Medicaid Section 1115 Monitoring Report

North Carolina - North Carolina Medicaid Reform Demonstration

DY4Q1 – November 1, 2021 through January 31, 2022

Submitted on April 01, 2022

State	*North Carolina*
Demonstration Name	*North Carolina Medicaid Reform Demonstration*
Approval Date	*October 24, 2018*
Approval Period	*November 1, 2019, through October 31, 2024*
Demonstration Goals and Objectives	*North Carolina seeks to transform its Medicaid delivery system by meeting the following goals:* *• Measurably improve health outcomes via a new delivery system;* *• Maximize high-value care to ensure sustainability of the Medicaid program; and* *• Reduce Substance Use Disorder (SUD).*

Contents

DEMONSTRATION YEAR 4 QUARTER 1 REPORT

Executive Summary

This quarterly report covers Demonstration Year 4, Quarter 1 (DY4Q1) of the North Carolina Medicaid Reform Demonstration, Nov. 1, 2021, through Jan. 31, 2022.

Following the July 1, 2021, launch of the NC Medicaid Managed Care Standard Plans (Standard Plans), the Department is continuing to address post-implementation concerns. To ensure members receive optimal care and support the provider community, several provisions and flexibilities have been extended or reinstated this quarter, including extension of the temporary COVID-19 rate increases for all home and community-based services (HCBS) and reinstatement of temporary suspensions for prior authorization of certain hospital, HCBS and long-term care services.

The Department announced on Nov. 15, 2021, that the launch of the Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Plans (Tailored Plans) will be moved from July 1, 2022, to Dec. 1, 2022. Several factors contributed to changing the launch date, including:

- Tailored Plan contracts were awarded later than originally planned.
- The need to respond to the COVID-19 pandemic by providers, Local Management Entities-Managed Care Organizations (LME-MCOs) and the Department required a reallocation of priorities and human and financial resources.
- Numerous counties chose to disengage from Cardinal Innovations Healthcare and to partner with new LME-MCOs.

Tailored Plans were given extensions on deliverable deadlines to align with the shifted timeline. The Department's goal continues to be to ensure a seamless and successful experience for LME-MCO beneficiaries, their families and advocates, providers and other stakeholders committed to improving the health of North Carolinians.

In January, the Department submitted an 1115 waiver amendment application to CMS. The amendment to the approved 1115 waiver would:

- Extend the end date of the current demonstration period to June 30, 2026 (from October 31, 2024) to reflect implementation delays and provide sufficient time to evaluate key components of the demonstration
- Adjust which populations will be covered by Tailored Plans
- Expand eligibility for and modify certain implementation details relating to the Healthy Opportunities Pilots
- Exclude the COVID-19 testing group from mandatory managed care
- Re-open discussions with CMS around a previous request to establish a Tribal Uncompensated Care Pool

In December, the Department announced that the Healthy Opportunities Pilots would adopt a phased launch approach to allow additional time for technical development and for pilot entities to finalize service delivery processes. Under the revised timeline, services will launch on the following schedule:

- Feb. 1, 2022: Newly developed "Base Pilot Functionality" in NCCARE360, North Carolina's statewide closed-loop referral system, becomes available
- March 15, 2022: Launch of food services and three Clinically Integrated Networks (CINs)
- May 1, 2022: Launch of housing and transportation services and additional CINs and Tier 3 Advanced Medical Homes (AMHs)
- June 15, 2022: Launch of toxic stress and cross-domain services and Tier 1 and 2 AMHs

In Quarter 1, the Department continued to hold regular implementation meetings with the CINs, Prepaid Health Plans (PHPs), and Network Leads to review pilot design questions and to align on the scope and timing of pilot activities. Key contracting milestones reached during this reporting period include the execution of the Network Leads' contracts with the PHPs and the Network Leads' contracts with the Human Services Organizations (HSOs) within their pilot network. The third issuance of Capacity Building Funds was provided to Network Leads on Jan. 4, 2022.

Medicaid Managed Care

Operational Updates

The Department submitted an 1115 waiver amendment application to CMS on Jan. 25, 2022. Prior to this, the waiver amendment was released for public comment on Nov. 18, 2021, and the State held four public hearings seeking input on the amendment. The amendment to the approved 1115 waiver would:

- Extend the end date of the current demonstration period to June 30, 2026 (from Oct. 31, 2024) to reflect implementation delays and provide sufficient time to evaluate key components of the demonstration
- Adjust which populations will be covered by Tailored Plans
- Expand eligibility for and modify certain implementation details relating to the Healthy Opportunities Pilots
- Exclude the COVID-19 testing group from mandatory managed care
- Re-open discussions with CMS around a previous request to establish a Tribal Uncompensated Care Pool

The Department continues to address post-implementation concerns following the July 1, 2021, launch of the Standard Plans. To provide optimal care to members and support the provider community, the following provisions and flexibilities have been extended:

- Extension of the temporary COVID-19 rate increases currently in place for all HCBS programs and some non-HCBS programs, including skilled nursing facilities
- Reinstatement of temporary suspension of prior authorization for inpatient rehabilitation hospital and long-term care hospital admissions.
- Reinstatement of temporary suspension of prior authorizations for new nursing home admissions being directly discharged from a hospital
- Home Health Skilled Nursing Visits prior authorization not required prior to discharge from hospital
- Temporary extension of NC Medicaid Managed Care minimum appeal timeframe.

In this quarter the Department began the final review of Standard Plans' network adequacy compliance, including ruling on network adequacy exception requests and identifying deficiencies as part of the overall network evaluation. Notices on network adequacy compliance were issued to Standard Plans in early February, and details will be provided in the next quarterly report.

In January 2022, the Department extended the timeline for required Standard Plan National Committee for Quality Assurance (NCQA) accreditation by one year, from June 2024 to June 2025. The change addresses concerns that there was not enough time between the launch of the NC Medicaid state credentialing program, which is scheduled to be operational in 2023, and the start of the look-back period for the NCQA Health Plan Accreditation Full Survey. The extended timeline allows for long-term supports and services (LTSS) distinction and full survey review to occur concurrently. The extension does not affect NCQA Accreditation requirements for Tailored Plans.

