substance use disorders with a focus on linkages to providers, PCHCs,

LME-MCOs and community supports. The project will seek to decrease ED visits/1,000 enrollees. Project participants will be required to include the following as a minimum in their project design:

- Designation of hospital-based care managers for the ED to facilitate follow-up appointments and address social and medical support needs and any LME-MCO coordination
- Expedited behavioral and substance use follow up appointments post-discharge, as well as any other specialty follow-up needs
- Efforts to identify and address social determinants of ED use for the individual and in the community.

3. **Ensuring improved and sustained access to home- and community-based supports for LTSS beneficiaries**. This will be a **hospital-based** project that requires engagement with various specialty providers, HCBS providers, community supports and PCHCs. The project will seek to increase HCBS placements and will measure both SNF admissions/1,000 enrollees and transition to community measures. Required approaches are anticipated to include:

   - Streamlined access to HCBS supports at the time of hospital discharge, including:
     - Effective transition planning at the time of admission.
     - Expedited HCBS program evaluation and enrollment.
     - Effective, post-discharge coordination with PCHC.
   - Strengthened "Hospital to Home" readmission reduction practices with particular emphasis on the needs of younger LTSS beneficiaries.
   - Improved fall prevention strategies.

4. **The Positive Parenting Program (Triple P).** Triple P is an evidence-based parent support intervention project for the **LHD DSRIP project**. The program provides training to key stakeholders within a community to offer parenting help. By taking a public health approach to parenting support, Triple P has been shown at the population level to strengthen positive parenting practices, promote children's healthy development, prevent children's social/emotional and behavioral problems, reduce child abuse and maltreatment, and lessen related injury and hospitalizations.

   DSRIP participants will be required to design project-based interventions to improve outcomes from the current baseline for beneficiaries, families and communities.

5. **Diabetes Prevention Program.** The Diabetes Prevention Program is a structured, evidence-based, CDC-recognized lifestyle change program that is intended specifically to prevent type 2 diabetes. It will be a **LHD DSRIP project** and is designed for people who have pre-diabetes or are at risk for type 2 diabetes. A trained lifestyle coach leads the program to help individuals learn about prevention activities like eating healthier, reducing stress and getting more physical activity. Evidence shows that people with pre-diabetes who take part in a structured lifestyle change program can cut their risk of developing type 2 diabetes by 58% (71% for people over 60 years old).[6]

   DSRIP participants will be required to design project-based interventions to improve outcomes from the current baseline for beneficiaries, families and communities.

[6] http://www.niddk.nih.gov/about-niddk/research-areas/diabetes/diabetes-prevention-program-dpp/Pages/default.aspx

7. Implementation of Demonstration

7.1. Implementation Schedule

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

North Carolina will implement the demonstration through enrollment in risk-based contracts within 18 months after approval by CMS of the demonstration and any other necessary state plan and waiver amendments. DHHS does not intend to implement PHPs using a phase-in approach.

DHHS proposes the following timeline for issuance of the PHP request for proposal (RFP) and selection of PHPs. This timeline is subject to revision and assumes CMS approval of the demonstration by January 1, 2018. SL 2015-245 requires that capitation begin and beneficiary enrollment be complete within 18 months following CMS approval. Based on these key milestones and considering the time and effort required to engage providers, beneficiaries and other key stakeholders in the program design, DHHS has developed the proposed timeline outlined below.

Proposed Timeline – Assuming CMS Approval January. 1, 2018

KEY ACTIVITY	DATE (Assuming 1115 is approved Jan. 1, 2018)
Submit demonstration application	June 1, 2016
Draft RFP (including contract)	October 2016–January 2018
CMS approval of the 1115	Jan. 1, 2018
Consult with Joint Legislative Oversight Committee on terms and conditions of the RFP	February 2018
RFP issued	March 2018
PHP proposals due	June 2018
PHP awards	September 2018
Readiness reviews	November 2018–June 2019
PHP go live	July 1, 2019

7.2. Enrollment and Auto-Assignment

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

Below is a description of DHHS' plans for use of an enrollment broker and an auto-assignment process to support beneficiary selection and enrollment in PHPs. This is separate from the Medicaid eligibility determination and Medicaid enrollment process, which will continue to be a function of the county DSS.

DHHS is aware of the recently released Medicaid managed care final regulations and intends to comply with the requirements at 42 CFR Part 438, including the requirements for enrollment and a beneficiary support system.

a) Enrollment Broker and Beneficiary Support System

To support the successful transition to capitated managed care, DHHS intends to contract with an enrollment broker to provide education, outreach and enrollment activities to help beneficiaries first select a primary care provider/practice (if they do not already have one) and then choose and enroll in a PHP with consideration for current provider relationships. The enrollment broker will be selected through a competitive solicitation and will be required to meet the independence and conflict of interest requirements in federal regulations.

The enrollment broker will conduct choice counseling, which includes activities such as helping beneficiaries select a primary care provider/practice if they do not already have one, answering questions and providing information (in an unbiased manner) on available PHPs, and advising on what factors to consider when choosing among the PHPs. The enrollment broker also will distribute and process enrollment materials and enroll beneficiaries in a PHP.

EBCI has expressed an interest in being able to assist Native Americans in their choice of PHPs, and DHHS will explore this concept further with EBCI during the development of the enrollment requirements and enrollment broker contract. The final Medicaid managed care regulations released in May 2016 require DHHS to provide a beneficiary support system that includes choice counseling, assistance to beneficiaries in understanding managed care and functions specific to LTSS activities. DHHS will further define its plans for enrollment support consistent with these rules.

b) Auto-Assignment Process

After conducting a robust process for informing potential enrollees about PHP enrollment, if a beneficiary does not choose a PHP, DHHS will deploy an auto-assignment process so that all beneficiaries are assigned to a PHP. DHHS proposes that the process for beneficiary assignment to PHPs first consider beneficiary factors, such as continuity of care and family linkages, with a focus on preserving primary care relationships. These factors would include whether the beneficiary's current or historical primary care provider is participating with a PHP, whether another of the beneficiary's providers (including LTSS providers) is participating with a PHP, whether a family member is enrolled with a PHP, and previous enrollment with a PHP.

After consideration of beneficiary factors, DHHS proposes to consider overall program goals, such as balancing PHP enrollment. In particular, DHHS intends to assign beneficiaries to help PHPs achieve a minimum enrollment threshold as needed to ensure financial viability and to not exceed a maximum threshold at least during the first year.

DHHS also is proposing to designate one of the statewide PHPs to provide specialized services to children and youth in the foster care program. This will be considered in the auto-assignment process.

DHHS proposes to review the assignment process after the first year to determine whether the assignment process should consider PHP quality, for example reflect the results of selected performance measures. DHHS proposes that PHP quality performance would be considered after beneficiary factors. Thus, beneficiaries who were not assigned to a PHP based on beneficiary factors would be assigned based on PHP performance. For example, the highest rated PHP could receive more default assignments than the next rated plan.

The auto-assignment process will be compliant with the Medicaid managed care requirements in 42 CFR Part 438.

c) Supports for Beneficiaries Enrolled in PHPs for LTSS

DHHS recognizes the importance of ensuring that beneficiaries requiring LTSS can receive conflict-free education, enrollment/disenrollment assistance, and advocacy. DHHS intends to leverage its enrollment broker for this purpose. DHHS will engage stakeholders to build a process that ensures the necessary supports are available to enable demonstration participants to be informed and to navigate through the system of the LTSS provided by the PHPs.

While the demonstration reflects principles that are widely supported in the LTSS community, DHHS will host opportunities for individuals and advocates to learn about managed care concepts. These opportunities will be constructed to support the LTSS principles outlined in the demonstration.

7.3. Procurement

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

DHHS will conduct a competitive solicitation to contract with PHPs. Anticipating that there will be significant competition for a limited number of contracts, DHHS will make certain that the process is designed and run rigorously to ensure integrity.

8. Demonstration Financing and Budget Neutrality

> *1) This section should include a narrative of how the Demonstration will be financed as well as the expenditure data that accompanies this application. The State must include 5 years of historical data, as well as projections on member month enrollment. In accordance with 42 CFR 431.412(a)(iii) and (iv), historical and projected expenditures as well as projected enrollment for the proposed demonstration project must be included in a state's application in order to be determined complete. The additional information requested will be needed before the application can be acted upon.*

8.1. Financing

North Carolina currently uses a combination of financing sources for the state share of Medicaid payments, including the State General Fund, intergovernmental transfers, certified public expenditures and provider assessment revenues. It is crucial to the stability of the safety-net system that DHHS be able to successfully transition the financing of Medicaid from today's model to the transformed model of tomorrow. A key focus of DHHS' efforts going forward will be to work with providers and other funding sources to develop a plan to transition this funding to one that is sustainable after implementation of PHPs.

8.2. Demonstration Budget Neutrality and Allotment Neutrality

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

DHHS is proposing a demonstration that encompasses most services (excluding certain services, such as those currently covered by LME-MCOs) and most non-dual eligible populations to provide broad flexibility to more effectively manage its programs while pursuing innovations to enhance access to quality care in Medicaid and NC Health Choice (CHIP).

8.2.1. Budget Neutrality Overview

The five-year demonstration is proposed to start Jan. 1, 2018 and end Dec. 31, 2022.

Demonstration Year (DY)	**DY1**	**DY2**	**DY3**	**DY4**	**DY5**
Time period	1/1/2018 – 12/31/2018	1/1/2019 – 12/31/2019	1/1/2020 – 12/31/2020	1/1/2021 – 12/31/2021	1/1/2022 – 12/31/2022

The budget neutrality projections include "Without Waiver" and "With Waiver" costs and caseloads for the populations included in the demonstration as described in Sections 3 through 6. These projections are based on five years of historical eligibility and expenditure data between Jan. 1, 2010 and Dec. 31, 2014. The components of budget neutrality are outlined in the following sections:

- Populations and Expenditures
- Per Member Per Month (PMPM) Projections for Eligibility Groups (EGs)
- Annual Projections for Expenditures Proposed for Aggregate Spending Caps
- Without Waiver Projections
- With Waiver Projections
- Budget Neutrality Summary

Title XXI allotment neutrality is described in Section 8.2.2.

8.2.1.1. Populations and Expenditures

Populations

Standards for eligibility are set forth under the Medicaid and CHIP state plans. There are no changes to Medicaid and NC Health Choice eligibility under the demonstration, except that DHHS proposes to allow parents to retain their Medicaid eligibility while their children are being served temporarily by the foster care program. Participation in the demonstration will be mandatory for all Medicaid eligibility categories, excluding certain populations, such as:

- Beneficiaries dually eligible for Medicare and Medicaid, including individuals in those categories limited to Medicare cost sharing programs.
- Beneficiaries enrolled in PACE.
- Beneficiaries in North Carolina's Health Insurance Premium Program.
- Individuals enrolled in Medicaid for emergency services only.
- Medically needy beneficiaries.
- Expenditures for periods of presumptive eligibility.
- Members of federally recognized tribes will be included in the demonstration but will not be required to enroll in PHPs. Members may voluntarily enroll in PHPs on an opt-in basis and may disenroll without cause at any time.

Section 4 of the demonstration application provides details of the included and excluded populations.

Services

All Medicaid mandatory and optional services and CHIP state plan services will be provided under the demonstration with certain exclusions, including the following:

- LME-MCO (prepaid inpatient health plan) services (applies to Medicaid, not NC Health Choice beneficiaries)
- Dental services (fluoride varnish provided by non-dental providers is included in the demonstration)
- Program of All-Inclusive Care for the Elderly (PACE)
- Local education agency (LEA) services
- Children's Developmental Services Agency (CDSA) services

Section 4 of the demonstration application provides details of included and excluded services.
In addition to these inclusions and exclusions, DHHS will continue to pay graduate medical education (GME) and disproportionate share hospital (DSH) amounts outside of the demonstration.

8.2.1.2. PMPM Caps for Eligibility Groups

The budget neutrality PMPM caps are defined for five eligibility groups (EGs) outlined in Table 1. EGs were developed based on the evaluation of historical data for the included populations outlined in Section 3 – Demonstration Eligibility.

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

Table 1 – Eligibility Groups/Program Groups
Historical Cost and Caseload Analysis

Eligibility Group	Description
01	Aged, Blind and Disabled (Medicaid Only)
02	TANF and Related Children (under age 21)
03	TANF and Related Adults (age 21 and older)
04	Nursing Facility Level of Care (CAP/DA, CAP/DA-Choice and Nursing Facility – age 18 and older - Medicaid Only)
05	Community Alternatives Program for Children (CAP/C),Medically Fragile (Medicaid Only)

Cost and caseload data were available for the Medicaid populations in this demonstration for the five-year historical period for calendar years 2010 through 2014 (Jan. 1, 2010 through Dec. 31, 2014). The data were aggregated on an incurred basis with paid run out through Dec. 31, 2015. Completed data for CY 2015 is not yet available. CY 2014 was used as the base year to develop each demonstration year cost and caseload estimate.

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

- Implementation of the Affordable Care Act (ACA)
- Reductions in provider reimbursement due to economic conditions in the state

ACA Impact

The ACA impacted the historical analysis of caseload and PMPM cost trends for the EGs. Evaluation of historical EG PMPM trends considered the following ACA impacts:

- **Increases in Pharmacy Rebates**
  The ACA reformed Medicaid payments for prescription drugs, increasing rebates and setting limits on federal reimbursements. The historical trend analysis measures the PMPM trends pre- and post-ACA (CY 2010–CY 2014), which were impacted by the increases in rebates, thus decreasing the observed trends. To address this situation for all EGs, the historical data were not reduced for pharmacy rebates to calculate the PMPM trend factors. Without this adjustment, these impacts would negatively distort the historical trend and inappropriately consider this one-time event as a trend throughout the projection for each demonstration year.

- **Changes to Eligibility and Enrollment**
  Implementation of streamlined enrollment, increased outreach efforts, changes to renewal processes, and income standards impacted TANF and Related Children, and TANF and Related Adult EGs, between CY 2013 and CY 2014. These changes increased enrollment for TANF and Related Children EG and TANF and Related Adult EG that were previously eligible but not enrolled in Medicaid beginning in CY 2014.

When beneficiaries shifted between aid categories like those who moved from NC Health Choice to MCHIP (Medicaid expansion CHIP), the beneficiary also may have experienced a change in benefit package, which reduced the PMPM cost between pre- and post-ACA periods. To address this situation, the historical trends for TANF and Related Children EG, and TANF and Related Adult EG, were measured for four years (CY 2010 through CY 2013). The trends for other EGs were measured for the five-year period (CY 2010 through CY 2014). Without this adjustment, these impacts would negatively distort the historical trend and would inappropriately consider these changes as a trend throughout the projection for each demonstration year.

Reductions in Provider Reimbursement Due to Economic Conditions

During the historical period, North Carolina faced significant budget challenges and the General Assembly took steps to ameliorate the state's financial situation. In a number of cases, the legislature directed DHHS to implement cost containment initiatives in the Medicaid program. These one-time reductions, outlined in Table 2 below, had an impact on the measured historical PMPM trends for all EGs. These reductions and their influence on the PMPM trend were addressed by reversing their impacts on the historical data to produce a longer term view of utilization and cost changes.

Table 2: Historical Cost Containment

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

Service Impacted	SFY2011	SFY2012	SFY2013	SFY2014	SFY2015
Optical Supplies		-2.66%		-3.00%	
Orthotics and Prosthetics		-2.67%			
Other Licensed Practitioner Services		-2.66%			
Personal Care Services				-3.00%	
Physician Drug Program					-1.00%
Physician Services				-3.00%	
Private Duty Nursing		-2.67%			
Transportation		-2.66%			

Historical Trend Evaluation

The prior sections discussed how the historical data were adjusted to remove distortions associated with the implementation of ACA and one-time payment rate reductions. These distortions and the corresponding adjustments made by DHHS are important in the evaluation of historical data for purposes of trend. Under budget neutrality, the lower of the historical trend factors or the President's Budget trends are used to project the base period PMPM into each demonstration period.

The adjustments to remove distortions yield the most appropriate measurement of trend in the historical period. As previously discussed, to address ACA impact on eligibility and enrollment changes, DHHS is using the adjusted four-year PMPM trend (CY 2010 through CY 2013) for the TANF and Related Children, and TANF and Related Adult EGs. The adjusted five-year PMPM trend (CY 2010 through CY 2014) is used for the other EGs (aged, blind, and disabled, long-term care nursing facility level of care and CAP/C).

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

8.2.1.3. Without Waiver Development

EG PMPM Projection

The Without Waiver budget neutrality PMPM projections were prepared using CY 2014 as the base period. Note that the base period used to develop demonstration year projections reflects the actual costs for each EG, including reductions for pharmacy rebates. The base period does not include adjustments considered in trend development, described in Section 8.2.1.2. The result is that the CY 2014 base period PMPM for each EG used for the demonstration Without Waiver PMPM projections represents actual cost and is less than what was used in the historical cost and caseload trend analysis.

Cost Trend

Historical trends were evaluated as described in Section 8.2.1.2 and used to project from the base period to each demonstration year. Consistent with CMS policy for budget neutrality, the trend used is the lower of the actual historical PMPM trend by EG or the President's Budget trend rates. The PMPM cost trend for each EG is illustrated in Table 3 below.

Table 3: Without Waiver Annual Medical Cost Trends

Medicaid Eligibility Group	Base Year to DY1	DY1 to DY2	DY2 to DY3	DY3 to DY4	DY4 to DY5
Aged, Blind and Disabled (Medicaid Only)	3.9%	3.9%	3.9%	3.9%	3.9%
TANF and Related Children (under 21 years)	2.4%	2.4%	2.4%	2.4%	2.4%
TANF and Related Adults (older than 20 years)	4.6%	4.6%	4.6%	4.6%	4.6%
Long-term Care Populations Nursing Facility Level of Care (Medicaid Only)	3.6%	3.6%	3.6%	3.6%	3.6%
Community Alternatives Program for Children (CAP/C) - Medically Fragile (Medicaid Only)	3.9%	3.9%	3.9%	3.9%	3.9%

*The PMPM trend is applied to the base year (CY 2014) PMPMs.

Enrollment Trend

Enrollment estimates for demonstration years 1–5 use actual caseload from CY 2014 and are projected using DHHS estimates for enrollment growth rates for all EGs except the TANF and Related Adults EG. This EG experienced increased enrollment beginning in CY 2014 through CY 2015 due to the implementation of the ACA. This increase in enrollment resulted in one-time enrollment growth for the TANF and Related Adults EG and is not expected to continue at the same rate. Instead of using historical experience, the enrollment trend for this EG used the President's Budget projected number of Medicaid beneficiaries by category. TANF and Related Children EG enrollment was similar to DHHS enrollment projections; therefore, DHHS enrollment projections were used.

Hypothetical Populations and Expenditures

The demonstration and budget neutrality appraisal includes the following proposed hypothetical eligibility groups and expenditures. The costs in the Without Waiver and With Waiver are projected to be the same, consistent with CMS budget neutrality policy that demonstration savings do not accrue to hypothetical populations and expenditures.

Extension of Coverage to Parents of Children in Foster Care

Discussed in Section 3, DHHS is proposing to the General Assembly and CMS to allow parents to retain their Medicaid eligibility while their children are being served temporarily by the foster care program. This will promote the overall health of children, families and communities, and potentially avert long-term costs to Medicaid. This population is included as a hypothetical in Without Waiver projections and includes physical health and behavioral health costs.

These parents are identified under the separate EG "Parents who lose eligibility-Foster Care." The projected PMPM includes two components: physical health services and behavioral health services. The demonstration year 1 PMPM physical health cost is based on the TANF and Related Adults EG. The behavioral health cost was developed by evaluating LME-MCO experience for adult utilizers. For demonstration projections for years 2–5, the PMPM trend from the TANF and Related Adult EG is applied to the demonstration year 1 PMPM.

Tribal Uncompensated Care Payments and Alternative Services

The demonstration includes funding to enhance and expand health services to Native Americans. A Tribal uncompensated care pool will be structured to fund payment for uncompensated care and payment to cover costs of nontraditional services for the Eastern Band of Cherokee Indians (EBCI) members, whether they opt to enroll in PHPs or remain in fee-for-service. DHHS requests that these expenditures be treated as hypothetical expenditures at 100% FMAP.

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

8.2.1.4. With Waiver Development

Per Member Per Month Projections

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

With Waiver estimates were calculated for each EG based on the implementation of managed care July 1, 2019, which is 18 months into the proposed demonstration. Savings are projected to begin in demonstration year 2 and to scale up through demonstration year 5.

Care Transformation through Payment Alignment Initiatives and Annual, Aggregate Expenditure Projections

As described in Section 6, DHHS will implement Medicaid payment reforms using a blended approach that includes direct payments to Medicaid safety net hospitals for Medicaid uncompensated care, delivery system reform incentive payment (DSRIP) programs, risk-based

payments paid as a part of the managed care rates, and investments in workforce initiatives in underserved areas. These initiatives are designed to ensure safety net providers are stable and prepared for success in delivery system reforms. DHHS requests expenditure authority and annual expenditure limits for each demonstration year for the following direct payments.

- **Safety Net Hospital Medicaid Uncompensated Care Payments**
  Expenditures for each demonstration year are included in the Without Waiver and With Waiver projections.
- **Tribal Uncompensated Care Payments and Alternative Services**
  Discussed in the hypothetical section, expenditures for each demonstration year are included in the Without Waiver and With Waiver projection.
- **DSRIP Program Initiatives**
  DHHS proposes the use of savings, as calculated by the difference between the Without Waiver and With Waiver projections (PMPM x Member Months) to fund these expenditures. Expenditure projections for the DSRIP are reflected in the With Waiver projection only.
- **Workforce Initiatives in Underserved Areas**
  DHHS proposes the use of savings, as calculated by the difference between the Without and With Waiver projections (PMPM x Member Months) to fund these expenditures. Expenditure projections for the workforce initiatives are reflected in the With Waiver projection only.

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

8.2.1.5. Budget Neutrality Summary

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

DHHS makes the following assumptions with regard to budget neutrality:

- Nothing in this demonstration application precludes DHHS from applying for enhanced Medicaid funding.
- Administrative costs for management of this demonstration are not subject to budget neutrality and have been excluded from the budget neutrality calculations.
- The projected savings is the difference between the Without Waiver and With Waiver PMPM projections. DHHS is proposing to reinvest a majority of these savings into the

North Carolina health care system as described in the section covering the DSRIP and workforce initiatives.

- The annual budget neutrality expenditure limit for the demonstration includes the products of the PMPM expenditure limits and actual member months (PMPM x Member Months) for each EG plus the annual expenditure limits for the safety net hospital Medicaid uncompensated care payments, Tribal uncompensated care payments and alternative services, DSRIP, and workforce initiatives.
- The final budget neutrality agreement will be expressed in terms of total computable, so the state's Medicaid budget would not be obligated by future changes to the FMAP rate on services.

The aggregate five-year summary for Without Waiver, With Waiver, and Estimated Savings are illustrated in Table 4.

Table 4 - Total Without Waiver, With Waiver and Savings

Funding Source	Without Waiver	With Waiver	Savings
Total Computable	$43,271,612,417	$43,259,178,621	$12,433,796
Federal Share*	$28,685,179,185	$28,676,943,038	$8,236,147

*FMAP rate 66.24% and 100% for Tribal uncompensated care pool.

Exhibit 1 – Historical EG caseload, PMPM and Annualized Trend

Total Computable

	CY 2010 (1/1/10 - 12/31/10)	CY 2011 (1/1/11 - 12/31/11)	CY 2012 (1/1/12 - 12/31/12)	CY 2013 (1/1/13 - 12/31/13)	CY 2014 (1/1/14 - 12/31/14)	4-YEARS CY10-CY13	5-YEARS CY10-CY14
EG-01 - Aged, Blind, and Disabled							
TOTAL EXPENDITURES							
Eligible Member Months	1,920,864	1,979,357	2,039,972	2,078,413	2,096,919	8,018,606	10,115,525
Cost per Eligible	$ 851.59	$ 869.38	$ 870.59	$ 939.98	$ 1,021.53	$ 883.73	$ 912.29
Expenditures	$ 1,635,786,030	$ 1,720,818,516	$ 1,775,977,992	$ 1,953,665,282	$ 2,142,061,770	$ 7,086,247,820	$ 9,228,309,590
TREND RATES			Annual Change			4 Year Average	5 Year Average
Eligible Member Months		3.0%	3.1%	1.9%	0.9%	2.7%	2.2%
Cost per Eligible		2.1%	0.1%	8.0%	8.7%	3.3%	4.7%
Expenditures		5.2%	3.2%	10.0%	9.6%	6.1%	7.0%
					President's Budget Trend - Disabled		*3.9%*
EG-02 - TANF & Related Children							
TOTAL EXPENDITURES							
Eligible Member Months	9,770,459	10,018,775	10,603,635	10,882,193	11,546,283	41,275,062	52,821,345
Cost per Eligible	$ 137.05	$ 140.49	$ 140.11	$ 147.26	$ 148.41	$ 141.36	$ 142.90
Expenditures	$ 1,339,029,499	$ 1,407,532,350	$ 1,485,694,783	$ 1,602,535,906	$ 1,713,622,532	$ 5,834,792,538	$ 7,548,415,070
TREND RATES			Annual Change			4 Year Average	5 Year Average
Eligible Member Months		2.5%	5.8%	2.6%	6.1%	3.7%	4.3%
Cost per Eligible		2.5%	-0.3%	5.1%	0.8%	2.4%	2.0%
Expenditures		5.1%	5.6%	7.9%	6.9%	6.2%	6.4%
					President's Budget Trend - Children		*4.4%*
EG-03 - TANF & Related Adults							
TOTAL EXPENDITURES							
Eligible Member Months	2,855,904	2,966,508	2,888,492	2,766,868	3,224,958	11,477,772	14,702,730
Cost per Eligible	$ 310.15	$ 312.79	$ 325.65	$ 355.37	$ 345.72	$ 325.63	$ 330.04
Expenditures	$ 885,753,941	$ 927,881,317	$ 940,632,277	$ 983,255,867	$ 1,114,935,935	$ 3,737,523,401	$ 4,852,459,336
TREND RATES			Annual Change			4 Year Average	5 Year Average
Eligible Member Months		3.9%	-2.6%	-4.2%	16.6%	-1.1%	3.1%
Cost per Eligible		0.9%	4.1%	9.1%	-2.7%	4.6%	2.8%
Expenditures		4.8%	1.4%	4.5%	13.4%	3.5%	5.9%
					President's Budget Trend - Adults		*4.7%*
EG-04 - Nursing Facility Level of Care							
TOTAL EXPENDITURES							
Eligible Member Months	37,893	37,162	36,388	36,821	38,275	148,264	186,539
Cost per Eligible	$ 4,920.24	$ 4,996.78	$ 5,107.88	$ 5,344.93	$ 5,675.28	$ 5,090.95	$ 5,210.84
Expenditures	$ 186,442,468	$ 185,690,172	$ 185,865,686	$ 196,805,806	$ 217,221,225	$ 754,804,132	$ 972,025,357
TREND RATES			Annual Change			4 Year Average	5 Year Average
Eligible Member Months		-1.9%	-2.1%	1.2%	3.9%	-1.0%	0.3%
Cost per Eligible		1.6%	2.2%	4.6%	6.2%	2.8%	3.6%
Expenditures		-0.4%	0.1%	5.9%	10.4%	1.8%	3.9%
					President's Budget Trend - Disabled		*3.9%*
EG-05 - CAP/C							
TOTAL EXPENDITURES							
Eligible Member Months	11,022	12,917	15,743	18,480	21,975	58,162	80,137
Cost per Eligible	$ 5,488.31	$ 5,783.56	$ 5,850.09	$ 6,288.09	$ 6,430.42	$ 5,905.92	$ 6,049.75
Expenditures	$ 60,492,148	$ 74,706,210	$ 92,097,992	$ 116,203,973	$ 141,308,524	$ 343,500,323	$ 484,808,847
TREND RATES			Annual Change			4 Year Average	5 Year Average
Eligible Member Months		17.2%	21.9%	17.4%	18.9%	18.8%	18.8%
Cost per Eligible		5.4%	1.2%	7.5%	2.3%	4.6%	4.0%
Expenditures		23.5%	23.3%	26.2%	21.6%	24.3%	23.6%
					President's Budget Trend - Disabled		*3.9%*
All Included Populations							
TOTAL EXPENDITURES							
Eligible Member Months	14,596,142	15,014,719	15,584,230	15,782,775	16,928,410	60,977,866	77,906,276
Cost per Eligible	$ 281.41	$ 287.49	$ 287.49	$ 307.45	$ 314.81	$ 291.20	$ 296.33
Expenditures	$ 4,107,504,086	$ 4,316,628,565	$ 4,480,268,730	$ 4,852,466,833	$ 5,329,149,986	$ 17,756,868,214	$ 23,086,018,200
TREND RATES			Annual Change			4 Year Average	5 Year Average
Eligible Member Months		2.9%	3.8%	1.3%	7.3%	2.6%	3.8%
Cost per Eligible		2.2%	0.0%	6.9%	2.4%	3.0%	2.8%
Expenditures		5.1%	3.8%	8.3%	9.8%	5.7%	6.7%
					President's Budget Trend		*4.2%*

Exhibit 2 – Historical EG caseload, PMPM and Annualized Trend

Federal Share

	CY 2010 (1/1/10 - 12/31/10)	CY 2011 (1/1/11 - 12/31/11)	CY 2012 (1/1/12 - 12/31/12)	CY 2013 (1/1/13 - 12/31/13)	CY 2014 (1/1/14 - 12/31/14)	4-YEARS CY10-CY13	5-YEARS CY10-CY14
EG-01 - Aged, Blind, and Disabled							
TOTAL EXPENDITURES							
Eligible Member Months	1,920,864	1,979,357	2,039,972	2,078,413	2,096,919	8,018,606	10,115,525
Cost per Eligible	$ 553.74	$ 563.81	$ 568.83	$ 616.44	$ 672.23	$ 576.31	$ 596.20
Expenditures	$ 1,063,653,082	$ 1,115,976,093	$ 1,160,393,654	$ 1,281,214,107	$ 1,409,605,630	$ 4,621,236,936	$ 6,030,842,566
TREND RATES			Annual Change			4 Year Average	5 Year Average
Eligible Member Months		3.0%	3.1%	1.9%	0.9%	2.7%	2.2%
Cost per Eligible		1.8%	0.9%	8.4%	9.1%	3.6%	5.0%
Expenditures		4.9%	4.0%	10.4%	10.0%	6.4%	7.3%
					President's Budget Trend - Disabled		*3.9%*
EG-02 - TANF & Related Children							
TOTAL EXPENDITURES							
Eligible Member Months	9,770,459	10,018,775	10,603,635	10,882,193	11,546,283	41,275,062	52,821,345
Cost per Eligible	$ 89.11	$ 91.11	$ 91.55	$ 96.57	$ 97.66	$ 92.19	$ 93.39
Expenditures	$ 870,690,193	$ 912,805,411	$ 970,727,568	$ 1,050,943,388	$ 1,127,666,813	$ 3,805,166,559	$ 4,932,833,372
TREND RATES			Annual Change			4 Year Average	5 Year Average
Eligible Member Months		2.5%	5.8%	2.6%	6.1%	3.7%	4.3%
Cost per Eligible		2.2%	0.5%	5.5%	1.1%	2.7%	2.3%
Expenditures		4.8%	6.3%	8.3%	7.3%	6.5%	6.7%
					President's Budget Trend - Children		*4.4%*
EG-03 - TANF & Related Adults							
TOTAL EXPENDITURES							
Eligible Member Months	2,855,904	2,966,508	2,888,492	2,766,868	3,224,958	11,477,772	14,702,730
Cost per Eligible	$ 201.67	$ 202.85	$ 212.77	$ 233.05	$ 227.51	$ 212.33	$ 215.66
Expenditures	$ 575,952,411	$ 601,744,668	$ 614,593,046	$ 644,819,406	$ 733,694,982	$ 2,437,109,532	$ 3,170,804,514
TREND RATES			Annual Change			4 Year Average	5 Year Average
Eligible Member Months		3.9%	-2.6%	-4.2%	16.6%	-1.1%	3.1%
Cost per Eligible		0.6%	4.9%	9.5%	-2.4%	4.9%	3.1%
Expenditures		4.5%	2.1%	4.9%	13.8%	3.8%	6.2%
					President's Budget Trend - Adults		*4.7%*
EG-04 - Nursing Facility Level of Care							
TOTAL EXPENDITURES							
Eligible Member Months	37,893	37,162	36,388	36,821	38,275	148,264	186,539
Cost per Eligible	$ 3,199.33	$ 3,240.48	$ 3,337.40	$ 3,505.21	$ 3,734.67	$ 3,319.50	$ 3,404.68
Expenditures	$ 121,232,302	$ 120,422,805	$ 121,441,461	$ 129,065,289	$ 142,944,646	$ 492,161,857	$ 635,106,503
TREND RATES			Annual Change			4 Year Average	5 Year Average
Eligible Member Months		-1.9%	-2.1%	1.2%	3.9%	-1.0%	0.3%
Cost per Eligible		1.3%	3.0%	5.0%	6.5%	3.1%	3.9%
Expenditures		-0.7%	0.8%	6.3%	10.8%	2.1%	4.2%
					President's Budget Trend - Disabled		*3.9%*
EG-05 - CAP/C							
TOTAL EXPENDITURES							
Eligible Member Months	11,022	12,917	15,743	18,480	21,975	58,162	80,137
Cost per Eligible	$ 3,568.72	$ 3,750.72	$ 3,822.35	$ 4,123.73	$ 4,231.60	$ 3,854.14	$ 3,957.65
Expenditures	$ 39,334,399	$ 48,448,075	$ 60,175,254	$ 76,206,590	$ 92,989,518	$ 224,164,317	$ 317,153,835
TREND RATES			Annual Change			4 Year Average	5 Year Average
Eligible Member Months		17.2%	21.9%	17.4%	18.9%	18.8%	18.8%
Cost per Eligible		5.1%	1.9%	7.9%	2.6%	4.9%	4.4%
Expenditures		23.2%	24.2%	26.6%	22.0%	24.7%	24.0%
					President's Budget Trend - Disabled		*3.9%*
All Included Populations							
TOTAL EXPENDITURES							
Eligible Member Months	14,596,142	15,014,719	15,584,230	15,782,775	16,928,410	60,977,866	77,906,276
Cost per Eligible	$ 182.98	$ 186.44	$ 187.84	$ 201.63	$ 207.16	$ 189.90	$ 193.65
Expenditures	$ 2,670,862,386	$ 2,799,397,052	$ 2,927,330,983	$ 3,182,248,781	$ 3,506,901,589	$ 11,579,839,202	$ 15,086,740,791
TREND RATES			Annual Change			4 Year Average	5 Year Average
Eligible Member Months		2.9%	3.8%	1.3%	7.3%	2.6%	3.8%
Cost per Eligible		1.9%	0.7%	7.3%	2.7%	3.3%	3.2%
Expenditures		4.8%	4.6%	8.7%	10.2%	6.0%	7.0%
						President's Budget Trend	*4.2%*

Notes:

1. Federal Medical Assistance Percentage (FMAP) is equal to the weighted average FMAP for claims incurred within the reporting period.
2. FMAP for CY 2010 equals 65.02%, CY 2011 equals 64.85%, CY 2012 equals 65.34%, CY 2013 equals 65.58%, and CY 2014 equals 65.81%.

