From: Van Vleet, Amanda M [redacted]
Sent: Thursday, August 17, 2023 11:56 AM
To: Bush, Melanie E [redacted] Lerche, Julia K [redacted];
Sandoe, Emma [redacted]
Subject: Feedback from NC DAC

Hi all,

I covered a presentation for Melanie today in Asheville for health care staff who work in correctional facilities on Medicaid expansion and the justice-involved re-entry initiative. They provided a couple pieces of good feedback I wanted to pass along:

1. There was really strong support for offering 60 (or 90) days (rather than 30) of medication in hand upon release. They already provide 30 days of medication upon release, and while Medicaid would pay for it under the waiver, they mentioned that it's really the 30 days after that (especially with behavioral health medication, where it can take 60-90 days to get an appointment as a new patient), when ppl still might not be connected to a doctor, that gets them in trouble health/safety wise or leads them back to incarceration. Of course 90 days would be better, but anecdotally, most are able to connect to a doctor in 60 days.

2. Many health care facilities won't serve individuals who are flagged as sex offenders, and while understandable, it may be the case that the crime was committed when the person was a teen/young adult and now they're seniors and can't get health care. This is becoming a larger issue with the aging populations in prisons.

Amanda Van Vleet, MPH (*she / her*)
Associate Director, Innovation
NC Medicaid Strategy Office
North Carolina Department of Health & Human Services
[redacted]
For coordination/scheduling: [redacted]

NC HOP
Medicaid Healthy Opportunities

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] Public comment for 9/20/23
Date: Wednesday, August 30, 2023 1:36:11 PM

The Innovation Waiver needs to include all RADSEs/Relative as Provider. All RADSes need to have that option not just the ones from 2015 and before. Our needs are just as important as the other RADSEs, coupled with the fact that there is not staff to cover our remaining hours we need to be able to work all of the service hours for our child.

Thank you,

Michelle Hicks.

[redacted]

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Friday, September 1, 2023 11:16:32 AM

I can say as a parent of an adult with I/DD that the Innovations Waiver is crucial if we are to start to meet the spirit of the ADA law. That said, the Waiver is not enough as currently constructed. Adults with I/DD have an extremely restricted access to housing. Most of today's "affordable housing" programs are geared for "working families", the mentally ill, people recovering from substance use, the homeless, veterans, and the elderly. All valid needs but largely ignoring the most vulnerable of the vulnerable—I/DD adults. Federal vouchers for I/DD adults are at a standstill and unlikely to increase. Even group homes and small-scale ICFs are struggling to stay open.

The CMS must address this!

Carol Conway
102 Rhododendron Court
Chapel Hill, NC 27517
And
Chair, Parent Advocates for Adult Children with I/DD
Board Member, The Arc of NC
Member, the NC Council on Developmental Disabilities
Advisor, Meet the Need NC

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Tuesday, September 5, 2023 7:40:44 PM

I am writing IN SUPPORT OF this waiver. We MUST do something about gun violence, and this is the least we can do. I cannot see any reason that anyone would not support this.

Again, I write in SUPPORT of the waiver.

Thank you,
Debbie Walker
Walkertown, NC

[redacted]

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] "NC Section 1115 Waiver"
Date: Monday, September 4, 2023 5:41:54 PM

I am writing to comment on the North Carolina Medicaid Reform Demonstration.

HERE IS MY COMMENT: PLEASE MAKE IT POLICY TO MAKE IT MANDATORY FOR CURRENT BENEFICIARIES WHO WANT THEM TO BE SERVED AHEAD OF THE NEWER BENEFICIARIES. FIRST COME FIRST SERVED. THANK YOU.

From: Stroud, Ellen
To: Medicaid.NCEngagement
Subject: 1115 waiver comment
Date: Wednesday, September 6, 2023 4:45:01 PM

Hello, when any Medicaid assessment is made and especially what is being proposed for the justice involved population individuals who may not meet the guidelines for Medicaid may be eligible at 300% of the poverty line and below with no insurance or underinsured for the State Opioid Response program that is operated at more than 100 locations across the state. It would seem efficient and helpful to provide a warm handoff when an inmate does not qualify for Medicaid and has an opioid use disorder and/or stimulant use disorder.

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Friday, September 8, 2023 8:56:06 AM

To NC DHHS,

Thank you for the opportunity to provide some feedback about the proposed medicaid waiver demonstration. I would like to comment specifically about the Justice Involved Reentry Initiative.

I am a family medicine and addiction medicine physician in Western North Carolina who focuses on marginalized populations. Many of these patients experience a complex combination of barriers to wellness and appropriate healthcare: childhood trauma, lack of housing, lack of transportation, lack of insurance, mental illness, substance use disorder, and criminal justice involvement. These patients are at the highest risk for early mortality, overutilization of emergency medical services, and incarceration. Often, effective treatments are available for their medical and behavioral health conditions, but lack of ability to cover costs of care cause persistent lack of improvement or stability. This is most obvious in individuals leaving jails and prisons, who have the added challenges of difficulty navigating rapidly evolved social service systems, restricted housing and employment opportunities, and reduced illicit substance tolerance, which result in high risks for overdose or suicide mortaility. In my personal experience treating these patients, both in carceral settings and directly after, I have seen firsthand what peer reviewed literature shows: providing evidence based medical, substance use disorder, and mental health treatment results not only in improved clinical outcomes, but also reductions in reincarceration and rearrest. Instead of waiting for expensive treatments after an overdose, it is much more cost effective and humane to provide inexpensive, effective treatments prior to carceral release. Thus, I wholeheartedly support the proposed coverage of medical and SUD/MH services for soon-to-be-released individuals. This will save taxpayer money, save anguish and suffering for families, and save lives, as well as improve public safety and improve workforce participation. To me, this is a no-brainer!

Thanks for your hard work advocating for the health of NC citizens, particularly the most vulnerable.

Shuchin Shukla MD MPH

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] Public Input Request - 1115 Waiver
Date: Friday, September 8, 2023 2:20:28 PM
Attachments: HOP Feedback for Waiver demonstration (1).pdf

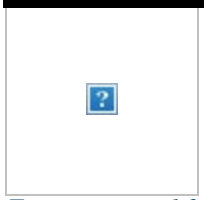
Hello,

Please find the Community Housing Coalition of Madison County's feedback regarding the Medicaid Reform Demonstration Waiver 1115 Application attached.

We are so grateful to be a part of this ground-breaking pilot program and look forward to its success for many more years!

Thank you!

--
Leigh Waters
Client Services Manager | Community Housing Coalition of Madison County
(828) 649-1200 | 798 Walnut Creek Rd, Marshall, NC 28753
[redacted] | www.chcmadisoncountync.org



To promote and facilitate healthy, safe, and affordable housing through advocacy, education, and resource development.

Community Housing Coalition of Madison County

798 Walnut Creek Rd
P.O. Box 1166, Marshall, North Carolina 28753
Phone: 828-649-1200 | www.chcmadisoncountync.org

To whom it may concern,

Hello, and thank you for considering the Community Housing Coalition of Madison County's (CHC) feedback on the Healthy Opportunities Pilot Program. We have been operating as a Human Service Organization for the pilot since May of 2022. The services CHC provides currently are an Environmental Exposure Assessment, Home Accessibility and Safety Modifications, Home Remediation Services and Healthy Home Goods.

Since May of 2022 CHC has worked with approximately 22 individual clients through 43 separate referrals. We have installed three HVAC units, completed two roof replacements, worked with four clients to remedy septic issues, installed new LVP flooring for two clients and have completed other door, electrical and plumbing/drain repairs.

Our agency has implemented this program with the support of the Capacity Building funds which allow us, in part, to cover the overhead cost of running this program. CHC's primary feedback for the program is that if the program extends, allocation of continued Capacity Building funds is imperative.

As the cost of goods, along with labor costs, continue to increase, at CHC we see a need for at least a 10-15% raise in the program cap for each service. We would also like to see the Home Accessibility and Safety Modification cap changed to every 3-5 pilot service delivery years instead of for the lifetime of the waiver demonstration.

Current program implementation allows flexibility for the agency to exercise continued and ever-changing best practices and standards. One point of standardization that may be beneficial is setting the Environmental Exposure Assessment authorization period for three months, and Home Accessibility and Safety and Home Remediation for an authorization period of six months.

In conclusion, CHC is grateful to be a part of this groundbreaking program that has allowed us to serve members of our community that previously fell outside of other home repair grants. It is our hope that this program, with its significant impact to date, will continue to be successful for many years to come.

Sincerely,

Leigh Waters
Client Services Manager

From: [redacted]
To: Medicaid.NCEngagement
Cc: [redacted]
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 4:13:10 PM
Attachments: image001.png
1115 Waiver Feedback Impact Health Submitted 9.20.23.pdf

Dear NC Medicaid colleagues,

Please find attached our feedback as a part of the public comment period for the NC Section 1115 Waiver.

Sincerely,

Laurie Stradley

IMPACT HEALTH

Laurie Stradley
she/her/hers
Executive Director
P.O. Box 5378
Asheville, NC 28813
828.688.0422

www.impacthealth.org
LinkedIn | Facebook | Twitter

Impact Health
866 Hendersonville Rd
Asheville, NC 28803
www.impacthealth.org
September 12, 2023

North Carolina Department of Health and Human Services
NC Medicaid Section 1115 Waiver Team
1950 Mail Service Center
Raleigh, NC 27699-1950
Subject: NC Section 1115 Waiver

As the Network Lead (NL) responsible for implementation of the Healthy Opportunities Pilot in Western North Carolina, Impact Health is providing the following feedback regarding the pilot portion of the draft NC Section 1115 Demonstration Waiver application.

1: RETAIN: Impact Health strongly supports the following items in the state's draft application:

- Expansion of geographic eligibility to include all 100 counties.
- Whole-person integrated approach to care supported by a care management model.
- Expansion of pilot eligibility to include all pregnant and postpartum women, justice-involved individuals, those who are "at risk of" a chronic condition, individuals with only one chronic health condition, individuals recently impacted by natural disasters, children/youth who receive adoption assistance and all Tailored plan members and Tailored Care Management eligibles in prepaid inpatient health plan (PIHP).
- Expansion of meal services to three meals per day.
- Availability of capacity building funds throughout the demonstration waiver period.
- Central role of NLs in ensuring the pilot's success.

2: MODIFY: Impact Health believes the following items could be improved upon:

- Refine language around rental assistance to include:
  - up to six months of rental assistance including payment of arrears.
  - for all enrollees who demonstrate need (not just high-needs enrollees).
- Prioritize investments in community-based organizations and local service delivery models.
- Increase capacity building budget allocation and/or significantly increase fee schedule payments to ensure there are sufficient and sustainable resources for human service organizations (HSOs) and NLs to scale pilot services across all 100 NC counties.

3: CLARIFY/ADD: Impact Health requests the following clarifications and additions:

- Expand eligibility to include all NC Medicaid members—regardless of coverage type—who screen positive for a pilot-supported social health need.
- Clarify HOP eligibility of Medicare/Medicaid dual enrollees.
- Include all HOP services in pre-release Medicaid services available to justice involved individuals.

- Allow continuous access to HOP services for justice-involved individuals for 1-year post-release.
- Clarify that current NLs and HSOs do not need to reapply under the new waiver.
- In at least one region with at least a few services, test a prospective fee schedule that allows HSOs to move away from the fee for service model in better alignment with the managed care approach.
- Reassess the current value based payment approach to an amount and set of metrics that truly incentivize improvements to implementation strategies.

Thank you for the opportunity to provide feedback from our perspective as a Network Lead, which includes feedback we have received to date from HSOs across our network.

Sincerely,

Laurie Stradley
Executive Director
Impact Health
WNC Network Lead

Additional Recommended Pilot Enhancements

Fee Schedule Improvements

- Standardize fee schedule statewide to reduce the potential for confusion, referral delays and rejections.
- Approve additional evidence-based parenting curricula in alignment with NC Partnership for Children and/or leveraging Head Start Parenting Curricula Review Database to allow HSOs to leverage existing resources to meet regional needs.
- Expand Healthy Home Goods or other appropriate service to include personal hygiene items, especially including diapers, tampons, sanitary pads, menstrual cups and other menstrual support items.
- Review all services to ensure a coordination or admin fee is included.

Network Development

- Give contracting preference and/or incentives to local, community embedded HSOs to promote equity and improve pilot enrollment, member satisfaction, expansion of services/geography and culturally inclusive service delivery.
- Prioritize and incentivize local health and social service agencies to participate in the pilot.
- Provide ongoing capacity building funding to support NLs who play a critical role in developing and maintaining network diversity, capacity and sustainability.
- Strengthen and expand NL's role to ensure pilot success by:
    - providing NLs with access to detailed member eligibility lists to allow NLs to build enrollment penetration maps by zip code, county, domain and/or attributed practice,
    - funding existing NLs to onboard and provide training and technical assistance to new NLs and new and existing PHPs, CINs and other stakeholders,
    - engaging NLs as primary regional representatives in state-level decision-making, and

- partnering with NLs to create and implement a comprehensive communications and public relations strategy.

Digital Platform & Billing Process Improvements

- Develop a clear pathway and process to support data sharing between pilot stakeholders to ensure NLs can make data-driven decisions and conduct continuous quality improvements.
- Improve the accuracy and efficiency of the pilot's digital billing processes by implementing technical solutions that
  - standardize billing practices using 837 and 835 data sets,
  - integrate benefits inquiries and responses (270/271 data sets) to provide HSOs with real-time access to client eligibility data, and
  - improve the user experience by providing functionality for data searches, claims management, and elimination of duplicate claims.

Compliance and Quality Assurance

- Require HSOs who directly contract with PHPs to participate in NL compliance activities to ensure network adequacy and service delivery quality.
- Increase accountability and transparency around PHP responsibilities regarding care management network adequacy, quality improvement, and payment processes.

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Tuesday, September 12, 2023 2:16:41 PM

Good afternoon,

I'm writing in support of providing the Medicaid Waiver to incarcerated people prior to release, as this will enable more successful reentry. Per the fact sheet on DHHS's Justice-Involved Reentry Initiative, North Carolina believes providing pre-release services has the potential to:

- **Improve access to physical and behavioral health services upon reentry into the community**
- **Improve coordination and communication between correctional systems, Medicaid systems, managed care plans, and community-based providers**
- **Improve physical and behavioral health outcomes**
- **Reduce the number of emergency department and inpatient hospitalizations for justice-involved populations**

To that end, North Carolina is requesting authority through the demonstration renewal request to provide a set of targeted pre-release Medicaid services within the 90-day period prior to release from a participating correctional setting, including **Case Management, Medication Assisted Treatment (MAT), and at least a a 30-Day Supply of Prescription Medication.**

Thank you for your consideration.

Irene Lawrence

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver Feedback
Date: Thursday, September 14, 2023 4:07:21 PM
Attachments: image001.png
image002.png
image003.png
image004.png
image005.png
image006.png

I support the following:

1. RETAIN: Impact Health strongly supports the following items in the state's draft application:

- Whole-person integrated approach to care supported by a care management model.
- Expansion of geographic eligibility to include all 100 counties.
- Expansion of pilot eligibility to include all pregnant and postpartum women, justice-involved individuals, those who are "at risk of" a chronic condition, individuals with only one chronic health condition, individuals recently impacted by natural disasters, children/youth who receive adoption assistance and all Tailored plan members and Tailored Care Management eligibles in prepaid inpatient health plan (PIHP).
- Expansion of meal services to three meals per day.
- Availability of capacity building funds throughout the demonstration waiver period.
- Central role of NLs in ensuring the pilot's success.

2. MODIFY: Impact Health believes the following items could be improved upon:

  - Refine language around rental assistance to include:
    up to six months of rental assistance including payment of arrears
  - for all enrollees who demonstrate need (not just high-needs enrollees).
- Prioritize investments in community-based organizations and local service delivery models.
- Increase capacity building budget allocation and/or significantly increase fee schedule payments to ensure there are sufficient and sustainable resources for human service organizations (HSOs) and NLs to scale pilot services across all 100 NC counties.

3. CLARIFY/ADD: Impact Health requests the following clarifications and additions:

- Expand eligibility to include all NC Medicaid members—regardless of coverage type—who screen positive for a pilot-supported social health need.
- Clarify HOP eligibility of Medicare/Medicaid dual enrollees.
- Include all HOP services in pre-release Medicaid services available to justice involved individuals.
- Allow continuous access to HOP services for justice-involved individuals for 1-year post-release.
- Clarify that current NLs and HSOs do not need to reapply under the new waiver.

Additional Recommended Pilot Enhancements

Fee Schedule Improvements

- Standardize fee schedule statewide to reduce the potential for confusion, referral delays and rejections.

Approve additional evidence-based parenting curricula in alignment with NC Partnership for Children to allow HSOs to leverage existing resources to meet regional needs.

- Review all services to ensure a coordination or admin fee is included.

Network Development

- Give contracting preference and/or incentives to local, community embedded HSOs to promote equity and improve pilot enrollment, member satisfaction, expansion of services/geography and culturally inclusive service delivery.
- Prioritize and incentivize local health and social service agencies to participate in the pilot.
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- Strengthen and expand NL's role to ensure pilot success by:

    - providing NLs with access to detailed member eligibility lists to allow NLs to build enrollment penetration maps by zip code, county, domain and/or attributed practice,
    - funding existing NLs to onboard and provide training and technical assistance to new NLs and new and existing PHPs, CINs and other stakeholders,
    - engaging NLs as primary regional representatives in state-level decision-making, and
    - partnering with NLs to create and implement a comprehensive communications and public relations strategy.

Digital Platform & Billing Process Improvements

- Develop a clear pathway and process to support data sharing between pilot stakeholders to ensure NLs can make data-driven decisions and conduct continuous quality improvements.
- Improve the accuracy and efficiency of the pilot's digital billing processes by implementing technical solutions that

    - standardize billing practices using 837 and 835 data sets,
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    - improve the user experience by providing functionality for data searches, claims management, and elimination of duplicate claims.

Compliance and Quality Assurance

- Require HSOs who directly contract with PHPs to participate in NL compliance activities to ensure network adequacy and service delivery quality.
- Increase accountability and transparency around PHP responsibilities regarding care management network adequacy, quality improvement, and payment processes.

Elizabeth Becker, MBA
Compliance Officer

Dogwood Health Trust
Phone: 828.771.6718 Mobile: [redacted]
890 Hendersonville Rd, Asheville NC 28803
Email: e.becker@dht.org

dogwood health trust

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] Public comment on 1115 waiver
Date: Wednesday, September 13, 2023 12:31:38 PM

Medical Respite/recuperative beds for patients experiencing homelessness is a very needed service across our state. I was very pleased to see it was added as a service under the current waiver, but it is needed greatly in cities and counties with high poverty and homelessness.
If the 1115 waiver is expanded to especially the urban regions, the counties with major hospitals would take
full advantage of this due to the growing crisis of homeless patients discharged every day with no where to go or heal. Readmissions sky rocket and pre mature death rates soar when vulnerable patients have no
where to go until there is opportunity for stable housing. Shelters are capped, and if hospitals had a safe place to discharge and a community based organization can be reimbursed for this service…this is sustainable model can prevent readmissions up to 50%. Also, this allows quality care for the most medically vulnerable so they can be safely placed in housing after they heal from their conditions. Medical respite/recuperative care is now a reimbursable service in most states, and you can find research based material with extraordinary outcomes at NIMRC.org.
Also, please reach out to me if you have any questions about medical respite including the quality standards and implementation.
Thanks so much,
Brooks Ann McKinney, MSW
Director of Vulnerable Populations

[redacted]

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Thursday, September 14, 2023 5:24:09 PM

Dear Civic Leaders:

As the Executive Director of a participating organization, I support the expansion of NC Section 1115 Waiver. But my reasons are not just the obvious because NC Section 115 Waiver allows my organization to do what no other nonprofit in Western North Carolina is doing: **address the Social Determinants of Health around the addiction recovery continuum of care.**

So, we strongly recommend that the state legislature expand NC Section 1115, but we also strongly recommend that you seek to increase the number of organizations participating in the program.

By assisting us in addressing the social determinants of health – those (sometimes unacknowledged) nonmedical factors that influence positive recovery outcomes – NC Section 1115 allows us to reduce the barriers to healing and recovery opportunities for all those North Carolinians impacted by addiction.

The experiences of my staff and the data will unequivocally support this fact: the NC Section 1115 Waiver is saving lives, bettering the North Carolina economy, reducing the negative impacts of the addiction epidemic, and promoting community wellness.

Renewing and expanding NC Section 1115 makes moral and economic sense.
We stand with ImpactHealth, and we agree with their comments and feedback without reservation regarding the NC Section 1115 Waiver.

We stand with all citizens of Western North Carolina, asking you to renew this powerful tool for our community.

I hope you will do the right thing and renew this vital component to the welfare and benefit of all North Carolinians.

Sincerely,

Niles Comer, M.A.
Executive Director
Eleanor Health Foundation
Asheville, NC

[redacted]

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Thursday, September 14, 2023 3:09:35 PM

We are submitting the following feedback regarding the pilot portion of the current draft of the NC Section 1115 Demonstration Waiver application.

1. RETAIN: Impact Health strongly supports the following items in the state's draft application:

- Whole-person integrated approach to care supported by a care management model.
- Expansion of geographic eligibility to include all 100 counties.
- Expansion of pilot eligibility to include all pregnant and postpartum women, justice-involved individuals, those who are "at risk of" a chronic condition, individuals with only one chronic health condition, individuals recently impacted by natural disasters, children/youth who receive adoption assistance and all Tailored plan members and Tailored Care Management eligibles in prepaid inpatient health plan (PIHP).
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- Availability of capacity building funds throughout the demonstration waiver period.
- Central role of NLs in ensuring the pilot's success.

2. MODIFY: Impact Health believes the following items could be improved upon:

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  - up to six months of rental assistance including payment of arrears
  - for all enrollees who demonstrate need (not just high-needs enrollees).
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3. CLARIFY/ADD: Impact Health requests the following clarifications and additions:

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- Clarify HOP eligibility of Medicare/Medicaid dual enrollees.
- Include all HOP services in pre-release Medicaid services available to justice involved individuals.

- Allow continuous access to HOP services for justice-involved individuals for 1-year post-release.
- Clarify that current NLs and HSOs do not need to reapply under the new waiver.

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Fee Schedule Improvements

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- Review all services to ensure a coordination or admin fee is included.

Network Development

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    - partnering with NLs to create and implement a comprehensive communications and public relations strategy.

Digital Platform & Billing Process Improvements

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- Improve the accuracy and efficiency of the pilot's digital billing processes by implementing technical solutions that
    - standardize billing practices using 837 and 835 data sets,
    - integrate benefits inquiries and responses (270/271 data sets) to provide HSOs with real-time access to client eligibility data, and
    - improve the user experience by providing functionality for data searches, claims management, and elimination of duplicate claims.

Compliance and Quality Assurance

- Require HSOs who directly contract with PHPs to participate in NL compliance activities to ensure network adequacy and service delivery quality.
- Increase accountability and transparency around PHP responsibilities regarding care management network adequacy, quality improvement, and payment processes.

--
All my best,

Jessica Mrugala, MPH

[redacted]
she/her/hers

From: [redacted]
To: Medicaid.NCEngagement
Cc: [redacted]
Subject: [External] NC Section 1115 Waiver
Date: Friday, September 15, 2023 2:32:25 PM
Attachments: image001.png
image002.png
image003.png
NC Prison Mental Health Advocacy Coalition in Support of 1115 Wwaiver Section 2c.pdf

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Dear NC DHHS,
We are a coalition of mental health advocacy organizations that have worked since 2011 to reduce the likelihood that North Carolinians with disabilities suffer incarceration and to improve the identification and treatment of those with disabilities in our prisons and jails. Our coalition, the NC Prison Mental Health Advocacy Coalition, applauds NC DHHS' application for renewal of the 1115 Demonstration Waiver including Initiative 2c, **Coverage for Pre-Release Services for Justice-Involved Individuals**, aimed at improving the successful reentry of people with disabilities.

Please find our letter in support of the Initiative attached to this email. The proposed services to this population will enhance our communities, making them safer and supporting greater integration of people with disabilities.

Our Coalition is committed to these important reforms in North Carolina and we are ready and willing to assist in a robust comprehensive plan that offers solutions to end the over-incarceration of people with disabilities.

Sincerely,
NC Prison Mental Health Advocacy Coalition

NC Psychiatric Association
Robin B. Huffman, Executive Director
[redacted]

NC Psychological Association
Martha Turner-Quest, Executive Director
[redacted]

National Association of Social Workers North Carolina
Valerie Arendt, MSW, MPP, Executive Director
[redacted]

Disability Rights NC
Susan H. Pollitt, Supervising Attorney
Criminal Legal Team
[redacted]

NAMI-NC
Nina Leger, MSW
Chief of Staff and Director of Programs and Affiliate Support
[redacted]

Susan H. Pollitt
Sr. Attorney|Disability Rights North Carolina
3724 National Drive, Ste 100, Raleigh, NC 27612
Ph: 919-856-2195 x.224 |Toll free: 877-235-4210 | Fax: 919-856-2244
Support Our Work | [redacted]

@DisabilityRtsNC @DisabilityRightsNC [instagram.com/disabilityrightsnc/]@disabilityrightsnc

NC's protection & advocacy system,
dedicated to advancing the rights of people with disabilities

September 15, 2023

North Carolina Department of Health and Human Services
NC Medicaid Section 1115 Waiver Team

Medicaid.NCEngagement@dhhs.nc.gov.

Re: NC Section 1115 Waiver, Initiative 2c: Coverage for Pre-Release Services for Justice-Involved Individuals.

Dear Secretary Kinsley,

We are a coalition of NC mental health advocacy groups (Disability Rights NC, NC Psychiatric Association, NC Psychological Association, NAMI-NC and the National Association of Social Workers North Carolina) that has worked since 2011 to reduce the likelihood that North Carolinians with disabilities suffer incarceration and to improve the identification and treatment of those with disabilities in our prisons and jails. Our coalition, the NC Prison Mental Health Advocacy Coalition, applauds NC DHHS' application for renewal of the 1115 Waiver including Initiative 2c, **Coverage for Pre-Release Services for Justice-Involved Individuals**, aimed at improving the successful reentry of people with disabilities.

As your application notes, people with disabilities are over represented in NC's prisons and jail. Justice involved individuals have high rates of mental and physical health needs. In fact, currently, the Department of Adult Correction identifies 24% of those incarcerated as needing mental health treatment – approximately 7,750 people. That number does not include others with mental conditions such as intellectual developmental disability, traumatic brain injury, fetal alcohol syndrome and more. 95% of the people in our prison will be returning to our communities.

In fact, pre-pandemic, an estimated 23,000 incarcerated individuals were returning from prison to North Carolina communities on an annual basis. As advocates we witness firsthand the lack of efficient handoffs to community behavioral health services. Often people only leave prison with an appointment with an intake office of the local LME MCO. There are many barriers to accessing treatment at this critical time – housing needs and survival needs are paramount after exit from prison and transportation to an appointment is often nonexistent. Critically, the current system too often fails to connect eligible people to Medicaid benefits. Currently thousands of returning citizens needing services are not caught by any safety net.

The lack of continuity in services from prison to community impact people's ability to safely and successful reenter the community. An April 2022 report by the North Carolina Sentencing and

Policy Advisory Commission found a 49 percent recidivist arrest rate within two years from a sample of 16,340 individuals released from prison in 2019. Thus, for everyone in the state, successful reentry services would promote public safety.

The 1115 Waiver services applied for are among those essential to successful reentry: Case Management, medication assisted treatment (MAT) and a supply of medications. These services will make an immediate and positive difference in people's lives and in community public safety. More services will be added over time: physical and behavioral health clinical consultation, laboratory and radiology services, medication and medication administration, Tobacco Cessation Treatment Services, and Durable Medical Equipment Upon Release.

The NC Prison Mental Health Advocacy Coalition is whole-heartedly supportive of the 1115Waiver Application regarding justice involved populations. Our Coalition is committed to these important reforms in North Carolina and we are ready and willing to assist in a robust comprehensive plan that offers solutions to end the over-incarceration of people with disabilities.

Sincerely,
NC Prison Mental Health Advocacy Coalition

NC Psychiatric Association
Robin B. Huffman, Executive Director
[redacted]

NC Psychological Association
Martha Turner-Quest, Executive Director
[redacted]

National Association of Social Workers North Carolina
Valerie Arendt, MSW, MPP, Executive Director
[redacted]

Disability Rights NC
Susan H. Pollitt, Supervising Attorney
Criminal Legal Team
[redacted]

NAMI-NC
Nina Leger, MSW
Chief of Staff and Director of Programs and Affiliate Support
[redacted]

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] Re: NC Section 1115 Waiver
Date: Friday, September 15, 2023 11:25:29 AM

In addition, I mirror ***all*** of Impact Health's comments and suggestions on the matter.

Corey Holland
Information Management Coordinator
HIGHTS, Inc
919-628-5301
[redacted]

On Fri, Sep 15, 2023 at 11:23 AM Corey Holland [redacted] > wrote:

> The Healthy Opportunities Pilot (HOP) program has turned out to be a highly effective way to combat insecurities of various forms for our most at-risk populations in North Carolina. Our organization serves Western NC, and I can personally attest that through our efforts in the food and transportation domain we have seen our clients be able to grow and succeed in numerous ways through our HOP-related service.
>
> To say that there is an equity-related problem, though, is an understatement. Vaya serves arguably the most at-risk populations in WNC yet refuses to join the HOP program for their own reasons, yet the families they have are the ones who would excel the most. Wellcare, United Healthcare, Healthy Blue (BCBS), AmeriHealth, and the various Community Care payers have had no issue "playing ball" - so why can't Vaya?
>
> We've had plenty of clients be able to increase the healthiness of their daily lives through being provided healthy foods, having their vehicles repaired, as well as being reimbursed for mileage to and from job interviews, daycares, farmer's markets, and all kinds of other daily needs. Meeting and/or assisting these needs has provided opportunities for the clients to meet other needs, such as having a better diet for a particular health problem as well as finally being able to drive to see a specialist for that health problem.
>
> While the referral process could be tightened up (having to play phone tag if we submit a referral for example) this program will only continue to grow and serve the people we share a community with who haven't been given the opportunities that others have.
>
> Hoping for legislative action,

Corey Holland
Information Management Coordinator
HIGHTS, Inc
919-628-5301
[redacted]

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] 1115 Demonstration Waiver advocate
Date: Friday, September 15, 2023 12:39:01 PM

Dearest Public Servants, this email is to urge **your yes vote** for the 1115 Demonstration Waiver. You may or may not be aware of our deep systems work to work toward re-entry processes that capture the strengths of folks who have been incarcerated, served there time and need to find supports to not repeat. This waiver is an opportunity to get health supports in place and fully connected prior to re-entry and having to look around town for health help. Having one's health services connected before leaving detention is clearly a big positive way that citizens can succeed at building healthy, non-legal involved lives. Please do all that you can to ensure Medicaid Services 90 days prior to release to allow for coverage for health care, MAT, prescription medication provided at release.

Please be on board with this healthy help!!!!

S.Kat Wies, MSW, Homeless Programs Coordinator, OCPEH (she/her)
Orange County Housing Department
Hillsborough, NC 27278 | [redacted] | [redacted]

For help with anything housing-related contact the Housing Helpline at 919-245-2655 (Monday-Friday 10am-4pm) or **housinghelp@orangecountync.gov**

For help to people living unsheltered, contact Street Outreach, Harm Reduction & Deflection at 919-886-3351 (Monday thru Friday 8am-9pm & Saturdays noon- 9pm) or **SOHRAD@orangecountync.gov**

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] Medicaid Waiver
Date: Friday, September 15, 2023 12:50:57 PM

Hi there,

My name is Catharine Reagan and I am a Durham, NC resident, UNC graduate student, and social worker. I'm writing in support of providing the Medicaid Waiver to incarcerated people prior to release to enable more successful reentry.

I, along with other North Carolinians, strongly believe that providing pre-release services has the potential to:

- Improve access to physical and behavioral health services upon reentry into the community;
- Improve coordination and communication between correctional systems, Medicaid systems, managed care plans, and community-based providers;
- Improve physical and behavioral health outcomes; and
- Reduce the number of emergency department and inpatient hospitalizations for justice-involved populations.

To that end, North Carolina is requesting authority through the demonstration renewal request to provide a set of targeted pre-release Medicaid services within the 90-day period prior to release from a participating correctional setting, including Case Management, Medication Assisted Treatment (MAT), and at least a 30-Day Supply of Prescription Medication.

Thank you for your consideration.

Warmly,
Catharine Reagan

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Friday, September 15, 2023 2:35:44 PM

New Hope of McDowell currently serves as an HSO for the HOP pilot program in NC. Please consider the following feedback regarding the pilot portion of the current draft of the NC Section 1115 Demonstration Waiver application.

1. RETAIN: Impact Health strongly supports the following items in the state's draft application:

- Whole-person integrated approach to care supported by a care management model.
- Expansion of geographic eligibility to include all 100 counties.
- Expansion of pilot eligibility to include all pregnant and postpartum women, justice-involved individuals, those who are "at risk of" a chronic condition, individuals with only one chronic health condition, individuals recently impacted by natural disasters, children/youth who receive adoption assistance and all Tailored plan members and Tailored Care Management eligible in prepaid inpatient health plan (PIHP).
- Expansion of meal services to three meals per day.
- Availability of capacity building funds throughout the demonstration waiver period.
- Central role of NLs in ensuring the pilot's success.

2. MODIFY: Impact Health believes the following items could be improved upon:

- Refine language around rental assistance to include:
  - up to six months of rental assistance including payment of arrears
  - for all enrollees who demonstrate need (not just high-needs enrollees).
- Prioritize investments in community-based organizations and local service delivery models.
- Increase capacity building budget allocation and/or significantly increase fee schedule payments to ensure there are sufficient and sustainable resources for human service organizations (HSOs) and NLs to scale pilot services across all 100 NC counties.

3. CLARIFY/ADD: Impact Health requests the following clarifications and additions:

- Expand eligibility to include all NC Medicaid members—regardless of coverage type—who screen positive for a pilot-supported social health need.
- Clarify HOP eligibility of Medicare/Medicaid dual enrollees.
- Include all HOP services in pre-release Medicaid services available to justice involved individuals.
- Allow continuous access to HOP services for justice-involved individuals for 1-year post-release.
- Clarify that current NLs and HSOs do not need to reapply under the new waiver.

Additional Recommended Pilot Enhancements

Fee Schedule Improvements

- Standardize fee schedule statewide to reduce the potential for confusion, referral delays and rejections.
- Approve additional evidence-based parenting curricula in alignment with NC Partnership for Children to allow HSOs to leverage existing resources to meet regional needs.
- Review all services to ensure a coordination or admin fee is included.

Network Development

- Give contracting preference and/or incentives to local, community embedded HSOs to promote equity and improve pilot enrollment, member satisfaction, expansion of services/geography and culturally inclusive service delivery.
- Prioritize and incentivize local health and social service agencies to participate in the pilot.
- Provide ongoing capacity building funding to support NLs who play a critical role in developing and maintaining network diversity, capacity and sustainability.
- Strengthen and expand NL's role to ensure pilot success by:
    - providing NLs with access to detailed member eligibility lists to allow NLs to build enrollment penetration maps by zip code, county, domain and/or attributed practice,
    - funding existing NLs to onboard and provide training and technical assistance to new NLs and new and existing PHPs, CINs and other stakeholders,
    - engaging NLs as primary regional representatives in state-level decision-making, and
    - partnering with NLs to create and implement a comprehensive communications and public relations strategy.

Digital Platform & Billing Process Improvements

- Develop a clear pathway and process to support data sharing between pilot stakeholders to ensure NLs can make data-driven decisions and conduct continuous quality improvements.
- Improve the accuracy and efficiency of the pilot's digital billing processes by implementing technical solutions that
    - standardize billing practices using 837 and 835 data sets,
    - integrate benefits inquiries and responses (270/271 data sets) to provide HSOs with real-time access to client eligibility data, and
    - improve the user experience by providing functionality for data searches, claims management, and elimination of duplicate claims.

Compliance and Quality Assurance

- Require HSOs who directly contract with PHPs to participate in NL compliance activities to ensure network adequacy and service delivery quality.
- Increase accountability and transparency around PHP responsibilities regarding care management network adequacy, quality improvement, and payment processes.

Thank You!

Jennifer Beaty
Executive Director/Court Advocate

New HOPE of McDowell
P.O. Box 1572
Marion, NC 28752
828-652-8538 (Office)
828-652-6150 (Crisis)

New HOPE of McDowell formally Family Services of McDowell County, Inc. is a Domestic Violence and Sexual Assault Agency providing services to victims, survivors, and their families in McDowell County. Our Mission is to provide services that support, empower, and increase the safety of victims of domestic violence and sexual assault and their families, with a focus on community outreach to promote awareness and social change.

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Saturday, September 16, 2023 2:27:10 PM

To Whom it May Concern:

I write with my comments in support of the state's renewal request to provide Medicaid services to justice-involved individuals. I am the Medical Director of Project CARA (Care that Advocates for respect, Resilience, and Recovery for All, a comprehensive perinatal substance use treatment program located in Asheville, NC. Together with my colleagues we provide medical, obstetrical, behavioral health, and case management services to pregnant and parenting people in the 18 westernmost counties in North Carolina. We are currently contracted by local county detention centers to provide pregnancy care and substance use treatment services to incarcerated individuals at Buncombe county detention center and other local county detention centers. We see time and again the need for pre-release services, particularly as it relates to ensuring follow up care management, pregnancy care and continues substance use treatment to ensure that once released, pregnant people continue to receive appropriate care.

What we see in practice is that most pregnant and postpartum detainees are disenrolled from Medicaid and have to re-enroll upon release. This is problematic for a variety of reasons, including the loss of continuity of substance use treatment, prenatal care, and potential loss of postpartum Medicaid that is now extended through 1 year postpartum. Once released, they are unprepared to access treatment and prenatal care services, and often face gaps or disengagement from care.

We strongly advocate that pre-release services, including case management, medication assisted treatment (MAT) and at minimum a 30 day supply of prescription medications upon release. Ensuring that detainees will have access to appropriate medical and behavioral health services upon release will help ensure improved maternal and infant outcomes, improved retention in recovery services, and help break intergenerational cycles of trauma and substance use.

Thank you for your time and consideration.
Sincerely,
Dr. Amy Marietta

MAHEC

Amy Marietta, MD, MPH, FAAFP, FASAM
Pronouns: she/her/hers
Medical Director, Project CARA
MAHEC Ob/Gyn Specialists

119 Hendersonville Rd. / Asheville, NC 28803
Phone: 828-257-4770 / Fax: 828-771-5479
[redacted]

https://mahec.net/obgyn/project-cara

Confidentiality Statement

From: [redacted]
To: Medicaid.NCEngagement; [redacted]
Cc: [redacted]
Subject: [External] NC Section 1115 Waiver
Date: Monday, September 18, 2023 9:14:14 AM

Dear Colleagues,

As a participating HSO in the food domain, Bounty & Soul is formally submitting the following feedback regarding the pilot portion of the current draft of the NC Section 1115 Demonstration Waiver application.

1. RETAIN: Impact Health strongly supports the following items in the state's draft application:

- Whole-person integrated approach to care supported by a care management model.
- Expansion of geographic eligibility to include all 100 counties.
- Expansion of pilot eligibility to include all pregnant and postpartum women, justice-involved individuals, those who are "at risk of" a chronic condition, individuals with only one chronic health condition, individuals recently impacted by natural disasters, children/youth who receive adoption assistance and all Tailored plan members and Tailored Care Management eligibles in prepaid inpatient health plan (PIHP).
- Expansion of meal services to three meals per day.
- Availability of capacity building funds throughout the demonstration waiver period.
- Central role of NLs in ensuring the pilot's success.

2. MODIFY: Impact Health believes the following items could be improved upon:

- Refine language around rental assistance to include:
    - up to six months of rental assistance including payment of arrears
    - for all enrollees who demonstrate need (not just high-needs enrollees).
- Prioritize investments in community-based organizations and local service delivery models.
- Increase capacity building budget allocation and/or significantly increase fee schedule payments to ensure there are sufficient and sustainable resources for human service organizations (HSOs) and NLs to scale pilot services across all 100 NC counties.

3. CLARIFY/ADD: Impact Health requests the following clarifications and additions:

- Expand eligibility to include all NC Medicaid members—regardless of coverage type—who screen positive for a pilot-supported social health need.
- Clarify HOP eligibility of Medicare/Medicaid dual enrollees.
- Include all HOP services in pre-release Medicaid services available to justice involved individuals.
- Allow continuous access to HOP services for justice-involved individuals for 1-year post-release.
- Clarify that current NLs and HSOs do not need to reapply under the new waiver.

Additional Recommended Pilot Enhancements

Fee Schedule Improvements

- Standardize fee schedule statewide to reduce the potential for confusion, referral delays and rejections.
- Approve additional evidence-based parenting curricula in alignment with NC Partnership for Children to allow HSOs to leverage existing resources to meet regional needs.
- Review all services to ensure a coordination or admin fee is included.

Network Development

- Give contracting preference and/or incentives to local, community embedded HSOs to promote equity and improve pilot enrollment, member satisfaction, expansion of services/geography and culturally inclusive service delivery.
- Prioritize and incentivize local health and social service agencies to participate in the pilot.
- Provide ongoing capacity building funding to support NLs who play a critical role in developing and maintaining network diversity, capacity and sustainability.
- Strengthen and expand NL's role to ensure pilot success by:
    - providing NLs with access to detailed member eligibility lists to allow NLs to build enrollment penetration maps by zip code, county, domain and/or attributed practice,
    - funding existing NLs to onboard and provide training and technical assistance to new NLs and new and existing PHPs, CINs and other stakeholders,
    - engaging NLs as primary regional representatives in state-level decision-making, and
    - partnering with NLs to create and implement a comprehensive communications and public relations strategy.

Digital Platform & Billing Process Improvements

- Develop a clear pathway and process to support data sharing between pilot stakeholders to ensure NLs can make data-driven decisions and conduct continuous quality improvements.
- Improve the accuracy and efficiency of the pilot's digital billing processes by implementing technical solutions that
    - standardize billing practices using 837 and 835 data sets,
    - integrate benefits inquiries and responses (270/271 data sets) to provide HSOs with real-time access to client eligibility data, and
    - improve the user experience by providing functionality for data searches, claims management, and elimination of duplicate claims.

Compliance and Quality Assurance

- Require HSOs who directly contract with PHPs to participate in NL compliance activities to ensure network adequacy and service delivery quality.
- Increase accountability and transparency around PHP responsibilities regarding care management network adequacy, quality improvement, and payment processes.

Many thanks for your work in this groundbreaking pilot!
Paula Sellars

--
PAULA SELLARS, M.S.W. (she, her, hers)
Deputy Director

t. [redacted] / Office 828-419-0533
a. 999 Old Hwy 70, Black Mountain, NC 28711
w. www.bountyandsoul.org

From: [redacted]
To: Medicaid.NCEngagement
Cc: [redacted]
Subject: [External] NC Section 1115 Waiver
Date: Monday, September 18, 2023 11:09:57 AM

I am a service provider through the Healthy Opportunities Pilot. I have worked for 12 years in the area of providing health and safety home repairs to people with low income. Our three-county service area is rural, and pockets of poverty exist in hidden corners, even though we are a beautiful tourist destination. In my experience many people on fixed incomes struggle to afford to maintain their homes when they are barely making day-to-day expenses. Helpful friends and relatives can assist, but unless they are professionals, can sometimes do more harm than good in trying to repair a home. For over three decades our organization has increased our services and outreach, but until the Impact Health Healthy Opportunities Program, we did not know there were vast populations of clients who need our assistance but had not reached out to us, and we did not know that they had fallen through the cracks of traditional referral systems. The clients that we are serving with this program have often not been aware of social services and resources available to them.

As a service provider, I am grateful to be able to help improve people's lives, and especially grateful to be in touch with the clients who were previously unaware of services. I know there are many, many more people whose health is being affected by their living conditions and who still don't have access to our resources. The work that is being done to build additional organizational capacity, connect a strong network of providers, and improve the health of North Carolina citizens is a vital benefit to those citizens and to the rest of our communities as well.

Stefanie Kompathoum
Home Repair Coordinator
Housing Assistance Corporation
828-692-4744 x 107
www.housing-assistance.com

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Monday, September 18, 2023 1:34:34 PM

We are submitting the following feedback regarding the pilot portion of the current draft of the NC Section 1115 Demonstration Waiver application.

1. RETAIN: I strongly support the following items in the state's draft application:

- Whole-person integrated approach to care supported by a care management model.
- Expansion of geographic eligibility to include all 100 counties.
- Expansion of pilot eligibility to include all pregnant and postpartum women, justice-involved individuals, those who are "at risk of" a chronic condition, individuals with only one chronic health condition, individuals recently impacted by natural disasters, children/youth who receive adoption assistance and all Tailored plan members and Tailored Care Management eligibles in prepaid inpatient health plan (PIHP).
- Expansion of meal services to three meals per day.
- Availability of capacity building funds throughout the demonstration waiver period.
- Central role of NLs in ensuring the pilot's success.

2. MODIFY: I believe the following items could be improved upon:

- Refine language around rental assistance to include:
  - up to six months of rental assistance including payment of arrears
  - for all enrollees who demonstrate need (not just high-needs enrollees).
- Prioritize investments in community-based organizations and local service delivery models.
- Increase capacity building budget allocation and/or significantly increase fee schedule payments to ensure there are sufficient and sustainable resources for human service organizations (HSOs) and NLs to scale pilot services across all 100 NC counties.

3. CLARIFY/ADD: I request the following clarifications and additions:

- Expand eligibility to include all NC Medicaid members—regardless of coverage type—who screen positive for a pilot-supported social health need.

Clarify HOP eligibility of Medicare/Medicaid dual enrollees.
- Include all HOP services in pre-release Medicaid services available to justice involved individuals.
- Allow continuous access to HOP services for justice-involved individuals for 1-year post-release.
- Clarify that current NLs and HSOs do not need to reapply under the new waiver.

Additional Recommended Pilot Enhancements

Fee Schedule Improvements

- Standardize fee schedule statewide to reduce the potential for confusion, referral delays and rejections.
- Approve additional evidence-based parenting curricula in alignment with NC Partnership for Children to allow HSOs to leverage existing resources to meet regional needs.
- Review all services to ensure a coordination or admin fee is included.

Network Development

- Give contracting preference and/or incentives to local, community embedded HSOs to promote equity and improve pilot enrollment, member satisfaction, expansion of services/geography and culturally inclusive service delivery.
- Prioritize and incentivize local health and social service agencies to participate in the pilot.
- Provide ongoing capacity building funding to support NLs who play a critical role in developing and maintaining network diversity, capacity and sustainability.
- Strengthen and expand NL's role to ensure pilot success by:
    - providing NLs with access to detailed member eligibility lists to allow NLs to build enrollment penetration maps by zip code, county, domain and/or attributed practice,
    - funding existing NLs to onboard and provide training and technical assistance to new NLs and new and existing PHPs, CINs and other stakeholders,
    - engaging NLs as primary regional representatives in state-level decision-making, and
    - partnering with NLs to create and implement a comprehensive communications and public relations strategy.

Digital Platform & Billing Process Improvements

- Develop a clear pathway and process to support data sharing between pilot stakeholders to ensure NLs can make data-driven decisions and conduct

continuous quality improvements.

- Improve the accuracy and efficiency of the pilot's digital billing processes by implementing technical solutions that
    - standardize billing practices using 837 and 835 data sets,
    - integrate benefits inquiries and responses (270/271 data sets) to provide HSOs with real-time access to client eligibility data, and
    - improve the user experience by providing functionality for data searches, claims management, and elimination of duplicate claims.

Compliance and Quality Assurance

- Require HSOs who directly contract with PHPs to participate in NL compliance activities to ensure network adequacy and service delivery quality.
- Increase accountability and transparency around PHP responsibilities regarding care management network adequacy, quality improvement, and payment processes.

Better Together,
Lauren Wilson
Director of Funds Development
Williams YMCA of Avery County
www.ymcaavery.com
E: [redacted]

Avery Office: 436 Hospital Drive, Newland, NC 28657
P: 828-737-5500 | **F:** 828-737-5504

Mitchell Office: 275 Oak Ave. Spruce Pine, NC 28777
P: 828-520-1392 | **F:** 828-520-1392

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Tuesday, September 19, 2023 9:47:21 AM
Attachments: image001.png
image002.png
image003.png
image004.png
image005.png

We are submitting the following feedback regarding the pilot portion of the current draft of the NC Section 1115 Demonstration Waiver application.

1. RETAIN: Pisgah Legal Services strongly supports the following items in the state's draft application:

- Whole-person integrated approach to care supported by a care management model.
- Expansion of geographic eligibility to include all 100 counties.
- Expansion of pilot eligibility to include all pregnant and postpartum women, justice-involved individuals, those who are "at risk of" a chronic condition, individuals with only one chronic health condition, individuals recently impacted by natural disasters, children/youth who receive adoption assistance and all Tailored plan members and Tailored Care Management eligibles in prepaid inpatient health plan (PIHP).
- Expansion of meal services to three meals per day.
- Availability of capacity building funds throughout the demonstration waiver period.
- Central role of NLs in ensuring the pilot's success.

2. MODIFY: Pisgah Legal Services believes the following items could be improved upon:

- Refine language around rental assistance to include:
    - up to six months of rental assistance including payment of arrears
    - for all enrollees who demonstrate need (not just high-needs enrollees).
    - Application fees up to $250 per enrollee
- Prioritize investments in community-based organizations and local service delivery models.
- Increase capacity building budget allocation and/or significantly increase fee schedule payments to ensure there are sufficient and sustainable resources for human service organizations (HSOs) and NLs to scale pilot services across all 100 NC counties.
- Include fees needed for car purchase and repair programs
- Linkages to Health Related Legal supports should include legal representation and negotiation, not merely advice.

3. CLARIFY/ADD: Pisgah Legal Services requests the following clarifications and additions:

- Expand eligibility to include all NC Medicaid members—regardless of coverage type—who screen positive for a pilot-supported social health need.
- Clarify HOP eligibility of Medicare/Medicaid dual enrollees.
- Include all HOP services in pre-release Medicaid services available to justice involved individuals.
- Allow continuous access to HOP services for justice-involved individuals for 1-year post-release.
- Clarify that current NLs and HSOs do not need to reapply under the new waiver.

Additional Recommended Pilot Enhancements
Fee Schedule Improvements

- Standardize fee schedule statewide to reduce the potential for confusion, referral delays and rejections.
- Approve additional evidence-based parenting curricula in alignment with NC Partnership for Children to allow HSOs to leverage existing resources to meet regional needs.
- Review all services to ensure a coordination or admin fee is included.
- Increase fee for Interpersonal Violence Services to the level of Housing Navigation.

Network Development

- Give contracting preference and/or incentives to local, community embedded HSOs to promote equity and improve pilot enrollment, member satisfaction, expansion of services/geography and culturally inclusive service delivery.
- Prioritize and incentivize local health and social service agencies to participate in the pilot.
- Provide ongoing capacity building funding to support NLs who play a critical role in developing and maintaining network diversity, capacity and sustainability.
- Strengthen and expand NL's role to ensure pilot success by:
    - providing NLs with access to detailed member eligibility lists to allow NLs to build enrollment penetration maps by zip code, county, domain and/or attributed practice,
    - funding existing NLs to onboard and provide training and technical assistance to new NLs and new and existing PHPs, CINs and other stakeholders,
    - engaging NLs as primary regional representatives in state-level decision-making, and
    - partnering with NLs to create and implement a comprehensive communications and public relations strategy.

Digital Platform & Billing Process Improvements

- Develop a clear pathway and process to support data sharing between pilot stakeholders to ensure NLs can make data-driven decisions and conduct continuous quality improvements.
- Improve the accuracy and efficiency of the pilot's digital billing processes by implementing technical solutions that
    - standardize billing practices using 837 and 835 data sets,
    - integrate benefits inquiries and responses (270/271 data sets) to provide HSOs with real-time access to client eligibility data, and
    - improve the user experience by providing functionality for data searches, claims management, and elimination of duplicate claims.

Compliance and Quality Assurance

- Require HSOs who directly contract with PHPs to participate in NL compliance activities to ensure network adequacy and service delivery quality.
- Increase accountability and transparency around PHP responsibilities regarding care management network adequacy, quality improvement, and payment processes.

Robin L. Merrell (she/her/hers)
Managing Attorney | Pisgah Legal Services
8282530406 | [redacted] | www.pisgahlegal.org
P.O. Box 2276 Asheville, NC 28802

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 9:08:15 AM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Emma Hutchens
57 Adams St Asheville, NC 28801-4302
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 8:22:28 AM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Sandra Candelario
106 E Margaret Ln Mebane, NC 27302
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 8:29:38 AM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

In addition, I would like to point out that several of my former and one current client, women who became involved with criminal justice system due to their severe emotional illness, addiction and h/o severe physical and sexual abuse, are desperately in need of both case management and therapy to enable them to become functioning and contributing members of our society.

Thank you for the opportunity to provide these comments.

Sincerely,
Lois Bernard
34 Maxwell St Asheville, NC 28801-2311
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 8:01:32 AM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Bobbi Lempert
55 Mountain Creek Ln Burnsville, NC 28714-8458
[redacted]

From: [redacted] behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Critical Medicaid Reform Needed
Date: Tuesday, September 19, 2023 7:56:40 AM

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Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

I am the Criminal Justice Resource Department Director for Orange County. Our department houses our Local Reentry Council. We work day in and day out to support individuals reentering Orange County from prison and jail.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Caitlin Fenhagen

Sincerely,
Caitlin Fenhagen
314 Winter Dr Chapel Hill, NC 27517-4838
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 7:52:18 AM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Lariza Garzon
1510 Scott Ave Unit 124 Charlotte, NC 28203-1524
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 7:30:47 AM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Stephanie Tyson
13414 Mallard Lake Rd Charlotte, NC 28262-1665
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Susan Howell
Date: Tuesday, September 19, 2023 7:28:30 AM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Susan Howell
513 Plymouth Dr Greenville, NC 27858-0005
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 6:56:55 AM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
LaTicia Hymam
7016 Fox Rd Raleigh, NC 27616-5514
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 6:43:51 AM

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Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
LISA MISROK
308 W Enterprise St Durham, NC 27707-1822
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 5:17:47 AM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
John Robinson
122 Cottonfield Ct Raeford, NC 28376-5770
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 12:51:01 AM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Kicab Castaneda-Mendez
878 Fearrington Post Pittsboro, NC 27312-5037
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 12:36:56 AM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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Thank you for the opportunity to provide these comments.

Sincerely,
Sirina Sucklal
PO Box 460 Savage, MD 20763-0460
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 11:50:03 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Tika Bordelon
1400 Hubbell Pl Seattle, WA 98101-1965
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 11:48:00 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Jim Head
15307 Northgate Blvd Oak Park, MI 48237-1220
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 11:35:51 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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Thank you for the opportunity to provide these comments.

Sincerely,
Cecilia Seabrook
1323 Post Oak Ct Crest Hill, IL 60403-3194
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 11:34:35 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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Thank you for the opportunity to provide these comments.

Sincerely,
Edith Simpson
15 Springdale Rd Asheville, NC 28805-1736
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 11:06:47 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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Thank you for the opportunity to provide these comments.

Sincerely,
Margaret Goodman
651 Sinex Ave Pacific Grove, CA 93950-4253
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 10:54:42 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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Thank you for the opportunity to provide these comments.

Sincerely,
Christine Payden-Travers
108 E Devonshire St Winston Salem, NC 27127-3035
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 10:52:36 PM

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Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

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Thank you for the opportunity to provide these comments.

Sincerely,
Lauren Murdock
3940 Via Lucero Santa Barbara, CA 93110-1669
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 10:31:32 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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Thank you for the opportunity to provide these comments.

Sincerely,
Timothy Young
1200 Wind River Pkwy Morrisville, NC 27560-9495
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 9:24:36 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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Thank you for the opportunity to provide these comments.

Sincerely,
Carol Carlson
801 Freemasons Dr Greensboro, NC 27407-1861
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 9:17:48 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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Thank you for the opportunity to provide these comments.

Sincerely,
karen winnubst
415 Houston St Cedar Hill, TX 75104-2643
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 9:15:45 PM

Dear NC DHHS,

I support DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Cama Merritt
1244 Arbor Rd Winston Salem, NC 27104-1135
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 9:13:17 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Kirk Reid
19 Woodstream Ln Apt E Greensboro, NC 27410-6242
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 9:11:49 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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Thank you for the opportunity to provide these comments.

Sincerely,
Lars Stephenson
4806 Riverside Dr Durham, NC 27704-9422
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 8:50:49 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
TJ Cawley
103 Trellingwood Dr Morrisville, NC 27560-7034
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 8:50:07 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Karen Stickney
27 Baril St Apt 1 Lewiston, ME 04240-5213
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 8:50:01 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Cynthia A Wheeler
9809 Miranda Dr Raleigh, NC 27617-7658
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 8:45:04 PM

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Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Jeffrey DeCristofaro
37 Lee Ave Asheville, NC 28804-3327
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 8:36:02 PM

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Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Rita Mullis
7908 Byrchmont Pl Charlotte, NC 28210-6763
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 8:20:31 PM

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Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Remove people being banned from food stamps and other services for a federal conviction after serving their sentence and requirements.

Thank you for the opportunity to provide these comments.

Sincerely,
Connie Rucker
134 Wildlife Trl Richlands, NC 28574-9429
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 8:13:06 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Bridget Tarrant
111 S 9th St Wilmington, NC 28401-4710
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 8:04:21 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Linda Eastman
7048 Sevilleen Dr SW Ocean Isle Beach, NC 28469-5865
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 7:34:13 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
William Welkowitz
1600 S Eads St Apt 526N Arlington, VA 22202-2972
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 7:22:03 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Michelle Mitchell
PO Box 1673 Cornelius, NC 28031-1673
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 7:15:52 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Amy Markin
4909 Harwood Ct Durham, NC 27713-8103
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 7:07:38 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Rachel McManus
1 Carolina Mdws Chapel Hill, NC 27517-8508
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 6:48:26 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Michael Sileno
1509 W Cornwallis Dr Greensboro, NC 27408-6311
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 6:08:09 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Patricia Fleetwood
5203 T C Steele Rd Nashville, IN 47448-9785
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 6:07:07 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Jody Gibson
317 E Wall Ave Des Moines, IA 50315-5259
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 6:03:32 PM

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Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Steven Hutton
217 Prestonwood Dr Pittsboro, NC 27312-7750
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] I Support DHHS reentry efforts
Date: Monday, September 18, 2023 5:59:21 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Basic medical care is necessary for everyone, so I hope the legislature soon does implement Medicaid expansion and include those reentering from incarcdration.

Thank you for the opportunity to provide these comments.

Sincerely,
Lynne Kane
625 Cedar Club Cir Chapel Hill, NC 27517-7215
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:54:26 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.
We need to train more people that look like the underserved, build access trust in areas where no medical facilities are, or no transportation to get to in reasonable time.
With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Robert Campbell
1711 Purefoy Dr Chapel Hill, NC 27516-9263
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:49:11 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Clara Stiers
5561 Spence Plantation Ln Holly Springs, NC 27540-7293
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:49:01 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Barbara Bennett
722 Cedar Point Blvd # 245 Cedar Point, NC 28584-8012
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:39:28 PM

Dear NC DHHS,

I support DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Jerry Markatos
180 Haw Tree Ln Pittsboro, NC 27312-9983
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:38:36 PM

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Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Peggy Fry
115 Pine Cone Rd Wilmington, NC 28409-5113
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:34:27 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Louise Romanow
1010 Reedy Creek Rd Cary, NC 27513-3048
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:33:08 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Jaelyn Miller
5228 Pinehall Wynd Raleigh, NC 27604-5826
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:24:44 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Richard Klett
4245 Little Fork Cove Rd Denver, NC 28037-9425
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:31:38 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Sheena Beasley
2104 Shepherd Watch Ct Greensboro, NC 27403-3559
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:30:36 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Regina Elliott
1308 Colonial Ave Aptb Greenville, NC 27834-1728
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] I strongly support DHHS reentry efforts
Date: Monday, September 18, 2023 5:28:15 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,

Richard Helgans
401 Highland Trail
Chapel hill, NC 27516

Sincerely,
Richrad Helgans
401 Highland Trl Chapel Hill, NC 27516-8633
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:24:33 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver. We know and research shows that people reentering society from being incarcerated adapt far better if they receive appropriate support and guidance. In fact they are more likely to find a more constructive lifestyle and not return to incarceration.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Virginia Boyle
23 A Trillium Ct Asheville, NC 28805-1357
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:24:24 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
JL Angell
2391 Ponderosa Rd Rescue, CA 95672-9411
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:21:29 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Kelly Greene
2620 Park Rd Charlotte, NC 28209-1343
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:18:56 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Whitney Turner-Williams
918 N 26th St Richmond, VA 23223-6552
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:14:53 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Corby Bridgers
618 E Highland Ave Rocky Mount, NC 27801-3434
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:14:41 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Ashley Jacobs
12934 HWY130W Maxton, NC 28364
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:11:53 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

57,000 North Carolinians are currently incarcerated in state prisons, jails and youth detention centers and nearly 1 in 3 have been identified as having physical health issues. 75% have substance abuse issues and 50% have other mental health issues.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Claire Stone
172 Leprechaun Ln Stoneville, NC 27048-7695
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:08:12 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Laura Cooper
400 N Church St Unit 205 Charlotte, NC 28202-2174
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:07:23 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
John Richkus
206 Congress St Jersey City, NJ 07307-3410
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:06:28 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Melissa Martin
220 Wimbish Rd Eden, NC 27288-7670
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:06:15 PM

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Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Jo Ann Mount
1238 W 4th St Winston Salem, NC 27101-3604
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:04:56 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Alyson Winters
2538 Selwyn Ave Charlotte, NC 28209-1606
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:04:48 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Kelly Prelipp
210 Box Turtle Trl Chapel Hill, NC 27516-3806
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:04:25 PM

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Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Violette Blumenthal
4125 Settlement Dr Durham, NC 27713-9153
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:03:19 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Barry Goldfarb
2420 Lynbridge Dr Charlotte, NC 28270-7773
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:01:21 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Jen Sharp
3920 Cashew Dr Raleigh, NC 27616-9538
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 2:11:42 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver because making sure that people who have been incarcerated have a transition to a decent life benefits us all.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities. This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Again, making sure that people who have been incarcerated have a transition to a decent life benefits us all.

Sincerely,
Anne Cassebaum
3469 Amick Rd Elon, NC 27244-8111
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Wednesday, September 20, 2023 4:41:55 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
B. Thomas Diener
1613 Cedar Ridge Dr NE Albuquerque, NM 87112-4504
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Wednesday, September 20, 2023 3:30:21 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Donald Harland
677 N Luther Rd Candler, NC 28715
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:10:31 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

After reading about this proposal, I wholeheartedly agree that it should be implemented. I teach sociology and psychology at a small community college in Eastern NC, and I have been doing so for over 14 years. Additionally, I participated in jail and prison ministry, off and on for 12 years. Likewise, I have had family members and friends who have been, and some currently are, incarcerated. These are people, not trash, and we need to treat them with the dignity and respect that Jesus commands of us in Matthew 25:31-44. If we do not get better at caring for "the least of these" now, we will regret it on judgment day.

Sincerely,
Rhonda Breed

Sincerely,
Rhonda Breed
PO Box 382 Grantsboro, NC 28529-0382
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Monday, September 18, 2023 5:19:36 PM

Dear NC DHHS,

I am *not* in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina needs to first care for those who are unable to care for themselves - not by choice by making bad decisions and excuses - but by actual physical or intellectual disability. Far too many physically disabled and IDD individuals do NOT have the care needed in this state. There are only two waiver programs now - CAP/C and Innovations which has over 10,000 people on the wait list who need medical care to survive. The burden of care has fallen on their families. This is not acceptable. CAP/DA provides so little that it is not worth mention.

NC needs to care for their elderly and medically fragile population first.

Thank you for the opportunity to provide these comments.

Sincerely,
Robin Marx
100 Sas Campus Dr Cary, NC 27513-2414
[redacted]

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 3:54:37 PM

Good afternoon -

I'm writing to express support for renewal of this waiver to make possible critical capacity in our community to effectively respond to homelessness. Thank you for your efforts to make resources available here that allow our service partners to provide essential care to our most vulnerable community members.

Emily Ball
Manager, Homeless Strategy Division
Community and Economic Development
City of Asheville
O: (828) 271-6129
[redacted]

To join in our community's response to homelessness, visit the Homeless Initiative Advisory Committee (HIAC) page and sign up here to receive updates about HIAC's work and homeless strategies.

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 8:41:49 AM

To Whom it May Concern:

I write with my comments in support of the state's renewal request to provide Medicaid services to justice-involved individuals. I am the Program Coordinator of Project CARA (Care that Advocates for respect, Resilience, and Recovery for All, a comprehensive perinatal substance use treatment program located in Asheville, NC. Together with my colleagues we provide medical, obstetrical, behavioral health, and case management services to pregnant and parenting people in the 18 westernmost counties in North Carolina. We are currently contracted by local county detention centers to provide pregnancy care and substance use treatment services to incarcerated individuals at Buncombe county detention center and other local county detention centers. We see time and again the need for pre-release services, particularly as it relates to ensuring follow up care management, pregnancy care and continued substance use treatment to ensure that once released, pregnant people continue to receive appropriate care.

What we see in practice is that most pregnant and postpartum detainees are disenrolled from Medicaid and have to re-enroll upon release. This is problematic for a variety of reasons, including the loss of continuity of substance use treatment, prenatal care, and potential loss of postpartum Medicaid that is now extended through 1 year postpartum. Once released, they are unprepared to access treatment and prenatal care services, and often face gaps or disengagement from care.

We strongly advocate that pre-release services, including case management, medication assisted treatment (MAT) and at minimum a 30 day supply of prescription medications upon release. Ensuring that incarcerated people will have access to appropriate medical and behavioral health services upon release will help ensure improved maternal and infant outcomes, improved retention in recovery services, and help break intergenerational cycles of trauma and substance use.

Thank you for your time and consideration.
Sincerely,
Rebekah Bass

MAHEC

Rebekah Bass
Pronouns: she/her/hers
Coordinator, Project CARA
MAHEC OB/GYN

119 Hendersonville Rd / Asheville, NC 28803
Phone: 828-220-6465
[redacted]

https://mahec.net/obgyn/project-cara

Confidentiality Statement

From: [redacted]
To: Medicaid.NCEngagement
Cc: [redacted]
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 3:30:11 PM
Attachments: NC AHEC NC Medicaid Reform 1115 Renewal Application Comment_9.20.23.pdf
NC AHEC Firearm and difficult conversation resources.pdf

Good afternoon,

On behalf of the NC AHEC System supporting the Healthy Opportunities Pilot please see the attached comment on the North Carolina Medicaid Reform Section 1115 Demonstration Renewal Application, 2023.
Thank you for your consideration.

Sincerely,
Laurel Booth

UNC HEALTH SCIENCES at MAHEC

Laurel Booth, MPH
Pronouns: She, her, hers
Program Manager, NC AHEC Healthy Opportunities Pilot Program
Community Health Transformation, Department of Community and Public Health

121 Hendersonville Road / Asheville, NC 28803
Phone: 828-220-6469
[redacted]

NC AHEC | RECRUIT TRAIN RETAIN

NORTH CAROLINA
AREA HEALTH EDUCATION CENTERS

145 N. Medical Drive, Campus Box 7165
The University of North Carolina
Chapel Hill, NC 27599-7165

Phone: 919-966-2461 | Fax: 919-966-5830
ncahec@ncahec.net | ncahec.net

September 20th, 2023

North Carolina Department of Health and Human Services
NC Medicaid Section 1115 Waiver Team
1950 Mail Service Center
Raleigh, NC 27699-1950

RE: NC Section 1115 Waiver

Public Comment on North Carolina Medicaid Reform Section 1115 Demonstration Renewal Application 2023, behalf of the North Carolina Area Health Education Center System

The North Carolina Area Health Education Center (AHEC) system has served the state for over 50 years, providing education, activities, and materials to promote health. As an organization that envisions a state where every North Carolinian is healthy and supported by an appropriate and well-trained health workforce that reflects the communities it serves, we are thrilled to support the Healthy Opportunities Pilot. The NC AHEC system has supported the Healthy Opportunities Pilot (HOP), providing convening opportunities, training, and technical assistance to Pilot entities. Comments made in this document will refer only to the HOP program - Initiative 2a of Objective 2 of the 1115 Demonstration Renewal Application.

1. The NC AHEC system **is in favor of the proposal to renew all prior features of HOP and the expansion of the Pilot statewide**. Given the delays in implementation due to the COVID-19 pandemic, and promising development of networks found in the first Rapid Cycle Assessment (RCA) (Cecil G. Sheps Center for Health Services Research (Sheps Center), 2023); further investment and evaluation of the Pilot is merited and will strengthen statewide health and social service infrastructure.
    a. While the expansion of Pilot services statewide should be the goal, **expansion must be balanced with the need to build and maintain network adequacy among the existing networks in each region**. During the Statewide Healthy Opportunities Pilot Conference in August 2023, attendees expressed concern regarding this balance. A key challenge noted was that some HSOs were at capacity and unable to provide services to members with a service need (Care Management Panel, Statewide HOP Conference, 2023). As of November 30, 2022, 63% of those enrolled had received at least one invoiced service (p.9 Sheps Center, 2023); while this data comes from early implementation before all services were rolled out, it does highlight the need to ensure that the current members enrolled are receiving services. Preliminary reflections on the Pilot indicated the Phased Pilot Launch was a successful strategy for rollout (Van Vleet & Ludlam, 2023) continuing this approach may be beneficial for statewide expansion.

b. When undertaking expansion, there may be a need to **streamline compliance requirements for HSOs operating in partnership with multiple Network Leads**. As the Pilot expands, some HSOs may operate in multiple regions. It will be important to consider the administrative burden on HSO staff to provide similar but unique administrative and compliance documentation and activities for multiple Network Leads. For HSOs already operating in a Pilot region the Department could consider a streamlined process to onboard the organization with the new Network Lead, leveraging existing compliance efforts from existing Network Leads.

2. The NC AHEC system is **in favor of the proposal to expand eligibility for Pilot enrollment**. Not only will this allow delivery of services to more North Carolinians, but expanding eligibility criteria may increase enrollment, which is necessary for rigorous evaluation. The need for continued enrollment was highlighted as a recommendation by evaluators (p.12, Sheps Center, 2023).
    a. **Clarification regarding the Pregnancy-related eligibility criteria** would be beneficial to implementation, particularly clarification regarding how long an individual may receive services post-partum.
    b. **Revision of eligibility criteria for children 0-3.** Providers working with technical assistance teams have observed that revising eligibility criteria to allow children to receive HOP services in the NICU (before graduation) would better prepare the member and their families for discharge. Existing guidance currently requires graduation from the NICU as one of the eligibility criteria. (p.1, *PESA companion guide*, n.d.).
    c. The NC AHEC system recommends NC DHHS **utilize the North Carolina Formerly Incarcerated Transition Program as a model determining the eligibility length of time that qualifies a person as "recently released" from incarceration.** The NC FIT program offers assistance to people during reentry and up to 2 years after release (FIT (Formerly Incarcerated Transition) Program, n.d.).
3. The NC AHEC system is **in favor of further inclusion of evidence-based services to the Pilot**. Support for expanded services include:
    a. Additional clarification is needed to define who qualifies as a "high-needs enrollee" to receive the newly proposed 6-month rental and arrears assistance services in the housing domain.
    b. Firearm-related deaths were the leading cause of violent deaths in North Carolina in 2020; that year, 1,651 deaths in North Carolina were due to firearms (15.6 deaths per 100,000), according to the NC Violent Death reporting System (2020). Firearm deaths among children 0-17 have increased in recent years by 231.3% from 2012-2021. In 2021, firearms were the lethal means used in over 70% of suicides and homicides, even higher (83%) for suicides and homicides among children 15-17 *(NC Child Fatality Task Force Annual Report to the Governor and General Assembly, 2023)*. Including evidence-based injury prevention services to HOP members may improve health outcomes by reducing injury and mortality related to firearms. We acknowledge that firearm safety may be a sensitive subject for members and Pilot staff to address. Additional resources and training may be needed to support these conversations. **The NC AHEC system has experience providing training related to facilitating conversations between healthcare providers and patients regarding firearm safety (Firearm Safety Counseling in Primary Care, 2023) in addition to training on having other**

difficult conversations with patients (e.g., Close Encounters of the Medical Kind: Conversations Related to Opioid Prescribing and Other Topics).

c. Further injury prevention could be supported by **implementing additional services to distribute medication storage boxes** to help patients adhere to taking medications as prescribed (CMS includes medication adherence in several quality measures including for diabetes (436), cholesterol (435), hypertension (437), and schizophrenia (18) (Centers for Medicare & Medicaid Services Measures Inventory Tool, n.d.). Safe storage of medication may reduce instances of accidental poisoning, sharing, or stealing of medication. Information regarding proper medication disposal practices could accompany this service.

d. The opioid epidemic continues to be a pressing public health challenge in North Carolina (Between 2000 and 2019 over 16,500 North Carolinians died from unintentional opioid-involved overdose deaths) (NC DHHS, 2021). As the waiver proposal includes expanding eligibility to people with a substance use disorder, NC DHHS may consider the **inclusion of education or access to Naloxone** (the opiate overdose reversal drug), in addition to connection with other harm reduction services such as needle exchange, for HOP eligible members who use opioids or who live with someone who uses opioids.

4. The NC AHEC system is in favor of the request for additional capacity building funds for the purposes specified in the proposal.

   a. **Training and Technical Assistance: Proposing a Core Curriculum for HSOs**. The NC AHEC system suggests that a strategic training plan accompanies statewide expansion efforts to develop a consistent and comprehensive baseline among new Human Services Organizations as they onboard into the Pilot. Currently, HSO training is the responsibility of each regional Network Leads *(Network Lead-HSO model contract,* 2021). In this second Pilot period, there is an opportunity to develop a core curriculum for HSOs, leveraging the existing training and lessons learned. The NC AHEC system could develop this curriculum in partnership with Network Leads. The core curriculum could provide a consistent baseline knowledge and common vocabulary between HOP partners across the state. In addition to the core, Network Leads could develop and lead specific regional trainings in response to their regional needs. This would alleviate the training burden on new and existing Network Leads.

   b. **Training and Technical Assistance: Including Care Manager training in capacity building plans.** Currently, the NC AHEC system provides Pilot training for Care Managers through philanthropic grant funding from the Kate B. Reynolds Foundation. This funding extends through April 2024. As the Pilot expands, there will be a need to train care managers on best practices working with newly eligible populations and changes in the program process and policy. Ensuring this workforce has access to training resources is a vital part of Pilot capacity building.

   c. Community Engagement/Training and Technical Assistance: **NC AHEC Practice Support Specialists may be a resource to promote awareness and engagement of the Pilot among clinicians.** Practice Support specialists assist providers in primary care, specialty, and behavioral health settings to adapt to new payment models and health care reforms while maintaining a focus on patient-centered care (*Practice Support: What we do,* n.d.). Practice Support staff are currently funded through Medicaid to support Managed Care implementation and optimization. Practice Support coaches may be available to raise awareness of and support providers interested in participating in HOP to develop workflows

for effectively engaging eligible beneficiaries. Engagement with practices may increase enrollment and balance use of services, such as Diabetic Nutrition services that have been underutilized. The NC AHEC system welcomes partnership with Network Leads, Care Management Entities, Health Plans and NC DHHS to leverage this resource.

d. Community Engagement: The NC AHEC system identifies community health workers, peer support specialists, and breastfeeding peer counselors, among others, as critical community-based resources who may already engage with individuals eligible for HOP services. These groups should be considered as **Pilot partners who may be able to support the No Wrong Door approach to enrollment** to connect individuals and serve their health-related social needs in addition to the non-pilot services they offer. NC DHHS may consider approaching these resources as a continuation of community engagement activities.

5. Additional considerations and suggestions for waiver renewal:
    a. **The NC AHEC system requests the Centers for Medicaid and Medicare Services address barriers caused by the existing definition of "health care operations" and "treatment" under the HIPAA Privacy Rule**. Specifically, to include unmet social need resource coordination as falling under the definition of "health care operations". Currently providers are required to gather additional consent forms from patients to refer them into the HOP system if they are not part of the NCCARE360 system. Many providers have not fully implemented NCCARE 360 due to the additional staffing needed to manage referrals. This additional need for formal consent is a barrier for both beneficiaries and providers.
    b. The NC AHEC system suggests requesting **further engagement of clinical providers in the Pilot, with one strategy including reimbursement for conducting SDOH screenings**. Subject matter experts have shared that providers are reluctant to conduct screening without this reimbursement. Additional screening through clinical providers may increase enrollment and reduce the time between diagnosis of a physical eligibility criteria condition and referral into the Pilot, thus building a more robust holistic care system. Currently, providers engaged in the NC InCK program utilize HCPCS (G codes) and ICD-10 (Z codes) for reimbursement when screening for food and housing needs (*New Billing Codes for Social Drivers of Health, 2022*).
    c. **The NC AHEC system recommends continued investment and improvement to coordinate and integrate Health IT systems**. Current practices involve duplication when storing information in NCCARE360 and the Electronic Health Record; this places an additional burden on Care Management Entities and Health Plans to track Pilot activities and data in multiple places.
    d. **The NC AHEC system supports investment in accessible and timely data sharing between Pilot partners**. This request was central during the Statewide Healthy Opportunities Pilot conference in August 2023. Partners across regions expressed a need for more access to Pilot data to enhance their service delivery and monitor their impact.