The Department announced on November 15, 2021, that Tailored Plans will launch Dec. 1, 2022, instead of July 1, 2022. Several factors contributed to changing the launch to Dec. 1, 2022, including:

- The Tailored Plan contracts were awarded later than originally planned.
- The need to respond to the COVID-19 pandemic by providers, LME-MCOs and the Department required a reallocation of priorities and human and financial resources.
- Numerous counties chose to disengage from Cardinal Innovations Healthcare and to partner with new LME-MCOs. These transitions are occurring over a short period, affecting about 115,000 beneficiaries – almost a quarter of all North Carolina counties and every LME-MCO. Delay of launch allows for the LME-MCOs to focus on transition activities and supporting beneficiaries.

Tailored Plans were given extensions on deliverable deadlines to align with the shifted timeline. NCDHHS' goal remains to ensure a seamless and successful experience for LME-MCO beneficiaries, their families and advocates, and providers. Beneficiaries who are currently in NC Medicaid Direct or the Eastern Band of Cherokee Indians (EBCI) Tribal Option and receive enhanced behavioral health, intellectual or developmental disabilities, or traumatic brain injury services from an LME-MCO will continue to receive care in the same way until the Tailored Plans launch. Providers will continue to prepare for the transition to Tailored Plans.

The Department continues to have regular meetings with the Tailored Plans, including weekly status meetings with each PHP to track development work and address potential business issues and risks and bi-weekly calls with the Tailored Plan leadership teams to address key issues. As part of these status calls, the Department has been engaging with the future Tailored Plans on system development and integration efforts, monitoring the progress closely.

Key achievements and to what conditions and efforts successes can be attributed

Standard Plans

- In collaboration with the Standard Plans and in alignment with the Department's proactive communication and transparency values, the Department has published the following reports and dashboards that provide insight into Standard Plan performance:
    - Network Adequacy Report: A summary report of network adequacy results for Standard Plans based on network data submitted by the Department in July and September 2021. (See Appendix A.)
    - NC Medicaid Managed Care Claim Denials Dashboard: Highlights top reasons for claims denials for each Standard Plan, is updated monthly, and includes notes to provide context.
    - NC Medicaid Enrollment Dashboard: Provides an overview which allows users to view enrollment by PHP, region, and county, along with NC Medicaid Managed Care status and program aid category. (See Appendix B for a pdf of the dashboard's January 2022 overview.)
- The Department recently updated the operational report related to claims payments. This updated report template has been shared with PHPs and monitoring of this report will begin in the next monthly submission.
- As part of their Quality Assessment and Performance Improvement Plan (QAPI), Standard Plans are required to submit at least three Performance Improvement Projects (PIPs), including one non-clinical PIP, annually. The Department approved the following clinical PIPs for Standard Plan Contract Year 2:
    - Timeliness of Prenatal Care: Prenatal and Postpartum
    - Childhood Immunization Status (Combo 10)
    - Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
- In January, the Department released the Quality Measurement Technical Specifications Manual for Standard Plans and Tailored Plans. (See Appendix C.) The manual provides an overview of the Department's plans for promoting high-quality care through NC Medicaid Managed Care and provides specific measure detail to the measurement of the goals and objectives of the Department's Quality Strategy. It includes a list of the quality measures and targets intended for use in the early years of the program.
- The Department continues to track key metrics related to the AMH program, including number of care management interventions, number of members assigned to an AMH Tier 3, and percent of members with a PCP reassignment each month. The Department convened the AMH Technical Advisory Group (TAG) to gain feedback on areas of concern and development for the program, including monitoring by PHPs, advancing alternative payment models (APMs), and aligning on an attribution model for quality measures for the AMH incentive program. The AMH TAG also gave input into the evaluation design approach for the AMH program. The AMH TAG asked the Data

Subcommittee to reconvene to prioritize areas for advancement and improvement to the data sharing model.

- The pharmacy clinical oversight teams (called "dyads") started to use a new Pharmacy Dashboard to identify areas where some PHPs vary significantly from other PHPs in coverage of drugs at the product level. This system allows the dyads to perform proactive oversight. When variances are identified, dyads reach out to PHPs to request data explaining the medication denials.

Tailored Plans

- The Department began facilitating meetings between the North Carolina Healthcare Association (NCHA) and the Tailored Plans to ensure a smooth transition. These meetings are focused on lessons learned from the Standard Plan implementation, including addressing potential claims questions ahead of launch to ensure continuity in members' access to services.
- Tailored Plans have submitted a total of 253 contractual deliverables for the Department to review and approve, including:
    - 200 - 90-day deliverables
    - 24 - 120-day deliverables
    - 29 - 150-day deliverables
- Readiness review activities, such as on-site and desktop reviews, have been scheduled with the Tailored Plans, with the readiness review kick off scheduled for March 17, 2022.
- The Department approved Contract Year 1 clinical PIPs for Tailored Plans, including:
    - Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
    - Follow-up After Hospitalization for Mental Illness: 7 and 30-day
    - One clinical PIP related to diversion, in-reach and/or transition for populations in or at risk of entering institutional settings
- The Department's certification vendor has conducted desk reviews (part 1 of the certification process) of round two Advanced Medical Home Plus (AMH+) practices/Care Management Agencies (CMAs) provider applications and has advanced 32 providers to the site review stage (part 2 of the certification process). Once certified, these organizations will be one vehicle through which Tailored Plan members receive comprehensive care management support, in addition to the Tailored Plans themselves. All Tailored Plan members will be offered choice of a Tailored Care Management entity (plan or provider-based), and members will be assigned to an entity if one is not selected.
- The Department released an updated Tailored Care Management Rate Guidance document, finalizing Tailored Care Management rates for Contract Year 1 and providing additional detail on the development of the rates. This guidance is an updated version of guidance originally released on May 14, 2021.