Exhibit 3 – Without Waiver Projections

Total Computable

Eligibility Group	Annual Trend Rate	Demonstration Years (DY) DY 01 (01/18 - 12/18)	DY 02 (01/19 - 12/19)	DY 03 (01/20 - 12/20)	DY 04 (01/21 - 12/21)	DY 05 (01/22 - 12/22)	Total
Aged, Blind, and Disabled							
Eligible Member Months	2.8%	2,289,581	2,354,559	2,421,380	2,490,098	2,560,766	
Without Waiver Cost Per Eligible	3.9%	$ 913.48	$ 948.76	$ 985.40	$ 1,023.46	$ 1,062.98	
Without Waiver Expenditures	6.8%	$ 2,091,479,747	$ 2,233,903,219	$ 2,386,025,301	$ 2,548,506,438	$ 2,722,052,052	$ 11,981,966,757
TANF & Related Children							
Eligible Member Months	0.7%	11,806,023	11,883,210	11,960,901	12,039,101	12,117,812	
Without Waiver Cost Per Eligible	2.4%	$ 134.65	$ 137.91	$ 141.25	$ 144.68	$ 148.19	
Without Waiver Expenditures	3.1%	$ 1,589,627,997	$ 1,638,819,165	$ 1,689,532,559	$ 1,741,815,282	$ 1,795,715,899	$ 8,455,510,901
TANF & Related Adults							
Eligible Member Months	0.7%	4,453,293	4,484,632	4,516,191	4,547,973	4,579,978	
Without Waiver Cost Per Eligible	4.6%	$ 340.76	$ 356.57	$ 373.12	$ 390.44	$ 408.56	
Without Waiver Expenditures	5.4%	$ 1,517,482,051	$ 1,599,086,489	$ 1,685,079,304	$ 1,775,696,488	$ 1,871,186,720	$ 8,448,531,053
Nursing Facility Level of Care							
Eligible Member Months	1.1%	37,630	38,032	38,437	38,848	39,262	
Without Waiver Cost Per Eligible	3.6%	$ 5,707.08	$ 5,914.45	$ 6,129.35	$ 6,352.06	$ 6,582.87	
Without Waiver Expenditures	4.7%	$ 214,758,079	$ 224,936,220	$ 235,596,739	$ 246,762,497	$ 258,457,440	$ 1,180,510,976
CAP/C							
Eligible Member Months	1.1%	27,856	28,154	28,454	28,758	29,064	
Without Waiver Cost Per Eligible	3.9%	$ 6,907.95	$ 7,174.74	$ 7,451.84	$ 7,739.64	$ 8,038.56	
Without Waiver Expenditures	5.0%	$ 192,430,187	$ 201,994,711	$ 212,034,629	$ 222,573,570	$ 233,636,337	$ 1,062,669,435
All Included Populations							
Eligible Member Months	0.9%	18,614,384	18,788,586	18,965,365	19,144,777	19,326,882	
Without Waiver Cost Per Eligible	4.3%	$ 301.15	$ 313.95	$ 327.35	$ 341.36	$ 356.04	
Without Waiver Expenditures	5.3%	$ 5,605,778,061	$ 5,898,739,804	$ 6,208,268,532	$ 6,535,354,276	$ 6,881,048,448	$ 31,129,189,121
Hypothetical Groups							
Parents who Lose Eligibility - Foster Care							
Eligible Member Months	6.3%	27,493	29,214	31,043	32,987	35,052	
Without Waiver Cost Per Eligible	4.6%	$ 874.02	$ 914.58	$ 957.03	$ 1,001.45	$ 1,047.93	
Without Waiver Expenditures	11.2%	$ 24,029,170	$ 26,718,661	$ 29,709,176	$ 33,034,409	$ 36,731,821	$ 150,223,237
Medicaid Uncompensated Care Payments							
Hospital	4.3%	$ 2,189,991,433	$ 2,283,593,575	$ 2,381,196,354	$ 2,482,970,760	$ 2,589,095,094	$ 11,926,847,216
Tribal UC and Alternative Services	4.3%	$ 12,000,000	$ 12,512,890	$ 13,047,702	$ 13,605,372	$ 14,186,878	$ 65,352,843
Total Expenditures	4.3%	$ 2,201,991,433	$ 2,296,106,466	$ 2,394,244,056	$ 2,496,576,133	$ 2,603,281,972	$ 11,992,200,059
Without Waiver Total Expenditures	**5.0%**	**$ 7,831,798,664**	**$ 8,221,564,931**	**$ 8,632,221,765**	**$ 9,064,964,817**	**$ 9,521,062,240**	**$ 43,271,612,417**

Excluded Expenditures:		
-Graduate Medical Expense	-PACE Capitation	-All services associated with excluded populations
-Disproportionate Share Hospital	-Local education agency (LEA) services	-Contracted local management entity/managed care organization (LME/MCO)
	-Children's Developmental Service Agencies	-Dental services (excluding dental varnish applied by non-dental practitioners)

Notes:

1. Budget neutrality estimates displayed above include Calendar Year (CY) trend factors and a base projection period starting from CY2014.
2. Base projections starting from CY2014 equals 48 trend months between the midpoint of the base projection year and the midpoint of demonstration year one, which is 2018.

Exhibit 4 – Without Waiver Projections

Federal Share

Eligibility Group	Annual Trend Rate	Demonstration Years (DY) DY 01 (01/18 - 12/18)	DY 02 (01/19 - 12/19)	DY 03 (01/20 - 12/20)	DY 04 (01/21 - 12/21)	DY 05 (01/22 - 12/22)	Total
Aged, Blind, and Disabled							
Eligible Member Months	2.8%	2,289,581	2,354,559	2,421,380	2,490,098	2,560,766	
Without Waiver Cost Per Eligible	3.9%	$ 605.09	$ 628.46	$ 652.73	$ 677.94	$ 704.12	
Without Waiver Expenditures	6.8%	$ 1,385,396,184	$ 1,479,737,492	$ 1,580,503,159	$ 1,688,130,665	$ 1,803,087,279	$ 7,936,854,780
TANF & Related Children							
Eligible Member Months	0.7%	11,806,023	11,883,210	11,960,901	12,039,101	12,117,812	
Without Waiver Cost Per Eligible	2.4%	$ 89.19	$ 91.35	$ 93.57	$ 95.84	$ 98.16	
Without Waiver Expenditures	3.1%	$ 1,052,969,585	$ 1,085,553,815	$ 1,119,146,367	$ 1,153,778,443	$ 1,189,482,211	$ 5,600,930,421
TANF & Related Adults							
Eligible Member Months	0.7%	4,453,293	4,484,632	4,516,191	4,547,973	4,579,978	
Without Waiver Cost Per Eligible	4.6%	$ 225.72	$ 236.19	$ 247.15	$ 258.63	$ 270.63	
Without Waiver Expenditures	5.4%	$ 1,005,180,111	$ 1,059,234,890	$ 1,116,196,531	$ 1,176,221,353	$ 1,239,474,083	$ 5,596,306,969
Nursing Facility Level of Care							
Eligible Member Months	1.1%	37,630	38,032	38,437	38,848	39,262	
Without Waiver Cost Per Eligible	3.6%	$ 3,780.37	$ 3,917.73	$ 4,060.08	$ 4,207.61	$ 4,360.49	
Without Waiver Expenditures	4.7%	$ 142,255,752	$ 148,997,752	$ 156,059,280	$ 163,455,478	$ 171,202,208	$ 781,970,470
CAP/C							
Eligible Member Months	1.1%	27,856	28,154	28,454	28,758	29,064	
Without Waiver Cost Per Eligible	3.9%	$ 4,575.83	$ 4,752.55	$ 4,936.10	$ 5,126.74	$ 5,324.74	
Without Waiver Expenditures	5.0%	$ 127,465,756	$ 133,801,297	$ 140,451,738	$ 147,432,733	$ 154,760,710	$ 703,912,233
All Included Populations							
Eligible Member Months	0.9%	18,614,384	18,788,586	18,965,365	19,144,777	19,326,882	
Without Waiver Cost Per Eligible	4.3%	$ 199.48	$ 207.96	$ 216.84	$ 226.12	$ 235.84	
Without Waiver Expenditures	5.3%	$ 3,713,267,387	$ 3,907,325,246	$ 4,112,357,076	$ 4,329,018,672	$ 4,558,006,492	$ 20,619,974,873
Hypothetical Groups							
Parents who Lose Eligibility - Foster Care							
Eligible Member Months	6.3%	27,493	29,214	31,043	32,987	35,052	
Without Waiver Cost Per Eligible	4.6%	$ 578.95	$ 605.82	$ 633.94	$ 663.36	$ 694.15	
Without Waiver Expenditures	11.2%	$ 15,916,922	$ 17,698,441	$ 19,679,358	$ 21,881,992	$ 24,331,158	$ 99,507,872
Medicaid Uncompensated Care Payments							
Hospital	4.3%	$ 1,450,650,325	$ 1,512,652,384	$ 1,577,304,465	$ 1,644,719,832	$ 1,715,016,590	$ 7,900,343,596
Tribal UC and Alternative Services	4.3%	$ 12,000,000	$ 12,512,890	$ 13,047,702	$ 13,605,372	$ 14,186,878	$ 65,352,843
Total Expenditures	4.3%	$ 1,462,650,325	$ 1,525,165,275	$ 1,590,352,167	$ 1,658,325,204	$ 1,729,203,468	$ 7,965,696,439
Without Waiver Total Expenditures	**5.0%**	**$ 5,191,834,635**	**$ 5,450,188,962**	**$ 5,722,388,601**	**$ 6,009,225,868**	**$ 6,311,541,118**	**$ 28,685,179,185**

Excluded Expenditures:		
-Graduate Medical Expense	-PACE Capitation	-All services associated with excluded populations
-Disproportionate Share Hospital	-Local education agency (LEA) services	-Contracted local management entity/managed care organization (LME/MCO)
	-Children's Developmental Service Agencies	-Dental services (excluding dental varnish applied by non-dental practitioners)

Notes:

1. Federal Medical Assistance Percentage (FMAP) is equal to the FFY 2016 rate, which is 66.24%.
2. Federal Medical Assistance Percentage (FMAP) is equal to 100% for Tribal UC and Alternative Services.

Exhibit 5 – With Waiver Projections

Total Computable

Eligibility Group	Annual Trend Rate	Demonstration Years (DY) DY 01 (01/18 - 12/18)	DY 02 (01/19 - 12/19)	DY 03 (01/20 - 12/20)	DY 04 (01/21 - 12/21)	DY 05 (01/22 - 12/22)	Total
Aged, Blind, and Disabled							
Eligible Member Months	2.8%	2,289,581	2,354,559	2,421,380	2,490,098	2,560,766	
With Waiver Cost per Eligible	2.6%	$ 913.48	$ 939.39	$ 952.17	$ 974.63	$ 1,012.27	
With Waiver Expenditures	5.5%	$ 2,091,479,747	$ 2,211,858,372	$ 2,305,560,459	$ 2,426,916,826	$ 2,592,182,553	$ 11,627,997,957
Estimated Costs (Savings)		$ -	$ (22,044,847)	$ (80,464,841)	$ (121,589,612)	$ (129,869,499)	$ (353,968,799)
TANF & Related Children							
Eligible Member Months	0.7%	11,806,023	$ 11,883,210	$ 11,960,901	$ 12,039,101	12,117,812	
With Waiver Cost per Eligible	2.0%	$ 134.65	$ 138.34	$ 140.48	$ 142.19	$ 145.64	
With Waiver Expenditures	2.6%	$ 1,589,627,997	$ 1,643,910,750	$ 1,680,268,338	$ 1,711,890,318	$ 1,764,864,904	$ 8,390,562,306
Estimated Costs (Savings)		$ -	$ 5,091,585	$ (9,264,221)	$ (29,924,965)	$ (30,850,995)	$ (64,948,595)
TANF & Related Adults							
Eligible Member Months	0.7%	4,453,293	4,484,632	4,516,191	4,547,973	4,579,978	
With Waiver Cost per Eligible	3.7%	$ 340.76	$ 354.92	$ 364.80	$ 376.63	$ 394.11	
With Waiver Expenditures	4.4%	$ 1,517,482,051	$ 1,591,694,044	$ 1,647,490,339	$ 1,712,893,569	$ 1,805,006,498	$ 8,274,566,500
Estimated Costs (Savings)		$ -	$ (7,392,445)	$ (37,588,966)	$ (62,802,919)	$ (66,180,222)	$ (173,964,552)
Nursing Facility Level of Care							
Eligible Member Months	1.1%	37,630	$ 38,032	$ 38,437	$ 38,848	39,262	
With Waiver Cost per Eligible	5.4%	$ 5,707.08	$ 6,140.30	$ 6,579.68	$ 6,800.33	$ 7,047.42	
With Waiver Expenditures	6.5%	$ 214,758,079	$ 233,525,706	$ 252,906,355	$ 264,176,556	$ 276,696,812	$ 1,242,063,508
Estimated Costs (Savings)		$ -	$ 8,589,486	$ 17,309,617	$ 17,414,058	$ 18,239,372	$ 61,552,533
CAP/C							
Eligible Member Months	1.1%	27,856	28,154	28,454	28,758	29,064	
With Waiver Cost per Eligible	6.9%	$ 6,907.95	$ 7,613.48	$ 8,359.75	$ 8,679.04	$ 9,014.23	
With Waiver Expenditures	8.0%	$ 192,430,187	$ 214,346,564	$ 237,868,186	$ 249,588,263	$ 261,993,765	$ 1,156,226,966
Estimated Costs (Savings)		$ -	$ 12,351,853	$ 25,833,557	$ 27,014,693	$ 28,357,428	$ 93,557,531
All Included Populations							
Eligible Member Months	0.9%	18,614,384	18,788,586	18,965,365	19,144,777	19,326,882	
With Waiver Cost per Eligible	3.6%	$ 301.15	$ 313.77	$ 322.91	$ 332.49	$ 346.71	
With Waiver Expenditures	4.6%	$ 5,605,778,061	$ 5,895,335,437	$ 6,124,093,678	$ 6,365,465,531	$ 6,700,744,532	$ 30,691,417,237
Estimated Costs (Savings)		$ -	$ (3,404,368)	$ (84,174,854)	$ (169,888,745)	$ (180,303,916)	$ (437,771,883)
Cost (Savings %)		*0.0%*	*-0.1%*	*-1.4%*	*-2.6%*	*-2.6%*	*-1.4%*
Hypothetical Groups							
Parents who Lose Eligibility - Foster Care							
Eligible Member Months	6.3%	27,493	29,214	31,043	32,987	35,052	
With Waiver Cost per Eligible	4.6%	$ 874.02	$ 914.58	$ 957.03	$ 1,001.45	$ 1,047.93	
With Waiver Expenditures	11.2%	$ 24,029,170	$ 26,718,661	$ 29,709,176	$ 33,034,409	$ 36,731,821	$ 150,223,237
Medicaid Uncompensated Care Payments							
Hospital	4.3%	$ 2,189,991,433	$ 2,283,593,575	$ 2,381,196,354	$ 2,482,970,760	$ 2,589,095,094	$ 11,926,847,216
Tribal UC and Alternative Services	4.3%	$ 12,000,000	$ 12,512,890	$ 13,047,702	$ 13,605,372	$ 14,186,878	$ 65,352,843
Total Expenditures	4.3%	$ 2,201,991,433	$ 2,296,106,466	$ 2,394,244,056	$ 2,496,576,133	$ 2,603,281,972	$ 11,992,200,059
Delivery System Reform Incentive Payments (DSRIP)							
Hospital Based Incentive Payment	4.3%	$ 12,000,000	$ 12,512,890	$ 13,047,702	$ 13,605,372	$ 14,186,878	$ 65,352,843
Local Health Department Incentive Payment	4.3%	$ 18,100,000	$ 18,873,610	$ 19,680,284	$ 20,521,437	$ 21,398,541	$ 98,573,872
Academic Health System Initiatives	4.3%	$ 18,000,000	$ 18,769,336	$ 19,571,553	$ 20,408,059	$ 21,280,317	$ 98,029,265
Total Expenditures	4.3%	$ 48,100,000	$ 50,155,836	$ 52,299,540	$ 54,534,868	$ 56,865,736	$ 261,955,980
Workforce Initiatives	4.3%	$ 30,000,000	$ 31,282,226	$ 32,619,256	$ 34,013,431	$ 35,467,195	$ 163,382,108
With Waiver Total Expenditures	**4.5%**	**$ 7,909,898,664**	**$ 8,299,598,625**	**$ 8,632,965,706**	**$ 8,983,624,371**	**$ 9,433,091,254**	**$ 43,259,178,621**

Excluded Expenditures:		
-Graduate Medical Expense	-PACE Capitation	-All services associated with excluded populations
-Disproportionate Share Hospital	-Local education agency (LEA) services	-Contracted local management entity/managed care organization (LME/MCO)
	-Children's Developmental Service Agencies	-Dental services (excluding dental varnish applied by non-dental practitioners)

Exhibit 6 – With Waiver Projections

Federal Share

Eligibility Group	Annual Trend Rate	Demonstration Years (DY) DY 01 (01/18 - 12/18)	DY 02 (01/19 - 12/19)	DY 03 (01/20 - 12/20)	DY 04 (01/21 - 12/21)	DY 05 (01/22 - 12/22)	Total
Aged, Blind, and Disabled							
Eligible Member Months	2.8%	2,289,581	2,354,559	2,421,380	2,490,098	2,560,766	
With Waiver Cost per Eligible	2.6%	$ 605.09	$ 622.25	$ 630.72	$ 645.59	$ 670.53	
With Waiver Expenditures	5.5%	$ 1,385,396,184	$ 1,465,134,986	$ 1,527,203,248	$ 1,607,589,705	$ 1,717,061,723	$ 7,702,385,847
Estimated Costs (Savings)		$ -	$ (14,602,507)	$ (53,299,911)	$ (80,540,959)	$ (86,025,556)	$ (234,468,933)
TANF & Related Children							
Eligible Member Months	0.7%	11,806,023	$ 11,883,210	$ 11,960,901	$ 12,039,101	12,117,812	
With Waiver Cost per Eligible	2.0%	$ 89.19	$ 91.64	$ 93.05	$ 94.19	$ 96.47	
With Waiver Expenditures	2.6%	$ 1,052,969,585	$ 1,088,926,481	$ 1,113,009,747	$ 1,133,956,146	$ 1,169,046,512	$ 5,557,908,471
Estimated Costs (Savings)		$ -	$ 3,372,666	$ (6,136,620)	$ (19,822,297)	$ (20,435,699)	$ (43,021,950)
TANF & Related Adults							
Eligible Member Months	0.7%	4,453,293	4,484,632	4,516,191	4,547,973	4,579,978	
With Waiver Cost per Eligible	3.7%	$ 225.72	$ 235.10	$ 241.64	$ 249.48	$ 261.06	
With Waiver Expenditures	4.4%	$ 1,005,180,111	$ 1,054,338,135	$ 1,091,297,600	$ 1,134,620,700	$ 1,195,636,304	$ 5,481,072,850
Estimated Costs (Savings)		$ -	$ (4,896,756)	$ (24,898,931)	$ (41,600,654)	$ (43,837,779)	$ (115,234,119)
Nursing Facility Level of Care							
Eligible Member Months	1.1%	37,630	$ 38,032	$ 38,437	$ 38,848	39,262	
With Waiver Cost per Eligible	5.4%	$ 3,780.37	$ 4,067.33	$ 4,358.38	$ 4,504.54	$ 4,668.21	
With Waiver Expenditures	6.5%	$ 142,255,752	$ 154,687,428	$ 167,525,170	$ 174,990,550	$ 183,283,968	$ 822,742,868
Estimated Costs (Savings)		$ -	$ 5,689,675	$ 11,465,890	$ 11,535,072	$ 12,081,760	$ 40,772,398
CAP/C							
Eligible Member Months	1.1%	27,856	28,154	28,454	28,758	29,064	
With Waiver Cost per Eligible	6.9%	$ 4,575.83	$ 5,043.17	$ 5,537.50	$ 5,748.99	$ 5,971.03	
With Waiver Expenditures	8.0%	$ 127,465,756	$ 141,983,164	$ 157,563,887	$ 165,327,266	$ 173,544,670	$ 765,884,742
Estimated Costs (Savings)		$ -	$ 8,181,868	$ 17,112,148	$ 17,894,533	$ 18,783,960	$ 61,972,509
All Included Populations							
Eligible Member Months	0.9%	18,614,384	18,788,586	18,965,365	19,144,777	19,326,882	
With Waiver Cost per Eligible	3.6%	$ 199.48	$ 207.84	$ 213.90	$ 220.24	$ 229.66	
With Waiver Expenditures	4.6%	$ 3,713,267,387	$ 3,905,070,193	$ 4,056,599,652	$ 4,216,484,368	$ 4,438,573,178	$ 20,329,994,778
Estimated Costs (Savings)		$ -	$ (2,255,053)	$ (55,757,423)	$ (112,534,304)	$ (119,433,314)	$ (289,980,095)
Cost (Savings %)		*0.0%*	*-0.1%*	*-1.4%*	*-2.6%*	*-2.6%*	*-1.4%*
Hypothetical Groups							
Parents who Lose Eligibility - Foster Care							
Eligible Member Months	6.3%	27,493	29,214	31,043	32,987	35,052	
With Waiver Cost per Eligible	4.6%	$ 578.95	$ 605.82	$ 633.94	$ 663.36	$ 694.15	
With Waiver Expenditures	11.2%	$ 15,916,922	$ 17,698,441	$ 19,679,358	$ 21,881,992	$ 24,331,158	$ 99,507,872
Medicaid Uncompensated Care Payments							
Hospital	4.3%	$ 1,450,650,325	$ 1,512,652,384	$ 1,577,304,465	$ 1,644,719,832	$ 1,715,016,590	$ 7,900,343,596
Tribal UC and Alternative Services	4.3%	$ 12,000,000	$ 12,512,890	$ 13,047,702	$ 13,605,372	$ 14,186,878	$ 65,352,843
Total Expenditures	4.3%	$ 1,462,650,325	$ 1,525,165,275	$ 1,590,352,167	$ 1,658,325,204	$ 1,729,203,468	$ 7,965,696,439
Delivery System Reform Incentive Payments (DSRIP)							
Hospital Based Incentive Payment	4.3%	$ 7,948,800	$ 8,288,539	$ 8,642,798	$ 9,012,199	$ 9,397,388	$ 43,289,723
Local Health Department Incentive Payment	4.3%	$ 11,989,440	$ 12,501,879	$ 13,036,220	$ 13,593,400	$ 14,174,393	$ 65,295,333
Academic Health System Initiatives	4.3%	$ 11,923,200	$ 12,432,808	$ 12,964,197	$ 13,518,298	$ 14,096,082	$ 64,934,585
Total Expenditures	4.3%	$ 31,861,440	$ 33,223,226	$ 34,643,215	$ 36,123,897	$ 37,667,863	$ 173,519,641
Workforce Initiatives	4.3%	$ 19,872,000	$ 20,721,347	$ 21,606,995	$ 22,530,497	$ 23,493,470	$ 108,224,308
With Waiver Total Expenditures	**4.5%**	**$ 5,243,568,075**	**$ 5,501,878,481**	**$ 5,722,881,388**	**$ 5,955,345,957**	**$ 6,253,269,137**	**$ 28,676,943,038**

Excluded Expenditures:		
-Graduate Medical Expense	-PACE Capitation	-All services associated with excluded populations
-Disproportionate Share Hospital	-Local education agency (LEA) services	-Contracted local management entity/managed care organization (LME/MCO)
	-Children's Developmental Service Agencies	-Dental services (excluding dental varnish applied by non-dental practitioners)

Notes:

1. Federal Medical Assistance Percentage (FMAP) is equal to the FFY 2016 rate, which is 66.24%.
2. Federal Medical Assistance Percentage (FMAP) is equal to 100% for Tribal UC and Alternative Services.

8.2.3. Title XXI (CHIP) Allotment Neutrality

This section presents DHHS' approach for CHIP allotment neutrality, and the data and assumptions used in the development of the cost and caseload estimates supporting this request. DHHS has projected that the CHIP allotment will be neutral using the CMS allotment neutrality in Exhibit 7.

Population Overview

The CHIP allotment neutrality includes two populations: Medicaid expansion CHIP (MCHIP) and North Carolina's separate CHIP program, NC Health Choice. Each population receives health care services differently, which is reflected in the allotment neutrality projections. The MCHIP population (over age 3) is currently enrolled in LME-MCOs for mental health and substance abuse services, but accesses all other health services through fee-for-service. Note that MCHIP beneficiaries between age 0 and 3 receive all services through fee-for-service, as does the NC Health Choice population.

Historical Expenditures

CHIP allotment and expenditures were sourced from CMS 21 for federal fiscal year 2014 (FFY 2014) and FFY 2015 and projected for FFY 2016 and FFY 2017. Under current law, CHIP funding is set to expire in FFY 2017; therefore, the projections are limited to FFY 2017.

FFY 2015 is the base year for FFY 2016 and FFY 2017 projections. In FFY 2015, DHHS received $395,016,255 in CHIP allotment plus $222,055,491 carried over from prior years.

Non-administrative expenditures for FFY 2015 totaled $422,019,479 million, with $168,400,634 being expended for NC Health Choice and $253,618,845 for MCHIP. Note, as discussed above, NC Health Choice furnishes all health services through fee-for-service and MCHIP furnishes services under a combination of managed care and fee-for-service.

The administrative component for FFY 2015 totaled $8,308,119. Total non-administrative and administrative expenditures totaled $430,327,598, which resulted in a carry-over amount for FFY 2016 equal to $289,505,894.

Cost and Caseload Projections

FFY 2016 and FFY 2017 projections are based on FFY 2015 non-administrative caseloads and PMPMs. Caseload projections are based on projected DHHS enrollment for NC Health Choice and MCHIP.

PMPM expenditures for NC Health Choice and MCHIP (non LME-MCO) are trended at 3.9%, based on the President's Budget for Low Income Families. PMPM expenditures for MCHIP associated with the LME-MCO are trended at 4.5% annually, consistent with the annual rate of change reflected in the LME-MCO 1915(b) waiver.

Summary

For this demonstration, the federal share of combined MCHIP and NC Health Choice expenditures for all population groups covered under the CHIP portion of the demonstration project will not exceed the federal CHIP allotment. Exhibit 7 summarizes the allotment neutrality estimates for the base year and over the five-year period.

Notes for Exhibit 7

The information in Exhibit 7 includes the following footnotes:

- Expenditures from 2014 and 2015 are sourced from CMS21.
- MCHIP administration is included under SCHIP, on line 25.
- FFY 2016 member months include actual enrollment through December 2015 and projections through September 2016.
- Annual FFS medical trends from FFY 2015 to FFY 2017 include President's Budget trend as of 2014, which is 3.9% per year for Low-Income Family populations.
- Trend projections from FFY 2015 to FFY 2017 are based on the annual rate of change reflected in the 1915(b) waiver for the MCHIP population, which is 4.5% per year.
- CHIP authority expires at the end of FFY 2017.

Exhibit 7 – Title XXI Allotment Neutrality Budget Template for Section 1115 Demonstrations (FFY 2013 – FFY 2017)

Title XXI Allotment Neutrality Budget Template for Section 1115 Demonstrations (FFY - Federal Fiscal Year is 10/1 through 9/30)					
		Actual		Projected	
Line	Line Description	FFY 2014 [1,2]	FFY 2015 [1,2]	FFY 2016 [2,3,4,5]	FFY 2017 [2,4,5,6]
01.	State's Allotment	$ 323,738,478	**$ 395,016,255**	**$ 395,016,255**	**$ 395,016,255**
02.	Funds Carried Over From Prior Year(s)	$ 220,188,974	**$ 222,055,491**	**$ 289,505,894**	**$ 238,484,558**
03.	SUBTOTAL (Allotment + Funds Carried Over)	**$ 543,927,452**	**$ 617,071,746**	**$ 684,522,149**	**$ 633,500,813**
04.	Reallocated Funds (Redistributed or Retained that are Currently Available)	**$ -**	**$ -**	**$ -**	**$ -**
05.	TOTAL (Subtotal + Reallocated funds)	**$ 543,927,452**	**$ 617,071,746**	**$ 684,522,149**	**$ 633,500,813**
06.	State's Enhanced FMAP Rate (Quarterly Blend)	76.05%	76.12%	99.37%	99.82%
07.	**COST PROJECTIONS OF APPROVED SCHIP PLAN: Health Choice**				
08.	**Benefit Costs**				
09.	Insurance payments				
10.	Total Managed Care				
11.	per member/per month rate				
12.	# of eligible (MM)				
13.	Total Fee for Service	$ 227,536,061	$ 168,400,634	$ 179,461,497	$ 184,706,547
14.	per member/per month rate	$ 191.17	$ 165.77	$ 172.23	$ 178.95
15.	# of eligible (MM)	1,190,224	1,015,883	1,041,971	1,032,170
16.	Total Benefit Costs (Managed Care + Fee for Service)	**$ 227,536,061**	**$ 168,400,634**	**$ 179,461,497**	**$ 184,706,547**
17.					
18.	**Administration Costs**				
19.	Personnel				
20.	General administration	$ 11,023,697	$ 8,308,119	$ 11,100,000	$ 11,100,000
21.	Contractors/Brokers				
22.	Claims Processing				
23.	Outreach/marketing costs				
24.	Other (specify)				
25.	**Total Administration Costs**	**$ 11,023,697**	**$ 8,308,119**	**$ 11,100,000**	**$ 11,100,000**
26.	10% Administrative Cap	4.6%	4.7%	5.8%	5.7%
27.					
28.	Federal Title XXI Share	$ 181,424,849	$ 134,511,169	$ 189,360,960	$ 195,454,095
29.	State Share	$ 57,134,909	$ 42,197,584	$ 1,200,537	$ 352,452
30.	**TOTAL COSTS OF APPROVED SCHIP PLAN**	**$ 238,559,758**	**$ 176,708,753**	**$ 190,561,497**	**$ 195,806,547**
31.	**COST PROJECTIONS FOR DEMONSTRATION PROPOSAL: MCHIP - Medicaid**				
32.	**Benefit Costs**				
33.	Insurance payments				
34.	Total Managed Care	$ 45,260,628	$ 54,675,620	$ 55,930,630	$ 58,875,831
35.	per member/per month rate	$ 45.26	$ 42.43	$ 44.33	$ 46.30
36.	# of eligible (MM)	999,939	1,288,475	1,261,800	1,271,547
37.	Total Fee for Service	$ 139,416,497	$ 198,943,225	$ 202,373,317	$ 211,909,633
38.	per member/per month rate	$ 119.70	$ 135.97	$ 141.27	$ 146.78
39.	# of eligible (MM)	1,164,756	1,463,185	1,432,543	1,443,742
40.	Total Benefit Costs (Managed Care + Fee for Service)	**$ 184,677,125**	**$ 253,618,845**	**$ 258,303,946**	**$ 270,785,464**
41.					
42.	**Administration Costs**				
43.	Personnel				
44.	General administration	$ -	$ -	$ -	$ -
45.	Contractors/Brokers				
46.	Claims Processing				
47.	Outreach/marketing costs				
48.	Other (specify)				
49.	**Total Administration Costs**	**$ -**	**$ -**	**$ -**	**$ -**
50.	10% Administrative Cap				
51.					
52.	Federal Title XXI Share	$ 140,447,112	$ 193,054,683	$ 256,676,632	**$ 270,298,051**
53.	State Title XXI Share	$ 44,230,013	$ 60,564,162	$ 1,627,315	$ 487,414
54.	**TOTAL COSTS FOR DEMONSTRATION**	**$ 184,677,125**	**$ 253,618,845**	**$ 258,303,946**	**$ 270,785,464**
55.	**TOTAL TITLE XXI PROGRAM COSTS (State Plan + Demonstration)**	**$ 423,236,883**	**$ 430,327,598**	**$ 448,865,443**	**$ 466,592,012**
56.	Federal Title XXI Share	$ 321,871,961	$ 327,565,852	$ 446,037,591	$ 465,752,146
57.	State Title XXI Share	$ 101,364,922	$ 102,761,746	$ 2,827,852	$ 839,866
58.	**Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)**	**$ 543,927,452**	**$ 617,071,746**	**$ 684,522,149**	**$ 633,500,813**
59.	**Total Federal Title XXI Program Costs (State Plan + Demonstration)**	**$ 321,871,961**	**$ 327,565,852**	**$ 446,037,591**	**$ 465,752,146**
60.	**Unused Title XXI Funds Expiring (Allotment or Reallocated)**	**$ -**	**$ -**	**$ -**	**$ -**
61.	**Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)**	**$ 222,055,491**	**$ 289,505,894**	**$ 238,484,558**	**$ 167,748,667**

Notes:

1. Expenditures from 2014 and 2015 are sourced from CMS21.
2. MCHIP administration is included under SCHIP, on line 25.
3. FFY 2016 member months include actual enrollment through December 2015 and projections through September 2016.
4. Annual Fee-For-Service Medical Trends from FFY2015 to FFY2017 include President's Budget trend as of 2014, which is 3.9% per year for Low Income Family populations.
5. Trend projection from FFY2015 to FFY2017 are based on the annual rate of change reflected in the 1915(b) waiver for the MCHIP population, which is 4.5% per year.
6. CHIP authority expires at the end of FFY2017.

9. List of Proposed Waivers and Expenditure Authorities

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

See Table A below.

2) Describe why the State is requesting the waiver or expenditure authority, and how it will be used.

Table A below describes the authorities requested under this demonstration.

Table A – Waiver and Expenditure Authorities Requested

WAIVER/EXPENDITURE AUTHORITY SECTION CITATION	TYPE	PROPOSED WAIVER/EXPENDITURE AUTHORITY LANGUAGE	DESCRIPTIVE REASON FOR WAIVER/EXPENDITURE AUTHORITY REQUEST
1. Amount, Duration, and Scope of Services Section 1902(a)(10)(B) and 1902(a)(17)	Waiver Authority	To the extent necessary to permit North Carolina to offer coverage through PHPs that provide additional or different benefits to enrollees, than those otherwise available to other eligible individuals.	To permit North Carolina to implement mandatory managed care through PHPs for demonstration participants. PHPs may offer additional benefits, such as health education and value-added services not available to other Medicaid beneficiaries not participating in the demonstration.
2. Freedom of Choice Section 1902(a)(23)	Waiver Authority	To the extent necessary to enable North Carolina to restrict freedom of choice of provider through the use of mandatory enrollment into MCOs for demonstration participants.	To permit North Carolina to implement mandatory managed care through selective contracting with PHPs for demonstration participants.
3. Statewideness Section 1902(a)(1)	Waiver Authority	To the extent necessary to allow North Carolina to implement managed care statewide on a phase-in basis if part of final program design.	To permit North Carolina to implement statewide mandatory managed care through PHPs for demonstration enrollees on a phased-in basis as necessary.

WAIVER/EXPENDITURE AUTHORITY SECTION CITATION	TYPE	PROPOSED WAIVER/EXPENDITURE AUTHORITY LANGUAGE	DESCRIPTIVE REASON FOR WAIVER/EXPENDITURE AUTHORITY REQUEST
4. Expenditures for targeted provider Medicaid uncompensated care costs (Safety Net Hospital Payments and Tribal uncompensated care payments and alternative services for members of federally-recognized tribes.)	Expenditure Authority	Expenditures for care and services that meet the definition of "medical assistance" contained in section 1905(a) of the Act that are incurred by eligible providers for uncompensated Medicaid medical care costs of medical services provided to Medicaid eligible or uninsured individuals. Expenditures for tribal uncompensated care and alternative services.	Expenditures to providers to stabilize and invest in safety-net providers to ensure access to care as North Carolina transforms Medicaid payments from FFS to capitation under PHPs. Expenditures for uncompensated care and alternative services provided by EBCI.
5. Expenditures for delivery system reform incentive payments	Expenditure Authority	Expenditures for incentive payments under a DSRIP program.	Expenditures to eligible providers to stabilize and invest in safety-net providers and enable North Carolina to transform to a system of VBP as the state transitions from FFS to capitation under PHPs.
6. Expenditures for non-hospital clinic, local health department, public ambulance services that support rural health, and non-hospital state facilities	Expenditure Authority	Expenditures for rural and public provider initiatives.	Expenditures to eligible FQHC/RHC-like clinics, local health departments, public ambulance providers, and non-hospital state facilities to preserve funding levels through "wrap-around" payments.
7. Expenditures for community-based residency and health workforce training programs	Expenditure Authority	Expenditures for outpatient community-based residency and health workforce training programs.	Expenditures to support rural health access through funding for outpatient community-based residency and health workforce education programs. Add-on payments for eligible Area Health Education Centers (AHECs), Teaching Health Centers Graduate Medical Education (THCGME) programs, and community-based residency program for services provided to a Medicaid recipient.

WAIVER/EXPENDITURE AUTHORITY SECTION CITATION	TYPE	PROPOSED WAIVER/EXPENDITURE AUTHORITY LANGUAGE	DESCRIPTIVE REASON FOR WAIVER/EXPENDITURE AUTHORITY REQUEST
8. Expenditures for value-based payment methodologies within capitated PHPs	Expenditure Authority	Expenditure for capitation payments to incent managed care plans to engage in activities that promote performance targets and identify strategies for VBP models for provider reimbursement.	To enable North Carolina to incent capitated PHPs to adopt VBP models for provider reimbursement that may vary from what is provided in the rules at 42 CFR 438 (e.g., incentive payments more than 5% of capitation payments.)
9. Expenditures for parents of foster care children who would otherwise be Medicaid eligible except for the placement of their children into the child welfare system.	Expenditure Authority	Expenditures for parents of foster care children who would otherwise be Medicaid eligible except for the placement of their children into the child welfare system.	To continue Medicaid eligibility for parents of children placed temporarily in foster care to address the comprehensive health care needs of the parents and increase the likelihood of successful reunification of the children with the family.

10. Public Notice

1) Prior public notice activities

Medicaid reform in North Carolina began with Governor McCrory's declaration, upon taking office in January 2013, that the Medicaid system needed to be reformed. In February 2013, DHHS issued a request for information inviting suggestions for Medicaid reform. DHHS received more than 160 responses from stakeholders. The Secretary of DHHS and the Medicaid Director also conducted a statewide listening tour.

In its June 2013 budget bill, the General Assembly directed DHHS to study Medicaid reform options and requested the Governor appoint a Medicaid Reform Advisory Group to guide the effort. The Advisory Group was comprised of a North Carolina senator, a representative, and three citizen health care experts chosen by the Governor. DHHS leaders and staff devoted hundreds of hours listening to stakeholders' ideas. Diverse groups such as beneficiaries and their advocates, medical associations, behavioral health providers, health system executives from urban and rural areas, local health departments, representatives from teaching hospitals and medical schools, community health center directors, pharmacists, representatives from long-term care facilities, and others contributed valuable input.

Through the fall/winter of 2013-2014, Governor McCrory hosted North Carolina health industry leaders at the Governor's mansion, and the Medicaid Reform Advisory Group met three times in public forums to consider reform options. These efforts culminated in March 2014 with DHHS delivering a Medicaid reform plan to the General Assembly. The plan proposed vesting North Carolina health care providers with principal responsibility and accountability for delivering improvements in quality and efficiency.

In the fall of 2014 and early 2015, DHHS began work on clinical measures for the envisioned reform. DHHS leaders met with medical and hospital leaders to solicit their priorities and concerns regarding quality measurement in general. Subsequently, a Quality Measurement Framework white paper was developed. National measure sets relevant to Medicaid were surveyed for measures consistent with the principles set forward in the framework. A draft measure set appropriate for key Medicaid populations was created. Follow up meetings on the framework and the draft measures set were held with representatives of professional associations, the NC ACO Collaborative, the Division of Public Health, local health departments and the NC Community Health Center Association. A second draft based on this feedback awaits further work.