References

Cecil G. Sheps Center for Health Services Research. (2023, March 24). *Rapid Cycle Assessment 1: NC Healthy Opportunities Pilots.* North Carolina Department of Health and Human Services – Division of Health Benefits. nc-medicaid-reform-demo-healthy-opportunities-pilots-rapid-cycle-assessment.pdf

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Firearm safety counseling in primary care. (2023). South East Area Health Education Center. Firearm Safety Flyer (nhrmc.us)

FIT (Formerly Incarcerated Transition) Program (n.d.). The Center for Community Transitions. FIT (Formerly Incarcerated Transition) Program - Center for Community Transitions

North Carolina Child Fatality Task Force Annual Report to the Governor and General Assembly. (2023, February). North Carolina Child Fatality Task Force. 2023 CFTF Annual Report (ncleg.gov)

New Billing Codes for Social Drivers of Health. (2022, May 20). NC Medicaid Division of Health Benefits, NC DHHS. New Billing Codes for Social Drivers of Health | NC Medicaid (ncdhhs.gov)

Network Lead-HSO Model Contract. (2021, October). North Carolina Department of Health and Human Services. https://www.ncdhhs.gov/network-lead-hso-model-contract/download?attachment

North Carolina Department of Health and Human Services. (2021, March). Opioid-Involved Overdoses, 2019. NC DHHS. OpioidFactsheet-FINAL.pdf (ncdhhs.gov)

North Carolina Violent Death Reporting System (2020). North Carolina Department of Health and Human Services, NC Injury and Violence Prevention Branch. Workbook: NCVDRSDashboard (ncdhhs.gov)

Practice Support: What we do. (n.d.) North Carolina Area Health Education Center. What We Do | NC AHEC

PESA Companion guide. (n.d.). North Carolina Department of Health and Human Services. https://www.ncdhhs.gov/pesa-companion-guide/download?attachment

Van Vleet, A. and Ludlam, J. (2023, April 27). *A First Look: Highlights From North Carolina's Healthy Opportunities Pilots*. Manatt, Phelps & Phillips, LLP. A First Look: Highlights From North Carolina's Healthy Opportunities Pilots - Manatt, Phelps & Phillips, LLP

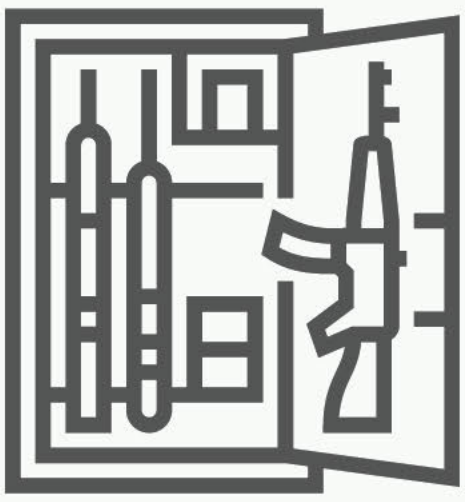
SEAHEC
PART OF NC AHEC

Firearm Safety

Studies show that hiding a gun is not enough. Kids usually know where a family keeps a gun in the home!

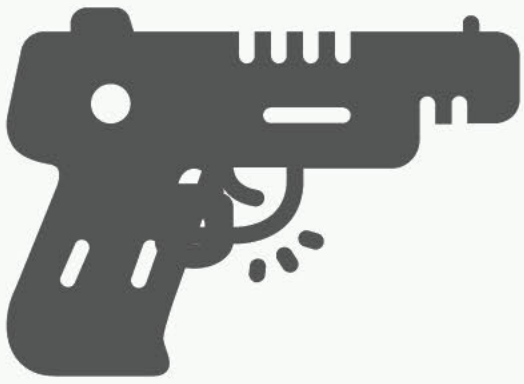
Properly storing firearms will lower the risk of a child getting hurt!

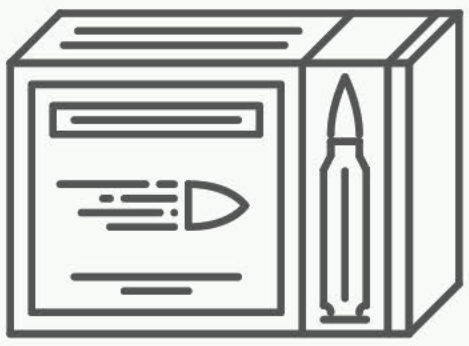
Handguns should be stored in a safe or lockbox



Rifles should be stored in a locked gun safe for rifles

Guns should have gun trigger locks





Ammo should be stored in a SEPARATE lock box from other firearms

Scan the QR code for more information:

FIREARM SAFETY

DID YOU KNOW?

01 According to NC S.A.F.E., firearms are the leading cause of injury-related death for children and youth in North Carolina

02 All firearms should have a trigger lock, or be kept in a gun lockbox; ammo should be stored in a separate lockbox from the firearms

03 The ASK Initiative (Asking Saves Kids) encourages parents to ask "Is there an unlocked gun in your house?" before letting your child play

04 By the age of 3, most children are strong enough to pull the trigger on a hand gun

SCAN THE OR CODE BELOW FOR MORE INFORMATION

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QUESTIONS TO ASK

Is your child going to a friends house for a playdate? Don't be afraid to ask questions about firearms in the home!

Always ask "Do you have guns in your home?"

If the answer is "Yes, we do have a gun in the home"

Respond by asking how the firearm is stored

If it is not stored properly, ask if that child can play at your house instead

Remember, Asking Saves Kids!

Scan the QR code for more information:

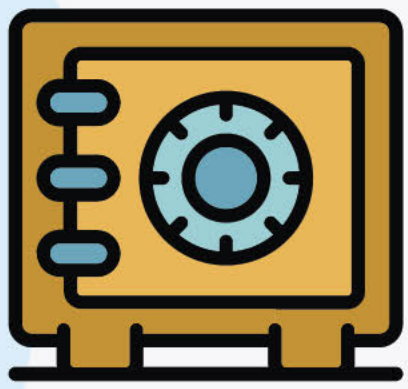
SEAHEC
PART OF NC AHEC

FIREARM SAFETY FOR FAMILIES

Children are curious by nature, especially about things you tell them not to touch, such as firearms.

Kids are **SAFER:**

With guns and firearms stored in a safe or lockbox UNLOADED. Amunition should always be stored separately!



Kids are **SAFEST:**

When guns and firearms are stored in a safe or lockbox UNLOADED. Ammunition should always be stored separately!

Scan the QR code for more information:

SEAHEC

PART OF NC AHEC

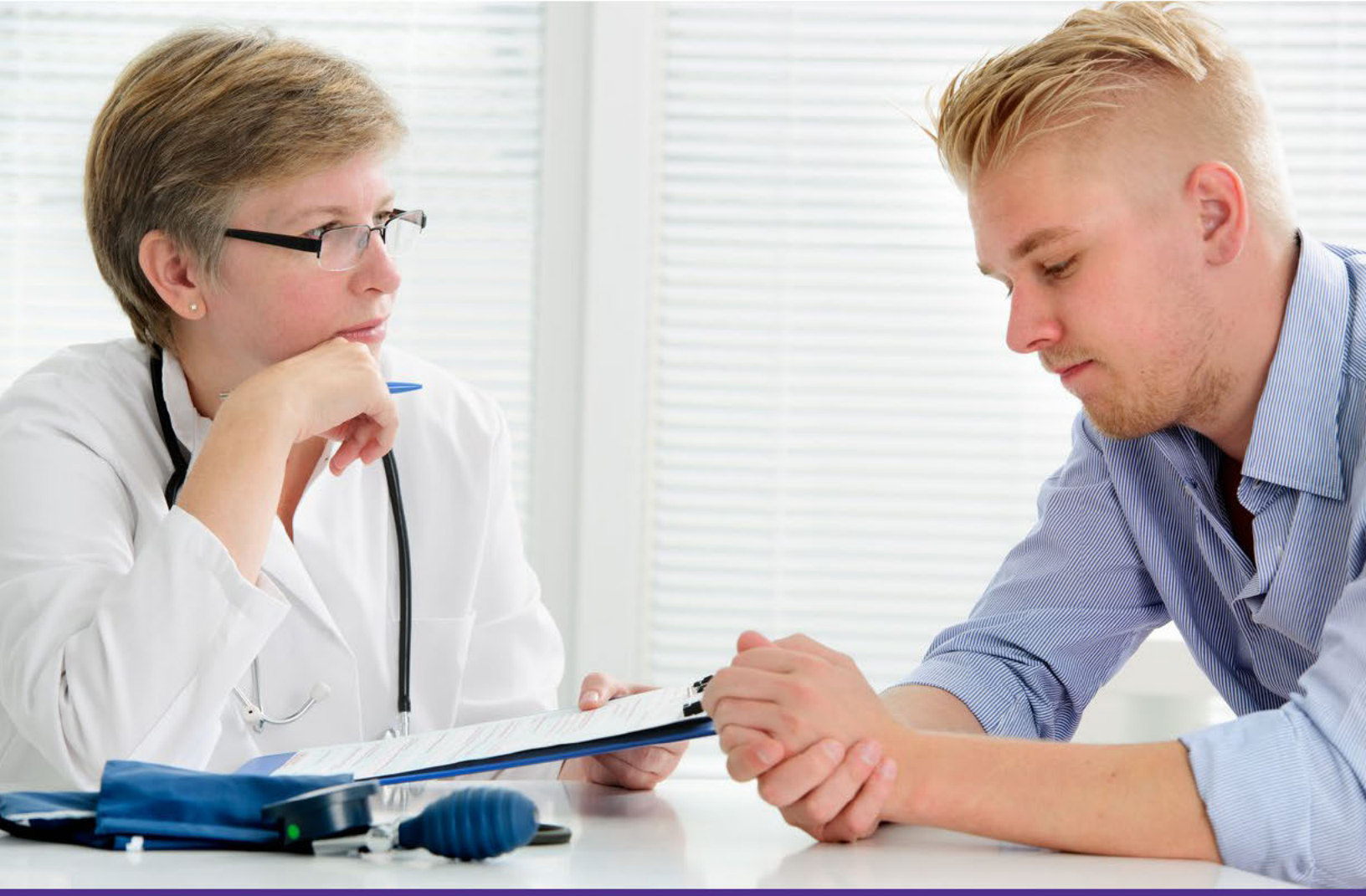
FIREARM SAFETY FOR TEENS

ALWAYS provide safety training and parental supervision and DO NOT let their friends handle the firearm

Parents should have full control of firearm access until AT LEAST age 18

All firearms should have a trigger lock and/or be stored in a gun lockbox

Scan the QR code for more information!



Close Encounters of the Medical Kind: Conversations Related to Opioid Prescribing and Other Topics

June 14, 2018

5:30-7:30 p.m.

Carteret Health Care
Meeting Room 3
3500 Arendell St.
Morehead City, NC

Jointly provided by:
The Office of Continuing Medical Education of the Brody School of Medicine at East Carolina University
and Eastern Area Health Education Center Department of Nursing and Allied Health Education.

ECU BRODY SCHOOL OF MEDICINE

EASTERN AHEC
Area Health Education Center

Close Encounters of the Medical Kind: Conversations Related to Opioid Prescribing and Other Topics

Program Description

Participants of this skills based program will have the opportunity to learn and practice effective interpersonal communication skills during emotionally charged encounters with standardized patients. Challenging topics such as opioid and stimulant prescribing, dementia and domestic violence will provide the backdrop for practicing essential communication skills.

Target Audience

This program has been planned for providers including Physicians, Nurse Practitioners and Physician Assistants

Objectives

At the conclusion of this competency based program, participants will be able to:

- Recognize effective interpersonal communication strategies for difficult conversations in the clinical setting
- Examine communication skills during difficult conversations
- Demonstrate appropriate techniques during emotionally charged conversations with patients or family members
- Evaluate interactions based on scenarios with standardized patients

Faculty

Pamela D. Hopkins, PhD
School of Communication
East Carolina University

Please bring a sweater or jacket to ensure your comfort.

Agenda

June 14, 2018

5:00 p.m. Sign In and box dinner

5:30-6:00 p.m. Setting the Stage: Communications Strategies

6:00-7:30 p.m. Scenarios and Debrief with Standardized Patients

Credit

ACCREDITATION: This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Brody School of Medicine at East Carolina University in association with the Eastern Area Health Education Center. The Brody School of Medicine at East Carolina University is accredited by the ACCME to provide continuing medical education for physicians.

CREDIT: The Brody School of Medicine at East Carolina University designates this live activity for a maximum of 2.0 AMA PRA Category 1 credit(s) ™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Other Professionals:
2.0 EAHEC Contact Hours

Planning Committee

L. Lorraine Basnight, MD, FAAP
Executive Director, Eastern AHEC
Associate Dean, CME, ECU BSOM

Laura Bliley, MSN, RN
Assistant Director
Nursing and Allied Health Education
Eastern AHEC

Maria C. Clay, PhD
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Office of Clinical Skills Assessment and Education
ECU BSOM

Pamela D. Hopkins, PhD
Associate Professor
College of Communication
East Carolina University

Tonia Joyner, MS, LCAS
Assistant Director
Mental Health Education
Eastern AHEC

Patrick Merricks, MBA
Associate Director/Standardized Patient Trainer
Office of Clinical Skills and Assessment Education
ECU BSOM

Faculty Disclosure:
In order to ensure balance, independence, objectivity and scientific rigor in all CME presentations, teaching faculty, planners and reviewers are required to disclose any financial or other relationship they have with commercial entities – pharmaceutical, equipment or other for-profit corporations – that could be construed by learners as posing a possible conflict of interest. Neither the physician director, Lorrie Basnight, MD, FAAP, the planners or reviewers nor faculty have financial or other relationships with ANY relevant commercial interest and none are aware of personal conflicts of interest related to this program.

Registration Information

Register online at **www.easternahec.net**.

There is no fee for this program. Space is limited for this simulation based activity, **so early registration is recommended.**

Eastern AHEC now requires a MyAHEC account to register for programs. Please create or update your MyAHEC account at **my.ncahec.net.**

By attending this event, I acknowledge that Eastern AHEC staff and/or their designees including news media may take general (not close-up) photos or videos of this event for marketing/publicity purposes, and I further allow my likeness to be used in this manner. If I do not wish to appear in these photos or videos, I understand that it is my responsibility to notify Eastern AHEC staff so my preference can be met.

Cancellation Policy

Cancellations must be emailed to easternahec@ecu.edu at least one week in advance of the activity. Substitutions are welcome; advance notification encouraged.

Evaluations

The program evaluation will be sent within 3 business days following the program by email. Once you complete the evaluation, your certificate will be populated with the hours awarded.

Americans with Disabilities Act

Individuals requesting accommodation under the Americans with Disabilities Act (ADA) should contact the Department of Disability Support Services at (252) 737-1016 (V/TTY) at least five business days prior to the program.

For more information, please contact Akshata Malur at 252-744-5211 or malurak17@ecu.edu.

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 4:56:21 PM

To Whom it may Concern,

Below is our feedback for the NC Section 1115 Waiver. Thank you!

Service Delivery/Reimbursement

Moving forward, our organization hopes to see a reimbursement rate that better reflects the true cost of producing, packing, storing, and delivering healthy meals and medically tailored meals. At the current per meal reimbursement rate, our organization will begin to lose a significant amount of money once we deplete our capacity funding.

A recent study of similar healthy meal delivery programs around the country found that the average total intervention cost was $9.20 per meal "based on 2019 contracts with health systems and payers among 11 Medically Tailored Meal organizations" (1-pager here, full study here). With a per meal reimbursement rate that more closely reflects the true cost of meal production and is more in line with the national average, our small business will be more able to achieve financial sustainability and can continue to expand without as much need for additional capacity funding and capital investment.

Our organization's mission is to support community members who are experiencing chronic illness and food insecurity by producing and delivering nutritious, wholesome meals using locally-sourced ingredients. Because we produce our meals in North Carolina, we are able to support our local economy through partnerships with NC farmers, food hubs, food cooperatives, and community kitchens. Using high-quality, local ingredients and maintaining robust nutrition standards means that all of our HOP members receive their recommended daily intake of whole grains, vegetables, and protein, meeting or exceeding the nutrition requirements outlined by the state. A higher per meal reimbursement rate would allow us to continue to support our local economy, pay farmers their fair share, and keep meal production within our state and communities.

Service Delivery/Reimbursement

The service definition for Medically Tailored Meal (MTM) program requires organizations to have a Registered Dietitian complete a clinical nutrition assessment for each member at the onset of their time in the MTM program. Based on the cohort of MTM members we currently have, that initial intake takes our RD about 1.5 hours per client, which includes a phone call to walk through the initial nutrition assessment, answer questions, take copious notes, assign members to the appropriate meal plan, and coordinate with our meal production team. The cost of this work is not reflected in the reimbursement rate. Currently, there is no additional reimbursement for the time it takes our RD to complete the initial intake, and there is no reimbursement for the follow-up she completes throughout the course of the member's time in the program. Based on NCDHHS's Division of Health Benefits Dietary and Nutrition Services

Fee Schedule, an initial medical nutrition assessment administered by a registered dietitian outside of a facility is $31.46 for every 15 minutes spent with the member. Moving forward, we hope the state will consider compensation in line with these numbers.

Service Delivery

We think that the state should strongly consider in its Medically Tailored Meal (MTM) service definition more robust clinical nutrition assistance from an RD. Other flagship MTM organizations that we've talked with emphasize that clinical, individualized nutrition education with a Registered Dietitian is incredibly important to the success of their MTM programs, leading to better health outcomes, fewer return visits to the hospital, and more overall service satisfaction.

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 5:00:51 PM
Attachments: image002.png
image003.png
image004.png
image005.png
image006.png
9.20_1115WaiverComments_CSHA.pdf

Good afternoon,

Please see our comments on behalf of Care Share Health Alliance.

Thank you,

Jalah Clayton, MPH (She/Her) -what's this?
Director of Innovation and Capacity Building
Care Share Health Alliance
1631 Midtown Pl., Suite 104
Raleigh, NC 27609
(919) 861-8360
[redacted]

Visit our new **Equity+** Network
for CBO resources and support:
www.equitypn.org

"The greatness of a community is most accurately measured by the compassionate actions of its members." – Coretta Scott King

September 20, 2023

North Carolina Department of Health and Human Services
NC Medicaid Section 1115 Waiver Team
1950 Mail Service Center
Raleigh, NC 27699-1950

Re: **North Carolina Medicaid Reform Section 1115 Demonstration Renewal Application;** (August 21, 2023)

Dear NC Medicaid Section 1115 Waiver Team,

Please see below our comments regarding the NC Section 1115 Waiver application on behalf of Care Share Health Alliance:

Care Share Health Alliance **strongly supports** the following items in the state's draft application:

- Whole-person integrated approach to care supported by a care management model.
- Expansion of pilot eligibility to include all pregnant and postpartum women, justice-involved individuals, those who are "at risk of" a chronic condition, individuals with only one chronic health condition, individuals recently impacted by natural disasters, children/youth who receive adoption assistance and all Tailored plan members and Tailored Care Management eligibles in prepaid inpatient health plan (PIHP).
- Expansion of meal services to three meals per day.
- Availability of consistent and adequate capacity building funds throughout the demonstration waiver period.
- Procurement of new Network Leads in expanded pilot regions, particularly in regions that applied, but were not previously selected as leads
- Health Plan and HSO flexibility to contract directly with one another
- Engaging with external partners to provide training and technical assistance

Care Share Health Alliance believes the following items can be **improved to maximize the program's impact:**

- Prioritize direct investments in community-based organizations and local service delivery models.

- Increase capacity building budget allocation and significantly increase fee schedule payments to ensure there are sufficient and sustainable resources for human service organizations (HSOs) and NLs to scale pilot services across all 100 NC counties.
- Provision of additional unrestricted funding to support HSO scalability and overall equity among participating HSOs.
- Refine language around rental assistance to include:
    - up to six months of rental assistance including payment of arrears
    - for all enrollees who demonstrate need (not just high-needs enrollees).

Care Share Health Alliance **requests the clarification, modification or additions** of the following items:

- Expand eligibility to include all NC Medicaid members—regardless of coverage type—who screen positive for a pilot-supported social health need.
- Clarify HOP eligibility of Medicare/Medicaid dual enrollees.
- Include all HOP services in pre-release Medicaid services available to justice involved individuals.
- Allow continuous access to HOP services for justice-involved individuals for 1-year post-release.
- Added supports to integrate Community Health Workers (CHWs) as a proven workforce to meet community needs beyond traditional healthcare. This integration will support the development of local community support networks, increased community engagement, and expanded capacity for currently involved pilot entities by:
    - continuing to support CHWs ability to apply as care management extenders within Tailored Care Management, by removing the barrier posed for CHWs to have high school diploma or equivalent qualification, especially since this is not required to access or enroll in the SCCT, nor is it required for certification
    - directly invest in the CHW workforce, which has demonstrated its capability to identify and engage individuals with unmet needs, to incorporate CHWs as key players in the successful expansion of HOP
    - involve CHWs in the feedback process of technology platform changes to ensure NCCARE360 is optimally tailored to better serve their communities. We strongly recommend addressing interfaces to address the platform's usability and impact to ensure alignment between CHWs, CBOs and health systems.
    - Continue initiatives to support CHWs with recruitment and retention payments, as provisions like childcare and transportation subsidies directly address some challenges faced by CHWs. We seek clarification on the eligible training programs for funding.

Additional Recommendations

Fee Schedule Improvements

- Standardize fee schedule statewide to reduce the potential for confusion, referral delays and rejections.
- Increase alignment between the fee schedule and actual cost of delivering service, accurately adjusted for inflation, especially related to food, housing and transportation services.
- Review all services to ensure a coordination or admin fee is included.

Network Development

- Give contracting preference and/or incentives to local, community embedded HSOs to promote equity and improve pilot enrollment, member satisfaction, expansion of services/geography and culturally inclusive service delivery.
- Prioritize and incentivize local health and social service agencies to participate in the pilot.
- Provide ongoing capacity building funding to support NLs who play a critical role in developing and maintaining network diversity, capacity and sustainability.
- Strengthen and expand NL's role to ensure pilot success by:
    - providing NLs with access to detailed member eligibility lists to allow NLs to build enrollment penetration maps by zip code, county, domain and/or attributed practice,
    - partnering with NLs to create and implement a comprehensive communications and public relations strategy.
- Strengthen and expand HSOs role to ensure pilot success by:
    - funding existing HSOs at a capacity that allows them to effectively and consistently deliver services
    - funding platforms that encourage shared learning and networking opportunities across regions and service domains
    - engaging HSOs in neutrally convened spaces as representative community experts in state-level decision-making related to the Pilot, especially considering their proximity to the daily operating successes and challenges of Pilot activities

Digital Platform & Billing Process Improvements

- Develop a clear pathway and process to support data sharing between pilot stakeholders to ensure NLs can make data-driven decisions and conduct continuous quality improvements.
- Improve the accuracy and efficiency of the pilot's digital billing processes by implementing technical solutions that:
    - standardize billing practices using 837 and 835 data sets,
    - integrate benefits inquiries and responses (270/271 data sets) to provide HSOs with real-time access to client eligibility data, and
    - improve the user experience by providing functionality for data searches, claims management, and elimination of duplicate claims.

Compliance and Quality Assurance

- Require HSOs who directly contract with PHPs to participate in NL compliance activities to ensure network adequacy and service delivery quality.
- Increase accountability and transparency around PHP responsibilities regarding care management network adequacy, quality improvement, and payment processes.

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 2:44:09 PM
Attachments: NCCHWA Comment Letter NC Section 1115 Waiver (1).pdf

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Good afternoon NC Medicaid Section 1115 Waiver Team,

Please find attached, the North Carolina Community Health Worker Association comment letter for the NC Section 1115 Demonstration Waiver.

Thank you,
Honey

--
Honey Yang Estrada, MPH, CHW
President
North Carolina Community Health Worker Association
[redacted]
704-659-6947

¿Prefiere español?
Contacto Lupe Avalos
704-313-8836
[redacted]

NORTH CAROLINA
Community
Health Worker
ASSOCIATION

September 20, 2023

North Carolina Department of Health and Human Services
NC Medicaid Section 1115 Waiver Team
1950 Mail Service Center
Raleigh, NC 27699-1950

Re: North Carolina Medicaid Reform Section 1115 Demonstration Renewal Application; (August 21, 2023)

Dear NC Medicaid Section 1115 Waiver Team,

The North Carolina Community Health Worker Association (NCCHWA) writes to provide comment on the North Carolina Medicaid Reform Section 1115 Demonstration Renewal Application, published on August 21, 2023.

NCCHWA's mission is to advance Community Health Worker (CHW) voices and elevate the health of communities. We advocate for CHWs to be deeply woven into the fabric of our systems as the local solution to public health delivery. Although NCCHWA formed in 2021, we have been actively leading CHW initiatives across NC since 2014. We have key partners across the state including community-based organizations, North Carolina Department of Health and Human Services (NCDHHS), institutes of higher education and area health education centers. Our teams include CHWs and allies with rich, lived experience as well as unique and diverse perspectives from various settings. We have developed a standardized core competency training (SCCT) curriculum, which is currently being taught by CHWs at 13 community colleges across our state. NCCHWA has certified over 800 CHWs within the past year and a half and have recently launched advanced certification levels to promote the advancement and pathways for CHWs in NC.

We are thankful for the opportunity to comment on the Medicaid Reform Section 1115 Demonstration Renewal Application, and would encourage the Division of Health Benefits to prioritize the full implementation of the North Carolina Medicaid's CHW Strategy, introduced in February 2023, which would significantly expand access to CHW services for clients across North Carolina and be complementary to the programs carried out under the 1115 waiver.

We commend the successes of the Medicaid Reform Demonstration in responding to the diverse needs of Medicaid beneficiaries in the state, most notably the launch of Standard Plans and implementation of the Healthy Opportunities Pilots (HOP) program. We welcome the continuation of programs under the current demonstration and look forward to the implementation of the new initiatives proposed in the renewal. We believe that the renewal application provides a promising foundation for Medicaid reform in North Carolina, however, NCCHWA emphasizes that the success of these programs is dependent on the meaningful inclusion and support of CHWs. While there was tremendous attention on this workforce during the COVID-19 pandemic, CHWs have been leading change in communities for decades. For years, CHWs have served as liaisons and bridges between communities and various systems.

Because they are trusted members of the community they serve, CHWs are able to reach vulnerable and under-resourced communities to provide education, outreach, social support and address a variety of gaps. During the pandemic, CHWs served over 3.3 million North Carolinians, reached over 1.7 million people with health education, scheduled over 52,000 vaccines and made over 140,000 referrals to address social drivers of health. CHWs are a proven workforce and their adaptability makes them a value add to our systems.

We have organized our responses based on the renewal's three objectives:

Objective 1: Support a continued, smooth transition to managed care with a focus on improving care for enrollees with the most complex needs

Recognize CHW workforce strengths and functions in the transition to managed care

NCCHWA emphasizes the pivotal role CHWs play in NCDHHS's transition to Medicaid managed care. As the state evolves its approach to improve the health and wellbeing for all North Carolinians, the expertise and versatility of CHWs have already been proven invaluable in enhancing the service experience of Medicaid enrollees.

With the rollout of Standard Plans, **CHWs have been important in bolstering care management engagement, outreach, education, health promotion, and facilitating connections to social services. NCCHWA recommends the continued integration of CHWs in the implementation of Standard Plans as well as the launch of the Tailored Plans and the Children and Families Specialty Plan.** NCCHWA believes that the involvement of the CHW workforce will be essential in aligning with the department's vision of a seamless transition to managed care and improving the quality of care for enrollees with the most complex needs.

Promote CHWs as Care Manage Extenders

NCCHWA is delighted that CHWs will be able to apply as care management extenders within Tailored Care Management. While we commend the state for recognizing that completing the NC CHW SCCT qualifies CHWs for these extender roles, **NCCWHA would like to highlight that the high school diploma or equivalent qualification poses a barrier for CHWs. NCCHWA strongly encourages reevaluation of this recommendation.** Having a high school diploma or equivalent is not required to access or enroll in the SCCT nor is it required for certification.

Objective 2: Strengthen access to a person-centered and well-coordinated system of care which addresses both medical and non-medical drivers of health

Incorporate CHWs as key players in the successful expansion of HOP

Being the nation's first comprehensive program to test and evaluate the impact of evidence-based, non-medical interventions, the Healthy Opportunities Pilots (HOP) program has made significant strides in responding to needs related to housing, food, transportation and interpersonal violence and toxic stress.

Witnessing the success of HOP in the three pilot regions, NCCHWA supports the request to expand the program statewide, modify services, and broaden eligibility to high-need individuals; illustrating the state's commitment to addressing social determinants of health but also ensures that vulnerable populations have access to vital resources they need.

While we support the expansion of both geographic reach and eligibility criteria, NCCHWA calls attention to the pressing need to invest in the CHW workforce. CHWs are key players in the care management team with roles that are essential to the program's success like screening individuals for eligibility and connecting enrollees to relevant services. CHWs also ensure that enrollees are able to successfully navigate the services offered, maximizing the benefits provided.

As HOP expands statewide, CHWs will be critical in actively engaging with populations that have historically been neglected including rural, non-English speakers, and transient populations. Efforts to enroll and engage in these populations will require targeted outreach strategies and working with trusted CHWs to meet people where they are to ensure equitable access to all resources. CHWs have not only been instrumental in HOP enrollment but have also played a vital role in other NCDHHS initiatives, such as the COVID-19 Support Services Program, where the state deployed CHWs to enhance awareness and utilization of services. **Given their proven track record, we recommend that the state directly invest in the CHW workforce, which has demonstrated its capability to identify and engage individuals with unmet needs.**

Mobilize CHWs to support justice-involved individuals

NCCHWA commends the state's proposal to enhance the health outcomes of justice-involved individuals by offering targeted Medicaid services in the 90 days leading up to their release. CHWs are well equipped to support these efforts, particularly with case management services. Drawing from similar program experiences such as North Carolina's Formerly Incarcerated Transition (FIT) Program, CHWs have demonstrated their expertise in linking individuals to health and social support services. The program employs CHWs with personal incarceration histories, leveraging their unique experiences to build trust and guide individuals during their reentry process. While the program's primary focus is on post-release support, the program's principles can be applied to the 90 days preceding release. **NCCHWA advocates for NCDHHS harnessing the potential of CHWs in this field, recognizing that there are already CHWs with lived experience who are leading efforts in this space and providing subject matter expertise. By facilitating early relationships with clients, assessing their needs, crafting person-centered plans, and ensuring proper linkage and referrals, CHWs can create a solid foundation that significantly enhances successful reintegration post-release.**

Enhance and refine NCCARE360

NCCHWA has received feedback from many of our CHWs and community based organizations (CBOs) regarding the NCCARE360 platform. While its foundational concept is commendable, several practical challenges prevent optimal utilization, including the lack of a mobile application option. We favor and support the proposal to make the platform more user-friendly. Among the primary concerns raised are the need for a consistently updated list of available services, comprehensive training to adequately navigate the platform, and a more streamlined referral management with a quicker response time. It is worth noting that in response to these challenges, some CBOs have found it more effective to rely on their independent resource lists, which are more current and reliable than what is offered in NCCARE360. Furthermore, the inability of NCCARE360 to interface with electronic health records (EHRs) has been a significant barrier for health systems and impacts CHW and CBO workflows. This lack of integration prevents seamless information exchange and care coordination, hindering the platform's effectiveness in providing holistic support to community members. This inability to interface causes CHWs and CBOs to perform redundant work, adding frustration and increasing administrative burden.

NCCHWA recommends that CHWs be involved in the feedback process of platform changes to ensure NCCARE360 is optimally tailored to their needs, enhancing their ability to better serve their communities. NCCHWA strongly recommends addressing interfaces to address the platform's usability and impact to ensure alignment between CHWs, CBOs and health systems.

Improve payment mechanisms for Community Based Organizations (CBOs) serving as Human Service Organizations (HSOs)

CBOs who serve as HSOs have encountered several challenges with payment mechanisms. The complex reimbursement processes which often involve multiple steps, documentation requirements and delays in receiving payments causes much strain on the limited resources of these organizations. CBOs have also voiced that reimbursement rates are insufficient to cover the cost of services delivered. These organizations often have to rely on other funding to operate. **NCCHWA recommends that NCDHHS prioritize feedback from CBOs contracted for these pilot services regarding enhancements to payment mechanisms.** This would not only ensure that these CBOs can effectively deploy CHWs but would also strengthen the overall infrastructure of community-based health support in the state.

Objective 3: Strengthen the behavioral health and I/DD delivery system

Champion CHWs within the behavioral health and LTSS workforce

NCCHWA appreciates that CHWs are named as part of the behavioral health and long-term services and supports workforce. CHWs play a vital role in enhancing behavioral health services. These roles include: outreach and education; screening and referral; system navigation; cultural mediation. **We applaud the initiative to support CHWs with recruitment and retention payments, as provisions like childcare and transportation subsidies directly address some challenges faced by CHWs. NCCHWA seeks clarification on the eligible training programs for funding.** We emphasize the importance of the NC CHW SCCT as a valuable resource.

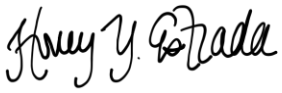
While the proposal outlines loan repayments for specific professions, we recommend NCDHHS to recognize the education and training investments made by CHWs in serving our communities that are outside the conventional bachelor's and master's degrees.

Conclusion

NCCHWA appreciates the opportunity to comment on the proposed renewal and looks forward to continued collaboration. The Medicaid Reform Demonstration's approval in October 2018 marked a pivotal step forward in improving the health and well-being of all North Carolinians. With the goals outlined in the 1115 renewal, combined with the potential implementation of the CHW Medicaid Strategy, we are confident that the state will continue to make significant advancements in its commitment to whole person health.

Please reach out to me if there are questions or if we can be of further assistance.

Sincerely,



Honey Yang Estrada, MPH, CHW
President
NC Community Health Worker Association
PO Box 576
Newton, NC 28658

From: [redacted]
To: Medicaid.NCEngagement
Cc: [redacted]
Subject: [External] NC Section 1115 Waiver Trish Farnham/NC COA Comments
Date: Wednesday, September 20, 2023 4:12:41 PM
Attachments: NC COA Comments on NC 1115 Waiver Renewal Submitted 9 20 2023.pdf

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Hello!

I'm pleased to submit these comments on NC's proposed Section 1115 waiver.

As always, please let us know how we can best support the Department's efforts to expand and strengthen NC's direct care/support workforce.

In Common Purpose,
Trish Farnham :)

Trish Farnham (she/her)
NC Coalition on Aging
910.233.2757
[redacted]
https://nccoalitiononaging.org/

To: NC Medicaid Section 1115 Demonstration Renewal Project Team at Medicaid.NCEngagement@dhhs.nc.gov

From: Trish Farnham, Interim Executive Director and Project Lead for NC COA's direct care/support workforce initiatives

Re: NC COA's Comments on the NC Section 1115 Demonstration Waiver Renewal

Date: September 20, 2023

Thank you for this opportunity to comment on the renewal of NC's 1115 Demonstration Waiver.

As someone who has depended on direct care workers and who has been a direct care worker herself, I am pleased to echo the comments NC COA Board Chair Mary Bethel made during the Public Hearing on September 6, 2023 and provide additional information.

The North Carolina Coalition on Aging (NC COA) is a 501(c)(3) organization that works to improve the quality of life for older adults in North Carolina through collective advocacy, education, and public policy work. We have a broad-based membership of advocacy organizations, service providers, trade associations, people who rely on services and family caregivers.

It is widely known that the current direct care/support workforce crisis is a product of fewer and fewer people (traditionally women) available to do this essential but historically devalued work for wages that often demean both the skills the work requires and the workers themselves. This crisis will become worse

with the growth of our older population. By 2028, 20% of North Carolina's population will be 65 or older.

NC COA members are increasingly experiencing situations where older adults and persons with disabilities are not able to receive the assistance they need due to workforce shortages. Individuals who need home or facility-based care are unable to discharge from acute care. And those who are receiving services in the appropriate setting are often not getting the duration or level of care they need.

The Coalition supports the Department's 1115 Waiver Renewal Application.

We specifically thank the Department's $20M designation for:

> "…. recruitment and retention payments for Paraprofessionals, Intellectual and Developmental Disabilities and LTSS Direct Support Professionals and other certified Behavioral Health professionals:
>
> - Sign-on/retention bonuses
> - Childcare subsidies
> - Transportation subsidies
> - Career advancement training
> - Certification/recertification exam fees."

This request is a good faith reflection of the Department's commitment to addressing the workforce crisis. We hope the Department will collaborate with its named workforce development partners, such as WECARE, AHEC, the NC Council on Developmental Disabilities, providers and the Department's own Caregiving Workforce Strategic Leadership Council in shaping and implementing these promising initiatives. But most importantly, we urge the Department to engage *direct care workers themselves, as well as the people and families who depend on them.*

We also ask the Department to go further. Please continue to leverage the power of the 1115 Demonstration Waiver, the resulting managed care contracts *and* other, existing authorities to meaningfully address the direct care workforce crisis.

Recognizing that most older Medicaid beneficiaries are *not* under the Medicaid Standard Plans, we encourage you to explore service models and payment arrangements under *all* appropriate authorities that reflect the following:

- A comprehensive rate-setting strategy that recognizes the skillset required to support a higher acuity population, the full labor costs entailed in providing quality care and the growing scarcity of the workforce itself.
- An examination of direct care/support worker wage disparities among different settings and services. NC needs reimbursement models that better ensure LTSS programs are able to recruit and retain direct care workers equitably and on par with larger health systems.
- An expansion of self-directed models that provide people who use services and their informal caregivers additional options and flexibility.
- Recognition of the direct care/support workforce's need for robust entry-level and ongoing training opportunities, with continuing education and skill building tied to meaningful and competitive wage increases.
- Improved integration of direct care/support workers into care teams.
- Collaboration with the State's own regulatory entities to create flexible, responsive workforce supports. Efforts to expand and sustain this workforce are often made more difficult by NC-specific licensing requirements.
- Value-based arrangements that support and recognize the role direct care/support workers play in improving care, ensuring safe and timely transitions and reducing hospital readmission rates.

We encourage NC to explore the direct care/support workforce strategies within TennCare and other sister state Medicaid programs as it prepares for the 1115 Waiver renewal and upcoming managed care contract development.

Again, thank you for the opportunity to provide these comments. We are steadfast partners in the Department's efforts to address this crisis and look forward to continued collaboration.

From: [redacted]
To: Medicaid.NCEngagement
Cc: [redacted]
Subject: [External] NC Section 1115 Waiver - Public comments (attached)
Date: Wednesday, September 20, 2023 5:20:44 PM
Attachments: NC Section 1115 Demonstration Waiver comments v09-20-2023.docx

Regarding the expansion of Healthy Opportunities statewide:

1. Please consider declaring SDOH referrals as operational data under HIPAA. The perceived nature of existing SDOH assessments and the referral data these assessments generate is such that they fall under protected health information (PHI) without being subject to the needs of operations. The very nature of the referrals creates a need to advance networks of human service organizations (HSO) and other community based organizations (CBO) to both build capacity and respond to the referrals. Allowing the social health needs and SDOH screening results to pass among trusted partner organizations via established Business Associate Agreements (BAA) is suggested as a rational step to supporting the responses necessary to serve more referrals.
2. As additional Lead Pilot Entities are made available to other parts of the state, please consider:
    a. *Awarding a 4th Lead Pilot Entity*. The current 115 waiver allows DHHS to award a 4th Lead Pilot Entity. Our recommendation is for that award to proceed at haste under NCDHHS' sole discretion. Several applications were received during the last competition and questionably disqualified. Although very credible protests were upheld, DHHS has adequate details in hand on whom they might find suitable. Prior applicants could be invited to update prior applications with missing information to shorten a procurement cycle and avoid further delays.
    b. *Elevating some of the existing unfunded pilots that are operating around the state to LPE status* as a way of getting the program operational more quickly. The Duke Margolis Center has researched and documented LPE applicants who initially applied and, although unfunded, provided a SDOH service model to their local communities via a combination of other funding streams. Perhaps NCDHHS could vet potential LPE applicants from existing ongoing efforts as reported by this research organization. At minimum, NCDHHS could give evaluation credit in any future competitive application to community lead organization who have been in continuous service since the last competition.
    c. Should an entirely new LPE application process be deemed as required, we respectfully request *the LPE RFP, and its response begin prior to receiving the any official 1115 waiver renewal*. Evaluation of the responses and tentative awards could be timed to the effective date of the waiver renewal (November 2024) and

the availability of the new capacity building funds as was requested.

3. Develop a shared service model for Lead Pilot Entities (LPEs). There are certain repeatable services which all LPEs will or may need help with while they effectively operate. A centralized business office approach could help DHHS consolidate purchasing, standardize business processes, and provide technical assistance to LPEs as they begin to stand up, continue to operate, and/or expand their geographic service areas.

   NCDHHS could well benefit from the support provided by a dedicated program office that helps them manage reporting across all of the various LPE domains and geographies, accelerates lessons learned from one site to the next, and potentially eliminates underperformance earlier than would otherwise be addressed.

   a. *Consider adding a procurement for an LPE shared services centralized business office location as you expand statewide*. Whether an existing HOP site wishes to apply or a new LPE applicant also wishes to serve in the role, allow the market to respond with capabilities worthy of being evaluated. There are creative ways to fortify the future HOP infrastructure, achieve expense reductions, and achieve scale on administrative tasks that are not well aligned with an LPE's core duties.

3. Consider extending HOP participation to Tailored Plans in order to help individuals with IDD especially those that live independently, with family, and/or in group homes who face SDOH challenges.

Regarding an improved coordinated system of care for people with behavioral health and I/DD needs through targeted new investments in technology:

5. Please consider adding mandatory language to improve IDD counts. Reliable health data is important to supporting people with intellectual and developmental disabilities (I/DD). Being counted is a health equity and civil rights issue. Please consider adding I/DD measures at all levels of city, county, and state governments. Advocates lack access to basic data in order to make a case for support with the exact same agencies who themselves are failing to measure the numbers that make the case in the first place.

   Counties frequently receive urgent calls for support after a caregiver passes away or is hospitalized. It is at this point that an individual with high support needs living in the home is first identified, i.e., when there is a need for immediate transitional housing. This orientation toward reactive services rather than proactive planning is a significant challenge to overcome. With few resources to address the crisis when it occurs, Counties often finds themselves on the receiving end of a long trail of dysfunction and missed opportunities.

   Using demographic data for Forsyth County, a recently funded study found the estimated upper bound of the total population of individuals with IDD is 5,922, based on projections using McBride et al. (2021). Using the slightly higher figure from the NC

Council on Developmental Disabilities we estimate approximately 6,877 individuals with IDD overall in the County. Both numbers are significantly higher than the number receiving Medicaid services.

Although data collection about people with disabilities generally has improved in recent decades, there is still not enough information on how many people with I/DD live in the U.S., how healthy they are, and what things affect their health. Many health surveys exclude questions about I/DD altogether, and when information about people with I/DD is collected, often it lacks other important information like age, sex, ethnicity, and race. In addition, the way data are collected varies widely among states and even within states. In many cases, I/DD is not tracked at all unless a person is receiving services through a state or federally funded program. We have known about this problem for decades, but the COVID-19 pandemic has shown how important it is to have data.

Since 2016, the Administration for Community Living (ACL) has been working with federal agencies and other stakeholders to address these issues through the I/DD Counts initiative. I/DD Counts is a cross-agency initiative to improve how information about health of people with I/DD is collected, analyzed, and understood. I/DD Counts created and updated the 2030 Roadmap for Health Data Equity for Persons with I/DD.

Regarding bolstering the behavioral health and LTSS workforce:

6. Require IDD supports to be measured and reported. Some is not a number and soon is not a time. Right now, individuals who are authorized and budgeted to receive mandatory IDD supports receive zero reporting on what they actually receive. They are not given reports on what was received today, this past week, the most recent month, or over an entire year. Consumers at no point in time are given the courtesy of receiving "budget vs. actual" detail.

   Please suggest 'explanations of benefits' are provided same as one would expect to receive under any other type of medical care. Every year, IDD service consumers are provided 'budget estimates' for their consumption of supports in the year ahead without any discussion or acknowledgement about the performance over the prior period. Require families, guardians, and recipients receive detailed reporting on the actual units, hours, and types of services they received under their most recent service period.

   Accountability for gaps in services is a longer term goal; however, the starting place must be to measure the baseline in order to understand where we are now. How can one suggest (let alone measure) any future policy recommendations when we don't know the current state and/or the recent trends over time? One won't be able to report on the improvements as there are some.

7. IDD Care Plans are universal building blocks for a better system of care. Under this

element we have several asks about a central role for IDD care plans. The care plan should mean something. It should serve to measure the fulfillment of goals over time. Items tracked year to year should include the intensity and types of supports being requested, the individual's choice architecture and what options are being developed, and any perceived risks to their networks of paid/natural supports, such as an aging parent. Both paid and unpaid resources providing support should be measured.

Firstly, *please declare ISP care plans are the property of the individual* and, same as medical records, individuals have the right to access and review what is in the record at any time. Too often today, the care plan is inconsistently maintained, driven by administrative processes rather than goal attainment, and isolated to paid supports.

Secondly, *please encourage care plans to follow more uniform charting standards*. These care plans should contain a minimum set of required data elements with standards similar to the Continuity of Care Document (CCD) and Continuity of Care Record (CCR) which were introduced to begin solving the problem of patient-data portability and interoperability. We believe at minimum that care plans should clearly document (if not illustrate) the existing network of paid and unpaid supports in the life of the individual recipient of services at a given point in time. Networks should be measured at least annually, and changes should be charted over time. Many recipients require 24/7 care although LME/MCOs are likely to only provide some portion of that care. Managing and enhancing robust networks of natural supports should be part of any care plan.

Finally, *require care plans to be interoperable*, i.e., the individual should be able to choose when, how and where to share it with others involved in their care. Reducing the redundant expense of duplicating care plans within various levels of the behavioral health system, among medical providers, and within community agencies should be a primary goal. Nonprofit agencies and Day Programs often must redo work that is already well documented elsewhere.

Regarding coverage for Justice-Involved Reentry:

8. Individuals with disabilities can end up in the justice system, too. The plan to support individuals with Medicaid prior to release should include:
    a. *Assignment to a medical home prior to release*. FQHCs, Free Clinics, and Public Health Departments have historically been among the most practiced primary care safety net providers for helping people re-enter society as they typically waited for their Medicaid coverage a month or more. Formalize the assignment of individuals to a Medicaid medical home as part of the re-entry process.
    b. *Complete SDOH screenings prior to re-entry*, as realistically possible.
    c. *Get Tailored Care Management engaged.* LME/MCOs are already prepaid for service provision within a defined geographic service area. The LME/MCO care coordinators should be engaged for all populations with high support needs,

including the justice involved. Care Coordinators well versed in helping people with high support needs find and make use of resources like peer supports and other persons with lived experience. Care Coordinators should be assigned prior to release to everyone with a perceived intellectual or developmental disability.

Timothy J. Gallagher, MPH, FACHE, PMP
NC Based Strategic Healthcare Consultant
Program Manager, Healthy Opportunities of the Piedmont

Tim Gallagher, LLC
[redacted]
571-213-8620

From: [redacted]
To: Medicaid.NCEngagement
Cc: [redacted]
Subject: [External] NC Section 1115 Waiver Renewal - Public Comments
Date: Wednesday, September 20, 2023 7:57:01 AM
Attachments: NCAFP Comments on NC 1115 Demonstration Renewal Application.pdf
Importance: High

Please find attached comments on the renewal of NC Medicaid's Section 1115 Waiver Renewal Application on behalf of the NC Academy of Family Physicians.

With best regards,

Greg

Gregory K. Griggs, MPA, CAE
Executive Vice President and CEO
NC Academy of Family Physicians
2501 Blue Ridge Road, Suite 120
Raleigh, NC 27607

Office Phone: 919-980-5228
[redacted]
E-Mail: [redacted]

NORTH CAROLINA ACADEMY OF FAMILY PHYSICIANS

919.833.2110 PH
919.833.1801 FAX

September 20, 2023

North Carolina Department of Health and Human Services
NC Medicaid Section 1115 Waiver Team
1950 Mail Service Center
Raleigh, NC 27699-1950

RE: NC Section 1115 Waiver Renewal
VIA Email: Medicaid.NCEngagement@dhhs.nc.gov

Dear NC Section 1115 Waier Renewal Team:

On behalf of the leadership of the NC Academy of Family Physicians and our 4,200 members across the state, it gives me great pleasure to submit the following comments on North Carolina's Section 1115 Demonstration Renewal Application. While we are supportive of the overall concept, we would like to provide specific comments in some areas.

Expanding Healthy Opportunity Pilots: We support plans to expand the Healthy Opportunity Pilots Statewide. As noted, over 13,000 North Carolina Medicaid recipients have received services through the three regional pilots. We support the statewide expansion of services addressing housing insecurity, food scarcity, the lack of transportation and interpersonal violence. We also support the efforts to add additional services including allowing up to three meals per day, providing housing assistance for more than one month, and particularly the effort to add a new "firearm safety" service that would provide locks and/or safes for proper storage of firearms.

Justice Involved Reentry Initiative: The NCAFP also supports the efforts to address the specific issues of justice-involved individuals. We applaud NC Medicaid's pursuit of authority to provide pre-release services such as case management, Medication-Assisted Treatment and a 30-day supply of prescription medication as individuals are preparing to be released from a correctional facility. We know that large numbers of incarcerated youth and adults have existing physical and mental health needs, and many come into a jail or correctional facility suffering from substance use disorder.

Ongoing Medicaid Transformation/Managed Care: We do have some suggestions regarding the ongoing transition to managed care in North Carolina. Due to the increased provider burden (particularly in primary care) caused by the move from one Medicaid plan to many managed care plans (Medicaid Direct, five Standard plans, up to six Tailored Plans, and a Children and Families Specialty Plan), we believe it is critically important to try to simplify processes and procedures.

The Sheps 2022 Medicaid Provider Experience Survey linked in the waiver request reports "notable administrative burden" for practices. In addition, an April 2022 survey of primary care physicians in North Carolina by our organization and the NC Pediatric Society found two-thirds of respondents reported an increase in administrative burden between 2021 and 2022, and further reported a 19% decline in ability of primary care physicians to help their patients get timely access to care. Many of these problems continue to persist and could impact the success of Tailored Plans as practices

become less willing to take on substantial administrative burden for a relatively small number of patients as other administrative implementation issues linger. We would suggest the following steps:

- Greater oversight of Managed Care plans specifically around denied and pended claims;
- Continued efforts to minimize the number of quality metrics, align quality metrics beyond the Medicaid market (commercial/Medicare) as possible, and to ensure that reporting and measurement requirements are consistent across plans;
- Definitive steps to correct beneficiary assignment areas, particularly when adults are assigned to pediatric practices, children are assigned to internal medicine practices, and men are assigned to obstetric practices;
- Specific efforts to reduce the number of prior authorizations required by the Pre-Paid Health Plans;
- Contract simplification, especially for new contracts such as the single statewide plan for children and youth in foster care;
- And continued efforts by the plans' Chief Medical Officers to simplify administrative processes and procedures.

Eligibility Changes: We support the proposed eligibility changes outlined in the Waiver Renewal application, particularly since many children "churn" on and off Medicaid. As a result, we support continuous enrollment for children under the age of five once they have been deemed eligible, 24 months of continuous coverage for older children, and coverage for youth aging out of foster care until age 26.

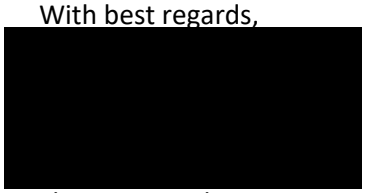
Investments in Behavioral Health Workforce: The NCAFP also supports the Department's efforts to increase the behavioral health workforce with investment in loan repayment and other mechanisms. Beyond what is outlined in your proposals, we wonder if a portion of the loan repayment program could further incentivize use of the evidence-based Collaborative Care Model (CoCM), a model in which the state is already making a significant investment. Given that the model increases the capacity of our state's psychiatrists and addresses the behavioral health care needs of patients in the primary care setting, using a portion of this funding for loans for the consulting psychiatrist, the Behavioral Health Care Manager and the billing primary care physician seems to make sense.

Single Statewide Plan for Children and Youth in Foster Care: We continue to support one statewide plan for children and youth in foster care and those transitioning out of foster care (Children and Families Specialty Plan). One single statewide plan will help resolve some of the many issues associated with foster children moving among LME regions.

Making Care Primary and Investment in Primary Care: While not directly related to your 1115 Waiver Application, the NCAFP is very pleased that North Carolina was selected as one of eight states for Medicare's Making Care Primary Initiative. We would encourage North Carolina Medicaid to find ways to further align with this initiative, particularly around the move toward value-based payment models such as prospective payment for core primary care services, as well as greater overall investment in primary care. Where states have moved toward greater investment in primary care and cross-payer alignment, overall healthcare costs have come down.

We look forward to continuing to work with the Department to make North Carolina's Medicaid program the best in the country. If you have any questions about our comments, please do not hesitate to reach out to Greg Griggs, our Executive Vice President and CEO at ggriggs@ncafp.com or 919-833-2110.

With best regards,



Shauna L. Guthrie, MD, MPH, FAAFP
President, NC Academy of Family Physicians

Cc: Gregory K. Griggs, MPA, CAE
NCAFP Executive Vice President and CEO

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 12:19:57 PM

Please note the following comments and recommendations from our organization:

Waiver recommendations for improvement:

Increase funding
The Healthy Opportunities Pilot program is currently authorized through October 31, 2024. To ensure the program's long-term success, it may be necessary to secure additional funding beyond this date.

Expand eligibility
To reach more people and have a greater impact, the eligibility criteria for the Healthy Opportunities Pilot program could be expanded beyond NC Medicaid Managed Care members who live in a Pilot region. To ensure that children have consistent access to healthcare, eligibility for Medicaid should be based on annual income rather than monthly income. This would allow children to remain eligible for Medicaid even if their family's income fluctuates throughout the year.

Improve data collection and analysis
To evaluate the effectiveness of the Healthy Opportunities Pilot program and the NC Medicaid 1115 waiver, it is important to collect and analyze data on health outcomes and program participation. Improvements could be made to the data collection process to ensure that data is accurate, comprehensive, and most importantly accessible to all agencies who support the project.

Increase community engagement
To ensure that the Healthy Opportunities Pilot program and the NC Medicaid 1115 waiver are meeting the needs of the communities they serve, it is important to engage with community members and stakeholders. This could involve holding town hall meetings, conducting surveys, and establishing community advisory boards so that the voices of those affected are centered.

Expand the scope of interventions
While the Healthy Opportunities Pilot program is a step in the right direction, there is still room for improvement. For example, the program could expand the scope of interventions to include a broader housing approach, such as payment of arrears, mortgage assistance, and financial support beyond the first month of tenancy.

Food Support
Currently, people with felony drug convictions are subject to restrictions or complete bans on food assistance under SNAP (Supplemental Nutrition Assistance Program). This policy should be revised to allow all people exiting prison to receive food stamp benefits, regardless of the

crime they committed. Providing access to food assistance can help reduce recidivism and improve health outcomes for people reentering society.

Allow children continuous eligibility
To ensure that children have consistent access to healthcare, eligibility for Medicaid should be based on annual income rather than monthly income. This would allow children to remain eligible for Medicaid even if their family's income fluctuates throughout the year

Social Security Disability Benefits
Do not discontinue Social Security benefits when a person has spent over 1 year in prison: Currently, Social Security benefits are suspended if an otherwise eligible person is confined in a jail, prison, or other penal institution for more than one year due to conviction of a crime. This policy should be revised to allow people who have spent over 1 year in prison to continue receiving Social Security benefits upon their release.

Transitional Housing Support
Provide funding for people exiting prison to pay for transitional housing for up to 6 months. Many people leaving prison face significant challenges in finding stable housing and employment. Providing funding for transitional housing for up to 6 months could help people successfully transition back into their communities.

Medical Respite
Establish or increase medical respite for people exiting behavioral hospitals. People exiting behavioral hospitals often have complex medical needs that require ongoing care. Establishing or increasing medical respite programs could help ensure that people receive the care they need after leaving the hospital.

PESA Forms (HOP)
Allow HSO access to the PESA forms. Allowing Healthy Opportunities Pilot program staff to access PESA forms would better support the client.

1-800 hotline
Establish a 1-800 hotline for enrollment for potential HOP clients. Many people find it difficult to navigate the enrollment process for Medicaid and other healthcare programs. Establishing a 1-800 hotline for enrollment could help make the process more accessible and user-friendly. Potential clients could answer the questions via an automated line instead of with a person to determine eligibility.

Eligibility criteria
Base eligibility on social risks and not chronic health conditions. Currently, eligibility for the Healthy Opportunities Pilot program is based on chronic health conditions. Eligibility for the program could be expanded to include people who are at risk solely due to social factors, not just chronic health conditions (known and unknown).

Health records
Give people their health records at the time when they leave prison and/or provide immediate access to their health records via a portal. People leaving prison often face significant barriers to accessing healthcare, including a lack of access to their medical records. Providing people with their health records at the time of their release could help ensure that they receive appropriate care after leaving prison.

Invoices
Revise the invoicing period to include automatic renewal for housing navigation and other monthly services. Allow batch invoices. Update and improve the Unite Us/NC Care 360 portal to reflect accuracy regarding paid and duplicate invoices.

NC Tracks
Allow HOP HSO staff access to NC Tracks. By granting access to NC TRACKS, staff would be able to more easily verify recipient eligibility and access other important information needed to provide services to program participants.

Michelle D. Gunn
LINC Deputy Director
Leading Into New Communities, Inc.
3311-2 Burnt Mill Drive, Wilmington, NC 28403
910-332.1134 (p) [redacted]
Website | Email | Facebook

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 3:09:38 PM

Recommendation:

First Month Rent and Deposit
Support the downpayment of people moving into their own homes. Use the Fair Market Rate to provide the new homeowner with the maximum allowable for that number of bedrooms. Provide the first month of full mortgage to allow the client to maximize the benefit.

Michelle D. Gunn
LINC Deputy Director
Leading Into New Communities, Inc.
3311-2 Burnt Mill Drive, Wilmington, NC 28403
910-332.1134 (p) [redacted]
Website I Email I Facebook

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC 1115 Waiver Feedback
Date: Wednesday, September 20, 2023 12:48:05 PM

Greetings,

I am writing to advocate for the following:

- Expand eligibility to include all NC Medicaid members—regardless of coverage type—who screen positive for a pilot-supported social health need, including Medicaid Direct, Tailored Care Management eligibles in prepaid inpatient health plan (PIHP), and Medicare/Medicaid dual enrollees.

- Expansion of pilot eligibility to include all pregnant and postpartum women, justice-involved individuals, those who are "at risk of" a chronic condition, individuals with only one chronic health condition, individuals recently impacted by natural disasters, foster care, and children/youth who receive adoption assistance.

- Include all HOP services in pre-release Medicaid services available to justice involved individuals.

- Allow continuous access to HOP services for justice-involved individuals for 1-year post-release.

- Approve additional evidence-based parenting curriculum and age range to allow HSOs to leverage existing resources to meet regional and individual family needs. There is not a one size fits all model. https://eclkc.ohs.acf.hhs.gov/parenting/article/parenting-curricula-review-databases

- Expansion of meal services to three meals per day.

- Refine language around rental assistance to include up to six months of rental assistance including payment of arrears for all enrollees who demonstrate need.

- Standardize fee schedule statewide to reduce the potential for confusion, referral delays and rejections.

- Review all services to ensure a coordination or admin fee is included.

- Availability of capacity building funds throughout the demonstration waiver period.

- Increase capacity building budget allocation and/or significantly increase fee schedule payments to ensure there are sufficient and sustainable resources for human service organizations (HSOs) and NLs to scale pilot services across all 100 NC counties.

- Prioritize investments in community-based organizations and local service delivery models.

- Give contracting preference and/or incentives to local, community embedded HSOs to promote equity and improve pilot enrollment, member satisfaction, expansion of services/geography and culturally inclusive service delivery.
- Prioritize and incentivize local health and social service agencies to participate in the pilot.
- Require HSOs who directly contract with PHPs to participate in NL compliance activities to ensure network adequacy and service delivery quality.
- Increase accountability and transparency around PHP responsibilities regarding care management network adequacy, quality improvement, and payment processes.

Thank you,

Kate Singogo

--
Kate Singogo
[redacted]

From: [redacted]
To: Medicaid.NCEngagement
Cc: [redacted]
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 8:45:17 AM
Attachments: image001.png
1115 Waiver Renewal Public Comments_final.docx

Attached are comments from CCPN staff on waiver expansion.

Thank you,
Wanda

Wanda Jenkins RN, MSN, CCM
Health Equity and Community Engagement Supervisor
Community Care OF NORTH CAROLINA
A 1255 Crescent Green Drive Ste 200 Cary, NC 27518
M 910-880-4490 | **E** [redacted]
Website | Facebook | Twitter | LinkedIn

1115 Waiver Renewal Public Comments

The following comments and suggestions are made on behalf of the HOP team, working with the Community Care Provider Network (CCPN). The team is currently a Healthy Opportunities Pilot participant in all 3 pilot regions.

Expanding HOP Statewide and Scaling Services

The expansion of HOP services statewide is an exciting opportunity to serve members outside of the three existing regions. It will be critical to ramp up services in a slow, methodical manner to ensure smooth implementation. HSOs that border other Medicaid regions may experience a large influx in requests from added regions, as well as the increased number of members in existing regions who may meet the expanded clinical criteria. We have the following recommendations for increasing HSO services:

- Consider working with community colleges and universities to address SDOH needs impacting students' educational and career development goals.
- Increase accountability and oversight of members, HSO, and network leads to prevent misuse or abuse of services.
- Utilize staff from Health Plans, CINs, and HSOs to update UniteUs platform and improve the currently burdensome workflow.
- HSOs need to promptly terminate services when at capacity. This would help care managers to make fewer referrals for the same service.
- Anyone working with members should enter contact information in UniteUs platform.
- Advise against HSOs contracting directly with health plans as this would remove the gatekeeper role from pilot. This role is important in identifying members that may need more intense care management related to medical/behavioral health needs.
- Suggest limits on the number of times a member can change HSOs for the same service (if not due to HSO capacity issue).
- More focus on coaching and helping members achieve improvement with SDOH needs.

Modifying HOP Services

<u>Food Service Expansion</u>

The food services, especially food boxes and food prescriptions, are both very popular and efficient programs for referral from a care management perspective. Increasing availability to three times a day is a sensible expansion of these services. We have the following feedback about various food domain services that may need to be taken into consideration:

- Families have reported the success of the Food/Vegetable Prescription: kids eating more fruits and vegetables, losing weight, improvement in labs, and reduction of medications. In addition to positive outcomes, this service provides a practical application for making healthy choices in the grocery store. We would recommend any further expansion of this service if possible. Consider working with grocery chains like Walmart, Food Lion, etc. to provide F/V service in pilot.
- Review of food insecurity needs at 6 months should include nutrition case management. At 12 months, if food insecurity persists, re-evaluate EBT amount. Require HSOs to provide services and work through issues instead of just stopping service all together when problems are encountered. Should be consequences for the HSO for prematurely ceasing services.
- Require cultural awareness training for HSOs.
- Food box issues that have been reported include:
    - Canned foods and foods with low protein content
    - Expired or stale food
    - Repetitive choices every week
    - No cultural awareness with food boxes
    - Members have missed food box deliveries due to not being able to get to the door fast enough to sign for the box.
    - HSO accepting referrals, but do not have the capacity to meet commitments.

Rental Assistance

We support the expansion of rental assistance to six months as a more reasonable service, however criteria for "high-needs enrollees" will need to be explicit in order for care managers to easily identify who qualifies. We also have the following recommendations/issues for your consideration:

- Recommend an additional service for financial/money management classes to improve this skill in the population.
- Suggest the State invest in innovative low-cost housing/HSOs such as tiny home developments or container homes.
- Members are reporting lack of services from the Housing Navigation Service, meaning they are unaware of any service the HSO is providing through this program.
- Improved oversight of these services to prevent abuse or waste.
- Suggest HSOs/Network Leads to hold job fairs in their service area.

Firearm Safety

CCPN is very supportive of adding a new "firearm safety" service to address legitimate safety concerns, especially related to IPV cases. We would recommend a strong link with local police for this service and potentially engaging via community events and schools. Care managers will

need extensive training on this domain, similar to IPV, as this is not an area of assessment they are currently engaging in with members.

Expanding Eligibility Criteria for HOP

CCPN is very supportive of expanding the eligibility criteria for HOP services to reach more members who would benefit from this program. The current criteria have proved quite limiting with increasing enrollment in the program. While it's critical to increase the reach of these services, there is currently an ongoing issue of HSO capacity to serve the existing members which has caused frustration among members and care managers. This will need to be addressed in the existing regions as well as new regions upon further expansion of the Pilot.

Thank you for the opportunity to provide comments on this exciting expansion of such an important program in North Carolina. We look forward to continuing our role in linking Medicaid members with these crucial services.

From: [redacted]
To: [redacted] Medicaid.NCEngagement
Subject: [External] NC Medicaid Section 1115 Waiver Re: REMINDER- Important Notice: Public Comment/Public Hearings on Medicaid Waiver Application for services to Justice Involved Population - Comment deadline 9/20
Date: Wednesday, September 20, 2023 3:30:08 PM
Attachments: Outlook-02zfnil3.png

Good afternoon,

Thank you very much for sending this message. I would like to offer my comments during the public comment period:

I could not express stronger support for the NC Medicaid Section 1115 Waiver. As an OB/GYN who provides prenatal care in the state prison system, the lack of Medicaid coverage for pregnant people leaving prison is truly unacceptable. In our program evaluations, we have found that pregnant and postpartum people, who all qualify for Medicaid, are significantly less likely to be covered after incarceration compared with before. In order to address disparities in maternal mortality and morbidity, I strongly encourage the waiver program to explicitly include pregnancy and postpartum services as a priority for what can be covered through the program.

Thank you, and please do not hesitate to reach out if you have further questions.

Best,

Andrea K. Knittel, MD, PhD, FACOG (she/her/hers, pronunciation)
Assistant Professor, Division of General Obstetrics and Gynecology
Director, General Obstetrics and Gynecology Research Fellowship
Medical Director for Incarcerated Women's Health
Department of Obstetrics and Gynecology
University of North Carolina, Chapel Hill
[redacted]

I often send e-mails outside of business hours, but do not expect responses outside of business hours. Thank you.

From: Bryant, Angela R [redacted]

Sent: Thursday, September 7, 2023 12:33 PM

To: [redacted] Public Hearings on Medicaid Waiver Application for services to Justice Involved Population - Comment deadline 9/20

Hello Community Partners and Advocates,

North Carolina will be requesting the Centers for Medicare & Medicaid Services renew the NC Medicaid Section 1115 Demonstration Waiver for a second five-year period, from Nov. 1, 2024 through Oct. 31, 2029. The Demonstration Waiver application has been posted for public comment through September 20, 2023.

This effort seeks to improve health and well-being for all North Carolinians through a whole-person, well-coordinated system of care that addresses both medical and non-medical drivers of health and advances health access by reducing disparities for historically marginalized populations. **In line with this overarching goal, and in line with recent federal guidance, North Carolina is seeking federal authority through the demonstration renewal to support reentry into the community for justice-involved individuals.** Attached to this email you will find a fact sheet on the proposed support initiatives for the Justice Involved community as well as the section from the application detailing these proposed support initiatives.

The comment period will be open until 5 pm EST on September 20, 2023. There will be five public hearings between now and September 20, three in person and two held virtually. The website and information provided below details the location of the public hearing sessions, the email where you may send comments and feedback, the mailing address where comments can be sent, and more information about the application renewal process and timeline.

Renewal website: https://medicaid.ncdhhs.gov/meetings-notices/proposed-program-design/nc-section-1115-demonstration-waiver

Public Hearing Details:
The Department knows that public input is crucial to ensuring the Demonstration Waiver will best serve the people of North Carolina. Five public hearings will be held; three will be in-person throughout the state and two will be online. These public hearings will provide an overview of the renewal application and gather comments. To ask questions about accessibility or request accommodations, please email Medicaid.NCEngagement@dhhs.nc.gov. At least two weeks' advance notice will help us to provide seamless access.

- Tuesday, Sept. 5, 2023, from 9:30-11 a.m. (in person)

Mountain Area Health Education Center (MAHEC)
Blue Ridge A & B in the Education Building
121 Hendersonville Road, Asheville, NC 28803

- Wednesday, Sept. 6, 2023, from 9:30-11 a.m. (in person)

McKimmon Conference & Training Center
NC State University, 1101 Gorman Street, Raleigh, NC 27606

- Wednesday, Sept. 6, 2023, from 5:30-7 p.m.

Virtual via Microsoft Teams, join on your computer, mobile app or room device.
Click here to join the meeting
Call in (audio only)
+1 984-204-1487, 902948880# United States, Raleigh
Phone Conference ID: 902 948 880#

- Thursday, Sept. 7, 2023, from 2:30-4 p.m. (in person)

Greenville Convention Center
303 SW Greenville Blvd., Greenville, NC 27834

- Friday, Sept. 15, 2023, from 11:30 a.m.-12:30 p.m. (during the Medical Care Advisory Committee Meeting)

Virtual via Microsoft Teams, join on your computer, mobile app or room device.
Click here to join the meeting
Call in (audio only)
+1 984-204-1487, 412615457# United States, Raleigh
Phone Conference ID: 412 615 457#

Written comments also will be accepted by email or U.S. Mail through 5 p.m., Wednesday, Sept. 20, 2023. Please include "NC Medicaid Section 1115 Waiver" as the subject.

Email: Medicaid.NCEngagement@dhhs.nc.gov

U.S. Mail:
North Carolina Department of Health and Human Services
NC Medicaid Section 1115 Waiver Team
1950 Mail Service Center
Raleigh, NC 27699-1950

More information on the Demonstration Waiver renewal along with the draft proposed application are available on the NC Medicaid website at medicaid.ncdhhs.gov/meetings-notices/proposed-program-design/nc-section-1115-demonstration-waiver.

Thank you as always for your efforts and support towards our justice-involved community. I encourage you to review the proposed application and provide any feedback you may have.

Thanks,

Angela Bryant
Asst. Secretary – Health Equity Portfolio

Jennifer Abrams (she/her)
MPH Intern
Health Equity Portfolio

Email: [redacted]
[redacted]

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES
Division of Public Health

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 3:57:50 PM
Attachments: NC 1115 Waiver Renewal Comments_Unite Us_September 2023.pdf

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Hello - Please find attached comments from Unite Us on the Draft Section 1115 Medicaid Demonstration Waiver Renewal Request. I would be glad to answer any questions you may have about our feedback.

Thanks,
Natalie

--
Natalie Kotkin
(she / her / hers)
Director, Regulatory Affairs | **Unite Us**

(860) 748-2257

LinkedIn | Facebook | Twitter | Instagram

September 20, 2023

North Carolina Department of Health and Human Services
NC Medicaid Section 1115 Waiver Team
1950 Mail Service Center
Raleigh, NC 27699-1950

Subject: Support for North Carolina's Draft Section 1115 Medicaid Demonstration Waiver Renewal Request

To Whom It May Concern:

Unite Us writes in strong support of North Carolina's Draft Section 1115 Medicaid Demonstration Waiver Renewal Request ("proposed waiver"). The proposed waiver builds on the State's early successes with the current Medicaid Reform Demonstration, including the Healthy Opportunities Pilots (HOP), and seeks to test additional ways to improve the health of low-income and vulnerable residents. We are encouraged that the proposed waiver reinforces the current waiver's focus on ensuring a whole-person, well-coordinated delivery system that addresses the medical and non-medical drivers of health that produce health disparities in North Carolina.

As the nation's leading software company enabling cross-sector collaboration to improve people's health and well-being, Unite Us is proud to support the North Carolina Department of Health and Human Services's (NC DHHS's) implementation of HOP. Unite Us serves as the technology backbone for NCCARE360, the statewide closed-loop referral platform, and facilitates eligibility, enrollment, and billing processes for the health-related social need (HRSN) services authorized under HOP. Through this partnership in North Carolina and our work across 43 other states, we have observed and contributed to establishing best practices in planning, delivering, and evaluating coordinated health and social care interventions. We draw on this experience to offer specific comments below in support of 1) the HOP expansion and 2) new justice-involved reentry services.

Section 1: Support for HOP Expansion

Unite Us strongly supports the extension of HOP under the proposed waiver and the program's expansion to include additional geographies, eligible populations, and services. HOP has already shown promising early results in its goals to improve unmet resource needs for individuals receiving Pilot services and to improve health outcomes for HOP participants through evidence-based, non-medical interventions. As indicated in the proposed waiver, the first Rapid Cycle Assessment demonstrated that HOP has enabled effective multi-sector collaboration between healthcare and human services organizations. Furthermore, more than 13,000 individuals have been enrolled in services, invoices for these services are being paid in a timely manner, and the State is gathering important information about the comparative effectiveness of different food, housing, transportation, and interpersonal violence / toxic stress interventions. NC DHHS is well poised to expand HOP as proposed in the waiver application.

In the Pilot expansion, Unite Us encourages the State to continue program design elements that have made HOP successful to date, including: 1) facilitating access to services for eligible individuals, 2) enabling a range of human services organizations (HSOs) to participate, and 3) ensuring visibility into the full lifecycle of service delivery from social needs screening through any post-service healthcare utilization. These focus areas have enabled the State to establish an equitable and accessible program that NC DHHS and evaluators can closely observe to measure outcomes and ensure compliance with the waiver's terms.

Together with our partners, Unite Us has observed the individual and population-level impact of accessible, accountable connections between health and social care. Unite Us has supported Sarasota Memorial Health Care System and the First 1,000 Days Suncoast Initiative since 2020 to improve coordination and increase access to care for pregnant women and families with young children. A recent evaluation of this program found that Medicaid-enrolled patients receiving referrals through Unite Us had a 79% reduction in odds of postpartum-related readmissions when compared to matched patients receiving usual care, and a 70% reduction in odds of all-cause readmissions. These findings demonstrate that accountable, accessible delivery of social care services can have a measurable impact on healthcare utilization.

Our work in Sarasota also demonstrates the potential value of expanding HOP to all Medicaid-enrolled pregnant women, as proposed by NC DHHS. Furthermore, Unite Us is encouraged that the State has proposed expanding eligibility to individuals impacted by natural disasters and individuals "at risk of" a chronic condition. Cross-sector coordination technology can address the health-related social needs precipitated or exacerbated by natural disasters. In Oregon, where the state Medicaid program has received 1115 waiver approval for HRSN services for individuals who experience weather-related emergencies, Unite Us partners with the Department of Human Services' Office of Resilience and Emergency Management (OREM) to meet the needs of individuals affected by natural disasters. Our network, Connect Oregon, has already been successfully used to connect fire survivors in Southern Oregon with disaster case management and transitional housing services.

Data tools that measure health and social risks at a granular level can help to proactively identify individuals in both existing and newly proposed HOP eligibility groups. For example, Unite Us' Social Needs System leverages the industry's largest health and social care data set to identify individuals' level of social risk across 12 factors. Complementary tools help to proactively identify level of clinical risk. Tools like the Social Needs System could be used to ensure individuals who are eligible for HOP get identified and that outreach and enrollment processes benefit from a detailed understanding of their relative clinical and social risks.

The expansion of eligibility categories, geographies served, and service types has the promise to impact the health and social needs of many North Carolinians. To realize this potential, we encourage NC DHHS to ensure that the delivery of HOP services remains accessible and standardized. The development of standardized eligibility, enrollment, and billing processes has facilitated a range of HSOs participating in HOP to date, enabling local organizations to address HOP enrollees' needs in ways that reflect local practices and draw on local innovations. We encourage NC DHHS to maintain this focus on standardization and accessibility as it considers facilitating HOP Administrators contracting directly with HSOs under the proposed waiver.

Section 2: Support for Proposed Justice-Involved Reentry Services

Unite Us strongly supports the justice-involved reentry request in the proposed waiver, which would enable delivery of a targeted set of services up to 90 days before release from carceral settings. We are also encouraged that the State separately proposes to make individuals who were recently released from incarceration eligible for HOP services. As NC DHHS notes in its draft waiver request, justice-involved individuals have higher rates of physical and behavioral health needs as well as substantial health-related social needs. Thoughtful discharge planning, including warm hand-offs to health and social care services, can facilitate more successful individual reentry experiences and improve community health.

Health and criminal justice institutions across the country are increasingly recognizing the importance of coordinated reentry services, beginning with but extending beyond re-enrollment in Medicaid. We facilitate partnerships between carceral settings and community-based organizations in multiple places, including with North Carolina's Department of Adult Corrections (DAC). DAC reentry coordinators and probation officers across the state have access to Unite Us, as do Local Reentry Councils focused on successful transitions from correctional facilities. This partnership has created additional visibility into available resources for formerly incarcerated individuals, facilitated case management for those individuals, and increased connections to resources. The additional flexibilities and funding in the proposed waiver will build on DAC's early successes and ensure individuals' full health and social care needs are addressed.

Conclusion

Unite Us supports NC DHHS's proposed waiver and its vision for further improving the health of low-income and vulnerable populations, and reducing disparities in outcomes. In particular, the HOP expansion and new justice-involved reentry supports will enable the State to further address the medical and non-medical drivers of health for North Carolinians using evidence-based strategies. We are proud to support North Carolina's Medicaid Reform Demonstration to date and would be eager to partner with the State as it expands its efforts.

Thank you for the opportunity to provide feedback on the proposed waiver. Please let me know if you have any questions about our comments or if there is further information we can provide.

Sincerely,

/s/ Natalie Kotkin

Natalie Kotkin
Director, Regulatory Affairs
Unite Us
[redacted]

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver_ NCCADV Comments
Date: Wednesday, September 20, 2023 4:21:42 PM
Attachments: Outlook-NCCADV log
Outlook-g3day0gb.png
Outlook-ccaxehtw.png
NCCADV Comments_NC Section 1115 Waiver (1).pdf

To Whom it May Concern:

Please see the attached letter for public comment from NCCADV on NC's Section 1115 Waiver.

Best,

Kathleen Lockwood
Policy Director
North Carolina Coalition Against Domestic Violence
Pronouns: she/her/hers (What is this?)
[redacted]

NCCADV
North Carolina Coalition
Against Domestic Violence

September 20, 2023

Medicaid NC Engagement
Medicaid.NCEngagement@dhhs.nc.gov

VIA ELECTRONIC MAIL

To Whom it May Concern:

The North Carolina Coalition Against Domestic Violence (NCCADV) is a statewide non-profit that provides training, technical assistance, and policy advocacy for and on behalf of domestic violence service providers and the domestic violence survivors they serve across our state. We are supportive of NCDHHS's Section 1115 Waiver Renewal and would like to uplift the perspectives of domestic violence service providers in our comments about this waiver.

The Healthy Opportunities Pilot Program (HOP) has provided domestic violence survivors in Pilot regions with more opportunities to be connected to life-saving IPV services in their communities. As this program evolves, we appreciate the continued availability of capacity building funds for HSOs providing IPV services and request NCDHHS assist Networks in thoughtfully limiting HSO eligibility to provide services in the IPV domain as HOP evolves.

Capacity building funds allocated to HSOs providing IPV services have been essential in integrating experienced IPV HSOs into HOP Networks. Most experienced domestic violence organizations across the state rely on government grants and individual donors to sustain their work. The billing and payment processes in HOP therefore require such organizations to create capacity to bill and receive payments using a system that is quite distinct from these HSOs' typical grant application and reporting processes. The availability of capacity building funds have allowed these experienced HSOs to hire additional administrative staff to support HOP reporting and ensure that at least one staff member trained in HOP procedures is always on-duty or back-up for HOP referrals and intake. We appreciate NCDHHS's attention to ensuring that these funds remain available as Pilot regions may expand and new HSOs must build capacity to integrate their services into the HOP framework. Additionally, HSOs providing services under the IPV domain have expressed a desire to receive HOP funding to pay for security enhancements to their services, such as installation of doorbell cameras and security lighting. Consideration of capacity building funds for these needs would be appreciated. A proposal to expand HOP statewide should incorporate commensurate funding to ensure HSOs can develop the capacity and safety features needed to do this work.