Key challenges, underlying causes of challenges, and how challenges are being addressed

Standard Plans

- The Department is engaging PHPs to ensure PHP Consumer Directories are accurate, including ensuring that providers who are no longer in-network are being removed from the network file in a timely manner. This concern is being addressed through formal notification and corrective action. The Department has added additional contract language around the timely resolution of these errors in addition to creating a liquidated damage to support this monitoring effort.
- To address concerns that PHPs are not distributing provider welcome packets in a timely manner, the Department is beginning to monitor the distribution of provider welcome packets and utilizing formal notification and corrective action.
- Based on reports of members having delayed access to therapy for a substance use disorder, the pharmacy clinical dyads asked PHPs to remove diagnosis as a hard-stop criteria from all suboxone claims for a substance use disorder. This action aligns protocol for suboxone claims with NC Medicaid Direct.
- The Department's pharmacy unit worked with PHPs to align methods for determining rebate eligibility of medications with NC Medicaid Direct protocols. The PHPs use a different vendor than NC Medicaid Direct to verify rebate eligibility, and the two databases do not always align.
- The PHPs identified a difference in how pharmacy claims were processed at point of sale (POS), as the PHPs were accustomed to determining coverage based on prescriber enrollment at date of service rather than date of prescribing. A guidance document for Health Plan reason codes on the Prescriber Enrollment File was created for the plans, indicating when claims should reject at POS based on prescriber enrollment and date of service, rather than date of prescribing.
- Based on issues identified by providers, the Department has been engaging the PHPs on AMH data sharing to ensure that PHPs are following data sharing requirements and specifications. The Department is reconvening its AMH TAG Data Subcommittee to evaluate and prioritize data sharing issues for improvement and further standardization as needed.

Tailored Plans

- Tailored Plans have experienced challenges ingesting the location codes on the provider records within the Provider Enrollment File. The Department is collaborating with PHPs to resolve the issue.

Milestones

- In December, the Department published Standard Plan network adequacy results based upon network data submitted by PHPs on July 12, 2021, and Sep. 20, 2021. This was the first release of network adequacy results following the Standard Plan launch. The Department reports on compliance with network time/distance standards in the Performance Metrics section of this report.

Issues or complaints identified by beneficiaries

The Department receives beneficiary complaints from the Office of Compliance and Program Integrity, Office of Administration, and the NC Medicaid Member Ombudsman. The NC Medicaid Ombudsman is an independent organization that provides education, guidance and referrals to NC Medicaid beneficiaries.

In Quarter 1, the Ombudsman handled 2,932 cases. Many calls involved educating beneficiaries or connecting them to the proper entity to provide the service they need. Aside from general inquiries, the most common issues were related to access to care; benefits and services; and eligibility, coverage, and referrals. (See Appendix D for a full list.) This quarter, the Office of Administration received nine complaints from NC Medicaid Managed Care members, and there were no complaints reported to the Office of Compliance and Program Integrity.

NC Medicaid Member Ombudsman Cases

November 2021		December 2021		January 2022		Total Cases
Information	Issue Resolution	Information	Issue Resolution	Information	Issue Resolution	
714	500	489	618	611	684	**2,932**

Office of Administration Member Concerns, November 2021 – January 2022

Issue Category	Number of Issues
Finance/PHP Claims Issues	3
Provider Operations	1
Beneficiary/Member	0
Non-Emergency Medical Transportation (NEMT)	0
LTSS	1
Clinical Policy - Medical Health	2
Clinical Policy - Behavioral Health	0
Durable Medical Equipment (DME) and Prosthetics Orthotics & Supplies	2
TOTAL	**9**

Lawsuits or legal actions

All Standard Plan protests/cases have now been dismissed in favor of the State.

For the Healthy Opportunities Pilots, the complaint filed with the Office of Administrative Hearings by Duke was dismissed in March. As such, there are no pending legal actions.

Unusual or unanticipated trends

- In late November, Envolve RX, the pharmacy benefit manager (PBM) vendor for three of the Tailored Plans - Eastpointe, Trillium Health Resources and Vaya Health - indicated that they will be exiting the PBM market nationally as of April 2022. This may impact the launch timeline for Tailored Plans, as these three plans will have to identify and contract with a new vendor, and subsequently assess any potential impact to the development timeline.
- In early December, OneCall, the NEMT vendor for Eastpointe and Vaya Health indicated that it will be exiting the national marketplace. This may impact the launch timeline for Tailored Plans, as Eastpointe and Vaya Health will have to identify and contract with a new vendor, and subsequently assess any potential impact to the development timeline.

Legislative updates

S.L. 2021-180, enacted on Nov. 18, 2021, makes base budget appropriations for the 2021-2023 biennium and enacts new programmatic, administrative and operational requirements for NC Medicaid. The following sections pertain directly to managed care implementation:

- § 9D.14 authorizes parents of children in foster care to retain Medicaid eligibility so long as the parent is making reasonable efforts to comply with a court-ordered reunification plan.
- §9D.15 increases wages for direct care workers employed at intermediate care facilities for individuals with intellectual disabilities and requires an increase in the capitation amount.
- §9D.15A and B increases direct care wages for providing home and community-based services as well as private duty nursing.
- § 9D.17 authorizes LME-MCOs to select any nationally recognized accreditation organization that the Department approves for purposes of operating a Tailored Plan during the initial contract.
- § 9D.19A requires PHPs to reimburse the prescription ingredient cost and dispensing fee at 100% of the fee-for-service rate from November 18, 2021, to June 30, 2023.
- § 9D.22 requires LME-MCOs to pay for behavioral health services while discharge from emergency department is pending starting July 1, 2022.

Additional sections listed below have an indirect impact on managed care implementation:

- § 9D.10 increases copayment for many Medicaid services to $4.00.
- § 9D.13 extends full array of Medicaid services to pregnant women twelve months post-partum.
- § 9D.19 authorizes reimbursement to podiatrists who prescribe orthotic devices, prosthetic devices and other durable medical equipment.

Descriptions of post-award public fora

On Dec. 10, 2021, the Department held a post-award public forum during North Carolina's quarterly Medical Care Advisory Committee (MCAC) meeting. The Department presented on progress in the implementation of the 1115 waiver as of the time of the presentation and provided an overview of upcoming work and the timeline for implementation of future key aspects of the waiver. The Department detailed areas that were brought to the attention of the state by providers and beneficiaries and provided details on how the state has addressed changes as part of the 1115 waiver amendment.