A combination of advocates and providers met on multiple occasions throughout 2014 to address whole-person integration in the LTSS community. The meetings were a strategic planning effort under the DHHS Medicaid Reform initiative. As part of the strategic planning, each services' stakeholder group (providers, families, beneficiaries, advocates and others) reviewed both intermittent services (hospice, home infusion therapy, home health and post-

acute nursing facility), and long-range services (CAP/DA, CAP/C, private duty nursing, personal care services, nursing facility and PACE).

In its 2014 session, the North Carolina House of Representatives unanimously adopted a bill to enact the Governor's plan. Ultimately, the Senate did not fully concur, and the session ended without the passage of legislation. In the 2015 session, leaders of the two chambers teamed up to draft a compromise Medicaid reform bill, which was enacted as SL 2015-245 in September 2015.

Since the passage of SL 2015-245, DHHS has proactively sought input from key stakeholders across the state, including physicians, beneficiaries, beneficiary advocates, hospitals, potential PHPs and many more. DHHS met with more than 50 stakeholder groups and collected written feedback used to develop a draft 1115 demonstration application released March 1, 2016. As described below, DHHS sought and received extensive stakeholder feedback on the draft application.

All along, DHHS has recognized and leveraged input from all of North Carolina's Medicaid stakeholders as crucial to the success of reform. The proposed model evolved over time as DHHS and legislative leaders listened to and engaged with stakeholders. The result reflects a spirit of collaboration that informed this process and that will ensure the acceptance of the upcoming changes. DHHS will continue seeking input throughout the development and implementation of Medicaid reforms.

2) Public Notice and Comment

As noted above, stakeholder input helped build the foundation for the draft demonstration application. The draft application was released to the public on March 1, 2016, for additional input and consideration by stakeholders and more broadly, the residents of North Carolina. The public comment period outlined in greater detail below, yielded a better understanding of the grassroots impact of the proposal. Importantly, the public comment process also has provided a resource to further refine the demonstration to better reflect the needs and concerns of those whom it will impact.

The public comment period for North Carolina's draft demonstration application began Monday, March 16, 2016, and ended at 11:59 p.m. Eastern time Monday, April 18, 2016. The draft demonstration application was released to the public March 1, 2016; the DHHS website for public notice and comment launched March 7; and the abbreviated public notices were published March 16. DHHS continues to accept comments focused on implementation and operations.

The following summarizes North Carolina's public notice activities (the public hearings and tribal consultation are described separately):

- Draft 1115 demonstration application was posted on the General Assembly website March 1, 2016, as part of the materials for presentation to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice (JLOC). The website is: http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=284&sFolderName=\2015-16%20Interim\March%201,%202016\Reports
- DHHS staff provided a summary of the draft demonstration application to the JLOC during a public meeting March 1, 2016.
- Governor McCrory issued a press release March 1, 2016 (see Appendix E for the press release).
- Draft 1115 demonstration application was published on the North Carolina DHHS Medicaid reform website, http://www.ncdhhs.gov/nc-medicaid-reform, March 7, 2016.
- Detailed public notice was published on the Medicaid reform website March 7, 2016 (see Appendix E for a copy of the detailed public notice). The detailed public notice included:
    - Summary of the demonstration.
    - Location and website address where copies of the demonstration application were available.
        - Hard copies of the draft demonstration application were provided on request at DHHS, 101 Blair Drive, Raleigh, North Carolina.
        - An electronic copy of the demonstration application was available at http://www.ncdhhs.gov/nc-medicaid-reform.
    - Postal and internet email addresses where written comments could be sent:
        - Postal mail to Division of Health Benefits, DHHS, 2501 Mail Service Center, Raleigh, NC 27699-2501.
        - Emails to MedicaidReform@dhhs.nc.gov.
    - Time period comments would be accepted was March 7, 2016, through 11:59 p.m. April 18, 2016.
    - Location, date and time of the three March public hearings, including the dial-in number for one of the hearings, a note that a complete list of hearings was available on the Medicaid Reform website, and a link to the website.
    - Additional modes for submitting comments[7]:

[7] Based on stakeholder feedback, DHHS also established a dedicated phone message line at (919) 855-3470. This information was posted on DHHS' Medicaid Reform website.

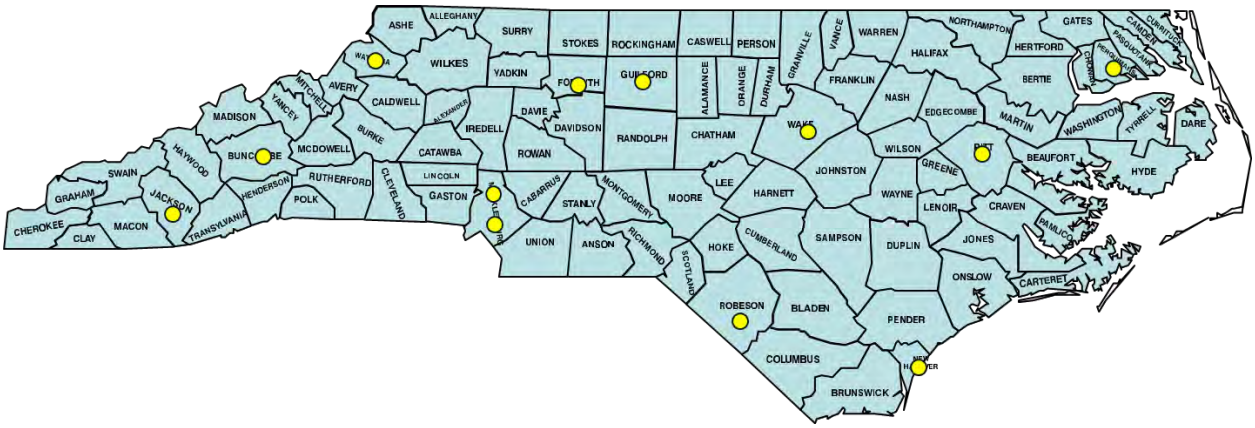
  - An online comment submission form at http://www.ncdhhs.gov/nc-medicaid-reform/medicaid-reform-comment-submission-form (see Appendix E for the online comment submission form).
  - In-person at DHHS, 101 Blair Drive in Raleigh, North Carolina.

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

GEOGRAPHIC AREA	NC CITIES WITH 100,000 RESIDENTS[8]	PUBLIC HEARING LOCATION[9]	NEWSPAPER
Western		Asheville Boone Sylva	Asheville Citizen-Times
Charlotte	Charlotte	Monroe Huntersville	Charlotte Observer
			Gaston Gazette
Greensboro	Greensboro	Greensboro	Greensboro News & Record
Greenville		Greenville	The Daily Reflector
High Point	High Point		High Point Enterprise
Raleigh-Durham-Fayetteville	Cary Raleigh Durham Fayetteville	Raleigh	News & Observer
			The Herald Sun
			The Fayetteville Observer
Wilmington	Wilmington	Wilmington	Wilmington StarNews
Winston-Salem	Winston-Salem	Winston-Salem	Winston-Salem Journal

[8] Source: United States Census Bureau
[9] The newspapers covering public hearings in Elizabeth City (The Daily Advance) and Pembroke (The Robesonian) did not respond to repeated requests to publish the abbreviated public notice.

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



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

* Dial-in option available.

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

The following table outlines the public hearing schedule, the number of attendees at each public hearing, and the number of speakers:

Public Hearing	Attendance and Speakers	
	Total Attendees	Speakers
March 30, 2016: Raleigh Time: 6:00 PM – 8:00 PM McKimmon Center Room 6 1101 Gorman Street Raleigh, NC 27606	213	33
March 31, 2016: Monroe (Charlotte Area) **Time:** 2:00 PM – 4:00 PM Union County Dept. of Social Services Auditorium 1212 W. Roosevelt Boulevard Monroe, NC 28110	231 157 (dial-in)	41 20 (dial-in)
March 31, 2016: Huntersville (Charlotte Area) **Time:** 6:30 PM – 8:30 PM Central Piedmont Community College, Merancas Campus Auditorium 11930 Verhoeff Drive Huntersville, NC 28078	70	27
April 5, 2016: Sylva Time: 4:00 PM – 6:00 PM Southwestern Community College Auditorium 447 College Drive Sylva, NC 28779	23	3
April 6, 2016: Boone Time: 12:00 PM – 2:00 PM Holiday Inn Express 1943 Blowing Rock Road Boone, NC 28607	72	7
April 6, 2016: Asheville Time: 6:30 PM – 8:30 PM Asheville-Buncombe Technical Community College Mission Health / A-B Tech Conference Center 340 Victoria Road Asheville, NC 28801	138	40
April 7, 2016: Greensboro Time: 6:30 PM – 8:30 PM Guilford County Health & Human Services 1203 Maple Street Greensboro, NC 27405	121	30

Public Hearing	Attendance and Speakers	
	Total Attendees	Speakers
April 8, 2016: Winston-Salem Time: 2:00 PM – 4:00 PM Forsyth County Department of Public Health Meeting Room 1 & 2 799 North Highland Avenue Winston-Salem, NC 27102	100	24
April 13, 2016: Wilmington Time: 6:00 PM – 800 PM University of North Carolina-Wilmington McNeill Hall Lecture Hall 601 S. College Road Wilmington NC 28403	114	27
April 14, 2016: Greenville Time: 2:00 PM – 4:00 PM Greenville Convention Center Emerald Ballroom 303 SW Greenville Boulevard Greenville, NC 27834	183	38
April 14, 2016: Elizabeth City Time: 10:00 AM – 12:00 PM College of The Albemarle AE 208 1208 N. Road Street Elizabeth City, NC 27909	31	11
April 18, 2016: Pembroke (Lumberton) Time: 3:30 PM – 5:30 PM UNC-Pembroke Moore Hall Auditorium 1 University Drive Pembroke, NC 28372-1510	84 53 (dial-in)	22 0 (dial-in)
TOTAL	**1,590**	**323**

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

3) Tribal Consultation

DHHS certifies that it conducted tribal consultation according to the consultation process outlined in North Carolina's approved state plan. DHHS staff met with staff from the Eastern Band of the Cherokee Indians (EBCI) Division of Public Health and Human Services and the Cherokee Indian Hospital Authority Feb. 16-17, 2016, to solicit input on the development of the Medicaid 1115 demonstration and other Medicaid issues. The visit and initial consultation were documented in a Feb. 21, 2016, letter to DHHS from the Cherokee Indian Hospital Authority dated.

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

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

Copies of communications between DHHS and EBCI can be found in Appendix C.

4) Summary of Public Comments (other than from EBCI)

As described above, DHHS solicited and received comments through various means, including the website, postal mail, email, voice mail, 12 public hearings (written and verbal), and two MCAC meetings. Overall DHHS received feedback from more than 750 commenters during the public comment period. The approximate break down by mode is 41% of commenters commented through the website, 41% spoke at a hearing, 8% by email, 5% through written comments at a hearing, 2% by postal mail, 2% at MCAC, and less than 1% by phone.

The commenters reflected a wide range of stakeholders including beneficiaries and their families, trade associations and advocates, providers, health plans, and other interested North Carolina residents. While the focus of the public hearings was the draft demonstration application, as part of the public notice and comment process, DHHS also requested feedback on the proposed regions, a report on Medicaid reform provided to the Joint Legislative Oversight Committee (the JLOC report), and any other items of concern. While most of the comments (approximately 90%) were about the demonstration application, there were also comments about the JLOC report, the regions, and other issues. Given the overlap in topics, DHHS reviewed the comments for potential revisions to the demonstration application and to prepare the summary of public comments (Appendix B).

Appendix B summarizes the comments received by DHHS during the public comment period and DHHS' response. Comments and responses are organized by topic, including key sections of the draft demonstration application and additional themes from the public comments. The summary does not reflect comments related to items in the JLOC report that are not addressed in the demonstration application (e.g., solvency requirements, application of insurance provisions, rate floors, and how to address the potential for anti-competitive behavior); comments about the structure of particular regions; comments about the current system (e.g., LME-MCOs, TBI waiver, PCP assignment, rates, current PDL); comments expressing personal grievances; and comments otherwise not related to the demonstration. Many of the comments were related to implementation issues and will be addressed during program development. Comments not related to the demonstration application will be published on DHHS' website.

11. Demonstration Administration

> *Please provide the contact information for the State's point of contact for the Demonstration application.*

Name and Title:	Rick Brajer, Secretary North Carolina Department of Health and Human Services
Telephone Number:	919 855 4800 (office); 919 715 4645 (fax)
Email Address:	Rick.Brajer@dhhs.nc.gov
Address:	101 Blair Drive 2001 Mail Service Center Raleigh, NC 27699-2001

Name and Title:	Dee Jones, Chief Operating Officer, Division of Health Benefits North Carolina Department of Health and Human Services
Telephone Number:	919 855 3471
Email Address:	Dee.Jones@dhhs.nc.gov
Address:	2104 Umstead Drive 2501 Mail Service Center Raleigh, NC 27699-2501

12. Appendices

Appendix A. Session Law 2015-245

Appendix B. Summary of Public Comments and Responses

Appendix C. Tribal Consultation and Assurances

Appendix D. North Carolina Health Transformation Center Report

Appendix E. Public Comment Period Communication

Appendix A. Session Law 2015-245

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

SESSION LAW 2015-245
HOUSE BILL 372

AN ACT TO TRANSFORM AND REORGANIZE NORTH CAROLINA'S MEDICAID AND NC HEALTH CHOICE PROGRAMS.

The General Assembly of North Carolina enacts:

PART I. TRANSFORMATION OF MEDICAID AND NC HEALTH CHOICE PROGRAMS

SECTION 1. Intent and Goals. – It is the intent of the General Assembly to transform the State's current Medicaid and NC Health Choice programs to programs that provide budget predictability for the taxpayers of this State while ensuring quality care to those in need. The new Medicaid and NC Health Choice e programs shall be designed to achieve the following goals:

(1) Ensure budget predictability through shared risk and accountability.
(2) Ensure balanced quality, patient satisfaction, and financial measures.
(3) Ensure efficient and cost-effective administrative systems and structures.
(4) Ensure a sustainable delivery system.

SECTION 2. Role of the General Assembly. – The General Assembly shall have the following roles and responsibilities in Medicaid and NC Health Choice transformation and governance:

(1) Define the overall goals of transformation and the structure of the delivery system for the programs.
(2) Monitor the development of transformation plans and implementation through the Joint Legislative Oversight Committee on Medicaid and NC Health Choice.
(3) Define and approve eligibility and income standards for the programs, including which populations will be covered by Prepaid Health Plans (PHPs).
(4) Appropriate the annual budget for the Medicaid and NC Health Choice programs.
(5) Confirm the Director of the Division of Health Benefits, as required by G.S. 143B-216.85, enacted by Section 1 2 of this act.

SECTION 3. Time Line for Medicaid Transformation. – The following milestones for Medicaid transformation shall occur no later than the following dates:

(1) When this act becomes law. –
    a. The Division of Health Benefits of the Department of Health and Human Services (DHHS) is created pursuant to Section 10 of this act.
    b. The Joint Legislative Oversight Committee on Medicaid and NC Health Choice is created pursuant to Section 15 of this act to oversee the Medicaid and NC Health Choice programs.
    c. The Division of Health Benefits shall begin development of the 1115 waiver and any other State Plan amendments and waiver amendments necessary to effectuate the Medicaid transformation required by this act.
(2) March 1, 2016. – The DHHS, through the Division of Health Benefits, shall report its plans and progress on Medicaid transformation, including recommended statutory changes, to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, as required by subdivision (1 2) of Section 5 of this act.

(3) On or before June 1, 2016. – The DHHS, through the Division of Health Benefits shall submit the waivers and State Plan amendments required by this act to the Centers for Medicare & Medicaid Services (CMS).

(4) Eighteen months after approval of all necessary waivers and State Plan amendments by CMS. – Capitated contracts shall begin and initial recipient enrollment shall be complete.

SECTION 4. Structure of Delivery System. – The transformed Medicaid and NC Health Choice programs described in Section 1 of this act shall be organized according to the following principles and parameters:

(1) DHHS authority. – The Department of Health and Human Services (DHHS) shall have full authority to manage the State's Medicaid and NC Health Choice programs provided that the total expenditures, net of agency receipts, do not exceed the authorized budget for each program, except the General Assembly shall determine eligibility categories and income thresholds. DHHS through the Division of Health Benefits, created in Section 10 of this act, shall be responsible for planning and implementing the Medicaid transformation required by this act.

(2) Prepaid Health Plan. – For purposes of this act, a Prepaid Health Plan (PHP) shall be defined as an entity, which may be a commercial plan or provider-led entity, that operates or will operate a capitated contract for the delivery of services pursuant to subdivision (3) of this section. For purposes of this act, the terms "commercial plan" and "provider-led entity" are defined as follows:

a. Commercial plan or CP. – Any person, entity, or organization, profit or nonprofit, that undertakes to provide or arrange for the delivery of health care services to enrollees on a prepaid basis except for enrollee responsibility for copayments and deductibles and holds a PHP license issued by the Department of Insurance.

b. Provider-led entity or PLE. – An entity that meets all of the following criteria:

1. A majority of the entity's ownership is held by an individual or entity that has as its primary business purpose the ownership or operation of one or more Medicaid and NC Health Choice providers.
2. A majority of the entity's governing body is composed of physicians, physician assistants, nurse practitioners, or psychologists.
3. Holds a PHP license issued by the Department of Insurance.

(3) Capitated contracts. – The Division of Health Benefits, created in Section 10 of this act, shall enter into capitated contracts with PHPs for the delivery of Medicaid and NC Health Choice services as specified in this act. All capitated contracts shall be the result of requests for proposals (RFPs) issued by the Division of Health Benefits and the submission of competitive bids by PHPs, pursuant to subdivision (6) of Section 5 of this act.

(4) Services covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice services, including physical health services, prescription drugs, long-term services and supports, and behavioral health services for NC Health Choice recipients, except as otherwise provided in this subdivision. Behavioral health services for Medicaid recipients currently covered by the local management entities/managed care organizations (LME-MCOs) shall be excluded from the capitated contracts until four years after the date capitated contracts begin. The capitated contracts required by this subdivision shall not cover dental services.

(5) Populations covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice program aid categories except recipients who are dually eligible for Medicaid and Medicare. Recipients in the aged program aid category that are eligible for

Medicare shall be considered recipients who are dually eligible for Medicaid and Medicare. The Division of Health Benefits shall develop a long-term strategy to cover dual eligibles through capitated PHP contracts, as required by subdivision (11) of Section 5 of this act.

(6) Number and nature of capitated PHP contracts. – The number and nature of the contracts required under subdivision (3) of this section shall be as follows:

a. Three contracts between the Division of Health Benefits and PHPs to provide coverage to Medicaid and NC Health Choice recipients statewide (statewide contracts).

b. Up to 10 contracts between the Division of Health Benefits and PLEs for coverage of regions specified by the Division of Health Benefits pursuant to subdivision (2) of Section 5 of this act (regional contracts). Regional contracts shall be in addition to the three statewide contracts required under sub-subdivision a. of this subdivision. Each regional contract shall provide coverage throughout the entire region for the Medicaid and NC Health Choice services required by subdivision (4) of this section. A PLE may bid for more than one region al contract, provided that the regions are contiguous.

c. Initial capitated PHP contracts may be awarded on staggered terms of three to five years in duration to ensure against gaps in coverage that may result from termination of a contract by the PHP or the State.

(6a) To the extent allowed by Medicaid federal law and regulations and consistent with the requirements of this act, PHPs shall comply with the requirements of Chapter 58 of the General Statutes. This requirement shall not be construed to require PHPs to cover services that are not covered by the Medicaid program pursuant to federal law and regulations. The Department of Health and Human Services, Division of Health Benefits, and the Department of Insurance shall jointly review the applicability of provisions of Chapter 58 of the General Statutes to PHPs, and report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2016, on the following:

a. Proposed exceptions to the applicability of Chapter 58 of the General Statutes for PHPs.

b. Recommendations for resolving conflicts between Chapter 58 of the General Statutes and the requirements of Medicaid federal law and regulations.

c. Proposed statutory changes necessary to implement this subdivision.

(7) Defined measures and goals. – The new delivery system and capitated PHP contracts shall be built on defined measures and goals for risk-adjusted health outcomes, quality of care, patient satisfaction, access, and cost. Each component shall be subject to specific accountability measures, including penalties. The Division of Health Benefits may use organizations such as National Committee for Quality Assurance (NCQA), Physician Consortium for Performance Improvement (PCPI), or any others necessary to develop effective measures for outcomes and quality.

(8) Administrative functions. – PHPs shall be responsible for all administrative functions for recipients enrolled in their plan, including, but not limited to, claims processing, care and case management, grievances and appeals, and other necessary administrative services.

(9) LME-MCOs. – LME-MCOs shall continue to manage the behavioral health services currently covered for their enrollees under all existing waivers, including the 1915(b) and (c) waivers, for four years after the date capitated PHP contracts begin. During this four-year period, the Division of Health Benefits shall continue to negotiate actuarially sound

capitation rates directly with the LME-MCOs in the same manner as currently utilized. Capitation payments under contracts between the Division of Health Benefits and the shall be made directly to the LME-MCO by the Division of Health Benefits during the four-year period.

SECTION 5. Role of DHHS. – The role and responsibility of DHHS, through the Division of Health Benefits, during Medicaid transformation shall include the following activities and functions:

(1) Submit to CMS a demonstration waiver application pursuant to Section 1115 of the Social Security Act and any other waivers and State Plan amendments necessary to accomplish the requirements of this act within the required time frames.

(2) Define six regions comprised of whole contiguous counties that reasonably distribute covered populations across the State to ensure effective delivery of health care and achievement of the goals of Medicaid transformation set forth in Section 1 of this act. Every county in the State must be assigned to a region.

(3) Oversee, monitor, and enforce capitated PHP contract performance.

(4) Ensure sustainability of the transformed Medicaid and NC Health Choice programs.

(5) Set rates, including the following:

a. Capitation rates that are actuarially sound. Actuarial calculations must include utilization assumptions consistent with industry and local standards. Capitation rates shall be risk adjusted and shall include a portion that is at risk for achievement of quality and outcome measures, including value-based payments.

b. Appropriate rat e floors for in-network primary care physicians, specialist physicians, and pharmacy dispensing fees to ensure the achievement of transformation goals.

c. Rates for services in the remaining fee-for-service programs.

(6) Enter into capitated PHP contracts for the delivery of the Medicaid and NC Health Choice services described in subdivision (4) of Section 4 of this act. All contracts shall be the result of requests for proposals (RFPs) issued by DHHS and the submission of competitive bids by PHPs. DHHS, through the Division of Health Benefits, shall develop standardized contract terms, to include at a minimum, the following:

a. Risk-adjusted cost growth for its enrollees must be at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for nonexpansion states.

b. A requirement that PHP spending for prescribed drugs, net of rebates, ensures the State realizes a net savings for the spending on prescription drugs. All PHPs shall be required to use the same drug formulary, which shall be established by DHHS, through the Division of Health Benefits.

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

d. A requirement that PHPs develop and maintain provider networks that meet access to care requirements for their enrollees. PHPs may not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates. Notwithstanding the previous sentence, PHPs must include all providers in their geographical coverage area that are designated essential providers by DHHS pursuant to subdivision (13) of this section, unless

DHHS approves an alternative arrangement for securing the types of services offered by the essential providers. e. A requirement that all PHPs assure that enrollees who do not elect a primary care provider will be assigned to one.

(7) Prior to issuing the RFPs required by subdivision (6) of this section, consult, in accordance with G.S. 12-3(15), with the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on the terms and conditions of the requests for proposals (RFPs) for the solicitation of bids for statewide and regional capitated PHP contracts.

(8) Develop and implement a process f or recipient assignment to PHPs. Criteria for assignment shall include at least the recipient's family unit, including foster family and adoptive placement, quality measures, and primary care physician.

(9) Define methods to ensure program integrity against provider fraud, waste, and abuse at all levels.

(10) Require all PHPs and Medicaid and NC Health Choice providers to submit data through the Health Information Exchange Network, as required by Section 12A.5 of House Bill 97, 2015 Regular Session, in order to ensure effective systems and connectivity to support clinical coordination of care, the exchange of information, and the availability of data to DHHS and the Division of Health Benefits to manage the Medicaid and NC Health Choice programs for the Stat e.

(11) Develop a Dual Eligibles Advisory Committee, which must include at least a reasonably representative sample of the populations receiving long-term services and supports covered by Medicaid. The Division of Health Benefits, upon the advice of the Du al Eligibles Advisory Committee, shall develop a long-term strategy to cover dual eligibles through capitated PHP contracts and report the strategy to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by January 31, 2017.

(12) Report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2016. At a minimum, this report shall include:

a. The proposed waiver application.
b. The expected time frame for the submission of the proposed waiver to CMS.
c. Proposed statutory changes required.
d. Status of staffing of the Division of Health Benefits, including a description of staff's key competencies and expertise.
e. Anticipated distribution of regional capitated PHP contracts.
f. Plans for recipient enrollment.
g. Recipient access standards.
h. Performance measures.
i. A plan for the proposed inclusion of the following features as part of Medicaid and NC Health Choice transformation:
    1. Rate floors in addition to those required by subdivision (5) of Section 5 of this act.
    2. Antitrust policies.
    3. Protections against the exclusion of certain provider types.
    4. Prompt pay requirements.
    5. Uniform credentialing requirements.
    6. Good-faith negotiations.

j. Time line for issuance of RFP and solicitation of bids.
k. Measures for sustainability of the transformed system.

l. A plan for transition of features of the contract with the North Carolina Community Care Network, Inc., (NCCCN) to the new delivery system, including a plan for utilizing, at the appropriate time, the Health Information Exchange Network to perform certain functions presently being performed by NCCCN's Informatics Center in conjunction with the primary care case management program.

m. A plan to stabilize the Division of Medical Assistance during the transition of the Medicaid and NC Health Choice programs to the Division of Health Benefits.

n. A plan that will ensure continuity of services for individuals in foster care and adoptive placements in the transformed Medicaid and NC Health Choice programs.

(13) Designate Medicaid and NC Health Choice providers as essential providers if the provider either offers services that are not available from any other provider within a reasonable access standard or provides a substantial share of the total units o f a particular service utilized by Medicaid and NC Health Choice recipients within the region during the last three years, and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid and NC Health Choice enrollees. DHHS shall not classify physicians and other practitioners as essential providers. At a minimum, providers in the following categories shall be designated essential providers:

a. Federally qualified health centers.

b. Rural health centers.

c. Free clinics.

d. Local health departments.

SECTION 6. Role of the Department of Insurance. – The transformed Medicaid and NC Health Choice system shall include the licensing of PHPs based on solvency requirements established and implemented by the Department of Insurance. The Commissioner of Insurance, in consultation with the Director of the Division of Health Benefits, shall develop recommended solvency requirements that are similar to the solvency requirements for similarly situated regulated entities and recommended licensing procedures that include an annual review by the Commissioner and reporting of changes in licensure to the Division of Health Benefits. The Commissioner shall report the recommendations as well as proposed fees to offset the cost of licensure and any necessary statutory changes to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2016.

SECTION 7. Primary Care Case Management. – By July 1, 2016, DHHS will renegotiate its contract with North Carolina Community Care Networks, Inc., (NCCCN) to reduce per member per month payments to NCCCN for administration, including informatics, by fifteen percent (15 %) from the amount of per member per month payments NCCCN received for January 2015. The re negotiated contract shall provide for greater efficiencies and facilitate a smooth transition of features of the enhanced primary care case management program, including case management, informatics center operations, and practice supports, to the primary care medical home model or other care management model that will be utilized by PHPs, consistent with the plan reported to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice pursuant to subdivision (12) of Section 5 of this act. The renegotiated contract shall also include performance measures and consequences for failing to meet those performance measures. DHHS shall continue to utilize NCCCN to perform existing functions until capitated PHP contracts begin as required by this act. When capitated PHP contracts begin, any contract with NCCCN existing on that date shall terminate. Funds equal to the amount of any savings achieved on or after August 1, 2015, by the Division of Medical Assistance as a result of the contract renegotiation required by this section shall be transferred to the Division of Health Benefits to be used for the transition to capitated PHP contracts.

SECTION 8. Innovations Center. – DHHS shall submit a program design and budget proposal no later than May 1, 2016, to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice that will create a Medicaid and NC Health Choice Transformation Innovations Center within the Division of Health Benefits with the purpose of assisting Medicaid and NC Health Cho ice providers in achieving the ultimate goals of better health, better care, and lower costs for North Carolinians. The center should be designed to support providers through technical assistance and learning collaboratives that foster peer-to-peer sharing of best practices. DHHS shall use the Oregon Health Authority's Transformation Center as a de sign model and shall consider at least the following features:

(1) Learning collaboratives, peer-to-peer networks.
(2) Clinical standards and supports.
(3) Innovator agents.
(4) Council of Clinical Innovators.
(5) Community and stakeholder engagement.
(6) Conferences and workshops.
(7) Technical assistance.
(8) Infrastructure support.

SECTION 9. Maintain Funding Mechanisms. – In developing the waivers and State Pl an amendments necessary to implement this act, the Department of Health and Human Services, through the Division of Health Benefits created in Section 10 of this act, shall work with the Centers for Medicare & Medicaid Services (CMS) to attempt to preserve existing levels of funding generated from Medicaid-specific funding streams, such as assessments, to the extent that the levels of funding may be preserved. If such Medicaid-specific funding cannot be maintained as currently implemented, then the Division of Health Benefits shall advise the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, created in Section 1 5 of this act, of any modifications necessary to maintain as much revenue as possible within the context of Medicaid transformation. If such Medicaid-specific funding streams cannot be preserved through the transformation process or if revenue would decrease, it is the intent of the General Assembly to modify such funding streams so that any supplemental payments to providers are more closely aligned to improving health outcomes and achieving overall Medicaid goals.

PART II. REORGANIZATION OF MEDICAID AND NC HEALTH CHOICE PROGRAMS

SECTION 10. Creation of the Division of Health Benefits. – The Division of Health Benefits is established as a new division of the Department of Health and Human Services. The Department of Health and Human Services, through the Division of Health Benefits, shall be responsible for implementing Medicaid transformation required by this act and shall administer and operate all functions, powers, duties, obligations, and services related to the transformed Medicaid and NC Health Choice programs. The Division of Medical Assistance shall continue to operate the current Medicaid and NC Health Choice programs until the Division of Medical Assistance is eliminated. Upon the elimination of the Division of Medical Assistance, all functions, powers, duties, obligations, and services vested in the Division of Medical Assistance of the Department of Health and Human Services are vested in the Division of Health Benefits. The Department of Health and Human Services shall remain the Medicaid single State agency.

SECTION 11. Elimination of the Division of Medical Assistance. – Twelve months after capitated PHP contracts begin, or at an earlier time as determined by the Secretary of the Department of Health and Human Services, the Division of Medical Assistance and all positions remaining in the Division of Medical Assistance at that time are eliminated. The Secretary shall notify the Office of State Budget and Management and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice three months prior to the date the Secretary anticipates that the Division of Medical Assistance will no longer

be needed for future operations of the Medicaid and NC Health Choice programs and will be eliminated. Upon elimination of the Division of Medical Assistance, the Secretary shall notify the Office of State Budget and Management and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice of the effective date of the elimination of the Division of Medical Assistance. The Department of Health and Human Services shall provide notice to employees of the Division of Medical Assistance whose positions will be eliminated due to a reduction in force in accordance with the reduction in force policies of the Office of State Human Resources.

SECTION 12.(a) Article 3 of Chapter 143B of the General Statutes is amended by adding a new part to read:

"Part 36. Division of Health Benefits."

§ 143B-216.80. Division of Health Benefits– creation and organization.

There is hereby established the Division of Health Benefits of the Department of Health and Human Services. The Department of Health and Human Services, through the Division of Health Benefits, shall have the powers and duties described in G.S. 108A-54(e). The Director shall be the head of the Division of Health Benefits."

SECTION 12.(b) Effective January 1, 2021, Part 36 of Article 3 of Chapter 143B of the General Statutes is amended by adding a new section to read:

"§ 143B-216.85. Appointment; term of office; and removal of the Director of the Division of Health Benefits.

a) Term. – The Director of the Division of Health Benefits shall be appointed by the Governor for a term of four years subject to confirmation by the General Assembly by joint resolution. The initial term of office for the Director of the Division of Health Benefits shall begin upon confirmation by the General Assembly and shall expire June 30, 20 2 5. Thereafter, the term of office for the Director of the Division of Health Benefits shall be four years and shall commence on July 1 of the year in which the term for which the appointment is made.

(b) Appointment. – The Governor shall submit the name of the person to be appointed Director of the Division of Health Benefits to the General Assembly for confirmation by the General Assembly on or before May 1 of the year in which the term of the office for which the appointment is to be made expires. If the Governor fails to submit a name by May 1, the President Pro Tempore of the Senate and the Speaker of the House of Representatives jointly shall submit a name of an appointee to the General Assembly on or before May 15 of the same year. The appointment shall then be made by enactment of a bill. The bill shall state the name of the person being appointed, the office to which the appointment is being made, the effective date of the appointment, the date of expiration of the term, the residence of the appointee, and that the appointment is made upon the joint recommendation of the Speaker of the House of Representatives and the President Pro Tempore of the Senate. Nothing precludes any member of the General Assembly from proposing an amendment to any bill making such an appointment. If there is no vacancy in the office of the Director, and a bill that would confirm the appointment of the person as Director fails a reading in either chamber of the General Assembly, then the Governor shall submit a new name within 30 days.

(c) Vacancy. – If a vacancy in the office of the Director occurs for any reason prior to the expiration of the Director's term of office, the Governor shall submit the name of the Director's successor to the General Assembly not later than 60 days after the vacancy occurs. If a vacancy occurs when the General Assembly is not in session, the Governor shall appoint an acting Director to serve the remainder of the unexpired term pending confirmation by the General Assembly. However, in no event shall an acting Director serve (i) for more than 12 months without General Assembly confirmation or (ii) after a bill that would confirm the appointment of the person as

Director fails a reading in either chamber of the General Assembly. The successor appointed to fill the vacancy shall serve until the end of the unexpired term.

(d) Removal. – The Director of the Division of Health Benefits may be removed from office only by the Governor and solely for the grounds set forth in G.S. 143B-13(b), (c), and (d)."

SECTION 13. G.S. 108A-54 reads as rewritten:"§ 108A-54. Authorization of Medical Assistance Program; administration.

(e) The Secretary of the Department of Health and Human Services, through the Division of Health Benefits, shall have the following powers and duties:

(1) Administer and operate the Medicaid and NC Health Choice programs provided that the total expenditures, net of agency receipts, do not exceed the authorized budget for each program. None of the powers and duties enumerated in the other subdivisions of this subsection shall be construed to limit the broad grant of authority to administer and operate the Medicaid and NC Health Choice programs.

(2) Employ clerical and professional staff of the Division of Health Benefits, including consult ants and legal counsel, necessary to carry out the powers and duties of the division. In hiring staff for the Division of Health Benefits, the Secretary may offer employment contracts for a term and set compensation for the employees, which may include performance-based bonuses based on meeting budget or other targets.

(3) Notwithstanding G.S. 143-64.20, enter into contracts for the administration of the Medicaid and NC Health Choice programs, as well as manage such contracts, including contracts of a consulting or advisory nature.

(4) Establish and adjust all program components, except for eligibility categories and income thresholds, of the Medicaid and NC Health Choice programs within the appropriated and allocated budget.

(5) Adopt rules related to the Medicaid and NC Health Choice programs.

(6) Develop midyear budget correction plans and strategies and then take midyear budget corrective actions necessary to keep the Medicaid and NC Health Choice programs within budget.

(7) Approve or disapprove and oversee all expenditures to be charged to or allocated to the Medicaid and NC Health Choice programs by other State departments or agencies.

(8) Develop and present to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Office of State Budget and Management by January 1 of each year, beginning in 201 7, the following information for the Medicaid and NC Health Choice programs:

a. A detailed four-year forecast of expected changes to enrollment growth and enrollment mix.

b. What program changes will be made by the Department in order to stay within the existing budget for the programs based on the next fiscal year's forecasted enrollment growth and enrollment mix.

c. The cost to maintain the current level of services based on the next fiscal year's forecasted enrollment growth and enrollment mix.

(9) Publish on its Web site and update on at least a monthly basis, at a minimum, the following information about the Medicaid and NC Health Choice programs:

a. Enrollment by program aid category by county.

b. Per member per month spending by category of service.

c. Spending and receipts by fund along with a detailed variance analysis.

d. A comparison of the above figures to the amounts forecasted and budgeted for the corresponding time period.

(f) The General Assembly shall determine the eligibility categories and income thresholds for the Medicaid and NC Health Choice programs. The Department of Health and Human Services, through the Division of Health Benefits, is expressly authorized to adopt temporary and permanent rules regarding eligibility requirements and determinations, to the extent that they do not conflict with the parameters set by the General Assembly.

(g) Although generally subject to the laws of this State, the following exemption s, limitations, and modifications apply to the Division of Health Benefits of the Department of Health and Human Services, notwithstanding any other provision of law:

(1) Employees of the Division of Health Benefits shall not be subject to the North Carolina Human Resources Act, except as provided in G.S. 126-5(c1)(31).

(2) The Secretary may retain private legal counsel and is not subject to G.S. 114-2.3 or G.S. 147-17(a) through (c).

(3) The Division of Health Benefits' employment contracts offered pursuant to G.S. 108A-54(e) (2) are not subject to review and approval by the Office of State Human Resources.

(4) If the Secretary establishes alternative procedures for the review and approval of contracts, then the Division of Health Benefits is exempt from State contract review and approval requirements but may still choose to utilize the State contract review and approval procedures for particular contracts."