As HOP may expand in its reach, we also strongly encourage NCDHHS to play a role in ensuring that IPV service providers in all Networks have sufficient expertise and the ability to confidentially hold survivor information. Domestic violence service providers that receive federal funding from the Violence Against Women Act, the Victim of Crime Act, and the Family Violence Prevention Services Act are required to keep confidential all personally identifying information of people receiving their services, absent a court

Klockwood@ncsadv.org

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 waiver feedback
Date: Wednesday, September 20, 2023 9:04:54 AM

- Expand eligibility to include all NC Medicaid members—regardless of coverage type—who screen positive for a pilot-supported social health need, including Medicaid Direct, Tailored Care Management eligibles in prepaid inpatient health plan (PIHP), and Medicare/Medicaid dual enrollees.

- Expansion of pilot eligibility to include all pregnant and postpartum women, justice-involved individuals, those who are "at risk of" a chronic condition, individuals with only one chronic health condition, individuals recently impacted by natural disasters, foster care, and children/youth who receive adoption assistance.

- Include all HOP services in pre-release Medicaid services available to justice involved individuals.

- Allow continuous access to HOP services for justice-involved individuals for 1-year post-release.

- Approve additional evidence-based parenting curriculum and age range to allow HSOs to leverage existing resources to meet regional and individual family needs. There is not a one size fits all model. https://eclkc.ohs.acf.hhs.gov/parenting/article/parenting-curricula-review-databases

- Expansion of meal services to three meals per day.

- Refine language around rental assistance to include up to six months of rental assistance including payment of arrears for all enrollees who demonstrate need.

- Standardize fee schedule statewide to reduce the potential for confusion, referral delays and rejections.

- Review all services to ensure a coordination or admin fee is included.

- Availability of capacity building funds throughout the demonstration waiver period.

- Increase capacity building budget allocation and/or significantly increase fee schedule payments to ensure there are sufficient and sustainable resources for human service organizations (HSOs) and NLs to scale pilot services across all 100 NC counties.

- Prioritize investments in community-based organizations and local service delivery

models.

- Give contracting preference and/or incentives to local, community embedded HSOs to promote equity and improve pilot enrollment, member satisfaction, expansion of services/geography and culturally inclusive service delivery.
- Prioritize and incentivize local health and social service agencies to participate in the pilot.
- Require HSOs who directly contract with PHPs to participate in NL compliance activities to ensure network adequacy and service delivery quality.
- Increase accountability and transparency around PHP responsibilities regarding care management network adequacy, quality improvement, and payment processes.

H. Michele Louzon (she/her)
Executive Director
Arms Around ASD
[redacted]

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver FEEDBACK
Date: Wednesday, September 20, 2023 8:21:43 AM
Attachments: image001.png

- Expand eligibility to include all NC Medicaid members—regardless of coverage type—who screen positive for a pilot-supported social health need, including Medicaid Direct, Tailored Care Management eligibles in prepaid inpatient health plan (PIHP), and Medicare/Medicaid dual enrollees.

- Expansion of pilot eligibility to include all pregnant and postpartum women, justice-involved individuals, those who are "at risk of" a chronic condition, individuals with only one chronic health condition, individuals recently impacted by natural disasters, foster care, and children/youth who receive adoption assistance.

- Include all HOP services in pre-release Medicaid services available to justice involved individuals.

- Allow continuous access to HOP services for justice-involved individuals for 1-year post-release.

- Approve additional evidence-based parenting curriculum and age range to allow HSOs to leverage existing resources to meet regional and individual family needs. There is not a one size fits all model. https://eclkc.ohs.acf.hhs.gov/parenting/article/parenting-curricula-review-databases

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- Increase capacity building budget allocation and/or significantly increase fee schedule payments to ensure there are sufficient and sustainable resources for human service organizations (HSOs) and NLs to scale pilot services across all 100 NC counties.

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- Give contracting preference and/or incentives to local, community embedded HSOs to

promote equity and improve pilot enrollment, member satisfaction, expansion of services/geography and culturally inclusive service delivery.

- Prioritize and incentivize local health and social service agencies to participate in the pilot.
- Require HSOs who directly contract with PHPs to participate in NL compliance activities to ensure network adequacy and service delivery quality.
- Increase accountability and transparency around PHP responsibilities regarding care management network adequacy, quality improvement, and payment processes.

Thank you,

Mikaila Mills (she/her)
Community Engagement Manager
P.O. Box 5378
Asheville, NC 28813
828.688.0439
[redacted]

www.impacthealth.org
LinkedIn | Facebook | Twitter

From: [redacted]
To: Medicaid.NCEngagement; [redacted]
Cc: [redacted]
Subject: RE: [External] Re: Public Comments RE: NC Section 1115 Waiver
Date: Thursday, September 21, 2023 12:10:37 PM
Attachments: NCJC Comments to DHHS on Medicaid Renewal Proposal_9.20.2023.pdf

Thank you for the opportunity to resend these comments. I apologize for not including the attachment initially.

Quisha Mallette

Quisha Mallette
Fair Chance Attorney
Pronouns: She/Her/Ella
PO Box 28068
Raleigh, NC 27611
Phone: (919) 861-2208| Fax: (919) 856.2175
Email: [redacted]
http://www.ncjustice.org
north carolina JUSTICE CENTER

From: Medicaid.NCEngagement <Medicaid.NCEngagement@dhhs.nc.gov>
Sent: Thursday, September 21, 2023 12:08 PM
To: Laura Holland [redacted] Quisha Mallette [redacted]
Cc: Hyun Namkoong [redacted]; Nicole Dozier [redacted]
Subject: RE: [External] Re: Public Comments RE: NC Section 1115 Waiver

We didn't receive the attachment, could you resend?

Thanks,
Kathy

Kathy Batton
Communications Manager
NC Medicaid
NC Department of Health and Human Services

[redacted]

From: Laura Holland [redacted]>
Sent: Wednesday, September 20, 2023 8:05 PM
To: Quisha Mallette [redacted]; Medicaid.NCEngagement <Medicaid.NCEngagement@dhhs.nc.gov>
Cc: Hyun Namkoong [redacted]; nicole ncjustice [redacted]

To: North Carolina Department of Health and Human Services - NC Medicaid Section 1115 Waiver Team
From: North Carolina Justice Center - Fair Chance Criminal Justice Team
Date: September 20, 2023
Re: Public Comments Request on Medicaid Reform Demonstration Renewal Application

The NC Justice Center (NCJC) is a statewide non-profit committed to ending poverty in the State of North Carolina. NCJC engages in state and local policy advocacy, litigation and public education efforts across multiple issue areas including health access and criminal legals system reform. The NCJC applauds NCDHHS initiative to expand the Healthy Opportunities Pilot program to include formerly incarcerated individuals and the inclusion of justice-involved individuals in the Medicaid Waiver Renewal, per guidance from the Centers for Medicaid and Medicare Services Guidance. NCJC submits these comments in support of the proposal along with recommendations on process and implementation.

Background

Access to healthcare and resources such as food, transportation, and behavioral health services are critical for individuals returning home from incarceration and living in communities where there is high risk of becoming justice involved. The conditions leading to and impacts of having a criminal record and being incarcerated are reflective of broader public health and safety challenges that in North Carolina and across the country. As noted in the NCDHHS Fact Sheet on North Carolina Medicaid Reform: Justice-Involved Reentry Initiative, 57,000 North Carolinians are currently incarcerated in prisons and jails across the state. More than 15,000 individuals cycle through North Carolina's prisons and jails and return home each year.[1] It is critical that necessary supports are put in place to help ensure their successful transition and to prevent further risk of justice-involvement.

More than 1.6 million state residents are living with criminal records, including both charges and convictions.[2] Criminal records create a major barrier for many individuals attempting to be make meaningful contributions to society and take care of their families. From denied access to babysitting services to barred access to housing and employment, many North Carolinians living with a criminal record are forced to pay well beyond any reasonable consequence for prior acts.

Broadly, black and brown communities and people living in poverty face higher instances of policing, such as traffic stops, and less access to resources, such as transportation, food, and healthcare.[3] These conditions threaten community stability and well-being and increase the likelihood of justice

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[1] Rehabilitation and Reentry, NC Department of Adult Corrections, https://www.dac.nc.gov/divisions-and-sections/rehabilitation-and-reentry y

[2] Lea Efird, Collateral Consequences of the Criminal Justice System- Durham NC Impact Initiative, UNC School of Government Available at: https://ncimpact.sog.unc.edu/2020/05/collateral-consequences-of-the-criminal-justice-system-durham/

[3] See Frank R. Baumgartner et al., Racial Disparities in Traffic Stop Outcomes, 9 *Duke Forum for Law & Social Change* 21-53 (2017)
Available at: https://scholarship.law.duke.edu/dflsc/vol9/iss1/2; See also Elizabeth Gignac, et al, West J Emerg Med. 2023 May; 24(3): 538–546.
Published online 2023 Apr 26. Available at: https://escholarship.org/uc/item/86x41415 (study of rural hospital patients in North Carolina finding that social insecurity including not having basic food, safety and transportation have a major impact on heath outcomes, particularly for marginalized populations)

involvement. The current NCDHHS proposal is a major step towards creating and supporting more sustainable structures that can prevent justice involvement and reduce recidivism over time.

Recommendations

The NCJC has several recommendations to promote accessibility and sustainability of the healthy opportunities pilot and the 1115 Medicaid Demonstration, such as providing plain language materials and training opportunities for service providers that might work closely with the Healthy Opportunities Pilot or 1115 Demonstration Waiver and ensuring that the implementation processes are well informed by reentry partners and directly impacted people.

Regarding accessibility, the fact sheets, listening sessions and public comment process have been a helpful start for both spreading awareness of the proposal and getting some community feedback. However, additional, plain language materials, webinars, or videos should include more details on timeline for implementation and how to determine eligibility or get involved as a local partner or implementation site. Lack of prior enrollment in Medicaid should not be a barrier for a justice-involved person who would otherwise be eligible for services. NCJC recommends having reviewers from the field, including reentry providers and peer support specialists, look over all public-facing materials to ensure the information is easy to understand for someone who may have to navigate or support someone navigating the process. Trainings for community partners and designated NCDHHS staff contacts could also be helpful to address site or project specific inquiries and make sure that as many people as possible know about the program updates and whether they are eligible for the services.

Regarding sustainability and effectiveness in implementation, ongoing conversations, and opportunities for feedback from community-based reentry networks is critical and should inform implementation of efforts concerning justice-involved and formerly incarcerated community members. Local reentry partners, community health workers, peer support specialists and other returning citizens know what programs have been effective and ineffective in navigating the transition from prison and return to communities and with the appropriate resources and supports are best suited to ensure long-term success.

Broader efforts to ensure long-term resources for community-based reentry programs should continue to be a priority to see lasting benefits of changes made through Healthy Opportunity Pilot programs and the 1115 Demonstration Waiver. NCDHHS and other state entities or convening bodies such as the State Reentry Council Collaborative should find new ways to support and keep reentry partners and local reentry networks informed on policies that intend to support the communities they serve and otherwise will impact their work. NCDHHS and other relevant decision-making bodies should also advocate for and support diversifying funding opportunities to sustain effective reentry programs and supportive services, including through the state budget.

Thank you for the opportunity to provide comments and for your consideration of the recommendations provided above. Please contact Quisha Mallette, Staff Attorney at quisha@ncjustice.org regarding any questions or request for more information.

From:	[redacted]
To:	Medicaid.NCEngagement
Cc:	[redacted]
Subject:	[External] NC Section 1115 Waiver
Date:	Wednesday, September 20, 2023 4:15:41 PM
Attachments:	image002.png Legal Aid of North Carolina 1115 Waiver Renewal Application Public Comments Submitted September 20 2023.pdf
Importance:	High

Dear Members of the NC Medicaid Section 1115 Waiver Team:

We are delighted to respond to the Department's request for public comments about the Section 1115 Demonstration Renewal Applicant. Please do not hesitate to contact me if you have any questions.

Sincerely, Madlyn Morreale

Madlyn C. Morreale, JD, MPH
Managing Attorney, Medical-Legal Partnership Program
Legal Aid of North Carolina, Inc.

LEGAL AID
OF NORTH CAROLINA

LEGAL AID OF NORTH CAROLINA

September 20, 2023

North Carolina Department of Health and Human Services
NC Medicaid Section 1115 Waiver Team
1950 Mail Service Center
Raleigh, NC 27699-1950

Via email to Medicaid.NCEngagement@dhhs.nc.gov

Re: Public Comments for NC Section 1115 Waiver

Dear Members of the NC Medicaid Section 1115 Wavier Team:

We appreciate the opportunity to respond to the Department's written notice seeking public comments about the Section 1115 Demonstration Renewal Application.[1] Our comments focus on the portions of the Department's application that would significantly improve the health and well-being of our clients and our client-eligible communities throughout the state.

Legal Aid of North Carolina (LANC) is a statewide, nonprofit law firm that provides free, high-quality legal services in civil matters to low-income individuals and families in North Carolina. Our mission is to ensure equal access to justice and to remove legal barriers to economic opportunity.

Our work addresses the critical needs of our client population who are among the poorest individuals and families in the State. Our services focus on providing "legal remedies" to prevent and address health-related social needs (HRSNs) including safe, affordable housing; family safety and stability; access to education and economic opportunity; access to food security, health insurance, and other safety net supports.

Each year, we provide direct legal assistance to approximately 30,000 households and offer legal education and outreach clinics to an additional 26,000 households. Unfortunately, with current funds, we are unable to provide legal assistance to the vast majority of the estimated 3.3 million people who are eligible for our services. During the past year, we responded to more than 400,000 discrete calls for assistance.

By participating as a Human Service Organization (HSO) in the Healthy Opportunities Pilot (HOP) Program, we have been able to expand the number of clients we are able to serve within all thirty-three counties within all three HOP regions. Through our HOP service, Linkages to Health-Related Legal

[1] NC Department of Health and Human Services (NC DHHS), North Carolina Medicaid Reform Section 1115 Demonstration Renewal Application, Draft for Public Comment, released August 21, 2023. This introductory section refers to page numbers within the Department's Draft for Public Comment.

Supports, we assist HOP participants to secure and/or maintain healthy and safe housing and to mitigate or eliminate exposure to interpersonal violence or toxic stress.

We strongly support the Department's stated objective to "strengthen access to a person-centered and well-coordinated system of care which addresses both medical and non-medical drivers of health." Specifically, we support the requests within the Department's Draft for Public Comment that would:

- ✓ Promote continuity of care by offering continuous enrollment in Medicaid for young children through age five, extending the continuous enrollment period to 24 months for children and youth ages six through 18, and for youth who aged out of foster care until age 26;

- ✓ Improve health outcomes and support reentry into the community for justice-involved individuals by providing authority for federal Medicaid matching funds to provide targeted Medicaid services for individuals incarcerated in the jails and youth correctional facilities within a 90-day period prior to release and by providing capacity-building funds to support service delivery to these individuals; and

- ✓ Build on HOP infrastructure investment and experience to expand HRSN services to North Carolinians across the state.

With respect to the Department's request to enhance HOP services, we support the provisions for the next demonstration period that would:

- ✓ Provide expenditure authority for HOP services, which would allow the Department to expand HOP statewide, scale services, and make other program improvements.
- ✓ Provide expenditure authority for HOP capacity building funding to support expansion of these services across the State.
- ✓ Permit the Department to support statewide HOP operations by procuring additional Network Leads who will develop HSO networks statewide.
- ✓ Expand HOP eligibility to new populations including:
    - All pregnant women enrolled in Medicaid;
    - Adults ages 21 and older who have one or more chronic conditions;
    - Individuals "at risk of" a chronic condition across all eligibility categories;
    - All Tailored Plan enrollees and individuals eligible for Tailored Care Management in Prepaid Inpatient Health Plans (PIHPs);
    - Individuals who have recently been released from incarceration;
    - Individuals who are currently or have recently been impacted by natural disasters; and
    - Children and youth who receive adoption assistance.
- ✓ Permit the state to continue offering and testing the efficacy of all existing services in current Pilot regions.

- ✓ Modify existing Pilot services to:
  - Allow up to three meals per day for key Pilot services within the food domain, including Healthy Food Boxes, Healthy Meals, and Medically Tailored Meals; and
  - Provide six months of rental assistance (including payment of arrears) for high-needs enrollees.
- ✓ Provide expenditure authority for HOP capacity-building activities, including but not limited to building the capabilities necessary to execute Pilot responsibilities; conducting stakeholder engagement and training/technical assistance; community engagement activities; hiring and training new staff; strengthening health information technology systems; essential overhead costs; and establishing operational workflows processes necessary participate in HOP.

The remainder of this document is organized as follows:

Part 1: Additional feedback about Medicaid-funded services for Justice-Involved Individuals

Part 2: Additional feedback about provisions related to the HOP Program

A. Expanding the populations that are eligible to receive HOP services

1) Justice-Involved Individuals
2) All Medicaid enrollees who screen positive for Pilot-supported health-related social needs

B. Simplifying the processes to identify potential HOP-Eligible enrollees and to assess their eligibility for HOP services

1) Prepaid Health Plans (PHPs) and other HOP Administrators
2) Health Providers
3) Expand and Simplify Qualifying Physical/Behavioral Health Criteria
4) Simplify the PESA Process and Increase HOP Entities That Can Administer the PESA

C. Expanding and enhancing the range of services that will be available to HOP participants

1) Expansion and Modification of Existing HOP Services
   a. Linkages to Health-Related Legal Supports
      (i.) Expand to Include More than Basic Advice and Counsel
      (ii.) Expand to Include Other Types of Legal Assistance
         (a) Services for Justice-Involved Individuals
         (b) Services for Individuals Impacted by Natural Disasters
         (c) Services to Support Economic Security
   b. Housing Domain
      (i.) Housing Navigation, Support, and Sustaining Services
      (ii.) Inspection for Housing Safety and Quality
2) Expansion of New HOP Services in Existing Domains
   a. Housing Domain
      (i.) Assistance to Cover Past-Due Rent
      (ii.) Assistance to Cover Past-Due Mortgage Payments for HOP Participants Who Reside in their Own Homes

b. Transportation Domain
3) Create a New Economic Security Domain

D. Support for Human Services Organizations
1) Fee Schedule for HOP Services
2) Allowance for HSOs to Contract Directly with PHPs
3) Administrative Burden
4) Capacity-Building Funds

E. Roles and responsibilities of HOP Entities
1) Network Leads
2) Care Managers
3) NC DHHS

F. Continuous Quality Improvement and Quality Assurance

Part 1: Additional Feedback about Medicaid-funded services for Justice-Involved Individuals

Incarceration and its impacts on one's ability to find housing, employment, and food have been strongly correlated with negative health impacts and outcomes.[2] Studies have also shown that reentry programs that include pre-release services are more likely to be effective in the long term—both in the individual health context and in larger social contexts.[3]

We recommend that all HOP services described in the Initiative to provide "Coverage for Pre-Release Services for Justice-Involved Individuals" should be available to **all** justice-involved individuals, not only those incarcerated in state prisons and county- and tribal-operated jails and youth correctional facilities.

Part 2: Additional feedback about provisions related to the HOP Program

A. Expanding the populations that are eligible to receive HOP services

1) Justice-Involved Individuals

As stated previously, we recommend that all HOP services described in the Initiative to provide "Coverage for Pre-Release Services for Justice-Involved Individuals" should be available to **all** justice-involved individuals, not only those incarcerated in state prisons and county- and tribal-operated jails and youth correctional facilities. We also recommend that justice-involved individuals be provided with continuous access to HOP services post-release throughout the duration of the renewed demonstration.

[2] "Prison & Jail Reentry & Health," Health Affairs Health Policy Brief, October 28, 2021, available at Prison And Jail Reentry and Health | Health Affairs.

[3] "Prison & Jail Reentry & Health," Health Affairs Health Policy Brief, October 28, 2021, available at Prison And Jail Reentry and Health | Health Affairs.

2) All Medicaid Enrollees Who Screen Positive for Pilot-Supported Health-Related Social Needs

We recommend that the HOP eligibility be expanded to include **all** Medicaid enrollees who screen positive for Pilot-supported health-related social needs (HRSNs), regardless of which type of Medicaid coverage they have. This includes Medicare/Medicaid dual enrollees and postpartum women.

B. Simplifying the processes to identify potential HOP-Eligible enrollees and to assess their eligibility for HOP services

1) Prepaid Health Plans (PHPs) and Other HOP Administrators

Only a small fraction of individuals who are potentially eligible for HOP services have received HOP services, and a substantial number of them are unaware that the program even exists. While expanding HOP statewide and expanding HOP eligibility to broader populations may simplify communication efforts to reach potential HOP-eligible members, PHPs and other HOP Administrators[4] can and should play a significant role in increasing HOP participation by examining the data they already have, e.g., results from screening for unmet HRSNs and claims data, to **proactively** refer members for HOP eligibility assessment.

This is especially true for "**priority populations**" which the Department defines "as populations likely to have care management needs and benefit from care management, including the following:

i. Individuals with long-term services and supports (LTSS) needs;
ii. Adults and children and adults with special health care needs;
iii. Individuals identified by the PHP as at rising risk;
iv. Individuals with high unmet health-related resource needs, as defined at a minimum to include:
    a) Members who are homeless, according to the U.S. Department of Housing and Urban Development definition of homelessness;
    b) Members experiencing or witnessing domestic violence or lack of personal safety; and
    c) Members showing unmet health-related needs in three or more Opportunities for Health domains on the Care Needs Screening;
v. At-risk children (age 0-5);
vi. High-risk pregnant women; and,
vii. Others as determined by PHP (i.e., Members with complex conditions like HIV, Hepatitis C, or Sickle Cell)."[5]

[4] As described in the Department's Draft Waiver Application, HOP Administrators include Prepaid-Health Plans (PHP) and other non-PHP Managed Care Entities including Primary Care Case Management Entities (PCCM-Es), Primary Care Case Managers (PCCMs), Prepaid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs) as defined in the State's special terms and conditions.

[5] Revised and Restated RFP 30-190029-DHB, Section V. Scope of Services, page 113 of 214.

2) Health Providers

Unfortunately, more than one year after the initial launch of HOP services, very few medical providers and other health professionals know how to refer their patients for an assessment about their potential eligibility for HOP services. Despite the efforts that DHHS and AHEC have made in the Back Porch Chat and Fireside Chat series, attendance at those webinars represents a fraction of those providers who may be treating HOP-eligible members.

Targeted outreach and technical assistance for health professionals could significantly expand the number of Medicaid enrollees who benefit from HOP services. These strategies could include encouraging all providers to post information about HOP in their clinics and helping providers, particularly those in Clinically Integrated Networks (CINs), to use the information from their electronic health records to identify patients with chronic health conditions, HRSNs, a history of ACEs, and other criteria for HOP services.

3) Expand and Simplify Qualifying Physical/Behavioral Health Criteria

Currently, the eligibility criteria are complicated and difficult to explain to Medicaid enrollees who live in the HOP-funded counties. This is particularly true for the current qualifying physical/ behavioral health criteria. As stated previously, we support the Department's proposal to expand HOP eligibility to individuals who are "at risk of" a chronic condition and individuals with only one chronic health condition. We also believe that simplifying these eligibility criteria would improve the PESA process.

4) Simplify the PESA Process and Increase HOP Entities That Can Administer the PESA

We are concerned that the current screening process is slow, complicated, and inadequate to identify the underlying needs to connect members to services quickly. We recommend simplifying and streamlining the eligibility screening process.

We believe that equipping all Care Managers to administer the PESA and investigating the use of CHWs to administer the PESA would make Pilot eligibility screening more accessible for members. We encourage a review of the PESA questions to ensure that Care Managers and other PESA administrators are better equipped to identify needs quickly and accurately.

C. Expanding and enhancing the range of services that will be available to HOP participants

1) Expansion and Modification of <u>Existing</u> HOP Services

a. Linkages to Health-Related Legal Supports

(i.) Expand to Include More Than Basic Advice and Counsel

The HOP service that we provide, "Linkages to Health-Related Legal Supports," helps HOP participants understand their rights and options with respect to housing and interpersonal violence. The best legal advice is based on analyzing the specific facts and relevant rules and laws for each individual client.

Currently, the scope of this service is limited to advice and counsel. This limitation also prohibits us from contacting a landlord to collect documents and other information (such as the grounds for which a landlord is proposing to evict a tenant or terminate a tenant's eligibility for subsidized housing) and negotiating with a landlord to achieve better outcomes for HOP participants.

For example, without access to HOP participants' leases, payment ledgers, requests for repairs, or information about whether their tenancy is subsidized (which implicates other legal rights and protections), we are forced to give advice based on hypotheticals (e.g., if your lease says X, then here are your rights and options but if your lease says Y or Z, then [....]).

Furthermore, by the time that most HOP participants are referred to us, their relationships with their landlords have deteriorated, so requiring HOP participants (rather than us, as needed) to contact their landlord or subsidy provider to request information that would enhance our legal assistance is often counterproductive or detrimental to the outcomes of our legal support.

We recommend that the Department seek approval to expand the scope of health-related legal support beyond merely providing legal advice and counsel. CMS has approved using Medicaid funds for more extended assistance in other states, such as New Jersey and California. In New Jersey, Medicaid funds may be used to pay for "[a]ssistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse actions."[6] In California, HSOs are allowed to coordinate with landlords to address housing issues.[7]

We recommend expanding the scope of this service to allow HSOs to contact and negotiate with landlords, mortgage companies, and other potential adverse parties to prevent evictions save homes from foreclosure and to ensure that landlords make repairs to unsafe housing conditions.

Permitting these activities will significantly enhance the value of the legal assistance for HOP participants and, in many cases, will result in faster and better outcomes.

We would welcome the opportunity to work with the Department to explore the possibility of expanding the scope of HOP-funded legal assistance.

(ii.) Expand to Include Other Types of Legal Supports

The scope of this service should expand to include assistance with <u>other</u> "legal remedies" for unmet health-related social needs. We ask the Department to expand the scope of legal assistance to include assistance for HOP participants with justice involvement, individuals impacted by natural disasters, and individuals who need assistance with enhancing access to economic security.

(a) Services for Justice-Involved Individuals

As stated previously, we support the Department's proposal to expand HOP eligibility to justice-involved individuals. We recommend that all HOP services should be available to justice-involved individuals post-release and that justice-involved individuals be provided with continuous access to HOP services throughout the duration of the waiver renewal period.

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[6] *See* Ctrs. For Medicare & Medicaid Services, *New Jersey Family Care Comprehensive Demonstration (formerly New Jersey Comprehensive Waiver)* 85 (2023).

[7] California Dept. of Health Care Services, *Transformation of Medi-Cal: Community Supports*, https://www.dhcs.ca.gov/CalAIM/Documents/DHCS-Medi-Cal-Community-Supports-Supplemental-Fact-Sheet.pdf.

Our Statewide "Second Chance" Initiative has been working for decades with local partners throughout the state to help justice-involved individuals access a wide range of community-based services, including legal assistance. We welcome the opportunity to work with the Department to identify HOP services that should be provided to justice-involved individuals.

In addition, to enhance the impact of HOP service for this population, we recommend expanding the scope of HOP legal assistance to include:

- Assisting HOP participants to obtain expunctions and certificates of relief; and
- Assisting HOP participants to restore their drivers' licenses.

(b) Services for Individuals Impacted by Natural Disasters

As stated previously, we support the Department's proposal to expand HOP eligibility to individuals impacted by natural disasters. We welcome the opportunity to work with the Department to identify HOP services that should be provided to these individuals.

Legal Aid has worked closely with Disaster survivors for many years and recognizes the profound barriers that they face in the wake of natural disasters. Communities impacted by disasters can take years to fully recover, and those residents who are most vulnerable may never fully recover. Natural disasters impact not only existing housing stock and the economy but also have long-lasting, negative impacts on the overall health of survivors. We hope that the Department will construe this eligibility broadly and will automatically enroll members with addresses in disaster-affected areas and allow for a renewal, as necessary, to those most impacted.

Through our work with survivors of natural disasters, we have seen the difficulty individuals have in navigating multiple systems to access assistance while in acute crisis. The North Carolina Department of Public Safety's Division of Emergency Management is working towards a system of coordinated entry to assist survivors of recent disasters in applying for FEMA benefits and other types of disaster assistance. To the extent possible, we recommend that HOP utilize coordinated entry as a means of allowing survivors to be enrolled for benefits.

In addition, to enhance the impact of HOP service for this population, we recommend that the Department expand the scope of HOP legal assistance to include assistance to HOP participants to secure FEMA and other disaster-related benefits.

(c) Services to Support Economic Security

As described in more detail below, we recommend creating a new Economic Security Domain. To supplement the services offered within that new domain, we ask the Department to expand the scope of HOP legal assistance to include helping HOP participants access disability-related benefits. As eligibility expands to include new populations, significant numbers of HOP-eligible enrollees will have serious, chronic illnesses. Helping HOP participants access disability income, such as SSI[8], will

[8] The monthly maximum Federal amounts for 2023 are $914 for an eligible individual, $1,371 for an eligible individual with an eligible spouse, and $458 for an essential person. See, https://www.ssa.gov/oact/cola/SSI.html

significantly enhance the long-term stability of HOP participants so they can pay for housing, food, and transportation, and other services that would otherwise be supported by HOP funding.

b. Housing Domain

(i.) Modify the Service Definition for Housing Navigation, Support, and Sustaining Services

Currently, HOP funds may be used to provide HOP participants with "One-Time Payment for Security Deposit and First Month's Rent." We support retaining this service in the next waiver period.

Unfortunately, many tenants are unaware of their rights related to obtaining their security deposits when they move from rented homes. As a result, a substantial number of those tenants, including HOP participants, do not obtain the refunds to which they are entitled.

We recommend modifying the service definition for Housing Navigation, Support, and Sustaining Services to include helping HOP participants obtain security deposits when they move to new homes.

(ii.) Modify the Service Definition for Inspection for Housing Safety and Quality

Some HOP participants live in counties or cities that have enacted local minimum housing codes. For those HOP participants who live in rental properties, local code enforcement officials may be able to perform inspections at no cost to tenants.

We recommend that this service definition be edited to encourage the use of those local government services. This could potentially reduce the need for HOP funds to support this service and, in some cases, might result in those inspections being provided more quickly.

The use of local code enforcement also has the potential to add "upstream" value to this service in three ways. First, when local code violations are discovered, local governments will work directly with landlords to ensure that essential repairs and services (e.g., ridding the premises of insect and rat infestations) are completed. Second, if a HOP participant moves from the premises before the cited repairs and services are "cured," those landlords will be prohibited from renting the home to **other** tenants until local code enforcement officials have determined that the landlord has completed the necessary work. Third, in some circumstances, if a landlord does not comply with minimum code violations within a reasonable period, that non-compliance may provide grounds for a HOP participant to terminate their lease.

As described above, we recommend that the scope of HOP legal assistance be expanded to permit legal advocates to negotiate with HOP participants who live in unsafe housing.

1) **Expansion of <u>New</u> HOP Services in Existing Domains**

a. **Housing Domain**

(i.) **Assistance to Cover Past-Due Rent**

As previously stated, we support the Department's recommendation to provide six months of rental assistance (including payment of arrears) to HOP participants. However, we strongly recommend that this service be available for **any** HOP-eligible enrollee who demonstrates the need for this service, rather than limiting eligibility to certain "high need" enrollees.

This proposal would be a significant benefit to many of the HOP participants. Unexpected financial disruptions, like the loss of a job or the termination of benefits such as SSI and SSDI, coupled with a lack of significant stock of safe, affordable housing, create an extremely challenging environment within which to try and assist someone with housing stability.

While the service for one-time payment for security deposit and first month's rent has assisted numerous HOP participants get into housing, it has been our observation that these financial disruptions often last for more than a month. As a result, some HOP participants have been placed into housing, only to be lawfully removed within a few months when the individual's financial emergency has not yet been resolved. Longer-term rental assistance will help fill a significant gap in the services currently offered through HOP to help stabilize housing for HOP participants.

(ii.) **Assistance to Cover Past-Due Mortgage Payments for HOP Participants Who Reside in their Own Homes**

Some HOP participants, particularly those who live in communities that have little or no subsidized rental properties, live in homes that they own but have fallen behind on making their mortgage payments. For the same reasons that we support the Department's recommendation to provide HOP assistance to cover past-due rent, we recommend that similar assistance be available for HOP participants who live in their own homes.

b. **Transportation Domain**

We support the recommendations made by other organizations to add financial support for driver's education to the Transportation domain. For HOP participants who cannot take a Driver's Education course in school settings, the cost of the program may be prohibitive and may be a major barrier to private transportation.

As described previously, we also recommend expanding the scope of Linkages to Health-Related Legal Supports to include assisting HOP participants to restore their driver's licenses.

2) Create a New Enhancing Economic Security Domain

Research has shown that income support programs have a strong correlation with improved health outcomes and health equity.[9] We recommend that the Department create a new domain, Enhancing Economic Security, to improve income security. Services in this domain should include helping HOP participants to apply for/secure assistance from other safety-net programs, such as:

- Earned Income Tax Credit;
- Tax Preparation;
- WIC and FNS benefits;
- FEMA and other disaster-related benefits; and
- SSI Benefits for disabled individuals (e.g., SOAR and other similar programs).

A sizable number of Medicaid enrollees need assistance to secure long-term housing security. For example, we have worked with HOP participants who, after receiving HOP-funded Housing Navigation and Support Services and/or HOP-funded assistance for the first month's rent in new housing, later face eviction due to their inability to pay the rent after HOP they are no longer eligible for those services.

While the current service definition for Housing Navigation and Support includes helping participants develop a budgeting plan, Medicaid enrollees often need more intensive services to help them apply for income support programs (SSI/SSDI) and ensure that they make use of EITC and other tax benefits for low-income households such as the Homestead Exemption. We believe that the addition of these services to the Enhancing Economic Security domain would fill this gap.

We also recommend including other forms of assistance in this new Enhancing Economic Security Domain, including:

- Employment assistance programs; and
- Credit counseling.

Employment assistance programs are designed to improve income security and help HOP participants transition from one job to another. Several states (Delaware, Illinois, Kansas, and Washington) have implemented employment assistance programs. These programs provide supportive employment, financial coaching, non-medical transportation to jobs, pre-employment and employment-sustaining services, and independent living training.[10]

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[9] See, e.g., Finkelstein D.M. et al. "Economic Well-Being and Health: The Role of Income Support Programs in Promoting Health And Advancing Health Equity," Health Affairs Analysis, December 2022, available at Economic Well-Being and Health: The Role of Income Support Programs in Promoting Health And Advancing Health Equity | Health Affairs .

[10] *Medicaid Waiver Tracker: Approved and Pending Section 1116 Waivers by State*, KAISER FAMILY FOUNDATION (August 11, 2023), https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/.

Currently, the HOP service definition for "Housing Navigation, Support, and Sustaining Services" includes a variety of services that **may** be provided, including "providing financial literacy education and on budget basics and **locating** [emphasis added] community based consumer credit counseling bureaus." We recommend that the Department include providing credit counseling, not merely locating agencies that offer that assistance.

Finally, as described previously, we also recommend expanding the scope of Linkages to Health-Related Legal Supports to include assisting HOP participants in securing FEMA and other disaster-related benefits for individuals impacted by natural disasters and SSI benefits for disabled individuals.

D. Support for Human Services Organizations

1) Fee Schedule for HOP Services

The current fee structure does not adequately support the work that HSOs provide to HOP participants. The fee schedule for most HOP services is based on cost estimates that were generated more than five years ago, before the Department submitted the HOP proposal to CMS. Moreover, there are additional activities and tasks that are part of delivering HOP services that need to be accounted for in the fee schedule. In fact, many HSOs, including our organization, are relying on capacity-building funds to carry out essential HOP work.

We recommend that the Department actively seek input from HSOs about the "true cost" of delivering specific HOP services to establish a sustainable fee structure. We also recommend that the Department review the fee schedule for **all** HOP services to ensure that they include coordination or administrative fees, and any other costs (activities) that are part of service delivery that the capacity building funds are currently funding.

2) Allowance for HSOs to Contract Directly with PHPs

Some have suggested that an HSO that elects to contract directly with one or more Plans would not be eligible to receive capacity-building funding or any other support from the NLs. We recommend that the Department not adopt this suggestion. Prohibiting an HSO from receiving funds for capacity-building work would undermine the entire premise of the Pilot program operating on a regional basis and would disconnect those HSOs (and their work on behalf of HOP participants) from all the important aspects of participating in a regional network, e.g., collaborating with other HSOs, receiving valuable, essential training. At a minimum, the Department should require HSOs that directly contract with PHPs and other HOP Administrators to participate in NL compliance activities to ensure network adequacy and the quality of HOP service delivery.

3) Administrative Burden

The current process for submitting and approving invoices and for tracking and disputing payments for HOP services creates a tremendous administrative burden on HSOs and NLs. As HOP referrals increase (as we all hope that they do), there will be no "economy of scale" for that work. Significant work is needed to streamline the invoicing and payment processes.

Currently, HSOs must use capacity-building funds to support the time spent submitting invoices, tracking payments, and disputing when payments are not made for approved and delivered HOP services not billable as HOP service. For our organization, we have implemented a schedule cadence by which our invoicing specialist submits service invoices on the 5th and the 20th of the month for review/approval by our invoice administrator. For our invoicing specialist, this process of submitting invoices remains a full-day activity that is currently being covered by capacity-building funding. The amount of time that our invoice administrator spends approving/reviewing invoices and tracking and disputing payments is even more time-consuming. We worry that once capacity-building funds are exhausted, these costs will be unsustainable.

We urge the Department to seek multifaceted approaches to improve the efficiency and accuracy of the invoicing and payment process, including implementing technical solutions to streamline the process for the user and allowing for flexible invoicing methods to be tailored to the nature of the service delivered.

For example, for Linkages to Health-Related Legal Supports, the current required method is for invoicing to be done "Per unit of service (*Multiple units allowed in one invoice if provided the same day)*," and the unit of service is a 15-minute interaction. This means that if our staff has two 30-minute calls with a client—one on a Monday and one on a Tuesday, and then a third 15-minute call on Wednesday, three separate invoices (two for two units of service and then one for one unit of service) must be created.

Unlike a food box delivery that is finite on a specific day, Linkages to Health-Related Legal Supports may extend across multiple units that may occur on the same day or on successive days. A requirement to bill each day separately creates a huge administrative burden on our staff. Since the needs of our individual clients may require us to have longer conversations on some days and shorter conversations on others, there will inevitably be variation in the number of days that it takes to serve each client. We believe that this requirement also creates an administrative burden on the PHPs and NLs, who must review multiple invoices for small increments of time.

We recommend that the Department modify the Service Index to permit HSOs providing Linkages to Health-Related Legal Supports to submit only one invoice (for each HOP participant) when the HSO has completed service for a client.

4) Capacity-Building Funds

As previously stated, we support the Department's request for expenditure authority for HOP capacity building funding to support the expansion of HOP services across the State. As described in the Department's draft waiver application, those funds will provide essential support for HOP capacity-building activities, including but not limited to building the capabilities necessary to execute Pilot responsibilities; conducting stakeholder engagement and training/technical assistance; community engagement activities; hiring and training new staff; strengthening health information technology

systems; essential overhead costs; and establishing operational workflows processes necessary participate in HOP. [11]

We recommend that the Department **increase capacity building budget allocation** to ensure there are sufficient and sustainable resources for current and new HSOs to scale Pilot services across all 100 counties.

We also recommend that the Department request that capacity-building funds be available to HSOs **throughout the demonstration waiver period** to ensure HSOs can deliver their services sustainably.

Contrary to how some people describe them, HOP capacity-building funds are not merely important for "start-up" activities. HSOs need capacity-building funds to participate in ongoing, essential HOP activities, such as (for example) training, learning collaboratives, evaluation and quality improvement activities, and work needed to "scale up" their services. Moreover, because of the inadequate fee schedule, HSOs currently rely on capacity-building funds to supplement the costs associated with assisting HOP clients and must rely on capacity-building funds while they wait to be reimbursed for sizable up-front costs.

E. Roles and responsibilities of HOP Entities

1) Network Leads

As previously stated, we support the Department's proposal to add new Network Leads to the program. We also support permitting (but not requiring) existing Network Leads to expand their geographic reach.

The Network Lead role is critical to helping to build coordinated networks of safety net providers within HOP. Network Leads have been invaluable resources for providing updates and guidance to HSOs and have been instrumental in helping HSOs learn about one another's services and forge connections with community partners in the HOP regions.

We appreciate that as the program expands beyond the initial 33 counties, the Department intends to continue the Network Lead model and implement a "champion" model by which the three original NL organizations can help establish best practices for new Network Leads.

While we appreciate the value of allowing Network Leads to pursue locally informed processes and protocols, as the program continues to expand, we recommend that the Department work closely with the Network Leads to standardize certain protocols across the state. As the program expands statewide, to enhance both efficiency and equity, we recommend that the Department (rather than Network Leads) develop statewide protocols and documents related to the delivery of HOP services.

[11] NC Department of Health and Human Services (NC DHHS), North Carolina Medicaid Reform Section 1115 Demonstration Renewal Application, Draft for Public Comment, released August 21, 2023. (pp. 15-16)

For example, documentation required for invoicing and quality control, such as the Landlord Attestation form that must be provided for various housing services and other documents that are required for HSOs providing Medical Respite and Short-Term Hospitalization, should be standardized by DHHS. Currently, many such documents have been created by Network Leads (and, in some cases, individual HSOs). The Department should provide standardized documents to ensure that these core administrative requirements do not vary by region or HSO.

We recommend that the Department enhance the roles of Network Leads by:

- Providing NLs with access to detailed member eligibility lists to allow NLs to build enrollment penetration maps by zip code, county, domain, and/or attributed practice;
- Funding existing NLs to provide training and technical assistance to newly added NLs, new and existing PHPs, HOP Administrators, CINs, and other stakeholders;
- Partnering with NLs to create and implement a comprehensive communications and public relations strategy; and
- Increasing capacity building budget allocation to ensure there are sufficient and sustainable resources NLs to scale Pilot services across all 100 NC counties.

2) Care Managers

The importance of Care Managers for the success of the Pilot cannot be overemphasized. While we have achieved a more refined process and protocols since the launch of the first HOP services, far too few HOP-eligible enrollees are receiving HOP services. All HOP entities share in the responsibility of increasing the number of enrollees who benefit from HOP-funded services. However, care managers play a distinct and vital role because they are responsible for assessing whether potential HOP enrollees are eligible for assistance, requesting authorization of payment from PHPs, and making referrals to HSOs.

Care Managers need additional and ongoing training to help them to screen for and assess needs, identify appropriate services for referral, and comply with referral protocols, including entering required referral information, such as the name and contact information for the parent or caregiver of minor Medicaid enrollees. Formal training opportunities and curriculum for Care Managers should be coupled with more regular convenings of Care Managers and HSOs for relationship-building and cross-pollination of knowledge and skills.

Moreover, the delayed launch of services within the IPV/toxic stress domain, and certain services in the cross-domain, including HOP-funded legal assistance, has had a profound and detrimental effect on care managers, many of whom are still uncomfortable screening for these needs and do not yet understand when to refer enrollees for these HOP services.

3) NC DHHS

We appreciate the Department's leadership in designing and launching HOP and its continued support in enhancing and refining the Program.

We urge the Department to ensure that its vendor, UniteUs, expedite essential modifications to the NCCARE360 platform which plays a significant role in a wide range of HOP processes, including several functions (such as invoicing and evaluation) that were not previously part of its national platform. Current challenges with the platform create unnecessary inefficiencies and administrative burdens for all HOP entities. HOP stakeholders have continuously expressed concerns and issues with the platform. Many of those concerns are also described in the CMS-approved evaluation reports.

For the remaining demonstrative period and for the new waiver period, the Department should actively seek feedback from HOP entities, especially HSOs, about how those concerns can be resolved. Prioritizing this effort is especially important before expanding HOP statewide.

We recommend that the Department work closely with NLs to standardize certain protocols across the state based on the valuable insight gained from the initial trial-and-error experimental phase. We recommend that the Department (rather than Network Leads) develop the following statewide protocols and documents related to the delivery of HOP services:

1. Standardize the HSO application process
    - Help HSOs understand what criteria will be used to evaluate their applications
    - This need not eliminate the role that NLs play in determining whether to offer contracts
2. Standardize access to guidance materials, tasks that must be completed, etc.
    - HSOs should not have to wait for/rely on NLs to provide information that comes from the Department
    - Since the Department is responsible for the terms of the NL-HSO contract, the Department should provide a uniform HSO manual as well as any updates as needed
    - NLs could then provide region-specific addenda to the Department's HSO manual
3. Standardize training requirements and ensure that HOP personnel (CMs, HSOs, etc.) have on-demand access to the required training.
4. Support Network Leads' efforts to develop other training materials, whether required or recommended for HSOs in their networks, and ensure that those additional training courses are available, on-demand, for any HSO.
5. Create a simple, uniform process to track participation in training events and HSO compliance with training requirements
6. Help HSOs that need assistance with developing policies and protocols that are included among the contract requirements

We believe this Department-led standardization will enhance both efficiency and equity as the program expands statewide.

F. Evaluation, Continuous Quality Improvement, and Quality Assurance

As we noted in the public comment meeting earlier this month, the current CMS-approved evaluation plan for HOP was not designed to determine the impact or value of any specific HOP service. Those data are critically important as the Department considers which criteria will be used to determine which HOP

services should be offered statewide, which service definitions should be changed, and which services should no longer be offered.

We are supportive of the Department's stated commitment to "Continuous Quality Improvement (CQI)." CQI is a progressive, iterative process that focuses on examining "how we are doing" and "what can we do better." In broad terms, CQI initiatives recognize that all processes can be improved, that performance, outcomes, and other indicators of quality can be improved through active engagement of project leadership and staff, and that data can be used to inform priorities and measure the effect of QI-related strategies.

However, it is unclear how the CMS-funded evaluation work will benefit HSOs to improve their ability to enhance service delivery. In fact, to our knowledge, HSOs have not received any information about the services that they provide to HOP participants. Nor have HSOs been invited to help interpret any evaluation data collected thus far.

Having reliable and sufficient data is the key to robust evaluations and without it, the Department and other HOP stakeholders face significant barriers to identify and resolve challenges that adversely affect the impact of the program.

For the final year of the current demonstration period, we ask that the Department explore and implement strategies to address all of lessons learned and recommendations that are cited in the Rapid Cycle Assessment Reports that are included in the Department's draft application.

For the remainder of the current waiver period and for the renewal period, HSOs and other HOP stakeholders should be provided with meaningful opportunities to ask questions and provide feedback about the measures and data collection methods for the HOP evaluation.

Conclusion

We appreciate the invitation to provide public comments about this important work that will benefit tens of thousands of North Carolinians. We are deeply committed to working with the Department and other key stakeholders to ensure the success of these potentially life-changing initiatives.

Sincerely,

[redacted]

Madlyn C. Morreale, JD, MPH
Managing Attorney, Medical-Legal Partnership Program
Legal Aid of North Carolina
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From: [redacted]
To: Medicaid.NCEngagement
Cc: [redacted]
Subject: [External] NC Section 1115 Waiver from NC Community Health Center Association
Date: Wednesday, September 20, 2023 5:00:03 PM
Attachments: 2023-9-20 NCCHCA Comments on NC 1115 Waiver Renewal.pdf

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Good afternoon,

Please find attached written comments from the North Carolina Community Health Center Association in response to the NC Section 1115 waiver proposed renewal.
We appreciate the chance to respond. Should you require additional information, please contact us.

Thank you,
Alice

Alice Pollard, MSW, MSPH (she/her)
Vice President of Operations and Strategy
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September 20, 2023

North Carolina Department of Health and Human Services
NC Medicaid Section 1115 Waiver Team
1950 Mail Service Center Raleigh, NC 27699-1950
Delivered via email to Medicaid.NCEngagement@dhhs.nc.gov

RE: NC Section 1115 Waiver

To whom it may concern,

The North Carolina Community Health Center Association (NCCHCA) is responding to the NC Department of Health and Human Services (DHHS, or the Department) solicitation for comments on the proposed renewal request of North Carolina's Medicaid Reform Section 1115 Demonstration. NCCHCA appreciates the opportunity to provide comment on the proposed renewal request.

NCCHCA is the state's primary care association, representing 43 North Carolina federally qualified health centers and look-alikes (FQHCs, community health centers, or health centers) with more than 450 sites in 87 of North Carolina's 100 counties. NCCHCA is a Section 501(c)(3) tax-exempt organization. North Carolina's FQHCs are a vital part of the health care delivery system, and as part of their mission to address the needs of underserved members of their communities, health centers provide additional services that many primary care practices may not, including integrated behavioral health, dental, pharmacy, and enabling services to all patients regardless of ability to pay.

In 2022, community health centers in North Carolina served more than 750,000 patients, approximately 174,000 of them Medicaid patients. Carolina Medical Home Network (CMHN) is a limited liability company owned by 35 FQHCs, of whom 23 are participating in a clinically integrated network to improve the quality of care and health outcomes for their patients. Across its network CMHN serves more than 100,000 Medicaid beneficiaries. NCCHCA serves as part owner and managing partner for CMHN. NCCHCA's below feedback comes from health center's extensive experience working with Medicaid beneficiaries in North Carolina.

After reviewing the proposed renewal, NCCHCA writes to provide feedback on the initiatives put forth that we hope the Department will consider as it finalizes the renewal application and implements these initiatives.

Comments

NC Objective 1: Support a continued, smooth transition to managed care with a focus on improving care for enrollees with the most complex needs.

Initiative 1a. Provide integrated whole-person, well-coordinated care for Medicaid enrollees through continued implementation of Standard Plans and Initiative 1b. Provide integrated care for individuals with serious mental

illness, serious emotional disturbance (SED), severe substance use disorder (SUD), intellectual and developmental disabilities (I/DD), and/or traumatic brain injury (TBI), through the launch of Tailored Plans.

NCCHCA and our member health centers have been active partners in the implementation of Standard Plans. We appreciate the focus on whole-person health, as well as the robust Advanced Medical Home Program, which aims to provide coordinated care.

NCCHCA and health centers are working hard to keep up with payment and delivery system reform, as well as be prepared to move to value based care and payment. NC's Medicaid Transformation has provided opportunities for a movement towards the payment reforms that allow focus on value. We encourage NC DHHS to explore aligning efforts with other payer initiatives, such as Making Care Primary, to make it easier for providers to participate in value-based care initiatives. In addition, we encourage DHHS' continued thoughtful collaboration in addressing some of the continued issues with standard plans, such as PCP attribution issues, that can make it more difficult for providers to serve patients.

As Tailored Plans are implemented, we encourage NC DHHS to take the same thoughtful approach to implementation that it has thus far in the process. Some community health centers have reported a desire to contract as primary care and integrated behavioral health providers with Tailored Plans but have experienced much confusion with the process. We encourage NC DHHS to work with Tailored Plans to ensure a robust provider network. We also encourage NC DHHS to learn from early issues with Standard Plan implementation, such as delayed payments to health care providers, to improve the experience of PCPs and beneficiaries under Tailored Plans. Further, we appreciate the opportunity for Tailored Care Management providers to begin offering services even as Tailored plans are delayed. We encourage NC DHHS to identify additional sources of capacity building funds for those PCPs who wish to become Tailored Care Management providers.

Initiative 1c. Provide integrated care to address the complex needs of youth and families served by the child welfare system through the implementation of the Children and Families Specialty Plan (CFSP).

NCCHCA appreciates the intent to provide one statewide plan for youth and families served by the child welfare system. This group can be particularly vulnerable to experience gaps in care and one statewide plan will support a robust set of services. Given the delayed implementation of Tailored Plans and other potential major changes to the Medicaid system in 2024 and 2025, we encourage NC DHHS to provide robust support for providers and beneficiaries to understand yet another transition in the system. We also support the robust care management outlined in the CFSP proposal. We encourage NC DHHS to align CFSP care management requirements with existing requirements to extent possible.

<u>Objective 2: Strengthen access to a person-centered and well-coordinated system of care which addresses both medical and non-medical drivers of health.</u>

Initiative 2a. Build on the Healthy Opportunities Pilot (HOP) infrastructure and experience to expand health-related social needs services to North Carolinians across the state.

- *Expansion Across State*

We commend the state for its dedication to advancing whole-person care through initiatives such as the Healthy Opportunity Pilots. NCCHCA supports expanding HOP beyond the current three pilot regions to all counties in the state. Health centers and patients have found that services provided by HOP have helped them meet their health-related social needs and be able to focus on improving their health conditions.

However, NCCHCA and member CHCs have experienced some issues with the current HOP program, which we hope will be addressed as the state considers expansion. In some cases, needed HOP services are not readily available in the current pilot regions, mostly due to Human Service Organization capacity. While we encourage expansion of HOP statewide, we urge NC DHHS to work with partners to build capacity of HSOs so that they are ready to meet the needs of beneficiaries. In the current pilots, there is variation with each lead pilot entity with HSO onboarding and oversight, which can create differences in services and coordination. If additional network leads are added, we encourage NC DHHS to work with all Network Leads for a more standardized approach to onboarding, training, technical assistance, and oversight, while at the same time ensuring grassroots HSOs can participate. Often these grassroots and local organizations are best suited to meet health related needs. We also encourage NC DHHS to ensure prompt and adequate payment to HSOs for services provided, as well as to consider the administrative costs of delivering services.

We also encourage NC DHHS to ensure appropriate supplemental and capacity building funding for Advanced Medical Homes who are helping ensure beneficiaries can access HOP services. The process for qualifying and enrolling in HOP is complex and requires extensive knowledge and time from AMH teams. Care managers and coordinators are an essential part of the HOP process and with additional regions of coverage, additional capacity will be needed.

- *Modify Services*

NCCHCA supports the modification of services as proposed. Health centers consistently report that housing is one of the most challenging health related social needs to help patients navigate, as there is a lack of affordable housing in many areas of the state. Unstable housing can also rapidly affect health conditions. We are especially supportive of the adaptation of the existing housing service and encourage the Department to consider additional housing support, such as utility assistance or short-term hotel stays for emergency needs. In addition, we appreciate the addition of the new "firearm safety" service. If approved, we urge NC DHHS to make this HOP service easily accessible to those who may qualify. Finally, we urge consideration of coverage of legal support services, including medical legal partnerships, which can assist beneficiaries across multiple domains.

- *Expanding Eligibility Criteria*

NCCHCA supports expanding the criteria for HOP beneficiary eligibility. Health centers and CMHN care managers have reported that some beneficiaries who need services are not currently able to benefit due to the eligibility criteria. With expanded eligibility, we also encourage further promotion of HOP services, as many providers working with those who do qualify are not aware of the potential access for their patients.

- *Capacity Building*

NCCHCA supports the additional request for capacity building funds and encourages NC DHHS to work with a wide range of partners to determine who may benefit from capacity building funds. Health centers who operate as HSO and HOP service providers say that capacity building funding has been essential in their ability to continue offering services.

Initiative 2b. Promote continuity of care by offering continuous enrollment in Medicaid to children and former foster care youth.

NCCHCA strongly supports the proposal for continuous enrollment for children and youth. As NC DHHS details in the proposed renewal, gaps in coverage for these populations can lead to missing essential early intervention

services, preventive screenings, and vaccinations. Even though they provide care regardless of insurance status, community health centers have seen the challenges that come when an individual, particularly a child, loses access to insurance coverage. Parents often must make difficult decisions about seeking care without knowing about the financial implications when a child is uncovered. In our experience, children who lose access to Medicaid are still categorically eligible but have been removed due to procedural reasons. There is much confusion on the part of children, parents, and often providers, about why coverage was ended and it is often not an easy process to re-enroll. Continuous enrollment will ensure that children are covered in this vital time in their lives. We are very pleased to see the intent to offer 24 months of continuous coverage for children ages six through 18. Health centers have seen an increased need among this age group for mental health services during and after the COVID-19 pandemic, reflecting larger national trends. A longer continuous coverage period will provide greater support for youth getting access to mental health services at a particularly vulnerable time.

In addition to the challenges for beneficiaries, providers can experience challenges when children lose coverage and are no longer assigned to the practice. This creates challenges for panel management and value-based incentives.

Initiative 2c. Improve health outcomes and support reentry into the community for justice involved individuals by providing targeted pre-release Medicaid services.

- *Learning from Existing Programs and Partnerships*

NCCHCA supports providing pre-release services for justice involved individuals. Health centers serve patients who have been recently released from incarceration and know that the time after release can be a particularly challenging time. Individuals leaving the justice system have multiple issues to deal with, and having ready access to health services will allow them to focus on securing housing, employment, and social support, all of which support a well-rounded transition back into their communities and reduce risk of recidivism. Many NC CHCs have engaged in partnerships with correctional institutions, including county jails and youth correctional facilities, to offer services to individuals during and after their incarceration. Working within the justice system can be complex, as both health care providers and correctional institutions have their own rules and systems. However, health centers have been able to overcome barriers and develop robust collaborations that help provide a safety net for individuals post release, supporting both their health and social needs.

NCCHCA was an early partner in the development of the North Carolina Formerly Incarcerated Transition (NC FIT) Program. Health centers continue to work as partners with NC FIT; providing primary care, integrated behavioral health, Medication Assisted Treatment for opioid use disorder, and other services to formerly incarcerated individuals with chronic health conditions. Key to the FIT model is a community health worker with a personal history of incarceration. NCCHCA encourages NC DHHS to build on this existing successful model in NC as it integrates pre-release Medicaid services.

- *Health Centers as Partners*

NCCHCA also encourages NC DHHS to explore working with community health centers for pre-release services. Health centers stand at the ready to assist this population with pre-and post-release services. Having a community partner involved in care pre-release is important for maintaining continuity of care. For example, a health center provider may be able to see people while they are incarcerated and upon release, which would

help to build trust and understanding of the individuals' care history. Health centers will continue to serve this population even with future changes in their insurance status, so they are an ideal medical home.

- *Services Proposed*

NCCHCA supports all the minimum and additional services described by NC DHHS. We appreciate the focus on case management as one of the pre-release services. We encourage NC DHHS to consider allowing community health workers to offer this service. As we have seen with the FIT program, a CHW professional with lived experience with incarceration is an invaluable member of the health care team for this group of people. In addition, we ask NC DHHS to consider flexibility with a longer medication supply if a provider deems it appropriate. Thirty days can pass quickly and even with the best intentions to establish a new medical home, an individual may need more time to get new prescriptions.

Many individuals leaving incarceration may need support with housing, food, income, and employment. Often, it is these needs that are most pressing on those recently released, as they seek to integrate back into their communities. We encourage NC DHHS to think about how HOP services may be available for individuals prior to and immediately upon release. We also encourage NC DHHS to work with partners in the state and local levels to support comprehensive re-entry support that will meet many needs.

Finally, while many justice-involved individuals will be eligible for Medicaid, there may be others who do not qualify. We encourage NC DHHS to use this initiative to help those who do not qualify for Medicaid to explore other coverage prior to release. This may include Marketplace coverage or seeking care at a safety net provider.

- *Capacity Building*

NCCHCA supports the request for capacity building funds. Health centers who have developed partnerships with the justice system have reported that these partnerships do require an investment of resources so that both systems are prepared to work together. NCCHCA urges these capacity building funds to be open to organizations beyond correctional facilities, including community health centers who partner in this initiative and community-based organizations that support re-entry.

<u>Objective 3: Strengthen the behavioral health and I/DD delivery system</u>

Initiative 3b. Improve the coordinated system of care for people with behavioral health and I/DD needs through targeted new investments in technology.

NCCHCA supports provision of health IT grants for providers who serve individuals with mental health conditions. We urge NC DHHS to broadly include all providers and Clinically Integrated Networks who serve this population and meet other listed requirements, including primary care providers. PCPs may incur additional HIT costs as they prepare to serve this population, especially under Tailored Plans. We are also supportive of requested funding for schools. We encourage NC DHHS to allow schools to use funds for HIT costs at school-based health centers.

In addition, we want to highlight how new investments in telehealth technology and investing in digital literacy and access, can help bolster access to services. Community health centers have found that telehealth technology is a key piece of the puzzle in helping with access to behavioral health services, whether it is a patient accessing services from a remote location, or a primary care provider consulting with a specialist. We encourage the exploration of how investments can support expanded telehealth access.

- *Initiative 3c. Bolster the behavioral health and long-term services and supports (LTSS) workforce.*

NCCHCA supports the expansion of the behavioral health student loan repayment program to support additional behavioral health professionals. NC health centers are facing a critical shortage of many different providers, including behavioral health providers. As health centers are increasingly called on to meet beneficiary behavioral health needs, both inside and outside the primary care setting, we need additional incentives to recruit behavioral health providers. Loan repayment programs, such as the State Loan Repayment Program, which require commitment to work in underserved areas, are one of the many levers that can support placement of qualified professionals in health centers. While NC CHCs consistently encourage providers to apply for existing loan repayment, there is often not enough funding to support all professionals who could benefit and be incentivized to work in a CHC. We are pleased to see the intent to expend funds in this way. In addition, we encourage NC DHHS to allow associate level professionals (e.g., LCSW-A) to participate in loan repayment opportunities. This group of professionals is not eligible under the current state programs. They are a valuable part of the workforce and often would like to work with CHCs, but they need to begin repaying loans immediately. Extending loan repayment to this professional group is essential to help address workforce needs.

In closing, NCCHCA and our member health centers are key partners in the implementation of the Medicaid program and many of the 1115 waiver initiatives. We stand ready to help NC DHHS to implement initiatives to provide robust and coordinated care for some of North Carolina's most vulnerable people.

Thank you for your consideration of these comments. Please do not hesitate to reach out to Chris Shank [redacted] or Alice Pollard [redacted] with any questions.

Best,

Alice Pollard

Vice President of Operations and Strategy

From: [redacted]
To: Medicaid.NCEngagement
Cc: [redacted]
Subject: [External] "NC Medicaid Section 1115 Waiver" as the subject.
Date: Tuesday, September 19, 2023 10:51:15 AM
Attachments: Outlook-goii1wmg.png
1115 Waiver Letter of Support.pdf

Good morning,

We at FHLI are excited to submit our letter of support for the 1115 Wavier. Please see the attached document and do not hesitate to contact me if you have any questions or require additional next steps.

B. David Reese, MBA
President/CEO
Foundation for Health Leadership and Innovation
2401 Weston Parkway,
Suite 203 Cary, NC 27513
919-821-0485 Office
[redacted]

FOUNDATION FOR HEALTH LEADERSHIP & INNOVATION
MOVING PEOPLE AND IDEAS INTO ACTION

40 YEARS SERVING NORTH CAROLINIANS

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MOVING PEOPLE AND IDEAS INTO ACTION

NC Medicaid Section 1115 Waiver Team
North Carolina Department of Health and Human Services
1950 Mail Service Center
Raleigh, NC 27699-1950

September 19, 2023

To Whom It May Concern:

On behalf of the Foundation for Health Leadership & Innovation (FHLI), I'd like to express the organization's full support for North Carolina's request to renew its Medicaid Reform Demonstration for another five-year period. The continuation and expansion of the waiver will allow North Carolina to continue its national leadership in improving the health and well-being for all North Carolinians through a whole-person system of care that addresses medical as well as social drivers of health. Since the launch of the Healthy Opportunity Pilots in the early days of the Covid-19 pandemic, nearly 13,000 individuals have enrolled in the three Pilot regions and have received almost 115,000 services, many of them lifelines to residents desperately in need of healthy food resources, housing assistance, and other critical sustaining services.

As the administrator of NCCARE360, the first in-the-nation statewide network that unites more than 3,200 healthcare and human service organizations on a shared technology platform, we have witnessed the direct positive impact of providing needed social services to North Carolinians in need. The continuation, enhancement, and expansion of the Pilot program statewide will allow health care organizations and community organizations to meet the needs of hundreds of thousands of North Carolina residents that currently lack adequate access to basic social services. Additionally, continuation and enhancements to this unique model will provide valuable lessons learned for other states who choose to pursue a whole-person care model to address disparities for historically marginalized populations.

Thank you for the opportunity to express our full support for North Carolina's pursuit of a renewal of its Medicaid Reform Demonstration for another five-year period. If you have questions or need additional information, please feel free to contact me via the information below.

Sincerely,

[redacted]

B. David Reese
President and CEO
Foundation for Health Leadership & Innovation
2401 Weston Parkway
Suite 203
Cary, NC 27513
(O) 919-821-0485
[redacted]

From:	[redacted]
To:	Medicaid.NCEngagement
Cc:	[redacted]
Subject:	[External] NC Section 1115 Waiver
Date:	Wednesday, September 20, 2023 3:26:37 PM
Attachments:	image001.png APNC_1115 Comments.pdf
Importance:	High

Good afternoon,

Attached are comments on the proposed North Carolina Medicaid Reform Demonstration renewal application from Addiction Professionals of North Carolina (APNC). We thank you for the opportunity to comment and look forward to working with you on implementation.

Sincerely,

Sara M. Howe, MBA, MS, CHES
Chief Executive Officer
[redacted]
[redacted]

APNC.org | @YourAPNC (FB, Instagram, Twitter, & LinkedIn)

Addiction Professionals of North Carolina
3733 National Drive, Suite 225
Raleigh, NC 27612
www.apnc.org

September 20, 2023

North Carolina Department of Health and Human Services
NC Medicaid Section 1115 Waiver Team
1950 Mail Service Center
Raleigh, NC 27699-1950

Dear 1115 Waiver Team:

Thank you for the opportunity to comment on the North Carolina Medicaid Reform Section 1115 Demonstration Renewal Application. As the trade association representing substance use professionals and providers in the state of North Carolina, the Addiction Professionals of North Carolina (APNC) commends the proposal for the ongoing advancement of expanding care to the Medicaid beneficiaries of North Carolina needing life-saving substance use disorder (SUD) treatment and recovery services. Overall, we applaud the efforts of the proposal, specifically the SUD components that will help achieve the goals of responding to the diverse needs of North Carolinians. The following comments will expand on the progress made over the past five years and support the future vision of the North Carolina Medicaid program.

Objective 1: Ensure Smooth Transition to Managed Care
As North Carolina transitions to managed care, APNC encourages the state to emphasize provider engagement during the transition period. This engagement should include transparent and ongoing communication to keep providers apprised of the changes that will impact their practices in the near and longer term. There is a recognition that when this change occurs, there may be a lag time across providers. The state could consider consulting best practices and case studies from other state experiences to adopt a process that will meet the unique North Carolina needs.

As the state transitions to managed care and expands Medicaid, providers, such as addiction professionals, may now find their current service offerings Medicaid-eligible. These services may have historically been funded by federal programs through state pass-through grants or other funds with different requirements or accountability structures than Medicaid. **APNC recommends that the state consider the current financing providers are receiving and ensure that Medicaid-managed care provides a sustainable model to continue offering services to beneficiaries. Furthermore, the state should provide change management and technical assistance support for providers new to Medicaid enrollment.**

Objective 2: Strengthen Access to Whole-Person, Coordinated Care
APNC supports the state's continuation on the path to whole-person care. However, some barriers have traditionally prohibited this integration with SUD providers. One of the greatest impediments to sustained recovery for patients is that various specialty SUD programs and treatment settings operate in isolation from mainstream health care with limitations in referrals and/or requisite information sharing with other key parties. The future of SUD care must be assertively linked with primary care and other social determinants of health initiatives by recognizing its impact as a condition on the total cost of care. Specialty providers serving this

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population must be included in shared savings arrangements created by improved coordination and efficiency. **APNC recommends that NCDHHS offer opportunities for providers to work together through shared accountability and shared risk arrangements where the economics of the model fully appreciate the value of the SUD care provided. This includes shared access to health information, shared long-term treatment and recovery goals for the patient, shared quality and process measurements, and shared performance and outcome-based payment.**

APNC strongly supports the coverage of targeted pre-release Medicaid services to justice-involved individuals. There is a precedent set forth by the recently approved California and Washington State waivers for coverage of services provided by community health workers (CHWs) with lived experiences. APNC recommends the inclusion of CHW or peer recovery coach services as part of the covered pre-release services.

APNC commends the investment in capacity funds for correctional facilities to meet Medicaid guidelines. To demonstrate outcomes, the waiver states there will be an analysis of data files such as claims linked with criminal justice indicators, preventive and routine physical and behavioral health care data, and data on avoidable ED visits and inpatient hospitalizations. Correctional settings or health care providers may require investment in IT infrastructure to ensure it is possible to report on these measures. APNC recommends emphasizing the IT infrastructure as an approved expenditure of capacity-building funds.

Objective 3: Investments in Behavioral Health and I/DD Technology
APNC agrees with the initiatives set forth under Objective 3. The current SUD waiver has enabled individuals to receive life-saving care, and APNC commends the state for extending the SUD components, including IMD coverage.

The HIT grants and other technology initiatives are critical for SUD providers in North Carolina. SUD and mental health providers were excluded from the 2009 HITECH Act, which incentivized physical health providers to invest in IT infrastructure. Consequently, SUD providers are operating with outdated systems. APNC recommends prioritizing SUD providers for IT grant funds to enhance IT to provide greater patient care for addiction treatment and recovery. Enhancing SUD provider IT will also lend to greater interoperability and data sharing across the entire health care continuum of providers, ensuring an individual is receiving comprehensive whole-person care.

As the state grapples with behavioral health workforce shortages, APNC supports initiatives in the waiver to bolster this challenge. The loan repayment program is comprehensive, offering support to individuals in the behavioral health field for education expenses. However, the program does not mention occupation certification or licensure expenses or offer repayment options for peer recovery roles. These critical requirements and roles in the SUD field should be considered with the repayment package options. APNC recommends adding reimbursement for licensure and certification across all professionals, and associated expenses to become a peer recovery professional.

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With deep knowledge and relationships across the provider community, APNC has a strong understanding of the SUD Provider community's most significant workforce challenges. In March of 2022, APNC released the results of our membership survey, which highlighted challenges such as low rates of pay, not enough workers to meet demands, secondary trauma, and limited services for direct workers. Based on these findings, APNC published recommendations to address these challenges, including waiving certain burdensome administrative work, financing equitable wages, and loan repayment programs outlined in the waiver. **APNC recommends a review of the published recommendations to consider including in the workforce initiatives outlined in the proposed waiver.**

Thank you for taking the time to review our feedback. Please contact me with any questions or to discuss our feedback.

Sincerely,

[redacted]

Sara M. Howe, MBA, MS, CHES
CEO

From:	Collan Rosier
To:	Medicaid.NCEngagement
Cc:	Bridget Cain
Subject:	[External] Pyramid Healthcare - NC Section 1115 Waiver Comment Letter
Date:	Wednesday, September 20, 2023 4:39:04 PM
Attachments:	image001.png 2023-09-20 - NC - Pyramid NC DHHS Comments re NC Section 1115 Waiver (FINAL).pdf

Good afternoon,

On behalf of the Pyramid Healthcare family of companies, attached please find our comments with regard to the North Carolina Medicaid Reform Section 1115 Demonstration Renewal Application.

Thank you and best wishes,
Collan

Collan B. Rosier
Vice President of Government Relations

PYRAMID HEALTHCARE, INC.
O: 667-270-1582 | [redacted] | **E:** [redacted]

Pyramid Healthcare
AN INTEGRATED BEHAVIORAL HEALTHCARE SYSTEM

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September 20, 2023

SUBMITTED VIA EMAIL to Medicaid.NCEngagement@dhhs.nc.gov

The Hon. Kody Kinsley, Secretary
North Carolina Department of Health & Human Services
NC Medicaid Section 1115 Waiver Team
1950 Mail Service Center
Raleigh, NC 27699-1950

RE: Pyramid Healthcare, Inc. Comments re NC Section 1115 Waiver

Dear Secretary Kinsley:

The Pyramid Healthcare, Inc. ("Pyramid Healthcare") family of companies is providing information and feedback below regarding the North Carolina Medicaid Reform Section 1115 Demonstration Renewal Application proposed by the North Carolina Department of Health & Human Services (hereinafter "NC DHHS" or "the Department").[1] We urge the acceptance of this demonstration renewal application to ensure that high-quality care is delivered to North Carolinians with substance use disorder. Costs associated with the nation's twin mental health and substance use disorder crises are huge economic burdens for states. Drug overdoses are now the leading cause of accidental death in the United States[2] and significantly tax state and local government resources through the Medicaid system as well as police, emergency services, and the criminal justice system.

As background, Pyramid Healthcare was founded in 1999 and is an integrated behavioral healthcare system that employs over 3,100 professionals caring for 12,000 unique commercial and Medicaid patients per day throughout our residential and outpatient locations across eight states. We offer a treatment continuum providing comprehensive behavioral healthcare specialties, including: substance use disorder, mental health, autism, and eating disorder treatment across an integrated network of service lines and affiliated behavioral healthcare organizations.

In North Carolina, we operate eight residential and outpatient facilities for adult and adolescent clients with mental health, substance use, and co-occurring needs. We serve a variety of local and state agencies and programs, including the Substance Abuse Intensive Outpatient Program (SAIOP), Substance Abuse Comprehensive Outpatient Treatment (SACOT) program, Assertive Community Treatment Team (ACTT) program, Cross Area Service Program (CASP) services as well as Medication-Assisted Treatment (MAT), Medication Management, Peer Support Services and other wrap-around services. In addition, Pyramid Healthcare maintains accreditation across all of our facilities through The Commission on Accreditation of Rehabilitation Facilities ("CARF").

[1] North Carolina Medicaid Reform Section 1115 Demonstration Renewal Application (Aug. 21, 2023), *available at* https://medicaid.ncdhhs.gov/nc-1115-waiver-demonstration-renewal-application-0/download?attachment.
[2] https://tinyurl.com/4ysxbre2.

Our comments are primarily in favor of the Department's emphasis on how to strengthen the behavioral health delivery system, especially initiatives focused on providing Medicaid coverage for individual obtaining short-term SUD treatment in IMDs and bolstering the behavioral health workforce.[3] We appreciate the opportunity to provide comments and feedback to NC DHHS below regarding the following topics that will aid the state in complying with its goals and milestones outlined in the waiver extension application:

- ASAM Alignment
- Provider Medicaid Reimbursement for Residential and Outpatient Mental Health and Substance Use
- Extension of the IMD Exclusion Waiver
- Bolstering the Behavioral Health Workforce

ASAM Alignment

The Department proposes to expand "its SUD service array to include the full ASAM continuum of care and aligning care with the ASAM standards. Under the demonstration, North Carolina is required to aim for a statewide average length of stay of 30 days in residential treatment settings to ensure short-term residential treatment stays."[4] One of the most important endeavors for North Carolina to pursue through its 1115 Waiver is to adopt alignment with the standards proposed by the American Society of Addiction Medicine (ASAM) for adolescent and adult residential and outpatient substance use treatment services.[5]

ASAM created levels of care as an industry guideline of best practices for behavioral healthcare treatment regarding placement, continued stay, transfer or discharge of patients with substance use disorders and co-occurring conditions. These criteria are recognized as the national gold standard for behavioral healthcare and illustrate the full continuum of care. Aligning state regulations with ASAM criteria will also help North Carolina comply with Milestone 2 – Placement Criteria and Milestone 3 – Provider Qualifications of the waiver extension application. North Carolina's adoption of ASAM Alignment would give providers clinical best practices and a framework for substance use disorder providers and encourage uniformity in admissions criteria into the various levels of care from outpatient (1.0) to hospitalization (4.0). With uniformity in the structure of programs and requirements, however, comes the need for rate increases to ensure this conformance and compliance is completed by appropriate staff.

Other states while launching ASAM Alignment have rolled out other unrelated requirements under the banner of "ASAM alignment" such as specific staffing ratios, lengths of each session, and others which are outside of the ASAM manual's dictation. We discourage North Carolina from creating duplicative and overlapping regulatory requirements and instead to adopt as its regulatory framework the actual ASAM criteria and standards. All other additional requirements should go through the appropriate approval process through state regulatory review committees or regulatory reform efforts. In particular, ASAM alignment will help right size funding and requirements related to North Carolina's .3400 level of licensure to bring it in alignment with ASAM's 3.5 level of care for residential substance use disorder treatment, which will rapidly expand provider treatment bed capacity for North Carolinians with substance use disorder issues. Currently, North Carolina's .3400 level of licensure [redacted] propriate staffing and program requirements of ASAM's level 3.5. Aligning and [redacted] erage of and funding for services will help the state better fulfill the terms of its

[3] NC Medicaid Reform Section 1115 Demonstration Renewal Application at 20-24.
[4] *Id*., at 20.
[5] https://www.asam.org/asam-criteria/about-the-asam-criteria.

Provider Medicaid Reimbursement for Residential and Outpatient Mental Health and Substance Use.
While we agree that ASAM alignment is a crucial step forward to ensuring access to substance use treatment services for North Carolinians across the care continuum, but coverage of these substance use disorder treatment services is insufficient without appropriate reimbursement to providers to be able to recruit, retain, and reward appropriate staffing levels necessary to assist clients occupying those residential treatment beds.

North Carolina's recent adoption of Medicaid expansion creates an opportunity to bring North Carolina in line with other states like Virginia[6] that have focused substance use efforts on ASAM alignment and the concurrent investment in sufficient and sustainable Medicaid reimbursement rates. Expanded reimbursement to better align with more competitive neighboring states will increase provider capacity and expand access in compliance with Milestones 1 – Access and 4 - Capacity, We encourage North Carolina to make substantial efforts to increase and maintain competitive Medicaid reimbursement rates for residential and outpatient substance use disorder and mental health treatment services in alignment with ASAM levels of care – especially residential substance use treatment services at the 3.7, 3.5, and 3.1 levels of care.

While ASAM Alignment is the right decision to ensure high quality outcomes for our clients, it does not come without additional – but necessary – administrative and staffing costs for providers. A decade has gone by without sustained enhanced rates and enhanced rates related to the COVID-19 pandemic expired in late 2022. Uncompetitive reimbursement rates do not allow providers to recruit, retain, and engage appropriate staffing to serve our patients. They force us to turn away patients in need of care. Continued high readmission rates to detox services, inpatient psychiatric hospitalizations, and high rates of emergency room utilization will occur without access to care. Furthermore, as a part of Medicaid transformation, providers have already been managing higher administrative burden and compliance costs as a result of the requirements of the various Local Management Entities/Managed Care Organizations (LMEs/MCOs).

Providers need to remain competitive to assure adequate, qualified staffing and to administer high-quality care and to provide access to treatment and recovery for some of the state's most vulnerable residents. North Carolina needs a robust provider network for mental health and substance use services; however, these services are not sustainable at the current reimbursement rates. This problem is getting worse as the cost to attract and retain staff, such as registered nurses, continues to rise without any commensurate increases in payment rates. These factors, combined with inflation, effectually result in annual rate decreases to providers.

Extension of the IMD Exclusion Waiver
Pyramid Healthcare has always prided itself on offering our clients the full continuum of care for treatment across our mental health and substance use programs. These efforts to provide a robust and integrated system of care are thwarted in states that retain outdated and unnecessary regulatory barriers that restrict access to care and prohibit a full and complete system of care in the community.

