Medicaid Section 1115 Monitoring Report

North Carolina - North Carolina Medicaid Reform Demonstration

DY4Q2 – Feb. 1, 2022, through April 30, 2022

Submitted on June 29, 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).*

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DEMONSTRATION YEAR 4 QUARTER 2 REPORT

Executive Summary

This quarterly report covers Demonstration Year 4, Quarter 2 (DY4Q2) of the North Carolina Medicaid Reform Demonstration, Feb. 1, 2022 through April 30, 2022.

In this quarter, the Department continued to address post-implementation concerns following the launch of the Standard Plans in July 2021. To ensure optimal care for members and support providers, the Department has extended the North Carolina State of Emergency Temporary Flexibilities, converted some COVID-19 policy flexibilities into permanent clinical coverage policies, and extended some temporary provider rate increases. In February 2022, the Department issued the results of its review of the Standard Plans' networks for compliance across all network adequacy standards. All five Standard Plans had gaps in compliance, which resulted in issuing corrective action plans (CAPs).

The Department continues to prepare for the launch of the Behavioral Health I/DD Tailored Plans (Tailored Plans) on Dec. 1, 2022. Tailored Plan operational readiness reviews officially kicked off March 17, 2022. The Department provided an overview of federal readiness requirements, presented the approach to Tailored Plan readiness reviews and reviewed the timeline of upcoming readiness activities. In April, the Department began issuing a weekly scorecard to the Tailored Plans. The scorecard presents a summary progress report and trends among Tailored Plans based on critical areas, including inbound deliverables, readiness reviews, provider network coverage, testing and technology operations.

In April, three Tailored Plans – Eastpointe, Trillium Health Resources and Vaya Health – announced that they had selected a new pharmacy benefit manager (PBM). This resolves an issue that the Department was alerted to in November 2021, when the former PBM vendor for these plans indicated it would exit the market nationally. Consequently, these plans underwent a reprocurement process to identify and contract with new PBMs. The Department is working diligently to assess and mitigate any impact on testing timelines resulting from the need to select a new PBM.

The Healthy Opportunities Pilots program launched Feb. 1, 2022, under a phased launch plan. In the first phase, newly developed "Base Pilot Functionality" in NCCARE360, North Carolina's statewide closed-loop referral system, became available. On March 15, food services launched, providing eligible members access to services such as food and nutrition access case management; healthy food boxes/meals; fruit and vegetable prescriptions; and group nutrition classes. Housing and transportation services launched in May, followed by toxic stress and cross domain services in June.

Per state legislation and the American Rescue Plan Act of 2021, North Carolina extended Medicaid postpartum health care coverage from 60 days to 12 months beginning April 1, 2022, for eligible beneficiaries. Beneficiaries who are currently pregnant or who gave birth between Feb. 1, 2022 and March 31, 2022, are also eligible for 12 months of continuous postpartum coverage. Additionally, Medicaid for Pregnant Women (MPW) will now provide full coverage Medicaid benefits for the duration of pregnancy and the extended 12-month postpartum period.

Medicaid Managed Care

Operational Updates

During this quarter, the Department continued to address post-implementation concerns following Standard Plan launch. To ensure continued optimal care to members and to support the provider community, the following provisions and flexibilities were extended:

- North Carolina State of Emergency Temporary Flexibilities scheduled to sunset March 31, 2022, were extended through June 30, 2022.
- Some COVID-19 policy flexibilities implemented during the North Carolina State of Emergency and federal Public Health Emergency (PHE) were converted into permanent medical clinical coverage policies.
- Several COVID-19 temporary provider rate increases were extended, including the vaccination counseling code reimbursement.

In February 2022, the Department issued the results of its review of the Standard Plans' networks for compliance with network adequacy standards and state and federal laws and regulations. All five Standard Plans had some gaps in compliance that resulted in issuing Corrective Action Plans (CAPs). Additionally, the state approved network adequacy exception requests for all Standard Plans. The state is currently monitoring the Standard Plans' progress under the CAPs and network adequacy exception requests.