SECTION 14.(a) Part 1 of Article 3 of Chapter 143B of the General Statutes is amended by adding the following new section to read:"

§ 143B-139.6C. Cooling-off period for certain Department employees.

(a) Ineligible Vendors. – The Secretary of the Department of Health and Human Services shall not contract for goods or services with a vendor that employs or contracts with a person who is a former employee of the Department and uses that person in the administration of a contract with the Department.

(b) Vendor Certification. – The Secretary shall require each vendor submitting a bid or contract to certify that the vendor will not use a former employee of the Department in the administration of a contract with the Department in violation of the provisions of subsection (a) of this section.

(c) A violation of the provisions of this section shall void the contract.

(d) Definitions. –As used in this section, the following terms mean:

(1) Administration of a contract. – Oversight of the performance of a contract, authority to make decisions regarding a contract, interpretation of a contract, or participation in the development of specifications or terms of a contract or in the preparation or award of a contract.

(2) Former employee of the Department. – A person who, for any period within the preceding six months, was employed as an employee or contract employee of the Department of Health and Human Services, and in the six months immediately preceding termination of State employment, participated personally in either the award or management of a Department contract with the vendor, or made regulatory or licensing decisions that directly applied to the vendor."

SECTION 14.(b) Subsection (a) of this section becomes effective November 1, 2015, and applies to contracts entered into on or after that date.

SECTION 15. Legislative Oversight of Medicaid and NC Health Choice Programs. –Chapter 120 of the General Statutes is amended by adding the following new Article:

"Article 23B.

"Joint Legislative Oversight Committee on Medicaid and NC Health Choice.

"§ 120-209. Creation and membership of Joint Legislative Oversight Committee on Medicaid and NC Health Choice.

(a) The Joint Legislative Oversight Committee on Medicaid and NC Health Choice is established. The Committee consists of 14 members as follows:

(1) Seven members of the Senate appointed by the President Pro Tempore of the Senate, at least two of whom are members of the minority party.

(2) Seven members of the House of Representatives appointed by the Speaker of the House of Representatives, at least two of whom are members of the minority party.

(b) Terms on the Committee are for two years and begin on the convening of the General Assembly in each odd-numbered year, except that initial appointments begin on the date of appointment. Members may complete a term of service on the Committee even if they do not seek reelection or are not reelected to the General Assembly, but resignation or removal from service in the General Assembly constitutes resignation or removal from service on the Committee.

(c) A member continues to serve until a successor is appointed. A vacancy shall be filled within 30 days by the officer who made the original appointment."

§ 120-209.1. Purpose and powers of Committee.

(a) The Joint Legislative Oversight Committee on Medicaid and NC Health Choice shall examine budgeting, financing, administrative, and operational issues related to the Medicaid and NC Health Choice programs administered by the Department of Health and Human Services.

(b) The Committee may make periodic reports, including recommendations, to a regular session of the General Assembly on issues related to Medicaid and NC Health Choice programs.

"§ 120-209.2. Organization of Committee.

(a) The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Joint Legislative Oversight Committee on Medicaid and NC Health Choice. The Committee shall meet upon the joint call of the cochairs.

(b) A quorum of the Committee is eight members. No action may be taken except by a majority vote at a meeting at which a quorum is present.

(c) Members of the Committee receive subsistence and travel expenses, as provided in G.S.120-3.1. The Committee may contract for consultants or hire employees in accordance with G.S.120-32.02. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. Upon the direction of the Legislative Services Commission, the Directors of Legislative Assistants of the Senate and of the House of Representatives shall assign clerical staff to the Committee. The expenses for clerical employees shall be borne by the Committee.

(d) The Committee cochairs may establish subcommittees for the purpose of examining issues relating to its Committee charge.

"§ 120-209.3. Additional powers.

The Joint Legislative Oversight Committee on Medicaid and NC Health Choice, while in discharge of official duties, shall have access to any paper or document and may compel the attendance of any State official or employee before the Committee or secure any evidence under G.S.120-19. In addition, G.S.120-19.1 through G.S.120-19.4 shall apply to the proceedings of the Committee as if it were a joint committee of the General Assembly.

"§ 120-209.4. Reports to Committee.

Whenever the Department of Health and Human Services, or any division within the Department, is required by law to report to the General Assembly or to any of its permanent, study, or oversight committees or subcommittees on matters relating to the Medicaid and NC Health Choice programs, the

Department shall transmit a copy of the report to the cochairs of the Joint Legislative Oversight Committee on Medicaid and NC Health Choice."

SECTION 16 .G.S.120-208.1(a)(2)b. is repealed.

SECTION 17 . Jurisdiction for legislative oversight of the Medicaid and NC Health Choice programs is transferred from the Joint Legislative Oversight Committee on Health and Human Services to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice. However, both Committees have concurrent jurisdiction over issues related to mental health, developmental disabilities, and substance abuse services covered by the Medicaid and NC Health Choice programs. Any reports related to the Medicaid or NC Health Choice programs shall be provided to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice.

SECTION 18. G.S.108A-54.1A reads as rewritten:

"§ 108A-54.1A. Amendments to Medicaid State Plan and Medicaid Waivers.

(a) ~~No provision in the Medicaid State Plan or in a Medicaid Waiver may expand or otherwise alter the scope or purpose of the Medicaid program from that authorized by law enacted by the General Assembly. For purposes of this section, the term "amendments to the State Plan" includes State Plan amendments, Waivers, and Waiver amendments.~~ The Department of Health and Human Services is expressly authorized and required to take any and all necessary action to amend the State Plan and waivers in order to keep the program within the certified budget, except as provided in G.S.108A-54(f).For purposes of this section, the term "amendments to the State Plan" includes State Plan amendments, Waivers, and Waiver amendments.

~~(b) The Department may submit amendments to the State Plan only as required under any of the following circumstances:~~

~~(1) A law enacted by the General Assembly directs the Department to submit an amendment to the State Plan.~~

~~(2) A law enacted by the General Assembly makes a change to the Medicaid Program that requires approval by the federal government.~~

~~(3) A change in federal law, including regulatory law, or a change in the interpretation of federal law by the federal government requires an amendment to the State Plan.~~

~~(4) A change made by the Department to the Medicaid Program requires an amendment to the State Plan, if the change was within the authority granted to the Department by State law.~~

~~(5) An amendment to the State Plan is required in response to an order of a court of competent jurisdiction.~~

~~(6) An amendment to the State Plan is required to ensure continued federal financial participation.~~

~~(c) Amendments to the State Plan submitted to the federal government for approval shall contain only those changes that are allowed by the authority for submitting an amendment to the State Plan in subsection (b) of this section.~~

(d) No fewer than 10 days prior to submitting an amendment to the State Plan to the federal government, the Department shall post the amendment on its Web site and notify the members of the Joint Legislative Oversight Committee on ~~Health and Human Services~~ Medicaid and NC Health Choice and the Fiscal Research Division that the amendment has been posted. For any amendments to the State Plan that add or eliminate an optional service, the notice required by this subsection shall be 90 days. This notice requirement shall not apply to draft or proposed amendments submitted to the federal government for comments but not submitted for approval. ~~The amendment shall remain posted on the Department's Web site at least until the plan has been approved, rejected, or withdrawn. If the authority for submitting the amendment to the~~

~~State Plan is pursuant to subdivision (3), (4), (5), or (6) of subsection (b) of this section, then, prior to submitting an amendment to the federal government, the Department shall submit to the General Assembly members receiving notice under this subsection and to the Fiscal Research Division an explanation of the amendment, the need for the amendment, and the federal time limits required for implementation of the amendment.~~

~~(e) The Department shall submit an amendment to the State Plan to the federal government by a date sufficient to provide the federal government adequate time to review and approve the amendment so the amendment may be effective by the date required by the directing authority in subsection (b) of this section. Additionally, if a change is made to the Medicaid program by the General Assembly and that change requires an amendment to the State Plan, then the amendment shall be submitted at least 90 days prior to the effective date of the change as provided in the legislation.~~

(f) Any public notice required under 42 C.F.R. 447.205 shall, in addition to any other posting requirements under federal law, be posted on the Department's Web site. Upon posting such a public notice, the Department shall notify the members of the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division that the public notice has been posted. Public notices shall remain posted on the Department's Web site."

SECTION 19. G.S.108A-54.2(d) is repealed.

SECTION 20. G.S.126-5(c1) is amended by adding new subdivisions to read:

"§ 126-5. Employees subject to Chapter; exemptions.

...

(c1) Except as to the provisions of Articles 6 and 7 of this Chapter, the provisions of this Chapter shall not apply to:

...

(33) Employees of the Division of Health Benefits of the Department of Health and Human Services.

(34) Employees of the Division of Medical Assistance of the Department of Health and Human Services hired on or after October 1, 2015."

SECTION 21. Funds appropriated in House Bill 97, 2015 Regular Session, to the Department of Health and Human Services, Division of Medical Assistance, for Medicaid transformation shall be used to implement this act. Upon the establishment of a budget code for the Division of Health Benefits, the Division of Medical Assistance shall transfer these funds to the Division of Health Benefits to be used to implement this act.

SECTION 22. If House Bill 97, 2015 Regular Session, becomes law, then Section12H.25 of that act is repealed.

SECTION 23. Except as otherwise provided, this act is effective when it becomes law. In the General Assembly read three times and ratified this the 22nd day of September, 2015.

s/ Ralph Hise
Presiding Officer of the Senate

s/ Tim Moore
Speaker of the House of Representatives

s/ Pat McCrory
Governor

Approved 1:15 p.m. this 23rd day of September, 2015

Appendix B. Summary of Public Comments and Responses

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

B.1. Rationale for the 1115 and the Quadruple Aim

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

B.2. Prepaid Health Plans (PHPs)

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

B.2. Prepaid Health Plans (PHPs)

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

B.2. Prepaid Health Plans (PHPs)

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

B.3. Person-Centered Health Communities (PCHCs)

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

B.4. Integrating Behavioral and Physical Health

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

B.4. Integrating Behavioral and Physical Health

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

B.5. Long-Term Services and Supports (LTSS)

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

B.5. Long-Term Services and Supports (LTSS)

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

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

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

B.7. Provider Administrative Ease

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

B.8. Provider Practice Supports, HIE and Statewide Informatics Layer

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

B.9. Child Welfare Initiatives

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

B.10. Payments and Budget Neutrality

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

B.10. Payments and Budget Neutrality

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

B.10. Payments and Budget Neutrality

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

B.10. Payments and Budget Neutrality

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

B.11. Eligibility and Enrollment

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

B.11. Eligibility and Enrollment

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

B.11. Eligibility and Enrollment

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

B.12. Pharmacy

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

B.12. Pharmacy

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

B.12. Pharmacy

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

B.13. Other Benefits

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

B.13. Other Benefits

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

B.14. Additional Comments

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

B.14. Additional Comments

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

B.14. Additional Comments

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

B.14. Additional Comments

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

B.14. Additional Comments

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

B.14. Additional Comments

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

B.14. Additional Comments

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

Appendix C. Tribal Consultation and Assurances

C.1. Cherokee Indian Hospital Authority Memorandum – Feb. 21, 2016

C.2. Division of Medical Assistance Letter – Feb. 29, 2016

C.3. Cherokee Indian Hospital Authority Memorandum – April 1, 2016

C.4. Division of Medical Assistance Memorandum – April 29, 2016

C.5. DHHS Assurances

C.1. Cherokee Indian Hospital Authority Memorandum – Feb. 21, 2016

An independent Component Unit of the Eastern Band of Cherokee Indians

Cherokee Indian Hospital Authority
Caller Box C-268
Cherokee, NC 28719
Phone: (828) 497-9163
Fax: (828) 497-5343

MEMORANDUM

TO: Mr. Dave Richards, Deputy Secretary DMA
Ms. Dee Jones, Chief Operating Officer, DHB

FROM: Casey Cooper, CEO

DATE: February 21, 2016

RE: **Initial Consultation with the Eastern Band of the Cherokee Indians (EBCI)**

Background

Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters likely to have a direct effect on Indians, Indian health programs and Urban Indian organizations. North Carolina Session Law 2015-245 (HB 372), "AN ACT TO TRANSFORM AND REORGANIZE NORTH CAROLINA'S MEDICAID AND NC HEALTH CHOICE PROGRAMS" meets the above conditions for the required consultation.

In accordance with the consultation procedures outlined in the approved January 1, 2011 Tribal consultation section of the NC Medicaid State Plan, pages 9-I through 9-IV, staff from NC Department of Health and Human Services (DHHS) met with staff from the Eastern Band of the Cherokee (EBCI) Division of Public Health and Human Services (PHHS) and the Cherokee Indian Hospital Authority (CHIA) on February 16-17, 2016 to solicit input on the development of the Medicaid 1115 Waiver, other Medicaid related issues and policies and State Plan Amendments (SPAs) as required to meet NC Session Law 2014-100, Section 12C.3(a)-(d) and subsequent versions. Once the draft 1115 waiver is released for public review, the sixty (60) day clock will begin for comments from EBCI. Anticipated release date is March 1, 2016.

Solicitation of Input

In attendance for the consultation visit were:

NC DHHS: Dave Richards, Roger Barnes, James Teske
EBCI PHHS: Aneva Turtle-Hagberg, Tate McCoy, Trina Owle, Darlene Creech
CIHA: Casey Cooper, Dr. Michael Toedt, Doug Trantham
Consultants with EBCI: Tara Larson, Lanier Cansler, Melanie Bush, Beth Nelson

Prior to the discussion of the pending Medicaid issues, EBCI staff gave presentations on the mission/vision of health and human service initiatives of the EBCI and of the Cherokee Indian Hospital. These presentations included a discussion of the EBCI Tribal Health Assessment, a tour of the new Cherokee Hospital, the health disparities prevalent within Indian Country, and an in depth discussion of how the initiatives pursued through the realignment of social service functions within EBCI address the overall health of the Cherokee people. Utilizing a medical home model, employing population health analytics, adapting services that embrace the culture of the Cherokee, realigning financial incentives, and addressing social determinants of health must be viewed in the gestalt rather than in isolated, fragmented solutions in order to address the health and well-being of the Cherokee people.

The CIHA's approach to care is founded on a commitment to greater patient and family involvement each step of the way, on prevention and management of chronic disease, and on processes to ensure proper use of specialty care and medications. Care is truly integrated. Patients are assigned a team of providers that includes a case manager, doctor, behavioral health specialist, nutritionist and pharmacist who all work together in one suite. Consultation rooms are adjacent to exam rooms. The restructuring of child and adult protective services to PHHS from the traditional county managed division of social services requires the assignment of a medical home and integrated assessments of child or adult vulnerabilities as part of protective services.

Understanding the principle of Indian self-determination and the vision for addressing the health and lives of the Cherokee is important to the development of the 1115 waiver. Also critical is enhancing eligibility to Medicaid and increasing access to Medicaid covered services. As such, EBCI PHHS and DHHS/DMA must continue in a timely and expeditious manner to seek the approval of the Medicaid/Health Choice eligibility determination SPA and other waivers/SPAs in which EBCI is a manager of the program or provider of services. Also essential is the completion of all other action steps associated with implementation of the SPAs or waivers.

Since EBCI has not seen a draft of the waiver to date, the following comments are offered to assist DHHS/DMA in the development and drafting of the wavier or to implement prior to the approval of the 1115 if other Medicaid authority is in place.

- The NC 1115 Waiver must not infringe on the rights of Tribal members or Tribal providers outlined in ACA, IHCA, or any other Federal laws.
- EBCI enrolled members and providers *shall not be required* to participate in the 1115 Waiver, and can continue to access Medicaid services through fee for service.
- EBCI enrolled members and providers *shall be permitted* to participate in the 1115 Waiver.

- There *shall not* be mandatory enrollment for tribal members or tribal providers into the general MCO/PLE arrangement as outlined in the session law.
- EBCI will serve as a state approved/contracted enrollment broker for educating Tribal members and other Native Americans *prior to* voluntary enrollment into managed care.
- CIHA shall be designated as a Health Home as allowed under Section 2703 for the EBCI community.
- CIHA *may* not meet the definition for a Provider Lead Entity (PLE) under the session law, such as being the PLE for one of the six (6) regions. The unique status, infrastructure, services, and treatment models provided by EBCI and CIHA may provide an opportunity to develop a specialty MCO/PLE for the Cherokee community in North Carolina. CIHA is interested in exploring a tribal MCO/PLE as allowed and outlined under Section 1932 of the Social Security Act.
- The waiver should address complementary medicine and social determinants of health.
- Funding of alternative or complementary services should be based upon outcomes.
- The waiver should accept the metrics currently used by CIHA which are nationally recognized and required by other funders for performance measures. Metrics should build off existing metrics within the healthcare system.
- CIHA and EBCI request to be eligible for any funding opportunities that are provided to other health entities or managed care entities as part of NC Medicaid reform.
- The waiver should explore alternative financial models that will serve to realign Medicaid service dollars and the use of Tribal funds to support services to Medicaid beneficiaries as well as the Tribe's under- or uninsured Members. CMS is currently considering expanding its 100 percent FMAP reimbursement policy for services "received through" Indian health facilities to cover non-IHS providers, which may incentivize the creation of such financial models. Potential options include cost sharing models with the State (Oklahoma), compensation for uncompensated care (Arizona, California, Oregon), and the Arkansas model using the revenue to fund expansion via the certified public expenditure (CPE) process and the use of federal dollars to purchase private health plan participation for recipients as alternative to Medicaid enrollment.
- We understand that NC legislation forbids the expansion of Medicaid at this point and as such, the 1115 may not be used to expand Medicaid eligibility as many other states have, but we would like to document our support for expansion.
- Copies of the relevant citations for the approved Oregon 1115 waiver were distributed.

As part of the discussion, DHHS and EBCI/CIHA agreed that while several of the above bullets required additional discussion over the next several months, immediately the following three (3) areas were agreed upon.

We have included **Recommended Language for Inclusion in NC 1115 Waiver:**

1. **ELIGIBILITY AND ENROLLMENT OF INDIVIDUALS IN COMMERCIAL PLANS OR PROVIDER LEAD ENTITIES (CPs/PLEs)**

Individuals identified as American Indian or Alaskan Native enrolled in a federally recognized tribe (AI/AN) are excluded from this demonstration unless an individual chooses to opt into

the demonstration and access coverage pursuant to all the terms and conditions of this demonstration.

Individuals who are AI/AN, and who have not opted in to this demonstration will receive the benefit plan generally available to individuals enrolled in the demonstration through a fee for service (FFS) system.

An AI/AN individual, whether receiving direct coverage or coverage through the demonstration will be able to access covered benefits through tribal programs.

Auto-assignment will not apply to AI/ANs unless they have opted in to participate in the demonstration. Prior to opting in, EBCI shall serve as an enrollment broker. The CP/PLE agrees that any Indian otherwise eligible to receive services from the Indian Health Care Provider may be allowed to choose the Indian Health Care Provider as the Indian's primary health care provider if the Indian Health Care Provider has the capacity to provide primary care services to such Indian, and any referral from such IHCP shall be deemed to satisfy any coordination of care or referral requirement of the CP/PLE. 42 U.S.C. §1396u-2(h).

2. ELIGIBILITY AND ENROLLMENT OF INDIAN HEALTH CARE PROVIDERS IN CPs/PLEs

Indian health care providers (IHCPs) – Indian Health Services, tribally operated facilities/programs, and urban Indian clinics (I/T/Us) – are excluded from participation in CPs or PLEs and shall continue to be reimbursed on a fee for service basis in accordance with the requirements set out in Sec. 1932(h) of the Social Security Act. 42 U.S.C. 1396u-2(h).

AI/AN individuals who receive services directly by an IHCP or through referral under Purchased/Referred Care services shall not be imposed any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing or similar charges, and payments to an IHCP or a health care provider through referral under Purchased/Referred care services for services provided to an eligible AI/AN shall not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing or similar charges. 42 U.S.C. § 1396o(j).

Under Section 206 of the Indian Health Care Improvement Act, (IHCIA), IHCPs are entitled to payment notwithstanding network restrictions.

The State acknowledges that eligibility for services at the IHCP's facilities is determined by federal law, including the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136. Nothing in this waiver shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs.

3. SUPPLEMENTAL PAYMENTS FOR UNCOMPENSATED CARE

The state shall make supplemental payments to Indian Health Service (IHS) and tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority:

- To pay for uncompensated care costs from medically necessary "in lieu of"-type services and services to address the social determinants of health that are not covered by the Medicaid State Plan but may be provided under a capitated arrangement by CPs and PLEs. CIHA and EBCI shall be reimbursed on a fee for service arrangement, and
- To pay for uncompensated care costs resulting from services provided to individuals not enrolled in Medicaid, Medicare, CHIP or other coverage. Supplemental payments shall be made according to fee for service as if covered under the Medicaid State Plan or to protocols to be negotiated with the Centers for Medicare and Medicaid Services (CMS).

4. APPLICABILITY OF OTHER LAWS

Nothing in this Demonstration precludes IHCPs from forming a provider-led entity (PLE) as defined in North Carolina Session Law 2015-245, Section 4(2)(b) or from incorporating as an Indian Managed Care Entity (IMCE) as defined in Sections 1932(h) and 2107(e)(1)(J) of the Social Security Act.

Nothing in this Demonstration shall waive the applicability of other federal laws and regulations affecting IHCPs, including but not limited to, the following:

(a) The IHS as a Provider:

(1) Anti-Deficiency Act, 31 U.S.C. § 1341;
(2) ISDEAA, 25 U.S.C. § 450 et seq.;
(3) Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 2671-2680;
(4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
(5) Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
(6) Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2;
(7) Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164; and
(8) IHCIA, 25 U.S.C. § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is a Provider:

(1) ISDEAA, 25 U.S.C. § 450 et seq.;
(2) IHCIA, 25 U.S.C. § 1601 et seq.;
(3) FTCA, 28 U.S.C. §§ 2671-2680;
(4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
(5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; and
(6) HIPAA, 45 C.F.R. Parts 160 and 164.

(c) An urban Indian organization that is a Provider:

(1) IHCIA, 25 U.S.C. § 1601 et seq. (including without limitation pursuant to the IHCIA Section 206(e)(3), 25 U.S.C. § 1621e(e)(3), regarding recovery from tortfeasors);
(2) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; and
(3) HIPAA, 45 C.F.R. Parts 160 and 164.

On behalf of the Tribe, we appreciate your willingness to make an onsite visit and to engage with the Cherokee on this important change in the Medicaid program. If we are able to model programs to the degree we discussed during the visit, I am sure the health and human services programs

offered to the Eastern Band of the Cherokee will address the needs of our community and people. Thank you for your support. We look forward to working with DHHS on the continued evolution of the program.

Cc: Vickie Bradley, Secretary EBCI PHHS

C.2. Division of Medical Assistance Letter – Feb. 29, 2016

North Carolina Department of Health and Human Services
Division of Medical Assistance

Pat McCrory
Governor

Richard O. Brajer
Secretary

Dave Richard
Deputy Secretary for Medical Assistance

February 29, 2016

Ms. Vickie L. Bradley, RN, MPH
Secretary
Public Health & Human Services Administration
Eastern Band of Cherokee Indians
43 John Crowe Hill Road
Cherokee, NC 28719

Mr. Casey Cooper, BSN, MBA, FACHE
Chief Executive Officer
Cherokee Indian Hospital Authority
188 Hospital Road
Cherokee, NC 28719

RE: Consultation on the North Carolina 1115 Waiver Application Authorized by Session Law 2015 – 245

Dear Vickie and Casey:

Attached is a copy of our most current draft of our 1115 Waiver Application for Medicaid Reform as authorized by the General Assembly. I am inviting your comments as we develop our application prior to submission to the Centers for Medicare and Medicaid (CMS).

The purpose of this application is to transform the current Medicaid services currently under fee for service to a managed care health plan in compliance with 42 CFR 438. All of our current Medicaid and Health Choice State Plan services will become part of this waiver application except for dental services and services provided to dual eligible Medicaid enrollees.

Our intent is to submit this waiver application to CMS not later than June 1, 2016. This letter serves as our notice to the Eastern Band of Cherokee Indians of our waiver application and begins the sixty (60) day comment period.

I look forward to receiving your comments concerning this waiver application. Should you have any questions, please do not hesitate to contact us.

Sincerely,

Dave Richard

Attachment

cc: Richard Brajer
Dee Jones
Teresa Smith

www.ncdhhs.gov
Tel 919-855-4100 • Fax 919-733-6608
Location: 1985 Umstead Drive • Kirby Building • Raleigh, NC 27603
Mailing Address: 2501 Mail Service Center • Raleigh, NC 27699-2501
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C.3. Cherokee Indian Hospital Authority Memorandum – April 1, 2016

An independent Component Unit of the Eastern Band of Cherokee Indians

Cherokee Indian Hospital Authority
Caller Box C-268
Cherokee, NC 28719
Phone: (828) 497-9163
Fax: (828) 497-5343

MEMORANDUM

TO: **Dee Jones, COO DHB**
Dave Richard, DHHS Deputy Secretary

FROM: **Casey Cooper, CEO**

DATE: **April 01, 2016**

RE: EASTERN BAND OF CHEROKEE INDIANS COMMENTS ON NORTH CAROLINA's DRAFT 1115 WAIVER

The Eastern Band of Cherokee Indians, North Carolina's only federally-recognized tribe, officially submits the following comments for response on the March 1st version of North Carolina's Department of Health and Human Services' "North Carolina Medicaid and Health Choice Draft Section 1115 Application" We are appreciative of the recognition in the waiver of the uniqueness and disparities of health care for Native Americans and for your willingness to continue to have dialogue about the possible development of a Tribal managed care entity.

GENERAL WAIVER COMMENTS

PERSON-CENTERED HEALTH COMMUNITIES

The Eastern Band of Cherokee Indians (EBCI) is supportive of the person-centered health community (PCHC) concept proposed by the North Carolina Department of Health and Human Services in its 1115 application. It is a much-needed step in the right direction towards whole-person care, and is the concept we have worked to implement over the last several years on the Qualla Boundary. We would encourage more details about the minimum requirements and desired outcomes of the model and ensure that financial arrangements support the model.

The re-organization of social and support service functions within the EBCI Department of Public Health and Human Services (PHHS) address the health disparities of the Cherokee community and focus on promoting safe, stable, and nurturing families. The waiver recognizes the role of social determinants in the overall health of people. The success of the new system is dependent upon a partnership between PHHS and the medical home, Cherokee Indian Hospital Authority (CIHA), creating a paradigm shift from traditional, siloed care to an integrated, holistic approach. This design provides a multi-system team that supports the family. The draft waiver outlines the concept of multi-system approach, but is not clear on the requirements or infrastructure the Department is requiring.

1

The CIHA's approach to care is founded on a commitment to greater patient and family involvement each step of the way. A focus on prevention, management of chronic disease, appropriate use of specialty care, and medication formulary control are priorities in this system. CIHA is Level 3 Certified Patient Centered Medical Home and provides services to the majority of Tribal members. The organization is a truly integrated model. Patients are empaneled to a team of providers that includes a case manager, physician, behavioral health specialist, nutritionist and pharmacist who are co-located to provide care. The Cherokee Indian Hospital Authority (CIHA) operates the tribal Behavioral Health Services and Recovery Center, ensuring whole person care in a truly integrated health system.

We feel the approach referenced above is a strong model, maximizing best practices, driven by data and supports the entire family in a comprehensive model. We encourage the use of this approach across NC. In order to implement the model, change is incremental, requires system and knowledge enhancements and also financial support during the change process. Current reimbursement models don't support the change in terms of addressing sustainability as well as supporting the transition process. We encourage the Department to provide resources for Medicaid transformation at the provider and the recipient level.

ELIGIBILITY

We are supportive of the statement on page 38 excluding Eastern Band of the Cherokee (EBCI) from mandatory enrollment and the Department's commitment to continue to work with EBCI on a Tribal Managed Care entity. We agree that EBCI is NC's only federally recognized Tribe; however, there are many other federally recognized Tribes whose members live across North Carolina. The exclusion should be for any enrolled federal Tribal member, not those enrolled members of just EBCI.

As discussed during our consultation conversation, EBCI is interested in exploring ways in which they may serve as an outreach, eligibility broker for Native Americans.

ENHANCING OUTCOMES FOR CHILDREN AND FAMILIES IN THE CHILD WELFARE SYSTEM

We are supportive of DHHS' focus on providing comprehensive health care and interventions for the most vulnerable children at risk of or experiencing abuse and neglect and their families. We are very supportive of maintaining eligibility for parents if their children are placed in foster care. The literature is very explicit about the need for the biological families of children in foster care to receive treatment and support if there will be successful family reunification.

CIHA Behavioral Health and PHHS' Family Safety Division implemented the Integrated Family Safety Team, bridging the gap between medical/behavioral health care and human services. This team is a combination of behavioral health staff and child/adult protective services staff working together to support families through integrated, comprehensive services utilizing a single family plan.

EBCI children may not necessarily participate in the statewide PHP proposed in the 1115 waiver, but stand to benefit from the expansion of Fostering Health NC, and any learnings or best practices that are disseminated through the program's expansion. Children of Indian heritage across North Carolina, especially those in the social services systems, deserve to be served in the manner respectful of their culture. We encourage submission of unique services that are unique to populations such as such as those approved in the New Mexico waiver for Native Americans only. Similarly, the EBCI request access, like the county directors of social services, to Medicaid claims data to fill information gaps, coordinate care, and identify potential problems early. Trauma informed care is critical for serving children. We also support allowing families of children placed in foster care to maintain Medicaid

eligibility while the child is placed outside the home. We hope that DHHS remains committed to improving the health outcomes of EBCI and Native American children and families in the child welfare system that may be outside the PHP health delivery system.

SOCIAL DETERMINANTS OF HEALTH

We are also supportive of the inclusion of screening for social determinants of health by PCHCs and inclusion of this data in electronic health records. To build truly healthy communities, health systems need to look outside of the traditional doctors' offices to understand the factors that may be influencing health where people live and work and learn. Moving treatment upstream towards prevention rather than intervention will have longer term effects on overall health than downstream treatment. We are pleased that it appears North Carolina is moving in this direction as well. We encourage a more detailed explanation of the allowable use of funds to support addressing social determinants. Does the state intend to go with a model of "buckets" of flexible funding such as the Oregon model or leave the flexibility up to the managed care entity such as the Utah approach?

CULTURAL COMPENTENCY

Finally, we would like to underline the importance of creating a culturally competent health care delivery system. We support and are encouraged by your designation as EBCI as one of the eligibility brokers to assist Native Americans in making informed choices. We also offer to DHHS assistance in developing education materials for the use by all county of social services in educating all Medicaid recipients in choosing culturally appropriate managed care entities. While most EBCI members may not choose a PHP for health care delivery, some may choose that option and we feel it is important for members to have access to culturally appropriate care, including traditional healing methods that could be paid for as "in lieu of" services. The Tribe's interest is supporting all aspects of cultural diversity and competencies unique to the various populations across the State, not just for the Eastern Band of Cherokee. We encourage DHHS to write into the waiver, the need for culturally appropriate services. We understand that this could be addressed during the RFP process; however, we feel that there is significant importance to culturally competent education and services that this issue should be addressed in the actual waiver application.

LANGUAGE PREVIOUSLY SUBMITTED BY THE EASTERN BAND OF CHEROKEE INDIANS FOR INCLUSION IN NORTH CAROLINA'S 1115 WAIVER

The following language was submitted in the previous submission of February, 2016 of comments to Secretary Brajer for inclusion in North Carolina's 1115 waiver. The Eastern Band of Cherokee Indians is pleased that the language exempting Indian Health Care Providers and Eastern Band of Cherokee enrolled members from mandatory participation in the 1115 waiver is captured in the draft version of the waiver, language leaving open the option for EBCI to create a sub-regional PLE, and acknowledgement of our desire for uncompensated care payments. However, the language submitted below has either not been explicitly addressed in the draft language and so we resubmit for consideration and inclusion.

ELIGIBILITY AND ENROLLMENT OF INDIVIDUALS IN CPs/PLEs

The CP/PLE agrees that any Indian otherwise eligible to receive services from the Indian Health Care Provider may be allowed to choose the Indian Health Care Provider as the Indian's primary health care provider if the Indian Health Care Provider has the capacity to provide primary care services to such Indian, and any referral from such

IHCP shall be deemed to satisfy any coordination of care or referral requirement of the CP/PLE. 42 U.S.C. §1396u-2(h).

ELIGIBILITY AND ENROLLMENT OF INDIAN HEALTH CARE PROVIDERS IN CPs/PLEs

AI/AN individuals who receive services directly by an IHCP or through referral under Purchased/Referred Care services shall not be imposed any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing or similar charges, and payments to an IHCP or a health care provider through referral under Purchased/Referred care services for services provided to an eligible AI/AN shall not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing or similar charges. 42 U.S.C. § 1396o(j).

The State acknowledges that eligibility for services at the IHCP's facilities is determined by federal law, including the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136. Nothing in this waiver shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs.

SUPPLEMENTAL PAYMENTS FOR UNCOMPENSATED CARE

The state shall make supplemental payments to Indian Health Service (IHS) and tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority:

1) to pay for uncompensated care costs from medically necessary "in lieu of"-type services and services to address the social determinants of health that are not covered by the Medicaid State Plan but may be provided under a capitated arrangement by CPs and PLEs; and
2) to pay for uncompensated care costs resulting from services provided to individuals not enrolled in Medicaid, Medicare, CHIP or other coverage who have incomes up to 138 percent of the Federal Poverty Level (FPL).

Supplemental payments shall be made according to protocols to be negotiated with the Centers for Medicare and Medicaid Services (CMS).

APPLICABILITY OF OTHER LAWS

Nothing in this Demonstration precludes IHCPs from forming a provider-led entity (PLE) as defined in North Carolina Session Law 2015-245, Section 4(2)(b) or from incorporating as an Indian Managed Care Entity (IMCE) as defined in Sections 1932(h) and 2107(e)(1)(J) of the Social Security Act.

Nothing in this Demonstration shall waive the applicability of other federal laws and regulations affecting IHCPs, including but not limited to, the following:

(a) The IHS as a Provider:

1) Anti-Deficiency Act, 31 U.S.C. § 1341;
2) ISDEAA, 25 U.S.C. § 450 et seq.;
3) Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 2671-2680;
4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
5) Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
6) Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2;
7) Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164; and
8) IHCIA, 25 U.S.C. § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is a Provider:

1) ISDEAA, 25 U.S.C. § 450 et seq.;
2) IHCIA, 25 U.S.C. § 1601 et seq.;
3) FTCA, 28 U.S.C. §§ 2671-2680;
4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; and
6) HIPAA, 45 C.F.R. Parts 160 and 164.

(c) An urban Indian organization that is a Provider:

1) IHCIA, 25 U.S.C. § 1601 et seq. (including without limitation pursuant to the IHCIA Section 206(e)(3), 25 U.S.C. § 1621e(e)(3), regarding recovery from tortfeasors);
2) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; and
3) HIPAA, 45 C.F.R. Parts 160 and 164.

Since the initial consultation between EBCI and DHHS and the release of the draft 1115 waiver application, CMS has issued guidance for expanding the availability of 100% FMAP for services offered by non-IHS, compact or tribal facilities if coordinated by Tribal facilities. We have made the initial contact with DHHS regarding implementation of this critical aspect of health care for federal recognized Tribes. We feel this is a critical element for today's health care market but will be more important as the state moves forward with managed care for all federally recognized tribal members, not just EBCI.

We are also very interested in continuing the conversation about the formation of a Tribal MCO, other covered services and initiatives as written in our original draft 1115 waiver submitted to DHHS in 2014. We are pleased with the enhanced collaboration and the recognition by DHHS in addressing the needs of the Cherokee and all Native Americans in NC. We stand ready and willing to assist the Department in implementing solutions.

Cc: Principal Chief Patrick Lambert, EBCI
Secretary Vickie Bradley, EBCI PHHS

5

C.4. Division of Medical Assistance Memorandum – April 29, 2016

North Carolina Department of Health and Human Services
Division of Medical Assistance

Pat McCrory
Governor

Richard O. Brajer
Secretary

Dave Richard
Deputy Secretary for Medical Assistance

To: Casey Cooper, CEO
Secretary Vickie Bradley, EBCI PHHS

From: Dave Richard, DHHS Deputy Secretary
Dee Jones, COO DHB

Date: April 29, 2016

RE: DHHS'S RESPONSE TO COMMENTS FROM THE EASTERN BAND OF CHEROKEE INDIANS (EBCI) ON NORTH CAROLINA'S DRAFT 1115 WAIVER

The North Carolina Department of Health and Human Services (DHHS) acknowledges the formal feedback submitted in response to the March 1st version of the "North Carolina Medicaid and Health Choice Draft Section 1115 Application." DHHS appreciates the willingness of EBCI to thoughtfully respond and discuss many of the concepts outlined in the 1115 demonstration (waiver) proposal. Through our multiple discussions with representatives of the Tribe and Tribal leadership prior to the initiation of our formal public notice, as well as our meeting yesterday with your designees to discuss the specific EBCI feedback and desired initiatives related to the waiver, we remain committed to working together to achieve our common goal of improving the health of all of North Carolina's Native American population. We look forward to ongoing collaboration with EBCI throughout the period prior to approval while DHHS negotiates these and the many other components of the waiver proposal.

DHHS appreciates EBCI's support of many of the concepts outlined in the waiver and looks forward to continuing our work together. Attached is a summary of our discussion on April 28, 2016.

EBCI Comments	DHHS Response
Person-Centered Health Communities (PCHC)	
• We (EBCI) encourage more details about the minimum requirements (of PCHC), desired outcomes and financial arrangements to support the PCHC model (Page 1). • The draft waiver outlines the concept of multi-system approach but is not clear on the requirements or infrastructure the Department is requiring (Page 1).	• Many of the details determining how DHHS will operationalize PCHC and integrated care concepts under Medicaid Reform have yet to be determined. DHHS will continue to work with all stakeholders to develop many of the concepts discussed in the waiver.