The Department seeks to extend its waiver of the institutions for mental disease ("IMD" exclusion for an [redacted] its current expiration date of October 31, 2023. We fully support the State's [redacted]ll continuum of care for North Carolinians with mental health and substance use [redacted]ovided separate comments in support of the SUD demonstration's renewal. We [redacted]usion waiver to continue to waive this outdated and burdensome requirement that prevents clients from receiving access to care and prevents providers from creating the appropriate mental health and substance use disorder treatment bed capacity in the State. These are highlighted as Milestones 1 and 4 of NC DHHS's 1115 substance use disorder waiver extension application.

[6] https://www.magellanofvirginia.com/documents/2022/10/10-27-22-va-dmas-medicaid-rates.pdf/.

NC DHHS has highlighted lack of access as creating a high risk of noncompliance with the demonstration and should be a primary focus of efforts going forward. This expansion of authority for providers to bill Medicaid for treatment centers with more than 16 beds has led to increases in access to care and reductions in Emergency Department utilization in states that have pursued this authority and will help the State comply with Milestone 1 of the waiver extension. We applaud North Carolina for pursuing this authority and urge the State to continue these flexibilities.

Bolstering the Behavioral Health Workforce

The United States is experiencing historically high student loan debt burdens across the economy. This is even more acute among healthcare professions, including behavioral health and substance use, where advanced degrees and continuous training and certification requirements add extraordinary time commitments and financial burdens. It creates ongoing stress and inevitably results in qualified clinicians and caregivers entering private practice or transitioning to commercial insurance as soon as possible rather than continuing to serve vulnerable but underfunded programs such as Medicaid.

The Department acknowledges these challenges in its renewal application and agrees that the State's "workforce lacks the capacity to address the state's growing behavioral health crisis"[7] due to acute shortages in various behavioral health provider types. Furthermore it proposes funding for a loan repayment program and recruitment and retention funds to "to support additional behavioral health professionals statewide who provide care to Medicaid enrollees, individuals who receive services via Indian Health Services (IHS), and other under-resourced populations."[8]

We support and applaud these efforts and urge their approval but request clarification that the loan repayment program and recruitment and retention funds would apply to applicable behavioral health professionals serving Medicaid and other beneficiaries at providers regardless of the tax status of the employer. Of note, some states have excluded for-profit providers from eligibility for behavioral health the loan forgiveness programs. Rather than dictating eligibility based on an arbitrary discrimination based on tax status, we believe the eligibility criteria should be based on the activities and services being provided by the facility and the clinician or behavioral health personnel. The loan repayment program should apply to all relevant behavioral health professionals serving Medicaid regardless of whether the employer is a for-profit or nonprofit behavioral health provider.

Please consider this feedback with regard to the 1115 Waiver. Thank you for your support of mental health, behavioral health, and substance use providers in North Carolina and for considering my requests on behalf of Pyramid Healthcare. If we can provide any additional information or materials, please contact me at crosier@pyramidhc.com or 667-270-1582. In addition, we invite you to reach out and schedule a visit to one of our North Carolina facilities sometime soon to learn more about our services and programs.

Sincerely,

[redacted]

Collan B. Rosier
Vice President of Government Relations

[7] NC Medicaid Reform Section 1115 Demonstration Renewal Application at 22.
[8] *Id.*

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115
Date: Tuesday, September 19, 2023 8:48:45 PM

I am submitting the following feedback regarding the pilot portion of the current draft of the NC Section 1115 Demonstration Waiver application.

1. RETAIN: I strongly support the following items in the state's draft application:

Whole-person integrated approach to care supported by a care management model.
Expansion of geographic eligibility to include all 100 counties.
Expansion of pilot eligibility to include all pregnant and postpartum women, justice-involved individuals, those who are "at risk of" a chronic condition, individuals with only one chronic health condition, individuals recently impacted by natural disasters, children/youth who receive adoption assistance and all Tailored plan members and Tailored Care Management eligibles in prepaid inpatient health plan (PIHP).
Expansion of meal services to three meals per day.
Availability of capacity building funds throughout the demonstration waiver period.
Central role of NLs in ensuring the pilot's success.

2. MODIFY: Impact Health believes the following items could be improved upon:

Refine language around rental assistance to include:
up to six months of rental assistance including payment of arrears
for all enrollees who demonstrate need (not just high-needs enrollees).
Prioritize investments in community-based organizations and local service delivery models.
Increase capacity building budget allocation and/or significantly increase fee schedule payments to ensure there are sufficient and sustainable resources for human service organizations (HSOs) and NLs to scale pilot services across all 100 NC counties.

3. CLARIFY/ADD: Impact Health requests the following clarifications and additions:

Expand eligibility to include all NC Medicaid members—regardless of coverage type—who screen positive for a pilot-supported social health need.
Clarify HOP eligibility of Medicare/Medicaid dual enrollees.
Include all HOP services in pre-release Medicaid services available to justice involved individuals.
Allow continuous access to HOP services for justice-involved individuals for 1-year post-release.
Clarify that current NLs and HSOs do not need to reapply under the new waiver.
Additional Recommended Pilot Enhancements

Fee Schedule Improvements

Standardize fee schedule statewide to reduce the potential for confusion, referral delays and rejections.

Approve additional evidence-based parenting curricula in alignment with NC Partnership for Children to allow HSOs to leverage existing resources to meet regional needs.
Review all services to ensure a coordination or admin fee is included.

Network Development

Give contracting preference and/or incentives to local, community embedded HSOs to promote equity and improve pilot enrollment, member satisfaction, expansion of services/geography and culturally inclusive service delivery.
Prioritize and incentivize local health and social service agencies to participate in the pilot.
Provide ongoing capacity building funding to support NLs who play a critical role in developing and maintaining network diversity, capacity and sustainability.
Strengthen and expand NL's role to ensure pilot success by:
providing NLs with access to detailed member eligibility lists to allow NLs to build enrollment penetration maps by zip code, county, domain and/or attributed practice,
funding existing NLs to onboard and provide training and technical assistance to new NLs and new and existing PHPs, CINs and other stakeholders,
engaging NLs as primary regional representatives in state-level decision-making, and
partnering with NLs to create and implement a comprehensive communications and public relations strategy.
Digital Platform & Billing Process Improvements

Develop a clear pathway and process to support data sharing between pilot stakeholders to ensure NLs can make data-driven decisions and conduct continuous quality improvements.
Improve the accuracy and efficiency of the pilot's digital billing processes by implementing technical solutions that
standardize billing practices using 837 and 835 data sets,
integrate benefits inquiries and responses (270/271 data sets) to provide HSOs with real-time access to client eligibility data, and
improve the user experience by providing functionality for data searches, claims management, and elimination of duplicate claims.

Compliance and Quality Assurance

Require HSOs who directly contract with PHPs to participate in NL compliance activities to ensure network adequacy and service delivery quality.
Increase accountability and transparency around PHP responsibilities regarding care management network adequacy, quality improvement, and payment processes.

From: Asheville Buncombe Homeless Coalition
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 4:14:15 PM

I am writing to express my support for the renewal of the NC Medicaid Section 1115 Demonstration Waiver. As a member of the Asheville Buncombe Homeless Coalition's executive team, an organization dedicated to resource connection and community education with a focus on addressing homelessness, I firmly believe that this waiver plays a crucial role in our collective efforts to improve the well-being of our community. The Asheville-Buncombe Continuum of Care (CoC) has set a goal of decreasing unsheltered homelessness in our county by 50% by 2025. While the NC Medicaid Section 1115 Demonstration Waiver may not directly address homelessness, it provides essential support for programs that are instrumental in reducing homelessness and addressing the complex needs of individuals at risk of homelessness.

As you consider the renewal of the NC Medicaid Section 1115 Demonstration Waiver, it's essential to recognize the profound link between substance abuse and homelessness. Substance use can be both a cause and consequence of homelessness. A 2014 report from the United States Conference of Mayors identified substance abuse as one of the top three causes of homelessness for both single individuals and families. Additionally, substance abuse often arises as a response to the immense stress of homelessness. Many turn to drugs or alcohol as a way to cope with the pressures they face. For those experiencing homelessness, breaking free from substance abuse can be exceptionally challenging. Access to treatment may be limited, their social support networks smaller, motivation to quit may decrease, and they may have immediate priorities such as finding shelter or food.

The Buncombe County Opioid Settlement Strategic Planning Report, based on surveys conducted among service providers and community members with experience in substance abuse, pinpointed common obstacles faced by both unhoused and housed individuals when attempting to access substance abuse resources. These barriers include limited treatment availability, affordability concerns, extended wait times, geographical isolation, and fear of job loss, which frequently leads to homelessness. These findings underscore the pressing necessity to bolster programs addressing substance abuse within the homeless community and as a preventive measure against homelessness. Efforts to reduce homelessness necessitate both the need for both housing placement and preventing new homelessness. The Waiver has the potential to positively impact both aspects of this mission.

It's crucial to highlight that supportive services represent an effective and economically efficient approach. One significant aspect of the waiver is its commitment to providing integrated care for individuals with complex behavioral health needs through the launch of Behavioral Health and I/DD Tailored Plans. This integrated approach is critical in preventing homelessness among individuals with complex needs by proactively addressing their unique challenges and reducing the risk of homelessness. I am particularly encouraged by recent developments in our community. This month, we celebrated the opening of Compass Point Village, a major Permanent Supportive Housing Facility in Asheville, offering low-barrier housing for our most vulnerable residents. Dr. Shuchin Shukla, a physician with expertise in

addiction, emphasized the profound impact such initiatives can have while offering a significant reduction in costs. This initiative will not only “decrease chronic homelessness in Buncombe County by 40% and undoubtedly save lives by preventing overdose and other health crises, it will also generate cost savings. While the average annual cost per unhoused person for a community can be up to $50,000, the cost per person served through a project like this will be $13,000." This waiver supports building greater capacity for organizations offering Permanent Supportive Housing, a key strategy identified by the Asheville-Buncombe Continuum of Care (CoC) for reducing homelessness.

Efforts to reduce homelessness necessitate both preventing new homelessness and increasing access to housing for those currently homeless. The expansion of the Healthy Opportunities Pilot (HOP) statewide promises greater access to evidence-based, non-medical interventions, particularly related to housing and transportation for geographically isolated individuals. These interventions are crucial in addressing common barriers identified in the Opioid Settlement Strategic Planning Report. HOP funding can provide essential support for programs that assist Medicaid recipients in accessing substance abuse and behavioral health resources, as well as in achieving stable housing or stabilizing current housing situations. In this way, HOP can significantly contribute to our collective efforts to prevent and reduce homelessness in our community.

In conclusion, I urge the Centers for Medicare & Medicaid Services to support the renewal of the NC Medicaid Section 1115 Demonstration Waiver. Medicaid plays a vital role in addressing the healthcare needs of our vulnerable population, and this waiver is a crucial component of our community's efforts to reduce homelessness and improve the well-being of individuals who are most at risk. Your support for this renewal will undoubtedly make a lasting and positive impact on the lives of individuals in our community.

--
Regards,
Ella Smith
Asheville/Buncombe Homeless Coalition

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Medicaid Section 1115 Waiver"
Date: Thursday, September 21, 2023 1:21:04 AM

Medical Respite is a proven, evidence-based model that addresses healthcare and housing. This is a complex service to launch, but it has changed the trajectory of many lives in the Cape Fear region. When measuring success for Medical Respite, would the state consider the quality of services and lives impacted by the number of people served or positive outcomes? This service model builds hope and addresses social determinants of health in a way our region has never seen before; capacity-building funds have allowed us to build, test, and modify the service model. Additional Capacity building funds will ensure sustainability.

Public Comment

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Jamie Stokley
Founder/Chief Executive Director

https://helpingcapefear.com/
910-447-9737

Helping others is our gift, serving others is our passion, and advocating for you is what we do.

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 5:02:37 PM
Attachments: image001.png

Good afternoon,

In addition to what we as a NL have submitted, please find these final thoughts on the waiver. There is so much more to add but much work to be done.

- ACEs are part of eligibility but are not included in the PESA or Care Management evaluation, so we are likely missing a large population of children due to this.
- For HSOs who have sensitive and nonsensitive configurations, it is confusing to have to turn services on and off in both configurations (for housing services as an example).
- It would be helpful if new services configured in NCCARE 360 would NOT be turned on once configured, allow the HSO to turn the service on when they are ready
- It would be helpful if NCCARE 360 had barriers to allow HSOs providing Holistic High Intensity CM to only get the supportive services for their members to allow them to best serve their members and stick to the population they serve.
- Reconciling across 5 platforms for payment reconciliation and statuses not being accurate in NCCARE 360 is a heavy burden for HSOs to reconcile payments.
- If member is HUD approved add a caveat to the definitions for 1st month rent that the HSO will only cover the out of pocket cost, it will not be in addition to what HUD covers (they would only cover deposit)

Plenty more could be shared, hoping to continue adding to the conversation.

Gratefully,

Jessica Stone, MPA
Healthy Opportunities Pilot QI Coordinator
Cape Fear HOP
Community Care of the Lower Cape Fear
[redacted] **F** 910-763-0222
E [redacted]
Website | Facebook | LinkedIn

Two decades of improving lives together

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 8:51:18 AM

The North Carolina Fragile X Foundation met to review the 1115 waiver and have the following comments, edits, and suggestions.

We would be happy to discuss any of our suggestions with you should you have any questions.

1. Expansion of the Healthy Opportunities Pilot Program -

The North Carolina Fragile X Foundation supports North Carolina's request to expand the pilot with additional funding and expansion of the pilot regions. The Foundation would like to see more promotion of the success of the pilots in reducing the cost of medical care through the use of these services. Additionally, the program needs to continue to partner with other organizations to ensure that the services provided through HOP do not duplicate what is available through other social service organizations.

2. Continuous Enrollment for Children and Youth

The North Carolina Fragile X Foundation heartily endorses North Carolina's request for continuous health coverage for children and youth. This continuous coverage will ensure that children will have access to prescriptions for chronic health conditions such as asthma. Continuous coverage also ensures that parents will not skip a visit to the doctor for their child's illness such as an earache, flu, RSV, or Covid-19 because of cost. Keeping children and youth healthy keeps them ready to learn with fewer school absences due to illness.

3. Investment in the Behavioral Health Workforce

The North Carolina Fragile X Foundation supports the investment of $70 million in funding to expand the student loan repayment program and to provide payments for the purpose of recruitment and retention of direct support workers. We offer the following enhancements to the program:

1. Provide attractive bonuses for recruitment and retention in an amount that demonstrates value for these positions. The retention bonus should be paid yearly and have a COLA adjustment tied to the COLA adjustment for Social Security recipients.

2. Increase the amount requested so that direct support workers could be awarded bonuses for long-term service beginning at 5 years of service that is in addition to an annual retention bonus.

3. Require that all direct support workers have paid time off for vacation and sick leave.

4. Develop a recruitment plan that would target young college graduates with high student loan debt that could help the State significantly reduce the vacancy rate in jobs supporting Medicaid enrollees.

5. Recruit more workers who speak multiple languages or use ASL to serve the expanding population of Medicaid enrollees whose first language is not English.

Regards,

Steve Strom
919-488-2326
--
Steven R. Strom, M.Ed., MBA
President, NC Fragile X Foundation

The mission of the North Carolina Fragile X Foundation is to improve the quality of life for those impacted by Fragile X through promoting awareness and understanding. This is accomplished by providing education, support and advocacy.

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver Response
Date: Wednesday, September 20, 2023 12:32:09 PM
Attachments: Demonstration Waiver_Healthy Blue Comment Letter_FINAL_9-20-23.pdf

Hello,

Attached please find comments from Healthy Blue in response to NC Department of Health and Human Services Section 1115 Waiver Draft Application. Thank you for the opportunity to provide feedback in response to the draft waiver application. Please feel free to reach out with any questions.

Best regards,
Lauren Vollmer

Lauren Vollmer | Director, Health Policy Office
984.777.5835 | [redacted]
Pronouns: She/Her/Hers

BlueCross BlueShield of North Carolina | HealthyBlue

PO Box 2291, Durham, NC 27702-229

September 20, 2023

North Carolina Department of Health and Human Services
NC Medicaid Section 1115 Waiver Team
1950 Mail Service Center
Raleigh, NC 27699-1950

Via: Medicaid.NCEngagement@dhhs.nc.gov

RE: NC Section 1115 Waiver

To Whom It May Concern:

Healthy Blue, Blue Cross NC's Medicaid managed care plan, welcomes the opportunity to provide feedback in response to the North Carolina Department of Health and Human Services (NCDHHS) Section 1115 Medicaid Waiver Draft Application. The waiver includes proposals to renew programs currently underway, modify existing programs and begin new initiatives entirely. Overall, we support the waiver and NCDHHS' efforts, and offer our detailed comments to those proposals in the pages to follow.

Healthy Blue has the privilege to serve nearly 500,000 of North Carolina's 2.9 million standard plan Medicaid enrollees today. For 90 years, Blue Cross NC has been committed to improving the health of all North Carolina's communities, and Healthy Blue's work, in partnership with NCDHHS, to increase access to high quality health care across the state is another example of that commitment. Healthy Blue has built strong relationships across the State, investing in a mobile medical unit to provide screenings and education and helping members, providers and community organizations understand the redetermination process. Our broad provider network, local connections and value-added services ensure that we can meet our enrollees where they are and focus on whole person care.

As an organization committed to making healthcare better, simpler and more affordable, we look forward to engaging with NCDHHS to imagine this next step in the managed care journey for the state.

Sincerely,

Angela Boykin
CEO, Healthy Blue

Detailed Comments

OBJECTIVE 2: STRENGTHENING ACCESS TO WHOLE-PERSON, COORDINATED CARE

INITIATIVE 2C. COVERAGE FOR PRE-RELEASE SERVICES FOR JUSTICE-INVOLVED INDIVIDUALS

Improve health outcomes and support re-entry into the community for justice-involved individuals by providing targeted pre-release Medicaid services.

Healthy Blue supports the State's actions to prioritize solutions that will improve health outcomes and support re-entry into the community by providing targeted pre-release Medicaid services for justice-involved individuals. We recommend that the State clarify and confirm if justice-involved individuals would be served by the Prepaid Health Plans (PHP) or only Medicaid Direct. We understand that justice-involved individuals should be offered choice and expect Standard Plans are allowed to provide all services necessary to serve this population well.

If it is confirmed that justice-involved individuals will be enrolled with PHPs, we seek clarity on whether copays or other eligibility considerations will apply, which would require this population to be identified as a separate benefit group.

OBJECTIVE 2: STRENGTHENING ACCESS TO WHOLE-PERSON, COORDINATED CARE

INITIATIVE 2C. COVERAGE FOR PRE-RELEASE SERVICES FOR JUSTICE-INVOLVED INDIVIDUALS

Improve health outcomes and support re-entry into the community for justice-involved individuals by providing targeted pre-release Medicaid services.

To help ensure a successful implementation and improved health outcomes, Healthy Blue recommends the following:

Justice-involved Adults - Healthy Blue requests that the State define how the member's resident county will be determined, considering catchment area may be in an area different from that of the correctional institution they reside in. We propose that the State consider enrolling justice-involved members into the integrated Standard statewide plans to help address seamless continuity of care, increased access, improved accountability and quality. Additionally, we recommend that the State identify which entity will be responsible for enrolling the member, for example auto enrollment in NC FAST, local DSS Eligibility staff, or another entity.

Justice-involved Youth - Healthy Blue requests that the State define how the member's resident county will be determined considering catchment area may be in an area different from that of the correctional institution they reside in. We propose that the State consider enrolling justice-involved members into the integrated Standard statewide plans to help address seamless continuity of care, increased access, improved accountability and quality. Additionally, it is recommended that the State identify which entity will be responsible for enrolling the member, for example auto enrollment in NC FAST, local DSS Eligibility staff, or other entity. And lastly, we strongly recommend that the justice-involved youth who

are also in DSS custody and enrolled 90 days prior to discharge and release, be enrolled in Children and Families Specialty Plan (CFSP).

OBJECTIVE 2: STRENGTHENING ACCESS TO WHOLE-PERSON, COORDINATED CARE

INITIATIVE 1C. LAUNCH OF CHILDRENS AND FAMILIES SPECIALTY PLAN

CHILDREN AND FAMILIES SPECIALTY PLAN (CFSP) RENEWAL REQUEST

Healthy Blue fully supports the State's efforts to implement CFSP statewide and to mitigate disruptions of care for impacted populations. In situations where parents and caretaker relatives of children/youth in foster care are making reasonable efforts to comply with a court-ordered plan of reunification, Healthy Blue recommends that the State define the length of time of enrollment that will be allowed for the biological parent or caretaker relative, after the Termination of Parental Rights (TPR). We propose a period of 90 days of continuous enrollment in CFSP after a TPR hearing which would therefore allow the member to exercise choice and consider other coverages, including traditional Medicaid.

OBJECTIVE 2: STRENGTHENING ACCESS TO WHOLE-PERSON, COORDINATED CARE

INITIATIVE 2A. BUILD ON HEALTHY OPPORTUNITIES PILOTS (HOP) INFRASTRUCTURE INVESTMENT AND EXPERIENCE TO EXPAND HRSN SERVICES TO NORTH CAROLINIANS CROSS THE STATE.

Healthy Blue applauds the State for the proposed expansion of Healthy Opportunities Pilots (HOP). We recommend the State confirm if the following CFSP members will be allowed enroll in CFSP and HOP concurrently to address unmet Health Related Social Needs (HRSNs):

i. Parents and caretaker relatives of children/youth in foster care who are making reasonable efforts to comply with a court-ordered plan of reunification; and
ii. Minor children and certain family members receiving Child Protective Services In-Home Services; and
iii. Former foster youth

Section VI – ENROLLMENT, DEMONTRATION FINANCING AND BUDGET NEUTRALITY

ENROLLEMENT – TABLE G. ESTIMATED CONTINUOUS ENROLLMENT IMPACTS

Healthy Blue appreciates the State providing estimated enrollment impacts. In Table G, "Former foster care youth" is shown to increase from 5,015 to 10,437 over the five-year period of DY7 to DY11. The increases from DY7 to DY8 and then to DY9, reflect a net increase of more than 2,500 members per year for the respective period. We recommend that the State clarify if these estimated member counts reflect youth who were in foster care on their 18th birthday and therefore "aged out," representing the group of young adults who are 18-26 years old.

SECTION II – CONTINUING DEMONSTRATION FEATURES AND CHANGES REQUESTED TO THE DEMONSTRATION

INITIATIVE 2A. BUILD ON HOP INFRASTRUCTURE INVESTMENT AND EXPERIENCE TO HOP AND HRSN SERVICES TO NORTH CAROLINIANS ACROSS THE STATE

Healthy Blue recommends the State focus the statewide expansion initially on the existing specific HOP services that can be effectively coordinated and managed by Network Leads among the current services available through HOP. In our experience, a smaller and more focused assortment of services allows all stakeholders to become experts in providing, managing, and coordinating payment for these services. Over a phased period, additional services could be added for expansion. Recommendations for the first phase of expansion include benefits that focus on childcare subsidies, employment procurement and retention, and financial stability.

Additionally, we recommend that workforce capacity be further assessed prior to HOP expansion. Healthy Blue strongly recommends the State consider augmenting capacity building funds which will further allow Prepaid Health Plans and delegated care management entities to support a more seamless process concerning care management assignments and administrative tasks. An example of where the process could benefit from greater resources is in coordinating services for members outside of NCCARE360 because it is not apparent that a Human Services Organization (HSO) has the ability to provide a service or has completed delivery of a service after accepting the referral. Increased capacity building will enable care managers to more directly focus on the complex challenges of members enrolled in this program. Network Leads have expert insight into the capabilities of the HSOs they manage and have shown great innovation in ways to help sustain the pilot.

NARRATIVE INFORMATION ON IMPLEMENTATION BY MILESTONE AND REPORTING TOPIC (TABLE PG. 286)

11. SUD-RELTAED DEMONSTRATION OPERATIONS AND POLICY

Healthy Blue supports the State's priority to add Intensive Outpatient and Partial Hospitalization Services to Standard Plan coverage. We recommend that the State clarify and confirm if the service(s) will be added to the Standard Plan benefit, or if the service(s) will be allowable "coverage" until claims are received by State and the enrollee is subsequently moved to the Local Managed Entities (LME) Tailored Plans (TP). Our experience has been that providers will not admit members up front if members are transferred to the LME/TP either due to billing, claims, or authorization concerns. To help ensure that the State's objective of 'seamless and successful experience' be realized, we recommend adding Intensive Outpatient and Partial Hospitalization Services to the Standard Plan. Standard Plans provide whole health care and can help optimize member outcomes if they provide Intensive Outpatient and Partial Hospitalization Services, which are currently referred to in the waiver document as currently 'underperforming'. We expect that this change would result in improved outcomes for pregnant enrollees.

From:	[redacted]
To:	Medicaid.NCEngagement
Cc:	[redacted]
Subject:	1115 Comments
Date:	Wednesday, September 20, 2023 4:41:23 PM
Attachments:	23.9.20 comment on 1115 Waiver.docx

Colleagues,

Please find comments on the 1115 Renewal attached.

Talley Wells
Executive Director
NC Council on Developmental Disabilities (NCCDD)
(984) 920-8203 office
[redacted]

Twitter | Facebook | YouTube

Sign up for our Newsletter to Stay Informed and to Keep Up with our Policy Updates:
https://nccdd.org/newsletter-signup.html

NCCDD
North Carolina Council on Developmental Disabilities
2010 Mail Service Center
Raleigh, NC 27699-2010
Toll Free 1-800-357-6916
(984) 920-8200. www.ncdd.org

September 20, 2023

To Whom It May Concern:

I write on behalf of the North Carolina Council on Developmental Disabilities (NCCDD) as its Executive Director. Due to the timing of the need for these comments, I was not able to share these comments with the Council or have them voted upon prior to submission. These comments are based on my experience working with NCCDD and three years of policy discussions.

NCCDD appreciates the opportunity to comment on the proposed renewal request of North Carolina's Medicaid Reform Section 1115 Demonstration.

I provide the following comments:

- **For Initiative 2b, it is essential as part of continuity of care efforts to ensure foster youth and former foster youth with I/DD and TBI apply for and receive the Innovations Waiver, the TBI Waiver, and 1915i and that the records to show eligibility for such services are preserved for minors who are wards of the state or for whom the state has a special responsibility:** The proposed plan to ensure continuity of care for children and former foster care youth is very important. As part of this continuity of care, it is critical that children, foster youth, and former foster youth with an intellectual or other developmental disability or with a traumatic brain injury be signed up for the Innovations Waiver, the TBI Waiver, and/or 1915i Medicaid and that the records showing eligibility are preserved and accessible for such individuals as they grow older. North Carolina has a 17,000 person waiting list for the Innovations Waiver and individuals receive the waiver on a first come/first served basis. It is imperative that as the state works to improve continuity of care for these individuals that state and non-state social workers, caregivers, parents, and guardians be educated about these Waivers and services and ensure that children and foster care youth and former foster care youth are signed up for these services. This is even more important because of the reality that these programs often require medical and psychological documentation from schools and professionals that were done prior to age 22. Often school and/other medical records may be mislaid or hidden after a minor becomes an adult even though such documents are essential for such individual to receive services.
- **Initiative 2c: It is very important to utilize 1115 to support individuals with I/DD and TBI and other disabilities to reenter society from jails and prison. At the same time, there needs to be flexibilities for this unique population in how Medicaid is paid to ensure that the (often) intense needs of these individuals are met such that**

a fee for service model may not be successful by itself. It is also very important that this work be done in partnership with social workers and other professionals both inside and outside of the prison and that individuals be connected to Tailored Care Managers, 1915i, and other Medicaid services to meet the needs of these individuals. NCCDD has supported a reentry initiative for the past three years for individuals with I/DD through the Alliance of Disability Advocates in partnership with mental health and developmental disability social workers inside the prison. This has been a very successful initiative that has provided a lot of lessons that can be used for this initiative. The reality is that Medicaid funding is very important to ensure the success of more individuals with disabilities returning from prison. At the same time, individuals returning from prison often have more intense needs than others with similar disabilities who are in the community. For this reason, the funding for how these services will be provided must be considered carefully and the higher level needs must be taken into account. North Carolina is very fortunate to have high quality social workers and other professionals inside its prisons. They must be part of the planning and implementation of a successful reentry program through 1115. It is equally important to have connections and buy in from Tailored Care Managers, LME/MCOs and providers. The new 1915i gives individuals with I/DD and TBI the opportunity to immediately receive services once individuals return to the community. It is essential that this program be designed in such a way to ensure that individuals returning from prison be connected to Tailored Care Management and 1915i when eligible including Community Living Supports and Supported Employment.

- **For Initiative 3b, it is important that new investments in technology enable individuals with I/DD to live more independently in the community and help fill gaps caused by the workforce shortage.** North Carolina has made a commitment for people with disabilities to be able to live full and meaningful lives in the community and to fulfill the vision of Olmstead. Technology can be an important tool to enable individuals with I/DD to live more independently. Investments should be made in such technology. It is also important that such technology be accessible and user friendly to the different needs and qualities of diverse individuals with disabilities. Technology can also help fill needs of the disability community caused by the Direct Care workforce shortage and should be done so. However, it is important that this be done thoughtfully so that where services are needed to be done by people instead of technology that human resources are still utilized.
- **For Initiative 3c, it is imperative that the state utilize 1115 to help meet the workforce shortages impacting people with I/DD, TBI and other behavioral health diagnoses.** Individuals with I/DD, TBI, and other behavioral health needs are not receiving services because of the workforce shortage. Providers and family members are exhausted because supervisors, managers, and family members are having to fill in when no Direct Support Professional or other professional is

available to provide long term services and supports. There are multiple groups looking at critical ways in which the state can improve its DSP and related workforce, including the DHHS/Department of Commerce Caregiver Council, the All Ages/All Stages group created by the Governor's Executive Order, the Money Follows the Person funded WeCare (Duke University/Aging Coalition), the DSP Working Group, AHEC, EJEC, NCCDD, and others. These groups should be included in planning and implementation of how the 1115 renewal will be utilized to help bolster long term supports and services. The following recommendations should be considered as the 1115 process moves forward:

  - Ensure regular high quality DSP rate studies, which include average pay and amount of allocated funds that actually are received by DSPs.
  - Project DSP needs for future years.
  - Ensure there are a sufficient number of quality DSPs in all fields and areas.
  - Support and fund quality DSP trainings.
  - Bring together the various NC groups working on DSP issues.
  - Ensure that regulatory issues are not so burdensome that they prevent providers from having sufficient DSPs.
  - Ensure that providers and DSPs have the funding and support to get DSPs the trainings that they need when they start work ***with pay*** so that the onboarding of DSPs is not so burdensome and costly to DSPs who often have little resources that they do not go to other jobs when they would be great DSPs.

- **NCCDD fully supports Initiative 3d to expand access to critical supports offered under the 1915i authority. It will be important to gather data, particularly for those on the waiting list or who qualify for the waiting list, to understand what services are being provided, the number of hours, the needs of individuals, and what needs are being met and are not being met by 1915i. The state should also allow individuals to self-direct through 1915i.** The I/DD community is very excited about the possibility 1915i will have to meet more of the needs of the community. At the same time, because 1915i is a new program there will be many obstacles that need to be overcome and lessons that will need to be learned and 1915i will need to be improved as it grows. It will also be essential to ensure that there is a sufficient Direct Support Professional workforce to provide 1915i services. 1915i services should also be paid at the same rates as Innovations Waiver services. LME/MCOs should be required to pay these same rates. The state should also allow self-direct to be an option for individuals who have 1915i. There also need to be expanded income eligibility and ways for individuals with disabilities to preserve more of their income who are on 1915i through ABLE accounts or other types of accounts or trusts. 1915i offers Supported Employment. However, individuals who receive

Supported Employment can lose their 1915i if they have income that takes them above the threshold for Medicaid. 1115 should be used as one of the tools to help get over this burden. 1915i should also be a tool used for individuals returning from prison. There needs to be robust data provided of individuals receiving 1915i and an active group of state, community leaders, individuals with disabilities, and families providing feedback and ideas for improvement on 1915i Medicaid.

- **As the 1115 process continues, make sure to include individuals with disabilities and families in all aspects of the design and implementation of this work.**
- **As the 1115 process continues, it will be important to ensure that as much data that will be useful to understanding what needs are being met and not being met for those with I/DD, TBI, and other behavioral health needs by 1115.**

NCCDD is very excited about the 1115 renewal application. We look forward to work with you as this process moves forward and is implemented.

Sincerely,

[redacted]

Talley Wells
Executive Director
North Carolina Council on Developmental Disabilities

From: [redacted]
To: Medicaid.NCEngagement
Cc: [redacted]
Subject: [External] NC Section 1115 Waiver - NC InCK Response
Date: Wednesday, September 20, 2023 3:00:34 PM
Attachments: NC InCK Comments re NC 1115 Waiver Renewal.pdf

Good afternoon,

Attached please find North Carolina Integrated Care for Kids' response to the request for feedback on the NC Section 1115 waiver.

Thank you for the opportunity to provide input.
Eleanor

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She, Her, Hers *Why Pronouns?*
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NC InCK
NC INTEGRATED CARE FOR KIDS

North Carolina Department of Health and Human Services
North Carolina Medicaid Section 1115 Waiver Team
Submitted via email, Medicaid.NCEngagement@dhhs.nc.gov

September 20, 2023

Re: North Carolina Section 1115 Demonstration Waiver Renewal Application

Dear North Carolina Medicaid Section 1115 Waiver Team,

We appreciate the opportunity to comment on North Carolina's section 1115 demonstration waiver renewal application. North Carolina Integrated Care for Kids (NC InCK) strongly supports the state's commitment to supporting whole-person care via statewide expansion and refinement of the Healthy Opportunities Pilots. Our feedback centers on recommendations to revise the HOP model to better serve the unique needs of children and their caregivers.

Our comments summarize the feedback from a team of NC InCK stakeholders with extensive professional experience in pediatric care management and clinical care, education, public health, early literacy, child welfare, public health, and Medicaid managed care. NC InCK's expertise in core child service areas, capacity-building for child-serving professionals, and experiences with clinical-community collaboration to improve child health position us well to focus on necessary waiver changes to further promote children's health.

About NC InCK

NC InCK is a model serving Medicaid-insured children ages 0-20 across Alamance, Durham, Granville, Orange, and Vance Counties that aims to improve whole-child health. NC InCK focuses on holistically understanding children's needs and integrating services across child-serving sectors to connect children to essential resources. Additionally, NC InCK's Alternative Payment Model links provider payments to meaningful measures of child well-being. NCDHHS, Duke University and the University of North Carolina at Chapel Hill co-lead the NC InCK model. NC InCK is supported by the federal Centers for Medicare and Medicaid Services as part of a 7-year, $16 million award.

Modifying Pilot Services

NC InCK strongly endorses NC DHHS' proposed expansion of existing services, particularly the increased scope of available rental assistance and meal support and the addition of a firearm safety service. All changes are likely to yield better outcomes for children and their families. We are also supportive of the Duke-Margolis Center's recommendations around Pilot services' scope expansion, payment adjustments to cover administrative effort related to service provision, and fee adjustment to account for variations in both the economic and physical landscape. Additionally, we recommend the addition of services that focus explicitly on improving HOP members' economic security.

Benefits Enrollment Support and Expanded Coverage of Household Essentials to Enhance Economic Security

By lifting children and families out of poverty, economic supports can reduce child abuse and child welfare placements, improve housing and food insecurity, and improve overall physical and mental health.[1–6] However, thousands of children and families do not access critical economic supports like SNAP, WIC, Child and Earned Income Tax Credits, and childcare subsidies due to structural and logistical barriers, stigma, and lack of awareness.[5,7] We recommend HOP consider the following waiver changes to help close enrollment gaps in key economic support programs and reduce family poverty:

- Provide payment and technical assistance for medical-financial partnerships. In-clinic financial support programs, staffed by trained financial navigators and focused on new parents, have the potential to increase both families' monthly income and preventive visit attendance.[7–9] Supporting these kinds of onsite partnerships not only improves economic and health outcomes for families but also offers providers an immediate resource for families who screen positive for income-related social needs.
- Provide funding for community-based benefits navigation services, **including free tax preparation services.** Significant enrollment gaps exist in SNAP & WIC despite the demonstrated economic and health value of both programs, and the burden and cost of paid tax preparation services deter low-income families from accessing hugely valuable tax benefits.[5,10] Increasing the capacity and availability of benefits navigation and free tax filing services would help families overcome barriers ranging from language and literacy challenges to lack of access to reliable in-home internet to access the full scope of benefits for which they qualify. Free tax filing programs that provide in-person support are particularly scarce, and online free filing options are wildly underused.[11] Clinically focused care management providers in health care and payer settings may be unfamiliar or even uncomfortable with supporting families in accessing public benefits and tax preparation services. Funding for robust, community-based support for benefits navigation and tax preparation could make a huge financial impact for low-income families.
- Provide direct payment for essential hygiene supplies not currently accessible via most social safety net programs and nonprofits. Menstrual hygiene supplies and infant and toddler diapers for children who do NOT have special health needs are costly essentials that are not reliably available through existing public benefits programs or local nonprofits. Diapers alone can cost families around $100 a month, and diaper scarcity can cause problems ranging from parental work disruption to infant skin problems; diaper banks, a critical community resource for free diapers, fall far short of meeting the full demand for diapers among low-income families.[11] Providing families with free access to basic hygiene supplies for their babies and children would preserve dignity and health while eliminating a key, costly line item from their monthly budgets.

<u>Expanding Eligibility Criteria for HOP</u>

NC InCK endorses the Duke-Margolis Center's recommendations for expanded HOP eligibility criteria, especially their recommendation for the use of community health workers and NC InCK's own cross-sector Integration Consultants to support assessment and enrollment. Our 14 Integration Consultants are based at all five Medicaid Prepaid Health plans; two LME/MCOs; Duke Health, Community Care of North Carolina, and UNC Health; Durham's Head Start Agency, Families and Communities Rising; and Orange County and Granville-Vance County Health Departments. Our Consultants have broad reach across several large and critical child-serving organizations in our five-county area and collaborate

directly with care managers within many of these entities to connect children and families to services. NC InCK's Integration Consultant team would have ample opportunity to assist with identification and enrollment of HOP-eligible children.

NC InCK strongly supports expanding eligibility based on elevated risk of a chronic condition and recommend further clarification on how elevated risk will be defined. There is an indisputably strong association between growing up in poverty and risk of chronic disease and developmental delays.[1] Explicitly naming poverty as a risk factor for a chronic condition will ensure the 43% of NC children living in poverty and their caretakers qualify to access health-promoting and life-prolonging services through HOP.[12]

Investing in Capacity to Support Program Growth

We appreciate the waiver's proposal to provide robust capacity-building to support statewide expansion of HOP. Based on our own experiences implementing a care model designed specifically for Medicaid-enrolled children, we propose intentionally incorporating training on child-specific needs into all capacity-building activities. We advise training all entities, especially care management teams, on child-specific topics including:

- Collaborating with schools and school personnel to reach and serve children
- Addressing the unique needs of children in foster care and children receiving post-adoption assistance
- Connecting children to affordable childcare and early childhood education
- Facilitating referrals to early intervention services for suspected developmental delays
- As discussed at length above, connecting caregivers of children to economic supports to mitigate the negative effects of poverty on children's physical and cognitive development

NC InCK also encourages establishing clear standards of care for HOP care management services and tailoring training to these standards. Clinical care management services are often designed to be short-term and focus on connection to clinical care and provision of resource lists rather than in-depth resource navigation. Establishing the expectation that care managers will vet resources prior to referring patients, close the loop on referrals to identify any barriers, and assist the referred person in accessing the referred services to the extent possible will increase the value and impact of care management services.

NC InCK has robust experience developing and disseminating training materials on both the child-specific content areas and the intensive care management approaches discussed above. We would be eager to share resources and lessons learned to support HOP's work as appropriate.

Cross-Cutting Suggestions

Incorporating Health Equity into HOP

We wholeheartedly endorse the Duke-Margolis Center's recommendations to more formally incorporate equity considerations into program design and incentives. The detrimental effects of structural and interpersonal racism on North Carolina's children cannot be overstated, and all HOP services should be designed with the intention of mitigating inequities. In addition to Duke-Margolis's excellent recommendations around health equity, we propose two additional considerations for equity promotion within HOP.

First, we support direct payment for services with potential to reduce the appalling epidemic of Black maternal and infant mortality. Specifically, we recommend funding doula services, particularly from Black-led organizations like MAAME Inc, for all pregnant HOP enrollees with a special focus on connecting Black pregnant people to services. Doula services not only improve birth outcomes and provide pregnant people of color with critical advocacy and support but also are highly cost-effective.[13–15]

Additionally, we recommend providing ongoing technical assistance and guidance on the administration of clinical preventive and behavioral services outside of traditional health care settings (e.g. in schools, churches, and neighborhoods). The COVID-19 pandemic illustrated the value of bringing health care services directly to underserved communities, e.g. via mobile vaccination units serving Black and Hispanic/Latino communities in trusted and readily accessible community spaces like churches. Offering health care providers guidance and support in providing and billing for services in nonclinical settings could help reduce racial inequities in chronic condition self-management and preventive screenings and services. Supporting billing for services delivered in school settings is another key opportunity to expand access to care and meet children where they are to deliver necessary care.

Incorporating Child-Specific Focus into HOP Operations and Evaluation
HOP has an unprecedented opportunity to create lasting health improvements at the population level by taking a two-generation approach to health promotion and disease prevention. By reducing caregivers' economic stressors and focusing specifically on issues that maximize children's opportunities for health and wellbeing, HOP can achieve both an immediate and long-term impact on health in North Carolina.

Besides adopting the considerations proposed elsewhere in this letter, the HOP model can include a more deliberate focus on children via its evaluation design. Specifically, we encourage a longitudinal evaluation that examines model outcomes outside of the health care system, e.g. in schools, juvenile justice, social services, etc. Our experiences in the realm of pediatric value-based care, including the implementation of our own alternative payment model, suggest that HOP interventions are also unlikely to yield immediate health care cost savings for children. However, interventions promoting children's health, e.g. via improved access to early childhood services, increased enrollment in WIC, etc. may yield generation-shifting improvements in health outcomes and significant "social return on investment" that will not be discernible from claims data alone.

Conclusion
NC InCK values NC Medicaid's consideration of our comments and overall aim to address both the clinical social drivers of health that affect the well-being of all North Carolinians. We welcome any follow up questions you have about our input and are eager to collaborate with you to support the HOP expansion.

Authors from the NC InCK team:
Rushina Cholera, Executive Director
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Eleanor Wertman, Director of Care Integration

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From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 4:49:22 PM
Attachments: image001.png
1115 Waiver feedback.pdf

Good afternoon, please see attached input consolidated from Cape Fear HOP Network, HSOs and CM entities.

Thank you,

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NEW FEEDBACK TO SHARE WITH DHHS – 1115 WAIVER:

- Suggestion for new pairing of services: After x number of food boxes, an additional service should be paired with one of the 3 following services: Food & Nutrition Case Management, Food & Nutrition Classes, and/or DPP classes. These naturally come after the member's food resources are more stable and they are able to move to a higher level of meeting their nutritional needs.
- The current automatic process in NCCARE 360 is causing issues with meeting contractual obligations (time standards for accepting referrals) because the date of creation for the referral is tracked as when the Care Manager begins the referral process, but it then goes to the Utilization Manager and may not get to the HSO for a few days, which then puts them beyond the 2 business day requirement. This process also does not allow the final review of if the HSO is still receiving services. If they turn off in the time it takes to authorize the referral then the HSO feels pressured to take the service, but may be unable to if they are out of funds to offer expensive housing services or have no further capacity.
- HSOs (especially in housing and food services) need to be able to see information added by sensitive service HSOs. It would be helpful to see all Primary Workers listed in the Care Team to help navigate needs. It is very difficult for Care Managers to be unable to see the case notes on a case they refer, and are even unable to know if the case is still open.
- The "pins" in NCCARE 360 that show HSO locations or locations served are always listed by distance and alphabetically which puts HSOs further down the list at a disadvantage for receiving referrals and meeting sustainability.
- Better training for Care Managers is important because they are essentially gate keepers for referrals, so it is important for them to have a good understanding of the services and have the training needed to feel comfortable having the conversations. IPV is an area where more training on conversations and ways to engage members in these disclosure conversations is needed.
- Food and Nutrition Case Management should be more focused on skill learning to prepare the member to better manage their nutrition needs moving forward such as meal planning, food preparation for the week, grocery list/shopping planning (including budgeting), and consideration of local resources for healthy foods, as well as best practices for shopping habits (don't shop hungry, start with the fruit and vegetables and move to meats vs starting on a snack isle). Teaching these skills would be more parallel with the outcomes we expect to see from housing navigation, set them up for long term success.
- Address current issue with invoicing for services such as move in support or healthy home goods that may require more than one invoice for the same referral/case, prior to meeting the cap, coming across as duplicates. Having a way to track the cap in NCCARE 360 would be a huge step in the right direction for these services. It would also be helpful if a household service could be

tracked by addresses in the system and family members, so HSOs are not at risk of providing a second service to the same family that would be considered duplicate and therefore are subject to rejection.

- Add boundaries to move in support use – when the member is moving in, the service should be used within 50 days, to put an end cap to this service beyond making HSOs create boundaries and to make sure the HSOs will be reimbursed.
- Unite Us not turning services on when they are configuring or notifying HSOs of when services are turned on.
- Disenrollment notifications need to go to multiple HSO members. It currently only goes to the primary worker. If this person is out, there is a potential for the HSO to deliver services after the disenrollment.
- HSOs need to have the ability to edit their service definitions in Unite Us.
- There is no way for LPEs to approve an HSO turning on services in Unite Us after they have gone through readiness. This has the potential to allow HSOs to turn services on when they have not successfully gone through the required readiness.
- The service delivery invoice status in Unite Us needs to reflect the actual status. The invoice status not being correct causes huge confusion with everyone.
- Unite Us/NCCARE 360 feedback:
- It would be helpful to have a banner in NCCARE 360 for disenrollment from Social Care Coverage pertaining to HOP. An email to the Primary Worker alone is not effective enough to stop all services to a member at an HSO if that person is out of office at the time of notification. If the banner is not acceptable, the option for an additional contact to be notified should be an option for HSOs.
- It would be helpful to align Service Types and Subtypes with the names of HOP services. It would also be helpful if the pathway of service types and subtypes was a little different to allow less human error. Home remediation and Accessibility have the same service type and subtype and so do Medical Respite and Short Term Post Hospitalization which also look exactly the same in a quick view of the services – both are called Social Service Case Management.

DHHS & NCCARE 360:

- Separate transportation services into 3 services with accompanying administrative fees: Ride Coordination, Vehicle Repairs, and Gas Cards/reimbursement for mileage. These also need to be named appropriately in NCCARE 360 to reduce confusion. They are all currently listed under Transportation Expense Assistance, with only PMPM services listed under Ride Coordination.
- DPP Classes should be able to be invoiced per class and there are opportunities as mentioned above to pair this service with either Fruit and Vegetable Prescription and/or Food Boxes to encourage the healthy lifestyle incorporated in the DPP classes.

- Recommend giving NCDHHS additional freedoms to review, approve and expedite additional evidence-based curricula for HOP services. For example, Parents

as Teachers is the only approved curriculum for Home Visiting Services. The cost and annual recertification is several thousand dollars which may prove unsustainable for some HSOs. There are two curriculum options for Evidence-Based Group Nutrition and one of them, Cooking Matters, will be phased out by Share Our Strength in 2023. Evidence-based Parenting Classes only allows one curriculum. Organizations may already be certified in other EB curriculum that can be used within a service which increase their ability to build cohorts that include participants outside of HOP. This is imperative for sustainability as referrals for this service are low. The limited choices create a barrier to HSOs participating due to time and cost of training staff in a curriculum in addition to the ones they are already trained in and the deviation from curricula HSOs already collaborate on in the community (with schools and other local institutions). It also reduces the variety of support systems for members. Finally, the fee schedule should be adjusted to include all materials costs for participants and class preparation and breakdown work. Nutrition classes require demonstrations which require shopping and food preparation in advance of cooking/participants arriving, clean up after the class, and making sure they have the space to safely complete the food demonstrations.

- Recommend providing NCDHHS additional freedoms to restructure class-based service definitions and/or payment structure (evidence-based parenting, DPP). Services that use a class-based approach (DPP, Evidence-based group nutrition, and Evidence-Based Parenting Curriculum) are currently not sustainable due to classroom-based approach. In theory, HSOs would have rolling classes where eligible members can join along with non HOP clients. This may work in some settings (e.g. some urban counties, organizations with multiple funding streams) but is a barrier for rural counties and tracts as well as HSOs with limited additional or restricted funding streams. We acknowledge that these services are evidence-based in "group" settings so it is important that NCDHHS has these additional freedoms to restructure class-based service definitions and/or payment structure to see if these services can remain in HOP but restructured. It is important to consider keeping them in HOP so eligible members have access to long term and short term supports (e.g. pairing healthy food boxes with a DPP program or evidence-based group nutrition).

- Unite Us Launch Date cadence. Currently, LPEs must submit HSO/organizational details into Unite Us 6 weeks prior to an HSO being able to go live in a service. If you miss the deadline (maybe you discover you are trending towards a gap 2 weeks later, you must then wait until the next cycle to submit causing up to 12 weeks until the HSO can go live/deliver services. This creates very little flexibility in filling service gaps. We recommend a shorter cadence for the Launch Date process and flexible request submissions versus the hard deadlines.
- As this scales it will be important to ensure adequate staffing at DHHS and Unite Us. It is taking longer and longer to address issues, make approvals, complete tasks and/or critical platform or process changes. DHHS is doing an incredible job however

as this scales so should the teams. Unite Us has a very heavy lift and it is critical that they are staffed up with decision makers and tech support.

- Allow existing NLs first choice to expand into other counties and have new NLs be "affiliates" of existing NLs. This would make expansion more streamlined, efficient and effective.

- Restructure payment of high cost services (housing) so half of the money is provided to HSO at time of referral acceptance. This would allow HSOs to maintain capacity without having to turn off due to cash flow. In addition, change timeframe for PHPs paying claims to HSOs; 60/90 days (if there is a dispute process) too long to wait for reimbursement. Recommend HSOs should have a 30-day max to get invoiced submitted. Service Delivery reimbursement from PHPs needs to be a Net 30 for payment.

- Revise PESA to allow care managers to more easily enroll members and use responses or additional follow up questions (standardized across all Care Managers) to help the Care Manager determine which services will be the best fit for the member. A great example of this could be sharing some risk factors for Diabetes to help determine if DPP classes could be a good fit for the member.

- Add care navigation/coordination as a NL role to enroll members and "tee up" for care managers to provide care management, working to the top of their license. NL care navigator could be the liaison to HSO and follow up with member to make sure receiving services and meeting their needs. This could be the needed feedback loop of HSO providing service and member receiving quality services. Additionally, if expedited enrollment is approved, have NL involved with care navigation to expedite enrollment in care management/coordination and then have NL oversee HSO quality and compliance.

- Require PHPs or DHHS use data to more quickly identify and qualify presumptive eligible members. Data flow that would autogenerate info into the PESA would help as well.

- If a member is referred by a medical office, any SDOH screenings that have recently occurred or any medically relevant information (thinking DPP or Medically Tailored Meal qualifying) should be shared/prepopulated into the PESA for the engaging Care Manager.

- Revise fee schedule and service definition for the diabetes prevention program to allow individual coaching sessions. As is, the DPP is not sustainable.

- Exclusion monitoring- change who needs to be reviewed monthly. Changing to those who are in charge of funds (Directors, finance individuals, board chairs/treasurers) and not the frontline workers (bus drivers, those packing boxes of

food etc.). We are checking over 600 names each month and have not had any hits. With federal grants some of these types of checks are only done annually. Changing the checks to once or twice a year would be helpful to all. Agency checks can be done monthly with little to no issues. (From NL)

- Recommend pairing some short term services with long term. Currently we are seeing members remain in some services (Food Box delivery) for 6+ months but have not been asked/or are not interested in a longer term support (like Food and Nutrition Access CM). If a member would like to continue some of the short term services after the 3 or 6 month mark we may want to require a longer term support.

- Inclusion of essential family supplies (diapers, formula, etc.) in food boxes/HHG: Support for this inclusion conditional on fee schedule adjustment to cover costs of these items and avoid trade-off of lower quality and/or quantity of food; recommend that these supplies be permissible but not required to be available by every HSO contracted for the service such that HSOs can "specialize" based on history of service and carve their own unique "market niches
- Inclusion of 3 meals per day in food box and prepared meals services: Support with adjustment of fee schedule to cover additional cost. **Additional/related recommendation** to consider payment/authorization for prepared meals for household members given the precedent set (1) by the food box size determination (considers other household members) and (2) by other healthcare-meal partnerships (such as Aetna's meal program in partnership with Manna in Pennsylvania). Providing all household and families members with adequate nourishment will ensure that enrolled members are receiving the entire "dose" of the intervention (prepared meals) and prevent dilution effects that may result from sharing meals
- Authorize and pay for additional engagement time with Registered/Licensed Dietitian Nutritionist for Medically Tailored Meal recipients. The current service definition requires a nutritional assessment by an RDN/LDN to inform the appropriate diet order/meal pattern. It does not include – or pay for – RDN/LDNs' time to provide individual medical nutrition therapy (MNT), counseling, or education to promote member understanding and behavior change after MTM service authorization ends. Other MTM providers which engage in healthcare partnerships include follow up nutrition education, but this is **distinct** from and will not be addressed by the HOP Evidence-Based Group Nutrition Class service, as that service is intended for general nutrition knowledge and skill building, not counseling for medical nutrition therapy (MNT).
- Medicaid currently covers medical nutrition therapy (MNT) only for individuals with high risk pregnancy and children with overweight or obesity. However, the recent passage of Medicaid Expansion will result in the enrollment of a broader and more diverse range of populations, including more working age adults, veterans, and rural populations. This may also come with greater representation of the conditions that qualify people for MTM (cardiovascular disease, kidney disease, diabetes, hypertension, HIV/AIDs, etc.), and may benefit from Medical Nutrition Therapy but

likely not otherwise have access to MNT or RDNs/LDNs, other than in a limited capacity (i.e. assessment *only*) through this service.

- Consider consolidating healthy prepared meals and medically tailored meals service. This will ensure that all members have access to nutrition expertise and an appropriate meal pattern informed by dietary needs and preferences
  - Recommend adjusting prepared meals nutrition requirements from a nutrient-based to a food group-based standard. This is in line with modifications made to National School Lunch/Breakfast and CACFP guidelines. This is also more feasible approach for HSOs to implement and monitor independently or with limited support from RDNs/nutrition experts. The service definition may also allow use of other existing nutrition standards (such as CACFP, School Meals, Older Adult Nutrition/Senior Congregate Nutrition, etc.) in place of HOP's food-based standards. Doing so would open up the opportunity for new institutions to join networks as HSOs without having to create new program streams (i.e. building on the capacity and structures that already exist)
  - Recommend enabling HSOs to serve members outside of their contracted county(ies) if member is within a certain distance radius of the HSO and that HSO would be the nearest or most convenient option. The same goal may be accomplished by contracting the HSO for multiple counties but only partial rather than whole counties; essentially, this creates less coverage than the surface level assessment would suggest and allowing HSOs to cover small parts of nearby counties would prevent this overestimation and miscommunication/misunderstanding on how to route referrals

  - Recommend providing an admin fee for coordination of transportation services. HSOs that directly provide transportation may build in their administrative costs as a base rate on the invoicing calculation, however, organizations that coordinate transportation and pay other providers (like subcontractors or apps) have no such avenue to cover the administrative/operational/coordination costs incurred. This is also true for organizations that coordinate and provide financial assistance on vehicle repairs, which requires staff time that is currently uncompensated.
- Consider workforce development/employment services to support housing navigation efforts.

- We suggest capacity building funding supporting a full-time accountant/ bookkeeper for the first two years an HSO participates in HOP. Due to the payroll and accounting setup requirements to successfully participate in the program a financial professional is essential. We have seen HSOs struggle with their quarterly reporting, budgeting, completing amendments and other required reports because they can't afford a dedicated financial professional.
- Unite Us needs to be replaced with an invoicing system that is built for invoicing and a proven track record that functions as HOP requires. The service delivery invoicing dispute process is cumbersome. This should be within the invoicing program.

- PHPs need to have access to the invoicing system so they have access to their members information and can research in real time.

- Before any changes are made in UniteUs/NCCARE360 platform (e.g. service delivery invoicing) all stakeholders (LPEs, HSOs & PHPs) need to have the opportunity to give feedback to ensure the changes will work with all systems.

- LPEs should have time to teach the HSOs before changes are made to the service delivery system. With a three-week minimum lead time.

- If using an 837 payment file, there needs to be a 835 file. If a major change happens in the way the systems are communicating from PHPs to an invoicing system, the changes must be tested before implementation.

- Status of the invoice should match what is in the Contracted Service to what is showing in the invoice file.

- Have a standardized budget/quarterly reporting template across all LPEs.

- Have a standardized capacity building HSO Financial Support Requirements document.
- LPEs need to have access to every HSO in Unite Us including cases and invoices (automatic open access). Asking for permission takes time and the HSO can choose not to give it or they intend to but it never happens. Having access allows us to research invoices issues and expedite solutions.
- Have a standardized list for all LPEs of approved items for Healthy Home Goods and Housing Move-in Support. There should be a definitive list of nonapproved items.

- The invoice number should follow the life cycle of the invoice regardless of what status it is in, instead of adding a -2 /-3 / -4 when the HSO Fixes and Makes New. This will also help with the accuracy of the data. This will result in only the active status being reflected at any given time, which would reduce confusion and duplication of work. It would also allow the rejected invoices to be an accurate reflection of invoices to address versus an ever-growing list.
- Unite Us needs several filter/search options. They should include: Invoice ID, service type, member name, PHP, and date created.
- Unite us resets and takes off filters when you go back a page, this is not efficient and should keep the filters until the user clears them.
- When downloading invoices out of Unite Us, it should download all, not only page by page. This is incredibly cumbersome when you have to download multiple pages and the download should not include attachments.

- When approving invoices, the system should take you to the next invoice instead of taking you back to the main dashboard. If this was fixed it would save a lot of HSO/LPE administrative time.

- The last update on the home page in Unite Us was changed to update when a note is added to the member case. This now makes the last update, date for invoicing useless. We need to be able to see how long an invoice has been in one status. I.e. we have 15 days to approve/reject an invoice, without the correct last update, we could miss our deadline and the HSOs could as well. Instead of last update, the date of last *status* update would better reflect our needs.

- **IPV Services** are extremely hard for Care Management Entities to navigate. CM/Care Coordinator cannot see anything in Unite Us regarding status of referrals after placing the referral for a member that is getting HOP services. CM/CC is part of that member's care team and should be able to see anything and everything in UU related to that member's HOP referrals. CM/CC can't tell if HSO has rejected or closed referrals. Unite Us needs to reconfigure the system to allow care management entities to have access to their member's cases.

- **Healthy Food Box for Delivery and/or Pickup**: Recommend CM ability to tailor this service more to member need. Some members need the weekly Healthy Food Box and others may only need twice monthly or a monthly option. We would be able to serve more members if we have that type of flexibility in the cadence for pick-up or delivery. Also need a date when food box would stop. Recommend that Nutritional Education be a part of this service.

- **Fruit & Vegetable Prescription Service**: The administrative burden on HSOs and costs to track and then invoice this monthly benefit is significant and well exceeds $5.25 PMPM. CM/CC propose removing this as a HOP service and the PHPs absorb this service/benefit into their value-based service opportunities for chronically ill members. Most PHPs already have value-based offerings that utilize pre-paid VISA cards and this benefit could be streamlined for members to receive money monthly for healthy fruits and vegetables. If PHPs cannot absorb this service, then this HOP service needs to have a higher administrative fee to cover the admin burden. We have several HSOs that would gladly move into this service but cannot do so without appropriate compensation. HSOs do need to be able to keep lights on and compensate their staff appropriately.

- **Unite Us/NCCARE360 Platform:** As CM are trying to find HSO to service a member's referral it would be extremely helpful if the information about the HSO and the counties they serve was more user friendly. Currently, CM must search within the HSO service details to see what county is served by that HSO. Perhaps having a system configuration that blocked you from sending a referral to the wrong county would be helpful. That program detail would eliminate a lot of problems and

delays in care. First the data would not be filled with rejections because of not being able to serve that county and second CMs would not have to find out up to 2 days later that they need to find another HSO to serve their member.

- Unite Us not turning services on when they are configuring or notifying HSOs of when services are turned on.
- Disenrollment notifications need to go to multiple HSO members. It currently only goes to the primary worker. If this person is out, there is a potential for the HSO to deliver services after the disenrollment.
- HSOs need to have the ability to edit their service definitions in Unite Us.
- There is no way for LPEs to approve an HSO turning on services in Unite Us after they have gone through readiness. This has the potential to allow HSOs to turn services on when they have not successfully gone through the required readiness.
- The service delivery invoice status in Unite Us needs to reflect the actual status. The invoice status not being correct causes huge confusion with everyone.

- **General comments about HOP Renewal:** If we are going to continue with the HOP Pilot, Care Management Entities and HSOs need to be better supported with adequate staffing. That may mean more monies to cover CM/CC salaries by PHPs and capacity dollars or higher administrative compensation for HOP services to support HSOs. Maximizing care management resources is needed to provide complex care management to these members to improve the health of our communities. Ideally, members would be engaged with their care manager regularly and it would not be 3-months before CM realized that HOP service had not started.

- Work on making improvements in the Unite Us platform to promote better communication between HSOs and CMs. Let's strengthen the Care Management process so that member's health improvement goals go more hand in hand with HOP services. AND let's not forget our mission to improve the health of our communities.

- Rent assistance for members. Regarding the possible 6 month rent service for members, best practice would be to provide this funding upfront for HSOs that will be contracted to provide this service. Also, a shorter reimbursement time frame of 2-3 weeks so reimbursement can be used to pay the member's rent. Also providing an administrative fee per member per month.

- Upfront funding for Housing supportive services to include- first month rent and security deposit, utilities, and housing move-in support. Also, shorter reimbursement time frames to less than two weeks. Currently due to high up-front costs averaging $4500 per move in and PHP reimbursement time frames of up to 60 days, HSOs are forced to turn off services until full reimbursements are received. HSOs may have to turn off services for 60 or more days until full reimbursements are received. Once fully received reimbursement, then they can help more members.

- Add Administration fees for providing first month rent and security deposits and housing move-in support.

- Restructuring the service index reimbursements and administrative fees to fit cost of doing business in 2023-2024. And reviewing/updating the service index annually to keep up with the cost of doing business. Must take into consideration the local housing market and inflation.

- Housing affordability. Establishing guidelines mandating HOP funds only be used when it has been established by the housing navigator the member can afford their new residence.

- Inspections for Housing Safety and Quality. Acknowledging there are two very different inspections within this one category and separating the two in Unite Us. First is the HQS inspection that is used to inspect properties for new move-ins. The second kind of inspection is used to assess a property for remediation and/or safety modifications. These two inspections are very different and most times the HQS inspector is not qualified to perform a home remediation/safety modification assessment because they cannot provide a quote for repairs.

- Combining Medical Respite and Short-term Post Hospitalization into one service. Start the service with 3-6 months of medical respite depending on medical condition and then follow up with up to 6 months of short-term post hospitalization to give the member a total of up to 12 months to find housing. Also amending eligibility to include being discharged from a rehabilitation facility.

- Increasing home remediation and safety modification project coordination fees.

- No longer using fair market rent rates. Instead using a more market comparable way of establishing rental assistance reimbursement rates. For example, using a formula that includes a property's square footage. For instance, a 3 bedroom apartment with a square footage of 1900sqft would qualify for rental assistance of up to $1900 per month.

- Increasing the Short-term post hospitalization rate. It's currently based on county one-bedroom FMR.
- Have the flexibility to find housing in an adjoining county even if not in HOP County
- Have the flexibility to offer alternative housing i.e. tiny houses, permanent RV living

NCCARE360 & Data

- "Undisclosed" data hinders our ability to determine effectiveness of the pilot in reaching various demographic groups for example: 16% of clients with gender undisclosed/ 52% with ethnicity undisclosed/ 46% with race undisclosed

- NLs have not had the ability/option to download raw data from UU since the launch of the pilot. The only way to obtain insights from UU is by looking at the dashboard, which is usually a very time-consuming process. There are also questions around how the dashboard pulls/processes raw data to turn into KPIs, and the consistency and validity of these KPIs over time.

- If at the time of enrollment, a client is authorized by a CM for a service but there's no HSO to accept that referral, that authorization will never become a referral. Currently there's no way to track these cases, and NLs have no idea of *actual need*/*needed capacity* because each time we are "at capacity" for certain services, data stops being collected. That prevents us from knowing the real number of client/services trying to be connected with HSOs. Recommend collecting this data

- The categories in UniteUs to indicate reasons for closing cases (either resolved or unresolved), rejecting cases, rejecting invoices, and turning off services need specific reasons. Currently, the categories do not do a good job at capturing the wide range of reasons for why an HSO would turn off services, or for why a PHP rejected an invoice. Often times, the actual reasons are captured in the notes (if that is an option), but there is no simple way to see such reasons to determine what is working and what is not.

- The fact that HSOs cannot turn on/off for certain counties prevents them from servicing a significant number of clients at any point in time. At times, HSOs reach capacity in a specific county (i.e. perhaps one that experienced a high volume of referrals) but still have capacity to serve other counties. As is, there is no way for HSOs to turn off only for the counties that are maxed out.

- Currently, there is no option for an HSO to turn on to accept referrals from recurring clients (i.e. clients that already have a referral that is about to expire).

- The "pins" system on NCCARE360 where HSOs drop pins in zip codes that they can serve has created inequities among HSOs in terms of the volume of referrals that they receive. Since HSOs can modify their pins at any point in time, it has been the case that certain HSOs change their pins on the platform but the Network Lead does not know until after many weeks.

It would be ideal to have guardrails in UU that standardize the usage/presence of pins across the board. For example, an HSO providing Food Boxes should have the same number and location of pins for pass-through and non-passthrough services, as well as for large/small food boxes.

As is, the only way for NLs to get a sense of pins/coverage by zip code (and thus, coverage *within* a county) is by looking at the list of pins *one at a time*. UU should make available an option to download a list of pins associated with each HSO/service pairing

- Ideally, NCCARE360 would have a functionality that notifies NLs when specific HSOs turn on/off. Similarly, NLs should be able to quickly download a list of all HSOs that are currently offline and why.

- The county restriction for HOP makes it difficult for members to access services closer to them in some cases. Need more flexibility across counties.

- Extent to which Outcomes data on NCCARE360 captures the full range of possible effects after service provision, and how this could potentially jeopardize efforts around program evaluation.

- Lack of data and clarity around expedited enrollments (NLs receive data infrequently and with a significant lag), and how these enrollments will roll into traditional care management. Ideally, expedited enrollment data (and timelines to join traditional case management) would be readily available for Network Leads to determine next steps around capacity and coverage.

- Standardizing services across NLs to ensure services across clients are somewhat comparable, and that the data collected from these efforts is consistent. Seems to have resulted in different working assumptions across NLs for some areas that ideally should be consistent rather than variable (both from a research perspective and an equity for HSOs).

- Concern about investment on data front and how problematic NCCARE360 has been in terms of accessing data that is consistent and reliable over time. The various issues we have had with the platform in terms of invoicing have also created myriad programmatic, financial, and other issues in our network. For example, PMs have to constantly check in with HSOs to see who's turned off services/is at capacity. Currently, that is the only way we have to get a sense of network coverage.

- **Outreach process**: Uncertain on extent of engagement efforts to historically underserved/marginalized populations (Muslim communities, LGBTQ populations, Hispanic/Latino/X populations, Indigenous populations) because not high population and/or well organized in region. Ensure PHP and local engagement with historically underserved/marginalized populations near go live phase in new counties, new network regions.

- **Onboarding**: The NC tracks process for HSOs was entirely too cumbersome and a high barrier. If HSOs will continue to register as a Medicaid provider in NCTracks and

then eventually Optim, streamline the process for HSO/CBOs vs. what practices/providers must do.

- **PESA**: degree to which screening questions on the PESA actually address/align with the service offerings? for example, what triggers DPP referral because DPP need is related to but separate from food insecurity screening; likewise with housing, if screening identifies risk of homelessness, how is healthy home goods or remediation referred for those who need it but are not at risk of homelessness (how CMs are understanding that definition)

- Strategy needed around getting CM feedback directly to HSOs (rather than always coming thru NL) to give them opportunity to resolve; identifying when to escalate feedback either because of frequency or severity of problem to start involving NL; A feedback loop is needed with NL looped in within the platform. Possible idea: create a form/workflow in platform to share with CMs with some structured/pre-set questions so that we can collect some baseline info from client/about case >> have form automatically send response back to CM and instruct them to always forward to the HSO in the case >> NL to monitor on weekly-bi-weekly basis rather than clog up an external HOP Support email

- Parenting Classes should include transportation, childcare and maybe meals or other incentives.

- Some HSO services should be coordinated with job placement services.

- Stop or modify Services that are used minimally or not at all.

- Allow the HSO and CM to determine the length of service need or modify referral timeframe as some services take time to complete.

- Allow CM to add services particularly in housing without the need to start a new referral – the housing navigator may find that the member needs an inspection or healthy home goods, etc.

Unite Us/NCCARE360 Platform:

- As CM are trying to find HSO to service a member's referral it would be extremely helpful if the information about the HSO and the counties they serve was more user friendly. You must search within the HSO service details to see what county is served by that HSO. Perhaps having a system configuration that blocked you from sending a referral to the wrong county would be helpful. That program detail would eliminate a lot of problems and delays in care. First the data would not be filled with rejections because of not being able to serve that county and second

CMs would not have to find out up to 2 days later that they need to find another HSO to serve their member.

- Develop some alerting tool that would help the HSO know they have a referral and can act on it in real time. This would help with member engagement.

- Better process within UU and NCARE360 to show member eligibility and disenrollment.

- Bi-directional communication between HSO and CM's to ensure service is being done and its quality. Some sort of feedback loop is needed.

- Tweak Care Management enrollment processes with regard to HOP services including timelines

- If we are going to continue with the HOP Pilot, Care Management Entities and HSOs need to be better supported with adequate staffing prior to actively accepting referrals. More money to cover CM/CC salaries by PHPs and capacity dollars or higher administrative compensation for HOP services to support HSOs. Current Case managers in the pilot have too big of a case load to properly impact the member and follow up.

- Standardize across all pilot regions a readiness process for HSOs – make sure the infrastructure is there before HSO can accept referrals (Bookkeeping, payroll, standards of each job/task, staffing, processes).

- Critical to include local, community HSOs and help them develop scalable services models.

- Develop guidelines, policies and procedures, evaluation, and other service components so they are standardized across network leads but allow for local HOP tweaking.

- Allow texting with members (without PHI) because most members will not answer the phone unless they recognize the number.

- Consider Dual eligibles as the first expansion group.

- Do cost analysis for each service so that the HSO will know prior to contracting what is expected. This includes staff, vehicles, upfront purchasing, etc.

- Ease up on the need to medical prove 2 chronic diseases in order to participate in HOP

- Must account for inflation and the rise of cost of living when reviewing reimbursement.

- Better timing (faster) on getting reimbursed. Maybe consider upfront funding.

- Clearer reasons for denials/ rejections. Standardization across all PHP on this process. Make the timelines and guidelines clear and all the same.

- Allow the members to fill out the PESA.

- Expanding to include natural disaster affected persons would mean that everyone in the affected area would be eligible – guidelines and rules need to be in place -specifically who is and is not eligible and for how long.

- Data sharing between HSO, NLs and PHP about health outcomes and improvements.

- Oversight and quality control of each HSO would stay with the NL.

- Continue to monitor claim metrics and find trends, areas for improvement, etc.
- Re-exam expediated enrollment – did it affect anything?
- Redefine service indexes.

- Streamline eligibility process.

From: [redacted]
To: Medicaid.NCEngagement
Cc: [redacted]
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 5:01:37 PM
Attachments: Duke-Margolis Comments re NC 1115 Waiver Renewal_v4.docx

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Hello,

On behalf of the Duke-Margolis Center for Health Policy, we appreciate the opportunity to provide comment on the draft renewal request for North Carolina's Section 1115 waiver. Please find our comment letter attached to this email. We are interested in seeing the other submitted public comments on the Medicaid Reform Section 1115 Demonstration renewal once available.

Many thanks,

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North Carolina Department of Health and Human Services
North Carolina Medicaid Section 1115 Waiver Team
Submitted via email, Medicaid.NCEngagement@dhhs.nc.gov

September 20, 2023

Re: North Carolina Section 1115 Demonstration Waiver Renewal Application

Dear North Carolina Medicaid Section 1115 Waiver Team,

Thank you for the opportunity to provide comment on North Carolina's Section 1115 demonstration waiver renewal application detailed in your recent announcement. Medicaid Transformation in North Carolina is vital to ensuring better health for the most vulnerable North Carolinians, and we applaud the state for their efforts to continue building an innovative, accountable, and well-coordinated system of care.

Importantly, by identifying and pursuing shared priorities for reforms, Medicaid Transformation garnered strong bipartisan support from the North Carolina legislature as well as from broad stakeholder groups, enabling progress on other important health and fiscal goals for the state. These include passing Medicaid expansion, paying for health and not just health care, addressing the current behavioral health and opioid crises, improving maternal health outcomes, and improving children's health through family-centered approaches to health and social care. Continuing to set clear goals, establish accountability for outcomes, and evaluate progress will reinforce the NC Department of Health and Human Services' (NC DHHS') investments in building trust and support for Medicaid Transformation. To support NC DHHS's transformation efforts and to inform the submission of the Section 1115 waiver renewal application, we provide our comments below informed by our research and multi-stakeholder engagement in North Carolina. We have prepared our comments with the support of staff and faculty from the Duke-Robert J. Margolis, MD Center for Health Policy at Duke University. We provide general feedback on the broad goals, and then we provide specific feedback on the topics outlined in the Section 1115 demonstration waiver renewal application.

About the Duke-Margolis Center

Established with a founding gift through the Robert and Lisa Margolis Family Foundation, the Duke-Margolis Center brings together capabilities that generate and analyze evidence across the spectrum of policy to practice, supporting the quadruple aim of health care–improving the experience of care, the health of populations, provider satisfaction, and reducing the per capita cost. The Duke-Margolis Center's activities reflect its broad multidisciplinary capabilities, fueled by Duke University's entrepreneurial culture. It is a university-wide program with staff and offices in both Durham, North Carolina, and Washington, DC, and collaborates with experts on health care policy and practice from across the country and around the world.

The mission of the Duke-Margolis Center is to improve health, health equity, and the value of health care through practical, innovative, and evidence-based policy solutions. The Center's work includes identifying effective delivery and payment reform approaches that support the transition to value-based care and collaborating with expert stakeholders to identify pathways to increase the value of biomedical innovation to patients – both through better health outcomes and lower overall health care spending.

Duke | MARGOLIS CENTER *for* Health Policy

General Feedback on Vision and Objectives for Proposed Waiver

North Carolina has been a leader in recent years in health care transformation, such as moving to paying for health; including a focus on whole-person, coordinated care; transforming Medicaid and health care programs; better integrating government and social services; and engaging and strengthening communities. As the state considers the next phase of its Medicaid waiver, an overarching challenge will be how to bring these initiatives together more effectively, measure the impact and generate evidence on what works, and support improvements in whole-person capabilities.

Supporting Health Care Workforce and Focusing Improvement through Aligned Measures and Data Supports

The vision set by North Carolina's 1115 waiver and progress toward shared goals has generated momentum for reforms beyond the Medicaid program, such as through the multi-stakeholder North Carolina State Transformation Collaborative that seeks to advance the Quadruple Aim and the health of all North Carolinians through measure alignment and data supports. Aligned measures and overall streamlined administrative requirements will be important to support the health care workforce, which is facing high levels of stress and burnout, as well as focus attention on the areas that are most important to improve for North Carolina. Other new initiatives, such as the Making Care Primary model, will also further the goals of alignment and support for primary care in the state.

Healthy Opportunities Pilots program

The Healthy Opportunities Pilots (HOP) program is a major component of the proposed waiver, especially as the waiver outlines how to expand the initial pilot authorized by the state's last Medicaid waiver. HOP is one of the country's most comprehensive efforts to address the health-related social needs of Medicaid members through accountable Medicaid managed care. It is central to NC DHHS's commitment to "buying health, not only health care," or advancing whole-person care that goes beyond just health needs with the purpose of making health care payment and delivery more effective and efficient. Further, much like North Carolina's bipartisan path to Medicaid expansion, HOP was born from a bipartisan commitment to strengthening the state's community infrastructure and workforce while improving the health and well-being of North Carolinians.

It is critical to generate evidence on HOP's design, implementation, and impact. HOP was originally slated to begin in mid-2019, but its launch was delayed due to the COVID-19 pandemic and state budget challenges. The capacity-building period eventually launched in June 2021, with service delivery launching in a phased fashion (by service domain) between March 2022 and April 2023. Despite this multi-year delayed launch, the current waiver period for the program is still set to end on its original date of October 31, 2024. Thus, the research on its design, capacity-building, implementation, and impact has been commensurately delayed and nascent. The first Rapid Cycle Assessment of HOP was released in Spring 2023 by the University of North Carolina Cecil G. Sheps Center for Health Services Research on data through November 2022, capturing a few months of service launch. It showed promising progress toward advancing multi-sector collaboration and delivering services, but it was extremely nascent on the effectiveness of HOP services at addressing social needs. The first qualitative evaluation report on lessons and recommendations from studying the design, capacity-building, and first

several months of implementation was released by us in September 2023. This report identifies challenges—unsurprisingly for a new initiative—but also illustrates potential solutions that have been implemented or suggested to solve those challenges.

As the evidence on HOP's impact is limited due to the short duration of the program, the renewal and expansion of HOP is an opportunity to address that challenge by generating additional years of evidence among a larger population. There are specific areas where stakeholders have asked for more evidence—service definitions, delivery methods, financial supports, and more—which can be explored as the program continues.

More broadly, the next phase will allow more time to assess different implementation strategies for addressing social needs of diverse populations across the state in order to reduce improve people's health and reduce inequities. It will be important to continue to support community participation, engagement, and trust in finding effective ways to meet those needs, prioritizing the best opportunities given limited resources, evidence, and time. Future work may include enhancing program data integration (in trusted and reliable ways), strengthening primary care to screen and refer people based on their social needs, and provide supports to help tailor the program based on local needs and resources (drawing on the organizations with good knowledge and trust in each community). The overall next phase should consider how to implement with the goals of flexibility and accountability, building on what the health care system has learned about moving away from payments for individual services.