The state continues to prepare for the launch of the Behavioral Health I/DD Tailored Plans (Tailored Plans) on Dec. 1, 2022. The Department has regular meetings with the selected Tailored Plans, including weekly status meetings with each plan to track development work and address any potential business issues and risks. The Department also holds biweekly calls with Tailored Plan executive leadership teams. As part of these status calls, the Department has been engaging with the Tailored Plans on system development and integration efforts, and closely monitored progress.

The Department continued to facilitate meetings between the North Carolina Healthcare Association (NCHA) and the Tailored Plans to support a smooth transition at launch. These meetings are focused on lessons learned from the Standard Plan implementation and Tailored Plan contracting information, with the goal of addressing potential issues prior to Tailored Plan launch.

In April, the Department began issuing a weekly scorecard to the Tailored Plans. The scorecards present a summary progress report on areas identified as critical to Tailored Plan launch and post-launch success. Plans are given scores for each area, which are used to calculate an overall score. The critical areas measured include the following:

- **Inbound Deliverables:** This section tracks the timely submission of contractual deliverables that the Department will review and approve as part of NC Medicaid Managed Care oversight activities.
- **Readiness Review:** Documents open items identified during desktop and onsite readiness reviews. Readiness reviews assess the plans' ability and capacity to operationalize the Tailored Plan design in CMS-defined Readiness Review Areas.

- **Provider Network Coverage:** These data show Tailored Plan network adequacy in the service categories of Hospital, OB/GYN, Outpatient Behavioral Health, Occupational Therapy, Physical Therapy and Speech Therapy. This section also evaluates progress on contracting with non-emergency medical transportation (NEMT) and Advanced Medical Home (AMH) providers.
- **Testing:** These metrics track Auto Assignment and Tailored Plan Launch execution status by path start dates, percent complete and status. This includes end-to-end (E2E) defect counts and defect aging by Tailored Plans, and project-specific System Integration Testing (SIT) status.
- **Technology Operations/Help Center:** These data include a count of late file submissions, critical Help Center cases, and any issues affecting operations and/or technology-related incidents and problems that have not been resolved by the expected timeframe. These data will not be included in the scorecard until at least August 2022.

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

Standard Plans

1. The Advanced Medical Home (AMH) Technical Advisory Group continues to advise and inform the Department on key aspects of the design and evaluation of the AMH program. This quarter, the Data Subcommittee reconvened to prioritize areas for advancement and improvement to the data sharing model. The Department surveyed the Data Subcommittee members, and they provided feedback for seven data issues with respect to impact, urgency for resolution and potential solutions.
2. The North Carolina Integrated Care for Kids (NC InCK) program launched in Standard Plans on Jan. 3, 2022, in five counties. The NC InCK model aims to improve quality of care and reduce expenditures for children under age 21 covered by NC Medicaid through prevention, early identification, and treatment of behavioral and physical health needs. While the program is distinct from the 1115 waiver, beneficiaries in NC InCK are included in the transition to NC Medicaid Managed Care. Currently, the approximately 95,000 NC InCK beneficiaries receive integrated care management through Standard Plans and NC Medicaid Direct.

   NC InCK beneficiaries in need of greater supports are identified through service integration level (SIL) assignments based on a child's and family's health, health care utilization, socioeconomic factors and the risk of being placed out-of-home. Higher risk beneficiaries are assigned a Family Navigator, which is a care management role unique to the NC InCK program. This quarter, the Department released the NC InCK Performance Measure Technical Specifications Manual outlining the 10 performance measures to be included in the NC InCK alternative payment model (APM).
3. The first preferred drug list (PDL) update to be implemented since the launch of Standard Plans was successfully completed April 1, 2022.
4. The provider engagement team offered a virtual office hour session and 13 provider engagement-related meetings, and published multiple articles and fact sheets to inform providers of upcoming events, activities and changes.

5. The External Quality Review Technical Report was posted to the Department website and sent to CMS in April 2022.
6. Health Services Advisory Group (HSAG), the Department's External Quality Review Organization, completed the validation of performance measures for Year 1.