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EBCI Comments	DHHS Response
Eligibility	
• The exclusion (of all tribe members from mandatory enrollment) should be for any enrolled federal Tribal member, not just those enrolled members of EBCI (Page 2). The EBCI prefer that members of federally recognized tribes have the opportunity to "opt in" enrollment into a PHP rather than an "opt out" (as stated in the 3/1 draft waiver).	• DHHS supports the EBCI's position and will adjust the waiver and/or future enrollment/eligibility determination processes to reflect this agreement regarding opting into managed care through PHPs. Operationalization will require agreement on how DHHS can identify members of federally recognized tribes at the time of enrollment as well as the capacity to track these members.
• Any Indian otherwise eligible to receive services from the Indian Health Care Provider may be allowed to choose the Indian Health Care Provider as the Indian's primary health provider if the Indian Health Care provider has the capacity to provide primary care services to such Indian, and any referral from such IHCP shall be deemed to satisfy any coordination of care or referral requirement of the CP/PLE (Pages 3-4). • EBCI prefers that if a Native American chooses to participate in a PHP, the individual will be assigned to an IHCP primary care provider (assuming the IHCP can be reasonably accessed by the member and/or meet appropriate network adequacy requirements). Similarly an Indian Health Provider will have the right to refer to other Indian Health Providers without pre-authorization from PHPs.	• DHHS supports the EBCI's position and will adjust the waiver and/or future enrollment/eligibility determination processes (and contract provisions) to reflect this provision. As noted above, operationalization in PHPs will require continued collaboration to identify these members.
• AI/AN individuals who receive services directly by an IHCP or through referral under Purchased/Referred Care Services shall not be imposed any enrollment fee, premium... (Page 4).	• Co-pays and premiums are not and will not be charged to NC Health Choice and Medicaid Native American beneficiaries. In addition, they are not part of the charges to ICHP. DHHS will continue to work with the EBCI to ensure that these protections will not be part of any future state and/or part of future PHP contracts.
• EBCI requests that the State acknowledge that nothing in the waiver shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through IHCP's programs.	• DHHS agrees to include this language in the waiver submission to CMS.
Enhancing Outcomes for Children and Families in the Child welfare system	
• We (EBCI) encourages submission of unique services that are unique to populations such as those approved in the New Mexico waiver for Native Americans (Page 2).	• DHHS agrees to continue to work with the EBCI to address this important issue. DHHS requests that EBCI provide a list of the services that are considered unique and will work with CMS to add allowable services to the waiver.

EBCI Comments	DHHS Response
• The EBCI requests that AI/AN children in the foster care system receive culturally appropriate services and care management.	• DHHS strongly agrees with the EBCI and commits to continue working with the EBCI to address this important issue currently and in the future.
• The EBCI requests access (like county directors of social services) to Medicaid claims data to fill information gaps, coordinate care, and identify potential problems early (Page 2).	• DHHS appreciates the Tribe's position. DHHS will need to review internal State protocols in order to better understand and work to resolve any barriers in order to satisfy this request. DHHS will continue to work with the Tribe outside of the scope of the waiver.
Social Determinants of Health	
• EBCI supports the inclusion of screening for social determinants of health by PCHCs and inclusion of this data in electronic health records (Page 3).	• DHHS appreciates the EBCI's support.
• EBCI encourages a more detailed explanation of the allowable use of funds to support addressing social determinants (Page 3).	• DHHS appreciates EBCI's comment and agrees to work with EBCI and other stakeholders to determine the allowable use of funds to support addressing social determinants as part of program implementation.
Cultural Competency	
• EBCI offers its expertise and will assist in developing culturally appropriate education materials for use by county of social services to educate all Medicaid recipients (Page 3).	• Many of the details determining how DHHS will operationalize Medicaid reform have yet to be determined. DHHS appreciates this offer and will seek EBCI's expertise as we plan and operationalize the program.
• EBCI encourages DHHS to write into the waiver the need for culturally appropriate services. EBCI believes it should be addressed in the actual waiver application and during the RFP process (Page 3).	• DHHS appreciates EBCI's position and agrees to consider how to write into the waiver and future PHP contracts the need for coverage of culturally appropriate services.
Supplemental Payments for Uncompensated Care	
• The state shall pay for uncompensated care costs resulting from services provided to individuals not enrolled in Medicaid, Medicare, CHIP, or other coverage, who have incomes up to 138 percent of the Federal Poverty Level (FPL) (Page 4).	• DHHS interprets Session Law 2013-5 (SL 2013-5) to not allow consideration of Medicaid coverage expansions up to this federal poverty level under Medicaid Reform.

EBCI Comments	DHHS Response
• The state shall make supplemental payments to pay for uncompensated care costs from medically necessary "in lieu of" type services and to address the social determinants of health that are not covered by the Medicaid State Plan but may be provided under a capitated arrangement by CPs and PLEs (Page 4).	• DHHS appreciates the EBCI's position and agrees to adjust the waiver to include a supplemental payment pool. As stated during our call, DHHS is unable to seek authorization for Medicaid coverage expansion in this waiver proposal. • DHHS commits to continuing to work with the Tribe to identify benefits and/or wrap payments available for supplemental payments, and develop a CMS allowable payment program that assures that IHCP providers can receive payments equivalent to existing statewide supplemental payment programs (many of the existing supplemental programs are designed to equate payments to 100% of Medicare). Any ability of DHHS to make supplemental payments will depend on CMS approval and be fully supported by federal tribal expenditure matching funds. • DHHS asks that the EBCI provide additional detail on a proposed supplemental payment program design. This includes but is not limited to: the total or total estimated amount of uncompensated care dollars – both historical and projected, how these are currently tracked, services covered, and/or any additional information available to assist in development of the budget neutrality for the waiver proposal.
Applicability of Other Laws	
• CMS has issued guidance for expanding the availability of 100% FMAP for services offered by non-IHS compact or tribal facilities if coordinated by Tribal facilities (Page 5).	• DHHS strongly supports the EBCI's interest in expanding the availability of the 100% FMAP. DHHS believes the opportunity to expand the availability of 100% FMAP can be pursued outside of the waiver and is likely to be implemented before the waiver is approved. DHHS requests that the EBCI continue to work with DHHS to continue to pursue this outside of the scope of the waiver.
• EBCI expressed an interest in continuing the conversation about the formation of a Tribal MCO (Page 5).	• DHHS strongly supports the EBCI's interest in the formation of a Tribal PHP and is committed to working with the EBCI to meet the Tribe's goals. DHHS will analyze whether this initiative requires a change to SL 2015-245 and will follow up accordingly. In addition, as agreed to on our call, the interest in becoming a PLE will be presented to CMS in the waiver proposal.

EBCI Comments	DHHS Response
• EBCI requests that nothing in the demonstration shall waive the applicability of other federal laws and regulations affecting IHCPs (Page 4).	• DHHS agrees to include this language in the waiver submission to CMS.

cc: Principal Chief Patrick Lambert, EBCI

C.5. DHHS Assurances

DHHS assures that PHP contracts will address the need for culturally appropriate services.

DHHS acknowledges that eligibility for services at Indian Health Care Provider (IHCP) facilities is determined by federal law, including the IHCIA, 25 U.S.C. 1601, et seq. and/or 42 CFR Part 136. Nothing in this waiver shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through IHCP's programs.

DHHS assures that nothing in this waiver application waives the applicability of other federal laws and regulations affecting IHCPs, including but not limited to the following:

(a) The IHS as a Provider:

1) Anti-Deficiency Act, 31 U.S.C.§1341;
2) ISDEAA, 25 U.S.C. § 450 et seq;
3) Federal Tort Claims Act ("FTCA), 28 U.S.C. §§ 2671-2680;
4) Federal Medical Care Recovery Act, 42 U.S.C §§ 2651-2653;
5) Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552c, 45 C.F.R. Part 5b;
6) Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2; Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164; and
7) IHCIA, 25 U.S.C § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is a Provider:

1) ISDEAA, 25 U.S.C. § 450 et seq;
2) IHCIA, 25 U.S.C. § 1601 et seq;
3) FTCA, 28 U.S.C. §§ 2671-2680;
4) Federal Medical Care Recovery Act, 42 U.S.C §§ 2651-2653;
5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; and
6) HIPAA, 45 C.F.R. Parts 160 and 164.

(c) An urban Indian organization that is a Provider:

1) IHCIA, 25 U.S.C. § 1601 et seq. (including without limitation pursuant to the IHCIA Section 206(e)(3), 25 U.S.C. § 1621e(e)(3), regarding recovery from tortfeasors);
2) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R Part 5b; and
3) HIPAA, 45 C.F.R. Parts 160 and 164.

Appendix D. North Carolina Health Transformation Center Report

LEGISLATIVE REPORT

NORTH CAROLINA HEALTH TRANSFORMATION CENTER (TRANSFORMATION INNOVATIONS CENTER) PROGRAM DESIGN AND BUDGET PROPOSAL

SESSION LAW 2015-245, SECTION 8

FINAL REPORT

State of North Carolina
Department of Health and Human Services

May 1, 2016

EXECUTIVE SUMMARY

The North Carolina Department of Health and Human Services is excited to provide the Joint Legislative Oversight Committee on Medicaid and NC Health Choice with a proposal to develop a health care transformation innovations center, as required by Session Law 2015-245 (House Bill 372).

The North Carolina Health Transformation Center (NCHTC) will be an integral part of the most significant reform in the history of the state's Medicaid system. Beginning with the transition to managed care from fee-for-service, this health care model will launch new systems of care, expand the role of certain providers, and create more defined competencies for those who provide health care services across the state.

Our goal is to transform health care and improve the health of citizens across North Carolina using a broad evidence-based consensus process to identify priorities for improvement of health outcomes. The health delivery system incentives will be aligned with these outcomes and activities, and will be organized around the quadruple aim of better patient experience, better care, better provider engagement and predictable costs. The NCHTC will drive health outcome improvements by nurturing promising innovations throughout the state health care system.

This proposal addresses the culture of health care innovations in North Carolina, insights from other states' experiences, what North Carolina needs to successfully develop a health transformation center, technology impacts, proposed governance structure, proposed budget and staffing, and next steps. The Department is defining the functional and operational details, organizational structure, and governance of the Medicaid reform plan. Similar to the Section 1115 demonstration waiver program, the NCHTC will be a North Carolina solution.

The NCHTC will be an outward facing center of excellence for clinical and technical improvements, designed for performing continuous quality improvement activities that will:

- Spur innovative programs
- Enable health care leadership transformation and development

- Foster clinical information sharing
- Disseminate grant funding and incentive payment programs
- Provide collaboratives and technical assistance to providers and prepaid health plans as they incorporate metrics defined for health care improvements
- Measure prepaid health plan performance
- Evaluate the effectiveness of the waiver program

The NCHTC also will perform a pivotal role to promote continued partnerships with existing community-based providers and care organizations. North Carolina has a successful history in the organization, management and medical care delivery at the community level, which also is recognized at the national and state levels. This model emerged and evolved over several decades to create a vigorous, collaborative network of more than 6,000 providers and care organizations that includes non-profits, health and education centers, and foundations that grow health leadership. Utilizing advanced care and payment analytics, the NCHTC will leverage and grow these existing community-based entities with their associated efforts, protocols, and provider and consumer relationships.

The Department will use a phased approach to implement the NCHTC. Initial improvement targets will focus on program areas with the greatest opportunity for positive impact.

We are looking forward to collaborating with the North Carolina General Assembly, and clinical and technical partners, to design an NCHTC that will help enable NC Medicaid reform and serve the people of North Carolina for years to come. NCHTC development will begin immediately.

TABLE OF CONTENTS

I. BACKGROUND

North Carolina Session Law 2015-245/House Bill 372, approved Sept. 23, 2015, directs the transformation of the state's current Medicaid and NC Health Choice programs to provide budget predictability while ensuring quality care. The Department of Health and Human Services will submit an 1115 demonstration waiver application to the Centers for Medicare & Medicaid Services by June 1, 2016. This demonstration waiver will transform the NC Medicaid delivery system to managed care for most of the eligibility categories of the Medicaid and NC Health Choice program.

Section 8 of the session law also directs the Department to develop a transformation innovations center – the North Carolina Health Transformation Center (NCHTC) – to assist providers and prepaid health plans achieve the ultimate goals of better health and better care for North Carolinians, better provider and clinician engagement, and predictable costs for the state. This proposal presents the Department's NCHTC program design and near-term budget to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice.

The General Assembly instructed the Department to use the Oregon Transformation Center as a design model for the NCHTC, and to consider features such as:

- Learning collaboratives and peer-to-peer relationships.
- Clinical standards and supports.
- Innovator agents.
- Council of Clinical Innovators.
- Community and stakeholder engagement.
- Conferences and workshops.
- Technical assistance.
- Infrastructure support.

In addition to the Oregon Health Authority's Transformation Center, the Department also held discussions with transformation organizations in Oklahoma, Arkansas, Delaware and Pennsylvania. The information gathered helped prepare the NCHTC program design.

II. CULTURE OF IMPROVEMENT AND HISTORY OF INNOVATION IN NORTH CAROLINA

North Carolina has a long and successful history of innovation in health care and clinical quality improvement. An assessment of the current innovations structure and initiatives across the state shows that many elements required for the NCHTC already exist and are well integrated throughout our communities and providers. Some of these were developed under Department guidance and funding, while others were developed by private, commercial and non-profit organizations.

North Carolina has the advantage of building on the existing innovations and initiatives for the NCHTC governance structure to create a rich set of offerings and mechanisms. Current state health care innovation and infrastructure initiatives include:

• Regional networks of physicians, nurses, pharmacists, hospitals, health departments, social service agencies and other community organizations that work together to provide cooperative, coordinated care through a medical home model.

• Academic health systems, hospital learning networks, large private health systems, statewide health care learning centers and major private foundations that drive innovation in care.

• Specialty medical associations, clinician organizations and other provider organizations that advance best practices.

• Existing mental health capitated payment program innovations that can be applied to physical health.

• Major private businesses that drive health care improvement in pharmaceuticals and information analytics.

Over the past several decades, a broad set of clinical improvement expertise has developed throughout the state. These crucial practices will be evaluated for inclusion in the NCHTC design.

III. INSIGHTS

North Carolina's extensive history of innovation in health care provides many insights that include these key lessons:

• Engagement of the primary care practice spectrum, from Federally Qualified Health Centers and health departments to traditional practices with few, yet high-cost patients.

• Systematic development of services that wrap around primary care practices, including care management and informatics that address both gaps in care and impact.

• The power of social learning networks in spreading innovations across the state.

• Importance of addressing the most difficult problems, such as transitions and behavioral health, and remaining dedicated to resolving them over time to achieve meaningful results.

The Department also reviewed efforts to transform Medicaid in Oregon, Oklahoma, Arkansas, Delaware and Pennsylvania to gain insights from the experiences of other states with similar undertakings. While differences exist between this group of states and North Carolina, including overall population numbers, the most significant advantage for North Carolina is an established, strong collaboration and innovation infrastructure.

A. Overall Practices

Several common practices emerged during the review:

• Engage a coalition of public and private leadership.

• Leverage existing collaboration and innovation infrastructure to identify and channel innovations.

• Define and measure desired health outcomes.

• Establish an independent group to set health outcomes and related metrics for care reorganization and improvement incentive programs.

• Recognize the crucial role of a strong health information exchange.

• Ensure stakeholders are aware that the transformation will take many years.

B. Oregon Health Authority (est. April 2013)

The Oregon Transformation Center (OTC) supports all health care endeavors. Its primary goal is to promote the spread and sustainability of innovations. The OTC exists within the Oregon Health Authority and funding is provided through the state budgeting process.

The Oregon Health Authority has seen many positive improvements in transforming its health care system by establishing a primary care foundation with regional coordinated care organizations which integrates with medical providers, local health departments, behavioral health, hospitals and payers. Results include a drop in emergency room use and in hospitalization for specific diseases, and some improvement in quality measures.

C. Delaware Center for Health Innovation (est. July 2014)

The Delaware Center for Health Innovation (DCHI), a 501(c)(3) entity, uses a clinical committee to improve care integration and patient focus. The DCHI has established "health hubs" in neighborhoods, started efforts to further develop health care workers' skills through education and recruitment, established a monitoring system for the payment model, and a patient/consumer advisory group to provide an "informed voice."

D. Oklahoma Center for Health Innovation and Effectiveness (est. October 2014)

The Oklahoma Center for Health Innovation and Effectiveness (CHIE) is tasked with improving the health of Oklahomans through innovative methods and research. The CHIE exists within the Oklahoma State Department of Health and funding is provided through the state budgeting process.

The CHIE's primary task is to support Oklahoma's shift to value-based payments from fee-for-service. This includes developing health information exchanges by 2020 for data analysis, and further developing a health care workforce with the skills needed to improve the efficiency and effectiveness of health services throughout the state, workforce development, and health efficiency and effectiveness.

E. Additional Insights

Additional insights include:

• Disperse ideas throughout the state to improve overall population health.

• Align quality and other measures with providers and payers.

• Integrate behavioral health services.

• Build leadership bench strength by identifying and developing transformative individuals across professions and regions.

• Improve financing in rural areas.

• Extend core statewide utilities for care transformation by investing in areas such as a health information exchange and community advisory councils.

These and other lessons shared by the reviewed states will be considered in the NCHTC design.

IV. WHAT NORTH CAROLINA NEEDS

Changing the Medicaid and NC Health Choice delivery and payment system will affect nearly every aspect of health care, from the role of primary care providers to where and how care will be regularly delivered. Supporting this transformation will require new systems of care, expanded roles of certain providers, and create more defined competencies for those entities who provide health care services across the state. North Carolina's advantage is its existing community-based health care organizations, learning networks, working collaborations focused on patient centered care, and active stakeholders within our communities. These groups already provide much of the foundation other states had to develop for their transformation efforts.

In addition to continuing the growth of this foundation of collaboration and innovation, the following goals are essential for successful Medicaid reform. These will be considered as the NCHTC role is defined:

• Foster, encourage and drive creation of *new and innovative methods* to improve care and contain costs in areas such as workforce development, clinical and operational best practices, and health care leadership; and to monitor and address administrative requirements to mitigate potential burdens to providers.

• Drive *continuous improvement of care* by our clinicians, hospitals and other providers by facilitating ongoing education on improving population health, the organization of health care, and providing clear guidelines for health outcomes driven by financial incentives.

• Provide *access to collaboratives and technical assistance* to working groups, and other programs for providers and organizations that will help their transition to managed care.

• Foster and encourage evidence-informed programs, policies, clinical interventions and practices for *rural health populations*. According to the NC Task Force on Rural Health, approximately one-in-five North Carolinians, almost 2.2 million people, live in a rural county and areas that are less likely to have access to health services, are more likely to engage in risky health behaviors, and have a higher mortality rate than North Carolinians living in non-rural areas.

• Develop new methods to increase *access to care* for underserved populations, including collaboratives, community engagement and examining new tools such as telemedicine.

• Develop a robust *analytics competency to identify areas of innovations and system improvements* by region and organization to encourage the use of evidence-based practices.

• Assist providers, prepaid health plans and community organizations in the *development of person centered health communities*. It is generally recognized that a strong primary care system is

fundamental to improving the health of populations, and North Carolina is a national leader in developing a medical home care model.

• Build additional mechanisms for *engaging with stakeholders*, including community outreach to help drive innovations.

There also is the need to establish a set of health outcomes and metrics to establish incentives, to measure performance of the overall Medicaid program and prepaid health plans.

Additional considerations:

• Potentially implement policy for evidence-based improvements and emerging challenges, such as subspecialty medication management.

• Enhance Department capacity to monitor the national and state health care landscape to identify opportunities for improvement and innovations.

There are many critical components needed to drive Medicaid reform. The NCHTC will hold a vital role in this transformation and its sustainability, and its contributions will have an immediate impact.

V. TECHNOLOGY IMPACTS AND CONSIDERATIONS

The development of deep and detailed program data is needed to manage the benefits of capitation, risk-based payments and contractual accountability. Several technology areas will be affected by the move to capitated arrangements. Some will directly affect NCHTC capabilities, while others will indirectly influence the data and processing that underlie the information that the NCHTC and the Department will use. Success of this transformation requires tight integration of systems and data needed for operational and analytical purposes. The most significant of these technology impacts and considerations are:

• The draft waiver application includes the role of an enrollment broker to facilitate enrollment in prepaid health plans. Enrollment brokers will introduce new processes and technology components that need to be integrated into the current Medicaid eligibility and enrollment systems and processes (NC FAST).

• State systems will be required to process a greater volume of capitation payments and encounter data. (“Encounter data” is conceptually the same as paid claims records that are created to pay providers on a fee-for-service basis.) The Department’s NCTracks multi-payer Medicaid management system currently processes medical, dental and pharmacy claims, and capitation payments and encounter data for behavior health services. NCAnalytics is the business intelligence, analytical and reporting platform for the NCTracks online transaction processing system. It provides a data warehouse, several data marts and portals, and reporting and dashboard capabilities for financial budgeting. It provides program integrity needs for fraud and abuse management, including surveillance and utilization review, extraction of information to external entities, and feeding information used for compliance reporting to the Centers for Medicare & Medicaid Services.

It is anticipated that NCTracks will be able to absorb the increased volume of encounter processing. Testing activities will be defined and conducted to properly test NCTracks with encounter data for the different types of encounter transactions that will occur once capitated payments begin.

• The NCHTC will analyze and communicate meaningful performance, quality and other metrics needed to drive innovations and system improvements, and enable greater budget predictability. The design and development of a more comprehensive set of clinical and outcome data, together with advanced data analytics, will be needed to enable the distilling of medical costs and health care imperatives into meaningful and actionable information. There are several systems and sources of data, and contractual considerations, that need to be considered when determining how these existing components will be used to develop the necessary data and analytic platform:

– **State Health Information Exchange (HIE).** Session Law 2015-241 s. 12A.4 and 12A.5, as modified by Session Law 2015-264, established a state-managed Health Information Exchange Authority (NC HIEA) to oversee and administer the NC Health Information Exchange Network. This law mandates all Medicaid providers to connect to the NC HIEA by Feb. 1, 2018, and all other state-funded health service providers to connect by June 1, 2018. The NC HIE Advisory Board has been established and appointments are forthcoming from the General Assembly. The Advisory Board will consult with the NC HIEA on the advanced administration and operation of the NC HIE Network. The HIE allows for secure electronic exchange of health-related information among health care providers, and collects local Medicaid hospital and ambulatory data. The HIE currently collects results, allergies, encounters, problems and medications data. Additional available data not currently collected include vitals, social history and immunizations.

– **Government Data Analytics Center (GDAC).** The GDAC provides integration of data from across several state agencies and provides a number of analytic capabilities. Currently, no Medicaid data exists in the GDAC. The Department anticipates that some of the data in GDAC, and other state data sources, will be useful if integrated with Medicaid data to provide a more comprehensive understanding of the determinants of health.

– **Medicaid Analytics Pilot (MAP).** Session Law 2015-241, Section 12A.17, provides funding to the Department "to develop a pilot program with GDAC and utilize the existing GDAC public-private partnership to apply analytics to maximize healthcare savings and efficiencies to the state and positive impacts on health outcomes." In partnership with SAS Institute, 27 months of Medicaid claims data have been loaded from the NCAnalytics system to perform the pilot. By May 31, 2016, the Department and GDAC will provide a final report on findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services.

VI. PROPOSED APPROACH

The Department is defining the functional and operational details of the Medicaid reform program, and its organizational structure and governance. Work will need to begin early to develop and implement the NCHTC. The NCHTC will need to be operational prior to the 1115 demonstration waiver implementation with appropriate staffing and budget levels.

The following provides a preliminary approach of the NCHTC role and capabilities.

A. Performance Measurement and Analytics

Performance Measurement and Analytics capabilities may include:

• Perform environmental scans across the community, beneficiaries, providers and prepaid health plans, and nationally, to identify leading practices, sources of new clinical or operational knowledge and innovations as they occur.

• Perform measurements against metrics to identify how prepaid health plans and the state are performing. Note that the Department will measure and incent health plan performance based on these metrics and expects that the health plans will do the same to the providers in their plans. A set of measures will be used to report various performance characteristics of the NC Medicaid program, and a set of measures will be used to report the various performance characteristics of the health plans against a set of health care metrics.

• Establish and track baseline performance measures.

• Identify opportunities for improvements by performing analysis using outputs from the measurement activities together with environmental scan information and other health care information.

• Evaluate reward mechanisms to appropriately incent plans and providers using lessons from other states, prepaid health plans and clinicians in this evaluation.

B. Stakeholder Engagement to Motivate Innovations and System Improvements

Stakeholder Engagement to Motivate Innovations and System Improvements may include:

• Identify internal and external stakeholders, and establish regular channels of communication to provide program transparency.

• Communicate results of performance measurement and analysis to the appropriate internal and external stakeholders.

• Gather information from stakeholders crucial to understanding the challenges and opportunities to improvements.

• Disseminate innovation and improvement information.

C. Liaison Center

Liaison Center capabilities may include services to providers, prepaid health plans, state agencies and communities to provide mechanisms the network will use to enact improvements to processes, procedures, systems or other items. For example:

• Provide access to collaborations and technical assistance to providers and prepaid health plans as they transition to value based payments.

• Provide assistance to state agencies as they transition to value based payments.

• Assist communities to develop person centered health communities.

• Serve as a liaison to providers and prepaid health plans, the community, patient advocate groups, and other agencies.

D. Center of Excellence

Center of Excellence capabilities will focus on the development and oversight of strategic programs, and may include:

• Health care leadership.

• Workforce development.

• Innovation pilots.

• Financial resources (grants, foundations, etc.) to nurture innovations.

• Clinical, operational and technology best practices for providers and other service organizations.

• Outcome collaborations.

• Learning and sharing conferences for providers.

• Spread of innovations.

• Continuous quality improvement.

E. Tools

The NCHTC will use tools with providers, prepaid health plans and the community to nurture and drive innovations and system improvements. The NCHTC will foster the development of a set of tools that may include:

• Analytical data tools.

• Stakeholder engagement tools.

• Clinical data sharing mechanisms.

• Access to clinical, operational and technical knowledge stores.

F. Implementation Approach

The Department recommends the NCHTC be implemented in phases with at least the following capabilities being operational before the 1115 demonstration waiver begins.

Performance Measurement and Analytics

• Perform a scan of current health care performance measures and enrollment metrics.

• Resolve whether a potential perpetual usage license contract of the Community Care of North Carolina Informatics data analytics toolset is needed.

• Define and enable other to-be-defined requisite technology tools that will enable the NCHTC analytics program.

Stakeholder Engagement to Enable Innovations and System Improvements

• Develop a stakeholder engagement plan.

• Engage appropriate key stakeholders to identify work needed before the 1115 demonstration waiver begins.

Liaison Center

• Begin gathering and categorizing current North Carolina innovation initiatives.

• Work with state agencies to stand up protocols and procedures needed for the NCHTC to operate when the new capitated payment system begins.

• Identify activities that may be needed by providers and prepaid health plans, state agencies and enrollment broker, as they begin to transition to value based payments.

Center of Excellence

• Begin to formulate approaches to coordinate across existing innovation organizations.

• Perform a scan of existing innovation organizations across the state.

• Perform a scan of in-flight innovation initiatives across the state to better understand current initiatives being considered, their source of creation and how innovators are currently collaborating.

VII. GOVERNANCE

The NCHTC will report to the Director of Health Benefits and there will be a formal advisory group established to advise the Medicaid program leadership on NCHTC activities.

There also will be a formal metrics and scoring group defined as part of the overall NCHTC design to establish incentive metrics, benchmarks and improvement goals for the prepaid health plans, and to be cascaded to the health plans' providers.

VIII. BUDGET AND STAFFING

The Department will submit a two-year budget during the state fiscal year 2017 legislative session for the design, development and implementation of the NCHTC. There are two distinct work efforts to develop this budget:

1. Evaluate the Department's current Medicaid systems, processes, and contracts, together with recommendations for actions.

2. Develop the approach and budget for the design, development and implementation of the NCHTC.

The NCHTC staff will be full-time employees supplemented by contract staff to be able to scale as needed for the work required. The NCHTC also will use consultants as needed to provide additional assistance.

IX. NEXT STEPS

The Department will create and maintain the NCHTC to promote health care innovations and system improvements. The NCHTC will help achieve care and budget predictability for the taxpayers of the state while ensuring quality care to those in need.

Upon submitting this report, the Department will begin the work to:

• Create a detailed two-year budget for the design, development and implementation of the NCHTC for the 2017 legislative session.

• Identify additional staff requirements to operationalize the contents of this proposal in order to begin high-level design work for the initial implementation phases of the NCHTC.

• Establish the formal metrics and scoring group that will establish incentive metrics, benchmarks and improvement goals for the prepaid health plans, and start defining appropriate outcome measures.

Appendix E. Public Comment Period Communication

E.1. Governor's Office Press Release

E.2. Detailed Public Notice

E.3. DHHS Website Public Comment Form

E.4. Abbreviated Public Notice

E.5. Legal Postings

E.1. Governor's Office Press Release

STATE OF NORTH CAROLINA
GOVERNOR PAT MCCRORY

Press Release

Medicaid Reform Plan Offers a North Carolina Solution

Plan seeks to achieve better patient outcomes, high quality care, increased budget predictability

FOR IMMEDIATE RELEASE
Tuesday, March 1, 2016

(919) 814-2100
govpress@nc.gov

Raleigh, N.C. – State health officials today unveiled an innovative, multi-year draft plan for reforming North Carolina's Medicaid program to achieve better patient care, better community health, improved doctor-patient engagement and cost containment. This comes after the September 2015 passage of historic Medicaid reform legislation, achieved under the leadership of Governor Pat McCrory and the North Carolina General Assembly.

"The Medicaid Reform plan outlined today will improve care and hold down costs and empower medical professionals to achieve better outcomes for their patients," Governor McCrory said. **"This patient-centered approach is the result of providers, associations, advocates, members of the General Assembly and DHHS leaders working together to prepare us to take this important step for all the citizens of North Carolina."**

The reform plan was presented to the Joint Legislative Oversight Committee by Department of Health and Human Services Secretary Rick Brajer. It transforms the state from a fee-for-service, or volume-based system to a pre-paid health plan which is valued based. This system will promote community-based, comprehensive care management that integrates behavioral health as well as physical health to ensure beneficiaries are reaching and maintaining the highest level of health possible. The new plan is also designed to provide more accurate and responsible budgeting each year.

Medicaid beneficiaries will continue receiving services in the way they do now, until reform is implemented, which is expected to take approximately 36 months. After implementation, beneficiaries can expect more choice, more engagement and more coordination of their care.

"This plan builds on what works in North Carolina," Brajer said, "by bringing innovation and new tools into the health care system to ensure the system puts people first, and rewards health plans and providers for making patients healthier while containing costs."

This proposal is the product of nearly three years of stakeholder engagement and planning, and is an important step in accomplishing the joint vision of Governor McCrory and the General Assembly.

To change a state's Medicaid plan, a waiver application must be submitted to the Centers for Medicare and Medicaid Services (CMS), the federal agency that works in partnership with state governments to administer Medicaid. DHHS will submit the state's waiver application June 1. It is expected to take at least 18 months to receive approval from CMS. Once approved, Medicaid reform will be implemented over the following 18 months.

Over the next two months, DHHS will hold a series of listening sessions across the state to gather feedback from citizens and other stakeholders.

Medicaid accounts for the care of nearly two million citizens in North Carolina at an annual cost to the federal and state government of $13 billion. It serves approximately one in five North Carolinians and covers about 55 percent of births in the state. About 80,000 healthcare providers in the state serve Medicaid clients.

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E.2. Detailed Public Notice

PUBLIC NOTICE

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

March 7, 2016

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

Description, Goals and Objectives

North Carolina's Demonstration Goal: Achieving the Quadruple Aim

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

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

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

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

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

Demonstration Initiative #1: Creating Systems of Accountability for Outcomes

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

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

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

Demonstration Initiative #3: Supporting Providers through Engagement and Innovations

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

Demonstration Initiative #4: Care Transformation through Payment Alignment

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

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

Eligibility

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

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

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

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

Benefits and Cost Sharing

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

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

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

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

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

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

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

Delivery System and Payment Rates for Services

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

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

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

Demonstration Hypotheses and Evaluation Plan

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

1) Building on North Carolina's current system of primary care and enhanced care management, the person-centered health communities will drive the primary care integration model by supporting coordinated access to specialty care, providing routine behavioral health screening, diagnosis and management, coordinating social and home-based services, and coordinating with the state's specialty behavioral health system to achieve integrated health goals.

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

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

   Improved supports for children in foster care: a) statewide expansion of "Fostering Health NC"; b) designating a prepaid health plan for children in foster care will provide continuity of care for the children regardless of their place of residence, and reduce unnecessary health care expenditures through dedicated and coordinated care management during the child welfare experience for children in foster care and their families; and c) continuation of Medicaid eligibility (especially to provide behavioral health services) for parent(s) of children temporarily

removed from the home, will result in shorter length of foster care placement. Shorter length of out-of-home placement will reduce Medicaid expenditures for services during the foster care service provision, as well as Medicaid eligibility for the former foster children after reaching age 18, up to age 26.

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

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

Estimated Impact on Expenditures and Enrollment

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

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

	DEMONSTRATION YEARS (DY)					
	DY 1 (1/1/2018 - 12/31/2018)	**DY 2 (1/1/2019 - 12/31/2019)**	**DY 3 (1/1/2020 - 12/31/2020)**	**DY 4 (1/1/2021 - 12/31/2021)**	**DY 5 (1/1/2022 - 12/31/2022)**	**5 Year Total**
Members	1,984,907	2,025,613	2,068,287	2,113,033	2,159,974	10,351,814
Historical Aggregate Expenditures	$9,617,763,981	$10,269,342,336	$10,972,001,556	$11,730,218,374	$12,548,984,673	$55,138,310,920

Waiver and Expenditure Authorities

The table below describes the authorities requested under the demonstration. DHHS will review this request in light of the final Medicaid managed care regulations once those rules are finalized.

Waiver/Expenditure Authority Section Citation	Type	Proposed Waiver/Expenditure Authority Language	Descriptive Reason For Waiver/Expenditure Authority Request
1. Amount, Duration, and Scope of Services Section 1902(a)(10)(B) and 1902(a)(17)	Waiver Authority	To the extent necessary to permit North Carolina to offer coverage through prepaid health plans that provide additional or different benefits to enrollees, than those otherwise available to other eligible individuals.	To permit North Carolina to implement mandatory managed care through prepaid health plans for demonstration participants. Prepaid health plans may offer additional benefits, such as health education and value-added services not available to other Medicaid beneficiaries not participating in the demonstration.
2. Freedom of Choice Section 1902(a)(23)(A)	Waiver Authority	To the extent necessary to enable North Carolina to restrict freedom of choice of provider through the use of mandatory enrollment into MCOs for demonstration participants.	To permit North Carolina to implement mandatory managed care through prepaid health plans and their network providers for demonstration participants.
3. Statewideness Section 1902(a)(1)	Waiver Authority	To the extent necessary to allow North Carolina to implement managed care statewide on a phase-in basis if part of final program design.	To permit North Carolina to implement statewide mandatory managed care through prepaid health plans for demonstration enrollees on a phased-in basis as necessary.
4. Expenditures for Targeted Provider Medicaid Uncompensated Care Costs (Safety Net Hospital Payments)	Expenditure Authority	Expenditures for care and services that meet the definition of “medical assistance‟ contained in section 1905(a) of the Act that are incurred by eligible providers for uncompensated Medicaid medical care costs of medical services provided to Medicaid eligible or uninsured individuals.	Expenditures to providers to stabilize and invest in safety-net providers to ensure access to care as North Carolina transforms Medicaid payments from FFS to capitation under prepaid health plans.
5. Expenditures for DSRIP	Expenditure Authority	Expenditures for incentive payments under a DSRIP program.	Expenditures to eligible providers to stabilize and invest in safety net providers and enable North Carolina to transform to a system of value-based payment (VBP) as the State transitions from FFS to capitation under prepaid health plans.

Waiver/Expenditure Authority Section Citation	Type	Proposed Waiver/Expenditure Authority Language	Descriptive Reason For Waiver/Expenditure Authority Request
6. Expenditures for Non-Hospital Clinic and Local Health Department Expenditures that Support Rural Health	Expenditure Authority	Expenditures for Rural and Public Provider Initiatives.	Expenditures to eligible federally qualified health centers (FQHCs) and rural health center (RHC)-like clinics and local health departments to preserve funding levels through "wrap-around" payments.
7. Expenditures for Community-Based Residency and Enhanced Training Programs	Expenditure Authority	Expenditures for outpatient community-based residency and enhanced training programs.	Expenditures to support rural health access through funding for outpatient community-based residency and enhanced team-based training programs. Graduate medical education (GME) - like payments for eligible Area Health Education Centers (AHECs), Teaching Health Centers Graduate Medical Education (THCGME) programs, and community-based residency program for services provided to a Medicaid recipient.
8. Expenditures for VBP Methodologies within Capitated Prepaid health plans	Expenditure Authority	Expenditure for capitation payments to incent managed care plans to engage in activities that promote performance targets and identify strategies for VBP models for provider reimbursement.	To enable North Carolina to incent capitated prepaid health plans to adopt VBP models for provider reimbursement.
9. Expenditures for Parents of Foster Care Children Who Would Otherwise be Medicaid Eligible Except for the Placement of Their Child(ren) into the Child Welfare System	Expenditure Authority	Expenditures for parents of foster care children who would otherwise be Medicaid eligible except for the placement of their children into the child welfare system.	To continue Medicaid eligibility for parents of children placed temporarily in foster care to address the comprehensive health care needs of the parents and increase the likelihood of successful reunification of the children with the family.