Comments and questions were received on the following topics:

- Comment expressing concern that creating an assessment on hospitals to fund the extension of post-partum services for Medicaid beneficiaries will create an undue burden for hospitals
- Comment in support of enacting Medicaid expansion in North Carolina to receive the enhanced Federal Medical Assistance Percentage (FMAP), in hopes of alleviating budgetary concerns and health care staffing issues.
- Question regarding NC Medicaid benefits for parents of children who enter foster care.
- Question on how the Department plans to manage the volume of Medicaid redeterminations that will need to be done at the end of the Public Health Emergency.
- Comment that NC Medicaid Managed Care members are not being shown as enrolled in Medicaid when trying to pick up prescriptions at pharmacies.
- Question regarding coverage for dual eligible beneficiaries.

Additionally, the Department received numerous questions about COVID-19 and coverage changes that were brought up in response to other presentations.

Performance Metrics

Impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population

No metrics to report in this category for the reporting period.

Outcomes of care

North Carolina measurement year 2021 outcomes measure results will be available beginning in July 2022.

Quality of care

North Carolina measurement year 2021 quality measure results will be available beginning in July 2022. Because NC Medicaid Managed Care launched on July 1, 2021, quality measure results for 2021 will represent the last six months of fee-for-service and the first six months of managed care for North Carolina's Standard Plan population.

Cost of care

Cost of care metrics will be available in next quarter's monitoring report.

Access to care

Network Time/Distance Standards

Based upon networks submitted on Jan. 31, 2022, all of the statewide PHPs (AmeriHealth Caritas, Healthy Blue, United Healthcare and WellCare) were able to ensure 100% member access in the five key service categories, except in Regions 5 and 6. Carolina Complete Health (CCH) reported 100% of members with access for the five key service categories in the three regions it covers. The state's time or distance network adequacy standards require that at least 95% of the membership meet the access standard.

The percentage of members with access to providers that meets network adequacy standards is shown below for each PHP by region and type of service provider.

AmeriHealth Caritas									
Region	# of Counties	# of Members*	Hospitals	OB/GYN	Primary Care (Adult)	Primary Care (Child)	Pharmacy	Outpatient Behavioral Health (Adult)	Outpatient Behavioral Health (Child)
			% Members	% Members	% Members	% Members	% Members	% Members	% Members
1	19	142,494	100%	100%	100%	100%	100%	100%	100%
2	13	295,899	100%	100%	100%	100%	100%	100%	100%
3	12	416,561	100%	100%	100%	100%	100%	100%	100%
4	14	341,131	100%	100%	100%	100%	100%	100%	100%
5	15	284,086	98%	100%	100%	100%	100%	100%	100%
6	27	217,018	97%	99%	100%	100%	100%	100%	100%

Carolina Complete Health									
Region	# of Counties	# of Members*	Hospitals	OB/GYN	Primary Care (Adult)	Primary Care (Child)	Pharmacy	Outpatient Behavioral Health (Adult)	Outpatient Behavioral Health (Child)
			% Members	% Members	% Members	% Members	% Members	% Members	% Members
1	19	142,494							
2	13	295,899							
3	12	416,561	100%	100%	100%	100%	100%	100%	100%
4	14	341,131	100%	100%	100%	100%	100%	100%	100%
5	15	284,086	100%	100%	100%	100%	100%	100%	100%
6	27	217,018							

Healthy Blue/Blue Cross Blue Shield of NC									
Region	# of Counties	# of Members*	Hospitals	OB/GYN	Primary Care (Adult)	Primary Care (Child)	Pharmacy	Outpatient Behavioral Health (Adult)	Outpatient Behavioral Health (Child)
			% Members	% Members	% Members	% Members	% Members	% Members	% Members
1	19	142,494	100%	100%	100%	100%	100%	100%	100%
2	13	295,899	100%	100%	100%	100%	100%	100%	100%
3	12	416,561	100%	100%	100%	100%	100%	100%	100%
4	14	341,131	100%	100%	100%	100%	100%	100%	100%
5	15	284,086	100%	100%	100%	100%	100%	100%	100%
6	27	217,018	99%	100%	100%	100%	100%	100%	100%

United Healthcare									
Region	# of Counties	# of Members*	Hospitals	OB/GYN	Primary Care (Adult)	Primary Care (Child)	Pharmacy	Outpatient Behavioral Health (Adult)	Outpatient Behavioral Health (Child)
			% Members	% Members	% Members	% Members	% Members	% Members	% Members
1	19	142,494	100%	100%	100%	100%	100%	100%	100%
2	13	295,899	100%	100%	100%	100%	100%	100%	100%
3	12	416,561	100%	100%	100%	100%	100%	100%	100%
4	14	341,131	100%	100%	100%	100%	100%	100%	100%
5	15	284,086	100%	100%	100%	100%	100%	100%	100%
6	27	217,018	100%	100%	100%	100%	100%	100%	100%

Wellcare									
Region	# of Counties	# of Members*	Hospitals	OB/GYN	Primary Care (Adult)	Primary Care (Child)	Pharmacy	Outpatient Behavioral Health (Adult)	Outpatient Behavioral Health (Child)
			% Members	% Members	% Members	% Members	% Members	% Members	% Members
1	19	142,494	100%	100%	100%	100%	100%	100%	100%
2	13	295,899	100%	100%	100%	100%	100%	100%	100%
3	12	416,561	100%	100%	100%	100%	100%	100%	100%
4	14	341,131	100%	100%	100%	100%	100%	100%	100%
5	15	284,086	100%	100%	100%	100%	100%	100%	100%
6	27	217,018	99%	100%	100%	100%	100%	100%	100%

Provider Enrollments by PHP

Provider enrollment by provider type is available by PHP, and there are 25 provider type categories. Provider enrollment for two categories, ambulatory health care facilities and behavioral health/social service providers, is provided below for illustration. See Appendix E for the full list.

Provider Enrollment by PHP – Select Categories

Provider Type	AmeriHealth	Healthy Blue	CCH	United	WellCare
Ambulatory Health Care Facilities	736	1212	807	880	951
Behavioral Health & Social Service Providers	6392	8843	6091	3718	4662

Beneficiaries Per AMH Tier

The Department developed the AMH model as the primary vehicle for care coordination in NC Medicaid Managed Care. AMH Tier 3s are the Department's highest level of primary care, focused on care management and quality. The tables below show the count and proportion of beneficiaries in each AMH tier by PHP.