Tailored Plans

1. Tailored Plan operational readiness reviews began March 17, 2022. The Department provided an overview of federal readiness requirements, presented the approach for Tailored Plan readiness reviews and reviewed the timeline of upcoming readiness activities. On March 29, 2022, the Department shared Desktop Review tools with the Tailored Plans and requested responses. The Department started reviewing initial Desktop Review responses and associated documentary evidence April 28.
2. The Tailored Care Management (TCM) Claims Billing Guide was completed and shared with the Tailored Plans. There are two guides – Claims for Providers and Tailored Plans, and Encounters for Tailored Plans.
3. Tailored Plan SIT began Feb. 21, 2022. This testing was performed at the business unit level to verify individual module functionality and interoperability with other vendor systems per the functional requirements. E2E testing began March 14, 2022, and will run through Nov. 15, 2022. The purpose of E2E testing is to verify end-to-end business flow across applications leveraging production data and operations according to agreed common practices. This facilitates smooth interaction between dependent systems (user interface, backend and database) as per identified business requirements.
4. On April 15, the Department began issuing a weekly scorecard to the Tailored Plans (described in Operational Updates on page 5).
5. User Acceptance Testing for the Enrollment Broker provider directory for Tailored Plans began this quarter to validate updates made for Tailored Plans and their network information. The provider directory launched in June.
6. All round one Advanced Medical Home Plus (AMH+) practices/Care Management Agencies (CMAs) candidates have initiated the site review process (part 2 of the certification process) for Tailored Care Management Certification, and 18 providers have been fully certified. For round two applicants, 33 providers started the site review 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. 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.

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

Standard Plans

1. Implementation of a new provider enrollment file (PEF) redesign is delaying the development of Standard Plan directory monitoring. To address this challenge, the Department has submitted

additional guidelines to Standard Plans on the data source required to build the consumer-facing directories to mitigate discrepancies. Additionally, the Department is amending contract language related to non-enrolled providers being removed from the data source to ensure timely directory updates.

2. The Department is addressing the following issues with pharmacy benefits in Standard Plans:
    - The Department was alerted to encounter data errors for pharmacy services, including inaccurate copay information. These appear to be data mapping issues, and the Department is working on a resolution.
    - Two Standard Plans did not meet the PDL compliance 95% benchmark during the first and second quarter of State Fiscal Year 2022. The Department is working to resolve the performance issue with each Standard Plan.
    - The Department is working with four Standard Plans to address inappropriate utilization of transaction fees. Standard Plans are required to resubmit claims without the transaction fees.
3. The NC Medicaid Contact Center did not meet its targeted service level, measured as percentage of calls answered within 30 seconds, due to understaffing and difficulty filling positions. The team is working to hire an additional five agents to fill open positions.

Tailored Plans

1. In late November, Envolve RX, the PBM vendor of three of the Tailored Plans (Eastpointe, Trillium Health Resources and Vaya Health) indicated that it would be exiting the PBM market nationally in April 2022. Consequently, these three Tailored Plans underwent a reprocurement process to identify and contract with new PBMs. This process took longer than anticipated, and the Department was notified of the selection of the last outstanding PBM on April 4, 2022. The Department is assessing any potential impact on the E2E testing timeline and identifying any needed mitigation strategies.
2. Tailored Plans experienced delays in their ability to ingest the Provider Enrollment File and produce a Provider Network File. To mitigate this issue, the Department has established individual meetings with each Tailored Plan to resolve specific issues, ensuring timelines can be met and implementation continues across all areas.
3. Several Tailored Plans are trending behind on Primary Care Provider (PCP) Auto Assignment development activities, which will assign Tailored Plan members to a PCP. The Department has guided Tailored Plans to work with subcontractors to support the completion of feature development by proposed end dates. The Department has adjusted the timeline for this milestone to allow Tailored Plans more time for testing and implementation.

Milestones

1. Tailored Plan operational readiness reviews began March 17, 2022.

Issues or complaints identified by beneficiaries

The Department receives beneficiary complaints primarily 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 DY4Q2, the Ombudsman handled 3,318 cases, an approximately 13% increase over last quarter. Many calls involved educating beneficiaries or connecting them to the entity that could provide the service they need. (See Appendix A for a full list of cases by category type.) This quarter, the Office of Administration received 33 complaints, compared to 9 last quarter. There were no complaints reported to the Office of Compliance and Program Integrity.