Public Notice Period and Comments

Stakeholders interested in reviewing the draft demonstration application, commenting on the draft application and receiving more information on the public notice period can visit the DHHS Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform. A copy of the application is available at:

Division of Health Benefits
Department of Health and Human Services
101 Blair Drive
Raleigh, NC 27603

The draft demonstration application is available for review and public comment from March 7, 2016, through 11:59 p.m. April 18, 2016. Along with the regularly scheduled Medical Care Advisory Committee (MCAC) meeting where the public can learn more about the 1115 waiver, DHHS will hold 12 public hearings to seek input on the draft demonstration application. Those who cannot attend in person will have the opportunity to dial into the Charlotte South public hearing, and also may view the presentation and provide comments through the Medicaid Reform website. Date, time and location of the public hearings for the demonstration are posted on the DHHS Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform.

The following table lists the public hearing schedule as of March 7, 2016:

Geographic Area	Location	Date	Start Time	End Time
Raleigh	McKimmon Center	3/30/2016	6:00 PM	8:00 PM
Charlotte (South)[1]	Union County Dept. of Social Services	3/31/2016	2:00 PM	4:00 PM
Charlotte (North)	CPCC Merancas Campus	3/31/2016	6:30 PM	8:30 PM
Western NC	To be determined			
Western NC - Boone	Holiday Inn Express	4/6/2016	12:00 PM	2:00 PM
Western NC - Asheville	Asheville-Buncombe Tech Community College	4/6/2016	6:30 PM	8:30 PM
Greensboro	Guilford County Health & Human Services	4/7/2016	6:30 PM	8:30 PM
Winston-Salem	Forsyth County Department of Public Health	4/8/2016	2:00 PM	4:00 PM
Wilmington	UNC-Wilmington	4/13/2016	6:00 PM	8:00 PM
Greenville	To be determined			
Elizabeth City	College of Albemarle	4/16/2016	10:00 AM	12:00 PM
Lumberton	UNC-Pembroke	4/18/2016	3:30 PM	5:30 PM
[1]This hearing will also provide dial-in access for those who cannot participate in person.				

This schedule is subject to change. The most current schedule is available on the DHHS Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform.

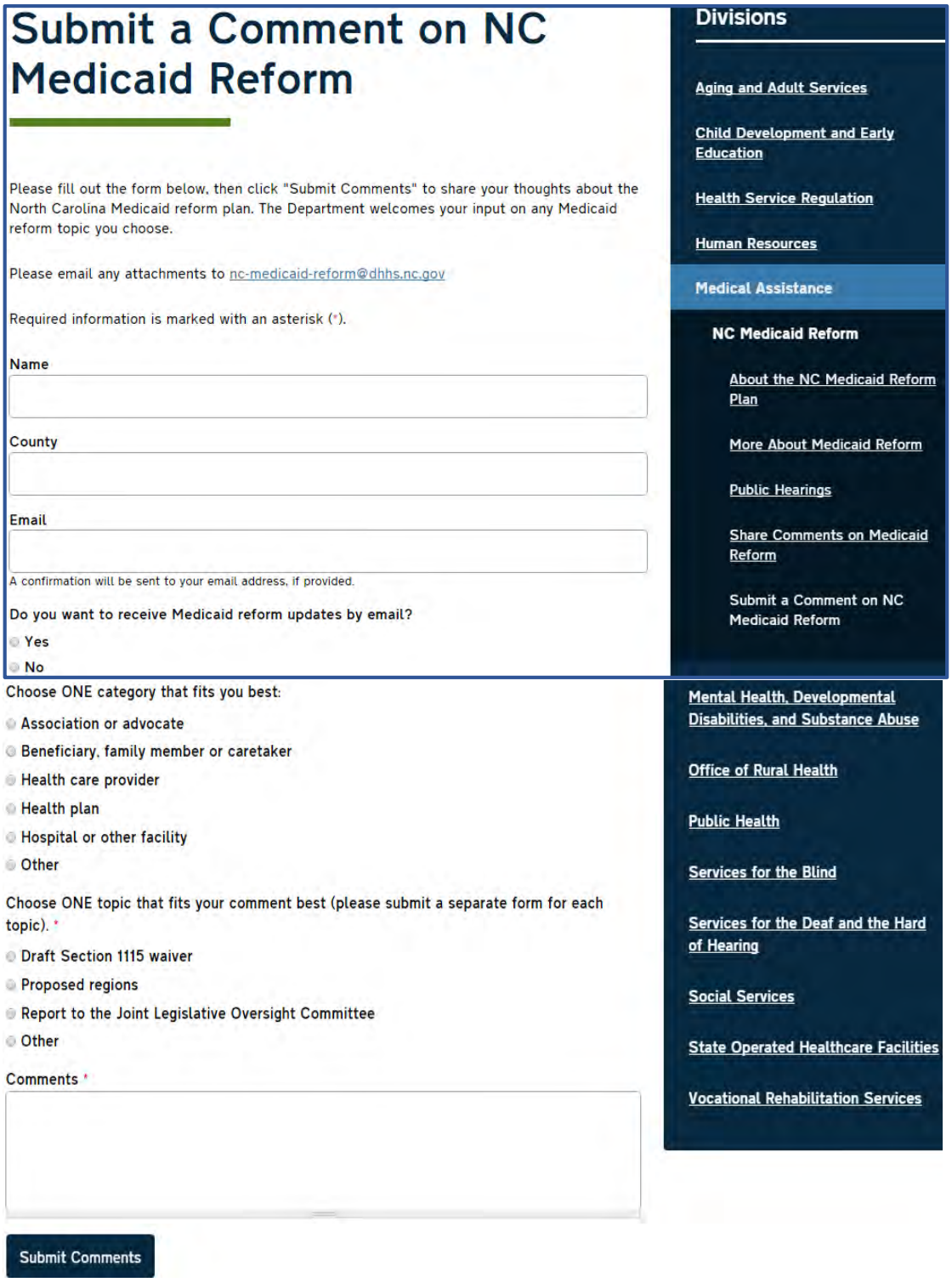
In addition to providing comments through the Medicaid Reform website or during a public hearing, written comments may be emailed, sent by postal mail or delivered in person:

Email: MedicaidReform@dhhs.nc.gov

Postal Mail
Division of Health Benefits
North Carolina Department of
Health and Human Services
2501 Mail Service Center
Raleigh, NC 27699-2501

Delivered in Person
Division of Health Benefits
North Carolina Department of
Health and Human Services
101 Blair Drive
Raleigh, NC 27603

E.3. DHHS Website Public Comment Form



Submit a Comment on NC Medicaid Reform

Please fill out the form below, then click "Submit Comments" to share your thoughts about the North Carolina Medicaid reform plan. The Department welcomes your input on any Medicaid reform topic you choose.

Please email any attachments to nc-medicaid-reform@dhhs.nc.gov

Required information is marked with an asterisk (*).

Name

County

Email

A confirmation will be sent to your email address, if provided.

Do you want to receive Medicaid reform updates by email?

- Yes
- No

Choose ONE category that fits you best:

- Association or advocate
- Beneficiary, family member or caretaker
- Health care provider
- Health plan
- Hospital or other facility
- Other

Choose ONE topic that fits your comment best (please submit a separate form for each topic). *

- Draft Section 1115 waiver
- Proposed regions
- Report to the Joint Legislative Oversight Committee
- Other

Comments *

Submit Comments

Divisions

- Aging and Adult Services
- Child Development and Early Education
- Health Service Regulation
- Human Resources
- Medical Assistance
  - NC Medicaid Reform
    - About the NC Medicaid Reform Plan
    - More About Medicaid Reform
    - Public Hearings
    - Share Comments on Medicaid Reform
    - Submit a Comment on NC Medicaid Reform
- Mental Health, Developmental Disabilities, and Substance Abuse
- Office of Rural Health
- Public Health
- Services for the Blind
- Services for the Deaf and the Hard of Hearing
- Social Services
- State Operated Healthcare Facilities
- Vocational Rehabilitation Services

E.4. Abbreviated Public Notice

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

Pursuant to 42 C.F.R. 431.408, the North Carolina Department of Health and Human Services is providing notice of intent to submit a Social Security Act Section 1115 Demonstration for the Medicaid and N.C. Health Choice plans (Medicaid reform waiver application), and requests public comment on the draft demonstration.

The North Carolina Department of Health and Human Services' (DHHS') proposed Section 1115 Demonstration sets forth a plan to improve the access to, and quality and cost effectiveness of health care for our growing population of Medicaid and N.C. Health Choice beneficiaries. The demonstration will restructure Medicaid care delivery using accountable, next-generation prepaid health plans; redesign payment to reward value rather than volume; and plan toward true person centered care grounded on the foundation of the current patient-centered medical homes, community support and informatics services.

Medicaid Reform will enable North Carolina to meet four goals defined by the North Carolina General Assembly:

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

The draft Section 1115 Demonstration documents are available for review on the N.C. Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform and include:

- Complete public notice with summary of the Section 1115 Demonstration
- Draft Section 1115 Demonstration proposal

A hard copy of the draft Section 1115 Demonstration is available at the Department of Health and Human Services, 101 Blair Drive, Raleigh NC, 27603.

Public comments are being accepted during the federally required comment period from March 7 through 11:59 p.m. on April 18, 2016. Input will be reviewed and considered by DHHS to help finalize the waiver application for submission to the Centers for Medicare & Medicaid Services by June 1, 2016. Comments can be submitted:

- **Online** at the N.C. Medicaid Reform website at http://www.ncdhhs.gov/nc-medicaid-reform/medicaid-reform-comment-submission-form
- **By email** to MedicaidReform@dhhs.nc.gov
- **By mail** to Division of Health Benefits, North Carolina Department of Health and Human Services, 2501 Mail Service Center, Raleigh, NC 27699-2501
- **In person** at North Carolina Department of Health and Human Services, 101 Blair Drive, Raleigh, NC 27603

Twelve public hearings will be held throughout the state during March and April 2016. Below are the hearings scheduled for March:

March 30, 2016; 6 p.m. – 8 p.m.

McKimmon Center, 1101 Gorman Street, Raleigh, NC 27606

March 31, 2016; 2 p.m. – 4 p.m.
Union County Dept. of Social Services, Auditorium, 1212 W. Roosevelt Boulevard, Monroe, NC 28110
Dial-in access available is available for this session: 1-888-585-9008; conference room number 780073319#.

March 31, 2016; 6:30 p.m. – 8:30 p.m.
CPCC Merancas Campus, Auditorium, 11930 Verhoeff Drive, Huntersville, NC 28078

A complete list of public hearings is available on the N.C. Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform. Dial-in instructions for the March 31 Union County session also will be posted when available to the website.

Visit the N.C. Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform to review the draft Section 1115 Demonstration application, detailed public notice and other documents; submit comments on the Medicaid Reform plan, including the draft application; and learn more about N.C. Medicaid Reform.

E.5. Legal Postings

GEOGRAPHIC AREA	NC CITIES WITH 100,000 RESIDENTS[10]	NEWSPAPER	PUBLICATION DATE[11]
Western		Asheville Citizen-Times	03-13-2016
Charlotte	Charlotte	Charlotte Observer	03-13-2016 03-19-2016 04-15-2016
		Gaston Gazette	03-13-2016
Greensboro	Greensboro	Greensboro News & Record	03-13-2016 04-14-2016
Greenville		The Daily Reflector	03-16-2016
High Point	High Point	High Point Enterprise	03-12-2016 04-14-2016
RDF	Cary Raleigh Durham Fayetteville	News & Observer	03-16-2016 04-14-2016
		The Herald Sun	03-15-2016
		The Fayetteville Observer	03-16-2016 04-17-2016
Wilmington	Wilmington	Wilmington StarNews	03-16-2016 04-15-2016
Winston-Salem	Winston-Salem	Winston-Salem Journal	03-15-2016 04-14-2016

Evidence of legal postings follows.

[10] Source: United States Census Bureau

[11] 3/12-3/16 – First posting; 3/19 (Charlotte Observer) – reposting with dial-in number; 4/14-4/17 – reposting with Pembroke dial-in number for 100,000+ locations.

REAL ESTATE FOR SALE

0734 Lots & Acreage

18.5 acres Randolph co
10.0 acres Rabdolph co
Call 336-906-4973

For Rent
Mobile home lot in Trinity
Call 336-476-5055

Lot For Sale
Trinity Darr Rd Lot 10
Cost $3500
Call 336-885-2780

0793 Monuments/ Cemeteries

2 Premier Burial Plots at Floral Gardens normally $3,900 each. **Now Buy One Get One FREE**. Call 869-3608

Guilford Memorial Park
Veterans Section double plot $2000 CALL 336-299-0307

TRANSPORTATION

0868 Cars for Sale

'02 Saturn 4 dr., 4 cyl., Auto., A/C, Pwr. Windows, Clean dependable car, New Inspection. $2200 Call 889-2165

'99 Nissan Altima, White, 4 dr., 4 cyl., Auto., Sunroof. Runs good & New inspection. $2100 Call 889-2165

Immaculate 2009 Mercedes CLS550 - 59,000 miles. North Carolina car, one owner, always garaged and serviced by Mercedes.
Contact Tiffany Harris at 336-882-4110 or tiffany@universalleather.com

FINANCIAL

LEGALS

0955 Legals

NORTH CAROLINA
GUILFORD COUNTY

NOTICE TO CREDITORS

THE UNDERSIGNED, having qualified as EXECUTOR of the Estate of CAROLYN J. DIGGS, deceased late of GUILFORD County, this is to notify all persons, firms, and corporations having claims against said Estate to present them to the undersigned on or before the 17TH day of JUNE, 2016, or this Notice will be pleaded in bar of their recovery. All persons indebted to said estate please make immediate payment to the undersigned.

This the 12th day of March 2016.

Vonda Diggs Ware Executor of Estate of Carolyn J. Diggs 518 Ashburn Street High Point, NC 27260

March 12, 19, 26, April 2, 2016

0955 Legals

NOTICE OF EXECUTOR TO CREDITORS AND DEBTORS

Megan Elaine Carr, having qualified as Executor for the Estate of **Laura Katherine Carr**, Deceased, late of Guilford County, North Carolina, does hereby notify all persons, firms, and corporations having claims against said estate to present them to the undersigned, at the address indicated below, on or before **May 19, 2016**, or this Notice will be pleaded in bar of their recovery. All persons, firms, and corporations indebted to said estate should please make immediate payment to the undersigned.

This the 19th day of February, 2016.

Megan Elaine Carr
Executor of the
Laura Katherine Carr Estate
Schell Bray PLLC
P.O. Box 21847
Greensboro, NC 27420

Jennifer L.J. Koenig
SCHELL BRAY PLLC
230 North Elm Street,
Suite 1500
Greensboro, NC 27401
Feb. 19, 26, March 4, 12, 2016

0955 Legals

NORTH CAROLINA
GUILFORD COUNTY

NOTICE TO CREDITORS

THE UNDERSIGNED, having qualified as ADMINISTRATOR of the Estate of ROSCOE MEANS, JR, deceased late of GUILFORD County, this is to notify all persons, firms, and corporations having claims against said Estate to present them to the undersigned on or before the 16TH day of JUNE, 2016, or this Notice will be pleaded in bar of their recovery. All persons indebted to said estate please make immediate payment to the undersigned.

This the 11th day of March 2016.

Lucille Means Administrator of Estate of Roscoe Means, Jr 2016 Arden Place High Point, NC 27265

March 11, 18, 25, April 1, 2016

More people...
Better results...
HPE Classifieds
(336) 888-3555

0955 Legals

RESOLUTION OF INTENT TO CONSIDER STREET ABANDONMENT (SA16-01)

WHEREAS, the City Council has been petitioned to abandon a portion (approximately 250 feet) of the unimproved Indian Drive right-of-way. The right-of-way to be abandoned is lying along the east side of St. Johns Street, approximately 750 feet north of Skeet Club Road.

WHEREAS, G.S. 160A-299 requires the Council to first adopt a resolution declaring its intent to abandon the above right-of-way and calling a public hearing on the question;

NOW, THEREFORE BE IT RESOLVED, THAT THE COUNCIL declares its intent to consider the abandonment of the right-of-way above described and sets Monday, March 21, 2016, at 5:30 p.m. as the date for said public hearing before the Council in the Council Chamber of the Municipal Building in High Point.

Persons wishing to be heard either for or against the said right-of-way abandonment are asked to be present for the hearing. The meeting facilities of the City of High Point are accessible to people with disabilities. If you need a special accommodation, call (336) 883-3298 or TDD# (336) 883-8517.

Further information pertaining to this request is available at the Planning and Development Department in Room 316 of the Municipal Office Building, 211 South Hamilton Street, High Point, North Carolina, (336) 883-3328 or FAX (336) 883-3056.

By Order of the City Council
This the 15th day of February, 2016.

Lisa B. Vierling, City Clerk

Petition Submitted By: West Mountain Funding, LLC
Feb. 19, 26, March 4, 11, 2016

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

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-MORE-
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The High Point Enterprise – March 12, 2016

WWW.CITIZEN-TIMES.COM | SUNDAY, MARCH 13, 2016 | PAGE 5C

In partnership with CAREERBUILDER

SUNDAY JOBS

In print, online and on the go

EMPLOYERS: To place a recruitment ad and learn more about our hiring resources, call 828-236-JOBS or email AshevilleJobs@gannett.com

0003 Disclaimer

1 Announcements and Financial

1001 Legals

2 Employment and Instruction

2170 Misc./Gen Employment

2180 Office/Clerical

4 Merchandise

9 Transportation

9030 Autos

Right Job. Right Now.

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- Have reliable transportation
- Valid driver's license
- Excellent service skills

We want to talk to you!

Profit varies by route

Routes currently available in Fletcher, Arden, Candler and N. Asheville

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6 FT TO 15 FT MOWERS AVAILABLE

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PH: 423-282-6969

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- BALE WRAPPERS
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CCM DRUM MOWERS

- Exterior Hydraulics are not needed
- Mows any hay in any conditions
- Never clogs up
- Works on compacts & utility size trailers
- Proven design since 1969

MODEL	LBS	CUT	HP
T-135	700	53"	20-40
T-165	820	65"	28-60
T-190	950	75"	33-70

HAY MAG 554 PRO TEDDER

- Working Width 18'2"
- Heavy Duty Rotors (4)
- Hydraulic Fold, Hydraulic Tilt, Hydraulic Fold (on one spool)
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- Rake Wheels * PTO's
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Deerfield

The area's premiere retirement community seeks the following positions:

Come work for a winning team
New Starting Wage and New wage scale
Increased Shift Differential
Flexible Scheduling
7 Holidays paid at time and ½

CNA
LPN or RN
Med Tech/CNA
RN Clinical Coordinator

Submit application by Fax: (828) 277-5615 or to: 1617 Hendersonville Rd.

Deerfield

The area's premiere retirement community seeks the following positions:

Dishwasher
PT Sat 1p-9p Sun 9a-5p

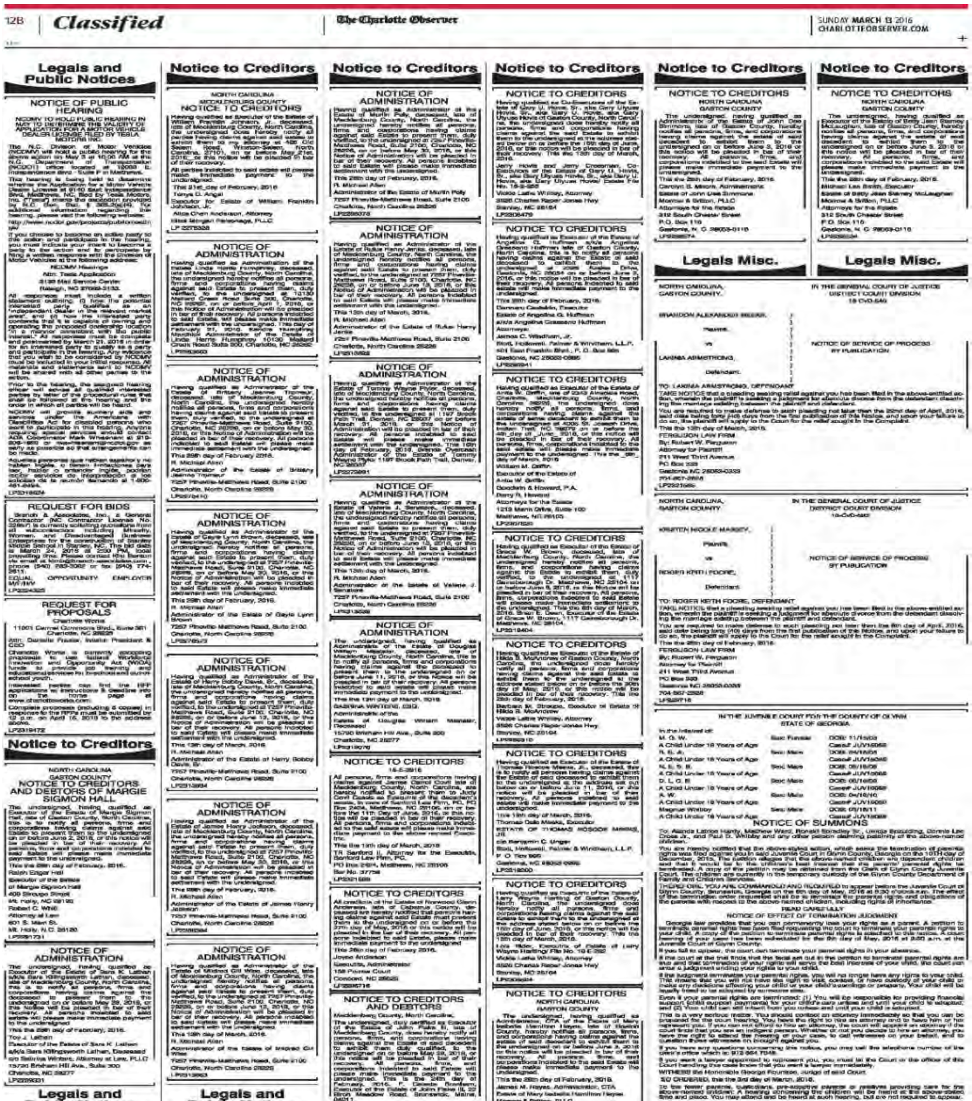
Housekeeper
FT 7a-3:30p or 9a-4:30p M-F w/occ wknd

Landscaper
FT M-F 7a-3:30p

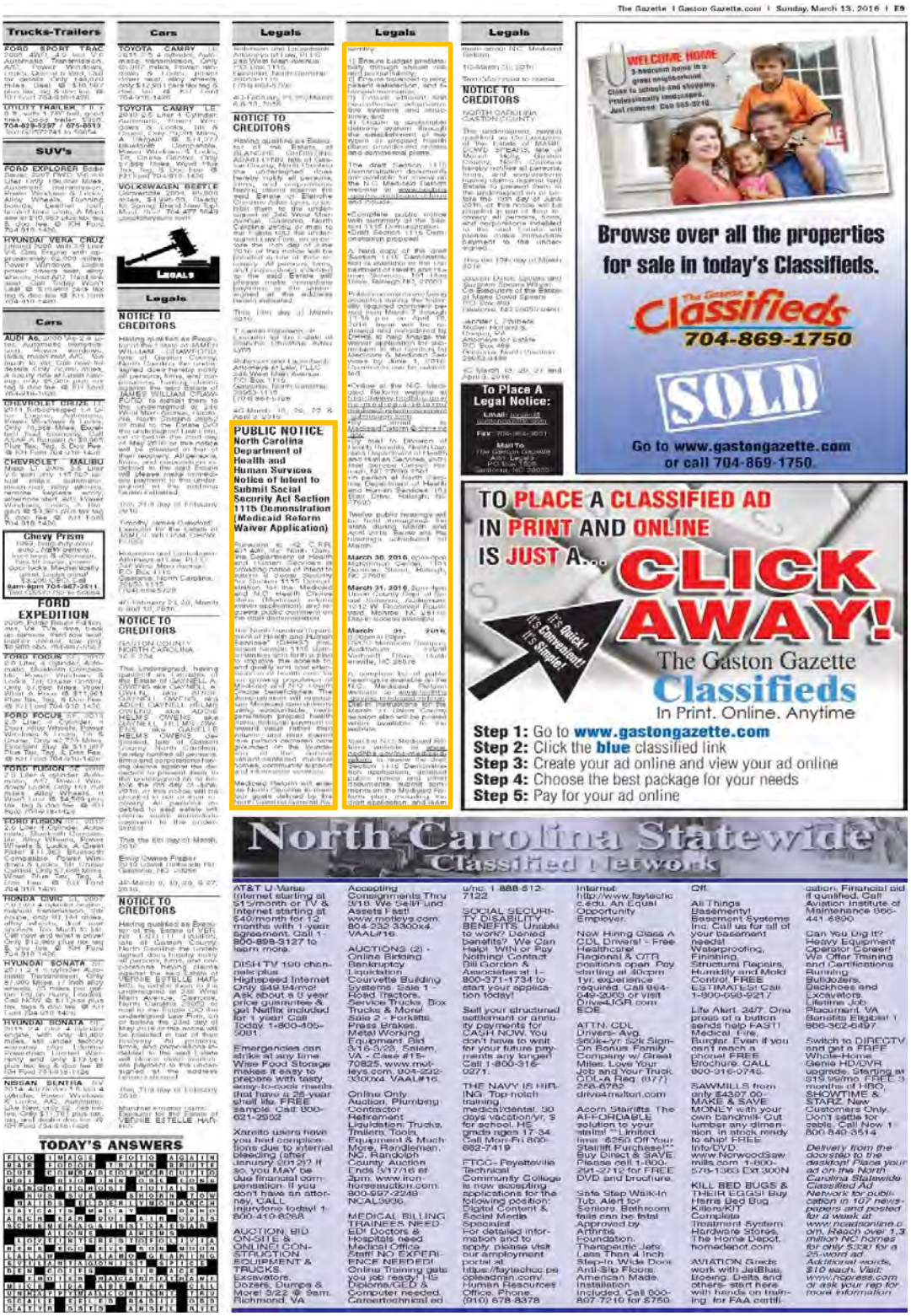
Waitstaff
PT 11a-3p & 4:30p-8p w/wknds

Submit application by Fax: (828) 277-5615 or to: 1617 Hendersonville Rd.

Asheville Citizen-Times – March 13, 2016



The Charlotte Observer – March 13, 2016



The Gazette | Gaston Gazette.com | Sunday, March 13, 2016 | E9

Trucks-Trailers

Cars

SUV's

Legals

NOTICE TO CREDITORS

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

To Place a Legal Notice:

WELCOME HOME
3-bedroom home in a great neighborhood
Close to schools and shopping
Professionally landscaped.
Just remove: Can 865-3216

Browse over all the properties for sale in today's Classifieds.

The Gaston Gazette Classifieds
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Go to www.gastongazette.com or call 704-869-1750.

TO PLACE A CLASSIFIED AD IN PRINT AND ONLINE IS JUST A... CLICK AWAY!

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Step 1: Go to www.gastongazette.com
Step 2: Click the blue classified link
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Step 5: Pay for your ad online

North Carolina Statewide Classified Network

AT&T U-Verse Internet starting at $21/month for TV & Internet starting at $40/month for 12 months with 1-year agreement. Call 1-800-868-3127 to learn more.

DISH TV 190 channels plus Highspeed Internet ONLY $49.99/mo! Ask about a 6 year price guarantee & get Netflix included for 1 year! Call Today: 1-800-455-0091.

Emergencies can strike at any time. Wise Food Storage makes it easy to be prepared with tasty, easy-to-cook meals that have a 25-year shelf life. FREE sample. Call: 800-021-2902

Xarelto users have you had complications due to internal bleeding (after January 2012)? If so, you MAY be due financial compensation. If you don't have an attorney, CALL injurylone today! 1-800-410-8268

AUCTION: BID ON-SITE & ONLINE! CONSTRUCTION EQUIPMENT & TRUCKS. Excavators, Dozers, Dumps & More! 3/22 @ 9am, Richmond, VA

Accepting Consignments Thru 3/16. We Sell Fund Assets Fast! www.motleys.com 804-232-3300x4, VAAL#16.

AUCTIONS (2) - Online Bidding Bankruptcy Liquidation Corvette Building Systems - Sale 1 - Road Tractors, Service Trucks, Box Trucks & More! Sale 2 - Forklifts, Press Brakes, Metal Working Equipment. Bid 3/16-3/23, Salem, VA - Case #15-70825, www.motleys.com 804-232-3300x4 VAAL#16.

Online Only Auction. Plumbing Contractor Retirement Liquidation: Trucks, Trailers, Tools, Equipment & Much More. Randleman, NC. Randolph County Auction Ends 3/17/16 at 2pm. www.ironhorseauction.com 800-997-2248 NCAL3936.

MEDICAL BILLING TRAINEES NEEDED! Doctors & Hospitals need Medical Office Staff! NO EXPERIENCE NEEDED! Online Training gets you job ready! HS Diploma/GED & Computer needed. Careertechnical ed

u/hic. 1-888-512-7122

SOCIAL SECURITY DISABILITY BENEFITS. Unable to work? Denied benefits? We Can Help. WIN or Pay Nothing! Contact Bill Gordon & Associates at 1-800-371-1734 to start your application today!

Sell your structured settlement or annuity payments for CASH NOW. You don't have to wait for your future payments any longer! Call 1-800-316-0271.

THE NAVY IS HIRING. Top-notch training, medical/dental, 30 days vacation/yr, $ for school. HS grads ages 17-34. Call Navy Rep Fri 800-662-7419

FTCC- Fayetteville Technical Community College is now accepting applications for the following position: Digital Content & Social Media Specialist For detailed information and to apply, please visit our employment portal at https://faytechcc.peopleadmin.com/. Human Resources Office. Phone: (910) 678-8378

Internet: http://www.faytechcc.edu An Equal Opportunity Employer.

Now Hiring Class A CDL Drivers! - Free Healthcare! Regional & OTR positions open. Pay starting at .40cpm. 1yr. experience required. Call 864-649-2060 or visit DriveHGR.com EOE.

ATTN: CDL Drivers- Avg. $80k+/yr. 52k Sign-On Bonus. Family Company w/ Great Miles. Love Your Job and Your Truck. CDL-A Req. (877) 258-8782 drive4melton.com

Acorn Stairlifts. The AFFORDABLE solution to your stairs! ** Limited time -$250 Off Your Stairlift Purchase!** Buy Direct & SAVE. Please call 1-800-291-2712 for FREE DVD and brochure.

Safe Step Walk-In Tub. Alert for Seniors. Bathroom falls can be fatal. Approved by Arthritis Foundation. Therapeutic Jets. Less Than 4 Inch Step-In Wide Door. Anti-Slip Floors. American Made. Installation Included. Call 800-807-7210 for $750

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All Things Basement! Basement Systems Inc. Call us for all of your basement needs! Waterproofing, Finishing, Structural Repairs, Humidity and Mold Control. FREE ESTIMATES! Call 1-800-698-9217

Life Alert. 24/7. One press of a button sends help FAST! Medical, Fire, Burglar. Even if you can't reach a phone! FREE Brochure. CALL 800-916-0745.

SAWMILLS from only $4397.00- MAKE & SAVE MONEY with your own bandmill- Cut lumber any dimension. In stock ready to ship! FREE Info/DVD. www.NorwoodSawmills.com 1-800-578-1363 Ext.300N

KILL BED BUGS & THEIR EGGS! Buy Harris Bed Bug Kill'n/KIT Complete Treatment System. Hardware Stores, The Home Depot, homedepot.com

AVIATION Grads work with JetBlue, Boeing. Delta and others- start here with hands on training for FAA certification. Financial aid if qualified. Call Aviation Institute of Maintenance 866-441-8890.

Can You Dig It? Heavy Equipment Operator Career! We Offer Training and Certifications. Running Bulldozers, Backhoes and Excavators. Lifetime Job Placement. VA Benefits Eligible! 1-866-362-6497.

Switch to DIRECTV and get a FREE Whole-Home Genie HD/DVR upgrade. Starting at $19.99/mo. FREE 3 months of HBO, SHOWTIME & STARZ. New Customers Only. Don't settle for cable. Call Now 1-800-840-3514

Delivery from the doorstep to the desktop! Place your ad on the North Carolina Statewide Classified Ad Network for publication in 107 newspapers and posted for a week at www.ncadsonline.com. Reach over 1.3 million NC homes for only $320 for a 25-word ad. Additional words, $10 each. Visit: www.ncpress.com or ask your rep for more information.

TODAY'S ANSWERS

Beautiful 4 Bedroom Building Site in Red Mountain
1.93 acres. Wooded and Level. Community Pool, Clubhouse & Playground.
13203 Quarterhorse Run. $47,000
Kim and Don Hanan, Fonville Morisey Realty
919.416.2263
www.NCHomeSearch.com

Four Beautiful Building Lots
Holeman Plantation
Timberlake, NC
S Old Lantern Road (lot 3) 1.10 Acres; $52,500
S Old Lantern Road (lot 44) 1 Acre, $54,900
Planters Way (lot 4) 1.12 Acres; $52,500
Planters Way (lot5) 1.32 Acres; $54,900
* Established neighborhood with beautiful custom built homes * Bring your own builder or let us find one for you * 2200 sq ft min. site built * Architectural Review
Kim and Don Hanan, Fonville Morisey Realty
919.416.2263
www.NCHomeSearch.com

0780 Misc. Real Estate

5 Plots in Woodlawn. Section 4, block 4, plots 1,2,4,5,6. $600 each. Will sell 1 & 2 separate from 4-6. Dan Riddle 919-605-2600 or danriddle10@yahoo.com

TRANSPORTATION

0864 Pickup Trucks for Sale

1995 GMC Work Truck. Extended cab. Runs good. 111K+ miles. $4,000 919-306-1185

0868 Cars for Sale

'96 Buick Regal GS Grand Sport - One lady owner. Excellent condition. New tires. 67K original miles. Sunroof. Fully equipped, like new. $4500 Neg. or would consider a trade: Camaro, Chevelle, or Noble
Serious Inquiries only!
(919)384-9319
(919)305-9419
Call Anytime!

2000 Chev S-10 For Sale $1600 O.B.O.
New Tires (less than 200 miles) New Brakes. All Around Well-Maintained. No leaks. AC, AT, Runs Great U-8 Vortex Engine
919-885-6080

1997 VOLVO - Sunrf, pwr lock & wdw, runs great, a/c. $1700 919-368-3431.

2010 CTS Silver Cadillac - fully loaded. Take over payments. Approx. 72k miles. 919-692-1113 or 919-309-6198.

2010 RS Camaro. 6. DOHC 50K miles in excellent condition. Tires and battery less than a year old. Maroon with leather interior. All records and car history available. Pricing of $17,500 o.b.o. within reason. Contact 336-364-5293.

2014 Ford MUSTANG Convertible, Beautiful & In EXCELLENT Cond. V6, Loaded, 35K mi $21,000
Southpoint Area
Call 919-469-8085

Nissan Sentra SR '12 22,505 miles WOW! only $12,000 v good condition inside&out. Must see. 919-894-9607

Classic/Sports/Collector Cars

'68 BUICK SKYLARK Custom, hardtop, all orig., $4000. Call (919)471-1814 or call 919-618-5714, lv. msg.

1994 Coupe Corvette, 76K miles, silver, kept in garage; $8,000. Excellent condition in Southern Durham. Call 919-423-5445.