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Specific Feedback on Individual Sections of Renewal Application

Drawing on the goals and vision from the prior section, we highlight where our research and broader evidence has implications for the proposed waiver sections related to:

- North Carolina's Healthy Opportunities Pilots (HOP) program to enhance impact and sustainability,
- Continuous enrollment for children enrolled in Medicaid,
- Covering pre-release services for justice-involved individuals,
- Behavioral health and intellectual and developmental disabilities (I/DD) delivery system, and
- Behavioral health and long-term services and supports workforce.

Feedback on Strengthening Access to Whole-Person, Coordinate Care (Objective II outlined in the renewal application)

Healthy Opportunities Pilots

As noted in the introduction to this comment letter, we appreciate the opportunity to provide comments on the draft renewal request for North Carolina's Healthy Opportunities Pilots (HOP) program. Our comments are informed by our years of research studying HOP to understand real-world experiences in preparing for and implementing it, and to generate timely and practical guidance to improve the program and similar initiatives. As part of this research, to date we have completed:

- 60 semi-structured interviews (with 95 unique individuals)
- Six expert stakeholder meetings (between December 2020-June 2023)
- Two focus groups (in May 2022, with eight individuals with NC Medicaid experience, most of whom received HOP services)

These research activities included a diverse and balanced set of stakeholders from all HOP regions and levels of administration, including NC DHHS, prepaid health plans (PHPs), Network Leads, human service organizations (HSOs), HOP service recipients, and subject matter experts outside of HOP (including stakeholders in North Carolina who are addressing social needs outside of current HOP regions, and leaders from other states who are implementing similar programs).

Our comments draw from evidence we generated from these activities, including a report that describes our findings and practical recommendations from our initial phase of research on HOP in more detail, as well as additional forthcoming analyses. We organized our comments and recommendations around the four categories or proposed changes in the HOP waiver renewal fact sheet (first four subheadings below), plus some additional cross-cutting recommendations beyond the fact sheet categories (fifth subheading below). Additionally, beyond our recommendations in this comment letter, stakeholders involved in NC Integrated Care for Kids (InCK)–a model co-led by NC DHHS, Duke University, and the University of North Carolina at Chapel Hill–is submitting a comment letter that includes specific considerations for how HOP could be modified or expanded to include a more a child- and family-centric approach based on their experiences in whole-person health care transformation to child- and family

wellbeing. We recommend NC DHHS review NC InCK's comments for potential alignment with HOP modifications toward a more efficient statewide approach to whole-person care.

NC DHHS HOP waiver renewal section 1: "Expanding the Pilots Statewide and Scaling Services"

NC DHHS' vision to expand HOP statewide, scale HOP services, and offer additional flexibility for direct contracting between health plans and HSOs is echoed by diverse stakeholders in our research. Additionally, as we laid out above, the renewal and expansion of HOP will help overcome one major challenge of HOP to-date: improving the generation of evidence needed for HOP to be most effective and efficient, and generating critical evidence for the broader field to design and implement similar efforts, including in bipartisan settings.

That said, there are key challenges in the current structure that also need to be addressed while expanding HOP's reach to make it more effective and efficient—while generating more evidence. In our research, stakeholders have identified administrative challenges with the current reimbursement model for service delivery as well as financial challenges participating in HOP. Challenges that we heard included:

- *Tension in building local capacity and scaling service delivery*. During HOP's early implementation, many stakeholders noted that they leveraged capacity-building funds, program flexibility, and regional infrastructure in efforts to balance these goals. For example, some networks established contracts with larger, well-established HSOs first to jumpstart service delivery while providing smaller HSOs with more time and assistance to participate. It will be important to continue to balance these goals as HOP expands to a statewide model.
- *Identifying scalable and financially predictable financial model.* HSOs have often noted cash flow issues in waiting for reimbursement as a major challenge to HOP implementation.
- *Move away from fee-for-service payment approach to broader value-based approach.* HOP could build on its value-based payment milestones (currently focused on meeting implementation milestones and process and referral achievements) by developing a strong process to define quality for all HOP services—to hold HSOs, NLs, and PHPs accountable for the HOP services they provide to ensure high levels of quality and fidelity. Quality measure achievement could be linked to incentive payments initially and then linked to any prospective payment shifts over time.

NC DHHS HOP waiver renewal section 2: "Modifying Pilots Services"

NC DHHS' proposed modifications to the current fee schedule (e.g., allowing up to three meals per day, providing six months of rental assistance) are echoed by diverse stakeholders in our research.

That said, there are key challenges in the current structure that stakeholders in our research emphasized need to be addressed through service definition modification and expansion to make it more effective and efficient—while generating more evidence. NC DHHS should reconvene their multistakeholder HOP fee schedule advisory panel to achieve the following goals:

- *Establish additional accountability guardrails for certain HOP services.* While some stakeholders appreciated the flexibility afforded by HOP service definitions, others in our research pointed out the need for additional guardrails for some broadly defined services (e.g., food boxes, healthy home goods) to protect against harmful variability and to ensure high fidelity and quality of services. We recommend that NC DHHS revisit all service definitions accordingly and consider additional

mechanisms for ensuring fidelity.

- *Investigate the cost of administrative effort in HOP services and adjust payments accordingly.* Currently, some services have no fees to cover administrative costs, such as setting up and coordinating services, and organizations have expressed concern about other administrative fees compared to the true cost of service delivery. These fees should be analyzed to ensure sustainable financial model for HOP scaling.

- *Investigate fees for certain HOP services to account for current landscape.* Generally, stakeholders in our research mentioned they would like the fee schedule to be periodically adjusted based on inflation. In terms of specific services, stakeholders in our research suggested reimbursement rates for transportation services to account for distance variation, especially in rural areas, and that coverage of certain housing services being dependent on Fair Market Rent standards contributed to challenges in securing housing in the current housing market.

- *Investigate the scope of certain existing HOP services.* Stakeholders and HOP beneficiaries in our research expressed interest in being able to offer the following services within existing service domains. As with the current HOP services, the challenge will be balancing offering new services against the evidence for their impact, ability to deliver, and trade-offs given constrained overall resources. Several states are exploring a variety of initiatives in housing services to promote housing stability, additional cross-domain services such as expanded legal support services, and additional transportation services.

- *Provide additional guidance on pairing certain services together.* Many HOP stakeholders in our research—including Network Leads, PHPs, and HSOs—expressed a need for more guidance on how to pair certain services together to increase effectiveness, efficiency, impact, and sustainability. Some services may benefit from being bundled, co-offered, or sequenced in a specific order to maximize effect (e.g., always offering housing navigation and inspection together—and before other housing support services). NC DHHS should assess opportunities to do so, pilot them, and make changes accordingly.

NC DHHS HOP waiver renewal section 3: "Expanding Eligibility Criteria for HOP"

Initial enrollment in HOP was slower than anticipated, and eligibility and enrollment for some domains is notably more complex than others (e.g., housing and interpersonal violence), necessitating improved processes and guidance for care managers and other providers involved in screening—although enrollment has improved following the implementation of several new flexibilities. We provide the following suggestions and examples to further improve eligibility and enrollment based on stakeholder feedback in our research studying the program and other similar initiatives nationwide.

NC DHHS should establish a multistakeholder process to investigate ways to improve outreach, screening, and enrollment in HOP. As additional people become eligible for HOP services (such as people recently released from incarceration), there are opportunities to streamline outreach, screening, and enrollment. Stakeholders in our research repeatedly recommended formally involving community health workers (CHWs) in community outreach and engagement for HOP. NC DHHS built out a CHW program

and required CHW usage for its COVID-19 Support Services Program, which mirrored the structure of HOP on a smaller scale for pandemic-related social needs. Further, creating more structured ways to screen Medicaid populations for potential HOP eligibility outside of clinical walls and connect with the other local government sectors working adjacent to HOP could facilitate improved health outcomes. For example, the Integrated Care for Kids (InCK) model employs clinical "integration consultants" that interface with county Departments of Social Services across health, education, and social sectors to assist with navigating eligibility between public programs.

NC DHHS HOP waiver renewal section 4: "Investing in Capacity to Support Program Growth"

NC DHHS' vision for extending HOP's capacity-building funds and technical assistance are repeatedly echoed by diverse stakeholders in our research as critical to program effectiveness, efficiency, impact, and sustainability.

That said, there are key challenges in the current structure that also need to be addressed while expanding HOP's capacity-building design to make it more effective and efficient—while generating more evidence. Guidance around when and how to use capacity-building funds was initially unclear, including concerns over liability for capital expenses, and some HSOs have had to pause service delivery while waiting for reimbursement to ensure proper cash flow. We provide the following suggestions and examples based on our research studying the program and other similar initiatives nationwide.

NC DHHS should establish a multistakeholder process to achieve the following goals:

- **Investigate additional opportunities for training and technical assistance.** Stakeholders mentioned additional training for care managers would be beneficial, especially on appropriate referrals for certain more complex services, such as housing and intimate partner violence (IPV) services.

- **Investigate additional guidance and flexibility on allowed uses of capacity-building funds.** Several stakeholders in our research emphasized that the single biggest threat to the effectiveness, efficiency, impact, and sustainability of HOP is the cessation of capacity-building funds, especially in the context of reimbursement delays to HSOs that cause severe cash flow issues.
    - Investigate allowing capacity-building funds as zero-interest loans to cover high upfront service costs for HSOs waiting for reimbursement.
    - Develop a pathway for HSOs to develop skills toward no longer needing capacity-building funds, such as a program to provide HSO training for good business practices and financial sustainability (e.g., Community Care of the Lower Cape Fear's Business Solutions Center). With this approach, there is a reduced risk of financial instability for HSOs and HOP when capacity-building funds end.
    - Provide formal guidance on HSO participation standards necessary for any capital expenses (e.g., vehicles, property) to not be subject to asset seizure. This would foster transparency and trust with HSOs.

- **Continue to explore ways to leverage data and technology to support HOP.** NCCARE360 is the country's first statewide cross-sectoral closed-loop referral system, and is playing a key role in facilitating program implementation. However, while NCCARE360 is an advancement for the field, there are naturally many challenges—and opportunities to improve the structure and function of

such technologies to support the program over time. Stakeholders across the spectrum in our research repeatedly emphasized that NC DHHS and its NCCARE360 data partners continue to:

- work toward a smoother process for transforming invoices for claims;
- build in functionality to assess referral equity and enrollee equity;
- include functionality for all HOP entities to see a historical view of what services have been approved and delivered over time (including when enrollees are approaching service limits, and how service delivery varies across peers);
- add enhanced functionality to display, filter, and export data;
- provide additional training and technical assistance; and
- better integrate NCCARE360 and other technology solutions in the state (e.g., NCTracks, NC HealthConnex).

Additional cross-cutting recommendations from our research

In addition to our recommendations above related to NC DHHS' proposed changes to HOP, based on our research, we offer two sets of new recommendations to further improve the program's effectiveness, efficiency, impact, return on investment, and ability to generate useful evidence.

NC DHHS should establish a multistakeholder process to achieve the following goals:

- *Investigate formally incorporating equity into program design and incentives.* HOP is critically important to addressing social needs, which is important for a whole-person approach to health and health care. Another important component of whole-person health care transformation is directly addressing inequities in social needs and health services. HOP could build from progress in the field to more explicitly include a focus on equity into program design and implementation. Key examples could include:
  - Tracking and reporting equity in program screening, enrollment, and service delivery by key sociodemographic characteristics and developing financial incentives for equitable service delivery; and
  - Developing standards for assessing equity in HOP network adequacy (such as ensuring all North Carolinians have their needs addressed by the program).

- *Expand the scope of program evaluation.* As required in the current waiver, CMS supports a critically-important formal evaluation of HOP conducted by the University of North Carolina Cecil G. Sheps Center for Health Services Research. It is important not only to continue evaluation of HOP, but also to expand its evaluation in several key ways:
  - Expand current evaluation methods to include an intentional focus on equity (specific examples of statistical methods to study equity and capture spillover effects are noted here).
  - Create new evaluation funding opportunities to supplement the current evaluation by supporting robust implementation science and qualitative research focused on timely guidance and engagement of HOP stakeholders. These types of evaluations are critically-important to generating multistakeholder-informed and timely guidance on program design and implementation—to maximize the effectiveness, efficiency, impact, and sustainability of

HOP. However, they are outside the scope of the current formal evaluation and reliant on grant funding.

- Examine cross-sectoral impact beyond just the health system—to capture concepts of "social return on investment"—in any expanded or new evaluation.

Continuous Enrollment for Children

The proposed continuous coverage provisions for children in the waiver renewal request include:

- Continuous enrollment for children ages zero to five,
- 24 months continuous coverage for youth 6-18, and
- Continuous enrollment for youth who aged out of foster care before January 1, 2023

Enabling continuous coverage for children and youth can help reduce churn in the Medicaid program. Churn is the process of individuals losing coverage from Medicaid and then returning to Medicaid coverage within a relatively short time period, likely indicating disenrollment due to administrative reasons rather than a loss of eligibility. Enrollment churn is a substantial challenge for Medicaid programs across the country and can lead to unnecessary administrative costs. Our comments in this section are informed by our research examining the impact of Medicaid churn.

- *Churn negatively impacts care outcomes for children.*As a result of churn, children experience gaps in coverage that disrupt patterns of care and increase the risk of having unmet health care needs. The longer the period of uninsurance, the less likely that child is to receive preventative care. Continuous long-term coverage supports consistent physician visits and is associated with higher reports of met medical needs.
- *Our research indicates a high risk of churn in the Medicaid program.*
    - We examined three years of enrollment for youth ages 1 to 20 as of January 1, 2016. Approximately a quarter of all youth in this cohort experienced at least one disenrollment. Of the disenrolled youth, approximately a quarter re-enrolled in Medicaid within a year.
    - Recent evidence from Minnesota suggests that the experience of enrollment churn is not unique to North Carolina's Medicaid program. Using the Minnesota state All Payer Claims Database, Frenier and McIntyre found approximately 50% of children who were disenrolled from Medicaid had no identifiable source of coverage six months after the disenrollment and 30% had no identifiable coverage a year after disenrollment. Among the children who experienced a disenrollment in this Minnesota study cohort, Medicaid re-enrollment was the dominant source of coverage after the disenrollment.
    - For both our NC Medicaid-based research and the research out of Minnesota, the findings suggest that administrative complexity and burdens rather than true ineligibility drove the initial disenrollment. Administrative burdens are most heavily borne by individuals who are facing systemic disadvantages (Christensen et al, 2020; Kyle et al, 2021; Bell et al, 2022; Elinder et al, 2023). Evidence in other contexts have shown substantial impact of seemingly small administrative frictions such as arranging a payment or selecting a new plan after an existing plan has been terminated has led to

substantial disenrollment. Continual enrollment is likely to reduce churn by reducing administrative burden and can contribute to the narrowing of health disparities.

- *In particular, our research suggests targeting specific populations to sustain enrollment: youth ages 12+, Black youth, Latinx youth, and youth with complex health conditions.*
    - Disenrollment was more likely for children 12 years older, providing evidence that continuous enrollment is especially needed among older youth to sustain access to care.
    - Black children and children with complex health needs were more likely to experience disruptions in coverage due to churn. Latinx children had a higher likelihood of short-term coverage disruptions (<6 months), suggesting likely eligibility during this period of disenrollment. These findings suggest that the current policy of 12 months of continuous Medicaid coverage is not sufficient to prevent churn, especially among minoritized populations.
- *Minimizing churn through continuous enrollment can reduce costs.*
    - Through our research, we simulated a policy that is similar to continuous enrollment and estimated the per member per month (PMPM) health care costs assuming no disenrollment allowed in a youth population. We estimated modest decreases in PMPM if all Medicaid members ages 1-20 were able to maintain continuous coverage. In other words, reducing churn among Medicaid-enrolled youth via a continuous coverage provision was associated with nominal health care savings, with the potential for longer-term health improvements and economic contributions stemming from continuous enrollment and ongoing access to care.
    - There is an administrative cost when individuals are disenrolled and subsequently reenrolled in coverage – estimated at $400-$600 per single churn event (disenrollment and reenrollment) in a 2015 study. This dis-enrollment and re-enrollment process creates significant administrative costs that are circumvented by continuous enrollment, potentially generating savings.
- *Reducing churn is critical to accelerate the adoption of value-based payment models.* Understanding and minimizing churn in population-based payment models are critical for implementing accountable care. NC DHHS has prioritized movement to population-based models to better enable whole-person, coordinated care as part of Medicaid Transformation in the 1115 waiver.
    - We simulated a single academic medical center pediatric-focused Accountable Care Organization for Medicaid members ages 1 through 20 and found variation in Medicaid enrollment and health care use in consecutive years. Our primary attribution methodology was prospective attribution, where utilization in the base year was used to assign beneficiaries to the ACO in the following performance year. A substantial number of individuals who had services in the base year were attributed to the ACO but had no utilization and minimal enrollment in the performance year.
    - Discontinuities in enrollment can lead to perverse incentives for care management and whole-person health. As more Medicaid funding flows through accountable population health models where attribution is key, continual enrollment will reduce the incentive of risk bearing entities to aggressively screen and select on the basis of likely future churn.

- *Approaches for minimizing burden in the redetermination process*

- Improved IT processes that allow for automated determination can ease the administrative burden of reenrollment. Coupling this advancement with coverage extensions to the end of the calendar year showed success in reducing churn.
- Additional solutions include opting for electronic information and communications as opposed to paper documentation and dependence on mail to maintain eligibility, reducing data verification requests that cause unnecessary coverage loss, and increasing the accessibility of online components of the redetermination and eligibility processes.
- Leveraging previously verified personal information from other public programs to support coverage renewals (e.g., Individuals who are enrolled in SNAP benefits already have verified information in their files).
- Enrollee burdens can also be reduced by allowing pre-populated renewal forms and extending the period to submit redetermination documents to a minimum of 30 days.

Coverage for Pre-Release Services for Justice-Involved Individuals

The waiver renewal proposes providing pre-release services including case management, Medication Assisted Treatment (MAT), and a supply of prescription medications for justice-involved individuals in North Carolina. The motivation for offering these services is the potential to increase access to needed physical and behavioral health services, improve communication between the correctional system and communities, improve outcomes, and support successful re-entry for justice involved populations.

Beyond the proposed pre-release services, the state can consider extending peer support services to individuals with mental health and/or substance use disorders within correctional settings. Although evidence is limited on its use for pre-release programs in Medicaid due to the recent nature of CMS's guidance, a systematic review of the effectiveness of peer-education and support in prisons suggests that educational interventions are effective at reducing risky behaviors, and that peer support services have a positive effect on recipients. CMS is currently working with states such as New Hampshire on their pending application to include peer supports to justice-involved individuals. As noted in a prior section, we also encourage the state to consider including certain HOP services to individuals in the 90-day pre-release period to improve care transitions and reentry outcomes. In particular, targeted HOP services (e.g., food and nutrition access case management, housing navigation services, and IPV services) would complement and enhance the existing case management services included in the waiver proposal.

Feedback on Strengthening Behavioral Health and I/DD Delivery System (Objective III outlined in the renewal application)

Investments in Behavioral Health and I/DD Technology

NC DHHS has prioritized strengthening the behavioral health and I/DD delivery system through targeted investments in technology. Historically, behavioral health providers have been excluded from programs supporting health information technology adoption, creating a barrier to delivering high-quality care across settings. Investments in technology for behavioral health providers, particularly designed to facilitate data sharing across care settings and sectors, support integrated care, facilitate care coordination and ultimately support improvements in access to quality care. For implementation, North

Carolina can look to states that have employed market-based strategies to increase health information technology uptake and interoperability.

HIT Grants

NC DHHS intends to strengthen the behavioral health and I/DD delivery system by providing health information grants to providers serving members with behavioral health needs to help cover costs associated with procuring new electronic health record (EHR) systems, updating EHR systems, and enabling connectivity to NC health information exchange (HIE). Investments in health information technology, such as EHR systems and decision support tools, have been shown to improve care processes and health outcomes. In addition, the state's efforts to invest in school health technology capabilities to support referrals, billing and other care coordination efforts between schools and other health care entities can improve access to mental health services, as well as both mental health and academic outcomes.

Cross-Cutting Suggestions to Support Behavioral Health and I/DD Systems of Care

To further support the state's efforts to strengthen the behavioral health and I/DD delivery stems through targeted investments in technology, we propose the following based on our empirical research and stakeholder convenings:

- *Adopt strategies to further support data interoperability.* We have done research and hosted convenings to identify strategies to support the state's data infrastructure. This year, we hosted convenings and conducted research to support North Carolina's State Transformation Collaborative—a public-private partnership designed to advance the quadruple aims of health care through multi-stakeholder alignment. Through this work, we identified the following strategies and considerations to support data interoperability:
  - Adopt data standards and consistent measurement approaches,
  - Establish trust among stakeholders to facilitate data exchange and to support care integration, and
  - Bolster participation in the state's HIE.
- *Strengthen the state's telehealth infrastructure.* In research exploring telehealth utilization among Medicaid members in North Carolina, we found that telehealth played an important role in facilitating access to care during the pandemic, particularly for those Medicaid members with behavioral health needs. Moreover, telehealth helped mitigate workforce shortages according to another study in which we explored community and provider perspectives of telehealth demonstrated. For example, telehealth allowed providers to serve Medicaid members in regions with fewer behavioral health providers and supported improvements in care quality (e.g., seeing patients in their home environment via telehealth allowed providers to understand a patient's holistic needs).
- *Direct investments to improve digital equity.* While telehealth has played and continues to play an important role in facilitating access to care, our research shows broadband access, limited availability of technology, and limited digital literacy continue to be a challenge. State leadership has already made considerable efforts to improve access to telehealth by maintaining permanent telehealth flexibilities for behavioral health and by investing in broadband and technology. To ensure these policies and investments effectively address the current behavioral health crisis, public-private partnerships can continue to provide digital

resources (e.g., broadband access, smart devices) to both providers and Medicaid members and support digital literacy among patients and providers.

Bolstering the Behavioral Health and LTSS Workforce

NC DHHS' proposed expansion of the state's loan repayment program and additional investments in recruitment and retention efforts can bolster the behavioral health and LTSS workforce. For our research on advancing whole-person care in North Carolina through Medicare-Medicaid Integration, we interviewed a range of North Carolina stakeholders and explored system-level supports needed to scale whole-person care in NC, such as building an adequate and diverse workforce.

Behavioral Health Student Loan Repayment Program

Through our research, North Carolina stakeholders noted the behavioral health workforce shortage and cited the need for increased supports and career advancement opportunities. Expanding the student loan repayment program is an opportunity to indirectly support career development by addressing financial burdens that might hinder continued education. Additionally, interviewees discussed the geographic variation in behavioral health access with rural stakeholders emphasizing workforce gaps in their communities. To help address this gap, the State could engage in targeted outreach to rural providers to increase awareness of loan repayment opportunities.

Recruitment and Retention Payments

Through interviews with North Carolina stakeholders, they noted limited resources and supports as a challenge for the direct care workforce. Providing bonus payments, childcare subsidies, funding for training programs, and transportation subsidies could help foster a sustainable workforce, especially if a diverse array of provider types are eligible for these payments. In particular, we support including other certified professionals such as CHWs. Through our research, we also heard the need for investments in a diverse and culturally competent workforce that is representative of the communities they serve. CHWs are seen a trusted community members who share lived experiences with their beneficiaries. Providing a pathway for recruitment and retention of CHWs could enhance opportunities to leverage the workforce to increase HOP outreach and screening, as discussed above.

Cross-Cutting Suggestions

In addition to our recommendations related to NC DHHS' proposed changes to bolstering the behavioral health and LTSS workforce, we offer two sets of new recommendations based on our research and stakeholder engagement in North Carolina and nationally.

- **Include caregiver education, training, and supports to bolster workforce efforts.** There is opportunity to invest in unpaid caregivers to help meet the needs of North Carolina residents in the short term while the state engages in longer term workforce investments. NC DHHS already includes many caregiver training and supports in their 1915(c) waiver for home- and community-based services (HCBS) beneficiaries. However, access to these services is capped and upwards of 15,000 NC residents (most of whom have I/DD) are on the state's HCBS waiver waiting list. This estimate does not include the estimated need for the Medicaid expansion population. Including an additional pathway for caregiver education, training, and supports could help better equip the informal workforce caring for their loved

ones. There is precedent for Medicaid coverage of these services through section 1115 waivers. For example, Rhode Island Medicaid supports caregiver training for treatment regimens and equipment specified in a beneficiary's care plan and Washington state's Medicaid program offers caregiver assistance services (e.g., home delivery meals, respite care, assistance with housework) to those enrolled in their Medicaid Alternative Care program.

- **Reduce administrative burden to support the behavioral health workforce.** Administrative burden is a source of burnout among diverse provider types but can be felt acutely by behavioral health providers who may be regulated by multiple state and federal agencies. In North Carolina, behavioral health providers may work with all seven Local Management Entities and the five Standard Plans, which can translate to many different approaches for billing, coding, and quality of care priorities. As part of our Center's work to support North Carolina's State Transformation Collaborative, our Center has conducted research to identify strategies to reduce administrative burden. Through our convenings and interviews, we have identified the following burden reduction strategies:
    - Reduce the number of measures providers have to report by requiring a core set of meaningful measures,
    - Reduce variation in the measurement process (e.g., measure specification, data collection and reporting, and performance evaluation), and
    - Facilitate data exchange by establishing standard data formats and encouraging participation in North Carolina's HIE.

  These can help reduce the burden on behavioral health providers, but the state may need to explore additional strategies given their unique challenges.

Conclusion

The Duke-Margolis Center appreciates NC DHHS's consideration of our comments. We will continue to generate and translate evidence to support the health of North Carolinians through an innovative, whole-person centered and well-coordinated system of care, which addresses both medical and non-medical drivers of health. We and our colleagues would be pleased to provide more information on these issues if that would be helpful. We look forward to our continued partnership with you to further develop and implement these policy reforms, including through our efforts to bring diverse stakeholders together and engage in developing a shared path forward.

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From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 11:57:44 AM
Attachments: image001.png

I am submitting my comments about the Section 1115 Waiver, specifically as pertains to Initiative 2c. I am a family physician and founding director of the North Carolina Formerly Incarcerated Transition (FIT) Program. NC FIT is a statewide program that focuses on connecting people to essential health services upon release from incarceration in our state prison system and county jails. We also lead efforts assisting the Department of Adult Correction (DAC) in initiating medication for opioid use disorder to people prior to release and linking them to community treatment. NC FIT also leads the Justice Technical Assistance Team, providing technical assistance across NC to communities improving reentry for people with opioid use disorder. NC FIT is part of the Transitions Clinic Network (TCN), based in California, which is heavily involved in the implementation of their 1115 Waiver, turning on Medicaid 90 days prior to release. My comments are based on our extensive knowledge of reentry in our state, especially as pertains to healthcare, and lessons from our TCN partners in California, working to operationalize their 1115 Waiver.

As per Benefits:

Case Management: Evidence supports case management services that utilize people with lived experience of incarceration (1,2) language should include a statement that prioritizes case management and in-reach services delivered by case managers with lived experience of incarceration, ideally certified Community Health Workers that are also certified Peer Support Specialists.

Include a provision for Enhanced Care Management (ECM) for this special population: ECM will allow reimbursement at the primary care medical home once people return to the community. Otherwise efforts during pre-release will fall short of expected outcomes. This will be especially important for Federally Qualified Health Centers (FQHCs) that will need additional funds to be able to hire care managers for this special population. We know that without dedicated care managers with lived experience, efforts to connect people to health services post-release often fail. ECM is an essential component included in California's 1115 Waiver (3).

Add Treatment for Chronic Hep C: Studies have shown 30% of people with of Hep C cycle through the carceral system (4). Treatment prior to release is imperative to reduce transmission back to the community and this controlled setting of incarceration is ideal to assure adherence.

Medications upon release: 90 days of medications should be provided upon release, as many people will likely run out of their meds if only given a 30 day supply, before establishing with medical care. Even with case management prior to release, many people will struggle establishing as a new patient for primary care. Home plans change frequently just before release further delaying the ability to make timely appointments for medical follow up.

Capacity Building Funds: There are $315 million requested but specifics about allocation are lacking. The correctional system is mentioned as a potential recipient of these funds. I recommend adding a percentage maximum that could be allocated to correctional institutions. The majority of these dollars should support reentry infrastructure in the community. Many parts of our state have very limited reentry resources and those areas with more services often struggle to meet demand. Capacity Building Funds should be directed to evidence based strategies delivered by community partners with track records of successful implementation. Housing is a high priority for this population and an array of options is needed from emergency shelter to transitional housing to more permanent housing and permanent supportive housing for those with mental illness. Additionally, community based organizations utilizing peers with lived experience of reincarceration, should be a prioritized for funding. As for correctional settings, a priority area should be medical discharge planning, not dissimilar to how it is done in hospitals.

Thanks for your consideration

References:

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2. The Reentry Health Care Hub: Creating a California-Based Referral System to Link Chronically Ill People Leaving Prison to Primary Care. *International Journal of Environmental Research and Public Health*, *20*(10), 5806.2023
3. https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-JI-a11y.pdf
4. https://www.cdc.gov/correctionalhealth/rec-guide.html

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Pronouns: he/him/his

NC FIT
FORMERLY INCARCERATED TRANSITION PROGRAM

From: [redacted]
To: Medicaid.NCEngagement
Cc: Hamlin, Monica B
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 10:29:51 AM

Good afternoon,
Partners appreciates the opportunity to provide feedback on the proposed 1115 Waiver Renewal. Please see our comments below.

- HOP Pilot Renewal funding request across the state:
  - Recommend available funding for all Tailored Plan members regardless of where they live. Currently, we are being told that if a Partners' member resides outside of the pilot region it would be up to the Network Lead to determine if funding would support the member and if the HSOs would have the capacity. This clearly does not make it equitable for all Medicaid members residing in a pilot region. For example, consider a pregnant woman with Partners' Medicaid who resides in McDowell County, which is in Vaya's catchment area. She would not receive HOP pilot services unless the HSO has capacity and if there is funding available. This would not be approved through Vaya. Essentially, we are creating a health disparity simply because she does not have Vaya Medicaid or does not reside in Burke or Rutherford County. Disparities of this nature must be addressed with the expansion of HOP.
  - All Tailored Plan enrollees and individuals eligible for Tailored Care Management in 14 Prepaid Inpatient Health Plans (PIHPs) - This language also creates a disparity for individuals in Medicaid Direct through Partners, but not eligible for TCM due to receiving a duplicative service (e.g., High-Fidelity Wraparound or ACT). Recommend all Tailored Plan or PHIP enrollees managed by a Tailored Plan be eligible for HOP.
  - Please clarify how Cross-Domain • Holistic High Intensity Enhanced Case Management is not duplicative of TCM.
  - Do the Capacity Building Funds include administrative funding for the Tailored Plans? As of now, Partners has received no funding to implement HOP and yet is required to have a HOP Director.
- Initiative 2c: Coverage for Pre-Release Services for Justice-Involved Individuals:
  - Benefits - Case Management: Who will be expected to provide this service? Will this be prison/jail personnel or fall to the Tailored Plan? If this falls to the Tailored Plan, will new funding be added to cover staffing and administrative costs for this function?
- Objective 3: Strengthen Behavioral Health and I/DD Delivery System
  - Initiative 3c: Bolstering the Behavioral Health and LTSS Workforce: Does the loan repayment program cover Care Managers? There is a need for RNs and Licensed Clinicians to not only perform Care Management for individuals receiving LTSS services, but also supervise the LTSS Care Managers.

- Consider Coverage for Individuals in State Hospitals-Involved Reentry Expenditures Related to Pre-Discharge Services Expenditures. The coverage would provide for pre-discharge services to qualifying demonstration beneficiaries who would be eligible for Medicaid if not for their hospitalization status, for up to 90 days immediately prior to the expected date of discharge from a participating state hospital or facility. Not currently approved.
- Reference section on Fact Sheet "Add a new “firearm safety” service that provides, at a minimum, locks and/or safes to support firearm: Recommend assuring alignment with other local agencies who may already provide these tools (locks).
    - Suggest creating a statewide resource guide for the public to include where members can attain these tools (various places) as well educational/training on firearm safety.
    - Recommend that we align with and utilize the NC State initiative NC S.A.F.E. (Secure All Firearms Effectively): https://www.ncsafe.org/about/. This initiative is about more than just storing a firearm in a lock box. It has a large focus on education and training.
- Consider incorporating additional means to address non-medical transportation means: Recommend bus vouchers and other means be incorporated into the HOP to better meet members needs with non-medical transportation.
- If approved, Continuous Enrollment for children will greatly help children and former foster youth.

Emily Bridgers, MPH, MSW, LCSW
Waiver Contract Manager
Partners Health Management
E: [redacted]
[redacted]

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 9:43:00 AM
Attachments: Outlook-1460574693.png

- Expand eligibility to include all NC Medicaid members—regardless of coverage type—who screen positive for a pilot-supported social health need, including Medicaid Direct, Tailored Care Management eligibles in prepaid inpatient health plan (PIHP), and Medicare/Medicaid dual enrollees.

- Expansion of pilot eligibility to include all pregnant and postpartum women, justice-involved individuals, those who are "at risk of" a chronic condition, individuals with only one chronic health condition, individuals recently impacted by natural disasters, foster care, and children/youth who receive adoption assistance.

- Include all HOP services in pre-release Medicaid services available to justice involved individuals.

- Allow continuous access to HOP services for justice-involved individuals for 1-year post-release.

- Approve additional evidence-based parenting curriculum and age range to allow HSOs to leverage existing resources to meet regional and individual family needs. There is not a one size fits all model. https://eclkc.ohs.acf.hhs.gov/parenting/article/parenting-curricula-review-databases

- Expansion of meal services to three meals per day.

- Refine language around rental assistance to include up to six months of rental assistance including payment of arrears for all enrollees who demonstrate need.

- Standardize fee schedule statewide to reduce the potential for confusion, referral delays and rejections.

- Review all services to ensure a coordination or admin fee is included.

- Availability of capacity building funds throughout the demonstration waiver period.

- Increase capacity building budget allocation and/or significantly increase fee schedule payments to ensure there are sufficient and sustainable resources for human service organizations (HSOs) and NLs to scale pilot services across all 100

NC counties.

- Prioritize investments in community-based organizations and local service delivery models.
- Give contracting preference and/or incentives to local, community embedded HSOs to promote equity and improve pilot enrollment, member satisfaction, expansion of services/geography and culturally inclusive service delivery.
- Prioritize and incentivize local health and social service agencies to participate in the pilot.
- Require HSOs who directly contract with PHPs to participate in NL compliance activities to ensure network adequacy and service delivery quality.
- Increase accountability and transparency around PHP responsibilities regarding care management network adequacy, quality improvement, and payment processes.

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From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] Medicaid Coverage
Date: Wednesday, September 20, 2023 2:15:38 PM
Attachments: image002.png

To Whom it May Concern:

I write with my comments in support of the state's renewal request to provide Medicaid services to justice-involved individuals. I am a Licensed Clinical Social Worker in Project CARA (Care that Advocates for Respect, Resilience, and Recovery for All, a comprehensive perinatal substance use treatment program located in Asheville, NC. Together with my colleagues we provide medical, obstetrical, behavioral health, and case management services to pregnant and parenting people in the 18 westernmost counties in North Carolina. We are currently contracted by local county detention centers to provide pregnancy care and substance use treatment services to incarcerated individuals at Buncombe county detention center and other local county detention centers. We see time and again the need for pre-release services, particularly as it relates to ensuring follow up care management, pregnancy care and continued substance use treatment to ensure that once released, pregnant people continue to receive appropriate care.

What we see in practice is that most pregnant and postpartum detainees are disenrolled from Medicaid and have to re-enroll upon release. This is problematic for a variety of reasons, including the loss of continuity of substance use treatment, prenatal care, and potential loss of postpartum Medicaid that is now extended through 1 year postpartum. Once released, they are unprepared to access treatment and prenatal care services, and often face gaps or disengagement from care.

We strongly advocate that pre-release services, including case management, medication assisted treatment (MAT) and at minimum a 30 day supply of prescription medications upon release. Ensuring that detainees will have access to appropriate medical and behavioral health services upon release will help ensure improved maternal and infant outcomes, improved retention in recovery services, and help break intergenerational cycles of trauma and substance use.

Thank you for your time and consideration.

Sincerely,
Tammy Cody, LCSW

MAHEC

Tammy Cody, MSW, LCSW
Pronouns: she/her/hers

Lead Navigator Project CARA
OB/GYN Department

119 Hendersonville Rd/Asheville NC 28803
[redacted], *Fax: (828) 232-8832*
[redacted]

https://mahec.net/obgyn/project-cara

Confidentiality Statement

From: [redacted]
To: Medicaid.NCEngagement
Cc: [redacted]
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 10:22:41 AM
Attachments: image001.png
Public Comment Period Response_Access East Inc..docx

CAUTION: External email. Do not click links or open attachments unless verified. Report suspicious emails with the Report Message button located on your Outlook menu bar on the Home tab.

Good Morning,

The attached document contains Access East's comments regarding the North Carolina 1115 Demonstration Waiver Renewal draft application. Thank you for the opportunity to participate in the application development process.

Respectfully,

Tina Dixon, MPA
Vice President, Healthy Opportunities

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September 14, 2023

Access East, Inc. (AEI) is one of three Network Leads awarded contracts in the current 1115 Waiver for North Carolina's Healthy Opportunities Pilot (HOP). We have been working diligently to implement the Pilot and establish the partnerships necessary to offer services in the four domains—housing, food, transportation and interpersonal violence & toxic stress—identified by the Department. We appreciate this opportunity to provide comment on the 1115 Waiver Renewal draft to be submitted to the Center for Medicare and Medicaid Services October 2023.

Expanding the Pilots Statewide and Scaling Services

AEI is in full support of expanding the Pilot to cover the entire state, and offer the opportunity for HSOs to contract directly with the PHPs to provide services. There are many counties surrounding the current pilot regions that have members that would benefit from having their health-related social needs (HRSN) addressed. As you consider this process we offer the suggestions below.

- **Support for Health Service Organizations (HSO), current and future, to improve the likelihood of success operating within the HOP Service Model**
  - **Core HOP Education** – Readiness assessments are completed for each HSO identified for participation in HOP, however, their business acumen cannot be adequately assessed during this process. Therefore we recommend that each HSO regardless of size (small, medium or large) be required to attend baseline education regarding sound business management practices (e.g. budget & finance, roles & responsibilities, standard operating procedures, staffing plans, etc.), and HOP businesses practices (e.g. service delivery, documentation/communication, invoicing, payment receipt & reconciliation). Having this base education requirement in place would facilitate discussions between the Network Lead (NL) and HSO as they move forward with the provision of member services, invoice submission/reimbursement and prepare for sustainability. Requiring all HSOs to participate in a core education series, regardless of their Network affiliation, prior to providing services will also facilitate the development of sound financial management practices and sustainability plans.
  - **Phased HSO Inclusion** – the continued inclusion of small businesses in HOP is definitely a strength, especially in rural communities. Unfortunately many of the businesses lack the structure and experience to fully participate in programming such as HOP. If we could consider delaying service provision for smaller businesses to allow them to not only build their capacity to provide services, but to also build their capacity to engage in the business of HOP or HOP like programs. Perhaps allowing a 6-month incubator period where the NL works with them and/or provides contracted technical support to prepare them for the provision of services while also assisting them in establishing their business office structure. This will also prepare more of the HSOs to contract directly with the prepaid health plans (PHP) where it makes sense to do so.
- **Technology Adequacy**
  - Functionality of the current technology, Unite Us—NCCARE360, used to coordinate enrollment, referrals and reimbursement is inadequate and administratively burdensome for most of the stakeholders—NLs, PHPs, care managers (CM) and HSOs. Key features within the platform to facilitate bi-directional communication and problem resolution either aren't available or aren't working properly. Key features that will need to be addressed to decrease the administrative burden and facilitate service provision include, but aren't limited to the following: filter and search features for invoices; dispute function/tool [disputes must be handled outside of the platform]; accurate claim/payment status; service delivery count/$ used by client ("accumulator" functionality); 837 claim submission that includes 835 response file; reconciliation function/tool; accurate dates in the system for payment, service, etc.; NL visibility that includes all aspects of invoicing and payment to facilitate audits and other required oversight/support functions; and notice to the NL of upgrades to the platform that impact functionality.
  - Training – training for HSOs who must use the NCCARE360 platform for all aspects of their work for HOP is limited. We respectfully request that Unite Us be required to offer instructor led continuing education for all users, especially

HSOs, on a regular cadence. Currently the majority of the education is provided on demand, which limits the participant's ability to ask questions to gain a better understanding of the topic or functionality being presented.

Modifying Pilot Services

We agree wholeheartedly with the modifications suggested as it relates to the provision of three meals a day, extending the rental assistance period, and "firearm safety" support. As you consider this process we offer the following suggestions:

- Rent Assistance (6-months vs 1-month)
  - Many of the members—families and individuals—we work with are on limited and/or fixed incomes with very few options for increasing their financial resources. It would be beneficial, where the member is of working age and able bodied, if we could also include in the housing navigation support employment training opportunities. This would enable the member to potentially increase their household income by gaining employment or better employment to increase the likelihood that they can remain in their home once assistance is received to place them. We have experienced turnover in this space due to rent increases as all other expenses are also increasing. If the member has no other income, it makes it very difficult to find affordable, long-term, stable housing for them in our service area. This can happen with deposit and first month assistance as well as 6-month assistance if we can proactively work with them to change their financial situation.

Expanding Eligibility Criteria for HOP

We wholeheartedly support expanding the eligibility criteria to increase access to HOP. We are especially grateful for the inclusion of people impacted by natural disasters and consistency in enrollment of children/youth who receive adoption assistance. As you consider expanding the eligibility criteria we offer these suggestions:

- **HSO Eligibility**
  - **Footprint Requirement** – current eligibility requires HSOs to be registered in North Carolina and to have a footprint in the respective Network's region. This sometimes poses a great level of difficulty in recruiting HSOs in a region that is resource poor and economically disadvantaged. AEI respectfully ask that consideration be given to allowing Networks to recruit and contract with HSOs that are registered in North Carolina, but may not have a footprint in their region. This will allow the Network to recruit HSOs that sit slightly outside of their region without imposing a huge financial burden on the HSO to establish a business location within, if they are able to effectively provide quality services from their current location.
- **Bundling and/or Coupling Services**
  - **Housing** – this service is very complex and expensive, and can be very stressful for both the member and the HSO to work through the process of identifying stable, long-term housing. It creates an added level of stress when the member has to work with multiple HSOs to get housing and housing navigation. It also creates an added burden for the HSOs if they are handling the component with a high upfront cost such as first month rent, deposit and utilities, and they do not have the referral for navigation services that comes with a monthly administrative fee. Bundling housing and housing navigation will enable the service to be provided by one HSO and enable them to better serve the client and also receive revenue from providing navigation services to assist in covering the high upfront cost.
  - **Housing Remediation** – housing repairs and other related services often requires an inspection prior to any work being completed. The inspections are often completed by an outside contractor at a cost of approximately $200, which is paid by the requesting HSO. Unfortunately, the inspection is not often included in the referral to the HSO receiving the remediation request, and must be requested from the CM in order for it to be paid by the PHP. It would improve process flows, if the inspection was coupled with the remediation referral since the two services are so closely linked. Doing so will reduce the number of calls to the CM to add the inspection, and decrease the administrative burden for the HSO.
- **Fee Schedule**
  - Inadequate Fees for Services – the current fee schedule does not allow the HSOs to adequately cover expenses associated with providing their agreed upon services in the current economy where the cost of goods and services continues to increase. It would be in the best interest of the program and the members if the fee schedule was reviewed more frequently to allow for adjustments to address inflation. Additionally, consider adjusting or adding a multiplier to the fee in situations where transportation is provided in rural areas, and housing is provided urban areas where the expense will be higher due to travel distance and housing markets, respectively.

Investing in Capacity to Support Program Growth

We support your proposal to provide additional capacity-building to support the statewide expansion of HOP.

- **Ensuring HSO Growth & Success**
  - **HSO Capacity Building Support** – new HSOs will receive capacity building support to enable them to provide services to HOP enrollees. Their ability to be successful in this space will require them to have cash reserves to facilitate service provision during start-up. This will enable them to cover up-front cash outlays as well as payment delays that may be present in the reimbursement process. Therefore we respectfully request that consideration be given to providing $30,000- $50,000 in cash reserves for new HSOs to allow them to grow into successful HSOs for HOP. Additionally, we respectfully request that existing HSOs be provided additional capacity building support to allow them to increase staffing and other resources to better serve a growing population of members expected as a result of expanding eligibility.
  - **HSO Self Sustainability** - to establish viable business among under-represented populations we must invest heavily in the tools necessary to increase the likelihood that they will be successful. A great example of this is CCLF's Business Solutions Center. It would be in the best interest of the department if this resource could be made available to all Networks regardless of their ability to secure external funding in addition to HOP to support it. This would be an excellent use of Capacity Building funds, and an opportunity for the Department to leverage resources in this space. The education provided could include training on how to identify the gap between revenue and expenses, and the effective use of capacity building dollars to bridge the gap. Doing so will help the HSO to be mindful of the gap, and develop strategies to close it and reduce their dependency capacity building dollars.

We would like to commend the request preparation team and writers for preparing such a comprehensive renewal request that addresses many of the challenges and/or pain points identified during the first two years of providing services. Thank you for listening and your attention to detail as we work to plan a path forward in providing HRSN support to all Medicaid eligible North Carolina residents.

From: [redacted]
To: Medicaid.NCEngagement
Cc: [redacted]
Subject: [External] Reinvestment Partners 1115 Waiver Public Comment, 2 of 2
Date: Wednesday, September 20, 2023 3:50:06 PM
Attachments: NCCARE360 memo_cover_letter.pdf
MJ RP NCCARE360 MEMO v1.pdf
Reinvestment Partners_Unite Us Analysis_Final.pdf

Greetings,

Please find attached Reinvestment Partners' written public comments on the 1115 Waiver Renewal Application. These comments have a particular focus on the use of NCCARE360 in the Healthy Opportunities Pilots.

Please confirm receipt.

Warm regards,
Sam Hoeffler
Reinvestment Partners

Attached:
Reinvestment Partners cover letter
Marshall Jones memo
Unite Us | NCCARE360 – Functional Failures

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Sam Hoeffler (she/they)
Director of Food Programs, Reinvestment Partners

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Reinvestment PARTNERS
PEOPLE • PLACES • POLICY

Unite Us | NCCARE360 – Functional Failures
May 1, 2023

Unite Us is a startup founded in 2013 that offers a software platform to help connect people to social services. Unite Us created a data platform specific to North Carolina health and human service providers called NCCARE360. In 2021, North Carolina Department of Health and Human Services (the Department) contracted with Unite Us to use NCCARE360 for the Healthy Opportunities Pilots, North Carolina's 1115 Demonstration Waiver. The company has received more than $24 million from the Department, including at least $12,150,000 for the Pilots. Despite the large contract, the platform is not fulfilling the day-to-day needs of participating human service organizations (HSOs), care managers, network leads, or prepaid health plans (PHPs).

NCCARE360 does not meet financial audit requirements. NCCARE360's invoice tracking is often inaccurate; invoices are improperly saved, improperly rejected, and improperly labeled. In addition, NCCARE360 allows for duplicate billing, does not reflect accurate accounting, and does not reliably track clients' health insurance coverage. The transition to claims has resulted in mismanaged invoices and severely delayed or missing payments for HSOs, or even payments sent to the wrong HSO. The platform's invoicing and claims functions lack controls and pose serious financial and compliance risks to HSOs and PHPs.

NCCARE360 does not properly secure sensitive patient data. HSOs have received notifications in NCCARE360 about cases and clients that are not theirs. HSOs can see sensitive information in the platform about other services that clients are receiving. HSOs have also received payments for services that they did not render for people who were not their clients. Unite Us does not sufficiently protect sensitive patient information.

NCCARE360 lacks basic functionality. As a referral platform, NCCARE360 fails to perform basic tasks on a consistent basis. NCCARE360 does not use case numbers; does not reliably track client and service provision data; does allow more than one provider to receive the same referral; and does not consistently save case notes. Even when judged as a basic referral platform, NCCARE360 is lacking.

The Healthy Opportunity Pilots were designed with NCCARE360 at the center, and now the use of NCCARE360 poses the single biggest threat to the success of the Healthy Opportunities Pilots. From data security to financial compliance, NCCARE360's lack of functionality and issue resolution is putting patients, HSOs, and other stakeholders at risk. Immediate action needs to be taken to protect stakeholders and create a technology response that is compliance and successful for North Carolina's Section 1115 Demonstration Waiver.

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NCCARE360 Does Not Meet Financial Audit Requirements

North Carolina's version of the Unite Us referral platform, NCCARE360, is enabled with social care payment capabilities. As a contractual requirement, the platform must allow community-based organizations to submit invoices and track payments for services rendered via the platform.

HSOs submit invoices by creating a new Contracted Service in NCCARE360. Unfortunately, NCCARE360 has not accurately managed invoices from the start. Invoices that were not paid have been marked as paid and invoices that had been paid were marked as unpaid. Invoices have been rejected erroneously or paid when they should not have been. NCCARE360 is not meeting its contractual requirement of consistently maintaining accurate invoicing information for HSOs.

The lack of controls in NCCARE360's invoicing platform presents a potentially damaging liability for all HSOs and exposes the platform's lack of financial compliance.

- NCCARE360 does not accurately track invoices sent and paid by PHPs. At times invoices are not labeled correctly and do not reflect accurate billing information.

- NCCARE360 allows for duplicate billing. The same service for the same date can be billed multiple times. This puts HSOs at risk for financial non-compliance because NCCARE360 is not blocking duplicate Medicaid billings.

- NCCARE360 does not accurately and consistently track health insurance coverage per client. NCCARE360 allows invoices to be sent to the wrong PHP. If these errors are not caught by Network Leads or PHPs, then HSOs receive payments for services from the wrong PHP, resulting in repayment to the PHP and missing the deadline to bill the correct PHP.

- HSOs sometimes receive payments for clients that are not theirs and NCCARE360 does not track these errors. This unnecessarily risks a breach of clients' sensitive and personal information.

- NCCARE360 does not communicate disenrollment to HSOs in a consistent and timely manner. HSOs are then providing services for non-eligible members. HSOs cannot receive payment for services rendered after disenrollment, which results in a financial loss.

- NCCARE360's failure to keep HSO addresses accurate during the switch to claims resulted in PHPs mailing checks with patient information to the wrong addresses. More than 20 checks to Reinvestment Partners were mailed to the wrong address, resulting in financial liability for both PHP and HSO as well as poorly protected patient data.

- HSOs need to closely monitor each PHP's remittance reports because HSOs cannot rely on NCCARE360 to report accurate invoicing information.

- After NCCARE360 switched from sending invoices to sending claims, HSOs received duplicate rejections and incomplete payments.

- HSOs had to go without payment for many weeks while NCCARE360's errors on claims were being addressed. The claims payment system is not functional.

Case Example: The platform does not systematically or consistently notify community-based organizations when a Medicaid member is disenrolled from managed care. Reinvestment Partners received an overpayment notification directly from a prepaid health plan (PHP) requiring us to return $3,062.59 in fee-for-service payments we had received for a healthy food box client. It turns out the client had not been covered with this PHP for more than six months. Yet, the referral platform did not catch the error, notify service providers of the issue, or stop invoices from being sent.

We therefore received a request to repay $3,062.59 even though we delivered (and paid for) those services under the assumption that our client was still a Medicaid member. We had to formally appeal to the PHP. We also had to ensure that all important case information was documented in a separate, secure system because we could no longer rely on the data in NCCARE360. Ultimately it is HSOs that are responsible for the financial risk and repercussions that NCCARE360 generates.

NCCARE360 Does Not Properly Secure Sensitive Patient Data

NCCARE360 does not properly secure patient data within its system. HSOs have received notifications from the platform about cases that are not theirs. HSOs have also received notifications from the platform about clients who are not their clients. HSOs can see sensitive information in the platform about other services that their clients are receiving. HSOs have even received payments for services that they did not render for people who were not their clients.

Furthermore, NCCARE360 lacks functionality which results in its users relying on an endless stream of workarounds. These workarounds result in patient data regularly being exchanged outside of the platform. For example, HSOs, care managers, and PHPs cannot effectively communicate within the platform. Instead, they exchange patient information and case details outside of NCCARE360 via email and phone, effectively losing any data security that the platform itself offers.

- HSOs receive and accept referrals using NCCARE360. Once a referral is accepted, it becomes a case. Once an HSO has cases, they must provide services according to each case based on notes. Notes added in NCCARE360 are not consistently saved, so HSOs have lost important case and patient data.

- Cases in NCCARE360 are not numbered, which makes effectively organizing a large client caseload nearly impossible. Instead of case numbers, HSOs must use clients' names and other identifying information to communicate issues and case updates outside the referral platform.

- NCCARE360 notifications are often inaccurate or tagged to the wrong case. Care managers and HSOs must communicate outside the platform.

These concerns are not simply a request for more functionality from the platform, they represent serious threats to the protection of patient information and data security compliance.

NCCARE360 Lacks Basic Functionality

The failure of NCCARE360 to perform core financial and data security functions is compounded by smaller daily issues with platform functionality. The effect is that Pilot stakeholders must devise solutions to ongoing problems outside the platform, resulting in significant variability in how situations, issues, and day-to-day questions are being answered and addressed. There are so many issues with the platform that almost everything Pilot stakeholders do includes at least one workaround to finish the task.

- NCCARE360 cannot accept batch uploads and exporting data is a challenge. All information must be manually entered one at a time. The result is that referrals and invoicing processes are slow, mostly manual processes. As an example, Reinvestment Partners has one staff person dedicated to invoicing full time. Any significant increase in clients means additional staff just for invoicing. PHPs and care managers must also enter client date one by one in greater numbers causing significant frustration and increasing cost.

- Referrals include authorized time periods and unit numbers. NCCARE360 does not keep track of how many units have been delivered, nor can it notify HSOs when the authorized period has lapsed. This puts HSOs at risk for non-compliance by delivering more than the allowable units and outside the authorization window.

- NCCARE360 sometimes allows for the same referral to be accepted by two HSOs. This is a serious Medicaid compliance issue. In some cases, multiple service providers are providing the same (duplicative) service to the same Medicaid member and both service providers are being reimbursed.

- It is difficult to determine a case timeline, particularly for clients with multiple referrals and cases.

- Cases cannot be grouped by household.

- One Pilot participant can receive many services, which results in multiple cases per participant.

- Cases are organized by Service Type, not Program. For food services, it is impossible to tell whether a client is receiving a healthy food box or produce prescription without clicking into each Service Type listed on the case. Only healthy meals are distinguished by the Service Type Prepared Meals.

- Open cases cannot be sorted alphabetically. The client list can be sorted alphabetically, but it includes all clients with no option for organizing or archiving.

- If a care manager changes a client's name in NCCARE360 HSOs have no way to track the name change or bill for services.

- NCCARE360's invoicing platform was down for many days, resulting in backlogs, late invoice submissions, delayed payment, and general confusion.

- NCCARE360 has launched multiple updates, which have caused significant and sustained issues for case management and service delivery.

- NCCARE360 inconsistently captures who the assigned care manager is for any given client, which makes seeking clarification, answering questions, and sharing updates very challenging.

- NCCARE360's data is meant to be a source of truth for Pilot stakeholders, but the platform is too unreliable to trust the data.

- Data dashboards are intermittently not working, which means stakeholders cannot access necessary information for reporting and compliance.

- Over the years, Unite Us has avoided opportunities to improve the platform and help platform users. When users raise issues, customer service can take weeks or months to resolve an issue, if they resolve the issue at all.

- Unite Us customer service also encourages HSOs to use workarounds because problems are not being fixed within NCCARE360.

Conclusion

The Healthy Opportunity Pilots were designed with NCCARE360 at the center, and now the use of NCCARE360 poses the single biggest threat to the success of the Healthy Opportunities Pilots. From data security to financial compliance, NCCARE360's lack of functionality and issue resolution is putting patients, HSOs, and other stakeholders at risk. Immediate action needs to be taken to protect stakeholders and create a technology response that is compliant and successful for North Carolina's Section 1115 Demonstration Waiver.

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marshalljones
certified public accountants

August 22, 2023

Reinvestment Partners
Peter Skillern, Chief Executive Officer
110 East Geer St, PO Box 1929
Durham, NC 27702

Marshall Jones has been engaged by Reinvestment Partners ("the Organization") to focus on the activities, operational areas, financial and nonfinancial information of the Organization's NCCARE360 contract, and its related implications on its financial reporting. In performing our services, we relied on the information provided by the Organization's management and personnel, including the accuracy and reliability of such information.

Per our review of the Organization's "Healthy Opportunities Pilot: Network Lead-HSO Model Contract" with Community Care of the Lower Cape Fear, Inc. ("Network Lead"), dated November 23, 2021, the Organization is a Human Services Organization ("HSO") that has contracted with Network Lead to participate in its network for the purposes of delivering Medicaid services. The NCCARE360 system is a technology infrastructure and coordinated community network uniting health care and human services through a statewide North Carolina resource directory, a community resource repository and a shared technology platform that enables health care and human services providers to send and receive secure closed-loop electronic referrals, communicate in real-time, securely share client appropriate information and track outcomes. The Organization has agreed to establish and maintain the capability to comply with all invoicing, reporting and oversight requirements. HSOs shall maintain an accurate accounting of Capacity Building Funds spent, including appropriate back-up documentation as appropriate for all expenditures. HSO shall generate and submit to Network Lead through NCCARE360 complete and accurate invoices and required supporting documentation for services completed consistent with the timeline and process in the Network Lead's HSO manual, department protocols, and with all privacy and security requirements. The HSO has agreed to track and reconcile invoice payments in HSO's accounts receivable accounting system.

These revenue transactions utilizing NCCARE360 involve contracts with customers, and Generally Accepted Accounting Principles in the United States of America ("GAAP") requires they be accounted for under ASU 2014-09: *Revenue from Contracts with Customers* (Topic 606). Topic 606 is intended to develop a single, principle-based revenue standard for GAAP, and is applicable to all entities, without regard to industry or entity size. The revenue standard aims to improve accounting for exchange contracts with customers by providing a robust framework for addressing revenue issues as they arise and increasing comparability across industries and capital markets.

The core principle behind Topic 606 is to recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The steps to apply the core principle are as follows:

1. Identify the contract with a customer (generally signed contract or purchase order)
2. Identify the performance obligations in the contract. To have multiple obligations, they must be a distinct product or service and separately identifiable in the contract.
3. Determine the transaction price (executed contract/purchase order adjusted for any variable costs, early completion incentives, late completion penalties, etc.)
4. Allocate the prices to the performance obligations.
5. Recognize revenue (could be at a point in time or over time).

A contract with a customer exists if all the following criteria are met:

1. The contract has been approved.
2. The rights and payment terms regarding goods and services to be transferred can be identified.
3. The contract has commercial substance.
4. It is probable that substantially all the consideration that the vendor is entitled to will be collected (considering only the customer's ability and intention to pay).

Financial audits conducted in accordance with auditing standards generally accepted in the United States of America are required to obtain audit evidence that is sufficient and appropriate to provide a basis for an independent audit opinion on the books and records of an organization.

Revenue is critically important in the financial statements of entities, and revenue recognition is frequently cited in financial reporting frauds. Thus, revenue recognition remains a priority for regulators and the accounting profession. Audit requirements include obtaining evidence regarding the recognition of revenues. A challenge to this is the sufficiency and appropriateness of persuasive audit evidence supporting revenue recognition. Revenue that may have been improperly recorded often includes missing documents to support sales transactions or journal entries.

Per our review of the "Unite Us | NCCARE360 – Functional Failures" memo dated May 1, 2023, the Organization believes NCCARE360's invoice tracking is often inaccurate; invoices are improperly saved, improperly rejected, and improperly labeled. In addition, the Organization has stated that NCCARE360 allows for duplicate billing, does not reflect accurate accounting, and does not reliably track client's health insurance coverage. The Organization believes this has resulted in mismanaged invoices and severely delayed or missing payments for HSOs, or even payments sent to the wrong HSO. The platform's invoicing and claims functions could possibly lack controls and pose serious financial and compliance risks to HSOs.

The Organization's policies and procedures should document appropriate controls that are either preventative or detective in nature to help ensure that enrolled participants are eligible and authorized, there is documented evidence of service provided, procedures are invoiced and paid, and there is a reconciliation to the Organization's accounting system.

Management controls should include the following:

1. Identifying contracts that meet the criteria defined by the standard.
2. Assessing management's and the customer's commitment and ability to perform under the contract.
3. Ensuring payment terms are properly considered.
4. Assessing the collectability criterion.
5. Identifying performance obligations.
6. Estimating the amount to which the organization expects to be entitled.
7. Including any variable consideration.
8. Estimating the standalone selling price, including maximizing the use of observable inputs in that process.
9. Measuring progress toward completion satisfaction of a performance obligation before recognizing revenue.

Improper controls and supporting documentation could have unintended negative change in net assets consequences for the HSO. These transactions may result in improper revenue recognition, resulting in reduced revenues, increased liabilities or increased bad debt allowances.

This memo was not designed for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, no such opinion is expressed. The procedures performed are not designed to constitute an examination or review of the subject matter. Therefore, we will not express any level of assurance on the identified risks or related recommendations. This communication is intended solely for the information and use of management, those charged with governance, others within the organization, and is not intended to be and should not be used by anyone other than these specified parties.

We appreciate the opportunity to continue to be of service to you.

Respectfully,

Marshall Jones
Atlanta, Georgia

September 20, 2023

North Carolina Department of Health and Human Services
NC Medicaid Section 1115 Waiver Team
1950 Mail Service Center
Raleigh, NC 27699-1950
Subject: NC Section 1115 Waiver

To NC Section 1115 Waiver Team:

Reinvestment Partners has been a participating HSO providing four services in the food and housing domains as part of the Healthy Opportunities Pilot since March 2022. Here we raise the issue of NCCARE360 failures as part of the Pilots. The use of NCCARE360 for referrals and invoices puts HSOs at audit risk.

NCCARE360, the required Pilot referral platform operated by Unite Us, has failed to meet the needs of Pilot stakeholders. From unreliable storage of case management data to inaccurate invoice tracking and HSOs not receiving timely payment, the referral platform has not contributed to efficiency for HSOs, care managers, or PHPs. We solicited the services of Marshall Jones, an auditing and accounting firm in Atlanta, to determine whether NCCARE360's inaccurate accounting and information put our organization at risk. In the attached draft memo, Marshall Jones articulated audit standards and concluded that improper controls could have unintended negative effects, as outlined below:

The platform's invoicing and claims functions could possibly lack controls and pose serious financial and compliance risks to HSOs. The Organization's policies and procedures should document appropriate controls that are either preventative or detective in nature to help ensure that enrolled participants are eligible and authorized, there is documented evidence of service provided, procedures are invoiced and paid, and there is a reconciliation to the Organization's accounting system.

Improper controls and supporting documentation could have unintended negative change in net assets consequences for the HSO. These transactions may result in improper revenue recognition, resulting in reduced revenues, increased liabilities or increased bad debt allowances.

The full draft memo is enclosed. We urge the Department act boldly to address NCCARE360's lack of function. A Pilot technology platform must, at minimum, make carrying out Pilot requirements and services easier and ensure that the information HSOs receive is accurate. That means reliably storing information, facilitating clear communication among users, accurately labeling and tracking invoices, and addressing issues in a timely manner. The current system requires duplicative work and results in less staff time spent on service delivery and quality assurance.

With regards,

CEO
Reinvestment Partners

Enclosures:
Marshall Jones Memo
Unite Us | NCCARE360 – Functional Failures

From: [redacted]
To: Medicaid.NCEngagement
Cc: [redacted]
Subject: [External] Reinvestment Partners 1115 Waiver Public Comment, 1 of 2
Date: Wednesday, September 20, 2023 3:40:39 PM
Attachments: Reinvestment Partners_Pilot_Public_Comments_Final_9-19-2023.pdf
APPENDIX 1.pdf
APPENDIX 2.pdf
APPENDIX 3.pdf

Greetings,

Please find attached Reinvestment Partners' written public comments on the 1115 Waiver Renewal Application.

Please confirm receipt.

Warm regards,
Sam Hoeffler
Reinvestment Partners

Attached:
Removing Barriers and Building Healthy Opportunities for All
Appendix I: Expedited Enrollment Results, Keys to Success, and Next Steps Appendix II: Breathe Easy Proposal
Appendix III: Unite Us | NCCARE360 – Functional Failures
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Sam Hoeffler (she/they)
Director of Food Programs, Reinvestment Partners

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September 20, 2023

North Carolina Department of Health and Human Services
1950 Mail Service Center
Raleigh, NC 27699-1950
Subject: NC Section 1115 Waiver

Reinvestment Partners is a non-profit based in Durham, North Carolina. We address the problems of poverty and social injustice in the areas of food, housing, community development, health, and financial services. We also advocate for policy and systems change at the local, state, and national levels.

We are deeply committed to developing programs and processes that are sustainable and compatible with the healthcare sector. We design our services to meet the needs of patients, providers, and payers. Above all, we center participant experience, making it easy and dignifying to access and receive high quality services. In addition, we ensure our processes can meet the business and regulatory requirements of health providers and health insurers.

As a Human Service Organization participating in all three Pilot regions, Reinvestment Partners welcomes the opportunity to offer written comments on the North Carolina Department of Health and Human Services' 1115 Waiver Renewal Application.

We support the broad goals included in the 1115 Waiver Renewal Application and offer the following high level recommendations:

We support: Expanding HOP statewide and scaling services.
We recommend: Allowing HSOs and PHPs that partner directly to do so outside of the existing referral platform.

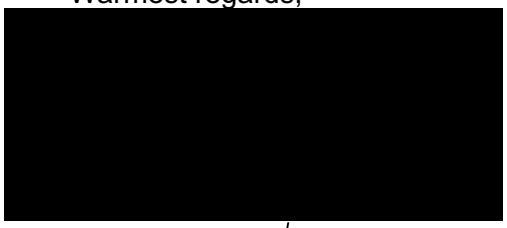
We support: Expanding eligibility criteria for HOP.
We recommend: Leveraging existing patient and claims data to proactively reach all eligible people, effectively removing enrollment barriers.
We support: Modifying HOP services.

We recommend: Developing a clear and streamlined process, inclusive of Pilot stakeholders, which identifies how the Department will determine efficacy of services. We must better understand the cost, impact, and feasibility of each service.

We support: Investing in capacity building to support program growth.
We recommend: Investing in capacity building pathways for interested HSOs to partner directly with PHPs. We also recommend strengthening health information technology systems by exploring alternatives to our current technology arrangement. The current referral platform requires too many workarounds to be deemed an effective tool for Pilot stakeholders.

In addition to these recommendations, Reinvestment Partners submits the enclosed, *Removing Barriers and Building Healthy Opportunities for All*.

Warmest regards,



Director of Food Programs
Reinvestment Partners

Enclosure:

Removing Barriers and Building Healthy Opportunities for All

Appendix I: Expedited Enrollment Results, Keys to Success, and Next Steps

Appendix II: Breathe Easy Proposal

Appendix III: Unite Us | NCCARE360 – Functional Failures

Removing Barriers and Building Healthy Opportunities for All

Executive Summary

Reinvestment Partners applauds the Department's request to expand the reach of the Pilots through eligibility changes and a statewide shift. This shift will result in thousands of North Carolinians with Medicaid receiving services they need.

If approved by CMS, we strongly urge the Department to address key structural components of program design and service delivery ahead of statewide expansion. Pilot participants deserve clear communication, high quality services, and exceptional care. We propose focusing efforts around removing barriers to success for Pilot participants, HSOs, and PHPs. We also propose launching a rapid cycle assessment to gauge the efficacy of the current referral platform; without technology that serves all stakeholders an expansion cannot be successful.

Remove barriers to enrollment and participation for Medicaid members.

- Leverage existing data to determine eligibility and proactively reach out to members.
- Expand access to online self-enrollment to increase accessibility of services.
- Institutionalize a hybrid enrollment approach so that all eligible Medicaid members can access services.
- Connect Pilot participants to care managers based on need rather than universally.
- Simplify screening requirements for Medicaid members.

Remove barriers for Human Service Organizations to reach scale.

- Ensure that the fee schedule reflects the true cost of services.
- Develop a clear path for HSOs to partner directly with PHPs as they are ready.
- Ensure capacity building funds result in organizational growth for service provision.

Remove barriers to long term adoption by strengthening the approach to evaluation.

- Develop a clear and streamlined process for determining efficacy of services.
- Prioritize the analysis of cost-effectiveness in the evaluation.

Remove barriers to sustainability by investing in effective technology.

- Adopt a technology solution that simplifies payments and accounting.
- Take advantage of existing technology systems to increase efficiency and adoption.

As practitioners and advocates, we know three things are at the core of Pilot success:

(1) We must first and foremost center equity and Medicaid member experience.
(2) The Pilot structure needs to work for all stakeholders, from HSOs to care managers to PHPs.
(3) We need to leverage technology that makes participating in the Pilots easier and more efficient.

Remove barriers to enrollment and participation for Medicaid members.

Centering the experience of Medicaid members anchors the Pilots in equity. The Pilots must be structured to meet the needs of Medicaid members, from accessible enrollment to effective care management and high-quality service delivery. When done well, member-centered design can also strengthen trust among enrollees, care managers, and HSOs.

1. Leverage existing data to determine eligibility and proactively reach out accordingly.

The Department and PHPs have existing patient and claims data that can be used to affirmatively outreach to Medicaid beneficiaries. Currently, the burden of Pilot enrollment falls on the Medicaid members. Reinvestment Partners recommends that PHPs determine Pilot eligibility using existing data sets and affirmatively reach out to eligible Medicaid members via text message, email, or phone. This proactive outreach ensures that all eligible Medicaid members are aware of the opportunity to participate in the Pilots anchors this endeavor in equity.

2. Expand access to online self-enrollment to increase accessibility of services.

In the current system, in order to access services, members have go through an extensive phone interview to allow a care manager to enroll them in the Pilot. Reinvestment Partners recommends allowing access to online self-enrollment to ensure that the enrollment process is accessible to more eligible Medicaid members. Online enrollment allows the Department to collect the necessary information for compliance and ensures members have access to a service quickly and easily. Once they are enrolled for a service, members can be connected with additional services as needed. Having the option of online enrollment allows for more equitable and far-reaching access to services.

***Please see Appendix I which outlines the Department's successful experiment with expedited enrollment, where 3,200 Medicaid members were swiftly enrolled in the Pilots using eligibility data, affirmative outreach, and online enrollment.*

3. Institutionalize a hybrid approach so that all eligible Medicaid members can enroll.

We understand that members may need multiple entry points to access services. Care manager and place-based enrollment is an important and effective way to enroll Medicaid managed care members into the Pilots. For certain services, care manager and place-based enrollments are the most effective. At the same time, affirmative outreach using existing data and online enrollment are also critical to effectively reaching a broader group of eligible Medicaid members for more population-based services.

Reinvestment Partners recommends layering multiple enrollment methods for a hybrid approach helps ensure equity and access to the Pilots. Each of these approaches can be catered to various geographies, service types, and communities. The Department has already piloted the affirmative enrollment approach and must expand that access to all eligible participants, in addition to care manager and place-based enrollment.

4. Connect Pilot participants to care managers based on need rather than universally.

Care managers carry a tremendous amount of responsibility and accountability under the current Pilot design. Currently, care managers play the role of care coordinator in addition to care manager and are responsible for finding the services for members. Reinvestment Partners recommends that the Department redistribute care manager responsibilities so that they can work where they are best suited with the highest needs members.

For example, care coordination may be handled through gains in technology or via Network Leads, which would free up care managers' time. In addition, some Medicaid members participating in the Pilots may not need intensive care management. In that case, care managers could focus their energies on a subset of participating Medicaid members that opt into care management or need care management. We must consider these and other ways to ensure that Pilot design does not rely so extensively on care managers for service provision.

5. Ease screening requirements for Medicaid members.

The screening process for Pilot participation is long and onerous. As a result, some members who would benefit from services fail to complete the enrollment process. Reinvestment Partners recommends alternatives so that Pilot participation is no longer contingent on the member's ability to take part in a long screening process. The process should meet people where they are and use all the information that we have at our disposal (such as administrative data) to lessen the time burden of screening and enrollment.

Reinvestment Partners recommends that the Department consider shorter alternatives to the PESA, and options like online or self-guided screening processes. The Department has much of the eligibility data that is collected at intake; using existing data can save Medicaid members' time and make them more likely to complete the enrollment process.

Remove barriers for Human Service Organizations to reach scale.

One of the goals of the Pilot is to develop the infrastructure to integrate social driver interventions into Medicaid. HSOs need targeted support to be successful partnering with healthcare providers in the long term. Reinvestment Partners recommends that the Department use its learnings from the past two years to strategically set up structures to support HSOs, including updating the fee schedule with HSO and Network Lead input, developing PHP and HSO connectivity that can be sustained, and ensuring that capacity building funds lead to meaningful growth for HSOs.

1. Ensure that the fee schedule sufficiently reimburses HSOs.

With few exceptions, the current fee schedule was created in 2018 – before the pandemic and before the rapid increase in the prices of many goods. The fee structure does not adequately cover the cost of services, nor the administrative burden. Reinvestment Partners recommends that the Department consult with HSOs and other stakeholders to set a fee schedule that covers the cost of service delivery, incorporates program administration costs, and ensures that the organization can be sustainable long term.

2. Develop a clear path for HSOs to partner directly with PHPs as they are ready.

Reinvestment Partners supports the proposal to allow those HSOs with capacity to partner directly with PHPs in the renewal. However, we recognize that many HSOs do not currently have the capacity.

HSOs seeking the capacity to become Medicaid vendors after the Pilots must be prepared to meet a set of core requirements. These requirements include HIPAA compliance, claims capacity, viable business models, and ability to reach necessary scale. We recommend that the Department build out pathways to direct PHP partnerships for HSOs that meet the necessary requirements. HSOs seeking long-term funding via the healthcare sector can be part of a more aggressive technical assistance campaign in collaboration with Network Leads.

Some smaller or newer HSOs may not be poised as organizations to move forward with healthcare integration after the Pilots end. These organizations could choose to stay on a grant-based path that does not require self-sufficiency in the next two to three years. This two-track model would allow HSOs to engage in the Pilots independent of their size or previous experience with the healthcare sector.

3. Ensure capacity building funds result in organizational growth for service provision.

HSOs need targeted capacity building funds that are not meant for operational and programmatic expenses. HSOs need funds that can be used to build their capacity for their next steps as healthcare providers – like claims capacity and HIPAA compliance – which are investments that help HSOs become self-sustaining in the healthcare landscape.

***Please see Appendix II which outlines the path for Breathe Easy, an evidence-based asthma intervention, to successfully transition from capacity building funds to sustainability with fee-for-service payments.*

Remove barriers to long term adoption by strengthening the approach to evaluation.

If successful, the Pilots and other 1115 Waiver programs could change the way that healthcare is conceptualized in the US. Effective evaluation that focuses on understanding the feasibility, cost, and impact of each service is critically important to determining whether services are adopted by Medicaid in the long term. Effective evaluation will lead to policy action and increased accessibility of services for Medicaid members.

1. Develop a clear and streamlined process for determining efficacy of services.

The renewal document requests the ability to remove and add services, which we support. However, the evaluation plan does not have an effective way to identify which services are working. The decision to add or discontinue services should be based on replicable, objective analysis.
The existing evaluation plan focuses on population health and does not have a way to evaluate individual services. Reinvestment Partners recommends that the evaluation partners develop a transparent process for determining the efficacy of individual services, especially as one service

compares to another. The development of this process should include input from Pilot stakeholders, especially HSOs. We need to better understand the cost, impact, and feasibility of each service.

2. Include cost-effectiveness analysis in the evaluation.

More important than a return on investment, analysis of the cost-effectiveness of services helps the Department and PHPs understand where to allocate limited funds. Important components of these analyses would include comparing different Pilot services to determine which is a better investment and which can feasibly be integrated into healthcare.

We will eventually need to consider which services can be adopted by Medicaid in the future. Some services are limited because they are localized, and some are limited because they are not financially viable in the long run. It is important to complete cost-effectiveness and efficacy analyses now, so that services can be altered or improved to eventually meet Medicaid standards.

Remove barriers to sustainability by investing in effective technology.

The required Pilot referral platform operated by Unite Us has failed to meet the needs of Pilot stakeholders. From unreliable storage of case management data to inaccurate invoice tracking and HSOs not receiving timely payment, the referral platform has not contributed to efficiency for HSOs, care managers, or PHPs. We recommend that the Department act boldly to address the platform's lack of function. A Pilot technology platform must, at minimum, make carrying out Pilot requirements and services easier. That means reliably storing information, facilitating clear communication among users, accurately labeling and tracking invoices, and addressing issues in a timely manner. The current system requires duplicative work and results in less staff time spent on service delivery and quality assurance.

An effective way to gain efficiency when integrating systems is to map new requirements onto existing systems. The more the Pilots can overlay or mimic the processes and systems that PHPs and care managers are already using, the easier meaningful collaboration will be.

***Please see Appendix III which outlines key technological failures of NCCARE360.*

1. A technology solution must simplify payments and accounting.

The current referral platform's handling of payments and accounting has failed. We need a technology solution that HSOs and PHPs can count on. We must adapt to existing Medicaid managed care payment systems and avoid PHPs having to create entirely new processes and work streams to interact with the referral platform. To be competitive in the long term, HSOs must have an opportunity to develop claims and payment capacity that aligns with the healthcare sector's expectations.

2. Take advantage of existing technology systems.

Now that the Department understands more about what it takes to run the Pilots, it is in a good position to survey the technology landscape and determine whether existing technologies may be better able to serve stakeholders.

For some time, Reinvestment Partners has advocated for a change in technology requirements for the Pilots. We have talked with other HSOs, PHPs, and care managers to better understand what a working solution might look like for all stakeholders.

We understand that the Department needs an easy way to access aggregated Pilot network and participant data. We would also like to remove duplicative work from the caseloads of care managers and HSOs. It is also important that PHPs integrate payment processes into their existing workflow. Right now, they must create different processes to manage payments with the referral platform.

An example of how the Department may invest in technology that is already integrated with healthcare practices is by adopting a care coordination module in Epic called Compass Rose for the Pilots. More than 70% of providers use Epic software for managing their electronic medical records. Compass Rose is an Epic module that works to increase care coordination for patient populations. It is an existing technology that addresses social determinants of health, connects caregivers to support networks, helps to connect people to community services, identifies risks, and measures outcomes.

Providers already using Epic can connect their patients to care via Compass Rose without entering any additional data in an outside system. Furthermore, the data is easily exported so that the Department can understand which services are being provided, to whom, and by what organization with one look. Compass Rose is bidirectional, so that providers can enter information and Epic's main function is to track EMR so extracting health data is also straightforward.

Lastly, the Compass Rose module could decrease the workload on HSOs. A provider that wants to prescribe a Pilot service to a patient can give them a QR code. The HSO that fulfills that service can scan that QR code and all necessary information is uploaded into Epic (HSO information, date of service, patient information, etc). If we could implement this process, it would be simple for providers, accessible for patients, and easier for HSOs.