Member Count by PHP and AMH Tier

	AmeriHealth	CCH	Healthy Blue	United	WellCare	Total
No PCP Tier	5,624	2,994	14,140	11,536	2,979	37,273
Tier 1	2,067	2,749	8,693	3,757	3,348	20,614
Tier 2	43,650	37,971	74,515	68,909	55,643	280,688
Tier 3	259,333	177,756	348,175	288,544	300,225	1,374,033
						1,712,608

Member Proportion by PHP and AMH Tier

	AmeriHealth	CCH	Healthy Blue	United	WellCare	Total
No PCP Tier	1.81%	1.35%	3.17%	3.09%	0.82%	2.18%
Tier 1	0.67%	1.24%	1.95%	1.01%	0.92%	1.20%
Tier 2	14.05%	17.14%	16.73%	18.49%	15.36%	16.39%
Tier 3	83.47%	80.26%	78.15%	77.41%	82.89%	80.23%

AMH Provider Enrollment

Proportion of Providers Contracted by State-Designated AMH Tier by PHP*

	AmeriHealth	Healthy Blue	CCH**	United	WellCare
Tier 1	23.33%	55.56%	52.00%	45.56%	37.04%
Tier 2	40.04%	85.69%	68.07%	63.77%	52.90%
Tier 3	82.02%	80.93%	91.88%	85.33%	86.72%

*Providers that are not contracted at the State-designated AMH tier are not included in these counts.

**CCH is only required to contract with providers in regions 3, 4 and 5. CCH's denominator only includes AMHs located in these three regions.

Care Management Penetration Rate

These data represent members enrolled in Standard Plans who are receiving care management through a PHP, AMH, the Care Management for At-Risk Children (CMARC) program, or the Care Management for High-Risk Pregnancies (CMHRP) program from July through December 2021. Beginning this quarter and

moving forward, this data will be provided with a one-month lag. (E.g., although DY4Q1 ends in January, data is only available through December.)

CMHRP is the State's primary vehicle for delivering care management to pregnant women who may be at risk for adverse birth outcomes. CMARC offers a set of care management services for at-risk children ages zero to five. Both services are performed by Local Health Departments (LHDs) as delegates of the PHPs.

Care management provided through a PHP or AMH is reported by PHPs on the BCM051 operational report. Care management provided for CMARC/CMHRP by LHDs is reported by Community Care of North Carolina (CCNC), the Department vendor that oversees the CMARC and CMHRP programs.

In general, care management rates are trending to meet annual penetration targets.

Care Management Penetration Rate: July – December 2021

	PHP	AMH	CMARC	CMHRP	Overall
% Of Total Members	2.9%	5.6%	0.7%	0.9%	8.7%
CM Distinct Member Count	49,811	96,987	13,027	16,087	151,760

Emergency Department Visits per 1,000 Members and Inpatient Admissions per 1,000 Members

Emergency department visits per 1,000 members and inpatient admissions per 1,000 members are measured for the adult NC Medicaid population (age 21 and older) and broken out by PHP and NC Medicaid Direct. Claims denied because they were erroneously billed to NC Medicaid Direct instead of a PHP are excluded from measurement calculations to avoid duplication.

Due to the lag in claims and encounter reporting, the rates below are an average of the monthly rates for only the first two months of this quarter, November and December of 2021. January 2022 rates will be provided in the next quarterly submission. It should be noted that higher rates are expected for NC Medicaid Direct, as members with substantial behavioral health issues who will be enrolled in Tailored Plans later this year currently remain in Medicaid Direct.

Emergency Department Visits per 1,000 Members, November – December

AmeriHealth	CCH	Healthy Blue	Medicaid Direct	United	WellCare
62.82	61.69	57.82	64.86	62.29	59.51

Inpatient Admissions per 1,000 Members, November – December

AmeriHealth	CCH	Healthy Blue	Medicaid Direct	United	WellCare
14.61	15.61	15.58	20.40	15.89	17.02

Results of beneficiary satisfaction surveys

North Carolina conducts an annual "Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey" for the North Carolina adult and child Medicaid populations. All written materials, in both English and Spanish, have been developed, reviewed and approved. A sample was drawn on schedule at the end of January 2022, but it was determined that the level of missing information on telephone numbers and addresses would compromise the response rate. A decision was made to delay survey fielding to allow the Department time to provide more complete contact information. Contact information will be updated by supplementing NC Medicaid enrollment data with data collected by NC HealthConnex, the state's health information exchange. The contractor and the Department have not yet agreed on a new timeline for fielding, analysis and report production.

Budget Neutrality and Financial Reporting Requirements

The State provided updated budget neutrality information through Dec. 31, 2021, to CMS in the budget neutrality workbook due to CMS on March 31, 2022. Per CMS' instructions, October 2021, along with November 2021 and December 2021, is being reported in DY4. North Carolina appears to be within budget neutrality limits for the demonstration.

Evaluation Activities and Interim Findings

The Department has contracted the Sheps Center for Health Services Research at the University of North Carolina to conduct evaluation activities. The DY4Q1 reporting period activities have continued the evaluation work by the Sheps Center team. The evaluation uses a mixed-methods approach, combining analysis of administrative data with qualitative data to obtain detailed insights into the transformation that are not easily captured through claims and surveys; for example, how providers are preparing for the transformation and what can be done to improve their satisfaction with the Medicaid program. Evaluation activities for this quarters are detailed below.

Transition to Capitated Encounter Data from Standard Plans

Sheps Center data scientists and analysts have been working closely with Department personnel to incorporate the substantially transformed data sources into the evaluation workflow. Utilization of services by NC Medicaid beneficiaries who were enrolled in Standard Plans is now packaged into encounter data rather than traditional claims data when it arrives at NC Medicaid. Since July 2021, this encounter data has arrived with a different type of scrambled beneficiary-level identifier, which did not allow it to be linked to prior NC Medicaid Direct claims data for beneficiaries that transitioned into Standard Plans. The evaluation team has been working closely with the Department to reconcile this issue and a solution has been identified. Once the corrected data has been reported to the Sheps

Center, anticipated in February 2022, the center will work with CMS to determine whether prior metrics should be replaced since they did not include people who transitioned to Standard Plans.