FINANCIAL

LEGALS

Legals

ADMINISTRATOR'S NOTICE
The undersigned, Deshon Khayre McClain, having duly qualified as Administrator of the estate of Donald Wayne Cameron, deceased, late of Durham County, North Carolina, notifies all persons, firms and corporations having claims against the estate of said deceased to exhibit them to the undersigned at 1214 N. Miami Blvd, Durham, NC 27703 on or before the 1st day of June, 2016, or this notice will be pleaded in bar of their recovery. All persons, firms and corporations indebted to said estate will please make immediate payment. This 1st day of March, 2016. Deshon Khayre McClain, Administrator of the estate of Donald Wayne Cameron, deceased
H-S: 3-1, 8, 15, 22, 2016

ADMINISTRATRIX'S NOTICE
The undersigned, Barbara Parrish Bradley, having duly qualified as Administratrix of the estate of Mary Helen Parrish AKA May H. Parrish, deceased, late of Durham County, North Carolina, notifies all persons, firms and corporations having claims against the estate of said deceased to exhibit them to 4808 Singing Woods Place, Durham, NC 27712 on or before the 15th day of June, 2016 or this notice will be pleaded in bar of their recovery.
All persons, firms and corporations indebted to said estate will please make immediate payment.
This 15th day of March, 2016.
Barbara Parrish Bradley
Administratrix of the estate of Mary Helen Parrish AKA May H. Parrish, deceased
H-S: 3-15, 22, 29, 4-5, 2016

NOTICE OF SERVICE OF PROCESS BY PUBLICATION
STATE OF NORTH CAROLINA
COUNTY OF DURHAM
In the Juvenile Court Division of Durham County
Sue-Ling v. King
15 JT 190
To: ERIC STILLMAN KING
Take notice that a pleading seeking relief against you has been filed in the above-entitled action. The nature of the relief being sought is TERMINATION OF PARENTAL RIGHTS
You are required to make defense to such pleading no later than forty days from March 1, 2016, and upon your failure to do so, the party seeking service against you will apply to the court for the relief sought. This the 1st day of March, 2016.
ELLIS FAMILY LAW, P.L.L.C.
Jillian E. Mack
Attorney for Plaintiff
Post Office Box 803
Durham, NC 27702
919.688.9400
H-S: 3-1, 8, 15, 2016

EXECUTRIX'S NOTICE
The undersigned, Julie Scoggins McFalls, having duly qualified as Executrix of the estate of Monroe Wade Scoggins, deceased, late of Durham County, North Carolina, notifies all persons, firms and corporations having claims against the estate of said deceased to exhibit them to the undersigned at 906 Arvin Road, Durham, NC 27704 on or before the 29th day of May, 2016 or this notice will be pleaded in bar of their recovery. All persons, firms and corporations indebted to said estate will please make immediate payment. This 1st day of March, 2016. Julie Scoggins McFalls, Executrix of the estate of Monroe Wade Scoggins, deceased
H-S: 3-1, 8, 15, 22, 2016

PUBLIC NOTICE
North Carolina Department of Health and Human Services
Notice of Intent to Submit Social Security Act Section 1115 Demonstration (Medicaid Reform Waiver Application)
Pursuant to 42 C.F.R. 431.408, the North Carolina Department of Health and Human Services is providing notice of intent to submit a Social Security Act Section 1115 Demonstration for the Medicaid and N.C. Health Choice plans (Medicaid reform waiver application), and requests public comment on the draft demonstration.
The North Carolina Department of Health and Human Services' (DHHS') proposed Section 1115 Demonstration sets forth a plan to improve the access to, and quality and cost effectiveness of health care for our growing population of Medicaid and N.C. Health Choice beneficiaries. The demonstration will restructure Medicaid care delivery using accountable, next-generation prepaid health plans; redesign payment to reward value rather than volume; and plan toward true person-centered care groundedon the foundation of the current patient-centered medical homes, community support and informatics services.
Medicaid Reform will enable North Carolina to meet four goals defined by the North Carolina General Assembly:
1) Ensure budget predictability through shared risk and accountability;
2) Ensure balanced quality, patient satisfaction, and financial measures;
3) Ensure efficient and cost-effective administrative systems and structures; and
4) Ensure a sustainable delivery system through the establishment of two types of prepaid health plans: provider-led entities and commercial plans.
The draft Section 1115 Demonstration documents are available for review on the N.C. Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform and include:
* Complete public notice with summary of the Section 1115 Demonstration
* Draft Section 1115 Demonstration proposal
A hard copy of the draft Section 1115 Demonstration is available at the Department of Health and Human Services 101 Blair Drive, Raleigh NC 27603.
Public comments are being accepted during the federally required comment period from March 7 through 11:59 p.m. on April 18, 2016. Input will be reviewed and considered by DHHS to help finalize the waiver application for submission to the Centers for Medicare & Medicaid Services by June 1 2016. Comments can be submitted:
* Online at the N.C. Medicaid Reform website at http://www.ncdhhs.gov/nc-medicaid-reform/medicaid-reform-comment-submission-form
* By email to MedicaidReform@dhhs.ncgov
* By mail to Division of Health Benefits, North Carolina Department of Health and Human Services, 2501 Mail Service Center, Raleigh, NC 27699-2501
* In person at North Carolina Department of Health and Human Services,101 Blair Drive Raleigh, NC 27603
Twelve public hearings will be held throughout the state during March and April 2016. Below are the hearings scheduled for March:
March 30, 2016; 6 p.m. – 8 p.m.
McKimmon Center, 1101 Gorman Street, Raleigh, NC 27606
March 31, 2016; 2 p.m. – 4 p.m.
Union County Dept. of Social Services, Auditorium, 1212 W Roosevelt Boulevard, Monroe NC 28110; Dial-in access available
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CPCC Merancas Campus Auditorium, 11930 Verhoeff Drive, Huntersville, NC 28078
A complete list of public hearings is available on the N.C. Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform. Dial-in instructions for the March 31 Union County session also will be posted when available to the website.
Visit the N.C. Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform to review the draft Section 1115 Demonstration application, detailed public notice and other documents; submit comments on the Medicaid Reform plan, including the draft application; and learn more about N.C. Medicaid Reform.
H-S 3-15-2016

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The Herald Sun 3-15-16

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The Herald Sun – March 15, 2016

WINSTON-SALEM JOURNAL.

Carolina Classified Marketplace 336-727-7426 — Tuesday, March 15, 2016 — WINSTON-SALEM JOURNAL B11

FINANCIAL — Business Opportunities

Carrier

Carrier needed to deliver the Winston-Salem Journal seven days a week in the **Elkin/State Road area.** Fuel-efficient vehicle is recommended.

If interested, please contact Donnie Wilson at 336-719-2488.

WINSTON-SALEM JOURNAL — A Berkshire Hathaway Company

Carrier

Carrier needed to deliver the Winston-Salem Journal seven days a week in the **Town of Boonville area.** Fuel-efficient vehicle is recommended.

If interested, please contact Sherry Lowe at 336-415-1928.

WINSTON-SALEM JOURNAL — A Berkshire Hathaway Company

National marketing company is seeking Independent Contractors to promote local print media subscription sales in major retail outlets within the Triad.

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Please call Gary 336-926-1743

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2010 Toyota Corolla S 1 owner, all service records by Modern Toyota. All power. Excellent condition, dark grey, alloy wheels, new tires, 150K Hwy. miles paid $18,000; book $9200; asking $8400. See at 4307 Idle Wild Ind. Park Dr. Call 336-462-2090.

2011 Buick Regal CXL Blue, 72,000 miles, 1 owner, leather interior, like new, Sunroof, **$16,500.** Call 336-971-0804 slcrump@aol.com

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Legal Notices

NOTICE OF PUBLIC SALE

NORTH CAROLINA, FORSYTH COUNTY BIG DADDY'S STORAGE INTENDS TO SELL THE CONTENTS OF THE FOLLOWING UNITS FOR UNPAID RENT AND EXPENSES

Bldg. 5-Unit 8, Edward W. Hayes, 4037 Lee Street, WS., NC 27105 ($472.50); Bldg. 3-Unit 6, Kenneth Adamo, PO Box 441, Lewisville, NC 27021 ($146.00); Bldg. 3-Unit 4, Kenneth Adamo, PO Box 441, Lewisville, NC 27021 ($690.00); Bldg. 3-Unit A06, Bonita Jackson, 3160 Butterfield Drive, WS., NC 27105 ($460.00); Bldg. 1, Unit 13A, Deonna Hardy, 244 Dunbar St., Kingsport, TN 37660 ($267.38). Household goods, personal items & more. Balance must be paid on or before March 28, 2016 at 5:00pm to avoid sale of unit. Sale date March 30, 2016 beginning at 10:00 am at 5286 Germanton Road, Winston-Salem, NC 27105. Cash or money order only. Call 336-744-8144. Winning bid to pay in full and to have all items removed from unit day of sale.

WSJ: March 15, 22, 2016

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WSJ: March 15, 2016

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Winston-Salem Journal – March 15, 2016

6C | Food/Classified | The News & Observer | WEDNESDAY MARCH 16 2016 NEWSOBSERVER.COM

Chicken Tinga is a long-simmering dish with smoky red sauce made with dried chiles.

MEXICAN

Try Chicken Tinga for burritos, tostadas

BY GRETCHEN MCKAY
Pittsburgh Post-Gazette

This spicy Mexican dish features shredded chicken simmered in a smoky red sauce made with six varieties of dried chile.

Given its lengthy cooking time, you'll probably want to try it on the weekend. But then you'll have plenty of leftovers to stuff into burritos or pile on crunchy tostadas.

Another plus: Because it's served with a variety of toppings – everything from shredded lettuce and Mexican crema to sliced avocado or guacamole, each diner can customize the final product. Look for the dried peppers in an international market or the international aisle of a well-stocked supermarket.

Chicken Tinga

For chile paste:
1 dried pasilla pepper
1 dried morita pepper
1 dried ancho pepper
2 dried guajillo peppers
2 dried chipotle peppers
2 dried chiles de arbol
For the chicken:
3 pounds boneless chicken breast or thigh
Vegetable oil for frying
Salt and pepper
Large onion, thinly sliced
3 cloves of garlic, chopped
1 (10-ounce) can diced tomatoes with chile, such as RoTel
1 (28-ounce) can diced tomatoes
1 cup chicken stock
2 to 3 tablespoons chili powder (such as Hatch chili powder from Reyna Foods)

Make chile paste: Remove the stems and seeds from the dried chiles. Place the chiles in a microwave-safe bowl, then microwave at 15-second intervals for 30 to 60 seconds to release flavors. Add enough water to bowl to coat peppers and microwave for 1 minute. Cool, then puree into a thick paste using a food processor or blender. Set aside.

Season chicken with salt and pepper. In a large pot or Dutch oven, heat a small amount of oil until almost smoking. In batches, brown pieces of chicken; remove to plate.

Once chicken is finished, add the sliced onion to the pan and cook in the juices until slightly browned. Add garlic and continue to cook another minute or two until light golden brown. Add pureed chile pepper paste and dried chili powder and cook for 1 minute. Add diced tomatoes and bring to a gentle boil.

Return cooked chicken to pot. Cover and place in 350-degree oven. Bake until chicken is tender, 1 hour to 90 minutes. Remove chicken from pan and shred into bite-sized strands. Place pan over medium heat and cook sauce until reduced by about half. Return shredded chicken to pan and cook with sauce, stirring occasionally, for 10 to 20 minutes until sauce is thick enough to coat a spoon.

Serve chicken with warm tortillas with your favorite toppings – fresh guacamole, crumbled queso fresco, crema or sour cream, salsa, and 1 or 2 slices ripe avocado.

Yield: 8 servings.

JOHNSTON COUNTY

Beer, Wine, Shine & Dine Tour announces dates

Johnston County's Beer, Wine, Shine & Dine Tour has announced its 2016 dates and destinations. Here they are:

March 19 – Hinnant Family Vineyards, Broadslab Distillery and Double Barley Brewing.
May 21 – Gregory Vineyards, Broadslab Distillery and Deep River Brewing Co.
Oct. 1 – Gregory Vineyards, Broadslab Distillery and Deep River Brewing Co.
Nov. 12 – Hinnant Winery, Broadslab Distillery and Double Barley Brewing.

Last September, Clayton Food Tours partnered with the Johnston County Visitors Bureau to offer the Beer, Wine, Shine & Dine Tour as a guided tour of the Beer, Wine, and Shine Trail with lunch.

"It's a great way to explore the trail while letting someone else do the driving," the Visitors Bureau said in a news release.

The inaugural tour last November was a success, the Visitors Bureau noted, paving the way for the tour to return this year.

"This will be an exciting and relaxing way to enjoy Johnston County's growing beverage scene," said Ashby Brame, manager of marketing and public relations for the Visitors Bureau.

The first tour, on March 19, will offer lunch by Simple Twist in downtown Smithfield. A motorcoach will depart at 11 a.m. from Double Barley Brewing, where the tour will end at 5 p.m. The brewery, on U.S. 70 near Wilson's Mills, has ample parking. Those taking the tour should arrive at least 15 minutes early to check in.

The cost is $89 per person, and space is limited. Call 919-585-4498 to reserve a spot, or purchase tickets online at clayton foodtours.com/trail/.

More information on the Beer, Wine and Shine Trail is online at beerwineshinetrail.com.

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The News & Observer – March 16, 2016

The Daily Reflector

REFLECTOR CLASSIFIEDS

THE DAILY REFLECTOR, WEDNESDAY, MARCH 16, 2016 C5

INSIDE

- Jobs, Real Estate, Stuff, Auto
- Abby, Horoscope
- Crossword, Cryptoquip, Bridge

Photo by Steve Tucker
Submit your photo
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Booklet full of 'keepers' is sure to give pleasure

Dear Abby: I have lost my copy of the "Letter From Your Pet," the essay that is written from the pet's viewpoint to his master, assuring him it is the right thing to do when it is time to put the pet down. Is it included in your "Keepers" booklet? If so, how can I order a copy? — **Ruth in the Villages, Fla.**

Dear Ruth: "A Dog's Prayer" by Beth Norman Harris is one of the most requested items that have ever appeared in my column. It addresses not only the pet's end of life, but also how to respectfully treat the animal during its days on earth.

My "Keepers" booklet includes "A Dog's Prayer," as well as amusing and thought-provoking poems and essays on a variety of subjects, ranging from children and parenting, to human nature, houseguests and more. It can be ordered by sending your name and mailing address, plus check or money order for $7 in U.S. funds, to: Dear Abby Keepers, P.O. Box 447, Mount Morris, IL 61054-0447. Shipping and handling are included in the price. Many people have told me that "Keepers" makes a welcome gift for newlyweds, new parents, animal lovers, or anyone who is recovering from an illness. Filled with humor and wisdom, it's an inspiring, positive, quick and easy read for anyone who could use a lift.

DEAR ABBY

Dear Abby: My boyfriend has worn panties since he was 12. We are both 20 and have been together for a year. I know it's odd, but I've always thought it was cute and, admittedly, sexy. We will graduate from college next year and are thinking about our futures.

I've been doing some reading and am concerned that he may have some repressed tendencies. He says he does not, and gets quiet and stubborn and won't discuss it. He always dresses as a female character for Halloween, wearing my undies. This year he went as Lady Gaga.

My "Keepers" booklet includes "A Dog's Prayer," as well as amusing and thought-provoking poems and essays on a variety of subjects ...

Are these good-enough reasons to be worried? And if so, what should I do? — **Tested in Tampa**

Dear Tested: Whether or not you should worry depends upon what you are worried about. I am more concerned that your boyfriend is unwilling to discuss this than what he's wearing under his Levis.

If you're afraid he may not be 100 percent heterosexual, you should know that some straight men wear ladies' panties because they like the way they feel. Also, some men who enjoy cross-dressing have successful marriages to women who aren't threatened by it and who help them do it.

Dear Abby: I would like to suggest that some wives be a little less traditional and inhibited. Lighten up! Be just a little bit more adventurous, open-minded and forward — nothing excessive, mind you. Variety, after all, is the spice of life.

What husband wouldn't enjoy an exceptionally nice surprise every once in a while? — **Wishful Thinking in Pennsylvania**

Dear Wishful Thinking: Inhibitions can be hard to overcome. However, if your wife is among those you are suggesting loosen up (etc.), you should definitely mention it to her and include your "wish list."

But don't be shocked if she gives you one, too.

Dear Abby is written by Abigail Van Buren, also known as Jeanne Phillips, and was founded by her mother, Pauline Phillips. Contact Dear Abby at www.DearAbby.com or P.O. Box 69440, Los Angeles, CA 90069.

Legal Notices

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

Pursuant to 42 C.F.R. 431.408, the North Carolina Department of Health and Human Services is providing notice of intent to submit a Social Security Act Section 1115 Demonstration for the Medicaid and N.C. Health Choice plans (Medicaid reform waiver application), and requests public comment on the draft demonstration.

The North Carolina Department of Health and Human Services' (DHHS') proposed Section 1115 Demonstration sets forth a plan to improve the access to, and quality and cost effectiveness of health care for our growing population of Medicaid and N.C. Health Choice beneficiaries. The demonstration will restructure Medicaid care delivery using accountable, next-generation prepaid health plans; redesign payment to reward value rather than volume; and plan toward true person centered care grounded on the foundation of the current patient-centered medical homes, community support and informatics services.

Medicaid Reform will enable North Carolina to meet four goals defined by the North Carolina General Assembly:

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

The draft Section 1115 Demonstration documents are available for review on the N.C. Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform and include:

- Complete public notice with summary of the Section 1115 Demonstration
- Draft Section 1115 Demonstration proposal

A hard copy of the draft Section 1115 Demonstration is available at the Department of Health and Human Services, 101 Blair Drive, Raleigh NC, 27603.

Public comments are being accepted during the federally required comment period from March 7 through 11:59 p.m. on April 18, 2016. Input will be reviewed and considered by DHHS to help finalize the waiver application for submission to the Centers for Medicare & Medicaid Services by June 1, 2016.

Comments can be submitted:

- Online at the N.C. Medicaid Reform website at http://www.ncdhhs.gov/nc-medicaid-reform/medicaid-reform-comment-submission-form
- By email to MedicaidReform@dhhs.nc.gov
- By mail to Division of Health Benefits, North Carolina Department of Health and Human Services, 2501 Mail Service Center, Raleigh, NC 27699-2501
- In person at North Carolina Department of Health and Human Services, 101 Blair Drive, Raleigh, NC 27603

-MORE-

Twelve public hearings will be held throughout the state during March and April 2016. Below are the hearings scheduled for March:

March 30, 2016; 6 p.m. – 8 p.m.
McKimmon Center, 1101 Gorman Street, Raleigh, NC 27606

March 31, 2016; 2 p.m. – 4 p.m.
Union County Dept. of Social Services, Auditorium, 1212 W. Roosevelt Boulevard, Monroe, NC 28110; Dial-in access available

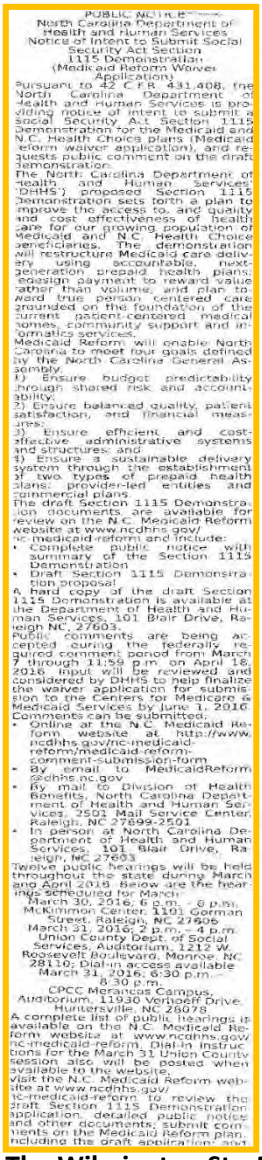
March 31, 2016; 6:30 p.m. – 8:30 p.m.
CPCC Merancas Campus, Auditorium, 11930 Verhoeff Drive, Huntersville, NC 28078

A complete list of public hearings is available on the N.C. Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform. Dial-in instructions for the March 31 Union County session also will be posted when available to the website.

Visit the N.C. Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform to review the draft Section 1115 Demonstration application, detailed public notice and other documents; submit comments on the Medicaid Reform plan, including the draft application; and learn more about N.C. Medicaid Reform.

3/16/16

The Daily Reflector – March 16, 2016



PUBLIC NOTICE
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- Online at the N.C. Medicaid Reform website at http://www.ncdhhs.gov/nc-medicaid-reform/medicaid-reform-comment-submission-form
- By email to MedicaidReform@dhhs.nc.gov
- By mail to Division of Health Benefits, North Carolina Department of Health and Human Services, 2501 Mail Service Center, Raleigh, NC 27699-2501
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A complete list of public hearings is available on the N.C. Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform. Dial-in instructions for the March 31 Union County session also will be posted when available to the website.

Visit the N.C. Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform to review the draft Section 1115 Demonstration application, detailed public notice and other documents; submit comments on the Medicaid Reform plan, including the draft application; and

The Wilmington StarNews – March 16, 2016

The Charlotte Observer – March 19, 2016

The Fayetteville Observer – March 16, 2016

LEGAL NOTICES

Legal Notices

PUBLIC NOTICE

North Carolina Department of Health and Human Services

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(Medicaid Reform Waiver Application)

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* **Online** at the N.C. Medicaid Reform website at http://www.ncdhhs.gov/nc-medicaid-reform/medicaid-reform-comment-submission-form

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Notice to Creditors

NOTICE TO CREDITORS
Having qualified as Executor of the Estate of Lloyd Franklin Hawkins, deceased, Guilford County, North Carolina, the undersigned does hereby notify all persons, firms and corporations having claims against the estate of said decedent to exhibit them to the undersigned on or before the 8 day of June, 2016, or this notice will be pleaded in bar of their recovery. This the 6 day of March, 2016.
Donna Ridge Ingle
4118 Thompson Mill Road
Graham, NC 27253

Request for Bids

INVITATION FOR BIDS FOR
REPLACEMENT
OF ROOFS, GUTTERS AND
DOWNSPOUTS
20160501

Sealed Bids will be received by the Housing Authority of the City of High Point (HPHA) at 500 East Russell Avenue, High Point, NC for Replacement of Roofs, Gutters and Downspouts until2:30 p.m. local time, April1, 2016. Immediately following the deadline at 2:30 p.m., the bids will be publicly opened at HPHA. Any bid received later than the specified time, whether delivered in person or mailed, will be disqualified. Emailed, faxed or other unsealed submissions will not be accepted.

The basic repair Scope of Work includes demolition and disposal of existing roofing, roof underlayment, gutters and downspouts, flashing of through roof vent pipes, cleaning of existing roof deck. The work includes the replacement of existing gutters with aluminum gutters and downspouts, and splash blocks. The contractor will include unit price cost for square foot of roof decking, linear foot cost for fascia, square foot cost for soffit, and linear foot of wood trim where downspouts will be anchored. Costs will include demolition of existing damaged areas, repair, patching, and painting of new wood trimming. The Contractor will perform an inventory of all the houses and prepare a report of the existing conditions of each house documenting areas that need repairs in addition to replacing the roof. The report will include documenting any areas that are suspected to be affected by water intrusion for further examination and assessment of repairs that will be needed. The areas included in addition to the roof will be the roof fascia, eave box soffits, trims, and splash blocks. Any repairs to the roof substrate and trims will be authorized by a representative of the HPHA.

A Pre-Bid Conference will be held on March 16, 2016 at 11 :00 a.m. at 2779 Gateworth Drive in High Point, NC. All interested Contractors may obtain IFB documents at Duncan-Parnell, Inc., 4275 Regency Drive, Suite 100, Greensboro, NC 27410 or via their website: www.duncan-parnell.com and through HPHA's website at www.hpha.net or by sending an email request to aoakley@hpha.net. All questions must be sent to HPHA by 5:00p.m. on March 18,2016. An addendum will be issued by 5:00 p.m. on March 23, 2016. It is important that the bids be submitted in a sealed envelope clearly marked in the lower left-hand corner with the name of the project: "Replacement of Roofs, Gutters and Downspouts- 20160501".

awarding general contracts.

The North Carolina Department of Transportation has agreed to reimburse the Owner for portions of the project costs. The Owner will not accept or consider proposals from any contractor whose name, at the time of opening of bids or award, appears on the current list of ineligible contractors published by the Comptroller General of the United States under Section 5.6 (b) of the Regulations of the Secretary of Labor (29) CFR nor a proposal from any firm, corporation, partnership, or proprietorship in which an ineligible contractor who, at the time of the opening of bids or the award, is removed from the North Carolina Department of Transportation's list of prequalified contractors.

Bidders submitting a Bid for the project must be registered with North Carolina Department of Transportation (NCDOT) as being a "Prequalified Bidder", "Prequalified POC Prime Contractor", or "Prequalified Subcontractor" at the time of Bid Opening. Subcontractors performing work on this project must be registered as a "Prequalified Bidder", "Prequalified POC Prime Contractor", or "Prequalified Subcontractor" prior to performing any work on this project. Failure to obtain the necessary registrations for ALL work categories to be performed by Prime Contractor and/or MBE/WBE Subcontractors at the time of Bid submission may disqualify Bidder.

The requirements for prequalification are listed in section 102-2 of the Standard Specifications for Roads and Structures, January, 2012. For more information please refer to the NCDOT website at: http://www.ncdot.org/business/pcs/prequalabout.html.

Each Bid shall be accompanied with a Bid Security equal to 5% of the total Bid in the form of a cash deposit or a Bid Bond. Contract Security in the form of 100% Performance and Payment Bonds will be required. No Bid may be withdrawn after closing time for the receipt of Bids for a period of ninety (90) consecutive calendar days.

A non-mandatory Pre-Bid Conference Meeting will be held at the Stanley Frank Board Room at the Piedmont Triad International Airport on Thursday, March 24, 2016 at 2:00 pm. The purpose of this meeting will be to familiarize the prospective bidders with the proposed project. The meeting will cover contract scope, security badging requirements, bid items, schedule requirements, and any questions from those in attendance. A representative of the Airthority and the Engineer will be on hand to respond to questions from potential Bidders in attendance.

Questions relating to the Contract and Contract Documents must be submitted in writing to the Engineer no later than 5:00 pm on Monday April 4. Bidding documents will be available starting on Wednesday, March 16, 2016 between the hours of 9:00 am and 5:00 pm and may be examined at the following locations.

WK DICKSON & CO, INC.
720 Corporate Center Drive
Raleigh, North Carolina 27607
Office: 919-782-0495 Fax: 919-782-9677

Notice to Creditors

NOTICE TO CREDITORS
Having qualified as Administrator of the Estate of Frances Eugenia Powers Tickle, deceased, Guilford County, North Carolina, the undersigned does hereby notify all persons, firms and corporations having claims against the estate of said decedent to exhibit them to the undersigned on or before the 15 day of June, 2016, or this notice will be pleaded in bar of their recovery. This the 13 day of March, 2016.
Harold E. Powers
2916 Pleasant Ridge Road
Summerfield, NC 27358

NOTICE TO CREDITORS
Having qualified as Administrator of the Estate of Ruby Kernodle, deceased, Guilford County, North Carolina, the undersigned does hereby notify all persons, firms and corporations having claims against the estate of said decedent to exhibit them to the undersigned on or before the 15 day of June, 2016, or this notice will be pleaded in bar of their recovery. This the 13 day of March, 2016.
Joan K. Rudd
4021 Hicone Road
Greensboro, NC 27405

1. Responder's Statement (Attachment A)
2. Profile of Firm (Attachment B)
3. Cost Proposal (Attachment C)
4. Construction Documents sign off
5. Financial Statement or Audit
6. Non-collusive Affidavit and/or North Carolina Roofer Contractors License
7. Section 3 and MWBE Certifications
8. E-Verify Affidavit
9. Personnel Certification
10. Representations, Certifications, and Other Statements of Bidders Public and Indian Housing Programs (form HUD-5369-A)
11. Change Order Acknowledgement form 12. Iran Divestment Act Certification
13. Estimated Project Work Force-Prime/Sub Contractor
14. Compliance with Executive Order No. 11246
15. North Carolina General Contractors License
16. References/Experience
17. Bid Bond
18. Performance/Payment Bond Certification

Any bid that is received by HPHA without a financial statement or audit will be considered non-responsive.
Direct all inquiries and sealed bids to:

Alan M. Oakley, Procurement Officer
Housing Authority of the City of High Point
500 East Russell Avenue
High Point, NC 27260
Phone: (336)878-2322
Email: aoakley@hpha.net

NOTICE TO BIDDERS

The Piedmont Triad Airport Authority will receive Bids for the HAECO Facility Improvements Project, in the Stanley Frank Board Room at the Piedmont Triad International Airport, until Tuesday, April 12, 2016 at 2:00 pm, at which time and place all Bids received will be publicly opened and read aloud. Bids received after 2:00 pm on April 12, 2016 will not be accepted.

The work may be generally described as construction associated with grading, drainage and erosion control to prepare the building site for a future hangar facility. The work items shall include, but not be limited to, erosion control earthwork, underdrains, seeding, mulching, and other incidental items necessary to complete the project.

Proposals must be submitted in sealed envelopes with the Bidder's name, full mailing address, and General Contractor License Number shown as the return address. Sealed envelopes shall be addressed to:
J. Alex Rosser, P.E.
Deputy Executive Director
Piedmont Triad Airport Authority
1000A Ted Johnson Parkway
Greensboro, NC 27409

All Contractors are hereby notified that they must have proper licenses under the state law for their trades. General Contractors are notified that applicable states of North Carolina will be observed in receiving and

PIEDMONT TRIAD AIRPORT AUTHORITY
Piedmont Triad International Airport
1000 A Ted Johnson Parkway
Greensboro, North Carolina 27409

Bidding and Contract Documents may be purchased at the WK Dickson online Plan room at www.wkdicksonplanroom.com.

Certain mandatory federal requirements apply to this solicitation and will be made a part of any contract awarded including, without limitation:

1. Buy American Preference (Title 49 United States Code, Chap 501);

2. Foreign Trade Restriction (49 CFR Part 30);

3. Disadvantaged Minority and Women Owned Business Enterprise (NCDOT SP1 G67);

4. Davis-Bacon Act (29 CFR Part 5);

5. Equal Employment Opportunity (Executive Order 11246 and 41 CFR Part 60);

6. Goals for Minority and Female Participation (41 CFR Part 60-4.2);

7. Certification of Non-Segregate

8. Debarment, Suspension, Ineligibility and Voluntary Exclusion (49 CFR Part 29).

NON DISCRIMINATION CLAUSE: The Special Provisions (SP1 G67) of the North Carolina Department of Transportation apply to this contract. It is the policy of the Piedmont Triad Airport Authority to practice nondiscrimination based on race, color, sex, or national origin in the award or performance of this contract. All firms qualifying under this solicitation are encouraged to submit bids/proposals. Award of this contract will be conditioned upon satisfying the requirements of this bid specification. These requirements apply to all bidders/offerors, including those who qualify as MBE/WBE. An MBE contract goal of 5% and a WBE contract goal 6% have been established for this contract. The bidder/offeror shall make good faith efforts, as defined in SP1 G67 to meet the contract goal by utilizing MBE/WBE in the performance of this contract.

The apparent successful bidder will be required to submit in the "Proposal" section of his bid the information concerning the MBE/WBE that will participate in this contract. This information will include: (1) the names, addresses and telephone numbers of MBE/WBE firms that will participate in the contract, and the certifying agency documentation of current status as a bona fide MBE/WBE; (2) a description of the work that each MBE/WBE firm will perform; (3) the dollar amount of the participation of each MBE/WBE firm participating (4) participation it submits to meet the contract goal; and (5) written confirmation from the

Greensboro News & Record – March 13, 2016

C8 NEWS & RECORD, *Thursday, April 14, 2016*

LEGAL NOTICES

Legal Notices

PUBLIC NOTICE

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

Notice of Option to Participate by Telephone during the April 18, 2016, Public Hearing

Pursuant to 42 C.F.R. 431.408, the North Carolina Department of Health and Human Services on March 7, 2016, provided notice of intent to submit a Social Security Act Section 1115 Demonstration for the Medicaid and N.C. Health Choice plans (Medicaid reform waiver application). Public comments are being accepted during the federally required comment period from March 7 through 11:59 p.m. on April 18, 2016. Input will be reviewed and considered by the Department to help finalize the waiver application for submission to the Centers for Medicare & Medicaid Services by June 1, 2016. The Department has added a dial-in option for one additional public hearing scheduled April 18, 2016. Below is information on this option and for the remaining public hearings:

April 14, 2016: 2 p.m. - 4 p.m.
Greenville Convention Center, Emerald Ballroom, 303 SW Greenville Boulevard, Greenville, NC 27834
April 16, 2016: 10 a.m. - 12 p.m.

College of The Albemarle, AE 208, 1208 N. Road Street, Elizabeth City, NC 27909

April 18, 2016: 3:30 p.m. - 5:30 p.m. - DIAL IN ADDED - See below
UNC-Pembroke, Moore Hall Auditorium, 1 University Drive, Pembroke, NC 28372-1510

To listen or participate in the April 18 session by telephone:

- Dial 1-888-585-9008 and, when asked, enter conference room number 780073319#.
- Instructions to comment by telephone will be provided during the public hearing and also are available on the Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform.

In addition to the public hearings, Comments can be submitted:

- Online at the N.C. Medicaid Reform website at http://www.ncdhhs.gov/nc-medicaid-reform/medicaid-reform-comment-submission-form
- By email to MedicaidReform@dhhs.nc.gov
- By phone at (919) 855-3470
- By mail to Division of Health Benefits, North Carolina Department of Health and Human Services, 2501 Mail Service Center, Raleigh, NC 27699-2501
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Visit the N.C. Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform to review the draft Section 1115 Demonstration waiver application, detailed public notice and other documents; submit comments on the Medicaid Reform plan; and learn more about N.C. Medicaid Reform. A hard copy of the waiver application also is available at the Department of Health and Human Services, 101 Blair Drive, Raleigh NC, 27603.

PUBLIC NOTICE
The Individuals with Disabilities Education Act (IDEA-Part B, Public Law 108.446) Project is presently being amended. The Project describes the special education programs that Guilford County Schools proposes for Federal funding for the 2016-2017 School Year. Interested persons are encouraged to review amendments to the Project and make comments concerning the implementation of special education under this Federal Program. All comments will be considered prior to submission of the amended Project to the North Carolina Department of Public Instruction in Raleigh, North Carolina. The IDEA-Part B Project is open to the public for review and comments during the week of April 18, 2016 through April 22, 2016 in the office of Dr. Alicia Tate, Executive Director of EC Programs located at 134 Franklin Boulevard, Greensboro, NC 27401 or electronically submitted to tatea@gcsnc.com.

The annual report of Whitener Foundation for the fiscal year ending December 31, 2015, required under section 6056 of the Internal Revenue Code of 1954 is available for inspection at Curry, Ireland & Co.,L.L.P., Certified Public Accounting Office, at 3819 Lawndale Drive, Greensboro, N.C., during regular business hours by any citizen who requests it within 100 days after the date on which this notice is published. The principal manager of Whitener Foundation at the above office is Wayne Curry.

Edgar Whitener
President
April 13,14,15,16,17,18,19,2016

Meetings and Events

High Point Urban Area Metropolitan Planning Organization (HPMPO)

The HPMPO has ranked the Transportation Projects within the HPMPO using the High Point MPO local ranking methodology that was approved by NCDOT.

The MPO is releasing the Draft Priority List of Projects, and local ranking methodology for public review and comment. These documents will be available for public review and comment from April 18, 2016 until May 17, 2006. A public hearing will be held on May 24, 2016 at the regularly scheduled HPMPO Transportation Advisory Committee Meeting. The Draft Priority List of Projects and local ranking methodology will be available at the following location:

- The High Point Public Library
- Archdale Public Library
- Jamestown Public Library
- Thomasville Library
- Davidson County Libraries
- High Point Department of Transportation
- Archdale Planning Department
- Denton Town Hall
- Jamestown Town Hall
- Lexington City Hall
- Thomasville Engineering Department
- Trinity City Hall
- Wallburg Town Hall
- Davidson County Planning Department
- Guilford County Planning Department
- Randolph County Planning Department
- The website of the MPO will post the Draft Priority List of Projects: http://www.highpointnc.gov/hpmpo/project_prioritization_process.cfm

Please submit all written comments to:

Greg Venable
High Point Urban Area Metropolitan Planning Organization
PO Box 230
High Point, NC 27261
336-883-3310
Fax: 336-883-8568

Email:
greg.venable@highpointnc.gov

Notice to Creditors

NOTICE TO CREDITORS
Having qualified as Administrator of the Estate of Jacqueline N. Gasque, deceased, Guilford County, North Carolina, the undersigned does hereby notify all persons, firms and corporations having claims against the estate of said decedent to exhibit them to the undersigned on or before the 26 day of June, 2016, or this notice will be pleaded in bar of their recovery. This the 24 day of March, 2016.
Stephanie A. Foster
607 Springwood Ave.
Gibsonville, NC 27249

NOTICE TO CREDITORS
Having qualified as Administrator of the Estate of Michael R. Surgeon, Sr. aka Michael Surgeon aka Michael Ricardo Surgeon, deceased, Guilford County, North Carolina, the undersigned does hereby notify all persons, firms and corporations having claims against the estate of said decedent to exhibit them to the undersigned on or before the 26 day of June, 2016, or this notice will be pleaded in bar of their recovery. This the 24 day of March, 2016.
Michael R. Surgeon, Jr.
2179 McLaughlin Drive
Greensboro, NC 27406

NOTICE TO CREDITORS
Having qualified as Administrator of the Estate of Virginia Beth Stanley, deceased, Guilford County, North Carolina, the undersigned does hereby notify all persons, firms and corporations having claims against the estate of said decedent to exhibit them to the undersigned on or before the 26 day of June, 2016, or this notice will be pleaded in bar of their recovery. This the 24 day of March, 2016.
Theresa W. Lowder
1064 Knox Road
McLeansville, NC 27301

NOTICE TO CREDITORS
Having qualified as Executor of the Estate of Betty Tucker Pierce, deceased, Guilford County, North Carolina, the undersigned does hereby notify all persons, firms and corporations having claims against the estate of said decedent to exhibit them to the undersigned on or before the 16 day of July, 2016, or this notice will be pleaded in bar of their recovery. This the 14 day of April, 2016.
Kasey Marie Lane Scott
5209 Folgers Mill Road
Julian, NC 27283

NOTICE TO CREDITORS
Having qualified as Executor of the Estate of Carmela Theresa Scutti, deceased, Guilford County, North Carolina, File #16E1196 the undersigned does hereby notify all persons, firms and corporations having claims against the estate of said decedent to exhibit them to the undersigned on or before the 26th day of June, 2016, or this notice will be pleaded in bar of their recovery. All persons indebted to said estate will please make immediate settlement with the undersigned. This the day 24th day of March, 2016.
Joanne Wheelus
302 W. Avondale Dr.
Greensboro NC 27403
Robert N. Crosswhite, attorney
239 E Broad St
Statesville NC 28677
704-873-7233

NOTICE TO CREDITORS
Having qualified as Executor, of the Estate of Earl W. Newnam aka Earl Wayne Newnam, deceased, Guilford County, North Carolina, the undersigned does hereby notify all persons, firms and corporations having claims against the estate of said decedent to exhibit them to the undersigned on or before the 16th day of July, 2016, or this notice will be pleaded in bar of their recovery. This the 14th day of April, 2016.
Craig T. Newnam aka
Craig Thomas Newnam
4102 Brookwood Acres Drive
Randleman, NC 27317

NEWS& RECORD

Notice to Creditors

NOTICE TO CREDITORS
Having qualified as Executor of the Estate of Inez Dixon Harrington, deceased, Guilford County, North Carolina, the undersigned does hereby notify all persons, firms and corporations having claims against the estate of said decedent to exhibit them to the undersigned on or before the 9 day of July, 2016, or this notice will be pleaded in bar of their recovery. This the 7 day of April, 2016.
L. Jackson Harrington, Jr.
1602 Alderman Drive
Greensboro, NC 27408

NOTICE TO CREDITORS
Having qualified as Executor of the Estate of Lorentz Donald Svedlius, II, deceased, Guilford County, North Carolina, the undersigned does hereby notify all persons, firms and corporations having claims against the estate of said decedent to exhibit them to the undersigned on or before the 26 day of June, 2016, or this notice will be pleaded in bar of their recovery. This the 24 day of March, 2016.
Pamela Svedelius Wilson
955 Spillman Road
Mocksville, NC 27028

NOTICE TO CREDITORS
Having qualified as Executor of the Estate of Marian Patricia Borowicz, deceased, Guilford County, North Carolina, the undersigned does hereby notify all persons, firms and corporations having claims against the estate of said decedent to exhibit them to the undersigned on or before the 26 day of June, 2016, or this notice will be pleaded in bar of their recovery. This the 24 day of March, 2016.
James Adrian Borowicz
1107 Condor Drive
Greensboro, NC 27410

Request for Bids

ADVERTISEMENT FOR PROPOSALS

BATTLEGROUND AVENUE AT CONE BLVD. U-5306 A

RE-BID

CONTRACT: 2009-03

CITY OF GREENSBORO, NC

Sealed proposals will be received by the City of Greensboro, NC, in the Engineering Conference Room located on the 3rd floor of the City of Greensboro's Melvin Municipal Office Building. The Melvin Municipal Office building is located at 300 West Washington Street, Greensboro, NC 27405, until 2:00 pm local time, on Wednesday, May 11, 2016, for the above listed contract as shown in the plans and described in the Special Conditions.