Reinvestment Partners recommends that the Department to explore this and other examples of technology solutions. This is just one example of how an alternative approach to technological connectivity may look. Pilot stakeholders are struggling under the required referral platform and its dysfunction. Extensive workarounds are keeping HSOs from being able to serve more Medicaid members. To be viable, statewide expansion must include an exploration of additional technology options.

Conclusion

The Healthy Opportunities Pilots hold the potential to improve the lives of tens of thousands North Carolinians and change the way we offer healthcare in the US. Reinvestment Partners strongly supports the expansion of this work. If approved, we also support addressing the aforementioned structural components of the Pilots. We hope that focusing efforts around removing barriers to success for Pilot participants, HSOs, and PHPs will lead to an effective, impactful statewide expansion.

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Delivering fruit and vegetable prescriptions with Healthy Opportunities Pilots: Expedited Enrollment Results, Keys to Success, and Next Steps

April 2023

Background

Fruit and vegetable prescriptions have the potential to generate substantial health gains and lower healthcare costs.[1] In 2018, Reinvestment Partners launched Eat Well, a produce prescription program that leveraged technology and centered patient experience. Since then, we have expanded into a statewide program that connects participants with money for fruits and vegetables using a customer loyalty card or a prepaid debit card. Reinvestment Partners' fruit and vegetable prescription is designed to maximize effectiveness at scale.[2] To date, more than 80,000 participants have spent $10 million on fruits and vegetables for themselves and their families. Outside of the Healthy Opportunities Pilots, 25,000 people are receiving Eat Well funds each month.

In November 2022, Reinvestment Partners proposed using our online enrollment process as part of the Healthy Opportunities Pilots, and expedited enrollment was born. Expedited enrollment leverages existing member data and targeted, tech-enabled outreach to expand access to Healthy Opportunities Services. The Department agreed to test this enrollment approach with one PHP (Healthy Blue), one HSO (Reinvestment Partners), and one service (produce prescriptions) in March 2023.

With expedited enrollment, Reinvestment Partners and Healthy Blue enrolled 3,200 people in six weeks. The enrollment process takes just a few minutes, making it very simple for people to sign up. The eligibility check has been automated and occurs in real time. Reinvestment Partners is now finalizing its claims and remittance capacity so that we can bill Healthy Blue directly for food purchases and the monthly administrative fee.

In the short term, expedited enrollment seeks to increase enrollment, improve member experience, and connect members to additional services as needed. In the long term, this approach can also increase overall referral volume for HSOs. Most importantly, the process can build a pathway to sustainable healthcare partnerships for all HSOs.

Expedited enrollment has successfully increased enrollment and improved member experience. This approach can be used as a model for an efficient, patient-focused, effective enrollment process. We outline key components of success and next steps below.

[1] Lee Y, Mozaffarian D, Sy S, Huang Y, Liu J, Wilde PE, et al. (2019) Cost-effectiveness of financial incentives for improving diet and health through Medicare and Medicaid: A microsimulation study. PLoS Med 16(3).
[2] John S, Lyerly R, Wilde P, Dexter Cohen E, Lawson E, Nunn A, "The Case for a National SNAP Fruit and Vegetable Incentive Program", American Journal of Public Health 111, no. 1 (January 1, 2021): pp. 27-29.

Key components of success

Targeted outreach

- PHP or Department builds an eligibility list using existing patient data
- PHP or Department sends text or email with enrollment information to eligible members

Why it's important: Targeted outreach allows eligible members to learn about the Pilots without having to seek that information from their local clinic or an HSO partner. Targeted outreach makes their eligibility known and online enrollment makes the service accessible.

Effective online enrollment

- Ensure process is accessible and simple
- Collect necessary information for compliance
- Include HIPAA Authorization form and allow for digital signatures
- Enrollment triggers the pre-paid debit card to be sent in the mail for service delivery

Why it's important: Online enrollment lets members have access to a service quickly and easily. Once they are enrolled, a care manager will reach out to them to see if they need additional services. Having the option of online enrollment allows for more equitable and far-reaching access to services.

Data sharing partnerships

- HSO and PHP develop secure data sharing processes
- PHP receives enrollment information daily
- PHP automates response file process and shares response file daily

Why it's important: Having automated data sharing in place allows for clear and mutual understanding of processes and enrollment levels. The real time eligibility check also ensures that pre-paid debit cards are not being sent to people who are not eligible.

Participant support capacity

- A participant support team must be available for troubleshooting enrollment and general inquires

Why it's important: About 2% of the total eligible population is likely to reach out for assistance with enrollment. Troubleshooting enrollment issues is a key part of improving member experience.

Ability to send claims and receive payments from PHP

- HSO must be able to bill and manage claims with PHP directly

Why it's important: The learning curve may be steep, but billing PHPs directly is a critical step in financial sustainability for HSOs large and small. Without billing capabilities, then HSOs cannot effectively integrate into the healthcare sector.

Next steps

Now that expedited enrollment has proven successful, it must be integrated alongside enrollment being done by care managers directly. Using multi-pronged enrollment approaches is key to improved enrollment numbers and to equity.
Our investment in this proof of concept is significant. We would like this model to be sustained and to be offered to additional HSOs. We have two requests as we move forward:

1. *Allow Reinvestment Partners to receive renewals directly from PHP.*

The initial authorization period for expedited enrollment is six months, after which point the Department has signaled that enrollees in continued need of a produce prescription will be required to switch providers. There is no need to force members to switch service providers. For the sake of continuity of care, we would like the ability to continue to serve these members should their authorization be renewed.

2. *Invite additional PHPs to use expedited enrollment immediately*

Now that the system is built and tested, other PHPs can take advantage of expedited enrollment as well. Their members can also have access to accessible, simple enrollment. Overall Pilot enrollment would significantly increase and we would have additional opportunities to improve the process as HSOs develop capacity to adopt this model as well.

Conclusion

Expedited enrollment increases enrollment, improves member health and satisfaction, and ensures reliable data for evaluation. This approach must be fully integrated into the Pilots building on the key components of success. In addition, we request that the Department allow us to accept renewals and expand access to expedited enrollment to all PHPs.

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Breathe Easy Proposal

Reinvestment Partners' (RP) Breathe Easy program is designed to demonstrate the cost effectiveness of identifying and mitigating in-home asthma triggers as a non-medical intervention to improve health outcomes. The program pairs home assessments through virtual home visits with the provision of equipment designed to help mitigate environmental triggers. The goals of the program are to reduce preventable asthma emergency department visits and hospitalizations among high-risk Medicaid members with asthma and therefore create better health and cost savings. In less than a year's time, Reinvestment Partners has delivered Breathe Easy services to 186 HOP clients.

RP's Breathe Easy program is a scalable program that can help the state meet its goals with the Healthy Opportunities Pilots:

- Consistent high-quality services that are research based and have been shown to reduce asthma ED visits and hospitalizations
- Utilize technology and data to conduct affirmative outreach to Medicaid beneficiaries that would benefit most from the intervention
- Increased enrollment through a scalable service that can provide services statewide
- Provide an intervention to study for cost effectiveness in the transition to value sharing

Reinvestment Partners requests that NCDHHS:

1) Revise the fee schedule for the Breathe Easy Healthy Homes intervention to a flat fee-for-service of $2500 per client served to allow for sustainability.
2) Allow Reinvestment Partners to develop an expedited enrollment process directly with PHPs for this program to use affirmative outreach for eligible members.

Breathe Easy is an evidence-based intervention designed to address in-home environmental triggers of asthma.

In North Carolina, 645,784 children and adults in North Carolina have asthma, representing 7.8% of the total population.[1] There are economic and racial disparities for asthma. Children living below the poverty line have higher rates of asthma, as do African American children. Black children are more likely to have asthma compared to white children – more than double the rate for children ages 5 to 14.[2] [3] Black children are also more likely to be hospitalized for asthma. Breathe Easy is working to address equity issues around asthma by addressing environmental triggers.

[1] Centers for Disease Control and Prevention, Most Recent Asthma State or Territory Data, https://www.cdc.gov/asthma/most_recent_data_states.htm, accessed February 28, 2023.
[2] https://wwwn.cdc.gov/NHISDataQueryTool/SHS_child/index.html, accessed 2/28/2023.
[3] Centers for Disease Control and Prevention. (2023). 2020 National Health Interview Survey data. U.S. Department of Health & Human Services. Retrieved from: https://www.cdc.gov/asthma/nhis/2020/data.htm, accessed 2/28/2023.

Asthma is a chronic medical condition that requires ongoing management. One of the approaches to asthma management is to address the triggers that drive asthma patients into hospitals. Up to 40% of all incidents of asthma for non-white children are attributable to home-based environmental health hazards.[4] Research estimates that 44.4% of those with doctor-diagnosed asthma have one or more residential exposures.[5] Home interventions that address environmental asthma triggers in the residential environment have been effective at helping control asthma and improving the quality of life for children and adults with asthma.

Home Asthma Response Program (HARP) in Rhode Island, in which families receive home visits to assess potential asthma triggers, education on asthma self-management, and supplies to reduce in-home triggers, found that program participation reduced pediatric asthma-related hospital and emergency department costs by 75%. The analysis suggested that the program produced a positive return on investment of $1.33 for every $1.00 invested.[6] The subset of high utilizers, which had two or more previous emergency department visits had an ROI of 126%, earning $2.26 for every dollar invested.[7]

Similarly, an asthma home visit program in Seattle, Washington, which targeted children with uncontrolled asthma enrolled in Medicaid found increased symptom-free days and caretaker asthma-related quality of life and reduced urgent health care utilization and costs. This program included multiple home visits by Community Health Workers, education on asthma self-management, and the provision of supplies to reduce in-home triggers (vacuum, cleaning supplies, roach abatement supplies, and bed covers). The program yielded a return on investment of 1.90.[8]

The Breathe Easy program is based on programs that have previously been successful in addressing in-home triggers of asthma. Reinvestment Partners seeks to replicate the positive results with a slightly different design that will build consistency among service delivery and allow the program to reach scale to integrate into the health sector.

The RP Breathe Easy program is easily scaled across the state with the expansion of HOPs statewide.

The Breathe Easy program is designed to harness the benefits of previous in-home asthma self-management programs while also being scalable beyond a specific geography. Expanding statewide allows for greater enrollment and spending to meet needs of more Medicaid beneficiaries.

After referral and intake, RP reaches out to the enrolled Medicaid member to gather additional information about their needs and to schedule a virtual home assessment. A Healthy Homes Specialist

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[4] Krieger, J. (2010). Home is Where the Triggers Are: Increasing Asthma Control by Improving the Home Environment. Pediatric Allergy, Immunology, and Pulmonology, 23(2), 139–145. http://doi.org/10.1089/ped.2010.0022

[5] Lanphear BP, Kahn RS, Berger O, Auinger P, Bortnick SM, Nahhas RW. Contribution of residential exposures to asthma in us children and adolescents. Pediatrics. 2001 Jun;107(6):E98. doi: 10.1542/peds.107.6.e98. PMID: 11389296.

[6] Center for Disease Control and Prevention. “Rhode Island: A Business Case for Asthma Home Visiting Services”, State Spotlight, June 2018.

[7] Rhode Island Department of Health. The Home Asthma Response Program (HARP) Factsheet. http://www.618resources.chcs.org/wp-content/uploads/2018/05/HomeAsthmaResponseProgram-1.pdf

[8] Campbell, Jonathan, et al. (November 2015). Community Health Worker Home Visits for Medicaid-Enrolled Children with Asthma: Effects on Asthma Outcomes and Costs. American Journal of Public Health, Vol 105 No. 11, 2366-2372. Doi:10.2105/AJPH.2015.302685

conducts a virtual home visit with the household through video conferencing. The virtual home assessment includes a detailed assessment of housing conditions to identify potential environmental asthma triggers in the home. The Healthy Homes Specialist conducts a standardized survey and also uses a visual assessment to identify the areas of most concern and tailor the Breathe Easy Kit, education on asthma triggers, and determine eligibility/need for optional items. In addition, if the Housing Specialist identifies home repair needs that are causing potential health issues, the Specialist refers eligible families to existing home repair programs for more extensive home repair issues.

After the assessment, Reinvestment Partners sends families a Breathe Easy Kit that provides tools and equipment to reduce environmental asthma triggers in homes.

In special cases, such as when video conferencing is not available, the Healthy Homes Specialist may determine it is preferable to conduct an in-person home visit rather than a virtual visit. In those cases, the Healthy Homes Specialist and an assistant will visit the home and conduct the home assessment in person. They may also potentially bring the Breathe Easy Kit with them rather than ship it.

Each Breathe Easy Kit contains:

- HEPA-filtered upright vacuum cleaner
- Twelve (12) replacement vacuum bags
- Hypoallergenic latex free mattress encasement
- Pillow covers for the bedroom
- Non-toxic, asthma-friendly multi-purpose cleaner
- Non-toxic pest/rodent control devices
- Non-toxic, safe products to kill roaches
- Smart True HEPA Air Purifier (for participant bedroom)
- One extra filter for the air purifier
- Allergen air filters for HVAC system

Optional items that are provided based on the needs determined in the home assessment may include:

- Pet hair remover attachment for vacuum cleaner
- Air conditioner/heater
- Fans
- Wet Mop
- Mattress
- Bed frame
- Fans
- Dehumidifier
- Moisture and humidity reader

Within 2-4 weeks after the initial home visit, the Healthy Homes Specialist follows up with a video phone call to check in on the family and answer any questions about the Breathe Easy kit and its use. This virtual follow-up home visit includes a short survey on housing conditions and the use of the healthy homes kit and includes follow-up on any previously identified issues. The Healthy Homes Specialist identifies any ongoing concerns and provides additional education and training. This follow-up visit provides an additional opportunity for education and keeps the family accountable to improve adherence to the program.

Revise the fee for the program to a flat fee of $2,500 per household served to simplify invoicing and claims and provide a path to sustainability.

Our Breathe Easy program is offered under the Healthy Home Goods services for the Healthy Opportunities Pilots. According to the pilot service definition, payment for Healthy Home Goods services is cost-based reimbursement up to $2,500 per year of service. This means that HSOs cannot bill for the staff time, cost of a home assessment, overhead, program management, or other costs they incur as part of service delivery. In April 2023, the Department began allowing HSOs to bill a $90 coordination fee, likely as an acknowledgement that staff time is necessary for service delivery.

Unfortunately, $90 per referral is not nearly enough to cover the staff and overhead necessary to effectively deliver Breathe Easy services to Healthy Opportunities clients. The administrative fee does not cover the overhead costs nor the cost of the home assessment. At $90 admin fee, Reinvestment Partners would have to serve nearly 900 households to cover the cost of one full time employee to manage the program – and that would not cover the cost of the home assessment or the costs of invoicing or other overhead. Therefore, it is not sustainable to continue delivering the service once capacity building funds run out.

Given that the Breathe Easy program is a standardized service delivery that includes the same essential components for all clients, RP recommends shifting to a flat fee of $2,500 per client served for the program. The $2,500 covers the cost of the equipment in the Breathe Easy kit (including optional items on an as-needed basis), the cost of the home assessment and follow-up using trained healthy homes specialists, the cost of program management, and overhead costs. That is the cost to fully cover the expenses of the program and allow for sustainability. A flat fee structure makes it simpler to invoice or submit claims for the service and allows the program to achieve sustainability over the long term.

For the biggest impact, allow Breathe Easy to use data analytics to target high-risk asthma patients who are high utilizers of high-cost services.

The intervention is designed for high-risk asthma patients. Those with uncontrolled asthma who are high utilizers of urgent health care generate the highest costs. Both the HARP program and the Seattle program found the most cost savings were generated by the highest utilizers. RP recommends targeting individuals whose asthma is not well controlled by medication as demonstrated by a hospitalization for asthma or two or more visits to the emergency department within the past six months. The goal is to reduce hospitalizations and emergency department visits for asthma.

Reinvestment Partners recommends that PHPs and/or NCDHHS use data analytics based on claims to identify the highest risk asthma members as identified by meeting one of the following criteria:

1) Hospitalization with primary diagnosis of asthma within the past six months
2) Two or more emergency department visits with the primary diagnosis of asthma within the past six months
3) Inhaled beta-agonist to anti-inflammatory ratio of 5:1 or greater

This claims-based screening will identify a subset of Medicaid members to target for the intervention who will be most likely to achieve the highest benefit from that intervention.

Allow Reinvestment Partners to partner directly with PHPs to use affirmative outreach to reach target populations rather than relying on the beneficiary to find us.

Rather than relying on Medicaid members to find their way to the Breathe Easy service, the use of claims data for risk stratification allows PHPs to conduct affirmative outreach to their members who will most benefit from the service. PHPs can send a text or email (or both!) with a unique link to a web-based enrollment portal that allows members to enroll in the Breathe Easy program directly. [9]

Alternatively, or in coordination with electronic outreach, PHPs could assign designated care managers to conduct affirmative phone outreach to target members whose claims data fits within the eligibility criteria. Care managers could then enroll the member through the enrollment portal if they are determined to be eligible.

As part of the enrollment process, members will respond to housing quality screening questions to help determine their eligibility and fit for the program.

Housing Quality Screening Questions[10]

- Do you have concerns about the condition or quality of your housing? Yes, Somewhat, No
- Think about the place you live. Do you have any problems with any of the following (check all that apply)?
    - Bug infestation
    - Mold
    - Rodents
    - Lead paint or pipes
    - Inadequate heat
    - No air conditioning
    - Water leaks
    - None of the above

If the screening questions are answered positively, then the Medicaid member moves onto an enrollment screen in which they enter their basic information, including name, address, Medicaid ID number, contact information, and electronically sign a HIPAA authorization allowing the PHP to share information with Reinvestment Partners. The enrollment process includes a text verification if the member has a mobile phone.

After enrollment, the member receives a welcome message that explains a little bit about the Breathe Easy program and shares that Reinvestment Partners will be contacting the individual (or guardian) with

[9] This affirmative outreach could come from RP, but becoming an approved vendor with DHHS would probably take too long even if we have BAAs with MCOs and therefore RP would not be able to receive the target list or contact information. Accordingly, we recommend that the Medicaid MCOs conduct the outreach with the link to the enrollment site, which could include a HIPAA authorization as part of the enrollment process.

[10] Screening questions adapted from NC DHHS, Using Standardized Social Determinants of Health Screening Questions to Identify and Assist Patients with Unmet Health-related Resource Needs in North Carolina, https://files.nc.gov/ncdhhs/documents/SDOH-Screening-Tool_Paper_FINAL_20180405.pdf

more information and to schedule an appointment. As Reinvestment Partners conducts intake with the beneficiary they can also provide contacts for case management if the member has additional needs or does not seem to be a good fit for the program upon further discussion.

Affirmative outreach will allow us to reach those high-risk members who will benefit most from the program and increase enrollment.

The Breathe Easy program allows for systematic evaluation to determine its effectiveness in improving health outcomes and reducing utilization costs.

Reinvestment Partners will evaluate the effectiveness of the program by tracking participation, participant satisfaction, the relative changes in targeted environmental markers, and asthma symptom scores.

Specifically, Reinvestment Partners will track:

- Who is enrolled and the date of initial RP outreach
- Which clients participate in a virtual home visit and the date of the home visit
- Participation in follow-up visits and phone calls
- Housing assessment data in the first visit and second visit and potential changes in environmental conditions
- Pre and post intervention scores on Asthma Control Questionnaire
- Participant satisfaction with the program

Reinvestment Partners would like NCDHHS to conduct an evaluation of the Breathe Easy program as part of its larger HOP evaluation program since it has access to claims and payment data. As part of the evaluation, SHEPS can review claims data to determine if the program improved asthma control, reduced utilization of the emergency department to treat asthma, and reduced hospitalizations for asthma for participants. These findings can then be used to determine potential cost savings of the program.

Breathe Easy provides a path to value-based payments.

One of the goals of the HOP as described by CMS in its approval of the 1115 waiver is the pathway to value-based payments in which cost savings based on identified outcomes are shared with the pilot services providers. The value sharing is based on reductions on the total cost of care related to specific benchmarks, such as a reduction in hospitalizations and emergency department visits.

Based on evidence from other similar interventions, Reinvestment Partners is confident that our Breathe Easy asthma intervention will reduce the total cost of care for high-risk Medicaid members with uncontrolled asthma by reducing hospitalizations and emergency department visits for the highest utilizers. These are in addition to improving the quality of life for members and their families impacted by asthma.

The average cost of an emergency department visit is $1,150.[11] The average cost of a hospital stay is $2873 per day and the average cost of a total hospital stay for Medicaid is $9,800.[12]

[11] https://consumerhealthratings.com/how-much-does-er-visit-cost/

[12] https://www.peoplekeep.com/blog/infographic-how-much-does-a-hospital-stay-cost#blog-section-2

The Breathe Easy intervention costs $2,500. If it reduces hospitalizations and limits emergency department visits it will reduce the overall cost of care. This is in addition to qualitative benefits of improving the quality of life for both the member and the caregiver in the case of pediatric cases. Given the potential for demonstrating improved health and cost savings, the Breathe Easy program should be prioritized for research and for value-based payments. The goal would be to create a long-term, post-HOP path to negotiate value-based payments directly with PHPs for the Breathe Easy program.

Reinvestment PARTNERS
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Unite Us | NCCARE360 – Functional Failures
May 1, 2023

Unite Us is a startup founded in 2013 that offers a software platform to help connect people to social services. Unite Us created a data platform specific to North Carolina health and human service providers called NCCARE360. In 2021, North Carolina Department of Health and Human Services (the Department) contracted with Unite Us to use NCCARE360 for the Healthy Opportunities Pilots, North Carolina's 1115 Demonstration Waiver. The company has received more than $24 million from the Department, including at least $12,150,000 for the Pilots. Despite the large contract, the platform is not fulfilling the day-to-day needs of participating human service organizations (HSOs), care managers, network leads, or prepaid health plans (PHPs).

NCCARE360 does not meet financial audit requirements. NCCARE360's invoice tracking is often inaccurate; invoices are improperly saved, improperly rejected, and improperly labeled. In addition, NCCARE360 allows for duplicate billing, does not reflect accurate accounting, and does not reliably track clients' health insurance coverage. The transition to claims has resulted in mismanaged invoices and severely delayed or missing payments for HSOs, or even payments sent to the wrong HSO. The platform's invoicing and claims functions lack controls and pose serious financial and compliance risks to HSOs and PHPs.

NCCARE360 does not properly secure sensitive patient data. HSOs have received notifications in NCCARE360 about cases and clients that are not theirs. HSOs can see sensitive information in the platform about other services that clients are receiving. HSOs have also received payments for services that they did not render for people who were not their clients. Unite Us does not sufficiently protect sensitive patient information.

NCCARE360 lacks basic functionality. As a referral platform, NCCARE360 fails to perform basic tasks on a consistent basis. NCCARE360 does not use case numbers; does not reliably track client and service provision data; does allow more than one provider to receive the same referral; and does not consistently save case notes. Even when judged as a basic referral platform, NCCARE360 is lacking.

The Healthy Opportunity Pilots were designed with NCCARE360 at the center, and now the use of NCCARE360 poses the single biggest threat to the success of the Healthy Opportunities Pilots. From data security to financial compliance, NCCARE360's lack of functionality and issue resolution is putting patients, HSOs, and other stakeholders at risk. Immediate action needs to be taken to protect stakeholders and create a technology response that is compliance and successful for North Carolina's Section 1115 Demonstration Waiver.

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NCCARE360 Does Not Meet Financial Audit Requirements

North Carolina's version of the Unite Us referral platform, NCCARE360, is enabled with social care payment capabilities. As a contractual requirement, the platform must allow community-based organizations to submit invoices and track payments for services rendered via the platform.

HSOs submit invoices by creating a new Contracted Service in NCCARE360. Unfortunately, NCCARE360 has not accurately managed invoices from the start. Invoices that were not paid have been marked as paid and invoices that had been paid were marked as unpaid. Invoices have been rejected erroneously or paid when they should not have been. NCCARE360 is not meeting its contractual requirement of consistently maintaining accurate invoicing information for HSOs.

The lack of controls in NCCARE360's invoicing platform presents a potentially damaging liability for all HSOs and exposes the platform's lack of financial compliance.

- NCCARE360 does not accurately track invoices sent and paid by PHPs. At times invoices are not labeled correctly and do not reflect accurate billing information.

- NCCARE360 allows for duplicate billing. The same service for the same date can be billed multiple times. This puts HSOs at risk for financial non-compliance because NCCARE360 is not blocking duplicate Medicaid billings.

- NCCARE360 does not accurately and consistently track health insurance coverage per client. NCCARE360 allows invoices to be sent to the wrong PHP. If these errors are not caught by Network Leads or PHPs, then HSOs receive payments for services from the wrong PHP, resulting in repayment to the PHP and missing the deadline to bill the correct PHP.

- HSOs sometimes receive payments for clients that are not theirs and NCCARE360 does not track these errors. This unnecessarily risks a breach of clients' sensitive and personal information.

- NCCARE360 does not communicate disenrollment to HSOs in a consistent and timely manner. HSOs are then providing services for non-eligible members. HSOs cannot receive payment for services rendered after disenrollment, which results in a financial loss.

- NCCARE360's failure to keep HSO addresses accurate during the switch to claims resulted in PHPs mailing checks with patient information to the wrong addresses. More than 20 checks to Reinvestment Partners were mailed to the wrong address, resulting in financial liability for both PHP and HSO as well as poorly protected patient data.

- HSOs need to closely monitor each PHP's remittance reports because HSOs cannot rely on NCCARE360 to report accurate invoicing information.

- After NCCARE360 switched from sending invoices to sending claims, HSOs received duplicate rejections and incomplete payments.

- HSOs had to go without payment for many weeks while NCCARE360's errors on claims were being addressed. The claims payment system is not functional.

Case Example: The platform does not systematically or consistently notify community-based organizations when a Medicaid member is disenrolled from managed care. Reinvestment Partners received an overpayment notification directly from a prepaid health plan (PHP) requiring us to return $3,062.59 in fee-for-service payments we had received for a healthy food box client. It turns out the client had not been covered with this PHP for more than six months. Yet, the referral platform did not catch the error, notify service providers of the issue, or stop invoices from being sent.

We therefore received a request to repay $3,062.59 even though we delivered (and paid for) those services under the assumption that our client was still a Medicaid member. We had to formally appeal to the PHP. We also had to ensure that all important case information was documented in a separate, secure system because we could no longer rely on the data in NCCARE360. Ultimately it is HSOs that are responsible for the financial risk and repercussions that NCCARE360 generates.

NCCARE360 Does Not Properly Secure Sensitive Patient Data

NCCARE360 does not properly secure patient data within its system. HSOs have received notifications from the platform about cases that are not theirs. HSOs have also received notifications from the platform about clients who are not their clients. HSOs can see sensitive information in the platform about other services that their clients are receiving. HSOs have even received payments for services that they did not render for people who were not their clients.

Furthermore, NCCARE360 lacks functionality which results in its users relying on an endless stream of workarounds. These workarounds result in patient data regularly being exchanged outside of the platform. For example, HSOs, care managers, and PHPs cannot effectively communicate within the platform. Instead, they exchange patient information and case details outside of NCCARE360 via email and phone, effectively losing any data security that the platform itself offers.

- HSOs receive and accept referrals using NCCARE360. Once a referral is accepted, it becomes a case. Once an HSO has cases, they must provide services according to each case based on notes. Notes added in NCCARE360 are not consistently saved, so HSOs have lost important case and patient data.

- Cases in NCCARE360 are not numbered, which makes effectively organizing a large client caseload nearly impossible. Instead of case numbers, HSOs must use clients' names and other identifying information to communicate issues and case updates outside the referral platform.

- NCCARE360 notifications are often inaccurate or tagged to the wrong case. Care managers and HSOs must communicate outside the platform.

These concerns are not simply a request for more functionality from the platform, they represent serious threats to the protection of patient information and data security compliance.

NCCARE360 Lacks Basic Functionality

The failure of NCCARE360 to perform core financial and data security functions is compounded by smaller daily issues with platform functionality. The effect is that Pilot stakeholders must devise solutions to ongoing problems outside the platform, resulting in significant variability in how situations, issues, and day-to-day questions are being answered and addressed. There are so many issues with the platform that almost everything Pilot stakeholders do includes at least one workaround to finish the task.

- NCCARE360 cannot accept batch uploads and exporting data is a challenge. All information must be manually entered one at a time. The result is that referrals and invoicing processes are slow, mostly manual processes. As an example, Reinvestment Partners has one staff person dedicated to invoicing full time. Any significant increase in clients means additional staff just for invoicing. PHPs and care managers must also enter client date one by one in greater numbers causing significant frustration and increasing cost.

- Referrals include authorized time periods and unit numbers. NCCARE360 does not keep track of how many units have been delivered, nor can it notify HSOs when the authorized period has lapsed. This puts HSOs at risk for non-compliance by delivering more than the allowable units and outside the authorization window.

- NCCARE360 sometimes allows for the same referral to be accepted by two HSOs. This is a serious Medicaid compliance issue. In some cases, multiple service providers are providing the same (duplicative) service to the same Medicaid member and both service providers are being reimbursed.

- It is difficult to determine a case timeline, particularly for clients with multiple referrals and cases.

- Cases cannot be grouped by household.

- One Pilot participant can receive many services, which results in multiple cases per participant.

- Cases are organized by Service Type, not Program. For food services, it is impossible to tell whether a client is receiving a healthy food box or produce prescription without clicking into each Service Type listed on the case. Only healthy meals are distinguished by the Service Type Prepared Meals.

- Open cases cannot be sorted alphabetically. The client list can be sorted alphabetically, but it includes all clients with no option for organizing or archiving.

- If a care manager changes a client's name in NCCARE360 HSOs have no way to track the name change or bill for services.

- NCCARE360's invoicing platform was down for many days, resulting in backlogs, late invoice submissions, delayed payment, and general confusion.

- NCCARE360 has launched multiple updates, which have caused significant and sustained issues for case management and service delivery.

- NCCARE360 inconsistently captures who the assigned care manager is for any given client, which makes seeking clarification, answering questions, and sharing updates very challenging.

- NCCARE360's data is meant to be a source of truth for Pilot stakeholders, but the platform is too unreliable to trust the data.

- Data dashboards are intermittently not working, which means stakeholders cannot access necessary information for reporting and compliance.

- Over the years, Unite Us has avoided opportunities to improve the platform and help platform users. When users raise issues, customer service can take weeks or months to resolve an issue, if they resolve the issue at all.

- Unite Us customer service also encourages HSOs to use workarounds because problems are not being fixed within NCCARE360.

Conclusion

The Healthy Opportunity Pilots were designed with NCCARE360 at the center, and now the use of NCCARE360 poses the single biggest threat to the success of the Healthy Opportunities Pilots. From data security to financial compliance, NCCARE360's lack of functionality and issue resolution is putting patients, HSOs, and other stakeholders at risk. Immediate action needs to be taken to protect stakeholders and create a technology response that is compliant and successful for North Carolina's Section 1115 Demonstration Waiver.

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NCPeds 1115 comments
Date: Wednesday, September 20, 2023 1:11:07 PM
Attachments: 2023-9 NCPeds 1115 Comments FINAL.pdf

Hello – attached please find comments from the NC Pediatric Society regarding the new 1115 proposal. If you have any questions or need anything further, please let me know.

Thank you.

~Elizabeth

Help support NCPeds' important work with a gift to the 2023 General Fund Campaign Today!
Thank you for the many ways you care for North Carolina's children!

ncpeds
North Carolina Pediatric Society
State Chapter of the American Academy of Pediatrics
Incorporated in North Carolina

Elizabeth Hudgins, MPP | Executive Director
North Carolina Pediatric Society
919-839-1156 x104 | [redacted]

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North Carolina Chapter

INCORPORATED IN NORTH CAROLINA

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

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North Carolina Pediatric Society

September 20, 2023

North Carolina Department of Health and Human Services
NC Medicaid Section 1115 Waiver Team
1950 Mail Service Center
Raleigh, NC 27699-1950

RE: NC Section 1115 Waiver Renewal
VIA Email: Medicaid.NCEngagement@dhhs.nc.gov

Dear NC Section 1115 Waier Renewal Team:

Thank you for the opportunity to submit responses to the NC Section 1115 Demonstration Waiver. The NC Pediatric Society (NCPeds) is the state chapter of the American Academy of Pediatrics incorporated in North Carolina. Representing 2,300 pediatricians and other child health professionals across NC, NCPeds has been deeply engaged in the Medicaid reform process. We offer the following comments.

We enthusiastically applaud the proposed eligibility changes for children. Allowing children younger than age 5 to have continuous Medicaid eligibility, older children to have 24 months of eligibility and youth aging out of foster care to remain eligible until age 26 without filing additional paperwork will reduce disruptions in care. Also, given the 40% "churn" rate, this proposal will reduce administrative burden for families, local DSS, practices and others.

We applaud the expansion of HOP and urge further expansion to children and youth at-risk of being removed from their homes. The Healthy Opportunities Pilot currently operates in regions of the state to help address social drivers of health while promoting non-medical interventions such as food insecurity, housing and transportation. Extending these services to children and youth at-risk of being removed from their home (as defined through the federal Family First Prevention Services Act) would provide important supports to families to help children stay in their current homes.

We applaud the focus on health equity. The Department has done a commendable job focusing on health equity. It is also a focus of various ancillary work groups. However, there is still great opportunity to close gaps.

We applaud efforts to increase the behavioral health workforce. We lift up increased rates as an additional strategy to help address the inability of some psychiatrists to participate.

We applaud the Justice Involved Reentry Initiative: NCPeds supports efforts to address the specific issues of justice-involved individuals, including justice-involved youth.

We continue to applaud one single statewide proposed plan for children and youth in foster care and transitioning out of foster care (Children and Families Specialty Plan). We also continue to have significant concerns about current services until that Plan begins. One single statewide plan will help resolve some of the many issues associated with foster children moving among LME regions. However, we continue to be deeply concerned about the current transition period, including how Tailored Care Management works in the interim for some of our most vulnerable children. Even before go-live of CFPF, much stronger communication with local child welfare experts is needed on TCM and Medicaid Direct for children and youth in foster care. We also urge strong attention to reducing the administrative burden in the CFSP, especially for contracting, given that most practices will only have a handful of children and youth in foster care or adults who have aged out of foster care. Assuring that practices can participate without navigating new contracts, value based payments based on very small panels and additional portals/panels/coordination of benefits procedures will be critical for Plan success of for these children, youth and young adults to get the care they need.

We urge a strong focus on administrative burden. The Sheps 2022 Medicaid Provider Experience Survey linked in the waiver request reports "notable administrative burden" for practices. An April 2022 survey in NC by the NC Pediatric Society and NC Academy of Family Physicians found two-thirds of primary care physicians reported an increase in administrative burden between 2021 and 2022, and further reported a 19% decline in ability of primary care physicians to help their patients get timely access to care.[1] Further, the concern about administrative burden is bolstered by regular and on-going informal reports from NCPeds' membership about challenges with panels, coordination of benefits, payments, contracting, challenges getting help from PHPs and other concerns. These problems continue to persist and could impact the success of Tailored Plans and a Specialty Plan as practices are not willing to take on substantial administrative burden for a relatively small handful of patients when other administrative implementation issues linger after months or years. Examples of ways to improve could include the following:

- Greater oversight of Managed Care plans specifically around denied and pended claims
- Definitive steps to correct beneficiary assignment areas, particularly when adults are assigned to pediatric practices, children are assigned to internal medicine practices, and patients are assigned away from their PCP with minimum burden to the PCP
- Strong monitoring and assurances of provisions of Tailored Care Management (not just care coordination) services for qualified individuals
- Contracting simplification requirements, especially for new contracts such as the single statewide plan for children and youth in foster care
- Specific efforts to reduce the number of prior authorizations required by the Pre-Paid Health Plans

[1] Survey of Primary Care on NC Medicaid Post Go-Live – April 2022, NC Pediatric Society and NC Academy of Family Physicians.
https://cdn.ymaws.com/www.ncpeds.org/resource/resmgr/medicaid_/ncpeds_ncafp_medicaid_survey.pdf

- Continued efforts to minimize the number of quality metrics, align quality metrics beyond the Medicaid market (commercial/Medicare) as possible, and to ensure that reporting and measurement requirements are consistent across plans
- Continued efforts by the Plans' Chief Medical Officers to simplify administrative processes and procedures

We urge stronger evaluation criteria, including more robust and better comparison data including for network adequacy. Shortly before go-live, the State stopped producing quarterly QMAF (Quality Measurement and Feedback) data to assess how children (including in foster care) compared to overall HEDIS data. That report is no longer provided. It would be helpful to have an apples-to-apples comparison on basic HEDIS indicators before and after go-live.

In terms of network adequacy, the State should consider reinstating the NC Medicaid Access Monitoring Review Plan[2] that included adult and child access to primary care, dental service, behavioral health services and other care with baseline and on-going data. This Plan reported on PCPS per 1000 enrollees. That report does not seem to have been issued since the beginning of the transition to Medicaid reform. Anecdotally, we hear some pediatric providers are dropping Medicaid patients, or not taking new patients, because of the administrative burden associated with PHP participation. We also hear anecdotally that practices, especially rural practices, struggle to find the other medical supports, such as specialized screenings/testing, therapies and subspecialty services, such as ophthalmological and optometric services. Part of this is due to workforce shortages but part seems anecdotally to be linked to lack of adequate networks both for PHPs and TCM, especially as some providers, such as therapy providers, may not have the infrastructure to contract with multiple Plans. Having strong data to assess network adequacy is critical to determining the success of Medicaid reform.

Restoring the Access Monitoring Review Plan with baseline and current data collected and reported in the same way would help provide an important line of sight into provider participation and network adequacy.

We strongly urge apples-to-apples data going into baseline comparisons. As the state chapter of the American Academy of Pediatrics, we hear numerous concerns on a weekly basis from pediatric practices about panel inaccuracy which suggests denominator information may not be representative. While we applaud the merging of CHIP and Medicaid, this did not happen until after go-live so tens of thousands of relatively healthy children have been added to the calculations and how that is being adjusted in any data comparisons is unclear.

Further, the State seems to be moving towards excluding commercial duals from rate calculation. While this is understandable given data complications, the State has not been able to provide us any data on the magnitude or overall health status of the commercial dual population. A handful of responding pediatric practices reported commercial duals represented 5% to 25% of their Medicaid patients. If the percentage is indeed substantial and children are commercial duals because of complex social dynamics, that would create barriers to getting well child visits and vaccines, removing these children from calculations could make comparisons seem unrealistically favorable. If children fall into commercial dual status because they have access to more resources and live in families better equipped to address social drivers of health, then removing them from the calculation could paint a different picture.

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[2] https://medicaid.ncdhhs.gov/documents/getinvolved/medicaid-plan/nc-medicaid-access-monitoring-review-plan-2016-2018-final-draft/download

Again, we need baseline data of the same data sets calculated in a consistent manner that allows for meaningful and accurate comparisons to determine if child health is better after managed care. Also, on-going data should continue to provide overall state information, in addition to specific information by PHP and Medicaid Direct.

Given churn and panel and attribution problems, looking at eligible patients of the population assigned to the practice for a year could result in concerning percentages of children being potentially dropped from the HEDIS calculations. For accurate comparisons, there should be reporting of the same data set with uniformity of the members calculated consistently before and after go-live.

If you would like to discuss any of these concerns further, please do not hesitate to reach out through our Executive Director, Elizabeth Hudgins.

Thank you.

Sincerely,

Kenya McNeal-Trice, MD, FAAP
President, NC Pediatric Society

CC: Shannon Dowler, MD
Elizabeth Hudgins, MPP
Jay Ludlam, JD

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115
Date: Wednesday, September 20, 2023 1:51:58 PM

I am submitting the following feedback regarding the pilot portion of the current draft of the NC Section 1115 Demonstration Waiver application.

1. RETAIN: I strongly support the following items in the state's draft application:

Whole-person integrated approach to care supported by a care management model.
Expansion of geographic eligibility to include all 100 counties.
Expansion of pilot eligibility to include all pregnant and postpartum women, justice-involved individuals, those who are "at risk of" a chronic condition, individuals with only one chronic health condition, individuals recently impacted by natural disasters, children/youth who receive adoption assistance and all Tailored plan members and Tailored Care Management eligibles in prepaid inpatient health plan (PIHP).
Expansion of meal services to three meals per day.
Availability of capacity building funds throughout the demonstration waiver period.
Central role of NLs in ensuring the pilot's success.

2. MODIFY: Impact Health believes the following items could be improved upon:

Refine language around rental assistance to include:
up to six months of rental assistance including payment of arrears
for all enrollees who demonstrate need (not just high-needs enrollees).
Prioritize investments in community-based organizations and local service delivery models.
Increase capacity building budget allocation and/or significantly increase fee schedule payments to ensure there are sufficient and sustainable resources for human service organizations (HSOs) and NLs to scale pilot services across all 100 NC counties.

3. CLARIFY/ADD: Impact Health requests the following clarifications and additions:

Expand eligibility to include all NC Medicaid members—regardless of coverage type—who screen positive for a pilot-supported social health need.
Clarify HOP eligibility of Medicare/Medicaid dual enrollees.
Include all HOP services in pre-release Medicaid services available to justice involved individuals.
Allow continuous access to HOP services for justice-involved individuals for 1-year post-release.
Clarify that current NLs and HSOs do not need to reapply under the new waiver.
Additional Recommended Pilot Enhancements

Fee Schedule Improvements

Standardize fee schedule statewide to reduce the potential for confusion, referral delays and rejections.

Approve additional evidence-based parenting curricula in alignment with NC Partnership for Children to allow HSOs to leverage existing resources to meet regional needs.
Review all services to ensure a coordination or admin fee is included.

Network Development

Give contracting preference and/or incentives to local, community embedded HSOs to promote equity and improve pilot enrollment, member satisfaction, expansion of services/geography and culturally inclusive service delivery.
Prioritize and incentivize local health and social service agencies to participate in the pilot.
Provide ongoing capacity building funding to support NLs who play a critical role in developing and maintaining network diversity, capacity and sustainability.
Strengthen and expand NL's role to ensure pilot success by:
providing NLs with access to detailed member eligibility lists to allow NLs to build enrollment penetration maps by zip code, county, domain and/or attributed practice,
funding existing NLs to onboard and provide training and technical assistance to new NLs and new and existing PHPs, CINs and other stakeholders,
engaging NLs as primary regional representatives in state-level decision-making, and
partnering with NLs to create and implement a comprehensive communications and public relations strategy.
Digital Platform & Billing Process Improvements

Develop a clear pathway and process to support data sharing between pilot stakeholders to ensure NLs can make data-driven decisions and conduct continuous quality improvements.
Improve the accuracy and efficiency of the pilot's digital billing processes by implementing technical solutions that
standardize billing practices using 837 and 835 data sets,
integrate benefits inquiries and responses (270/271 data sets) to provide HSOs with real-time access to client eligibility data, and
improve the user experience by providing functionality for data searches, claims management, and elimination of duplicate claims.

Compliance and Quality Assurance

Require HSOs who directly contract with PHPs to participate in NL compliance activities to ensure network adequacy and service delivery quality.
Increase accountability and transparency around PHP responsibilities regarding care management network adequacy, quality improvement, and payment processes.

Best,

--
Madison Laws (she/her/hers)
Community Engagement Team
Caja Solidaria
Office Phone: (828) 290-9717

Google Voice: (828) 338-9524

www.cajasolidaria.org

Ensuring everyone has access to the abundance the Southern Appalachians offer.

From: [redacted]
To: Medicaid.NCEngagement
Cc: [redacted]
Subject: [External] NC Medicaid Section 1115 Waiver
Date: Wednesday, September 20, 2023 2:40:53 PM
Attachments: image001.png
UHC Comments NC 1115 2023-0920.pdf

Hello –

Please find comments from UnitedHealthcare Community Plan of North Carolina attached.

Thank you,

Angela Lello, MPAff (she/her)
Regional Policy Director, East
UnitedHealthcare Community & State

952-251-4580
[redacted]

United Healthcare Community Plan

September 20, 2023

Jay Ludlam
North Carolina Department of Health & Human Services
NC Medicaid Section 1115 Waiver Team
1950 Mail Service Center
Raleigh, North Carolina 27699-1950
Submitted via email: Medicaid.NCEngagement@dhhs.nc.gov

RE: NC Medicaid Section 1115 Waiver

Deputy Secretary Ludlam,

UnitedHealthcare Community Plan of North Carolina (UnitedHealthcare) appreciates the opportunity to provide comments on the North Carolina Department of Health & Human Services' (DHHS) renewal request of North Carolina's Medicaid Reform Section 1115 Demonstration Waiver (1115 Waiver). We support DHHS's vision to build on its early successes and lessons learned and continue progress over the next five years to improve the health and well-being of all North Carolinians through a whole-person, well-coordinated system of care that addresses both medical and non-medical drivers of health and advances health access by reducing disparities for historically marginalized populations. Continued collaboration between DHHS, Prepaid Health Plans (PHPs), and providers is the foundation for moving forward in our collective efforts to continue the smooth transition to managed care, including for those with the most complex needs, support access to a system of care, and strengthen the delivery system.

We value the state's commitment to stakeholder engagement and look forward to continuing working with DHHS as it refines the implementation of the 1115 Waiver renewal request. Should you have any questions or seek further information about the feedback provided, please do not hesitate to contact me by phone at (336) 540-7057 or by email at anita.bachmann@uhc.com.

Sincerely,

Anita H. Bachmann
Chief Executive Officer
UnitedHealthcare Community Plan

Continuing Medicaid Transformation

UnitedHealthcare applauds DHHS for its commitment to its focus on providing integrated, whole-person, well-coordinated care for Medicaid enrollees through continued implementation of Medicaid managed care. We are proud of our partnership with DHHS to transform North Carolina Medicaid through the implementation of the Standard Plans, marking a significant shift from fee-for-service to managed care. As part of this transformation, North Carolina residents have been able to receive well-coordinated, quality care through collaborations with providers that are aligned with the state's dedication to creating a high-functioning Medicaid managed care program focused on innovation, access, quality, value, and successful relationships.

In line with North Carolina's Medicaid transformation, UnitedHealthcare supports the state's efforts to improve population health, engage and support providers, and establish a sustainable program with predictable costs. The proposed 1115 Waiver renewal also underscores the sustaining efforts needed to keep moving North Carolina Medicaid towards a more integrated delivery system focused on whole-person, quality care.

We appreciate North Carolina's interest in continuing to refine and improve its Medicaid program and understand the importance of implementing program design features that support the state's efforts to continue delivering high quality, comprehensive care to its enrollees at sustainable costs.

The implementation of the managed care program has provided an opportunity to improve the quality of care provided to Medicaid enrollees in North Carolina. North Carolina's strong framework, along with the continued efforts of DHHS to engage stakeholders, has facilitated a smooth transition from the state's fee-for-service environment to managed care, which has been positively shaped by the focus on whole-person care, value-based models, and addressing the unmet needs among its Medicaid population. DHHS' focus on these areas has created a strong foundation for partnerships between the Department, PHPs, and providers, thereby improving health outcomes and reducing costs. Additionally, the shift to Medicaid managed care and person-centered health communities has made the entire system more accountable for health outcomes and quality of care.

As the state continues its Medicaid transformation from fee-for-service to managed care, we encourage DHHS to consider a feasible path for transitioning dual eligible enrollees to a Medicaid managed care program that protects consumer choice, simplifies provider experience, and minimizes administrative complexity for the state. UnitedHealthcare agrees that the 1115 Waiver renewal provides DHHS with the authority necessary to seamlessly transition the Medicaid benefits that full benefit dual eligibles receive into Managed Care and we recommend that DHHS begin this transition by adding those benefits to the State Medicaid Agency Contract for the community well full benefit dual eligibles as an initial phase of this transition.

In conclusion, UnitedHealthcare strongly supports the continuation of the authority as requested.

Tailored Plans

We remain eager to work with DHHS to assist with the launch of Tailored Plans for people with behavioral health needs and those with an Intellectual or Developmental Disability (I/DD) so that they benefit from comprehensive, whole-person care. Enrolling these populations into comprehensive managed care will ensure that they receive a person-centered approach to enrollee engagement and communication. This approach ensures that the needs of the individual are positioned as paramount and that they receive the full range of services necessary to optimize their health status and quality of life.

Comprehensive managed care will also improve access to services, particularly for those residing in rural areas. This can be achieved through the availability and accessibility of providers that travel to enrollees' residences when necessary and by leveraging technology to improve access to previously isolated individuals. Care coordination afforded by comprehensive managed care plays a significant role in improving services. By monitoring progress and updating the care plan regularly, care coordinators can support improved health outcomes. Furthermore, managed care will help promote independent living in the least restrictive setting and support family caregivers by providing resources and tools that help manage conditions and address ongoing needs as well as resolve urgent crises when they arise.

Children and Families Specialty Plans

UnitedHealthcare supports the renewal request to continue authority to operate the Children and Families Specialty Plans (CFSP) for children and youth served by the child welfare system. The transition to Managed Care in North Carolina for this population aims to bring about several improvements. One of the key improvements is enhancing the quality of care, particularly during transitions of care, and bolstering the support provided to caregivers.

When implemented, the CFSP will help DHHS reduce and remove barriers to improve coordination of care for this highly complex population. A comprehensive managed care program that includes behavioral health, pharmacy, and dental benefits, provides the best opportunity for improving health outcomes. With a focus on whole-person care and value-based models, CFSP can address unmet needs among this specific Medicaid population, thus laying the groundwork for partnerships across all systems and entities serving this population.

Furthermore, the data and reporting from the CFSP will bring about increased transparency. Migrating to a managed care platform will also enable outsourcing of administrative oversight, claims processing, and call centers to the private sector. This is especially useful for children engaged with the child welfare system who often have co-occurring medical and behavioral health care needs.

HOP Improvements

UnitedHealthcare remains supportive of DHHS's implementation of the Healthy Opportunities Pilot (HOP). We have partnered with DHHS, Network Leads, and Human Service Organizations (HSO) to implement the system of services and supports that states around the nation are looking to as they design Medicaid benefits to address health-related social needs. We are proud of the work that North Carolina has done with the initial implementation of HOP, and we support the request to renew the authority for continuing the HOP and its existing program. We look forward to working with DHHS to continue its momentum to focus on addressing non-medical drivers of health, including housing instability, transportation insecurity, food insecurity, interpersonal violence, and toxic stress.

Many North Carolina Medicaid enrollees benefit from HOP. In the last year alone, UnitedHealthcare has served over 2,000 members in the HOP program – over one third of which are children. We estimate that with statewide expansion, over 10,000 new members will enroll in the program. We appreciate DHHS's recognition of the enormity of the statewide needs and its commitment to bringing HOP to all Medicaid members across the state. We also recognize the role that dedicated care management plays in the success of the program, and we recommend DHHS create incentives for PHPs to develop specialized HOP care management approaches.

Address Capacity Issues

We recommend DHHS use the 1115 Waiver renewal as an opportunity to address some of the HOP service capacity issues, which are spread unevenly across services and geographies across the state. In particular, we recommend DHHS develop targeted strategies to address counties that are "provider deserts"— that lack any HSO providers serving the county (e.g., Halifax, Martin, Northampton, Jackson). In addition, DHHS should also examine utilization patterns at the county level to identify areas with the highest service disparities and leverage this data to target and deploy capacity building funds by service type.

We also recommend that the state develop specific strategies to monitor the capacity of HSOs and identify any service shortages to ensure individuals in need have access to necessary services. Finally, we strongly recommend that DHHS require as a condition of grant eligibility that HSOs must provide direct services to Medicaid enrollees within twelve months of receiving capacity building grant funding.

Supporting Providers

Providers and community-based organizations are trusted partners and key to the ongoing success of HOP. Network Leads play a critical role in ensuring the availability of quality services and that HSOs are delivering services as contracted. UnitedHealthcare recommends DHHS empower Network Leads to conduct quality monitoring and improvement activities so that they can assess performance and determine where targeted technical assistance is needed. Network Leads can also evaluate the entire HSO network for adequate coverage and monitor performance, address opportunities for improvement, and communicate follow-up

actions. We recommend that DHHS direct portions of HOP capacity building grants to both the new Network Leads as well as the existing Network Leads to equip them to provide the quality improvement and technical assistance activities needed to help HSOs fill gaps and address access barriers.

Additional Services

UnitedHealthcare supports the expanded array of HOP services included in the 1115 Waiver renewal. We applaud DHHS for expanding both the amount and duration of the nutrition support and housing services to include three daily meals and the payment of rental arrears, respectively. In our implementation of the HOP program, we have seen how food and housing insecurity persistently affects the ongoing health of Medicaid enrollees. With these expanded benefits, North Carolina will be able to directly address these needs.

We also recommend DHHS consider additional services to complement the existing HOP array, including enhancing the transportation benefit. Specifically, we recommend separating transportation into two categories: 1) private and public transportation and 2) services to assist members in repairing / remediating member-owned vehicles to make safe and legally drivable. We have found that locating transportation providers – whether they be private transportation providers or public transportation systems – is challenging for enrollees in many parts of the state, especially rural areas. However, when enrollees have access to vehicles that may require minor repairs or remediation to become drivable, that may be a more readily accessible solution that can address their transportation needs.

New Initiatives

UnitedHealthcare supports the new initiatives included in the 1115 Waiver renewal request. We are eager to partner with DHHS in the development of specific implementation plans for the Justice-Involved Pre-release Services, Continuous Eligibility for Children and Youth and investments in Behavioral Health Technology and Workforce.

Justice-Involved Reentry

UnitedHealthcare appreciates DHHS' commitment to serving all North Carolinians in need of health care, including those transitioning from carceral settings. We strongly support the Department's proposed inclusion of pre-release services for the Justice-Involved population and are eager to work with DHHS to develop plans to address specific considerations. We recommend that DHHS convene stakeholder workgroups to develop implementation plans and protocols to guide the launch of this component of the 1115 Waiver renewal.

In coordinating with managed care entities, we recommend that DHHS prioritize continuity of care for this population. Specifically, we recommend that DHHS ensure that these individuals maintain assignment with the PHP they were assigned to prior to incarceration and that PHPs are engaged early on to develop implementation plans to help identify and deploy pre-release case management services.

We are also eager to learn more from DHHS about how they will identify and assist individuals who will be newly eligible to Medicaid upon release and how they will identify those potentially eligible with these new services, including how they will ensure incarcerated individuals will be enrolled in Medicaid upon their release. For newly-eligible Medicaid enrollees, we recommend that DHHS follow its existing auto-assignment algorithm and assign members to PHPs based on that logic. We also welcome the opportunity to learn how the state will ensure Medicaid capacity building funds will create systems that connect members with clinical services and ensure that carceral costs are not shifted to the Medicaid program.

DHHS also has the opportunity to ensure that enrollees are connected to a continuum of care post-release. We recommend DHHS explore the post-release suite of services needed by this population and consider how best to prioritize referrals to HOP benefits. We also support DHHS' approach to add in Physical and Behavioral Health clinical consultation services, lab and radiology services, medications and medication administration. We also recommend that DHHS consider reviewing and updating this suite of pre-release services on a regular basis in conjunction with PHPs that are serving this population as they become familiar with their needs.

Finally, we encourage DHHS to consider how best to target eligibility criteria. The proposed 1115 Waiver renewal limits eligibility to individuals in state prisons however there are over 24,000 individuals at county jails and federal correctional facilities in North Carolina. In addition, four of the thirteen juvenile detention centers in North Carolina are operated by counties. Therefore, we encourage DHHS to consider taking a phased approach that is inclusive of additional settings to ensure that all individuals released from carceral settings are able to receive the care they need to successfully transition to life in the community.

Continuous Enrollment for Children and Youth

UnitedHealthcare supports DHHS' request for multi-year eligibility for children and youth. Maintaining access to Medicaid eligibility will help ensure that children are fully leveraging benefits under Early, Periodic, Screening, Diagnostic, and Testing requirements of Medicaid. In particular, this approach helps ensure that children receive access to the preventive care and health screenings and treatment needed to support their development. In addition, we know that continuous eligibility for children supports parents in staying connected and engaged in their own health and the health of their children. Finally, supporting continuous enrollment for youth that have aged out of foster care supports their continued access to services and helps ensure that there are no gaps in coverage for this population. There are many challenges these youth are facing as they age out of care and given the particular health and social challenges they face, allowing their health care coverage to continue will support their transition to independence.

Investments in Behavioral Health Technology and Workforce

UnitedHealthcare recognizes the critical need for investments in behavioral health and we support DHHS' request for $45 million in expenditure authority for assistance for providers to

improve access to behavioral health services and promote care integration and whole-person care. We recommend that DHHS specify that to be eligible to receive the health information technology grants, providers must also be participating in Standard Plan networks to incentivize increased integration. We also recommend that DHHS consider allowing recipients of prior provider incentive payments under the Health Information Technology for Economic and Clinical Health Act to apply for grants if there is demonstrated provider gaps in a geographic area and if the provider has identified additional capacity needs.

Conclusion

We look forward to ongoing collaboration with the Department in its efforts to transform health care delivery in North Carolina. UnitedHealthcare further appreciates DHHS's commitment to engaging stakeholders as reforms are developed and before any significant programmatic or payment changes are implemented.

September 20, 2023

Jay Ludlam
North Carolina Department of Health & Human Services
NC Medicaid Section 1115 Waiver Team
1950 Mail Service Center
Raleigh, North Carolina 27699-1950
Submitted via email: Medicaid.NCEngagement@dhhs.nc.gov

RE: NC Medicaid Section 1115 Waiver

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[redacted]

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In line with North Carolina's Medicaid transformation, UnitedHealthcare supports the state's efforts to improve population health, engage and support providers, and establish a sustainable program with predictable costs. The proposed 1115 Waiver renewal also underscores the sustaining efforts needed to keep moving North Carolina Medicaid towards a more integrated delivery system focused on whole-person, quality care.

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When implemented, the CFSP will help DHHS reduce and remove barriers to improve coordination of care for this highly complex population. A comprehensive managed care program that includes behavioral health, pharmacy, and dental benefits, provides the best opportunity for improving health outcomes. With a focus on whole-person care and value-based models, CFSP can address unmet needs among this specific Medicaid population, thus laying the groundwork for partnerships across all systems and entities serving this population.

Furthermore, the data and reporting from the CFSP will bring about increased transparency. Migrating to a managed care platform will also enable outsourcing of administrative oversight, claims processing, and call centers to the private sector. This is especially useful for children engaged with the child welfare system who often have co-occurring medical and behavioral health care needs.

HOP Improvements

UnitedHealthcare remains supportive of DHHS's implementation of the Healthy Opportunities Pilot (HOP). We have partnered with DHHS, Network Leads, and Human Service Organizations (HSO) to implement the system of services and supports that states around the nation are looking to as they design Medicaid benefits to address health-related social needs. We are proud of the work that North Carolina has done with the initial implementation of HOP, and we support the request to renew the authority for continuing the HOP and its existing program. We look forward to working with DHHS to continue its momentum to focus on addressing non-medical drivers of health, including housing instability, transportation insecurity, food insecurity, interpersonal violence, and toxic stress.

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New Initiatives

UnitedHealthcare supports the new initiatives included in the 1115 Waiver renewal request. We are eager to partner with DHHS in the development of specific implementation plans for the Justice-Involved Pre-release Services, Continuous Eligibility for Children and Youth and investments in Behavioral Health Technology and Workforce.

Justice-Involved Reentry

UnitedHealthcare appreciates DHHS' commitment to serving all North Carolinians in need of health care, including those transitioning from carceral settings. We strongly support the Department's proposed inclusion of pre-release services for the Justice-Involved population and are eager to work with DHHS to develop plans to address specific considerations. We recommend that DHHS convene stakeholder workgroups to develop implementation plans and protocols to guide the launch of this component of the 1115 Waiver renewal.

In coordinating with managed care entities, we recommend that DHHS prioritize continuity of care for this population. Specifically, we recommend that DHHS ensure that these individuals maintain assignment with the PHP they were assigned to prior to incarceration and that PHPs are engaged early on to develop implementation plans to help identify and deploy pre-release case management services.

We are also eager to learn more from DHHS about how they will identify and assist individuals who will be newly eligible to Medicaid upon release and how they will identify those potentially eligible with these new services, including how they will ensure incarcerated individuals will be enrolled in Medicaid upon their release. For newly-eligible Medicaid enrollees, we recommend that DHHS follow its existing auto-assignment algorithm and assign members to PHPs based on that logic. We also welcome the opportunity to learn how the state will ensure Medicaid capacity building funds will create systems that connect members with clinical services and ensure that carceral costs are not shifted to the Medicaid program.

DHHS also has the opportunity to ensure that enrollees are connected to a continuum of care post-release. We recommend DHHS explore the post-release suite of services needed by this population and consider how best to prioritize referrals to HOP benefits. We also support DHHS' approach to add in Physical and Behavioral Health clinical consultation services, lab and radiology services, medications and medication administration. We also recommend that DHHS consider reviewing and updating this suite of pre-release services on a regular basis in conjunction with PHPs that are serving this population as they become familiar with their needs.

Finally, we encourage DHHS to consider how best to target eligibility criteria. The proposed 1115 Waiver renewal limits eligibility to individuals in state prisons however there are over 24,000 individuals at county jails and federal correctional facilities in North Carolina. In addition, four of the thirteen juvenile detention centers in North Carolina are operated by counties. Therefore, we encourage DHHS to consider taking a phased approach that is inclusive of additional settings to ensure that all individuals released from carceral settings are able to receive the care they need to successfully transition to life in the community.

Continuous Enrollment for Children and Youth

UnitedHealthcare supports DHHS' request for multi-year eligibility for children and youth. Maintaining access to Medicaid eligibility will help ensure that children are fully leveraging benefits under Early, Periodic, Screening, Diagnostic, and Testing requirements of Medicaid. In particular, this approach helps ensure that children receive access to the preventive care and health screenings and treatment needed to support their development. In addition, we know that continuous eligibility for children supports parents in staying connected and engaged in their own health and the health of their children. Finally, supporting continuous enrollment for youth that have aged out of foster care supports their continued access to services and helps ensure that there are no gaps in coverage for this population. There are many challenges these youth are facing as they age out of care and given the particular health and social challenges they face, allowing their health care coverage to continue will support their transition to independence.

Investments in Behavioral Health Technology and Workforce

UnitedHealthcare recognizes the critical need for investments in behavioral health and we support DHHS' request for $45 million in expenditure authority for assistance for providers to

improve access to behavioral health services and promote care integration and whole-person care. We recommend that DHHS specify that to be eligible to receive the health information technology grants, providers must also be participating in Standard Plan networks to incentivize increased integration. We also recommend that DHHS consider allowing recipients of prior provider incentive payments under the Health Information Technology for Economic and Clinical Health Act to apply for grants if there is demonstrated provider gaps in a geographic area and if the provider has identified additional capacity needs.

Conclusion

We look forward to ongoing collaboration with the Department in its efforts to transform health care delivery in North Carolina. UnitedHealthcare further appreciates DHHS's commitment to engaging stakeholders as reforms are developed and before any significant programmatic or payment changes are implemented.

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver Comments
Date: Wednesday, September 20, 2023 10:14:08 AM

Dear Deputy Secretary Ludlam,

Disability Rights North Carolina (DRNC) is North Carolina's federally mandated protection and advocacy organization tasked with defending and advancing the rights of people with disabilities. We appreciate the opportunity to comment on the draft 1115 Demonstration Waiver.

The premise and the promise of managed care implementation in North Carolina was that LME/MCOs would be tasked and empowered to operate local systems of care that would meet the needs of beneficiaries in their catchment areas. LME/MCOs would control their own networks, and set their own reimbursement rates, as required by managed care regulations. For a negotiated rate, LME/MCOs would take on the responsibility and the risk of ensuring access to care. A key premise of managed care is that PHPs negotiate a contract rate that they believe will enable them to meet service needs for those they serve; the MCO sets its own reimbursement rates and then bears the risk of any losses associated with costs that exceed those that were projected, including expenditures associated with paying increased rates necessary to attract and retain providers. It is this feature that creates budget predictability for the state; the state pays one price and the PHP bears the risk of a surplus or loss in performing the contract. MCOs are also given the power to control their own provider networks, and the responsibility to ensure that those networks are adequate to meet the needs of beneficiaries. These obligations are both contractual and required under the managed care regulations. *See*, *e.g*. 42 C.F.R. §§ 207, 438.68 (requiring managed care contracts to include adequate provider network standards).

Behavioral health managed care in North Carolina has not delivered on either the promise of care or budget predictability. LME/MCOs have failed to take the necessary steps – including paying adequate rates – to ensure the provider network meets the needs of beneficiaries. The result is that services are not being delivered as promised, and the State is paying for other governmental services and costs as a result. DHHS has failed to hold MCOs accountable for failing to deliver on their obligations. DRNC hopes that highlighting these implementation issues will result in better outcomes and greater accountability in the future.

1. Continuation of Medicaid Managed Care

Medicaid Managed Care is failing in many ways to serve people with disabilities in NC. It is not meeting either of its two goals, 1. to improve health outcomes through integrated care, and 2. to bring financial predictability to the state budget.

First, North Carolinians with disabilities are not seeing improved outcomes and, in

fact, have extremely high unmet needs. For example, Medicaid pays millions of dollars for institutional non-evidenced based PRTFs that **do not have good outcomes rather than re-purposing that money into community-based resources. In other words, the State is spending a lot of money to achieve bad outcomes.** LME/MCOs as a whole are not meeting their end of the bargain to ensure that NC's provider infrastructure keeps pace with demand. Too many people with disabilities are approved for services but do not receive them because the LME/MCO simply says there are no available providers in the community. In this way and others, institutional bias is baked into the system. People are boarded in emergency rooms or other institutional placements, sometimes out of state, even though they could receive medically appropriate care in a community setting, if only there were providers. Costly readmission rates are extremely high due to the scarcity of providers and inability of individuals to obtain less expensive appropriate services. Delayed rollout of the Tailored Plan due to network inadequacy is another indication of the severity of the provider shortage, which we believe in caused in part by providers' past experiences with the LME/MCOs' complex billing systems and administrative hurdles impeding timely and full payment.

Also, we see cherry picking among providers, leaving what have been called "hard to serve" individuals (who are in fact part of the core population entitled to services) with little to no real care. This is especially evident in the area of behavioral health care and DSPs. The hallmark feature of managed care for people with severe disabilities, Tailored Care Management, was designed to address whole person needs but has proven to be significantly less independent than initially designed, with what we believe is only about 20-25% of participants assigned to independent care managers. This development is especially troubling since it impacts the use of care extenders, many of whom have disabilities themselves and are uniquely positioned to assist others. Reimbursement models absolutely must ensure that home and community-based care workers are paid the same as institutional providers. Also, **hourly pay rates for DSPs absolutely must be raised**, and NC must commit to **mental health parity**. Both are extremely urgent priorities. NC also must engage in **robust public outreach that is equitable and accessible** when new services like Tailored Care Management and 1915(i) roll out. The proposed comments reveal an "unexpectedly low volume of enrollees" in the Healthy Opportunities Pilot (HOP) and low rates of training of Tailored Care Managers, which we believe is a symptom of weak outreach. Because so many people are still unfamiliar with these programs and others, they are not living up to their potential, affecting members with the highest needs, especially those with I/DD. We believe the Department would benefit from one **staff position with authority to act, in charge of overseeing and coordinating all I/DD services and/or other disability categories**, to maximize efficiency and communications, and to ensure that people with specific disabilities learn about and maximize all available services.

Second, Medicaid Managed Care has not created the promised financial predictability to the state. While the capitated rates stabilize the amount of money NCGA allocates for the limited purpose of Medicaid Managed Care, LME/MCOs are collecting those funds and failing to provide services at a level required to meet the needs of Medicaid beneficiaries with disabilities. When needs are not met, the state pays in other ways.

Absent needed behavioral health services, individuals may become justice involved or experience prolonged or frequent hospitalizations, both much more costly and restrictive options. When people cannot find a Direct Support Professional, for example, the costs take the form of lost economic productivity and reduced income tax revenues when family members have to quit work to help a loved one. If Medicaid Managed Care continues, we recommend **strong and robust enforcement of LME/MCO contracts**, meaning not tolerating "lack of providers" or "low staffing" as an excuse. If enforcement is not possible as the contracts are currently written, we recommend editing those contracts or seeking legislative changes if necessary. In violation of *Olmstead,* the current system continues to encourage/strengthen/endorse? institutional bias, forcing people into facilities and then preventing them from leaving. This applies to both adults and children.

In particular the DSS system could be improved with **increased coordination with counties to develop kinship supports, therapeutic foster care, and respite**. We know the Department shares these concerns, and that the General Assembly's failure to expand Medicaid has been a barrier in terms of attracting and retaining quality providers. We hope that expansion will allow the Department to begin creating true benchmarks, deadlines, and accountability. One good start, for example, would be robust implementation of 1915(i) services to help people not already receiving any I/DD services.

2. Expansion of Healthy Opportunities Pilot

We appreciate the proposed expansion of the Healthy Opportunities Pilot, and we believe it has the potential to reduce criminal justice involvement and recidivism of people with disabilities. We also appreciate that the expansion includes people in the Tailored Plan and eligible for Tailored Care Management. We find the eligibility criteria, however, to be unnecessarily complicated, so we are concerned that participation in the program will not be equitable and accessible. We recommend a simplified eligibility process and/or referral program with public outreach.

3. New Justice-Involved Re-Entry Services

We appreciate the Department's embrace and creative use of CMS guidance about ways to support reentry despite the inmate exclusion, and DRNC submitted a joint letter along with several other partners supporting this new model. Here we provide a few additional suggestions we think may make the program even stronger. DRNC is deeply involved in facilitating reentry procedures for people with disabilities exiting the system, and as you know from prior engagement with DRNC on this issue, we support efforts to arrange for Medicaid to be reinstated on the date of release so that people re-entering the community are not only reliant on state funded services, which often are inadequate, especially for those with SUD or OUD. Also, as suggested during public comment by advocate Kerwin Pittman, we believe it is vital that this new service be coordinated with other agencies and **external partners, including people with lived experience and organizations representing those with lived experience. We also recommend that case managers have lived experience and/or be trained in trauma-informed care.** We appreciate that the proposal includes both incarcerated youth and adults, and we request that the **participating facilities be expanded to include PRTFs**, which in many cases are equally if not

more restrictive and traumatic to youth as compared to the other facilities listed in the proposal. Because we regularly monitor in and have youth clients living in PRTFs, we know those residents would benefit from these same services.

4. New Continuous Enrollment for Children and Youth

Children with disabilities whose Medicaid eligibility expires often experience permanent setbacks. When disability needs are not met, children may experience health deterioration, criminal justice involvement, long-term suspension from school, and other extreme, life-altering consequences. We appreciate the Department's commitment to continuous coverage.

5. New Behavioral Health Technology / Workforce Incentives

We appreciate the proposal to provide health information technology (HIT) grants to providers who serve behavioral health patients, and to invest in technology for health in Title I middle and high schools. To the extent possible, we recommend also **including our private-run behavioral health / I/DD specialty schools.** As for workforce, for the reasons set forth above, we strongly support the proposed expansion of the student loan repayment program. To the extent possible, we would like the program to include **social workers, as well as stipends for training or living expenses of people with lived experience who offer peer support at evidence-based community peer support programs providing behavioral health services**. We also strongly support the funding to recruit and retain DSPs and other behavioral health professionals, as long as those professionals commit to working in a community environment. However, we are concerned that the proposal is limited to one-time bonuses and stipends rather than **ongoing hourly pay raises**, which are desperately needed for community based DSPs, as set forth above, to stay competitive in the market. Also, we wonder why a **third-party vendor** is needed to administer the payments, as that appears to create an additional cost for a function that could be performed in the regular course of employment by the LME/MCOs who are already paying their employees.

6. Miscellaneous

The proposed demonstration waiver omits significant public input and engagement between DRNC and DHHS, including litigation and notices of systemic problems. At pages 9, 23, 15, 32, 43, and 50, the proposal indicates that there are no lawsuits or legal actions to report. However, *Samantha R., et al. v North Carolina and the NC Department of Health and Human Services* was pending during the demonstration year and addressed, among other things, adults with I/DD illegally segregated in institutional settings under Medicaid Managed Care. Also, the proposal indicates that during the demonstration year of November 1, 2021 to October 31, 2022, DRNC, along with other organizations, submitted one letter on behalf of constituents to address concerns. In actuality, during the demonstration year, DRNC engaged with and notified the Department approximately monthly of a list of serious problems experienced by people with disabilities as a result of Medicaid implementation problems. Also in November and December 2021 during the demonstration year, Gannett newspapers, including *USA Today*, ran a series of articles exploring NC's continued overreliance on dangerous and abusive Psychiatric Residential Treatment

Facilities (PRTFs). The National Disability Rights Network published *Desperation Without Dignity*, exposing the conditions in for-profit residential facilities for children across the country and in North Carolina. Also in 2022 during the demonstration year, DRNC conducted a series of monitoring visits in PRTFs and reported to the Department via direct communications and public pleas, that children in foster care were experiencing long stays in these highly restrictive, institutional settings. This engagement during the demonstration year may not qualify as a lawsuit, but the failure to address and remedy the problems during the demonstration year did ultimately lead to a lawsuit, *Timothy B et al v. Kody Kinsley*, filed in December 2022, just after the initial demonstration year ended. We believe all this activity should be included in the proposal, as it is highly relevant to assessments of the flaws in the current system.

As always, we appreciate the opportunity to engage, and we hope that you find these comments helpful. Please contact our Policy Director Corye Dunn if you would like to discuss.

Cordially,

Tara Muller

NORTH CAROLINA'S PROTECTION AND ADVOCACY SYSTEM

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From: [redacted]
To: Medicaid.NCEngagement; [redacted]
Cc: [redacted]
Subject: [External] NC Medicaid Section 1115 Waiver
Date: Wednesday, September 20, 2023 9:31:34 AM
Attachments: NC_1115_Waiver_Demonstration_Renewal_Application_20230818_FINAL_Vaya_feedback.pdf

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Attach you will find Vaya's feedback on NC 1115 Waiver Demonstration Renewal Application.

Please let me know if you have any questions.

Thank you

Marvin E. Sanders, MS, HQSI, CI, CHC
Vice President of Regulatory Affairs
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| E [redacted]

From: Gooch, Brenda <brenda.gooch@dhhs.nc.gov>
Sent: Friday, August 25, 2023 10:03 AM
Subject: North Carolina Medicaid Section 1115 Demonstration Renewal Posted for Public Comment

North Carolina will be requesting the Centers for Medicare & Medicaid Services renew the NC Medicaid Section 1115 Demonstration Waiver for a second five-year period, from Nov. 1, 2024 through Oct. 31, 2029. The Demonstration Waiver application has been posted for public comment through September 20, 2023.

The Demonstration Waiver, initially approved in October 2018, supports the state's goal to improve health and well-being for all North Carolinians through a whole-person, well-coordinated system of care that addresses both medical and non-medical drivers of health, while advancing health access by reducing disparities for historically marginalized populations.

Renewing the Demonstration Waiver will allow North Carolina to build on successes and continue the work of the state and its partners, in addition to requesting four new initiatives that will help drive the Department's overall goals. North Carolina is requesting:

- extensions of ongoing managed care authorities;
- expansion of and refinements to the Healthy Opportunities Pilot program; and
- implementation of four new initiatives focused on streamlining Medicaid enrollment for

children and youth; improving care for justice-involved individuals; and investing in behavioral health.

The Department knows that public input is crucial to ensuring the Demonstration Waiver will best serve the people of North Carolina. Five public hearings will be held; three will be in-person throughout the state and two will be online. These public hearings will provide an overview of the renewal application and gather comments. To ask questions about accessibility or request accommodations, please email Medicaid.NCEngagement@dhhs.nc.gov. At least two weeks' advance notice will help us to provide seamless access.

Tuesday, Sept. 5, 2023, from 9:30-11 a.m. (in person)
Mountain Area Health Education Center (MAHEC)
Blue Ridge A & B in the Education Building
121 Hendersonville Road, Asheville, NC 28803

Wednesday, Sept. 6, 2023, from 9:30-11 a.m. (in person)
McKimmon Conference & Training Center
NC State University, 1101 Gorman Street, Raleigh, NC 27606

Wednesday, Sept. 6, 2023, from 5:30-7 p.m.
Virtual via Microsoft Teams, join on your computer, mobile app or room device.
Click here to join the meeting
Call in (audio only)
+1 984-204-1487, 902948880# United States, Raleigh
Phone Conference ID: 902 948 880#

Thursday, Sept. 7, 2023, from 2:30-4 p.m. (in person)
Greenville Convention Center
303 SW Greenville Blvd., Greenville, NC 27834

Friday, Sept. 15, 2023, from 11:30 a.m.-12:30 p.m. (during the Medical Care Advisory Committee Meeting)
Virtual via Microsoft Teams, join on your computer, mobile app or room device.
Click here to join the meeting
Call in (audio only)
+1 984-204-1487, 412615457# United States, Raleigh
Phone Conference ID: 412 615 457#

Written comments also will be accepted by email or U.S. Mail through 5 p.m., Wednesday, Sept. 20, 2023. Please include “NC Medicaid Section 1115 Waiver” as the subject.

Email: Medicaid.NCEngagement@dhhs.nc.gov

U.S. Mail:
North Carolina Department of Health and Human Services
NC Medicaid Section 1115 Waiver Team
1950 Mail Service Center
Raleigh, NC 27699-1950

More information on the Demonstration Waiver renewal along with the draft proposed application are available on the NC Medicaid website at medicaid.ncdhhs.gov/meetings-notices/proposed-program-design/nc-section-1115-demonstration-waiver.

Thank you for your assistance.

Brenda Gooch
Senior Manager, Non-Emergency Medical Transportation
NC Medicaid
Division of Health Benefits

NC Department of Health and Human Services

(919) 270-4104 Office
[redacted]

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North Carolina Medicaid Reform Section 1115 Demonstration Renewal Application

State of North Carolina

Department of Health and Human Services

Release Date: August 21, 2023

Draft for Public Comment (8/21/23 through 9/20/23)

This draft is intended for public comment. Based on public input and continuing analyses, all figures and descriptions may be subject to refinement prior to submission to CMS.

Contents

Section I – Program Objectives and Vision

Introduction

North Carolina Medicaid provides comprehensive health care coverage to over two million state residents. Since receiving federal approval for the North Carolina Medicaid Reform Demonstration[1] on October 19, 2018, North Carolina has undertaken significant efforts to transform its Medicaid program in line with its overarching goal of improving health and well-being for all North Carolinians through a whole-person, well-coordinated system of care that addresses both medical and non-medical drivers of health and advances health access by reducing disparities for historically marginalized populations. Specifically, North Carolina is in the midst of implementing a significant managed care transition, affecting the majority of Medicaid enrollees. Ultimately, eligible, non-dually enrolled individuals will be enrolled in managed care through three types of managed care plans, or Prepaid Health Plans (PHPs): Standard Plans (currently available), Behavioral Health and Intellectual/Developmental Disabilities (Tailored Plans), and a Children and Families Specialty Plan, all of which offer or will offer comprehensive physical health, behavioral health, LTSS, and pharmacy services, in addition to care management programs serving enrollees with the most intensive needs. Members of federally recognized tribes, including members of the Eastern Band of Cherokee Indians (EBCI), may voluntarily enroll in PHPs on an opt-in basis. Individuals who are not enrolled in PHPs will continue to receive services through NC Medicaid Direct or the EBCI Tribal Option. North Carolina also instituted reforms to strengthen its substance use disorder (SUD) delivery and launched the nation's first Medicaid-funded health-related social needs (HRSN) pilot program, called the Healthy Opportunities Pilot.