NC Medicaid Member Ombudsman Cases

February 2022		March 2022		April 2022		Total Cases
Information	Issue Resolution	Information	Issue Resolution	Information	Issue Resolution	
648	746	846	1034	695	980	**3,318**

Office of Administration Member Concerns, February 2022 – April 2022

Issue Category	Number of Issues
Beneficiary/Member	10
Clinical Policy - Medical Health	3
Dental	1
Finance/Standard Plan Claims Issues	4
Non-Emergency Medical Transportation (NEMT)	3
Outpatient Specialized Therapies (Prior Approvals) Leadership Escalation	3
Plan Administration	1
Provider Operations	8
TOTAL	**33**

Lawsuits or legal actions

No lawsuits or legal actions this quarter.

Legislative updates

No legislative updates this quarter. North Carolina's 2022 legislative session began May 18, 2022.

Unusual or unanticipated trends

1. The Department received a concerned citizens letter from three advocacy groups (Charlotte Center for Legal Advocacy, National Health Law Program and Disability Rights NC) on behalf of their constituents. The letter outlined concerns regarding the physical health benefit of Tailored Plans and the potential impact on member provider choice. The Department is in the process of responding to the outlined concerns.

Descriptions of post-award public fora

No public fora this quarter.

Performance Metrics

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

No metrics in this category for DY4Q2.

Outcomes of care

No metrics in this category for DY4Q2.

Quality of care

North Carolina measurement year 2021 quality measure results will be available beginning in July 2022. Because NC Medicaid Managed Care launched 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.

The Department continues to work on statewide performance improvement projects related to increasing Immunizations in Children, Early Access to Prenatal Care, Postpartum Care and Diabetes Control for adults.

Cost of care

No metrics in this category for DY4Q2.

Access to care

Network Time/Distance Standards

The percentage of members with access to provider types that meet network adequacy standards is shown below for each Standard Plan by region and type of service provider. The state's time or distance network adequacy standards require that at least 95% of the membership meet the access standard. All Standard Plans met the state's time or distance standards for the five key service categories of hospitals, OB/GYN, primary care (adult and child), pharmacy and outpatient behavioral health (adult and child) as of DY4Q2.

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	144,528	100%	100%	100%	100%	100%	100%	100%
2	13	301,358	100%	100%	100%	100%	100%	100%	100%
3	12	425,773	100%	100%	100%	100%	100%	100%	100%
4	14	347,226	99%	100%	100%	100%	100%	100%	100%
5	15	288,877	100%	100%	100%	100%	100%	100%	100%
6	27	220,708	99%	100%	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	144,528							
2	13	301,358							
3	12	425,773	100%	100%	100%	100%	100%	100%	100%
4	14	347,226	100%	100%	100%	100%	100%	100%	100%
5	15	288,877	100%	100%	100%	100%	100%	100%	100%
6	27	220,708							

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	144,528	100%	100%	100%	100%	100%	100%	100%
2	13	301,358	100%	100%	100%	100%	100%	100%	100%
3	12	425,773	100%	100%	100%	100%	100%	100%	100%
4	14	347,226	100%	100%	100%	100%	100%	100%	100%
5	15	288,877	100%	100%	100%	100%	100%	100%	100%
6	27	220,708	99%	100%	100%	100%	99%	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	144,528	100%	100%	100%	100%	100%	100%	100%
2	13	301,358	100%	100%	100%	100%	100%	100%	100%
3	12	425,773	100%	100%	100%	100%	100%	100%	100%
4	14	347,226	100%	100%	100%	100%	100%	100%	100%
5	15	288,877	100%	100%	100%	100%	100%	100%	100%
6	27	220,708	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	144,528	100%	100%	100%	100%	100%	100%	100%
2	13	301,358	100%	100%	100%	100%	100%	100%	100%
3	12	425,773	100%	100%	100%	100%	100%	100%	100%
4	14	347,226	100%	100%	100%	100%	100%	100%	100%
5	15	288,877	100%	100%	100%	100%	100%	100%	100%
6	27	220,708	99%	100%	100%	100%	99%	100%	100%

* Number of members currently mandated in Managed Care population. This metric is NOT representative of each Standard Plan's membership.

Provider Enrollments by Standard Plan

Standard Plan provider enrollment is available in 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 B for the full list.