Quantitative Update

The Sheps quantitative team continues to onboard new metrics that will be tracked during the evaluation period, drawing metrics both from established custodians consistent with the NC Medicaid Quality Strategy, many Adult and Child Core measures, and other metrics that will allow the center to address the study hypotheses. Sheps continues to evaluate the use of Marketplace enrollees from a NC-based insurer as a potential comparison group for the difference-in-differences analysis through the comparison in trends in seven identified measures.

Sheps has started building a second set of dashboards to allow visualization of non-SUD metrics. The first draft of this dashboard will be available in the next reporting period and will be included in data updates.

Qualitative Update

Codebooks for the DHHS and PHP interview guides underwent final review and refinement before being uploaded to the coding software. DHHS and PHP interviews were coded to identity themes across interviews, as well as to further inform findings from the provider and practice interview analysis. Findings from these interviews were used to develop an abstract for the Academy Health conference, specifically related to themes around patient engagement. The qualitative team developed an interview guide for the second wave of practice and provider interviews. This interview guide, along with updated outreach materials, are currently under Institutional Review Board (IRB) review, and outreach to practices will begin once approval is received.

The qualitative team finalized the outreach plan for second wave interviews, including both contact with Wave I practices (n = 32) and new practices (n = 25). The qualitative team aims to speak with both a practice manager and provider (e.g., lead physician, medical director) from each practice. Outreach to practices from Wave I will allow for longitudinal analysis as well as follow-up on themes from initial interviews. Currently, the qualitative team is developing a manuscript outline which will be reviewed and refined in the coming weeks.

Enhanced Case Management (ECM) and Other Services Pilot Program

Operational Updates

Introduction

In December, the Department announced that the Healthy Opportunities Pilots would adopt a phased launch approach to allow additional time for technical development and for pilot entities to finalize service delivery processes. Under the revised timeline, services will launch on the following schedule:

- Feb. 1, 2022: Newly developed “Base Pilot Functionality” in NCCARE360, which includes capabilities to document Pilot eligibility and enrollment, authorize Pilot services, and invoice for Pilot services, becomes available

- March 15, 2022: Launch of food services and three CINs
- May 1, 2022: Launch of housing and transportation services and additional CINs and Tier 3 AMHs
- June 15, 2022: Launch of toxic stress and cross-domain services and Tier 1 and 2 AMHs

The Department continued to hold regular implementation meetings with Tier 3 AMHs and their CINs, PHPs, and Network Leads to review pilot design questions and align on the scope and timing of pilot activities. Key contracting milestones reached during this quarter include the execution of the Network Leads' contracts with the PHPs and the Network Leads' contracts with the HSOs in their pilot networks.

Key achievements and to what conditions and efforts successes can be attributed

The Department continued weekly individual and group engagement sessions with the PHPs and Healthy Opportunities Network Leads to discuss the progress of their implementation activities. Both the PHPs and Network Leads began developing internal processes and updating policies during this period. Establishing these internal processes is an important milestone in preparation for pilot launch and these processes will be reviewed as part of the Department's readiness evaluation of the Network Leads and PHPs in February 2022. Additionally, the technical development for both the NCCARE360 platform and the Standard Plans systems was completed in time to begin end-to-end testing in early January 2022.

The Network Leads completed contracting efforts with both the PHPs and HSOs during this period, which enabled these entities to move forward with pilot implementation.

Key challenges, underlying causes of challenges, and how challenges are being addressed

Key challenges for the Healthy Opportunities Pilots program during this period included assisting the pilot entities in adjusting their implementation plans based on the adoption of the phased launch approach, finalizing the technical solution requirements for Advanced Pilot Functionality enhancements in NCCARE360 that will be implemented after initial pilot launch, and addressing concerns from PHPs regarding the service delivery invoicing process.

In December, the Department adopted a phased rollout approach that enabled the pilot service delivery to be scaled-up incrementally over a four-month period, beginning in February 2022 with the release of the NCCARE360 pilot training environment and ending in June 2022 with the launch of toxic stress and cross-domain services. The Department adopted a phased launch approach in response to requests from partners and to ensure a smooth rollout, given the various new business and technical requirements that all partners are adopting for the pilot. The shift to a phased rollout resulted in the task reprioritization and timeline adjustment of several implementation activities for both the PHPs and Network Leads. Through reoccurring engagement sessions, the Department worked with these entities to ensure they made appropriate adjustments to their implementation plans.

The Department also continued to hold weekly working sessions with Unite Us, the vendor for the NCCARE360 platform, to align on requirements for the key enhancements to the NCCARE360 pilot functionality (Advanced Pilot Functionality) that will be implemented after the initial phased launch. The enhancements, which seek to automate the manual processes included in Base Pilot Functionality, will require customization of the existing platform, and the Department is working with the Unite Us team to

prioritize which improvements must be implemented after pilot launch to mitigate any potential delays in development and deployment.

Additionally, the PHPs continued to raise concerns through the North Carolina Association of Health Plans (NCAHP) regarding the challenges of implementing a technical solution to ingest and process pilot invoices. The Department engaged Unite Us to develop a solution to convert pilot invoices into a standard 837 claim, which would mitigate technical challenges faced by the PHPs, while still allowing HSOs to use a simpler invoicing system instead of processing claims. The Department continues to work with both Unite Us and the PHPs to implement this solution.

Issues or complaints identified by beneficiaries

No issues or complaints identified by beneficiaries for this reporting quarter.

Lawsuits or legal actions

The complaint filed with the Office of Administrative Hearings by Duke was dismissed in March. As such, there are no pending legal actions.

Unusual or unanticipated trends

No unusual or unanticipated trends during this reporting quarter.

Legislative updates

No legislative updates during this reporting quarter.

Descriptions of post-award public for a

Please see the description of the Dec. 10, 2021, post-award public forum on page 12.

Performance Metrics

No performance metrics to report for the Pilots this reporting quarter as they have not launched yet.