Commented [RB1]: First time use of an acronym should be spelled out.

During this demonstration period, North Carolina also learned important lessons as it navigated the COVID-19 Public Health Emergency (PHE), which significantly disrupted ongoing implementation efforts and diverted key agency resources towards emergency response, resulting in delays to the launch of all of the managed care reforms noted above. In addition to these notable transformation efforts, during this demonstration period, North Carolina also obtained initial legislative authorization in March 2023 to expand Medicaid eligibility to childless adults under the Affordable Care Act (ACA), once a State budget has been enacted. Once implemented on October 1, 2023, this measure is expected to result in health coverage for over 600,000 North Carolinians.

North Carolina is now seeking to renew its Section 1115 demonstration for another five-year period to continue the important work underway and pursue select new opportunities to advance the State's goal of improving health and well-being for all North Carolinians through a whole-person, well-coordinated system of care that addresses both medical and

[1] North Carolina Demonstration Approval October, 19 2018 (link)

non-medical drivers of health and advances health access by reducing disparities for historically marginalized populations.

Historical Summary of the Medicaid Reform Demonstration: 2019-2024

On October 19, 2018, North Carolina received federal approval for the North Carolina Medicaid Reform Demonstration. The goals of this demonstration are to:

- Measurably improve health outcomes with the implementation of a new delivery system;
- Maximize high-value care to ensure sustainability of the Medicaid program; and
- Reduce substance use disorder (SUD).

Over the demonstration period, North Carolina has made significant strides towards achieving these goals by:

- **Launching Standard Plans:** On July 1, 2021, North Carolina transitioned most of its non-dually eligible Medicaid enrollees to fully capitated and integrated managed care plans called Standard Plans. Standard Plan members receive integrated physical health, behavioral health, long term services and supports (LTSS), and pharmacy services. As of July 2023, approximately 1.9 million Medicaid enrollees receive care across the five Standard Plans. North Carolina has also launched its Advanced Medical Home (AMH) program to provide community-based care management to higher need Standard Plan enrollees.
- **Preparing to Launch Behavioral Health and Intellectual / Developmental Disabilities (Tailored Plans):** North Carolina is planning to launch specialized managed care plans for approximately 160,000 individuals with intensive behavioral health conditions (including serious mental illness, serious emotional disturbance, and severe SUD), intellectual and developmental disabilities (I/DD), traumatic brain injury (TBI), called Tailored Plans.

  Tailored Plan members will have access to all Standard Plan services, in addition to specialized behavioral health and I/DD services to meet their needs, including, but not limited to, Innovations and TBI waiver and 1915(i) services. The specialized services will include Tailored Care Management, a health home benefit designed to address Tailored Plan members' whole-person needs across physical health, behavioral health, I/DD, TBI, pharmacy, LTSS, and unmet HRSNs.
- **Preparing to Launch the Children and Families Specialty Plan (CFSP):** North Carolina is preparing to launch the CFSP. The CFSP, formerly referred to as the "Specialized Foster Care Plan," will be a single statewide managed care plan that seeks to mitigate disruptions in care and coverage for children, youth, and families

served by the child welfare system.

Designed to meet the unique health care needs of this population and maintain treatment plans across placement changes, the CFSP will offer all benefits available in Standard Plan and nearly all benefits covered by Tailored Plans. The CFSP will include a robust, integrated care management model that helps coordinate a member's needed health and health-related services and support transitions between treatment settings or health plans to ensure continuity of care and transition planning, and serve as the central entity accountable for the care of these members.

- **Implementing the SUD Component of the Demonstration:** The current demonstration includes expenditure authority for the state to obtain Medicaid match for services provided to short-term residents of institutions for mental diseases (IMDs) who are obtaining SUD treatment. Concurrently, North Carolina is expanding its continuum of SUD services available and fully aligning with American Society of Addiction Medicine (ASAM) standards. Since beginning implementation on May 1, 2019, North Carolina has observed a 26 percent increase in the number of Medicaid enrollees with SUD who accessed medication-assisted treatment.

  The SUD expenditure authority expires on October 31, 2023. Therefore, North Carolina is preparing to submit a five-year extension request to CMS through a separate application, and intends to align effective and expiration dates across all demonstration components during the next demonstration period.

- **Implementing Healthy Opportunities Pilot (HOP):** On March 15, 2022, North Carolina began delivering the first of a broad array of services intended to address unmet Health Related Social Needs (HRSNs). HOP is the nation's first comprehensive program under Medicaid to test and evaluate the impact of providing select evidence-based, non-medical interventions related to housing, food, transportation, and interpersonal safety and toxic stress. To date, North Carolina has built networks of community-based providers, enrolled over 9,000 enrollees, launched 28 services across three largely rural regions, and delivered 70,025 services.[2]

Vision and Goals for 1115 Demonstration Renewal

During the first demonstration period, North Carolina began its transition to managed care and invested in novel programs to better respond to the diverse needs of North Carolinians who are enrolled in Medicaid. North Carolina is now ready to build on early successes and lessons learned to continue this progress over the next 5-year 1115 demonstration period, while also implementing select new targeted initiatives in line with the State's overall goal

[2] North Carolina Department of Health and Human Services. Healthy Opportunities Pilots at Work (**link**)

to improve health and well-being for all North Carolinians through a whole-person, well-coordinated system of care that addresses both medical and non-medical drivers of health and advances health access by reducing disparities for historically marginalized populations.

Section II – Continuing Demonstration Features and Changes Requested to the Demonstration

North Carolina's overarching goal for its 1115 demonstration renewal is to improve health and well-being for all North Carolinians through a whole-person, well-coordinated system of care that addresses both medical and non-medical drivers of health and advances health access by reducing disparities for historically marginalized populations.

The 1115 demonstration renewal will advance this goal through the following specific objectives and related initiatives:

Objective 1: Support a continued, smooth transition to managed care with a focus on improving care for enrollees with the most complex needs:

- **Initiative 1a.** Provide integrated whole-person, well-coordinated care for the majority of Medicaid enrollees through continued implementation of Standard Plans.
- **Initiative 1b.** Provide integrated care for individuals with serious mental illness, serious emotional disturbance, severe SUD, I/DD, and/or TBI, through the launch of Tailored Plans.
- **Initiative 1c.** Provide integrated care to address the complex needs of children and families served by the child welfare system and former foster youth through the implementation of the CFSP.

Objective 2: Strengthen access to a person-centered and well-coordinated system of care which addresses both medical and non-medical drivers of health:

- **Initiative 2a.** Build on HOP infrastructure investment and experience to expand HRSN services to North Carolinians across the state.
- **Initiative 2b.** Promote continuity of care by offering continuous enrollment in Medicaid to children and former foster care youth.
- **Initiative 2c.** Improve health outcomes and support reentry into the community for justice-involved individuals by providing targeted pre-release Medicaid services.

Objective 3: Strengthen the behavioral health and I/DD delivery system:

- **Initiative 3a.** Reduce incidence of OUD/SUD by providing Medicaid coverage for individuals obtaining short-term residential services for SUD in an IMD.

- **Initiative 3b.** Improve the coordinated system of care for people with behavioral health and I/DD needs through targeted new investments in technology.
- **Initiative 3c.** Bolster the behavioral health and LTSS workforce.
- **Initiative 3d.** Expand access to critical supports offered under1915(i) authority.

Objective 1: Ensure Smooth Transition to Managed Care

Objective 1: North Carolina seeks to ensure a continued, smooth transition to managed care, with a focus on improving care for Medicaid enrollees with the most complex needs through the following initiatives:

- **Initiative 1a.** Provide integrated whole-person, well-coordinated care for the majority of Medicaid enrollees through continued implementation of Standard Plans.
- **Initiative 1b.** Provide integrated care for individuals with serious mental illness, serious emotional disturbance, severe SUD, I/DD, and/or TBI, through the launch of Tailored Plans.
- **Initiative 1c.** Provide integrated care to address the complex needs of youth and families served by the child welfare system through the implementation of the CFSP.

North Carolina is broadly requesting continued authority across its managed care initiatives to (1) allow for phase-in of managed care programs as set forth in this application; (2) continue mandatory enrollment in managed care[3]; and (3) enable the State to vary the amount, duration, and scope of services offered to individuals in managed care under this demonstration, regardless of eligibility category. More information on the initiative-specific demonstration requests is outlined below.

Initiative 1a: Continued Implementation of Standard Plans

Background

In July 2021, North Carolina completed the first phase of managed care implementation with the launch of Standard Plans. This program provides integrated physical health, behavioral health, long-term services and supports (LTSS), and pharmacy services for the majority of North Carolina's Medicaid enrollees.

Standard Plan Renewal Request

Under the next demonstration period, North Carolina requests to extend the authority to implement Standard Plans for the next 5-year 1115 demonstration renewal period. The

[3] Enrollees have choice with respect to network providers once enrolled in a managed care plan.

Standard Plans will continue to serve the majority of enrollees by providing integrated physical health, behavioral health, long-term services and supports (LTSS), and pharmacy services. See Section III for additional information on benefits, eligibility, delivery system changes, and cost sharing for Standard Plans.

Initiative 1b: Launch of Tailored Plans

Background

Due to the COVID-19 pandemic and other factors, including organizational consolidation among local management entity/managed care organizations (LME/MCO), North Carolina has yet to implement Tailored Plans, which were authorized during the initial demonstration period.

Tailored Plan Renewal Request

Under the next demonstration, North Carolina requests to extend the authority to launch and implement Tailored Plans for the next 5-year 1115 demonstration renewal period. Managed care-eligible Medicaid enrollees with serious mental illness, serious emotional disturbance, severe SUD, I/DD, and/or TBI will be enrolled in Tailored Plans, which will be regional, specialized managed care products focused on the needs of these populations. The State is requesting to continue the ability to offer a set of specialized behavioral health and I/DD services in the Tailored Plans that are not offered in the Standard Plans; specifically Tailored Plans will offer Innovations and TBI waiver services, 1915(i) services, and North Carolina's Tailored Care Management Health Home benefit, in addition to the most intensive State Plan behavioral health and I/DD services. In addition to managing Medicaid services, Tailored Plans will be responsible for managing state-funded behavioral health, I/DD and TBI services.

North Carolina is requesting to continue its existing expenditure authority that permits the State to limit the choice to a single Tailored Plan in each county for individuals meeting one of the following criteria:

- Individuals who reside in an intermediate care facility for individuals with intellectual disabilities (ICF-IID)
- Individuals who participate in North Carolina's Transitions to Community Living
- Individuals who are enrolled in the Innovations or Traumatic Brain Injury 1915(c) waiver
- Individuals who receive services/supports in state-funded residential treatment (i.e., individuals receiving services to support them in their residence/house setting, including services provided in group homes or non-independent settings such as Group Living, Family Living, Supported Living, and Residential Supports).

See Section III for additional information on benefits, eligibility, delivery system changes, and cost sharing for Tailored Plans.

Commented [RB2]: Will this line change with the expansion of the current process of Provider-TCMs trained in TCL who achieve the designator?

Initiative 1c: Launch of Children and Families Specialty Plan

Background

North Carolina has yet to implement the Children and Families Specialty Plan (CFSP) for which it previously obtained authority.

Children and Families Specialty Plan Renewal Request

Under the next demonstration period, North Carolina requests to extend the authority to launch and implement the CFSP for the 5-year 1115 demonstration period. The CFSP, formerly referred to as the "Specialized Foster Care Plan," will be a single statewide managed care plan that seeks to mitigate disruptions in care and coverage for the following groups:

- Children in foster care;
- Children receiving adoption assistance;
- Former foster youth up to age 26;
- Parents and caretaker relatives of children/youth in foster care who are making reasonable efforts to comply with a court-ordered plan of reunification;
- Siblings of children/youth in foster care;
- Minor children and certain family members receiving Child Protective Services In-Home Services; and
- Minor children of children/youth in foster care, of children/youth receiving adoption assistance, or of former foster youth.

This plan is designed to meet the unique health care needs of this population and enable children, youth and families served by the child welfare system across the state to access a broad range of physical health, behavioral health, pharmacy, LTSS, and I/DD services and resources to address unmet HRSNs and maintain treatment plans even if placement changes occur. The State is requesting to continue its authority to offer a specialized set of services for the CFSP in comparison to the Standard Plans. Specifically, the CFSP will offer all of the specialized behavioral health and I/DD State Plan benefits besides ICF-IID that will be available through Tailored Plans, in addition to 1915(i) services. The CFSP must meet a set of requirements ensuring robust care management and medication management specifically for this vulnerable population. See Section III for additional information on benefits, eligibility, delivery system changes, and cost sharing for CFSP.

Commented [RB3]: Is this synonymous with the bullets above or separate? Could "child welfare system" be defined? It occurs a few times in this document before this point.

Objective 2: Strengthen Access to Whole-Person, Coordinated Care

Objective 2: North Carolina seeks to strengthen access to a person-centered and well-coordinated system of care which addresses both medical and non-medical drivers of health through the following initiatives:

- **Initiative 2a.** Build on Healthy Opportunities Pilots (HOP) infrastructure investment and experience to expand HRSN services to North Carolinians across the state.
- **Initiative 2b.** Promote continuity of care by offering continuous enrollment in Medicaid to children and former foster care youth.
- **Initiative 2c.** Improve health outcomes and support reentry into the community for justice-involved individuals by providing targeted pre-release Medicaid services.

Initiative 2a: Healthy Opportunities Pilot

Background

In October 2018, North Carolina received federal 1115 demonstration authority to implement the Healthy Opportunities Pilot (HOP). HOP is a comprehensive program to test and evaluate the impact of providing evidence-based, non-medical interventions that address housing instability, transportation insecurity, food insecurity, interpersonal violence (IPV) and toxic stress to qualifying Medicaid enrollees. Through HOP, North Carolina is dedicated to ensuring enrollees can access necessary HRSN services in a way that meets their needs and improves their health. At the same time, HOP has strengthened community capacity to provide HRSN services, enabled a diverse ecosystem of stakeholders to work together, and pursued the elimination of health disparities across the Pilot regions.

Today, Medicaid enrollees must live in one of the three regions where HOP operates and have at least one qualifying physical or behavioral health condition and one qualifying social risk factor to receive Pilot services.

Pilot services include 29 HRSN services defined and priced in the State's Pilot fee schedule, 28 of which have been launched. The fee schedule was originally approved by CMS in December 2019. These services were selected based on their potential to improve health outcomes and/or lower health care costs and address the needs of qualifying enrollees. To ensure system readiness, HOP was launched in March 2022 with a purposefully limited scope and scale, focusing first on food and nutrition services, before expanding to housing and transportation, toxic stress, and most recently, services targeted to address IPV. The phased approach allowed the Department to work closely with a wide range of partners, quickly address issues that arose and focus on emerging best practices—thereby ensuring a smooth launch. Despite the challenges associated with launching the program during the COVID-19 pandemic, HOP began delivering services in March 2022 and as of May 31, 2023, has provided over 82,000 services to over 10,000 enrollees across the three Pilot regions.

A diverse set of stakeholders across the health and human services continuum work together to implement and operate HOP. Key Pilot entities and respective responsibilities include:

- North Carolina Department of Health and Human Services (NCDHHS): North Carolina is responsible for designing, establishing and overseeing HOP, and is accountable to CMS for all aspects of the program.
- HOP Administrators[4]: HOP Administrators ~~s~~ are responsible for approving which individuals qualify for the HOP, and which services they receive. HOP Administrators also manage a capped allocation of funding to pay for Pilot services delivered by HSOs and other administrative expenses.
- Care Managers: Care Managers work with Medicaid enrollees on their full range of physical, behavioral and non-medical needs and work with the HOP Administrators to identify people who would benefit from and qualify for Pilot services. Care managers are responsible for proposing services that may benefit the individual, and coordinate, track and manage their Pilot services over time.
- Network Leads: Network Leads serve as a single point of accountability for HSOs and HOP Administrators, effectively bridging the gap between the healthcare and social services industries. Network Leads develop and manage a high-quality network of HSOs, provide technical assistance and distribute capacity-building funds to ensure HSOs are able to participate in the HOP.
- Human Service Organizations (HSOs): HSOs, comprised of community-based organizations and social service agencies, contract with Network Leads to deliver high-quality Pilot services in a culturally competent manner to qualifying individuals. HSOs develop capabilities to participate in the health care delivery system, including tracking, reporting and invoicing for Pilot services delivered to Pilot enrollees.

Healthy Opportunities Pilot Renewal Request

Under the next demonstration period, North Carolina requests to renew all prior features of HOP, in addition to implementing new Pilot-related program changes during the demonstration period. Specifically, North Carolina is requesting $1.7 billion in total computable expenditure authority for HOP services, allowing the State to expand HOP statewide, scale services, and make other program improvements over the course of the next demonstration. North Carolina is also requesting $300 million in total computable HOP capacity building funding to support expansion of these services across the State. North Carolina currently has the authority to operate HOP in select regions of the State, with one

[4] HOP Administrators include Prepaid-Health Plans (PHP) and other non-PHP Managed Care Entities including Primary Care Case Management Entities (PCCM-Es), Primary Care Case Managers (PCCMs), Prepaid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs) as defined in the State s special terms and conditions.

Network Lead per region. To support statewide HOP operations, the State intends to procure additional Network Leads who will in turn develop HSO networks statewide.

These requested changes build on the lessons learned and successes of HOP to date. Central to HOP is the Department's commitment to continuous improvement, transparency and learning. HOP is the first initiative of its kind, a large-scale undertaking reliant on partnerships between organizations with different cultures, missions and business practices that have not historically worked together. Continuous improvement is vital to promoting an environment of shared learning and evolution based on these organizations' experiences on-the-ground. The State intends to continue its practice of gathering and analyzing real time data about Pilot enrollment, service delivery and partnership development between organizations via Rapid Cycle Assessments (RCAs). North Carolina's recent RCA revealed that North Carolina has been successful in implementing Pilot infrastructure and establishing effective collaborations between the State, HOP Administrators, healthcare systems, and HSOs to enable the delivery of Pilot services in current Pilot regions. This includes development of a statewide technology platform that allows Pilot entities to leverage a single system for exchanging Pilot data and operationalizing HOP, implementation of required legal and regulatory systems, and effective relationship-building with stakeholders. The RCA preliminarily found that Pilot enrollees receiving services are reporting decreased needs in respective domains. While this data is based on a limited period of Pilot service delivery, these early findings highlight the potential for HOP to meaningfully address the HRSN of enrollees. North Carolina is well positioned to scale these early successes from the first demonstration period to broaden the reach of HOP and impact population health. North Carolina remains committed to continuous improvement, transparency and learning as HOP expansion proceeds in the demonstration period.

Commented [JM4]: Could it be of benefit to include specific data on these findings?

Eligibility

Under the current waiver, to be eligible for and receive Pilot services, Medicaid enrollees must live in one of the three Pilot regions and have at least one qualifying physical or behavioral health condition and one qualifying social risk factor, as defined in Attachment G of the existing demonstration. Based on experience to date, the State is seeking authority to expand the geographic reach of HOP statewide and expand Pilot eligibility criteria to allow additional high-need individuals to access Pilot services.

Requested changes HOP eligibility that build on the state's existing criteria include:

- For adults 21+, presence of one or more chronic conditions
- Individuals "at risk of" a chronic condition across all eligibility categories
- All pregnant women enrolled in Medicaid
- All Tailored Plan enrollees and individuals eligible for Tailored Care Management in

Prepaid Inpatient Health Plans (PIHPs)

- Individuals who are currently or have recently been impacted by natural disasters
- Individuals who have recently been released from incarceration
- Children/youth who receive adoption assistance

Services

North Carolina currently has authority to provide 29 Pilot services across four domains (housing, food, transportation and interpersonal violence/toxic stress) in Pilot regions. North Carolina will determine which services are scaled in new regions of the State based on service effectiveness, regional and population-based readiness to participate, and HSO capacity to provide select Pilot services. The State requests to continue offering and testing the efficacy of all existing services in current Pilot regions:

Housing

- Housing Navigation, Support and Sustaining Services
- Inspection for Housing Quality
- Housing Move-In Support
- Essential Utility Set-Up
- Home Remediation Services
- Home Accessibility and Safety Modifications
- Healthy Home Goods
- One-Time Payment for Security Deposit and First Month's Rent
- Short-Term Post Hospitalization Housing

Interpersonal Violence (IPV) and Toxic Stress

- IPV Case Management Services
- Violence Intervention Services
- Evidence-Based Parenting Curriculum
- Home Visiting Services
- Dyadic Therapy

Food

- Food and Nutrition Access Case Management Services
- Evidence-Based Group Nutrition Class
- Diabetes Prevention Program
- Fruit and Vegetable Prescription
- Healthy Food Box (For Pick-Up)
- Healthy Food Box (Delivered)
- Healthy Meal (For Pick-Up)
- Healthy Meal (Home Delivered)
- Medically Tailored Home Delivered Meals

Transportation

- Reimbursement for Health-Related Public Transportation
- Reimbursement for Health-Related Private Transportation
- Transportation PMPM Add-On for Case Management Services

Cross-Domain

- Holistic High Intensity Enhanced Case Management
- Medical Respite
- Linkages to Health-Related Legal Supports

The State is also seeking authority to modify the Pilot services as follows:

- Allow up to three meals per day for key Pilot services within the food domain, including Healthy Food Boxes, Healthy Meals and Medically Tailored Meals
- Adapting existing service to provide six months of rental assistance (including payment of arrears) for high-needs enrollees
- Add a new "firearm safety" service that provides, at a minimum, locks and/or safes to support firearm safety.

In addition, the State wishes to retain its existing ability to remove Pilot services as appropriate, based on experience, service effectiveness, and HSO capacity to provide services across the State.

Other Program Improvements

Central to the existing Pilot model is the essential role of the Network Lead as a bridge between health care (HOP Administrators and care management entities) and social services (HSOs). Network Leads contract with HOP Administrators on behalf of their networks of HSOs, providing a level of standardization and consistency to both entities. Existing and new Network Leads will continue to play an essential role in Pilot administration. At the same time, the State wishes to foster innovation and flexibility with contracting relationships among HOP entities that are ready and prepared to do so. The State is seeking authority to allow HOP Administrators and HSOs to contract directly with one another where both parties have demonstrated readiness to do so.

Capacity Building Funds

North Carolina is requesting $300 million in total computable HOP capacity building funding to support expansion of the Pilot statewide. The State's first RCA indicated that access to capacity building funding was critical to developing the necessary systems, relationships and infrastructure to deliver Pilot services. Capacity building funds will build on the investments made during the prior demonstration by further building the necessary infrastructure to deliver Pilot services statewide. This funding will support HOP-related capacity building activities, including but not limited to: building the capabilities necessary to execute Pilot responsibilities, conducting stakeholder engagement and training/technical assistance,

Commented [JM5]: How is this defined?

Commented [RB6]: Would like the training to also provide a teaching element to children and families, such as: 1) what to do if you find a fire arm, 2) how to support a loved one in crisis who has access to a gun. Cub Scouts teaches kids if they find a gun to leave the scene, to get help, AND take their friend with them.

Commented [SF7]: Can this also include the opportunity for HOP Administrators to act as a Network Lead?

community engagement activities, hiring and training new staff, strengthening health information technology systems, essential overhead costs, and establishing operational workflows processes necessary participate in HOP.

Initiative 2b: Continuous Enrollment for Children

Background

Nationally, approximately four in ten children eligible for Medicaid/CHIP who are disenrolled, are re-enrolled within one year, also known as "churn."[5] In North Carolina, of youth who lose coverage, one in four regained coverage within the year.[6] This temporary loss in coverage can lead to gaps in care during critical periods of child development as well as administrative confusion and complexity.[7] Continuous enrollment can help reduce churn, prevent disruptions in care, and promote access to healthcare , while also reducing administrative burden for the state, counties, and families.

North Carolina currently offers a 12-month period of continuous enrollment for children ages 0 to 18.

Continuous Eligibility Renewal Request

Under the next demonstration, North Carolina is requesting authority to implement continuous enrollment for young children through age five and extend the continuous enrollment period to 24 months for children and youth ages six through 18. North Carolina is also requesting to offer continuous enrollment to youth who aged out of foster care prior to January 1, 2023 until age 26, aligning eligibility determination practices for these former foster care youth with other former foster care youth who aged out of foster care after January 1, 2023.

For children and youth, these continuous enrollment changes will be a valuable tool to help ensure that individuals receive critical screenings, vaccinations, and preventative services early in life.[8] Moreover, providing continuous enrollment during vulnerable periods, such as when an individual ages out of the foster care system, can help promote access to much-needed services that address physical health, behavioral health, and HRSNs.[9] North Carolina expects that more than 140,000 children and youth will benefit from these continuous enrollment changes annually, once fully implemented.

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[5] Medicaid and CHIP Payment and Access Commission. An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP. 2021 (**link**)
[6] Duke University. Churn Patterns Among Youth Medicaid Beneficiaries in North Carolina: 2016-2018. 2021 (**link**)
[7] Kaiser Family Foundation. Medicaid Enrollment Churn and Implications for Continuous Coverage Policies. December 2021 (**link**)
[8] Kaiser Family Foundation. Implications of Continuous Eligibility Policies for Children s Medicaid Enrollment Churn. December 2022 (**link**)
[9] Child Welfare and Foster Care Statistics. May 2023 (**link**)

Eligibility

Under the demonstration renewal, except for individuals eligible for Medicaid on the basis of 42 CFR 435.217, section 1902(a)(10)(C) of the Act and 42 CFR 435.301, or individuals eligible for Medicaid under the non-MAGI or aged, blind, and disabled categories, the following groups of children and youth will be eligible for the following extended periods of continuous enrollment:

- Children ages zero through five who enroll in Medicaid shall qualify for continuous enrollment beginning on the effective date of the child's most recent eligibility determination or redetermination and extending through the end of the month in which their sixth birthday falls;
- Individuals ages six through 18 who enroll in Medicaid shall qualify for a 24-month continuous enrollment period beginning on the effective date of the individual's most recent eligibility determination or redetermination; and
- Individuals under age 26 who aged out of foster care prior to January 1, 2023 and were enrolled in Medicaid at the time they aged out shall qualify for continuous enrollment period beginning on the effective date of the individual's most recent eligibility determination or redetermination extending through the end of the month in which their twenty-sixth birthday falls. This will align eligibility determination practices for these former foster care youth with other former foster care youth who aged out of foster care after January 1, 2023.

If any of the following circumstances occur during an individual's designated continuous eligibility period, the individual's Medicaid eligibility shall be redetermined or terminated:

- The individual is no longer a North Carolina resident;
- The individual requests termination of eligibility;
- The individual dies; or
- The agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual.

North Carolina will establish procedures designed to ensure that enrollees can make timely and accurate reports of any changes in circumstances that may affect their eligibility as outlined in this demonstration. For all continuous enrollment periods longer than 12 months, North Carolina will establish procedures and processes to accept and update enrollee contact information on an annual basis and to check for the exceptions defined above and as required by CMS.

Initiative 2c: Coverage for Pre-Release Services for Justice-Involved Individuals

Commented [CO8]: Vaya is in full support of Initiative 2c.

Background

Approximately 57,000 adults and youth in North Carolina were incarcerated as of May 2023.[10] Stark racial disparities are reflected across the state's justice-involved population;[11] Black adults are nearly six times as likely and Hispanic adults are approximately three times as likely to be incarcerated as individuals of other races. Individuals leaving incarceration are particularly at risk of experiencing poor health outcomes. Compared to individuals who have never been incarcerated, justice-involved individuals have higher rates of physical and behavioral health needs.[12] Among justice-involved individuals who were recently released from a correctional setting in North Carolina, approximately 30% are identified as having physical health needs, approximately 75% are identified as having substance use disorder (SUD), and approximately 50% are identified as having other mental health needs.[13] Those recently released from a correctional setting in the state also have significant health-related social needs: 29% are identified as having housing needs, 71% are identified as having transportation needs, and around 45% are identified as having vocational or employment needs.[14]

Moreover, justice-involved individuals are particularly vulnerable during the period immediately following release from a correctional setting, with one study reporting that the risk of death is over 10 times greater during this period for justice-involved individuals as compared to community members who are not involved with the justice system.[15] In North Carolina, individuals recently released from correctional settings are 40 times more likely to suffer an opioid overdose compared to individuals who have never been incarcerated.[16]

Justice-Involved Reentry Request

Ensuring continuity of health coverage and care and improving health outcomes for justice-involved populations is a high priority for North Carolina.[17] In line with this goal, and with CMS guidance,[18] North Carolina is requesting authority for federal Medicaid matching funds to provide a set of targeted Medicaid services to eligible justice-involved populations within the 90-day period prior to release, and to provide $315 million total computable in capacity

[10] Prison Policy Initiative (link)
[11] Governor Cooper Establishes Task Force to Address Racial Inequity in the State Criminal Justice System. June 2020 (link)
[12] The Commonwealth Fund. September 2022 (link)
[13] Correctional Program Evaluation. 2019 (link)
[14] Correctional Program Evaluation. 2019 (link)
[15] The Commonwealth Fund. September 2022 (link)
[16] NCDHHS Announces Funding Opportunity to Serve Justice-Involved Individuals as COVID-19 Impacts Overdoses. October 2021 (link)
[17] North Carolina Department of Health and Human Services 2021-2023 Strategic Plan (link)
[18] CMS State Medicaid Directors Letter on Justice-Involved Reentry. April 2023 (link)

building funding to support service delivery. These services will be available to individuals incarcerated in the State's prisons as well as to individuals incarcerated in select county- and tribal-operated jails and youth correctional facilities.

Eligibility

North Carolina aims to implement this initiative in its 53 State prisons over the course of the demonstration, as well as in a subset of county- and tribal-operated jails and youth correctional facilities that meet Department-defined readiness standards (e.g., have automated enrollment and suspension services, have agreed to participate in the initiative, and have appropriate operational capacity).

North Carolina will phase in participating correctional facilities based on readiness over the course of the demonstration period.

All adults and youth who are incarcerated in a participating correctional setting and are enrolled in Medicaid will be eligible to access pre-release services. Services will be available to individuals both pre- and post-adjudication. North Carolina estimates that approximately 39,000 individuals will receive pre-release services under this demonstration.

Benefits

North Carolina seeks public comment on the scope of pre-release services that should be offered beginning up to 90-days prior to release from a participating correctional setting. Eligible individuals will, at a minimum, be able to access the following three services:

- **Case Management** under which case managers will establish client relationships, conduct a needs assessment, develop a person-centered care plan, and make appropriate linkages and referrals to post-release care and supports.
- **Medication Assisted Treatment (MAT)** including medication in combination with counseling/behavioral therapies, as clinically appropriate.
- **At a Minimum, a 30-Day Supply of Prescription Medication** in hand upon release, consistent with Medicaid State Plan coverage.

In addition to the above three services, the following additional services will be phased in over the course of the demonstration period based on readiness to implement:

- **Physical and Behavioral Health Clinical Consultation Services** that are intended to support the creation of a comprehensive, robust, and successful reentry plan, such as clinical screenings and pre-release consultations with community-based providers.
- **Laboratory and Radiology Services** as clinically appropriate, consistent with Medicaid State Plan coverage.
- **Medications and Medication Administration** as clinically appropriate, consistent with Medicaid State Plan coverage.

Commented [CO9]: Vaya's current Department of Adult Corrections Re-Entry Coordination is underway with processes which encompass the case management component. We look forward to sharing data outcomes and recommend this program be expanded upon to fulfill this element of the initiative.

- **Tobacco Cessation Treatment Services** as clinically appropriate.
- **Durable Medical Equipment Upon Release** in hand upon release, consistent with Medicaid State Plan coverage.

Capacity Building Funds

To support cross-system implementation efforts for this initiative, North Carolina is requesting $315 million total computable in capacity building funds. Capacity building funds will be available to entities partnering with DHHS to implement the initiative, including correctional facilities. This funding will support planning and implementation activities, including but not limited to: conducting stakeholder engagement, hiring and training new staff, strengthening health information technology systems, and establishing new operational workflows, processes, and space modifications needed to implement this initiative across participating correctional settings.

Commented [CO10]: In addition to capacity building funds, we recommend provision for a small amount of funding per participant to assist with initial Social Determinant of Health (SDOH) needs such as clothing, food, shelter. This could be modeled off the Transition Year Stability Resource (TYSR) allowances and guidelines in the Transitions to Community Living program.

Objective 3: Strengthen Behavioral Health and I/DD Delivery System

Objective 3: Strengthen the behavioral health and I/DD delivery system through the following initiatives:

- **Initiative 3a.** Reduce incidence of OUD/SUD by providing Medicaid coverage for individuals obtaining short-term residential services for SUD in an IMD.
- **Initiative 3b.** Improve the coordinated system of care for people with behavioral health and I/DD needs through targeted new investments in technology.
- **Initiative 3c.** Bolster the behavioral health and LTSS workforce.
- **Initiative 3d.** Expand access to critical supports offered under 1915(i) authority.

Initiative 3a: Providing Medicaid Coverage for Individuals Obtaining Short-Term SUD Treatment in IMDs

Background

The current demonstration permits North Carolina to obtain Medicaid reimbursement for individuals obtaining short-term SUD treatment in an IMD, regardless of whether they are enrolled in Medicaid managed care or NC Medicaid Direct, North Carolina's fee-for-service delivery system. Concurrently, North Carolina is expanding its SUD service array to include the full ASAM continuum of care and aligning care with the ASAM standards. Under the demonstration, North Carolina is required to aim for a statewide average length of stay of 30 days in residential treatment settings to ensure short-term residential treatment stays.

The SUD component of the demonstration is effective January 1, 2019, through October 31, 2023. North Carolina is preparing to submit a separate request to extend the SUD component of the 1115 demonstration for an additional five years and intends to align

expiration dates across demonstration components during the next demonstration period.

Initiative 3b: Investments in Behavioral Health and I/DD Technology

Background

Behavioral health concerns—further exacerbated by the COVID-19 pandemic—are a significant and growing issue in North Carolina that has been identified as a key priority for increased investment. Nearly one in five North Carolinians has a mental illness. During the COVID-19 pandemic, approximately one in three North Carolinians surveyed reported symptoms of depression and/or anxiety.[19] However, more than half of North Carolinians and nearly three out of four children with a behavioral health condition have not received needed treatment for their condition.[20,21] In fact, more than half of North Carolina's counties have no child and adolescent psychiatrist.[22] Nationally, North Carolina is ranked within the bottom ten states for youth mental health, largely due to inadequate access to care and lack of adequate insurance coverage for mental health.[23]

Nearly half of all children in North Carolina have endured at least one Adverse Childhood Experience (ACE). ACEs are traumatic experiences, such as neglect or exposure to violence, which can contribute to toxic stress, exacerbate physical and mental health conditions, and negatively affect educational and employment outcomes later in life.[24] In 2022, 68% of teachers in North Carolina reported that their students had greater needs for social, emotional, and mental health support than in a typical school year.[25]

In recognition of the state's behavioral health crisis, Governor Roy Cooper released a $1 billion plan to bolster key aspects of the State's behavioral health system.[26] The plan prioritizes investment in data and technology to improve health access and outcomes through increased use of technology and data-driven decision-making. In particular, supporting under-resourced behavioral health providers' access and use of electronic health records to share data and connect with the North Carolina Health Information Exchange, HealthConnex, is a key priority to ensure access to integrated, whole-person care as North Carolina continues its managed care transition. In addition, in recognition of the important role that schools play in identifying and addressing students' health and health-related

[19] North Carolina Department of Health and Human Services. Behavioral Health Convening. 2022 (**link**)
[20] North Carolina Department of Health and Human Services. Investing in Behavioral Health and Resilience. March 2023 (**link**)
21 North Carolina Department of Health and Human Services. Session Law 2021-132. April 2023 (**link**)
22 American Academy of Child and Adolescent Psychiatry. Workforce Maps by State. 2022 (**link**)
23 Reinert, M., T. Nguyen, and D. Fritze, The State of Mental Health in America 2022. 2022, Mental Health America: Alexandria VA (**link**)
[24] Child Welfare. The prevalence of adverse childhood experiences, nationally, by state, and by race or ethnicity. 2018 (**link**)
[25] North Carolina Teacher Working Conditions Survey. 2022 (**link**)
26 North Carolina Department of Health and Human Services. Investing in Behavioral Health and Resilience. March 2023 (**link**)

social needs and addressing adverse childhood experiences that impact behavioral health, North Carolina is seeking to invest in technology to support schools to appropriately document and bill for services delivered and make connections to external providers and other community-based resources and supports.

Behavioral Health and I/DD Technology Request

In the 1115 demonstration renewal, North Carolina is seeking $45 million in expenditure authority to allow Medicaid match for health information technology and related technical assistance for behavioral health, I/DD and TBI providers and schools to improve access to behavioral health services and promote care integration and whole-person care.

HIT Grants

North Carolina requests expenditure authority to provide health information technology (HIT) grants of up to $200,000 per practice ($30 million total computable) for providers who serve individuals with mental health conditions, substance use disorders, TBI, and/or I/DD located in North Carolina with a minimum of ten Medicaid patients and a Medicaid patient volume of at least 20%. Recipients of provider incentive payments under the Health Information Technology for Economic and Clinical Health (HITECH) Act who used funds to purchase or upgrade an electronic health record (EHR) system that can share real-time data with the North Carolina Health Information Exchange (NC HIE) would not be eligible for funding. Grants could cover costs of purchasing a new EHR system, making EHR system upgrades, and costs associated with enabling connectivity to NC HIE. Grants could also support training costs on EHR and NC HIE to enable providers to utilize technology to document and share patient data electronically and to utilize data to improve Medicaid enrollee health outcomes and identify and address disparities.

School Health Technology Capabilities

North Carolina requests expenditure authority to provide technology and related technical assistance to expand school's health and health-related capabilities for North Carolina Title I middle and high schools. Grants of up to $100,000 per school ($15 million total computable) could be used to purchase new technology and/or make upgrades to existing technology to support Medicaid functions, including to enable use of and data-sharing with Medicaid referral systems, support Medicaid billing, and provide related technical assistance.

Initiative 3c: Bolstering the Behavioral Health and LTSS Workforce

Background

North Carolina's workforce lacks the capacity to address the state's growing behavioral health crisis as well as fully meet the needs of people with intellectual and developmental disabilities (I/DD) and those in need of long-term services and supports (LTSS). Data indicate acute shortages with the state's current behavioral health workforce. For example, psychiatrists serving in North Carolina are only meeting 13% of the need in the state

(compared to 28% nationally),[27] and nearly a third of counties do not have any practicing psychologists.[28] As of 2021, more than 2.6 million North Carolinians resided in a community without sufficient mental health professionals overall.[29] In addition to community-based provider shortages, North Carolina lost more than nine percent of its direct care workforce between 2016 and 2021.[30]

North Carolina has identified investment and support for the workforce within the behavioral health, I/DD and LTSS spaces as a key priority to reduce the current strain on the delivery system and improve access to behavioral health, LTSS, and other needed services.

Behavioral Health and LTSS Workforce Request

Under the renewed 1115 demonstration, North Carolina is seeking expenditure authority for $70 million in total computable funding to strengthen the behavioral health workforce, as well as providers and other professionals who serve individuals with intellectual and developmental disabilities (I/DD) and who provide long-term services and supports (LTSS). Studies have demonstrated that access to care is an important indicator of people's abilities to remain in or join the labor market, with a strong focus on health care and home care workers in particular.[31]

Loan Repayment Program

North Carolina requests $50 million in total computable expenditure authority to expand the state's behavioral health student loan repayment program to support additional behavioral health professionals statewide who provide care to Medicaid enrollees, individuals who receive services via Indian Health Services (IHS), and other under-resourced populations. This includes up to $300,000 in loan repayments for psychiatrists, nurse practitioners, and physician assistants as well as loan repayments ranging from $25,000 to $50,000 (depending on the professional type) for master's-level licensed clinicians (or above), bachelor's level behavioral health professionals, and registered nurses-, in exchange for a service commitment in a qualified setting that serves Medicaid beneficiaries, individuals who receive services via IHS, and uninsured individuals.

Commented [CO11]: Recommend including a provision that includes loan repayment for professionals working in Home Health (CNA, RN, OTA, OT, PTA, PT) and Personal Care who serve Medicaid beneficiaries. The current payment structure for these services dissuades provider agencies from working with Medicaid beneficiaries, creating health inequity.

Recruitment and Retention

North Carolina requests $20 million in total computable expenditure authority to provide recruitment and retention payments for direct support professionals and other behavioral

[27] Kaiser Family Foundation. Mental Health in North Carolina (link)
[28] North Carolina Department of Health and Human Services. Investing in Behavioral Health and Resilience. March 2023 (link)
[29] National Alliance on Mental Illness. North Carolina Fact Sheet (link)
[30] North Carolina Department of Health and Human Services. North Carolina Launches Caregiving Workforce Strategic Leadership Council. March 2023 (link)
[31] The White House Briefing Room. FACT SHEET: White House Announces over $40 Billion in American Rescue Plan Investments in Our Workforce – With More Coming. July 2022 (link)

health professionals who provide Medicaid beneficiaries with behavioral health services, long term services and supports, and/or services and supports for individuals with I/DD, including: LTSS and BH/I/DD direct support professionals (DSPs), paraprofessionals as defined in North Carolina state administrative code, and other certified professionals (e.g., Peer Support Specialists, Family Partners, or Community Health Workers). The program would support recruitment and retention bonus payments, childcare subsidies, funding for training programs, and/or transportation subsidies. Payments for each category would be capped and would not exceed up to $15,000 per year in total for qualifying professionals. North Carolina would contract with one or more vendors to distribute and administer these payments.

Initiative 3d: Changes to 1915(i) Eligibility

Background

In July 2023, North Carolina began transitioning select critical home and community-based services (HCBS) for enrollees with significant behavioral health needs, I/DD and TBI previously covered under 1915(b)(3) authority to 1915(i) authority. The State initiated this transition to reflect when Tailored Plans launch, Tailored Plan members will no longer be enrolled in North Carolina's prepaid inpatient health plans authorized under the State's 1915(b) waiver, meaning that they will not be able to access 1915(b)(3) services. Under 1915(b)(3) authority, North Carolina has allowed certain flexibilities that are not permitted under 1915(i); specifically, the State has allowed individuals with incomes above 150% FPL to be eligible for 1915(i) services and pays for one-time transitional costs for individuals to move from an institution for mental diseases (IMD) into their own private residence in the community or to divert an enrollee from entering an adult care home.

1915(i) Renewal Request

In order to maintain the eligibility criteria for critical HCBS as North Carolina transitions services from 1915(b)(3) to 1915(i) authority, North Carolina is requesting authority under the 1115 demonstration to:

- Allow individuals with incomes above 150% FPL to be eligible for 1915(i) services
- Permit individuals transitioning out of an IMD to obtain North Carolina's 1915(i) community transition benefit, if they otherwise meet the 1915(i) eligibility criteria. The community transition benefit provides up to $5,000 in one-time transitional costs for individuals to move from an institutional setting into their own private residence.

Designated State Health Programs

North Carolina is seeking expenditure authority to support the non-federal share of funding for pre-release services for justice-involved individuals and related capacity building and new HOP expenditures for the next demonstration period using Designated State Health

Program (DSHP) expenditures. North Carolina is requesting $610 million in total computable DSHP funding. North Carolina will work with CMS to finalize the demonstration initiatives that can be supported with DSHP funding, and to develop Special Terms and Conditions (STCs) and DSHP funding and reimbursement protocols for the demonstration period to reflect the demonstration's goals and funding levels.

Section III – Benefits, Eligibility, Delivery System, and Cost Sharing

Benefits

Managed care benefits will continue to be defined under the State Plan or, where applicable, the 1915(c) waiver. The State is continuing to request an enhanced set of benefits for the Tailored Plans and Children and Families Specialty Plan in comparison to the Standard Plans as described in Section II.

Other changes to benefits proposed in the renewal are described in Section II above, and include:

- Expanding HOP statewide, reauthorizing the existing list of Pilot services, and modifying service definitions as proposed above
- Providing targeted pre-release services for justice-involved individuals in the 90 days prior to release
- Allowing individuals with incomes above 150% FPL to be eligible for 1915(i) services
- Permitting individuals transitioning out of an IMD to obtain North Carolina's 1915(i) community transition benefit, if they otherwise meet the 1915(i) eligibility criteria.

Eligibility

This demonstration renewal proposes to continue managed care eligibility as authorized in the current demonstration with no changes. All eligibility is defined under the State Plan, including M-CHIP, or, where applicable, the 1915(c) waiver. This demonstration affects all eligibility groups other than those listed in Table B below. The groups listed in Table B below will not be affected by the demonstration and will continue to receive Medicaid benefits through the service delivery system under the approved state plan or under existing waivers.

Table A: Full Benefit Medicaid Beneficiaries in This Table Are Eligible for SUD and HOP (if they meet the HOP criteria and are served by a HOP Administrator consistent with these STCs)[32]

GROUP NAME	CITATIONS
Duals Eligible for Full Medicaid, except those who are enrolled in the state's Innovations and TBI 1915(c) waiver programs, which qualifies the beneficiary for enrollment in the Tailored Plans	
Medically Needy • Medically Needy Pregnant Individuals except those covered by Innovations or TBI waivers • Medically Needy Children under 18 except those covered by Innovations or TBI waivers • Medically Needy Children Age 18 through 20 except those covered by Innovations or TBI waivers • Medically Needy Parents and Other Caretaker Relatives except those covered by Innovations or TBI waivers • Medically Needy Aged, Blind, or Disabled except those covered by Innovations or TBI waivers • Medically Needy Blind or Disabled Individuals Eligible in 1973 except those covered by Innovations or TBI waivers	1902(a)(10)(C)
Individuals Participating in the NC Health Insurance Premium Payment (HIPP) program except those covered by Innovations or TBI waivers	1906
Medicaid-only Beneficiaries Receiving Long-Stay Nursing Home Services	State Plan Eligibility
Community Alternatives Program for Children (CAP/C)	1915(c) waiver
Community Alternatives Program for Disabled Adults (CAP/DA)	1915(c) waiver

[32] North Carolina, consistent with requirements in state statute, intends to enroll dual eligible and long-term stay nursing home populations into managed care in the future, and will update these tables as appropriate when more information is available on that change.

GROUP NAME	CITATIONS
Individuals in any eligibility category not otherwise excluded during their period of retroactive eligibility or prior to the effective date of PHP coverage[33]	1902(a)(34)

Table B: Populations Excluded from Comprehensive Managed Care and This Demonstration

GROUP NAME	CITATIONS
Duals Eligible for Cost-Sharing Assistance • Qualified Medicare Beneficiaries • Qualified Disabled and Working Individuals • Specified Low Income Medicare Beneficiaries • Qualifying Individuals	• 1902(a)(10)(E)(i) • 1905(p)(1) • 1902(a)(10)(E)(ii) • 1902(a)(10)(E)(iii) • 1902(a)(10)(E)(iv)
Individuals with Limited or no Medicaid Coverage (e.g., eligible for emergency services only)	• 1903(v)(2) and (3)
Individuals Eligible for Family Planning Services	• 1902(a)(10)(A)(ii)(XXI) • 42 CFR 435.214
Incarcerated Individuals *(Inpatient stays only), except for the provision of pre-release services to certain incarcerated individuals as described in this application*	• Clause (A) following 1905(a)(29)(A) • 42 CFR 435.1009, 1010
Presumptively Eligible • Presumptively Eligible Pregnant Individuals • Presumptively Eligible MAGI Individuals	• 1902(a)(47) • 1920 • 1920A • 1920B • 1920C

[33] Individuals in any eligibility category not otherwise excluded during their period of retroactive eligibility or prior to the effective date of PHP coverage are eligible for the SUD component of the demonstration but are not eligible for HOP.

GROUP NAME	CITATIONS
Individuals Participating in the Program of All-Inclusive Care for the Elderly (PACE)	• 1905(a)(26) • 1934

Other eligibility-related changes proposed in the demonstration are described in more detail in Section II and include continuous enrollment to certain children and youth

Delivery System

The delivery system will remain as proposed and authorized in the last demonstration with changes to implementation dates as described in Section III and in Table C below.

Beneficiaries, except those excluded or exempted, shall be enrolled to receive services through a PHP under contract with the state. All Medicaid populations except for those who are excluded or exempt are either currently enrolled in PHPs or will be phased in to PHPs according to the schedule detailed below in Table C. For these populations, Medicaid managed care enrollment is mandatory. Members of federally recognized tribes, including members of the EBCI, may voluntarily enroll in PHPs on an opt-in basis.

Table C: Managed Care Phase-in Schedule[34]

Managed Care Plan	Populations	Phase-In Timeline
Standard Plan	Medicaid and M-CHIP beneficiaries except those who are: • Excluded as described in Table B of this application; • Exempted individuals who choose not to enroll in managed care[35]; or • Eligible to enroll in a Tailored Plan or the Children and Families Specialty Plan[36]	Complete; implemented on July 1, 2021
Tailored Plan	Medicaid and M-CHIP beneficiaries eligible to enroll in Tailored Plans	Pending; anticipated to launch in 2024
Children and Families Specialty Plan	Medicaid and M-CHIP beneficiaries who are children in foster care; children receiving adoption assistance; former foster youth up to	Pending; anticipated to launch in late 2024 or 2025

[34] North Carolina, consistent with requirements in state statute, intends to enroll dual eligible and long-term stay nursing home populations into managed care in the future, and will update these tables as appropriate when more information is available on that change.
[35] These populations may opt to enroll in a Standard Plan.
[36] These populations may opt to enroll in a Standard Plan.

	age 26; parents and caretaker relatives of children/youth in foster care who are making reasonable efforts to comply with a court-ordered plan of reunification; siblings of children/youth in foster care; minor children and certain family members receiving Child Protective Services In-Home Services; minor children of children/youth in foster care, of children/youth receiving adoption assistance or of former foster youth.	

Cost Sharing

There are no changes to cost sharing proposed under this demonstration. Cost sharing under this demonstration is consistent with the provisions of the approved state plan.

Section IV – Requested Waivers and Expenditure Authorities

Under the authority of Section 1115(a) of the Act, the following waivers and expenditure authorities shall enable North Carolina to implement the North Carolina Medicaid Reform Section 1115 demonstration from November 1, 2024, to October 31, 2029. To the extent that CMS advises the State that additional authorities are necessary to implement the programmatic vision and operational details described above, the State is requesting such waiver or expenditure authority, as applicable. North Carolina's negotiations with the federal government, as well as State legislative/budget changes, could lead to refinements in these lists as we work with CMS to move this demonstration forward.

Table D. Requested Waiver and Expenditure Authorities

Waiver/ Expenditure Authority	Use for Waiver / Expenditure Authority	Currently Approved Waiver / Expenditure Authority
Waiver Authorities		
Statewideness: Section 1902(a)(1)	To the extent necessary to enable the state to operate managed care on less than a statewide basis	Currently approved
	To the extent necessary to enable the state to implement the Healthy Opportunities	Currently approved

	Pilot in geographically limited areas of the state	
	To enable the state to provide pre-release services to qualifying beneficiaries on a facility limited basis, as outlined in this application	Not currently approved
Freedom of Choice: Section 1902(a)(23)(A)	To the extent necessary to enable the state to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans for the receipt of covered services including individuals in the Innovations and TBI 1915(c) waivers NC 0423.RO2.00, NC1326.R00.00, respectively. No waiver of freedom of choice is authorized for family planning providers.	Currently approved
	To enable the state to require qualifying beneficiaries to receive pre-release services, as described in this application, through only certain providers.	Not currently approved
Amount, Duration, and Scope of Services: Section 1902(a)(10)(B) **Comparability:** Section 1902(a)(17)	To the extent necessary to enable the state to vary the amount, duration, and scope of services offered to individuals in managed care under this demonstration, regardless of eligibility category	Currently approved
	To enable the state to provide Healthy Opportunities Pilot services as described in this application and that are not otherwise available to all beneficiaries in the same eligibility group.	Currently approved *(Note: language is slightly modified from previous approval)*
	To enable the state to provide additional benefits to Medicaid beneficiaries who are enrolled in the Healthy Opportunities Pilot program.	Currently approved
	To enable the state to provide only a limited set of pre-release services to qualifying beneficiaries, as described in this application, that is different than the services available to all other enrollees	Not currently approved

	outside of carceral settings in the same eligibility groups authorized under the state plan or the demonstration	
Expenditure Authorities[37]		
Managed Care		
Tailored Plans	Expenditures under contracts with managed care entities that do not meet the requirements in 1903(m)(2)(A) and 1932(a) of the Act as implemented in 42 CFR 438.52(a), to the extent necessary to allow the state to limit the choice to a single Tailored Plan in each county for Medicaid enrollees meeting one of the following criteria: a. Residing in an ICF-IID b. Participating in North Carolina's Transitions to Community Living c. Enrolled in the Innovations or Traumatic Brain Injury 1915(c) waiver d. Receiving services/supports in state-funded residential treatment (i.e., individuals receiving services to support them in their residence/house setting, including services provided in group homes or non-independent settings such as Group Living, Family Living, Supported Living, and Residential Supports)	Currently approved
Healthy Opportunities Pilot		
Expenditures Related to Healthy Opportunities Pilot Services	Expenditures to provide Healthy Opportunities Pilot services for individuals who meet the eligibility criteria and in accordance with this application.	Currently approved *(Note: language is modified from previous approval to reflect statewide*

[37] In the SUD waiver extension request submitted to CMS on [XXX], North Carolina requested to continue expenditure authority for Residential and Inpatient Treatment for Individuals with a Substance Use Disorder (SUD).

		expansion and to remove October 31, 2024 expiration date)
Expenditures Related to Healthy Opportunities Pilot Program Capacity Building Funding	Expenditures for capacity building funding to support implementation of HOP.	Currently approved *(Note: Capacity building dollars were previously incorporated in the expenditure authority for Pilot services; North Carolina is proposing a separate expenditure authority in this application)*
Continuous Enrollment for Children		
Expenditures Related to Continuous Enrollment	Expenditures for continued benefits for individuals who have been determined eligible for the applicable continuous eligibility period who would otherwise lose coverage during an eligibility determination.	Not currently approved
Coverage for Justice-Involved Reentry		
Expenditures Related to Pre-Release Services	Expenditures for pre-release services provided to qualifying demonstration beneficiaries who would be eligible for Medicaid if not for their incarceration status, for up to 90 days immediately prior to the expected date of release from a participating state prison, county jail, or youth correctional facility.	Not currently approved
Expenditures Related to Pre-Release Services Capacity Building Funding	Expenditures for capacity building funding to support implementation of Justice-Involved Reentry Initiative.	Not currently approved

Behavioral Health and I/DD Technology		
Expenditures Related to Behavioral Health and I/DD HIT Infrastructure	Expenditures for the HIT Grants initiative.	Not currently approved
Expenditures Related to School Health Capabilities	Expenditures for the School Health and Health-Related Capabilities initiative.	Not currently approved
Behavioral Health and LTSS Workforce		
Expenditures Related to Clinical Loan Repayment Program	Expenditures for the Clinical Loan Repayment initiative.	Not currently approved
Expenditures Related to Recruitment and Retention	Expenditures for the Recruitment and Retention Payments for Direct Care Workers and Paraprofessionals initiative.	Not currently approved
1915(i) Services		
Community Transition Services	Expenditures to provide 1915(i) community transition services to Medicaid-enrolled individuals transitioning out of an IMD	Not currently approved
Expenditures Related to 1915(i) Services	Expenditures to provide 1915(i) services to Medicaid-enrolled individuals with incomes above 150% FPL	Not currently approved
Designated State Health Programs		
Designated State Health Programs	Expenditures for Designated State Health Programs, as described in this application, which are otherwise fully state-funded, and not otherwise eligible for Medicaid matching funds.	Not currently approved

Section V – Summaries of External Quality Review Organization (EQRO) Reports, Managed Care

Organization (MCO), and State Quality Assurance Monitoring

External Quality Review Organization Reports

Health Services Advisory Group (HSAG), North Carolina's EQRO, uses its analyses and evaluations of external quality review (EQR) activity findings to assess each Standard Plans' (and later Tailored Plans' and other managed care entities') performance in providing quality, timely, and accessible healthcare services to beneficiaries as required in 42 CFR §438.364. In the latest EQR report, HSAG includes overall findings and conclusions regarding quality, timeliness, and access for all Standard Plans. High-level findings include:

EQRO Results	
Domain	**Conclusion**
Quality	• **Strength:** The Standard Plans demonstrated a member-centric, quality-driven approach to serving the Medicaid population. • **Strength:** The encounter data validation (EDV) information systems (IS) review assessed self- reported qualitative information from all five Standard Plans. Based on the Standard Plan contract and the Department's requirements, Standard Plans demonstrated their capability to collect, process, and transmit encounter data to the Department, as well as develop data review and correction processes that can promptly respond to quality issues identified by Department. • **Strength:** The performance measure validation (PMV) activity identified that all five Standard Plans demonstrated extensive knowledge and experience in claims and encounter, membership/enrollment, data integration, rate production, and medical record procurement and abstraction processes. • **Strength:** All five Standard Plans achieved a PIP validation status of *Met* and 100 percent of the validation criteria for the first six steps submitted for validation. All PIPs were found to be methodologically sound. • **Opportunity for Improvement:** To improve the quality of encounter data submissions from the Standard Plans, the Department may want to assess whether there are common root cause(s) for Standard Plan encounter rejections. • **Opportunity for Improvement**: The Standard Plans did not consistently ensure that policies, procedures, processes, or committee materials

	satisfied program integrity (PI) requirements. These findings suggest that the Standard Plans may not have implemented processes to ensure all federal and Department requirements were met. • **Opportunity for Improvement:** Results of the PMV activity indicated that two health plans had an opportunity to establish consistent data feeds with the State immunization registry. This finding may impact the Standard Plans' ability to accurately assess enrollees for gaps in care.
Access	• **Strength:** Provider participation in quality forums revealed interest in continuing discussions to address access to care and best practices to improve Healthcare Effectiveness Data and Information Set (HEDIS) access measures.
Timeliness	• **Strength:** There was strong participation in EQRO activities, with consistent and timely submission of information that provided evidence of progress toward goals and continued improvement. • **Opportunity for Improvement:** Results of the PMV activity indicated that two health plans had an opportunity to establish consistent data feeds with the State immunization registry. This finding may impact the Standard Plans' ability to ensure that timely reporting of services is captured in quality measure reporting.

Note that reporting of the state's HEDIS quality measure performance is one year following the year reflected in the data. HEDIS measures require one full year of data; however, the Standard Plans' contracts did not go into effect until July 1, 2021. In consideration of this, HSAG and the Department worked closely with the Standard Plans to understand several nuances and complexities in the Standard Plans' abilities to produce 2021 HEDIS performance rates for review and validation. HSAG ensured that calendar year (CY) 2021 PMV methods aligned with CMS EQR Protocol 2. Validation of Performance Measures: A Mandatory EQR- Related Activity, October 2019; however, final measurement year (MY) 2021 rates were not available until mid-calendar year (CY) 2022 and will, therefore, be subsequently integrated into the EQR technical report produced in state fiscal year (SFY) 2023 (release pending).

The Standard Plans' primary performance improvement project (PIP) activities in the first year of managed care were initiating new PIPs and completing the first six steps of the submission form. For the 2022 validation, the PIPs had not progressed to including baseline

data or initiating QI activities or interventions. These will also be reported in the next annual EQR technical report in 2023.

More information is available in the full 2021-2022 EQR report here. The Department will include in the October submission of the final waiver renewal the 2022-2023 EQR report and update this section, as needed.

In the October submission, the Department will include (with 2021 data):

- Managed Care Health Equity Report
- Annual Quality Report
- Access to Care Report

Managed Care Organization and State Quality Assurance Monitoring

North Carolina's managed care contracts include robust requirements to ensure that managed care plans meet and, in many cases, exceed the standards outlined in 42 CFR Part 438, Subpart D, and as specified by the Department. These standards are detailed throughout the Quality Strategy and EQR report and include requirements for enrollee access to care, network adequacy, availability of services, access to care during transitions of coverage, assurances of adequate capacity and services, coordination and continuity of care and coverage, and authorization. Further, these requirements focus on the structure and operations that managed care plans and other entities delivering managed care must have in place to ensure the provision of high-quality care.

Other Quality Documentation

The Department's CMS 416 Form (2021) can be found here.

The Department's Consumer Assessment of Healthcare Providers and Systems (CAHPS) reflects reporting respondents' experiences with their health care. Results from the 2022 report are here.

The Department administered a Medicaid Provider Experience Survey in the first year of managed care (2022), to assess the impact of the North Carolina Medicaid Transformation on primary care and obstetrics/gynecology (Ob/Gyn) practices that contract with NC Medicaid. The full report is available here; a baseline survey was conducted in 2021.

Section VI – Enrollment, Demonstration Financing and Budget Neutrality

This section describes the historical and expected enrollment impact, historical and expected financial expenditures, and budget neutrality considerations associated with the proposed demonstration renewal initiatives.[38]

Enrollment

Table E provides historical data on Member Months and estimated Person Count for North Carolina Medicaid Reform 1115 demonstration populations from November 1, 2019, to October 31, 2024. Note that a portion of the DY5 and all of the DY6 figures reflect continuation of reported experience through March 31, 2023.

Table E. Estimated Historical Person Count

		Historical Member Months and Person Count				
		DY2[39]	DY3	DY4	DY5	DY6
Medicaid Eligibility Group		Nov 2019 to Oct 2020	Nov 2020 to Oct 2021	Nov 2021 to Oct 2022	Nov 2022 to Oct 2023	Nov 2023 to Oct 2024
Aged, Blind, Disabled (ABD)	Member months	0	303,156	1,198,700	1,256,600	1,256,600
	Person count	0	101,052	99,892	104,717	104,717
TANF & Related Adults	Member months	0	937,257	4,326,423	5,180,866	5,180,866
	Person count	0	312,419	360,535	431,739	431,739

[38] The calculations and figures included in this Section have been developed for purposes of illustrating 1115 demonstration budget neutrality as required by CMS. 1115 demonstrations must be budget neutral to the federal government, not to the State, according to the policies negotiated in each demonstration. The required approach, inputs and methods for CMS may not align with estimates performed by the State for other purposes. For example, the illustrated per capita caps and expenditures do not consider the impact of pharmacy rebates or other costs that are outside of the managed care programs and populations included in this document.

[39] Demonstration Year 1 was associated with SUD waiver implementation only. This table reflects the appropriate Demonstration years for the comprehensive Medicaid Reform Demonstration.

		Historical Member Months and Person Count				
		DY2[39]	DY3	DY4	DY5	DY6
TANF & Related Children	Member months	0	2,856,570	11,789,555	12,238,814	12,238,814
	Person count	0	952,190	982,463	1,019,901	1,019,901
Innovations/ Traumatic Brain Injury (TBI)	Member months	0	0	0	0	0
	Person count	0	0	0	0	0
Medicaid Expansion	Member months	N/A	N/A	N/A	0*	0*
	Person count	N/A	N/A	N/A	0*	0*

*Launch of Medicaid expansion is pending given ongoing budget negotiations. Estimates in DY5 and DY6 are subject to change. North Carolina will update and include final projections in the demonstration renewal request submitted to CMS.

North Carolina has estimated enrollment for the next demonstration period for the purposes of public comment. Table F provides the estimated enrollment for the five years of the 1115 demonstration renewal from November 1, 2024, to October 31, 2029. The State will include final projections in the demonstration renewal request submitted to CMS; final numbers may differ as North Carolina continues to finalize enrollment data under the current 1115 demonstration, to determine the impact that the COVID-19 public health emergency has had on enrollment trends, to prepare to implement Medicaid expansion and to consider any new initiatives contemplated as part of the 1115 demonstration renewal.

Table F. Projected Member Months and Person Count Under Renewal

		Projected Member Months and Person Count Under Renewal				
		DY7	DY8	DY9	DY10	DY11
Medicaid Eligibility Group		**Nov 2024 to Oct 2025**	**Nov 2025 to Oct 2026**	**Nov 2026 to Oct 2027**	**Nov 2027 to Oct 2028**	**Nov 2028 to Oct 2029**
Medicaid Eligibility Groups						
ABD	Member months	2,217,445	2,239,620	2,262,016	2,284,636	2,307,482

		Projected Member Months and Person Count Under Renewal				
		DY7	DY8	DY9	DY10	DY11
	Person count	184,787	186,635	188,501	190,386	192,290
TANF & Related Adults	Member months	3,682,854	3,719,682	3,756,879	3,794,448	3,832,393
	Person count	306,904	309,974	313,073	316,204	319,366
TANF & Related Children	Member months	15,642,839	16,212,785	16,792,565	16,960,491	17,130,095
	Person count	1,303,570	1,351,065	1,399,380	1,413,374	1,427,508
Innovations/TBI	Member months	168,000	168,000	168,000	168,000	168,000
	Person count	14,000	14,000	14,000	14,000	14,000
Medicaid Expansion	Member months	7,415,187	7,489,339	7,564,232	7,639,874	7,716,273
	Person count	617,932	624,112	630,353	636,656	643,023

Continuously enrolled children and former foster youth are included in the TANF & Related Children Medicaid Eligibility Group projections noted above. Table G provides a summary of the estimated number of individuals impacted by these continuous enrollment changes.

Table G. Estimated Continuous Enrollment Impacts

	Estimated Number of Individuals Affected by Continuous Enrollment				
	DY7	DY8	DY9	DY10	DY11
Continuous Enrollment Groups	**Nov 2024 to Oct 2025**	**Nov 2025 to Oct 2026**	**Nov 2026 to Oct 2027**	**Nov 2027 to Oct 2028**	**Nov 2028 to Oct 2029**

	Estimated Number of Individuals Affected by Continuous Enrollment				
	DY7	DY8	DY9	DY10	DY11
Children age 0 through five	27,431	41,558	55,964	56,524	57,089
Individuals age 6 through 18	35,792	54,224	73,022	73,752	74,490
Former foster care youth	5,015	7,597	10,231	10,333	10,437

Justice-involved individuals are not included in the Medicaid Eligibility Group projections noted above. Table H provides a summary of the estimated number of individuals who will receive pre-release services under this demonstration.

Table H. Estimated Justice-Involved Reentry Initiative Impacts

	Estimated Number of Individuals Affected by Justice-Involved Reentry Initiative				
	DY7	DY8	DY9	DY10	DY11
	Nov 2024 to Oct 2025	Nov 2025 to Oct 2026	Nov 2026 to Oct 2027	Nov 2027 to Oct 2028	Nov 2028 to Oct 2029
Justice-involved Individuals	2,925	6,825	9,750	9,750	9,750

Expenditures

Table I provides historical data on the total expenditures for the North Carolina Medicaid Reform 1115 demonstration services and populations from November 1, 2019, to October 31, 2024. Note that a portion of the DY5 and all of the DY6 figures are estimated based on reported experience through March 31, 2023.

Table I. Historical Total Computable Expenditures

	Historical Total Computable Expenditures (in $M)				
	DY2[40]	DY3	DY4	DY5	DY6
Historical Expenditures	**Nov 2019 to Oct 2020**	**Nov 2020 to Oct 2021**	**Nov 2021 to Oct 2022**	**Nov 2022 to Oct 2023**	**Nov 2023 to Oct 2024**
Medicaid Eligibility Groups					
ABD	0	$508,987,665	$2,046,744,665	$2,253,393,450	$2,253,393,450
TANF & Related Adults	0	$374,099,591	$2,287,582,053	$2,738,045,214	$2,738,045,214
TANF & Related Children	0	$620,287,515	$2,708,208,039	$2,863,757,092	$2,863,757,092
Innovations/TBI	0	0	0	0	0
Medicaid Expansion	0	0	0	0*	0*
Healthy Opportunities Pilot					
ECM Capacity Building	0	$19,024,872	$18,689,376	$10,000,000	0
ECM Services	0	$16,660,324	$5,010,877	$84,000,000	$84,000,000

*Launch of Medicaid expansion is pending given ongoing budget negotiations. Estimates in DY5 and DY6 are subject to change. North Carolina will update and include final projections in the demonstration renewal request submitted to CMS.

For the purposes of public notice and comment, the State has summarized in the table below the projected expenditures for the renewal. The State will include final projections in the demonstration renewal request submitted to CMS; final numbers may differ as North Carolina continues to finalize financial data demonstrating the State's historical expenditures under the current 1115 demonstration, to determine the impact that the COVID-19 public health emergency has had on enrollment and expenditure trends and consideration for new and emerging State

[40] Demonstration Year 1 was associated with SUD waiver implementation only. This table reflects the appropriate Demonstration years for the comprehensive Medicaid Reform Demonstration.

initiatives included in the 1115 renewal. For example, the anticipated distribution of capacity building funds for the justice-involved reentry initiative across the demonstration period reflects the current program implementation design; the distribution of costs may change as the design is refined.

Projected expenditures were developed using a blended approach of reported DY4 expenditure and enrollment levels and DY6 approved per capita caps, amongst other data sources. The blended approach considers estimated prospective trends intended to align with President's Budget trend levels, adjustments for program adjustments as identified in the bullets below, and projected expenditures for new initiatives as outlined in this document.

Projected expenditures include new initiatives for which the State is requesting aggregate expenditure authority under the 1115 demonstration renewal as well as the following program adjustments which impacted the historical and/or future demonstration years:[41]

- Continuous enrollment for children and former foster youth are included in expenditure projections for the TANF & Related Children MEG.
- Fee schedule increases for select service types including: hospital payment increases implemented July 1, 2021, HCBS direct care worker service rate increase implemented by DHHS in March 2022, and rate increases for Personal Care.
- Increased payments to SNFs based on a percent of Medicare payment approach required in managed care.
- Consideration for the impact of the public health emergency on future expenditures and enrollment.
- Tailored Plan and CFSP acuity and enrollment, once implemented.
- Expenditures to provide 1915(i) services to Medicaid-enrolled individuals.

[41] The following programs which have not yet been approved and are still pending given ongoing budget negotiations may have financial impact on the projected expenditures: Healthcare Access and Stabilization Program (HASP), Behavioral Health Fee Schedule increases, Innovations/TBI, Private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID). North Carolina will update and include final projections in the demonstration renewal request submitted to CMS.

Table J. Projected Total Computable Expenditures Under Renewal

	Projected Total Computable Expenditures				
	DY7	DY8	DY9	DY10	DY11
With Waiver Expenditures	**Nov 2024 to Oct 2025**	**Nov 2025 to Oct 2026**	**Nov 2026 to Oct 2027**	**Nov 2027 to Oct 2028**	**Nov 2028 to Oct 2029**
Medicaid Eligibility Groups					
ABD	$5,586,941,191	$5,896,737,080	$6,223,711,151	$6,568,815,934	$6,933,056,778
TANF & Related Adults	$3,064,472,454	$3,234,397,451	$3,413,744,790	$3,603,036,938	$3,802,825,337
TANF & Related Children	$5,188,185,940	$5,619,191,812	$6,082,044,107	$6,419,293,452	$6,775,243,274
Innovations/TBI	$1,561,052,272	$1,631,299,624	$1,704,708,107	$1,781,419,972	$1,861,583,871
Medicaid Expansion	$9,780,541,039	$10,372,263,772	$10,999,785,730	$11,665,272,767	$12,371,021,789
Healthy Opportunities Pilots					
Services	$340,000,000	$340,000,000	$340,000,000	$340,000,000	$340,000,000
Capacity Building*	$50,000,000	$100,000,000	$100,000,000	$25,000,000	$25,000,000
Justice-Involved Reentry					
Services	$4,096,381	$10,036,134	$15,054,201	$15,806,911	$16,597,256
Capacity Building*	$100,000,000	$125,000,000	$50,000,000	$30,000,000	$10,000,000
Behavioral Health and I/DD Provider Technology					
	$15,000,000	$15,000,000	$0	$0	$0
Behavioral Health and LTSS Workforce					
	$35,000,000	$35,000,000	$0	$0	$0
Technology to Advance Schools					
	$7,500,000	$7,500,000	$0	$0	$0
DSHP					

	Projected Total Computable Expenditures				
	DY7	DY8	DY9	DY10	DY11
	$122,000,000	$122,000,000	$122,000,000	$122,000,000	$122,000,000

*North Carolina has allocated the total requested capacity building funding for the Healthy Opportunities Pilot and the Justice-Involved Reentry Initiative across the demonstration years based on the State's best estimates and requests flexibility on the timing of actual payments.

Budget Neutrality

As described above, North Carolina's proposed demonstration renewal seeks to continue existing demonstration initiatives and proposes new demonstration features. The demonstration is expected to be budget neutral as measured by CMS. Budget neutrality will align with the projected expenditures for the demonstration proposal as described above in Table J. Below, Table K shows the requested budget neutrality treatment across initiatives in the renewal. North Carolina will continue to work with CMS to confirm and finalize budget neutrality during the demonstration negotiation and approval process.

Table K. Budget Neutrality (BN)

Waiver Initiative	Per Capita or Aggregate	Proposed Budget Neutrality Treatment
Managed Care	Per Capita	Main BN Test
Healthy Opportunities Services	Aggregate	Capped Hypothetical
Healthy Opportunities Capacity Building	Aggregate	Capped Hypothetical
Continuous Enrollment for Children	Per Capita	Hypothetical
Justice Involved Pre-Release Services	Per Capita	Hypothetical
Justice Involved Pre-Release Capacity Building	Aggregate	Hypothetical
Behavioral Health (BH) and LTSS Workforce Investments	Aggregate	Main BN Test

Behavioral Health and I/DD Provider HIT	Aggregate	Main BN Test
Technology to Expand Schools' Health and Health-Related Capabilities	Aggregate	Main BN Test
1915(i) Benefit Changes	Per Capita	Hypothetical
Designated State Health Programs (DSHP)	Aggregate	Main BN Test

Section VII – Evaluation

Evaluation Results from the Current Demonstration

Background

The purpose of the previously approved North Carolina Medicaid Reform 1115 Demonstration is to improve Medicaid enrollee health outcomes through the implementation of a new delivery system, to enhance the viability and sustainability of North Carolina's Medicaid program by maximizing the receipt of high-value care, and to reduce SUD statewide. As required under the special terms and conditions (STCs) of the North Carolina Medicaid Reform Section 1115 demonstration, the state engaged an independent research organization, the North Carolina University Cecil G. Sheps Center for Health Services Research ("Sheps Center"), to evaluate the performance of the demonstration initiatives, including, but not limited to, managed care transformation, expansion of SUD coverage, and HOP.

Because the many programs included in the demonstration have different time frames, structures, and funding streams, the evaluation designs and timelines for the programs also vary. The approved demonstration evaluation design, inclusive of the Department's objectives and hypotheses, is available here (the separate HOP evaluation design is available here). For initiatives where interim evaluation reports, rather than final evaluation reports, have been completed, work on the final evaluations is continuing and will be provided to CMS as required by the demonstration STCs, unless otherwise discussed and agreed upon by the State and CMS. The State's evaluation materials will be made available at specified areas of DHHS' website, such as the Quality Management and Improvement homepage or are available upon request.

Demonstration Evaluation Findings to Date

Managed Care Evaluation

The Department's annual report from Demonstration Year 4 is available in the Appendix and the interim evaluation report will be submitted to CMS in October. The Department will include in the final submission to CMS in October the most recent evaluation findings.[42]

Summaries of qualitative evaluation findings from Demonstration Year 3 are provided below for reference:

- Demonstration Year 3 Summary – Providers
- Demonstration Year 3 Summary – Standard Plans
- Demonstration Year 4 Summary – Providers

SUD Components of the Demonstration Evaluation

The Department, in collaboration with the Sheps Center, conducted an Interim Evaluation between October 1, 2015 – September 31, 2022, of the SUD components of the demonstration. May 1, 2019 is used as the official start of the SUD expenditure authority. Many SUD changes were phased in over time and thus estimates will be conservative since Sheps included months prior to each event. Two major events occurred during the SUD implementation period. First, the COVID-19 PHE began with stay-at-home orders in March 2020 and only ended in May 2023, after the study period for this report. Sheps developed a novel method of identifying the return-to-normal dates in our data. Second, the launch of Standard Plans occurred on July 1, 2021. While most of the population with an SUD has not yet enrolled in a managed care plan, but will be enrolled in a Tailored Plan, the launch of Standard Plans may have affected outcomes for people with SUD if Standard Plans' benefit design affected access to care or if Standard Plans changed providers' patterns of care, directly or indirectly. Sheps found that 25% of the population identified as having a SUD were enrolled in Standard Plans.

Sheps used interrupted time series models to examine the trends in metrics before the start of the SUD waiver and during the waiver implementation period. These models control for changes due to other factors, such the COVID-19 time period, Standard Plan implementation, month effects, county effects, and beneficiary-level controls for age, race/ethnicity, sex, and the Chronic Disease Payment System (CDPS- Rx) risk score. This evaluation does not incorporate a comparison group that was not exposed to the NC Medicaid transformation and thus the models will attribute

42 The Department is pending feedback from CMS for the following: SUD Mid-Point Assessment and the SUD Interim Evaluation Report.

any remaining factors that occurred during the SUD implementation period to the SUD waiver. Sheps takes this into account when describing results.

Below is a summary of findings by major hypothesis. The Department will include in the final demonstration renewal application to CMS updated evaluation findings, as available.

Hypothesis 3.1: Expanding coverage of SUD services will result in improved care quality and outcomes for beneficiaries with SUD.

Sheps examined 27 metrics reflecting quality of care and outcomes for Medicaid beneficiaries with substance use disorders to test hypothesis 3.1. Analysis of these variables found that only six metrics represented progress in improving outcomes and quality of care for people with SUD, one metric demonstrated no change, one had data issues and could not be analyzed, while the remaining 19 metrics demonstrated declines. The metrics that improved during the SUD waiver were important high- level reflections of the health of the population of Medicaid beneficiaries who struggle with substance use disorders. These include proportionately a greater percent of beneficiaries with diagnosed with SUD after a peak around the time of the COVID-19 pandemic, potentially indicating better access to care (although Sheps notes that it is impossible to tell whether this reflects a higher prevalence of SUD or a higher diagnosed prevalence), greater use of withdrawal management services, the growth in the availability of providers to provide SUD and medications for opioid use disorder (MOUD) treatments, continued low lengths of stay in inpatient or residential treatment facilities, often referred to as IMDs, and greater continuity of care for opioid use disorder (OUD). These are important metrics of the success of the SUD waiver. Many of the metrics demonstrating declines were measures of access to specific types of services, initiation and engagement in care. Most of these metrics declined during the COVID PHE, despite our effort to control these effects using trends from Medicaid beneficiaries without SUD diagnoses. The remaining metrics that did not demonstrate progress examined availability and use of specialty behavioral health services, which may reflect the fact that many of the expansions in benefits offered to meet American Society of Addiction Medicine (ASAM)'s levels of care have only been recently introduced or are still in process. In addition, the Tailored Plans had been envisioned as a major driver of improvements in care have still not been implemented and potentially caused disruption in care during the two prior delayed launches of this benefit plan.