Plans and specifications are distributed through Duncan Parnell. Duncan Parnell is located at 4275 Regency Road, Suite 100; Greensboro, NC 27410. Their phone and fax number respectively are (o) (336)-855-1211 and (f) (336)-855-8868. There store hours are Monday through Friday 8:00 am to 5:00pm. Plan and Specification fees are payable directly to Duncan Parnell. No partial sets will be issued; plans and specifications are non-refundable. Registration with Duncan Parnell digital plan room (http://www.dpibidroom.com) is required to acquire access to plans, specifications and to receive e-mail updates of addenda changes to the contract documents.

The City reserves the right to waive any informality or to reject any or all bids or to award such contract as in its judgment is deemed to be in the best interest of the City.

All contractors submitting bids (Prime, Sub and DBE) for this contract are required to be pre-qualified and listed in the NCDOT's "Directory of Transportation Firms" on the following website:

https://apps.dot.state.nc.us/vendor/directory/

A pre-bid meeting will be held at 11:00am Wednesday, April 27, 2016 in the Melvin Municipal Office Building; 300 West Washington Street, Greensboro, NC third (3rd) Floor Engineering Conference Room.

TED PARTRICKCITY ENGINEER

ADVERTISEMENT FOR PROPOSALS
LAWNDALE DRIVE SEWER EXTENSION
CONTRACT NO 2013-111
CITY OF GREENSBORO, N. C.

Sealed proposals will be received by the City of Greensboro, N. C., in the Engineering Conference Room located on the 3rd floor of the City of Greensboro's Melvin Municipal Office Building. The Melvin Municipal Office building is located at 300 West Washington Street, Greensboro, NC 27405, until 2:00 p.m. local time, on Thursday, May 12, 2016, for the above listed contract as shown in the plans and described in the contract documents.

The work in this contract consists of installing approximately 1100 LF of 8" dia. sanitary sewer line along with precast manholes and 4" dia sewer line laterals. Installing 8" sanitary sewer line and laterals shall be by an open cut trench method and directional bore used where possible when driveways are encountered. Driveways shall be repaired with like materials where disturbed by way of an open cut trench method.

Sealed proposals and MWBE Good Faith Efforts must be submitted on the blank forms provided and as specified in the bound copies of the contract documents. The bid shall be enclosed in two different sealed envelopes addressed to Mr. Donald Saintsing, Engineering Division, 300 West Washington Street, Greensboro, North Carolina. The outside of each envelopes shall be plainly marked with the Project Name; Contract Number; the name, address and license number of the Bidder; and with the notation "BID ENCLOSED" and the other envelope with the MWBE participation noted as "MWBE GOOD FAITH EFFORTS".

Plans and specifications are distributed through Duncan Parnell. Duncan Parnell is located at 4275 Regency Road, Suite 100; Greensboro, NC 27410. Their office phone and fax number respectively are (O) (336)-855-1211 and (F) (336)-855-8868. Their store hours are Monday through Friday 8:00 am to 5:00pm. Plan and Specification fees are payable directly to Duncan Parnell. No partial sets will be issued; plans and specifications are non-refundable.

CROSSWORD

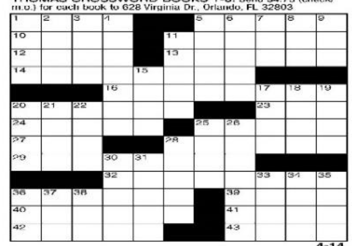
By THOMAS JOSEPH

ACROSS
1 Enjoys Aspen
5 Pistachio part
10 Bike part
11 Sound system
12 Heaps
13 Belgian sleuth
14 Many Swiss bankers
16 Heredity study
20 Sheep sounds
23 Heckler's cry
24 Restaurant freebies
25 Used up
27 Gardner of film
28 Flimflams
29 Army brass
32 "The Odd Couple" director
36 Didn't punish
39 Clarinet's kin
40 Not attractive
41 Radius partner
42 Fixes copy
43 League member

DOWN
1 Antlered animal
2 Toy with a tail
3 Press
4 West African nation
5 Cherry center
6 Bank job
7 Misstep
8 Summer sign
9 Auction unit
11 Stretches over
15 Horse healers
17 Alpine goat
18 Volcano shape
19 Lushes
20 Be boastful
21 Valentine word
22 Dash
25 Shoe part
26 Faint
28 Convenient
30 Snowy bird
31 Film units
33 Skilled
34 Hawaiian coffee area
35 Clothing line
36 That girl
37 Pea holder
38 Paris pal

Yesterday's answer

THOMAS CROSSWORD BOOKS 1-8! Send $4.75 (check/m.o.) for each book to 628 Virginia Dr., Orlando, FL 32803



4-14

AXYDLBAAXR
is LONGFELLOW

One letter stands for another. In this sample, A is used for the three L's, X for the two O's, etc. Single letters, apostrophes, the length and formation of the words are all hints. Each day the code letters are different.

4-14 **CRYPTOQUOTE**

RJQB G QAQBLIDXXE UQL UZ. ZGCJL G JDN BH GNQD LJDL JGY OGZYL BDUQ RDY "DXRDEY." — ZGLD ZINBQZ

Yesterday's Cryptoquote: I FEEL LIKE MY SECRET MAGIC TRICK THAT SEPARATES ME FROM A LOT OF MY PEERS IS THE BRAVERY TO BE VULNERABLE AND TRUTHFUL AND HONEST. — KATY PERRY

Request for Bids

Registration with Duncan Parnell digital plan room (http://www.dpibidroom.com) is required to acquire access to plans, specifications and to receive e-mail updates of addenda changes to the contract documents.

A pre-bid meeting will be held at 10:00am Thursday, April 28, 2016 in the Melvin Municipal Office Building 3rd Floor Engineering Conference Room located at 300 West Washington Street. Greensboro, NC. City of Greensboro personnel will discuss MWBE requirements and the ENGINEER will be available to discuss the Contract and answer pertinent questions. Attendance is strongly encouraged.

The City reserves the right to waive any informality or to reject any or all bids or to award such contract as in its judgment is deemed to be in the best interest of the City.

TED PARTRICK
CITY ENGINEER

ROCKINGHAM LEGALS

Meetings and Events

NOTICE OF PUBLIC HEARING

The City of Eden Historic Preservation Commission will conduct a public hearing on Monday, April 18, 2016 at 5:30 pm in the conference room at City Hall at 308 E. Stadium Dr. for the following purpose:

1. Consideration of a Local Historic Landmark Designation for the National Guard Armory located on at 615 Henry Street. The request was submitted by the property owner. HPCL-16-01.

Persons interested in these items are invited to attend the public hearing and make comments regarding these requests. Further information may be obtained from the Planning and Inspections Department at 336-623-2110, option 2.

Authority: N.C.G.S. 160A-400.6(4); City of Eden Planning Organization Ordinance, Section 2-102(4).

This the 8th day of April, 2016.

CITY OF EDEN
By: Beth Pulliam, Chair
Eden Historic Preservation Commission

Meetings and Events

NOTICE OF PUBLIC HEARING

The Eden City Council will conduct a public hearing on Tuesday, April 19, 2016 at 7:30 pm in the City Council Chamber at City Hall at 308 E. Stadium Dr. for the following purpose:

1. Consideration of a Local Historic Landmark Designation for the National Guard Armory located on at 615 Henry Street. The request was submitted by the property owner. HPCL-16-01.

Persons interested in these items are invited to attend the public hearing and make comments regarding these requests. Further information may be obtained from the Planning and Inspections Department at 336-623-2110, option 2.

Authority: N.C.G.S. 160A-400.6(4); City of Eden Planning Organization Ordinance, Section 2-102(4).

This the 8th day of April, 2016.

CITY OF EDEN

By: Wayne Tuggle, Mayor

Notice to Creditors

NOTICE TO CREDITORS
Having qualified as Executor of the Estate of REVELLE FARMER BAILEY AKA EUNICE REVELLE FARMER BAILEY, deceased, Rockingham County, North Carolina, the undersigned does hereby notify all persons, firms and corporations having claims against the estate of said decedent to exhibit them to the undersigned on or before the 16th day of July, 2016, or this notice will be pleaded in bar of their recovery. This the 14th day of April, 2016.

Charles R. Bass
2955 S.E. Bella Road
Port St. Lucie, FL 34984
Publish: 4/14, 21, 28, 5/5/2016

NOTICE TO CREDITORS AND DEBTORS OF THE ESTATE OF KATHLEEN H. BARRETT A/K/A KATHLEEN MARIE HANDY BARRETT

All persons, firms and corporations having claims against the Estate of Kathleen H. Barrett a/k/a Kathleen Marie Handy Barrett, deceased are notified to exhibit them to Elizabeth Ann Barrett, as Executor of the decedent's estate on or before July 14, 2016, at Post Office Box 528, Eden, North Carolina 27289-0528, or be barred from their recovery. Debtors of the decedent are asked to make immediate payment to the above named Elizabeth Ann Barrett, Executor.

This the 14th day of April, 2016

Elizabeth Ann Barrett
452 Early Avenue
Eden, NC 27288

WALKER, MELVIN & WOODALL, LLP
Attorneys and Counsellors at Law
Post Office Box 528
640 Fagg Drive
Eden, North Carolina 27289-0528
(336) 623-3138

Publication Dates: April 14th, 21st, 28th and May 5th, 2016

NOTICE TO CREDITORS AND DEBTORS OF THE ESTATE OF J. PHILIP SAPP

All persons, firms and corporations having claims against the Estate of J. Philip Sapp, deceased are notified to exhibit them to Margaret S. Doyle, as Executrix of the decedent's estate on or before June 30, 2016, at Post Office Box 528, Eden, North Carolina 27289-0528, or be barred from their recovery. Debtors of the decedent are asked to make immediate payment to the above named Margaret S. Doyle, Executrix.

This the 31st day of March, 2016

Margaret S. Doyle
725 Taylor Street
Eden, NC 27288

WALKER, MELVIN & WOODALL, LLP
Attorneys and Counsellors at Law
Post Office Box 528
640 Fagg Drive
Eden, North Carolina 27289-0528
(336) 623-3138

Publication Dates: March 31st, April 7th, 14th and 21st, 2016

Tickets

READERS & ADVERTISERS
North Carolina General Statute 14-344 makes it illegal to sell admission tickets in excess of the printed ticket price plus a $3.00 service fee. Airline tickets, and many other tickets, awards and coupons are non-transferable. Restrictions may apply. Buyers are advised to check with travel carrier or others, as appropriate before making the purchase."

The Greensboro News & Record – April 14, 2016

REAL ESTATE FOR SALE

0710 Homes for Sale

2-3 Bedrooms, Fenced Yard, Large Front Porch, Price Reduced, Off S. Elm St. High Point 336-883-5918

HP MKT+HOSP Short Walk. 3 Bed Historic House. $95,000 409 Gatewood 336-887-5130

0734 Lots & Acreage

2.24 Acres Jackson Lake Rd, High Point. Call 423-241-2288

Lot For Sale
Trinity Darr Rd Lot 10
Cost $3000
Size 50x275
Call 336-885-2780

0793 Monuments/ Cemeteries

2 Cemetery Plots in Veteran's section at Floral Garden $2,500 each buyer pays transfer fee of $250 each. 474-2170

2 Plots: Rose Garden (Holly Hill Cem) $1000 a piece; Call 336-803-0567

TRANSPORTATION

0804 Boats for Sale

16ft Bass Boat 99 Trolling mtr, depth finder 75 horsepower Mercury VGC $5500 Call After 1pm 336-848-9678

0832 Motorcycles

01' Super Glide Harley Davidson new paint, lots of chrome 38,0000mi $5000 (FIRM) Call 905-0245

0864 Pickup Trucks for Sale

1979 Ford Sb pickup, PS, 302 Engine Automatic, 20in Chrome Wheels, $2500 or trade. Call 336-431-1354

0868 Cars for Sale

R&S Enterprises
750 Litwin Dr Tville
Use Honda Cars
Sales & Services
35 yrs + Of Experience

0872 Classic/Sports/ Collector Cars

1986 Pontiac Parisienne 1 owner. All original, garaged, 44,000 miles. $6800. Call 336-255-6712

FINANCIAL

LEGALS

Buy • Save • Sell

Place you ad in the classifieds!

0955 Legals

Notice

Pursuant to North Carolina General Statute 160A-280, the Archdale City Council will consider a Resolution approving the donation of a Police K-9 to the City of High Point Police Department. The K-9 will be used for public purpose by providing narcotic detection. All interested persons may attend the April 26, 2016 Archdale City Council meeting to be held at the Municipal Office Building, 307 Balfour Drive, Archdale, NC at 7:00 p.m.

Susan T. Swaim
City Clerk
April 14, 2015

High Point Urban Area Metropolitan Planning Organization (HPMPO)

The HPMPO has ranked the Transportation Projects within the HPMPO using the High Point MPO local ranking methodology that was approved by NCDOT.

The MPO is releasing the Draft Priority List of Projects, and local ranking methodology for public review and comment. These documents will be available for public review and comment from April 18, 2016 until May 17, 2006. A public hearing will be held on May 24, 2016 at the regularly scheduled HPMPO Transportation Advisory Committee Meeting. The Draft Priority List of Projects and local ranking methodology will be available at the following location:

* The High Point Public Library
* Archdale Public Library
* Jamestown Public Library
* Thomasville Library
* Davidson County Libraries
* High Point Department of Transportation
* Archdale Planning Department
* Denton Town Hall
* Jamestown Town Hall
* Lexington City Hall
* Thomasville Engineering Department
* Trinity City Hall
* Wallburg Town Hall
* Davidson County Planning Department
* Guilford County Planning Department
* Randolph County Planning Department
* The website of the MPO will post the Draft Priority List of Projects: http://www.highpointnc.gov/hpmpo/project_prioritization_process.cfm

Please submit all written comments to:
Greg Venable
High Point Urban Area Metropolitan Planning Organization
PO Box 230 High Point, NC 27261
336-883-3310 Fax: 336-883-8568
Email: greg.venable@highpointnc.gov

NORTH CAROLINA
GUILFORD COUNTY (High Point)

IN THE GENERAL COURT OF JUSTICE
DISTRICT COURT DIVISION
15 JT 276

NOTICE OF SERVICE OF PROCESS BY PUBLICATION

IN THE MATTER OF: V. M. O., A minor female child born on November 25, 2012 in Greensboro, Guilford County, North Carolina

TO: THE MOTHER and the UNKNOWN FATHER of the juvenile referenced above

TAKE NOTICE that a Petition seeking to terminate the parental rights of VALERIE MARIE ORELLANA and ANY UNKNOWN FATHER of the above juvenile was filed on March 30, 2015 with the Clerk of Superior Court, Juvenile Division, High Point, Guilford County, NC.

You must answer this Petition within 30 days of April 14, 2016, exclusive of that date. You are entitled to attend any hearing affecting your rights. You are entitled to a court appointed attorney if you cannot afford to hire an attorney. Unknown Father must call the Juvenile Clerk at 336-822-8700 immediately. Your parental rights as to the juvenile will be terminated upon your failure to answer the Petition within the time prescribed. If you fail to attend any hearing in this matter, the Court may release your court appointed attorney without further notice to you.

This the 11th day of April, 2016

Shannon Peterson (#20805)
Attorney for the Petitioner
258 S. Graham-Hopedale Road; Suite 105
Burlington, NC 27217
336-270-4406 (telephone)
April 14, 21, 28, 2016

Public Review and Comment

The Winston-Salem Urban Area Metropolitan Planning Organization (MPO), the Piedmont Authority for Regional Transportation (PART) and the Winston-Salem Transit Authority (WSTA) are seeking public review and comment on the following documents:

- Amendments and Modifications to the Fiscal Years 2016-2022 Winston-Salem Urban Area Metropolitan Transportation Improvement Program (MTIP)
- Federal and State Transportation Funds Obligated in 2015 in the Winston-Salem Urban Area MPO

The Fiscal Years 2016-2022 MTIP amendments includes six projects programmed due to additional revenue (House Bill 97). Three roadway projects will accelerate funding of the Interstate 40 widening and bridge over the Yadkin River, widen of NC 150 from Frye Bridge Road to the Forsyth County Line, a build a new two-lane road from Farm Parkway to University Parkway. Three bicycle and pedestrian projects are contingent on local matching funds and include a multi-use path bridge over the Salem Creek Connector, the extension of Salem Creek Greenway from Marketplace Mall to Forsyth Technical Community College and sidewalks along Barbara Jane Avenue, Byerly Road and Barry Streets in Winston-Salem. The MTIP modifications accelerate existing project phases due to additional revenue (House Bill 97) for the widening of Reidsville Road (US 158) to Belews Creek Road, Old Hollow Road in Walkertown, two bridge replacements, two interchange projects and all sections of the Northern Beltway- Eastern Section. Other modifications include existing project cost increases and delays.

The Federal and State Transportation Funds Obligated in 2015 in the Winston-Salem Urban Area MPO is a listing of transportation projects by date, phase and amount of funds authorized during Federal Fiscal Year ending September 30, 2015.

The documents are online at www.DOT.CityofWS.org and www.hpdot.net/hpmpo/ and at public libraries in Forsyth County and King, each municipal town hall, the N.C.DOT office at 375 Silas Creek Parkway, the Winston-Salem Department of Transportation, Room 307, 100 E. First St., Winston-Salem and the High Point Department of Transportation, 211 South Hamilton Street, High Point. Si tiene preguntas o necesita ayauda en espandacerca de este document puede llamar a David Avalos al 336-747-6831.

ONLY WRITTEN COMMENTS WILL BE ACCEPTED. COMMENTS MUST BE RECEIVED BY 5 P.M. FRIDAY, MAY 13, 2016.

Mail, e-mail or fax comments to:
Fredrick Haith
Winston-Salem DOT
P.O. Box 2511
Winston-Salem, NC 27102
E-mail: fredrickh@cityofws.org
Fax: (336) 748-3370

The Winston-Salem Urban Area Metropolitan Planning Organization (MPO) does not exclude participation or discriminate in any program or activity receiving Federal assistance on the grounds of race, color, national origin, sex, age, or disability.

Any person who believes they have been aggrieved by an unlawful discriminatory practice regarding the **Winston-Salem Urban Area MPO** programs has a right to file a formal complaint with Angela Carmon, City Attorney, City of Winston-Salem, P.O. Box 2511, Winston-Salem, NC 27102, within one hundred and eighty (180) days following the date of the alleged discrimination occurrence.
April 14, 2016

PUBLIC NOTICE
North Carolina Department of Health and Human Services
Social Security Act Section 1115 Demonstration
(Medicaid Reform Waiver Application)

Notice of Option to Participate by Telephone during the April 18, 2016, Public Hearing

Pursuant to 42 C.F.R. 431.408, the North Carolina Department of Health and Human Services on March 7, 2016, provided notice of intent to submit a Social Security Act Section 1115 Demonstration for the Medicaid and N.C. Health Choice plans (Medicaid reform waiver application). Public comments are being accepted during the federally required comment period from March 7 through 11:59 p.m. on April 18, 2016. Input will be reviewed and considered by the Department to help finalize the waiver application for submission to the Centers for Medicare & Medicaid Services by June 1, 2016.
The Department has added a dial-in option for one additional public hearing scheduled April 18, 2016. Below is information on this option and for the remaining public hearings:
April 14, 2016; 2 p.m. – 4 p.m.
Greenville Convention Center, Emerald Ballroom, 303 SW Greenville Boulevard, Greenville, NC 27834

April 15, 2016; 10 a.m. – 12 p.m.
College of The Albemarle, AE 208, 1208 N. Road Street, Elizabeth City, NC 27909

April 18, 2016; 3:30 p.m. – 5:30 p.m. – DIAL IN ADDED – See below
UNC-Pembroke, Moore Hall Auditorium, 1 University Drive, Pembroke, NC 28372-1510
To listen or participate in the April 18 session by telephone:

.Dial 1-888-585-9008 and, when asked, enter conference room number 780073319#.

.Instructions to comment by telephone will be provided during the public hearing and also are available on the Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform.

In addition to the public hearings, Comments can be submitted:
.Online at the N.C. Medicaid Reform website at http://www.ncdhhs.gov/nc-medicaid-reform/medicaid-reform-comment-submission-form
.By email to MedicaidReform@dhhs.nc.gov
.By Phone at (919) 855-3470
.By mail to Division of Health Benefits, North Carolina Department of Health and Human Services, 2501 Mail Service Center, Raleigh, NC 27699-2501
.In person at North Carolina Department of Health and Human Services, 101 Blair Drive, Raleigh, NC 27603
The North Carolina Department of Health and Human Services (DHHS) proposed Section 1115 Demonstration waiver application sets forth a plan to improve the access to, and quality and cost effectiveness of health care for our growing population of Medicaid and N.C. Health Choice beneficiaries.
The demonstration will restructure Medicaid care delivery using accountable, next-generation prepaid health plans; redesign payment to reward value rather than volume; and plan toward true person centered care grounded on the foundation of the current patient-centered medical homes, community support and informatics services.

Medicaid Reform will enable North Carolina to meet four goals defined by the North Carolina General Assembly:
1) Ensure budget predictability through shared risk and accountability;
2) Ensure balanced quality, patient satisfaction, and financial measures;
3) Ensure efficient and cost-effective administrative systems and structures; and
4) Ensure a sustainable delivery system through the establishment of two types of prepaid health plans: provider-led entities and commercial plans.

Visit the N.C. Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform to review the draft Section 1115 Demonstration waiver application, detailed public notice and other documents; submit comments on the Medicaid Reform plan; and learn more about N.C. Medicaid Reform. A hard copy of the waiver application also is available at the Department of Health and Human Services, 101 Blair

0955 Legals

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ERIE
Index No. SF2016800091
Date Summons Filed: 01/13/16
Plaintiff designates Erie County as the place of trial.
The basis of venue is CPLR Sec. 509.
SUMMONS WITH NOTICE
Plaintiff resides at 30 West 141 St., Apt. 1N, New York, NY 10037.
Defendant resides at UNKNOWN.

YUSEF L. GREEN,
Plaintiff,
-against-
TYSHI D. BAKER-GREEN,
Defendant.

ACTION FOR DIVORCE

To the above named Defendant:
YOU ARE HEREBY SUMMONED to serve a notice of appearance on the Plaintiff's Attorneys within twenty (20) days after the service of this summons, exclusive of the day of service (or within thirty (30) days after the service is complete if this summons is not personally delivered to you within the State of New York); and in case of your failure to appear, judgment will be taken against you by default for the relief demanded in the notice set forth below.
Dated: January 4, 2016

David Centeno, Esq.
David Centeno Law, PC
Attorneys for Plaintiff
300 International Dr. Suite 100
Buffalo, NY 14221
(866) 830-2064

NOTICE: The nature of this action is to dissolve the marriage between the parties, on the grounds: DRL Section 170 subd. (7) - the relationship between the Plaintiff and Defendant has broken down irretrievably for a period of at least six months.

The relief sought is a judgment of absolute divorce in favor of the Plaintiff dissolving the marriage between the parties in this action. The nature of any ancillary or additional relief demanded is:

That the parties do not require maintenance and no claim will be made by either party for maintenance.

That the parties do not require payment of counsel and experts' fees and expenses.

That both parties may resume the use of any prior surname.

That the Court grant such other and further relief as the Court may deem fit and proper.

The parties have divided up the marital property, and no claim will be made by either party under equitable distribution.

Notice of Automatic Orders pursuant to DRL Sec. 236(B)(2) and Notice Concerning Continuation of Health Care Coverage pursuant to DRL Sec. 255(1) accompany this summons.

NOTICE OF ENTRY OF AUTOMATIC ORDERS (D.R.L. 236)
Rev. 1/13
FAILURE TO COMPLY WITH THESE ORDERS MAY BE DEEMED
A CONTEMPT OF COURT

PURSUANT TO the Uniform Rules of the Trial Courts, and DOMESTIC RELATIONS LAW Section 236, Part B, Section 2, both you and your spouse (the parties) are bound by the following AUTOMATIC ORDERS, which have been entered against you and your spouse in your divorce action pursuant to 22 NYCRR Section 202.16(a), and which shall remain in full force and effect during the pendency of the action, unless terminated, modified or amended by further order of the court or upon written agreement between the parties:

(1) ORDERED: Neither party shall sell, transfer, encumber, conceal, assign, remove or in any way dispose of, without the consent of the other party in writing, or by order of the court, any property (including, but not limited to, real estate, personal
property, cash accounts, stocks, mutual funds, bank accounts, cars and boats) individually or jointly held by the parties, except in the usual course of business, for customary and usual household expenses or for reasonable attorney's fee in connection with this action.

(2) ORDERED: Neither party shall transfer, encumber, assign, remove, withdraw or in any way dispose of any tax deferred funds, stocks or other assets held in any individual retirement
accounts, 401k accounts, profit sharing plans, Keogh accounts, or any other pension or retirement account, and the parties shall further refrain from applying for or requesting the payment of retirement benefits or annuity payments of any kind, without the consent of the other party in writing, or upon further order of
the court; except that any party who is already in pay status may continue to receive such payments thereunder.

(3) ORDERED: Neither party shall incur unreasonable debts hereafter, including, but not limited to, further borrowing against any credit line secured by the family residence, further encumbrancing any assets, or unreasonably using credit cards or cash advances against credit cards, except in the usual course of business or for customary or usual housing expenses, or for reasonable attorney's fees in connection with this action.

(4) ORDERED: Neither party shall cause the other party or the children of the marriage to be removed from any existing medical, hospital and dental insurance coverage, and each party shall maintain the existing medical, hospital and dental insurance coverage in full force and effect.

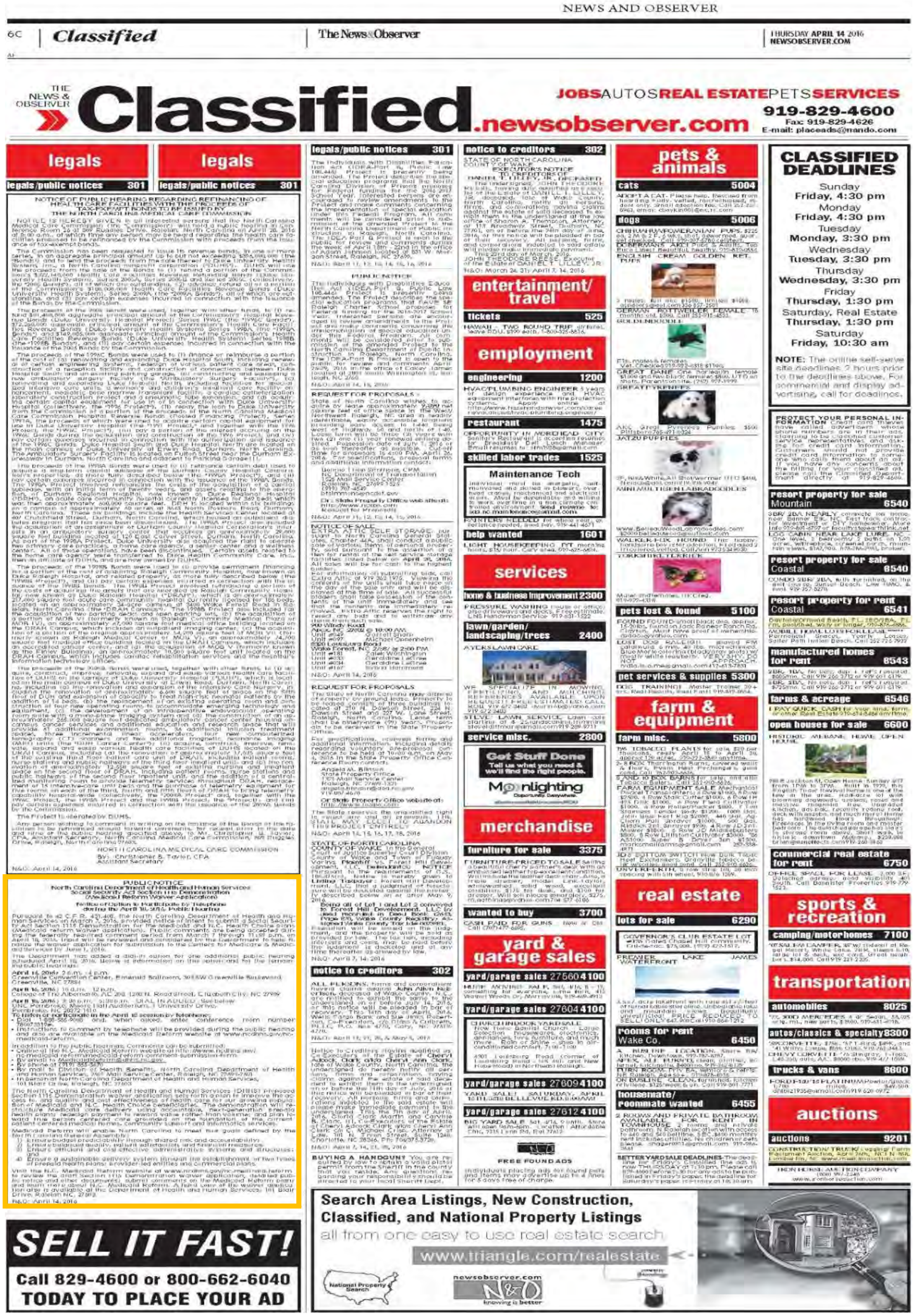
(5) ORDERED: Neither party shall change the beneficiaries of any existing life insurance policies, and each party shall maintain the existing life insurance, automobile insurance, homeowners and renters insurance policies in full force and effect.
IMPORTANT NOTE: After service of Summons with Notice or Summons and Complaint for divorce, if you or your spouse wishes to modify or dissolve the automatic orders, you must ask the court for approval to do so, or enter into a written modification agreement with your spouse duly signed and acknowledged before a notary public.

NOTICE CONCERNING CONTINUATION OF HEALTH CARE COVERAGE
(Required by Section 255(1) of the Domestic Relations Law).

PLEASE TAKE NOTICE that once a judgment of divorce is signed in this action, both you and your spouse may or may not continue to be eligible for coverage under each other's health insurance plan, depending on the terms of the plan.
April 14, 21, 28, 2016

The High Point Enterprise – April 14, 2016

NEWS AND OBSERVER



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The News & Observer

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The News & Observer – April 14, 2016

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Legal Notices

PUBLIC NOTICE

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

Notice of Option to Participate by Telephone during the April 18, 2016, Public Hearing

Pursuant to 42 C.F.R. 431.408, the North Carolina Department of Health and Human Services on March 7, 2016, provided notice of intent to submit a Social Security Act Section 1115 Demonstration for the Medicaid and N.C. Health Choice plans (Medicaid reform waiver application). Public comments are being accepted during the federally required comment period from March 7 through 11:59 p.m. on April 18, 2016. Input will be reviewed and considered by the Department to help finalize the waiver application for submission to the Centers for Medicare & Medicaid Services by June 1, 2016.

The Department has added a dial-in option for one additional public hearing scheduled April 18, 2016. Below is information on this option and for the remaining public hearings:

April 14, 2016: 2 p.m. - 4 p.m.
Greenville Convention Center, Emerald Ballroom, 303 SW Greenville Boulevard, Greenville, NC 27834

April 16, 2016: 10 a.m. - 12 p.m.
College of The Albemarle, AE 208, 1208 N. Road Street, Elizabeth City, NC 27909

April 18, 2016: 3:30 p.m. - 5:30 p.m. -
DIAL IN ADDED - See below
UNC-Pembroke, Moore Hall Auditorium, 1 University Drive, Pembroke, NC 28372-1510
To listen or participate in the April 18 session by telephone:

- **Dial 1-888-585-9008 and, when asked, enter conference room number 780073319#.**
- **Instructions to comment by telephone will be provided during the public hearing and also are available on the Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform.**

In addition to the public hearings, Comments can be submitted:

- **Online** at the N.C. Medicaid Reform website at http://www.ncdhhs.gov/nc-medicaid-reform/medicaid-reform-comment-submission-form
- **By email** to MedicaidReform@dhhs.nc.gov
- **By phone** at (919) 855-3470
- **By mail** to Division of Health Benefits, North Carolina Department of Health and Human Services, 2601 Mail Service Center, Raleigh, NC 27699-2601
- **In person** at North Carolina Department of Health and Human Services, 101 Blair Drive, Raleigh, NC 27603

The North Carolina Department of Health and Human Services (DHHS) proposed Section 1115 Demonstration waiver application sets forth a plan to improve the access to, and quality and cost effectiveness of health care for our growing population of Medicaid and N.C. Health Choice beneficiaries. The demonstration will restructure Medicaid care delivery using accountable, next-generation prepaid health plans; redesign payment to reward value rather than volume; and plan toward true person-centered care grounded on the foundation of the current patient-centered medical homes, community support and informatics services.

Medicaid Reform will enable North Carolina to meet four goals defined by the North Carolina General Assembly:

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

Visit the N.C. Medicaid Reform website at www.ncdhhs.gov/nc-medicaid-reform to review the draft Section 1115 Demonstration waiver application, detailed public notice and other documents; submit comments on the Medicaid Reform plan; and learn more about N.C. Medicaid Reform. A hard copy of the waiver application also is available at the Department of Health and Human Services, 101 Blair Drive, Raleigh NC, 27603.

WSJ: April 14, 2016

The Winston-Salem Journal – April 14, 2016

CHARLOTTE OBSERVER

The Charlotte Observer – April 15, 2016

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The Wilmington StarNews – April 15, 2016

Old-fashioned Social Security not complicated

Your Social Security
Tom Margenau

Q: My wife and I don't know if we should "File and suspend" or "file and restrict" and if we should do it now or if we should wait. Please help! I can't believe how incredibly complicated Social Security is. It's worse than the tax code!

A: I made a little promise to myself that I would NOT write another column about all the confusion over the much ballyhooed and mostly misunderstood Social Security maximizing strategies called "file and suspend" and "file and restrict." At least not for the next couple of weeks. I would guess that more than half of my columns over the past several months have focused on this one topic alone, including my last three columns in a row. So if you are looking for information on that topic, just go to your newspaper's online archives or to my syndicator's website, creators.com, and check out my recent columns and you will find all the information you need to know about the topic.

In the case of this letter writer, I answered his questions via email. But I wanted to start this column by addressing his point about Social Security being "incredibly complicated."

For 70 years, Social Security wasn't complicated at all. You applied for benefits at 62 or maybe waited until 65. A very few people waited until 70. Nobody tried to "maximize" their Social Security. Again, they simply filed for benefits at whatever age they decided they wanted and the checks just started rolling in.

But then these "File and suspend" and "file and restrict" loopholes inadvertently opened up as the result of some mostly unrelated Social Security amendments. And then financial planners and other Social Security "experts" got into the act and things really got bizarre. People started twisting the rules in a variety of convoluted ways to try to squeeze all sorts of unintended benefits out of the system.

Thankfully, Congress finally stepped in and eliminated these loopholes, albeit in a gradual way. In a few months, we will finally be done with the "file and suspend" strategy, and in about four years, we will be rid of "file and restrict" claims. Then we will get back to the good old-fashioned and relatively simple Social Security program.

Q: Can you please advise me on some Medicare issues that I have. I tried calling Social Security's hotline, but they didn't do much. Can you help me?

A: I've explained many times before that as a retired Social Security Administration employee, I know all about Social Security benefits, but very little about the Medicare program.

SSA's role in the Medicare program is minimal. They simply help people sign up for Medicare coverage. But an entirely different government agency, called the Centers for Medicare and Medicaid Services, actually runs the Medicare program. You can call them at 800-MEDICARE Or go to their website: medicare.gov.

If you have a Social Security question, Tom Margenau has the answer. Contact him at thomas.margenau@comcast.net.

The Fayetteville Observer – April 17, 2016

North Carolina Medicaid and NC Health Choice
Section 1115 Demonstration Waiver Application

Prepared by: North Carolina Department of Health and Human Services

June 1, 2016