Incentive Payments to PHPs, NLs, and Pilot providers

To ensure a successful Pilot launch, the Department determined milestones for each Network Lead and PHP to reach during the Pilot Implementation Period (May 2021 through March 2022). These milestones were tied to meeting key Pilot implementation measures, including establishing an HSO network, providing training to HSOs and care management staff, establishing payment and reporting processes, and completion of readiness testing.

The Department developed an incentive payment fund for both Network Leads and PHPs during the implementation year and weighted each milestone based on importance to Pilot launch to determine the milestone payment amounts. The Incentive Payment Milestone Guides for Network Leads and PHPs can be found as Appendices F and G.

This reporting period, the State disbursed incentive payments to Network Leads for the timely submission of key deliverables to ensure that Network Leads were on track in developing processes and procedures needed to perform essential Pilot responsibilities. The “HSO Capacity Building Payment Distribution Approach” detailed how Network Leads would distribute capacity building payments among

HSOs in their network. The "Data Reporting Plan" outlined how the Network Lead would report data to the State for monitoring and evaluation. All three Network Leads submitted these deliverables on time and received the corresponding incentive payment for reaching each milestone. The details of each incentive payment made are listed in the following table:

Incentive Payments

Entity	Milestone Achieved	Milestone Deadline	Documentation Submitted	Amount Paid
Access East	Establish an HSO Capacity Building Payment Distribution Approach	7/26/2021	"HSO Capacity Building Payment Distribution Approach" Deliverable	$17,857.00
Access East	Establish data reporting processes	10/29/2021	"Data Reporting Plan" Deliverable	$17,857.00
Community Care of the Lower Cape Fear	Establish an HSO Capacity Building Payment Distribution Approach	7/26/2021	"HSO Capacity Building Payment Distribution Approach" Deliverable	$17,857.00
Community Care of the Lower Cape Fear	Establish data reporting processes	10/29/2021	"Data Reporting Plan" Deliverable	$17,857.00
Impact Health	Establish an HSO Capacity Building Payment Distribution Approach	7/26/2021	"HSO Capacity Building Payment Distribution Approach" Deliverable	$17,857.00
Impact Health	Establish data reporting processes	10/29/2021	"Data Reporting Plan" Deliverable	$17,857.00

ECM Capacity Building

The third issuance of Capacity Building Funds for the May 27, 2021–May 26, 2022 budget period was provided to Network Leads on Jan. 4, 2022. The State has permitted Network Leads to request up to $10,000,000 in capacity building funds for the May 27, 2021–May 26, 2022 budget period and up to $10,000,000 for the May 27, 2022–May 26, 2023 budget period. Network Leads must disburse at least 51% of their capacity building funds to HSOs in their Pilot network.

Additionally, the State permitted Network Leads to invoice up to 25% of their remaining annual capacity building budget in their third invoice this reporting period.

Amount Paid to Access East: $1,350,247.00

Description of Expense	Category of NL Allowable Use	Category of HSO Allowable Use	Invoiced Amount
Program Manager/Staff	N/A	Salary/Fringe for Staff Operationalizing Day-to-Day Pilot Responsibilities	$ 672,891.00
Fringe Costs (25%)	N/A	Salary/Fringe for Staff Operationalizing Day-to-Day Pilot Responsibilities	$ 230,208.00
Program and General Supplies	N/A	Purchases for Functional Systems	$ 45,000.00
Furnishings: Office	N/A	Office Furnishings, Supplies, and Equipment	$ 95,700.00
Minor Equipment: Refrigeration	N/A	Office Furnishings, Supplies, and Equipment	$ 79,980.00
Minor Equipment: Metal Shelving Kits	N/A	Office Furnishings, Supplies, and Equipment	$ 63,720.00
Minor Equipment: Computer/Technology Pkg	N/A	Purchases for Functional Systems	$ 69,750.00
HSO Patient Engagement	N/A	Other Use Approved by the Department	$ 45,000.00
HSO - Internet Svc & Hotspot Mobile Devices	N/A	Purchases for Functional Systems	$ 48,000.00

***Amount Paid to Community Care of the Lower Cape Fear**: $2,500,000.00

Description of Expense	Category of NL Allowable Use	Category of HSO Allowable Use	Invoiced Amount
Executive Director	Staff Time: Establishing the LPE	N/A	$ 1,715.00
Program Director	Staff Time: Establishing the LPE	N/A	$ 3,792.75
Recruiting	Administrative Overhead costs	N/A	$ 1,625.00
Office Space/Rent	Administrative Overhead costs	N/A	$ 4,625.00
Office Supplies	Administrative Overhead costs	N/A	$ 3,250.00
Travel	Administrative Overhead costs	N/A	$ 9,750.00
Training and Development	Administrative Overhead costs	N/A	$ 4,875.00
Payroll Services	Administrative Overhead costs	N/A	$ 3,325.75
Liability Insurance	Administrative Overhead costs	N/A	$ 5,500.00
Misc.	Administrative Overhead costs	N/A	$ -
Executive Director	Staff Time: Developing a Network of HSOs	N/A	$ 1,715.10
Program Director	Staff Time: Developing a Network of HSOs	N/A	$ 9,482.10
Care Council Leads	Staff Time: Developing a Network of HSOs	N/A	$ 23,087.05
QI Coordinator	Staff Time: Developing a Network of HSOs	N/A	$ 5,277.00
Program Managers	Staff Time: Developing a Network of HSOs	N/A	$ 22,156.00
Marketing	Administrative Overhead costs	N/A	$ 13,125.00
Misc.	Administrative Overhead costs	N/A	$ -
Executive Director	Staff Time: Developing Infrastructure/Systems	N/A	$ 1,715.00
QI Coordinator	Staff Time: Developing Infrastructure/Systems	N/A	$ 2,638.50
Compliance Manager	Staff Time: Developing Infrastructure/Systems	N/A	$ 23,086.75
Program Managers	Staff Time: Developing Infrastructure/Systems	N/A	$ 22,206.25
Data Analyst	Staff Time: Developing Infrastructure/Systems	N/A	$ 26,770.50
Office Management	Administrative Overhead costs	N/A	$ 4,062.50
HR Management	Administrative Overhead costs	N/A	$ 5,687.50