Hypothesis 3.2: Expanding coverage of SUD services will increase the use of MOUD and other appropriate opioid treatment services and decrease the long-term use of prescription opioids.

Sheps examined the trends in 16 additional metrics reflecting medication and other treatments for OUD and long-term use of opioids in order to test Hypothesis 3.2 (Table 1). Four of the metrics demonstrated appreciable progress since the SUD waiver implementation,

one demonstrated no change, and the remaining 11 moved in the opposite direction as the waiver goals. The metrics that indicated appreciable progress during the SUD waiver implementation period included the use of pharmacotherapy for OUD, 30-day follow up after emergency department (ED) visit for mental health among beneficiaries with SUD diagnoses; two metrics reflecting the receipt of opioids from multiple providers. The use of non-medication services for OUD did not change. The eleven metrics that did not demonstrate progress included metrics reflecting follow up care after emergency and hospital visits for SUD, use of opioids at high doses, and the rate of ED and inpatient use per 1000 beneficiaries with SUD.

Hypothesis 3.3: Expanding coverage of SUD services will result in no changes in total Medicaid and out-of-pocket costs for people with SUD diagnoses and increases in Medicaid costs on SUD IMD services.

Sheps examined six measures reflecting total spending, per beneficiary spending, and out-of-pocket costs overall for SUD services and specifically for IMD services. Sheps found that total spending on SUD services increased after SUD waiver implementation, as expected. This reflects both the greater number of beneficiaries receiving benefits, especially after the start of the PHE, but also greater spending per capita, even after controlling for changes in case mix. Spending on SUD services in IMDs remained stable, although per capita spending on SUD services in IMDs grew slightly. A somewhat greater percent of beneficiaries with SUD had out-of-pocket spending after the SUD waiver was implemented, affecting 2% of beneficiaries with SUD. However, the average copay among beneficiaries with some out-of-pocket spending declined during the SUD implementation period.

Additional Hypothesis 4.1: The implementation of the SUD waiver will increase access to health care and improve the quality of care and health outcomes.

Sheps examined eight measures reflecting general health care quality and health outcomes in order to test the effect of the SUD waiver implementation on overall health. Sheps notes that the largest component of the SUD waiver intended to improve overall health among beneficiaries with SUD, Tailored Plans, were intended to launch earlier in the demonstration period, but have not yet launched, and thus the mechanisms for improving overall health outcomes for people with SUD are not strong. In this set of analyses, Sheps found an improvement in one measure of care – access to ambulatory / preventative visits. Sheps found that three of the measures did not have a measurable effect of the SUD waiver, and four of the measures showed worse outcomes associated with the SUD waiver implementation.

Additional Hypothesis 4.2: The implementation of the SUD waiver will increase the rate of use of behavioral health services at the appropriate level of care and improve the quality of

behavioral health care received.

This section mostly focuses on the impact of the SUD waiver on mental health measures. A high proportion of people with substance use disorders also qualify for mental health diagnoses. Sheps tested hypothesis 4.2 on access to and quality of behavioral health care for beneficiaries with SUD diagnoses using 18 measures, including 13 that had been used in prior hypotheses (see Table 1). One of the measures was unaffected by the Medicaid SUD transformation (antidepressant management during the acute phase), while all remaining 17 measures declined during SUD implementation. These estimates attempt to control for trends observed during the COVID-19 PHE in the Medicaid beneficiary population without SUD and not transitioned to standard plans, but these adjustments are not without limitations due to the differences in these populations.

Stratified analyses show important declines in several disparities in care across numerous dimensions and effects both directly from SP implementation as well as indirect effects in the beneficiary population with SUD diagnoses.

Conclusions

The results from this assessment reflect the tremendous sacrifices and pivots that North Carolina, like virtually all other states, had to make during the COVID-19 PHE. The components of the demonstration that affect SUD treatment were only beginning to gain traction as the PHE began, having been implemented only 10 months before its start. Most NC DHHS staff and providers worked under extraordinary conditions that lasted longer than anyone expected. Many professionals left the public health and medical workforce at a time of greater demand for substance use services. The findings in this evaluation do not in any way detract from the dedication of the thousands of dedicated public health professionals who accomplished daily miracles during this time. The SUD waiver is the most challenging demonstration component to evaluate because it is not a discrete event, like managed care launch, but comprised multitudes of policy changes and approvals, many of which are still in progress. For example, the launch of Tailored Plans has been postponed several times and may have limited the momentum of SUD waiver implementation.

There are some bright spots in this assessment: the number of beneficiaries diagnosed with a substance use disorder has started to decline, consistent with the stated goals of the demonstration, the number of people using evidence-based medication treatments for opioid use disorder is increasing, the continuity of pharmaceutical care for OUD is increasing, more providers are available to provide SUD services to beneficiaries, fewer beneficiaries without cancer are receiving opioid prescriptions from multiple providers, and beneficiaries with SUD diagnoses are accessing more ambulatory and preventative care.

However, Sheps clearly identified serious lack of access to many essential services for people with substance use disorders, even after the implementation of many of the components of the SUD waiver. Performance on most of the SUD metrics required by CMS for SUD 1115 waiver monitoring declined rather than improved during the demonstration period. The percent of beneficiaries with SUD receiving any type of care has stagnated at 35-40% of the population identified for treatment. This statistic alone indicates that more than 60% of people in the target population are not receiving any type of Medicaid-paid SUD service in a given month. The percent of beneficiaries with a diagnosed SUD condition receiving outpatient SUD services has dropped to levels below those experienced during the initial months of the PHE when the state was under stay-at-home orders. These levels indicate that in a typical month almost 75% of the eligible population is not receiving a single outpatient service. Finally, over 40% of non- elderly adults with opioid use disorder are not accessing evidence-based medication treatments for opioid use disorder, an essential tool to fight this deadly condition.

HOP Evaluation

Commented [JM12]: Will there be plans in the future to compare standard plan metrics to tailored plans/PIHPs?

The Department's first Rapid Cycle Assessment (RCA) on the HOP program includes data regarding preparations for service delivery and delivery of services from March 15, 2022, to November 30, 2022. A subsequent RCA, interim evaluation and summative evaluation will be submitted to CMS by the end of the demonstration period. The Department will include in the final submission to CMS in October updated evaluation findings, if available.

The Pilot aims to test evidence-based, non-medical interventions for their direct impact on North Carolina's Medicaid beneficiaries' health outcomes and healthcare costs, with the purpose of incorporating findings into the Medicaid program. The three evaluation questions and hypotheses for HOP that are explored in the first Rapid Cycle Assessment are:

- Evaluation Question 1 ("Effective Delivery of Pilot Services") analyses relate to activities undertaken by Network Leads and HSOs to establish the necessary infrastructure, workforce, and data systems needed to effectively contract with and build the capacity of a network of HSOs, and to deliver Pilot services once established. Overall, Evaluation Question 1 analyses help test the hypothesis that Network Leads will enable effective delivery of Pilot services
- Evaluation Question 2 ("Increased Rates of Social Risk Factor Screening and Connection to Appropriate Services") analyses relate to how the coordinated activities of HOP Administrators, Network Leads, and HSOs facilitate screening for social risk factors/needs in Pilot regions, and connect a higher proportion of those with social risk factors/needs to services to address those needs in Pilot regions, compared with non-Pilot regions that do not have these coordinated activities. Overall, Evaluation Question 2 analyses help test the

hypothesis that HOP will increase rates of Medicaid beneficiaries screened for social risk factors and connected to services that address these risk factors.

- Evaluation Question 3 ("Improved Social Risk Factors") analyses relate to improving the social risk factors that Pilot enrollees experience, across all eligibility categories: adults, pregnant individuals, children ages 0 to 21, and the subset of children age 0 to 3. Evaluation Question 3 analyses help test the hypothesis that HOP will measurably improve the qualifying social risk factors in participants.

The findings of the assessment are largely positive:

- North Carolina's goal of establishing effective multi-sector collaboration between the state, HOP Administrators, healthcare systems, and HSOs has been achieved. Although there are always areas of operations that can be improved, this was a major undertaking completed in a relatively compressed timeframe after unavoidable disruption due to the COVID-19 pandemic. In preparation to deliver services, staff at Network Leads and HSOs interviewed expressed concern about the scale of the task and the differences between the structure of HOP and their usual methods of operation, including interfacing with the Medicaid regulatory environment. Network Leads and HSOs began by collaborating with a core group of other organizations they had previously worked with, but substantially grew their collaborations so that a wide array of Pilot services could be offered.
- From the perspective of Network Leads and HSOs, benefits of participating in HOP include building networks of collaboration, supporting growth of HSOs, and improving community health and wellness. Components of HOP that Network Leads and HSOs thought were key to success included support for capacity building, facilitating of communication between HOP Administrators, Network Leads, and HSOs, and detailed planning for the complicated logistics of delivery Pilot services to a large number of participants.
- Operational data reveals that despite challenges, Pilot services are being delivered successfully. As of November 30, 2022 (seven months following launch), 2,705 unique individuals have been enrolled, and 14,427 services have been delivered across many different intervention types by 84 HSOs. Initial assessments of social needs occur quickly (most commonly at the time of enrollment). Within the data used for this report, 63% of those who enrolled—1,713 out 2,705 Pilot participants—had received at least one invoiced service, with more participants in the pipeline to receive services as time progresses. Further, there can be a lag between service delivery and invoicing for services. Services delivered typically began quickly--over 75% of services had a start of service date within 2 weeks of enrollment in HOP. The rate of service receipt varied across need types. 68% of individuals reporting a food need received an invoiced food service during this

period, while 40% of those reporting a housing need received an invoiced housing service, and 16% of those reporting a transportation need received an invoiced transportation service. This difference may reflect both the phased rollout of services, with food services preceding all other services, and the complexity of delivering services to address the varying needs. For example, housing shortages are common in many communities served by HOP, and the availability of transportation resources varies across communities as well. Very few cross-domain services were invoiced during this period, and no toxic stress services were invoiced during this evaluation period including IPV-related services, as these services were not yet offered. Food services constituted the majority (90%) of services delivered.

- Invoices for services were paid in a timely fashion. 56.2% of invoices were paid within 30 days, 90.3% within 60 days, and 97.9% within 90 days. This is important as a major goal of HOP was to ensure that HSOs, many of which historically depend on grant funding received prior to delivery of services, could operate successfully with a financing model that includes payments made after services were delivered.
- Overall, the evidence regarding the effectiveness of Pilot services at addressing social needs was mixed. As anticipated, Sheps observed an initial increase in recorded needs as needs are identified by detailed assessments around the time of enrolling in the Pilot, followed by a decrease in needs as Pilot services address them. However, the magnitude of the decrease in needs was small and may not be clinically meaningful. For example, Sheps estimated that soon after enrollment in HOP, individuals reported an average of 1.73 needs, which declined to 1.68 needs at 90 days after enrollment. While statistically significant, whether a decrease of this magnitude is likely to improve health, healthcare utilization, or healthcare cost is unclear. Although prior studies have shown that improvements in social needs can be seen within 90 days, this is still a very brief time period for assessment, and greater changes may become evident over longer periods of observation. At present, there have not been enough individuals with longer Pilot participation to examine needs at 180 or 365 days. Such analyses will be reported in subsequent assessments.
- When examining specific needs, Sheps estimated that the probability of an individual reporting a food need at 90 days after Pilot enrollment (0.85) was almost identical to the probability around the time of enrollment (0.86). Similarly, the probability of reporting a housing need was 0.55 around the time of enrollment and still 0.55 at 90 days after Pilot enrollment, and the probability of reporting a transportation need was 0.31 around the time of enrollment and 0.29 at 90 days after Pilot enrollment. IPV-related and toxic stress needs were not reported very frequently during this evaluation period, so Sheps cannot

draw conclusions about changes in those need types (and again, IPV-related services were not yet available in this time period. Two key limitations in interpreting these findings, however, are the relatively short enrollment time for most Pilot participants, and the possibility of bias owing to differential reassessment such that those whose needs went unmet were reassessed more frequently than those whose needs were met and required less contact with Pilot staff.

- Sheps observed interesting findings regarding specific services. A key rationale for conducting and evaluating HOP is that there are often different services that might plausibly address a need, without sufficient comparative effectiveness evidence to choose one over another. For example, both a food subsidy (such as a fruit and vegetable prescription) and delivery of healthy meals might address food needs, but which is more effective is not clear. Sheps did find suggestions of variations across intervention types. Healthy meal delivery was associated with lower probability of reporting a food need at 90 days of enrollment in HOP than other food services offered within HOP like fruit and vegetable prescriptions and food boxes, and these differences were large enough that they may be clinically meaningful. For example, the probability of reporting a food need at 90 days was 0.08 lower (95% Confidence Interval [CI]: 0.12 lower to 0.02 lower, p = .001) with delivered meals compared with fruit and vegetable prescriptions. Similarly, with regard to housing services, tenancy support and sustaining services (which provide one-to-one case management and/or educational services to prepare an enrollee for stable, long-term housing) were associated with lower probability of reporting a housing need after 90 days of Pilot enrollment than other types of housing services.
- These findings thus support the rationale of using HOP to develop evidence on the comparative effectiveness of social needs interventions, so that the State of North Carolina can make an evidence-informed decision as to what services to offer for all Medicaid beneficiaries in subsequent years. However, these findings should also be interpreted cautiously at this time, as receipt of services was not randomly assigned, and thus the association observed may be confounded. Subsequent stages of the evaluation will be better able to address this potential threat to the validity of the findings.
- The ability to address some questions of interest in this assessment was hindered by the number of individuals enrolled in HOP. HOP was designed to ramp up during this assessment period, and so the enrollment numbers may reflect that. Another explanatory factor could be that methods of social need assessment and enrollment require iteration. In any event, working to increase enrollment in HOP is a major goal going forward.

Plans for Evaluating Impact of Demonstration Renewal

North Carolina will continue to contract with an independent evaluator to assess the impact of proposed new demonstration features. North Carolina is proposing the research questions, hypotheses, and proposed evaluation approaches described below to include as part of its evaluation design.

North Carolina will continue to incorporate rapid cycle evaluation into its broader evaluation strategy to understand the impact of the services funded through managed care savings in real time. North Carolina will use the findings to adjust how it spends its savings to ensure that it is investing in models that advance the demonstration goals, while discontinuing initiatives that are not making an impact.

North Carolina will also continue to identify strategies to assess the extent to which the demonstration is addressing gaps in health outcomes and decreasing health disparities. During the demonstration period, North Carolina is working to improve its data systems and collaborate with community partners to strengthen the State's ability to collect and analyze data related to health outcomes, disparities and gaps in care for populations which have marginalized. This demonstration seeks to test the hypotheses outlined in Table L below through its continuing and new initiatives. Specific evaluation methodology will be submitted upon approval of the application via the revised evaluation design. As appropriate, the State will work with CMS to refine the evaluation goals and the hypotheses described in Table L prior to submitting the proposed evaluation design.

Table L. Approach to Evaluation for Demonstration Renewal

Hypotheses	Evaluation Approach and Data Sources
Managed Care	
• Improve health outcomes for Medicaid enrollees in managed care via a new delivery system • Maximize high-value care to ensure sustainability of the Medicaid program • Reduce Substance Use Disorder (SUD)	Approach and data sources will be consistent with the North Carolina Medicaid Reform Demonstration Approved Evaluation Design, including: • Primary care/OB survey • Beneficiary interviews
Healthy Opportunities	

• Improve health outcomes for Healthy Opportunities Pilot participants • Improve the share of Medicaid enrollees receiving Pilot services that report improvements in unmet resource needs	Approach and data sources will be consistent with the Enhanced Case Management and Other Services Pilots Evaluation Design; Attachment H
Continuous Enrollment	
• Reduce churn and gaps in Medicaid coverage for children and youth, including for racial and ethnic groups that experience disproportionately high rates of churn • Improve health outcomes for children and youth	Analysis of enrollment and claims files
Justice Involved Pre-Release Services	
• Increase Medicaid coverage for justice-involved individuals • Improve health outcomes for justice-involved individuals, including by improving transitions into the community following release	Analysis of data files, including: • Claims linked with criminal justice indicators • Data on preventive and routine physical and behavioral health care • Data on avoidable ED visits and inpatient hospitalizations
Behavioral Health and I/DD Technology	
• Improve rates of real-time data sharing with the North Carolina HIE (HealthConnex) among participating behavioral health and I/DD providers • Improve rates of schools equipped with technologies need to improve billing and tracking for delivery of services and referrals among participating school providers	• Analysis of Medicaid Enterprise Systems (MES) documentation • Survey and/or analysis of providers
Behavioral Health and LTSS Workforce	

• Reduce workforce shortages • Increase provider retention and Medicaid participation among BH, I/DD and LTSS providers who serve Medicaid beneficiaries in North Carolina	• Analysis of administrative data such as Medicaid billing data, NC Health Professions Data System, and/or HCBS electronic visit verification • Survey and interviews of providers

From: [redacted]
To: Medicaid.NCEngagement
Cc: [redacted]
Subject: [External] NC Section 1115 Waiver Renewal Application
Date: Wednesday, September 20, 2023 12:37:17 PM
Attachments: Comments to DHHS on Medicaid Waiver Application_Final.pdf

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Dear NC Medicaid Section Waiver Team,

We are pleased to offer our comments on the Department's proposed Section 1115 Renewal application to CMS.

We hope that our feedback is helpful and informative and appreciate your diligent pursuit of creating a stronger, more equitable, and sustainable healthcare system for all North Carolinians.

Sincerely,
Tina

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TINA SIMPSON, JD, MSPH
Principal

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North Carolina Department of Health and Human Services
NC Medicaid Section 1115 Waiver Team
1950 Mail Service Center
Raleigh, NC 27699-1950

Medicaid.NCEngagement@dhhs.nc.gov

RE: NC Section 1115 Waiver Renewal Application

Dear NC Medicaid Section 1115 Waiver Team,

Please find enclosed our comments in response to the Department's Draft Section 1115 Waiver Renewal.

We admire the vision the Department of Health and Human Services (the Department) has outlined for a transformed health system equipped to support wellness and equity across communities. We applaud the successes of the Healthy Opportunities Pilot to date. Finally, we appreciate the opportunity to share our experiences and comments to continue strengthening North Carolina's pursuit of Medicaid Transformation and improving the health and well-being of all residents.

All feedback and comments are based on our direct experience assisting providers, Network Leads, and Human Service organizations under the most recent Medicaid waiver over the past five years. For your ease of reference, our ten comments are organized into three categories based on the Department's three stated objectives of the renewal application and are numbered. We have focused our comments on Objectives 1 and 2.

If there is a single unifying takeaway that we wish to stress through these comments, it is this: our collective ability to transform our healthcare delivery system depends upon the independence, resilience, and adaptability of our providers and supporting health service organizations. North Carolina must continue to practice constant vigilance to ensure a fair and equitable playing field and that these organizations – particularly the smaller provider practices and community-based organizations have the resources and support needed to complete their missions. Investments in the integrity of the system and the empowerment of stakeholders continue to be necessary and a sound investment.

Sincerely,

[redacted]H

Principal
Atrómitos, LLC

Comments Regarding Objective 1 Initiative 1a

> ***"Provide integrated whole-person, well-coordinated care for the majority of Medicaid enrollees through continued implementation of Standard Plans. "***

In our experience, the ability to offer integrated, well-coordinated whole-person care for Medicaid beneficiaries relies upon the strength, stability, and resilience of Medicaid providers. This means that it is essential that Medicaid providers are systemically supported while undertaking this care delivery transformation envisioned and adjusting to the operational challenges inherent to the transition to managed care.

Comment 1:

What support or oversight does the Department envision for fair, effective, and responsive contracting between providers and PHPs?

The relationship between Medicaid providers and Pre-Paid Health Plans (PHPs) is governed, first and foremost, by contract. The Advanced Medical Home model and Medicaid Transformation are predicated on the flexibility of good faith contract negotiations between providers and PHPs. The Department has a critical and indispensable role in ensuring (1) fair and good faith contract negotiations between providers and PHPs that are consistent with the objectives and framework outlined by the State and (2) oversight of PHP adherence to contract protections of both providers and Medicaid beneficiaries.

North Carolina is fortunate to have a high number of independent provider practices compared to other states.[1] While this presents important advantages as it relates to the "health" of the State's health system – it is important to recognize the power disparity between providers (specifically independent providers) and PHPs. It is, unfortunately, too common for PHPs to be unwilling or operationally unable[2] to negotiate contract terms with smaller, independent providers. This includes everything from Care Management rates to other contract terms. During the implementation of Medicaid Managed Care, the Department had to intervene on multiple occasions, issuing guidance on its expectations on contract negotiations – and eventually establishing minimum care management rates.

The Department has recently communicated that it will not publish a minimum care management rate for AMH contracts between Standard Plans and providers going into the new procurement period. In our direct experience negotiating contracts with PHPs on behalf of providers absent this protection from the state, the PHPs intended to pay insufficient care management fees, between 2 and 4 times less than what NC DHHS ultimately identified as the likely cost of providing the required level of care management. Can the Department outline its rationale for this approach? Are there other supports or resources the Department anticipates having in place or utilizing to ensure the integrity and efficiency of provider contracting under the Standard Plans going forward?

Comment 2:

What support or oversight does the Department envision deploying to ensure timely adherence to contract terms by PHPs as may arise related to (1) claims administration, (2) appeals, and (3) systemic operational challenges?

The transition to managed care represented a huge operational transformation for many practices. The Department and all stakeholders are to be commended for the rapid troubleshooting associated with systemic operational issues that arose during implementation (particularly during the Public Health Emergency). We particularly wish to applaud the Department for the institution and maintenance of the AMH Technical Advisory Group and hope this workgroup continues. This monthly forum allows the Department to collect “real-time” stakeholder feedback and troubleshoot issues.

In addition to the AMH Technical Advisory Group, we encourage the Department to consider additional avenues and resources that the Department may use or have available to oversee PHP administration – particularly on operational issues impacting providers, particularly providers operating outside of a large health system. Again, we commend the Department for its efforts to track and resolve issues at a systemic and aggregate level. **However, we suggest that additional resources and infrastructure may be needed to collect direct feedback from smaller, independent providers as the aggregate level monitoring may not be**

sufficient to capture the day-to-day administrative and operational challenges experienced by many providers as it relates to issues such as (1) PHP responsiveness; (2) claims administration; and (3) appeals and claims disputes. In our experience, many providers feel "caught" navigating the various byzantine PHP operations and procedures. When issues fall through the cracks, it feels like there is no effective recourse.

We raise this question and concern because of our own experience related to the NC Medicaid Ombudsman. In one experience, a pressing issue regarding a PHP's failure to follow its procedures related to claims disputes and appeal procedures remained outstanding with the Ombudsman for nearly five months without any discernable action by the assigned representative, despite routine follow-ups and our updates to the Ombudsman of our independent efforts at resolution. While eventual, important progress was made, the experience was very frustrating and required the provider to expend considerable resources on external support and internal staffing to obtain any resolution.

We identify additional resources for the administration of the Ombudsman office as a necessary measure in the ongoing operation of Medicaid managed care. **There is a strong public interest in preserving the viability of smaller, independent healthcare providers across the State – particularly in rural areas**. **An important step in accomplishing this is to ensure that those providers are supported when seeking to address operational issues or otherwise enforce negotiated contract terms with PHPs.**

Comments Regarding Objective 2 – The Expansion of Healthy Opportunities Pilot Services

We are thrilled that the State has decided to expand the Healthy Opportunities Pilot (HOP) services and infrastructure to beneficiaries across the State. North Carolina is leading the nation in the design, deployment, and evaluation of the effective delivery and integration of health-related social needs through Medicaid, and we are very proud of the State's vision and the progress made by all contributing stakeholders.

Comment 3:

We suggest reframing and rephrasing Objective 2 to acknowledge the need to establish the necessary infrastructure and capacity development in non-pilot regions before being able to expand access to integrated services.

Our first comment relates to the phrasing and framing of the second objective, which is currently framed as "expanding access to a person-centered and well-coordinated system of care integrating both medical and non-medical drivers of health." We suggest that this should be reframed to more accurately reflect the diversity of preparedness or implementation of this desired future state of a person-centered and well-coordinated system of care that systematically addresses both medical and non-medical drivers of health.

We suggest the following revision of the objective so that it reads:

> *Establish or expand and sustain a person-centered and well-coordinated system of care that addresses both medical and non-medical drivers of health across the State.*

As currently phrased – where the focus is on expanding access – it sets an unrealistic expectation that the desired final state (namely a person-centered and well-coordinated system of care that addresses both medical and non-medical drivers of health) exists – and that it is primarily a matter of expanding access to this network and system to more people. While extraordinary and laudable progress has been made in this aspiration - this is not the case even in existing Pilot counties where HRSN services are already available. Acknowledging the evolving need for continued refinement, capacity development, and system transformation in no way undermines the significant and critical investments made by the State to date – or the stellar work of all stakeholders in launching this initiative. Instead, it simply illustrates the magnitude of the task – and the iterative nature of any transformation.

North Carolina's vision for integrating health and health-related social needs is revolutionary and transformative. Establishing the foundations for this level of complex system transformation will take more time and resources than a single waiver period. Developing the model and processes for implementing

that vision is iterative and evolving. There remains a great deal of network and capacity development work to be done – in addition to refining the administration of services in a way that is (1) sustainable, (2) equitable, (3) representative of community needs, and (4) imposes the least unnecessary burden on network Health Service Organizations. This includes requiring continued investment in and resources for current pilot regions.

We believe that it is a disservice to the Department's vision of care transformation to not fully and frankly recognize that even in a renewal of the waiver application, we are necessarily still developing, testing, and refining the model, which we hope will help us realize this objective of integrated, person-centered care, delivered in a manner that is well-coordinated, repeatable, and equitable.

We also offer the following additional comments and questions related to HOP Expansion for your consideration:

Comment 4:

We are pleased to see the allocation of capacity development funds for counties yet to be served by the Pilot. Does the Department anticipate allocating resources or support for HSOs in Pilot counties going forward? As explained above, the existing Pilot sites need ongoing investment to develop further the community's capacity to meet the community needs.

Comment 5:

In our experience and observation, there is a great diversity in the nature and scope of support needed by Health Service Organizations. Has the Department considered developing a plan to address HSO needs or maturity development at a state level? Frequently, the smaller organizations – the ones with the most immediate relationships within the community – and, therefore, with potentially the most significant impact, need the most assistance. We strongly recommend the Department, potentially in coordination with other State Agencies, consider creating an initiative to provide additional resources, capital funds, and technical assistance and support to smaller nonprofit organizations. This support for HSOs should include investments covering information technology, contract negotiation

and understanding, and continued compliance and billing support. Our experience working directly with a Network Lead and its HSO network has conclusively identified these needs, with many critical HSOs not participating in the pilot because of these needs and lack of capacity internally.

Comment 6:

While recognizing the need for flexibility, we encourage the State to provide greater guidance regarding the planned deployment of HRSN services across the state. For example, which domains (and services within those domains) are expected to be launched statewide? Information on the projected direction and format of expanded services will assist stakeholders seeking to support the expanded launch in capacity development planning and coordination with potential HSO partners. In addition to helping stakeholders in the State prepare for this next phase of Medicaid Transformation, we believe the Centers for Medicare and Medicaid Services will likely expect additional controlling criteria or navigational direction.

Comment 7:

One recurring concern identified through the State's stakeholder engagement and evaluation of the Pilot centered on questions around the sustainability of Pilot services and the administration of the HSO network going forward. Lack of clarity around the long-term sustainability of pilot service delivery was identified as a barrier to various HSOs in the pilot through stakeholder engagement and program evaluation. While this remains a "moving target," we firmly believe that planning for and communicating the Department's long-term strategy to sustain the infrastructure and networks developed through these waivers is critical. We strongly encourage the State to provide guidance on its expectations or aspirations regarding the sustainability of (1) Network Lead administration and support and (2) HRSN service delivery by HSOs. **Without this guidance, Network Leads and HSOs may feel they cannot take steps to implement sustainability efforts, which will significantly impede efforts later.**

Comment 8:

The Department highlighted the importance of the close communication and collaboration of Network Leads, PHPs, and the Department throughout the design and deployment of the Pilot. We commend the Department for the success of this complex implementation and rapid evaluation and

iteration. We agree that the structured collaboration and troubleshooting across stakeholders was critical to the pilot's effective implementation. **How does the Department anticipate maintaining this effective communication and collaboration level while expanding pilot services statewide?**

We strongly encourage the Department to plan for the same level of communication and collaboration in the next phase of the pilot – including the availability of the Network Lead's access to Department expertise and resources. We also recommend that the Department formally leverage existing Pilot Network Leads to support new lead entities as they enter the coalition.

Comment 9:

A big takeaway from the published evaluation of the pilot to date has been the depth of need across communities related to health-related social needs and, in some instances, the degree to which existing resources and networks struggle to meet those needs: housing being the pre-eminent example. Has the Department considered any statewide or regional plans to expand access to affordable housing to complement or dovetail with pilot services? While the Department is likely already well aware of other state's efforts in this area – we would like to highlight Washington State's inter-agency housing initiative (Apple Health and Homes), which provides capital development and other capacity development and support funding for organizations to assist in the recruitment and retention of participation in the state's Foundational Community Support Service program. While this pilot anticipates significant capacity development funds available to HSOs, **planning for additional funding and coordination from other state departments is likely to be (1) needed to meet needs and (2) advantageous to North Carolina's application to CMS, which has identified coordination across Department and demonstrating that the state has maintained or expanded state funding for HRSN programs external to Medicaid funding as a controlling criterion in its evaluation of new applications**.

Comment 10:

Finally, we wish to applaud the State on its HOP network design and the creation of Network Leads as a critical player in the pilot. Network Leads are responsible for essential administrative and operational tasks and represent

the needs and interests of diverse network HSO participants. Their depth of understanding of community needs and potential "levers" of influence is invaluable. **We strongly encourage the Department to draw upon the expertise and experience of the existing Network Leads in planning for and deploying HOP services and networks across the state. Similarly, we hope the infrastructure developed throughout this first phase of Medicaid Transformation is sustained and expanded**. Network Leads, as community-based organizations, serve as an essential bridge between health systems and human service organizations and constitute a critical "public forum" and center of innovation and transformation going forward.

[1] Provider consolidation has been associated with increased costs and, in some measures, stagnation or reduced quality by some metrics and reduced access in more rural communities. *See e.g.,* Karyn Schwartz, Eric Lopez et al, "What We Know About Provider Consolidation," Kaiser Family Foundation, September 2, 2020.

[2] A specific example of this is the use of PHP provider representatives who do not have the authority to negotiate any changes to the model contract.

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 9:30:59 AM

Good Morning,

Please see comments below regarding feedback for the Healthy Opportunities Pilot. Over the last year, the services provided through HOP have been vital to the overall health and well-being of our clients and their long term sucess.

1. RETAIN: Impact Health strongly supports the following items in the state's draft application:

- Whole-person integrated approach to care supported by a care management model.
- Expansion of geographic eligibility to include all 100 counties.
- Expansion of pilot eligibility to include all pregnant and postpartum women, justice-involved individuals, those who are "at risk of" a chronic condition, individuals with only one chronic health condition, individuals recently impacted by natural disasters, children/youth who receive adoption assistance and all Tailored plan members and Tailored Care Management eligibles in prepaid inpatient health plan (PIHP).
- Expansion of meal services to three meals per day.
- Availability of capacity building funds throughout the demonstration waiver period.
- Central role of NLs in ensuring the pilot's success.

2. MODIFY: Impact Health believes the following items could be improved upon:

- Refine language around rental assistance to include:
  - up to six months of rental assistance including payment of arrears
  - for all enrollees who demonstrate need (not just high-needs enrollees).
- Prioritize investments in community-based organizations and local service delivery models.
- Increase capacity building budget allocation and/or significantly increase fee schedule payments to ensure there are sufficient and sustainable resources for human service organizations (HSOs) and NLs to scale pilot services across all 100

NC counties.

3. CLARIFY/ADD: Impact Health requests the following clarifications and additions:

- Expand eligibility to include all NC Medicaid members—regardless of coverage type—who screen positive for a pilot-supported social health need.
- Clarify HOP eligibility of Medicare/Medicaid dual enrollees.
- Include all HOP services in pre-release Medicaid services available to justice involved individuals.
- Allow continuous access to HOP services for justice-involved individuals for 1-year post-release.
- Clarify that current NLs and HSOs do not need to reapply under the new waiver.

Additional Recommended Pilot Enhancements
Fee Schedule Improvements

- Standardize fee schedule statewide to reduce the potential for confusion, referral delays and rejections.
- Approve additional evidence-based parenting curricula in alignment with NC Partnership for Children to allow HSOs to leverage existing resources to meet regional needs.
- Review all services to ensure a coordination or admin fee is included.

Network Development

- Give contracting preference and/or incentives to local, community embedded HSOs to promote equity and improve pilot enrollment, member satisfaction, expansion of services/geography and culturally inclusive service delivery.
- Prioritize and incentivize local health and social service agencies to participate in the pilot.
- Provide ongoing capacity building funding to support NLs who play a critical role in developing and maintaining network diversity, capacity and sustainability.
- Strengthen and expand NL's role to ensure pilot success by:
    - providing NLs with access to detailed member eligibility lists to allow NLs to build enrollment penetration maps by zip code, county, domain and/or attributed practice,
    - funding existing NLs to onboard and provide training and technical assistance to new NLs and new and existing PHPs, CINs and other stakeholders,
    - engaging NLs as primary regional representatives in state-level decision-making, and
    - partnering with NLs to create and implement a comprehensive communications and public relations strategy.

Digital Platform & Billing Process Improvements

- Develop a clear pathway and process to support data sharing between pilot stakeholders to ensure NLs can make data-driven decisions and conduct continuous quality improvements.
- Improve the accuracy and efficiency of the pilot's digital billing processes by implementing technical solutions that
    - standardize billing practices using 837 and 835 data sets,
    - integrate benefits inquiries and responses (270/271 data sets) to provide HSOs with real-time access to client eligibility data, and
    - improve the user experience by providing functionality for data searches, claims management, and elimination of duplicate claims.

Compliance and Quality Assurance

- Require HSOs who directly contract with PHPs to participate in NL compliance activities to ensure network adequacy and service delivery quality.
- Increase accountability and transparency around PHP responsibilities regarding care management network adequacy, quality improvement, and payment processes.

Jennifer Turner-Lynn Assistant Director, REACH of Macon County
Phone: 369-5544
[redacted]
REACH Work Email:
[redacted]
Website: www.reachofmaconcounty.org
Address: 29 Meadowlark Drive, Franklin, NC 28734

From: [redacted]
To: Medicaid.NCEngagement
Cc: [redacted]
Subject: [External] NC Section 1115 Demonstration Waiver Renewal Comments
Date: Wednesday, September 20, 2023 10:30:20 AM
Attachments: 1115 Waiver Renewal Comment_Reinvestment Partners.pdf

Good afternoon,

Please see attached document with comment regarding the NC Section 1115 Demonstration Waiver Renewal, submitted by Reinvestment Partners, a participating Healthy Opportunities Pilot Health Service Organization.

Please contact Kate Gonzalez Redding with questions or follow-up regarding these comments.

Thank you,
Kate

--

Kate Gonzalez Redding (she/her)
Healthy Homes Coordinator, Reinvestment Partners

A 110 East Geer St, PO Box 1929, Durham, NC 27702
D (984) 209-1788 **P** (919) 667-1000 Ext. 35
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W reinvestmentpartners.org

Reinvestment PARTNERS
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September 19, 2023

North Carolina Department of Health and Human Services
NC Medicaid Section 1115 Waiver Team
1950 Mail Service Center
Raleigh, NC 27699-1950
Subject: NC Section 1115 Waiver

To NC Section 1115 Waiver Team:

Reinvestment Partners (RP) has been a participating HSO providing Healthy Home Goods services in the Healthy Opportunities Pilot since May 2022. We would like to submit the following comments and enclosed attachments regarding the pilot portion of the draft NC Section 1115 Demonstration Waiver application.

RP supports the expansion of the pilot to all 100 counties, statewide.
The design of RP's Healthy Home Goods service is easily adaptable for statewide service delivery. Please see page two of the enclosed attachment for more information on our support of expansion.

RP supports the flexibility for health plans and HSOs to contract directly with one another.
RP has contracted directly with Healthy Blue for 'expedited enrollment' of the produce prescription program and demonstrated that some HSOs have the capacity and infrastructure to partner directly with PHPs. We are able to sign Master Service Agreements with PHPs and submit batch claims to them. Furthermore, partnering directly with PHPs would allow us to use administrative data to target specific populations who would be best served with healthy home goods for improved health outcomes and cost-savings. Please see page four of the enclosed attachment for more information.

RP requests a revision of the fee schedule for healthy home goods to a flat fee-for-service.
The greatest hurdle for RP's Healthy Home Goods program is that the fee structure does not support sustainability. In fact, it does not cover the costs of the program. RP requests a shift from reimbursables to a $2500 per client fee-for-service which would allow for program sustainability. Please see page four of the attached document for supporting research and further explanation.

Thank you for your consideration of these comments.

Sincerely,

[redacted]

Peter Skillern
CEO, Reinvestment Partners

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Tel (919) 667-1000 • Fax (919) 688-0082 • www.ReinvestmentPartners.org

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Breathe Easy Proposal

Reinvestment Partners' (RP) Breathe Easy program is designed to demonstrate the cost effectiveness of identifying and mitigating in-home asthma triggers as a non-medical intervention to improve health outcomes. The program pairs home assessments through virtual home visits with the provision of equipment designed to help mitigate environmental triggers. The goals of the program are to reduce preventable asthma emergency department visits and hospitalizations among high-risk Medicaid members with asthma and therefore create better health and cost savings. In less than a year's time, Reinvestment Partners has delivered Breathe Easy services to 186 HOP clients.

RP's Breathe Easy program is a scalable program that can help the state meet its goals with the Healthy Opportunities Pilots:

- Consistent high-quality services that are research based and have been shown to reduce asthma ED visits and hospitalizations
- Utilize technology and data to conduct affirmative outreach to Medicaid beneficiaries that would benefit most from the intervention
- Increased enrollment through a scalable service that can provide services statewide
- Provide an intervention to study for cost effectiveness in the transition to value sharing

Reinvestment Partners requests that NCDHHS:

1) Revise the fee schedule for the Breathe Easy Healthy Homes intervention to a flat fee-for-service of $2500 per client served to allow for sustainability.
2) Allow Reinvestment Partners to develop an expedited enrollment process directly with PHPs for this program to use affirmative outreach for eligible members.

Breathe Easy is an evidence-based intervention designed to address in-home environmental triggers of asthma.

In North Carolina, 645,784 children and adults in North Carolina have asthma, representing 7.8% of the total population.[1] There are economic and racial disparities for asthma. Children living below the poverty line have higher rates of asthma, as do African American children. Black children are more likely to have asthma compared to white children – more than double the rate for children ages 5 to 14.[2] [3] Black children are also more likely to be hospitalized for asthma. Breathe Easy is working to address equity issues around asthma by addressing environmental triggers.

[1] Centers for Disease Control and Prevention, Most Recent Asthma State or Territory Data, https://www.cdc.gov/asthma/most_recent_data_states.htm, accessed February 28, 2023.
[2] https://wwwn.cdc.gov/NHISDataQueryTool/SHS_child/index.html, accessed 2/28/2023.
[3] Centers for Disease Control and Prevention. (2023). 2020 National Health Interview Survey data. U.S. Department of Health & Human Services. Retrieved from: https://www.cdc.gov/asthma/nhis/2020/data.htm, accessed 2/28/2023.

Asthma is a chronic medical condition that requires ongoing management. One of the approaches to asthma management is to address the triggers that drive asthma patients into hospitals. Up to 40% of all incidents of asthma for non-white children are attributable to home-based environmental health hazards.[4] Research estimates that 44.4% of those with doctor-diagnosed asthma have one or more residential exposures.[5] Home interventions that address environmental asthma triggers in the residential environment have been effective at helping control asthma and improving the quality of life for children and adults with asthma.

Home Asthma Response Program (HARP) in Rhode Island, in which families receive home visits to assess potential asthma triggers, education on asthma self-management, and supplies to reduce in-home triggers, found that program participation reduced pediatric asthma-related hospital and emergency department costs by 75%. The analysis suggested that the program produced a positive return on investment of $1.33 for every $1.00 invested.[6] The subset of high utilizers, which had two or more previous emergency department visits had an ROI of 126%, earning $2.26 for every dollar invested.[7]

Similarly, an asthma home visit program in Seattle, Washington, which targeted children with uncontrolled asthma enrolled in Medicaid found increased symptom-free days and caretaker asthma-related quality of life and reduced urgent health care utilization and costs. This program included multiple home visits by Community Health Workers, education on asthma self-management, and the provision of supplies to reduce in-home triggers (vacuum, cleaning supplies, roach abatement supplies, and bed covers). The program yielded a return on investment of 1.90.[8]

The Breathe Easy program is based on programs that have previously been successful in addressing in-home triggers of asthma. Reinvestment Partners seeks to replicate the positive results with a slightly different design that will build consistency among service delivery and allow the program to reach scale to integrate into the health sector.

The RP Breathe Easy program is easily scaled across the state with the expansion of HOPs statewide.

The Breathe Easy program is designed to harness the benefits of previous in-home asthma self-management programs while also being scalable beyond a specific geography. Expanding statewide allows for greater enrollment and spending to meet needs of more Medicaid beneficiaries.

After referral and intake, RP reaches out to the enrolled Medicaid member to gather additional information about their needs and to schedule a virtual home assessment. A Healthy Homes Specialist

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[4] Krieger, J. (2010). Home is Where the Triggers Are: Increasing Asthma Control by Improving the Home Environment. Pediatric Allergy, Immunology, and Pulmonology, 23(2), 139–145. http://doi.org/10.1089/ped.2010.0022

[5] Lanphear BP, Kahn RS, Berger O, Auinger P, Bortnick SM, Nahhas RW. Contribution of residential exposures to asthma in us children and adolescents. Pediatrics. 2001 Jun;107(6):E98. doi: 10.1542/peds.107.6.e98. PMID: 11389296.

[6] Center for Disease Control and Prevention. “Rhode Island: A Business Case for Asthma Home Visiting Services”, State Spotlight, June 2018.

[7] Rhode Island Department of Health. The Home Asthma Response Program (HARP) Factsheet. http://www.618resources.chcs.org/wp-content/uploads/2018/05/HomeAsthmaResponseProgram-1.pdf

[8] Campbell, Jonathan, et al. (November 2015). Community Health Worker Home Visits for Medicaid-Enrolled Children with Asthma: Effects on Asthma Outcomes and Costs. American Journal of Public Health, Vol 105 No. 11, 2366-2372. Doi:10.2105/AJPH.2015.302685

conducts a virtual home visit with the household through video conferencing. The virtual home assessment includes a detailed assessment of housing conditions to identify potential environmental asthma triggers in the home. The Healthy Homes Specialist conducts a standardized survey and also uses a visual assessment to identify the areas of most concern and tailor the Breathe Easy Kit, education on asthma triggers, and determine eligibility/need for optional items. In addition, if the Housing Specialist identifies home repair needs that are causing potential health issues, the Specialist refers eligible families to existing home repair programs for more extensive home repair issues.

After the assessment, Reinvestment Partners sends families a Breathe Easy Kit that provides tools and equipment to reduce environmental asthma triggers in homes.

In special cases, such as when video conferencing is not available, the Healthy Homes Specialist may determine it is preferable to conduct an in-person home visit rather than a virtual visit. In those cases, the Healthy Homes Specialist and an assistant will visit the home and conduct the home assessment in person. They may also potentially bring the Breathe Easy Kit with them rather than ship it.

Each Breathe Easy Kit contains:

- HEPA-filtered upright vacuum cleaner
- Twelve (12) replacement vacuum bags
- Hypoallergenic latex free mattress encasement
- Pillow covers for the bedroom
- Non-toxic, asthma-friendly multi-purpose cleaner
- Non-toxic pest/rodent control devices
- Non-toxic, safe products to kill roaches
- Smart True HEPA Air Purifier (for participant bedroom)
- One extra filter for the air purifier
- Allergen air filters for HVAC system

Optional items that are provided based on the needs determined in the home assessment may include:

- Pet hair remover attachment for vacuum cleaner
- Air conditioner/heater
- Fans
- Wet Mop
- Mattress
- Bed frame
- Fans
- Dehumidifier
- Moisture and humidity reader

Within 2-4 weeks after the initial home visit, the Healthy Homes Specialist follows up with a video phone call to check in on the family and answer any questions about the Breathe Easy kit and its use. This virtual follow-up home visit includes a short survey on housing conditions and the use of the healthy homes kit and includes follow-up on any previously identified issues. The Healthy Homes Specialist identifies any ongoing concerns and provides additional education and training. This follow-up visit provides an additional opportunity for education and keeps the family accountable to improve adherence to the program.

Revise the fee for the program to a flat fee of $2,500 per household served to simplify invoicing and claims and provide a path to sustainability.

Our Breathe Easy program is offered under the Healthy Home Goods services for the Healthy Opportunities Pilots. According to the pilot service definition, payment for Healthy Home Goods services is cost-based reimbursement up to $2,500 per year of service. This means that HSOs cannot bill for the staff time, cost of a home assessment, overhead, program management, or other costs they incur as part of service delivery. In April 2023, the Department began allowing HSOs to bill a $90 coordination fee, likely as an acknowledgement that staff time is necessary for service delivery.

Unfortunately, $90 per referral is not nearly enough to cover the staff and overhead necessary to effectively deliver Breathe Easy services to Healthy Opportunities clients. The administrative fee does not cover the overhead costs nor the cost of the home assessment. At $90 admin fee, Reinvestment Partners would have to serve nearly 900 households to cover the cost of one full time employee to manage the program – and that would not cover the cost of the home assessment or the costs of invoicing or other overhead. Therefore, it is not sustainable to continue delivering the service once capacity building funds run out.

Given that the Breathe Easy program is a standardized service delivery that includes the same essential components for all clients, RP recommends shifting to a flat fee of $2,500 per client served for the program. The $2,500 covers the cost of the equipment in the Breathe Easy kit (including optional items on an as-needed basis), the cost of the home assessment and follow-up using trained healthy homes specialists, the cost of program management, and overhead costs. That is the cost to fully cover the expenses of the program and allow for sustainability. A flat fee structure makes it simpler to invoice or submit claims for the service and allows the program to achieve sustainability over the long term.

For the biggest impact, allow Breathe Easy to use data analytics to target high-risk asthma patients who are high utilizers of high-cost services.

The intervention is designed for high-risk asthma patients. Those with uncontrolled asthma who are high utilizers of urgent health care generate the highest costs. Both the HARP program and the Seattle program found the most cost savings were generated by the highest utilizers. RP recommends targeting individuals whose asthma is not well controlled by medication as demonstrated by a hospitalization for asthma or two or more visits to the emergency department within the past six months. The goal is to reduce hospitalizations and emergency department visits for asthma.

Reinvestment Partners recommends that PHPs and/or NCDHHS use data analytics based on claims to identify the highest risk asthma members as identified by meeting one of the following criteria:

1) Hospitalization with primary diagnosis of asthma within the past six months
2) Two or more emergency department visits with the primary diagnosis of asthma within the past six months
3) Inhaled beta-agonist to anti-inflammatory ratio of 5:1 or greater

This claims-based screening will identify a subset of Medicaid members to target for the intervention who will be most likely to achieve the highest benefit from that intervention.

Allow Reinvestment Partners to partner directly with PHPs to use affirmative outreach to reach target populations rather than relying on the beneficiary to find us.

Rather than relying on Medicaid members to find their way to the Breathe Easy service, the use of claims data for risk stratification allows PHPs to conduct affirmative outreach to their members who will most benefit from the service. PHPs can send a text or email (or both!) with a unique link to a web-based enrollment portal that allows members to enroll in the Breathe Easy program directly. [9]

Alternatively, or in coordination with electronic outreach, PHPs could assign designated care managers to conduct affirmative phone outreach to target members whose claims data fits within the eligibility criteria. Care managers could then enroll the member through the enrollment portal if they are determined to be eligible.

As part of the enrollment process, members will respond to housing quality screening questions to help determine their eligibility and fit for the program.

Housing Quality Screening Questions[10]

- Do you have concerns about the condition or quality of your housing? Yes, Somewhat, No
- Think about the place you live. Do you have any problems with any of the following (check all that apply)?
    - Bug infestation
    - Mold
    - Rodents
    - Lead paint or pipes
    - Inadequate heat
    - No air conditioning
    - Water leaks
    - None of the above

If the screening questions are answered positively, then the Medicaid member moves onto an enrollment screen in which they enter their basic information, including name, address, Medicaid ID number, contact information, and electronically sign a HIPAA authorization allowing the PHP to share information with Reinvestment Partners. The enrollment process includes a text verification if the member has a mobile phone.

After enrollment, the member receives a welcome message that explains a little bit about the Breathe Easy program and shares that Reinvestment Partners will be contacting the individual (or guardian) with

[9] This affirmative outreach could come from RP, but becoming an approved vendor with DHHS would probably take too long even if we have BAAs with MCOs and therefore RP would not be able to receive the target list or contact information. Accordingly, we recommend that the Medicaid MCOs conduct the outreach with the link to the enrollment site, which could include a HIPAA authorization as part of the enrollment process.

[10] Screening questions adapted from NC DHHS, Using Standardized Social Determinants of Health Screening Questions to Identify and Assist Patients with Unmet Health-related Resource Needs in North Carolina, https://files.nc.gov/ncdhhs/documents/SDOH-Screening-Tool_Paper_FINAL_20180405.pdf

more information and to schedule an appointment. As Reinvestment Partners conducts intake with the beneficiary they can also provide contacts for case management if the member has additional needs or does not seem to be a good fit for the program upon further discussion.

Affirmative outreach will allow us to reach those high-risk members who will benefit most from the program and increase enrollment.

The Breathe Easy program allows for systematic evaluation to determine its effectiveness in improving health outcomes and reducing utilization costs.

Reinvestment Partners will evaluate the effectiveness of the program by tracking participation, participant satisfaction, the relative changes in targeted environmental markers, and asthma symptom scores.

Specifically, Reinvestment Partners will track:

- Who is enrolled and the date of initial RP outreach
- Which clients participate in a virtual home visit and the date of the home visit
- Participation in follow-up visits and phone calls
- Housing assessment data in the first visit and second visit and potential changes in environmental conditions
- Pre and post intervention scores on Asthma Control Questionnaire
- Participant satisfaction with the program

Reinvestment Partners would like NCDHHS to conduct an evaluation of the Breathe Easy program as part of its larger HOP evaluation program since it has access to claims and payment data. As part of the evaluation, SHEPS can review claims data to determine if the program improved asthma control, reduced utilization of the emergency department to treat asthma, and reduced hospitalizations for asthma for participants. These findings can then be used to determine potential cost savings of the program.

Breathe Easy provides a path to value-based payments.

One of the goals of the HOP as described by CMS in its approval of the 1115 waiver is the pathway to value-based payments in which cost savings based on identified outcomes are shared with the pilot services providers. The value sharing is based on reductions on the total cost of care related to specific benchmarks, such as a reduction in hospitalizations and emergency department visits.

Based on evidence from other similar interventions, Reinvestment Partners is confident that our Breathe Easy asthma intervention will reduce the total cost of care for high-risk Medicaid members with uncontrolled asthma by reducing hospitalizations and emergency department visits for the highest utilizers. These are in addition to improving the quality of life for members and their families impacted by asthma.

The average cost of an emergency department visit is $1,150.[11] The average cost of a hospital stay is $2873 per day and the average cost of a total hospital stay for Medicaid is $9,800.[12]

[11] https://consumerhealthratings.com/how-much-does-er-visit-cost/

[12] https://www.peoplekeep.com/blog/infographic-how-much-does-a-hospital-stay-cost#blog-section-2

The Breathe Easy intervention costs $2,500. If it reduces hospitalizations and limits emergency department visits it will reduce the overall cost of care. This is in addition to qualitative benefits of improving the quality of life for both the member and the caregiver in the case of pediatric cases. Given the potential for demonstrating improved health and cost savings, the Breathe Easy program should be prioritized for research and for value-based payments. The goal would be to create a long-term, post-HOP path to negotiate value-based payments directly with PHPs for the Breathe Easy program.

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Friday, September 22, 2023 8:47:47 AM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Chassidy Justice
111 Jazz Ln Bostic, NC 28018-8524
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Wednesday, September 20, 2023 1:40:55 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

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With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
June Elliott Cattell
200 Pineview Rd West Columbia, SC 29169-5251
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Wednesday, September 20, 2023 12:12:23 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments. I appreciate your service.

Sincerely,
Soph Myers-Kelley
2151 Portertown Rd Greenville, NC 27858-8490
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Wednesday, September 20, 2023 10:15:12 AM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Case managers should also be given access to the SOAR application to assist disabled individuals returning from prison in applying for expedited social security benefits

Thank you for the opportunity to provide these comments.

Sincerely,
Renee Johnson
PO Box 480635 Charlotte, NC 28269-5305
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Wednesday, September 20, 2023 9:39:57 AM

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Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Beth Bullock Johnson
300 Lodge Dr Hendersonville, NC 28791-2418
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Wednesday, September 20, 2023 9:34:27 AM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Linda Brinkley
4008 Cardigan Pl Raleigh, NC 27609-6475
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Wednesday, September 20, 2023 8:21:23 AM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Evelyn Fraser
2724 28th St NE Washington, DC 20018-1417
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 6:48:44 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Carolyn Cooper
7175 N Uber St Philadelphia, PA 19138-2115
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 5:44:45 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Chermia Miller
5519 Market St Wilmington, NC 28405-3509
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 5:43:25 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Carl Bond
1249 Governors Rd Windsor, NC 27983-9758
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 4:41:39 PM

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Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Diane Krisanda
PO Box 816 Forest City, NC 28043-0816
[redacted]

From: [redacted] behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry
Date: Tuesday, September 19, 2023 8:58:51 AM

Dear NC DHHS,

I support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is important to ensuring continuous access coverage, especially for people who need medication-assisted treatment and are at risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Judith Porter
927 MULBERRY MILL ROAD WILKESBORO NC 28659 N North Wilkesboro, NC 28659
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 8:51:49 AM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals. Re-entry services also need to be provided by providers that use evidence-informed practices and not solely rely on religious services.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Shagufta Hakeem
108 Kellerhis Dr Apex, NC 27502-4161
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 8:50:41 AM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Karen Mallam
810 Buckner Springs Rd Siler City, NC 27344-8219
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Improve Healthcare Access
Date: Tuesday, September 19, 2023 6:39:25 AM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Natashalyn Snipes
809 Statler Dr Durham, NC 27703-6350
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Big money will not effectively render good health care to All American residents as long as a bunch of high political sloganeering working out of The FearMonger Shoppe.e to All American
Date: Tuesday, September 19, 2023 1:42:40 AM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Allan Krall
1501 Morehead Ave Durham, NC 27707-1207
[redacted]

From:	[redacted] on behalf of [redacted]
To:	Medicaid.NCEngagement
Subject:	[External] Well I am a formally incarcerated individual and believe it or not it"s been over a decade and my past still haunts me due to having a criminal background life has been financially hard and very stressful I just wish there was some relief or...
Date:	Monday, September 18, 2023 8:54:08 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Jacinda Farrow
982 Driftwood Dr Manteo, NC 27954-9348
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Support can make a difference
Date: Monday, September 18, 2023 5:43:32 PM

Dear NC DHHS,

As a former foster parent who provided care for some children whose parents were incarcerated, I came to realize how challenging reentry was. I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver because it would offer much needed transition support.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Rebecca Burmester
2121 N Hills Dr Apt I Raleigh, NC 27612-3938
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] All people need healthcare, some more than others, but all need access to healthcare providers, services and medicines.
Date: Monday, September 18, 2023 5:06:02 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Melva Okun
108 High St Carrboro, NC 27510-1328
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 12:37:27 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Melissa Essary
8057 Brandyapple Dr Raleigh, NC 27615-4907
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 12:33:23 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Jeff Kulp
5417 Oldtowne Rd Raleigh, NC 27612-6111
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 12:22:24 PM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Marcia Foutch
3810 New Garden Cmns Greensboro, NC 27410-2348
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 11:44:34 AM

Dear NC DHHS,

I am writing in wholehearted support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Jane Simpson
2807 Daniel Rd Chevy Chase, MD 20815-3148
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 11:43:34 AM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Kim-Marie McLellan
8316 Druids Ln Raleigh, NC 27613-4321
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 11:34:32 AM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
Melissa Elliott
115 Westlake Dr Henderson, NC 27536-4778
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 11:07:15 AM

Dear NC DHHS,

I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry services. For effective implementation of these programs, please solicit additional, ongoing input from reentry service providers and directly-impacted individuals.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health inequities.

This crucial step to preemptively enroll people into Medicaid prior to release is also important to ensuring continuous access to care and coverage, especially for people who need medication-assisted treatment and are at high risk of an overdose.

With implementation of Medicaid expansion on the horizon, creating a pathway so that people who are incarcerated can also enroll into Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts.

Thank you for the opportunity to provide these comments.

Sincerely,
William Garrard
472 22nd Ave NE Hickory, NC 28601-1520
[redacted]

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Tuesday, September 19, 2023 9:47:21 AM
Attachments: image001.png
image002.png
image003.png
image004.png
image005.png

We are submitting the following feedback regarding the pilot portion of the current draft of the NC Section 1115 Demonstration Waiver application.

1. RETAIN: Pisgah Legal Services strongly supports the following items in the state's draft application:

- Whole-person integrated approach to care supported by a care management model.
- Expansion of geographic eligibility to include all 100 counties.
- Expansion of pilot eligibility to include all pregnant and postpartum women, justice-involved individuals, those who are "at risk of" a chronic condition, individuals with only one chronic health condition, individuals recently impacted by natural disasters, children/youth who receive adoption assistance and all Tailored plan members and Tailored Care Management eligibles in prepaid inpatient health plan (PIHP).
- Expansion of meal services to three meals per day.
- Availability of capacity building funds throughout the demonstration waiver period.
- Central role of NLs in ensuring the pilot's success.

2. MODIFY: Pisgah Legal Services believes the following items could be improved upon:

- Refine language around rental assistance to include:
    - up to six months of rental assistance including payment of arrears
    - for all enrollees who demonstrate need (not just high-needs enrollees).
    - Application fees up to $250 per enrollee
- Prioritize investments in community-based organizations and local service delivery models.
- Increase capacity building budget allocation and/or significantly increase fee schedule payments to ensure there are sufficient and sustainable resources for human service organizations (HSOs) and NLs to scale pilot services across all 100 NC counties.
- Include fees needed for car purchase and repair programs
- Linkages to Health Related Legal supports should include legal representation and negotiation, not merely advice.

3. CLARIFY/ADD: Pisgah Legal Services requests the following clarifications and additions:

- Expand eligibility to include all NC Medicaid members—regardless of coverage type—who screen positive for a pilot-supported social health need.
- Clarify HOP eligibility of Medicare/Medicaid dual enrollees.
- Include all HOP services in pre-release Medicaid services available to justice involved individuals.
- Allow continuous access to HOP services for justice-involved individuals for 1-year post-release.
- Clarify that current NLs and HSOs do not need to reapply under the new waiver.

Additional Recommended Pilot Enhancements
Fee Schedule Improvements

- Standardize fee schedule statewide to reduce the potential for confusion, referral delays and rejections.
- Approve additional evidence-based parenting curricula in alignment with NC Partnership for Children to allow HSOs to leverage existing resources to meet regional needs.
- Review all services to ensure a coordination or admin fee is included.
- Increase fee for Interpersonal Violence Services to the level of Housing Navigation.

Network Development

- Give contracting preference and/or incentives to local, community embedded HSOs to promote equity and improve pilot enrollment, member satisfaction, expansion of services/geography and culturally inclusive service delivery.
- Prioritize and incentivize local health and social service agencies to participate in the pilot.
- Provide ongoing capacity building funding to support NLs who play a critical role in developing and maintaining network diversity, capacity and sustainability.
- Strengthen and expand NL's role to ensure pilot success by:
    - providing NLs with access to detailed member eligibility lists to allow NLs to build enrollment penetration maps by zip code, county, domain and/or attributed practice,
    - funding existing NLs to onboard and provide training and technical assistance to new NLs and new and existing PHPs, CINs and other stakeholders,
    - engaging NLs as primary regional representatives in state-level decision-making, and
    - partnering with NLs to create and implement a comprehensive communications and public relations strategy.

Digital Platform & Billing Process Improvements

- Develop a clear pathway and process to support data sharing between pilot stakeholders to ensure NLs can make data-driven decisions and conduct continuous quality improvements.
- Improve the accuracy and efficiency of the pilot's digital billing processes by implementing technical solutions that
    - standardize billing practices using 837 and 835 data sets,
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    - improve the user experience by providing functionality for data searches, claims management, and elimination of duplicate claims.

Compliance and Quality Assurance

- Require HSOs who directly contract with PHPs to participate in NL compliance activities to ensure network adequacy and service delivery quality.
- Increase accountability and transparency around PHP responsibilities regarding care management network adequacy, quality improvement, and payment processes.

Robin L. Merrell (she/her/hers)
Managing Attorney | Pisgah Legal Services
8282530406 | [redacted] | www.pisgahlegal.org
P.O. Box 2276 Asheville, NC 28802

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Justice Involved Youth Program Director
Date: Monday, September 18, 2023 8:27:51 PM

Dear NC DHHS,

As a Director of youth programming, I am writing in support of DHHS' proposal to strengthen DHH in its 1115 Demonstration Waiver. Many youth have mental health and substance abuse diagnosis at the root of their contact with the justice system. Ensuring they have adequate treatment is often the first crucial step to rehabilitation and avoiding recidivism.

North Carolina's plan to improve health access for individuals transitioning from incarceration is a critical step to creating a better transition for people going home. The Healthy Opportunities Pilot proposal would provide resources necessary for more robust reentry.

The research shows that justice-involved individuals have more chronic conditions and worse health outcomes but are less able to access healthcare. Medicaid enrollment prior to release has the potential to help reduce some of these health.

Medicaid is critical to closing health inequities, reducing overdoses and strengthening our state's reentry efforts. Who better to start with but our youth.

Thank you for the opportunity to provide these comments.

Sincerely,
Tiffany McCoy
3004 Butterwood Dr Jamestown, NC 27282-7728
[redacted]

From: [redacted] on behalf of [redacted]
To: Medicaid.NCEngagement
Subject: [External] Comments on DHHS reentry efforts
Date: Tuesday, September 19, 2023 12:12:19 PM

Dear NC DHHS,

I agree I feel like people should have more access to what they need, especially when it comes to their health. A few things I would like to add, especially working in the healthcare field. This should be modified. I feel like the healthcare is forgotten when it comes to the workers. Our pay rates are not where it should be especially when you're taking care of other people and not really taking care of yourself because you don't have the time working out in the healthcare field Is exhausting mentally and physically. It would be nice if we got paid good money to take more days off to be with our family we cannot stress about other peoples mental health, but not care about the workers that's providing this care. There's a lot of health care, workers that have mental illnesses as well and we tough it out for the community. I agree a lot of people need help, but don't forget about your healthcare workers and first responders. We come in contact with the residents/patients/ people the most, most of the time we are putting our life in danger especially when you have a combative resident. We are already short staffed and providing funds to the people who needs it is fine, but not having an increase for the health care workers, or the first responders is crazy to me. $14 an hour is not a living out here anymore. Health insurance is crazy for us as well, because how are we working so hard and having to pay higher premiums? How are we working so hard taken care of everyone else but when it comes to our needs, they are not met. This is the reason why a lot of people left the healthcare field and a lot of first responders as well. I say we should fix the problem all in one if you have 315 million dollars to give I feel like some of that should've been given to the workers as well.

Sincerely,
Jesenia Clark
1420 Fairington Dr NW Apt 304 Concord, NC 28027-7916
[redacted]

From: [redacted]
To: Medicaid.NCEngagement
Subject: RE: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 1:18:20 PM
Attachments: image001.png
image002.png
image003.png
image004.png
image005.png

I have additional input:

1. Please raise the reimbursement rate for Linkages to Health Related Legal Support.
2. Create protocols to increase knowledge of available services and to increase the rate of referrals.

Thank you,
Robin Merrell

Robin L. Merrell (she/her/hers)
Managing Attorney | Pisgah Legal Services
8282530406 | [redacted] | www.pisgahlegal.org
P.O. Box 2276 Asheville, NC 28802

PISGAH LEGAL SERVICES

From: Medicaid.NCEngagement <Medicaid.NCEngagement@dhhs.nc.gov>
Sent: Tuesday, September 19, 2023 10:06 AM
To: Robin Merrell <Robin@pisgahlegal.org>
Subject: RE: [External] NC Section 1115 Waiver

Thank you for your comments. Stakeholder feedback is essential to the NC Section 1115 Demonstration Waiver Renewal, and we appreciate you taking the time to provide input.

Sincerely,
NC Medicaid

From: Robin Merrell [redacted]
Sent: Tuesday, September 19, 2023 9:47 AM

To: Medicaid.NCEngagement <Medicaid.NCEngagement@dhhs.nc.gov>
Subject: [External] NC Section 1115 Waiver

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- Central role of NLs in ensuring the pilot's success.

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    - up to six months of rental assistance including payment of arrears
    - for all enrollees who demonstrate need (not just high-needs enrollees).
    - Application fees up to $250 per enrollee
- Prioritize investments in community-based organizations and local service delivery models.
- Increase capacity building budget allocation and/or significantly increase fee schedule payments to ensure there are sufficient and sustainable resources for human service organizations (HSOs) and NLs to scale pilot services across all 100 NC counties.
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- Linkages to Health Related Legal supports should include legal representation and negotiation, not merely advice.

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- partnering with NLs to create and implement a comprehensive communications and public relations strategy.

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- Require HSOs who directly contract with PHPs to participate in NL compliance activities to ensure network adequacy and service delivery quality.
- Increase accountability and transparency around PHP responsibilities regarding care management network adequacy, quality improvement, and payment processes.

Robin L. Merrell (she/her/hers)
Managing Attorney | Pisgah Legal Services
8282530406 | [redacted] | www.pisgahlegal.org
P.O. Box 2276 Asheville, NC 28802

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Tuesday, September 19, 2023 9:47:21 AM
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Robin L. Merrell (she/her/hers)
Managing Attorney | Pisgah Legal Services
8282530406 | [redacted] | www.pisgahlegal.org
P.O. Box 2276 Asheville, NC 28802

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 4:05:42 PM
Attachments: NC Medicaid 1115 Waiver Public Comment, MANNA FoodBank 20Sep2023.pdf

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Hello. Please find attached our comments regarding the renewal of the NC Medicaid Section 1115 Waiver. These comments are submitted by MANNA FoodBank. We serve the western counties in North Carolina and are one of the Human Service Organizations supporting the Healthy Opportunities Pilot in Impact Health's Network.

Thank you for the opportunity to provide our insight on the project.
Glenn Wise

Glenn Wise (he/him)
Director of Programs
MANNA FoodBank
627 Swannanoa River Rd, Asheville, NC 28805
MANNAFoodBank.org

Office: 828-299-3663 x1254
Direct Line: 828-774-5916
[redacted]

Book time to meet with me

MANNA FoodBank

627 Swannanoa River Road

Asheville NC 28805

Healthyopp@mannafoodbank.org

828-299-3663

September 20, 2023

North Carolina Department of Health and Human Services

NC Medicaid Section 1115 Waiver Team

1950 Mail Service Center

Raleigh, NC 27699-1950

RE: Public Comment on the renewal of the NC Section 1115 Demonstration Waiver Application

Dear NC Medicaid Section 1115 Waiver Team,

As the Senior Leadership Team of MANNA FoodBank, we are writing to provide our collective feedback and express our strong support for the renewal of the Medicaid 1115 waiver for NC Medicaid and the Healthy Opportunities Pilot in North Carolina. Our organization plays a pivotal role in the success of this initiative, and we are deeply committed to its continued growth and effectiveness in our community. We would like to commend the efforts put forth thus far and offer key recommendations for further enhancements during the renewal process.

Continued Support for Food, Housing, Transportation, and Interpersonal Violence:

- We recommend maintaining the core pillars of food, housing, transportation, and interpersonal violence support, as they address vital social determinants of health (SDOH) in our region.

Expanding Geographic Eligibility:

- We strongly recommend expanding the geographic eligibility of the Healthy Opportunities Pilot to include all 100 counties in North Carolina to ensure equitable access to SDOH services across the state.

Broadening Pilot Eligibility Criteria:

- We advocate for broadening the Pilot's eligibility criteria to include pregnant and postpartum women, justice-involved individuals, those "at risk of" chronic conditions, those with one chronic health condition, those affected by natural disasters,

children/youth with adoption assistance, and all Tailored plan members and Tailored Care Management eligible members in prepaid inpatient health plans (PIHP). Also, expand eligibility to all NC Medicaid members screening positive for pilot-supported social health needs.

- Additionally, we suggest expanding eligibility to include all NC Medicaid members, regardless of coverage type, who screen positive for a pilot-supported social health need.

Expansion of Meal Services:

- We support expanding meal services within the Pilot to include three meals per day, recognizing the critical role of nutrition in overall health and well-being.

Capacity Building Funds:

- It is imperative to ensure that capacity building funds are available throughout the demonstration waiver period. We recommend increasing the capacity building budget allocation and/or significantly increasing fee schedule payments to guarantee sufficient and sustainable resources for human service organizations (HSOs) and NLs (Network Leads) to scale Pilot services across all 100 counties.

Reimbursement Rates:

- We respectfully urge NCDHHS to consider a comprehensive review of the reimbursement rates associated with services provided under the Pilot to ensure that they adequately cover the costs of essential services such as food boxes, produce prescriptions, and healthy meals. Given the significant increase in the cost of food, HSOs are not able to adequately cover the costs associated with many of the services in the food domain, including food and the resources required to provide the services.
- We recommend reviewing all services to ensure that a coordination or admin fee is included to support the sustainability of participating organizations.

Preference for Local, Community-Embedded HSOs:

- Providing contracting preference and/or incentives to local, community-embedded HSOs is essential to promote equity, improve Pilot enrollment, enhance member satisfaction, expand services/geography, and ensure culturally inclusive service delivery.

Ongoing Capacity Building Funding for NLs:

- Ongoing capacity building funding is crucial to support NLs, who play a critical role in developing and maintaining network diversity, capacity, and sustainability. NLs should be engaged as primary regional representatives in state-level decision-making, and partnerships with NLs should be established to create and implement a comprehensive communications and public relations strategy.

Data Sharing and Evaluation:

- We emphasize the importance of strengthening data collection and evaluation methods, highlighting transparency in reporting outcomes and findings. We recommend establishing a clear pathway for data sharing among stakeholders to enable data-driven decision making and quality improvements.

Improvements in Digital Billing Processes:

- To enhance the accuracy and efficiency of the Pilot's digital billing processes, we recommend implementing technical solutions for standardized billing including using 837 and 835 data sets, real-time eligibility data access (270/271 data sets), and user-friendly functionality.

Accountability and Transparency for PHP Responsibilities:

- We encourage an increase in accountability and transparency around PHP (Prepaid Health Plan) responsibilities regarding care management network adequacy, quality improvement, and payment processes.

Expanded Nutrition Education Curriculum:

- While the program has made strides in providing nutrition education, we recommend diversifying the nutrition education curriculum to offer more resources and flexibility to organizations with existing high-quality nutrition curricula.

Community Engagement and Input:

- To ensure the enduring relevance and effectiveness of the Healthy Opportunities Pilot, we strongly recommend an ongoing commitment to engaging with community members and organizations. Regular feedback and collaboration with local stakeholders are vital to aligning the program with evolving community needs.

In conclusion, the Healthy Opportunities Pilot has already demonstrated its potential to enhance the health and well-being of individuals and families in our region. However, there is room for improvement and expansion to better serve our community. We look forward to continued collaboration with NCDHHS in addressing these issues and working together to create a healthier, more resilient North Carolina.

We extend our gratitude for your dedication to this important endeavor and your consideration of our input. Together, we can continue to make a significant positive impact on the lives of those we serve.

Sincerely,

MANNA FoodBank

From: [redacted]
To: Medicaid.NCEngagement
Subject: [External] NC Section 1115 Waiver
Date: Wednesday, September 20, 2023 3:16:08 PM
Attachments: NC Medicaid 1115 Waiver Renewal_Meals4Families public comment.docx

<<PDF version attached>>

North Carolina Department of Health and Human Services
North Carolina Medicaid Section 1115 Waiver Team
Submitted via email, Medicaid.NCEngagement@dhhs.nc.gov

September 20, 2023

Re: North Carolina Section 1115 Demonstration Waiver Renewal Application

Dear North Carolina Medicaid Section 1115 Waiver Team,

Thank you for the opportunity to provide comment on North Carolina's section 1115 demonstration waiver renewal application. Meals4Families works to break down barriers that prevent families from accessing food, healthcare, and economic support through public benefit programs. Our work is focused on community health, community wealth, and wealth equity as pathways to ending child hunger in North Carolina. We are excited for the expanded opportunities for children and families reflected in the Section 1115 waiver renewal application.

Feedback on proposed expansion of the Healthy Opportunities Pilot:

1. **Review personal hygiene supplies as an essential part of whole-person health.**

- We recommend consideration of coverage for personal hygiene supplies within the Healthy Opportunities Pilot services.

- Personal hygiene supplies are essential supplies. They are also a significant expense for families, and can cost hundreds of dollars per month, with few market options for discounted or less expensive brands.

- Many families and individuals can not afford personal hygiene supplies to adequately meet their health needs.

- Currently, none of the public benefit programs provide support for purchasing or obtaining diapers, menstrual products, incontinence supplies, or adult diapers. These products are also typically left out of value-added benefits offered through health insurance providers.

- Schools in North Carolina do not generally or universally provide access to personal hygiene supplies for students, particularly menstrual hygiene supplies.

- Research has shown that inadequate access to personal hygiene supplies puts children at risk, leads to students missing school and adults missing work, and can lead to social isolation and poor health outcomes.

2. **Tailor the proposed HOP expansion to meet the service needs of children and pregnant individuals.**
    - The proposed inclusion of pregnant individuals and children/youth who receive adoption assistance as eligible for HOP services is an incredible opportunity for North Carolina families.

    - We encourage the proposal to maximize the time frame that pregnant individuals will be able to receive HOP benefits, to ensure that these critical support services persist long enough beyond pregnancy to positively impact and support the family following the birth or end of pregnancy.

    - We encourage DHHS to plan for and articulate how HOP eligibility for pregnant individuals can be tailored to specifically address pregnancy-related needs and evidence-based services that improve maternal health outcomes. This should include the addition of HOP services to specifically address known disparities in maternal health outcomes in North Carolina, and include additional support for midwife and doula services, increased lactation support, and support for mental health and postpartum depression.

    - We encourage DHHS to similarly consider additions and expansions to HOP services that specifically address the needs of children, with the proposed expansion to extend eligibility for children/youth who receive adoption assistance.

Thank you for your work to create a healthier North Carolina, and thank you again for the opportunity to provide feedback on this proposal.

Sincerely,

Kate Hanson

Executive Director, Meals4Families
[redacted]

--
Kate Hanson she | her
Founder and Executive Director, Meals4Families

Get free or low-cost internet service.
Learn more at affordableconnectivity.gov.

Get money for groceries through SNAP and WIC.
Check your SNAP eligibility.
Connect with WIC services in North Carolina or find your state's agency.

M4F | MEALS FOR FAMILIES

North Carolina Department of Health and Human Services
North Carolina Medicaid Section 1115 Waiver Team
Submitted via email, Medicaid.NCEngagement@dhhs.nc.gov

September 20, 2023

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M4F | MEALS FOR FAMILIES

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Thank you for your work to create a healthier North Carolina, and thank you again for the opportunity to provide feedback on this proposal.

Sincerely,

Kate Hanson

Executive Director, Meals4Families
[redacted]

From: [redacted]
To:
Cc:
Subject: Waiver Feedback re: Pilots
Date: Tuesday, September 19, 2023 10:32:47 AM
Attachments: image001.png

Good morning Pavitra and Aliya,

We've included below some feedback we heard during the informal Pilot stakeholder 1:1s that we think should be included in the waiver feedback inventory. I've formatted the feedback to align with how the inventory is organized. Let us know of any questions. Thank you.

Date Comment Received	Method of Submission	Commenter	Commentor Type	Primary Waiver Type	Topic Area	Comment
8/31	Comment provided at the following meeting: 8/31 Ad Hoc LHD/CIN Office Hours: Pilot-related 1115 Waiver Renewal Public Comment Questions	Donata Brown Albemarle Regional Health Services	LHD/CIN	1115 Waiver	Pilot	HSOs should have a seat at the table and have an active role in HOP program decision-making and implementation.
8/31	Comment provided at the following meeting: 8/31 Ad Hoc LHD/CIN Office Hours: Pilot-related 1115 Waiver Renewal Public Comment Questions	Wanda Jenkins CCNC	LHD/CIN	1115 Waiver	Pilot	People are very concerned about asking members questions about firearms as this is a touchy subject with many people.
8/31	Comment provided at the following meeting: 8/31 Ad Hoc LHD/CIN Office Hours: Pilot-related 1115 Waiver	Eric Christian CCNC	LHD/CIN	1115 Waiver	Pilot	People will need scripts for fire-arm conversations. Therapists have done this work when constructing safety and crisis plans. Here's an example of a training for PCPs that came in today. Hopefully, the trend will create conversations about gun safety in many healthcare encounters. http://www.nhrmc.us/seahec/71241FirearmSafety.pdf

	Renewal Public Comment Questions					
8/31	Comment provided at the following meeting: 8/31 Ad Hoc LHD/CIN Office Hours: Pilot-related 1115 Waiver Renewal Public Comment Questions	Deborah Noreski CCLCF	LHD/CIN	1115 Waiver	Pilot	There is insufficient HSO capacity to provide services which results in additional work to identify HSOs that actually are able to accept service referrals. This slows up the process of enrolling Pilot members
9/5	Comment provided at the following meeting: 9/5 HOP - TP Engagement on the NC 1115 Waiver Renewal Public Comment Period	Lou Anne Simmons Eastpointe	TP	1115 Waiver	Pilot	In speaking with our NL CHWs, there has been concern about capacity of HSO providers to meet the demand. For Eastpoint, our Pilot county is Edgecombe, with plans to expand HOP to all counties, will there be consideration for capacity building funds for new CBOs to become HSO providers (in existing HOP regions) and be part of HOP?

Best,

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