Description of Expense	Category of NL Allowable Use	Category of HSO Allowable Use	Invoiced Amount
IT Management	Administrative Overhead costs	N/A	$ 4,062.50
CRM Licenses	Administrative Overhead costs	N/A	$ 10,750.00
Software Licenses	Administrative Overhead costs	N/A	$ 1,625.00
CRM/ Cultural Competency Training	Administrative Overhead costs	N/A	$ 5,687.50
Computer and Communication Equipment	Administrative Overhead costs	N/A	$ 9,000.00
Executive Director	Staff Time: Providing TA/Training to HSOs	N/A	$ 1,715.10
Program Director	Staff Time: Providing TA/Training to HSOs	N/A	$ 1,896.60
Care Council Leads	Staff Time: Providing TA/Training to HSOs	N/A	$ 23,086.80
QI Coordinator	Staff Time: Providing TA/Training to HSOs	N/A	$ 5,277.00
Program Managers	Staff Time: Providing TA/Training to HSOs	N/A	$ 22,156.11
Executive Director	Staff Time: Distributing Capacity Building Funding to HSOs	N/A	$ 1,715.10
Program Director	Staff Time: Distributing Capacity Building Funding to HSOs	N/A	$ 9,482.10
Accountant/Claims	Staff Time: Distributing Capacity Building Funding to HSOs	N/A	$ 19,788.80
CFO Services (by CCLCF)	Administrative Overhead costs	N/A	$ 18,750.00
Executive Director	Staff Time: Facilitating Collaboration and Governance	N/A	$ 1,715.00
Program Director	Staff Time: Facilitating Collaboration and Governance	N/A	$ 1,896.50
QI Coordinator	Staff Time: Facilitating Collaboration and Governance	N/A	$ 2,638.50
Team Consultant	Staff Time: Facilitating Collaboration and Governance	N/A	$ 8,923.50
Legal Services	Administrative Overhead costs	N/A	$ 12,500.00
Meetings, Facilitation and Travel	Administrative Overhead costs	N/A	$ 50,000.00

Description of Expense	Category of NL Allowable Use	Category of HSO Allowable Use	Invoiced Amount
Cultural Competency Training (UNC-W)	Administrative Overhead costs	N/A	$ 25,000.00
Teambuilding, Coaching and Facilitation	Administrative Overhead costs	N/A	$ 8,125.00
Collaboration and Teambuilding	Administrative Overhead costs	N/A	$ 16,250.00
Communication	Administrative Overhead costs	N/A	$ 4,875.00
BOD Expenses	Administrative Overhead costs	N/A	$ 1,000.00
Executive Director	Staff Time: Reporting	N/A	$ 1,715.00
Program Director	Staff Time: Reporting	N/A	$ 5,689.25
Care Council Leads	Staff Time: Reporting	N/A	$ 23,087.00
QI Coordinator	Staff Time: Reporting	N/A	$ 10,554.00
Reporting (Audit & Tax Prep Fees)	Administrative Overhead costs	N/A	$ 5,000.00
Executive Director	Staff Time: Participating in Community Engagement	N/A	$ 1,715.00
Program Director	Staff Time: Participating in Community Engagement	N/A	$ 5,689.25
Care Council Leads	Staff Time: Participating in Community Engagement	N/A	$ 23,087.00
Team Consultant	Staff Time: Participating in Community Engagement	N/A	$ 8,923.50
Program Managers	Staff Time: Participating in Community Engagement	N/A	$ 22,156.11
HSO Funding*	N/A	N/A	$ 1,925,000.00

*$1,925,000 for HSO Funding will be released to Community Care of the Lower Cape Fear on April 5, 2022. Due to an error, this funding was not released on Jan. 4, 2022, with the rest of the capacity building funds.

Amount Paid to Impact Health: $2,491,377.00

Description of Expense	Category of NL Allowable Use	Category of HSO Allowable Use	Invoiced Amount
Lead Pilot entity establishment	Staff Time: Establishing the LPE		$ 407,958.75
Lead Pilot entity establishment	Administrative Overhead costs		$ 146,450.75
Lead Pilot entity establishment	Administrative Overhead costs		$ 45,511.25
HSO network development	Staff Time: Developing a Network of HSOs		$ 22,255.25
Infrastructure/IT system development	Staff Time: Developing Infrastructure/Systems		$ 9,680.00
HSO technical assistance and training	Staff Time: Providing TA/Training to HSOs		$ 114,021.00
HSO capacity building funding distribution		Other Use Approved by Department	$ 1,673,000.00
Governance and cross-entity collaboration	Staff Time: Facilitating Collaboration and Governance		$ 46,250.00
Program administration, evaluation, and oversight	Administrative Overhead costs		$ 22,500.00
Community engagement	Staff Time: Participating in Community Engagement		$ 3,750.00

Healthy Opportunities Pilots Evaluation Activities and Interim Findings

In this quarter, the pilot's evaluation team has been involved in weekly project meetings aimed at solving issues, making decisions on project implementation, and working with pilot entities to set up data collection contracts. Dr. Kathie Ricks attends weekly meetings with the Network Leads to keep abreast of new changes, respond to Network Lead questions, monitor how HSO selection is progressing, and to provide feedback regarding the evaluation as needed.

During this period, evaluation consisted of three main activities. The first was continuing to provide technical assistance to the Department regarding operationalization of the Healthy Opportunities Pilots. Dr. Seth Berkowitz provided the Network Leads with needed information and held meetings with Network Leads to provide guidance on workflows for delivery of pilot services, issues regarding provision of interpersonal violence services, issues related to payment activities, issues related to eligibility criteria for services and types of services to emphasize to achieve desired outcomes.

The second key activity was working with the data team at the Sheps Center to prepare the necessary information technology infrastructure to receive data regarding Pilot activities once they launch. This involved identifying necessary data elements and owners of the needed data and making necessary arrangements to receive data. The third focus of this quarter was developing the qualitative interview schedule and quantitative surveys that will be used to understand the preparation that the Network Leads and HSOs undertook in implementing pilot services. The Pilot team at UNC worked together to find, analyze and choose appropriate questions that will encourage sharing of experiences on each level of the organizations.

Residential and Inpatient Treatment for Individuals with a Substance Use Disorder

The Department will provide detailed information in the Substance Use Disorder quarterly submission that is due to CMS May 1, 2022.