Provider Enrollment by Standard Plan – Select Categories

Provider Type	AmeriHealth	Healthy Blue	CCH	United	WellCare
Ambulatory Health Care Facilities	974	1,219	941	860	833
Behavioral Health & Social Service Providers	8,090	9,207	6,597	3,961	5,466

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 members in each AMH tier by Standard Plan.

Member Count by Standard Plan and AMH Tier

	AmeriHealth	CCH	Healthy Blue	United	WellCare	Total
No PCP Tier	6,654	1,296	15,278	11,788	4,211	**39,217**
Tier 1	2,154	3,080	8,697	3,800	3,353	**21,084**
Tier 2	43,513	39,198	76,074	68,009	54,647	**281,441**
Tier 3	257,788	178,768	353,729	288,458	303,693	**1,382,436**

Member Proportion by Standard Plan and AMH Tier

	AmeriHealth	CCH	Healthy Blue	United	WellCare	Total
No PCP Tier	2.15%	0.58%	3.37%	3.17%	1.15%	**2.27%**
Tier 1	0.69%	1.39%	1.92%	1.02%	0.92%	**1.22%**
Tier 2	14.03%	17.63%	16.76%	18.28%	14.93%	**16.32%**
Tier 3	83.13%	80.40%	77.95%	77.53%	83.00%	**80.18%**

AMH Provider Enrollment

Proportion of Providers Contracted by State-designated AMH Tier by Standard Plan*

	AmeriHealth	Healthy Blue	CCH**	United	WellCare
Tier 1	23.50%	54.85%	51.22%	45.52%	37.31%
Tier 2	40.23%	87.87%	64.07%	63.80%	52.60%
Tier 3	82.61%	80.63%	92.95%	86.70%	85.14%

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

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

Care Management Penetration Rate

These data represent members enrolled in Standard Plans receiving care management through a Standard Plan, AMH, Care Management for At-Risk Children (CMARC) program or Care Management for High-Risk Pregnancies (CMHRP) program since Standard Plan launch (July 2021). These data are provided with a one-month lag (e.g., DY4Q2 ends April 30; however, data are available only through March.)

CMHRP is the Department's primary vehicle to deliver 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 0 to 5. Both services are performed by local health departments (LHDs) as delegates of the Standard Plans. Care management provided through a Standard Plan or AMH is reported by Standard Plans 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 CMARC and CMHRP programs.

In general, care management rates were beginning to trend behind the annual penetration target of 20% of members receiving care management by the end of Year 1 of NC Medicaid Managed Care. The Department is working with Standard Plans to ensure accurate data reporting. Standard Plans are working to ensure their data are accurate and that enough members are being engaged in care management.

Care Management Penetration Rate: July 2021 to March 2022

	Standard Plan	AMH	CMARC	CMHRP	Overall
% of Total Members	3.4%	9.3%	0.9%	1.2%	**13.0%**
CM Distinct Member Count	61,645	167,123	17,054	20,925	**233,688**

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 Standard Plan and NC Medicaid Direct. Claims denied because they were erroneously billed to NC Medicaid Direct instead of a Standard Plan were excluded from measurement calculations to avoid duplication. Medicaid beneficiaries not eligible for hospital coverage (e.g., family planning participants) were excluded from NC Medicaid Direct calculations

Due to the lag in claims and encounter reporting, the rates below are reported with a one-month lag. It should be noted that higher rates were expected for NC Medicaid Direct, as members with substantial behavioral health issues to be enrolled in Tailored Plans in December 2022 currently remain in NC Medicaid Direct.

Emergency Department Visits per 1,000 Members, January – March 2022

AmeriHealth	CCH	Healthy Blue	NC Medicaid Direct	United	WellCare
57.73	59.88	54.70	69.66	59.62	55.41

Inpatient Admissions per 1,000 Members, January – March

AmeriHealth	CCH	Healthy Blue	NC Medicaid Direct	United	WellCare
13.75	14.92	14.69	22.49	14.72	16.39

Results of beneficiary satisfaction surveys

The Department has released the results of the latest *Consumer Assessment of Healthcare Providers and Systems* (CAHPS) surveys. NC Medicaid administers the CAHPS surveys to adult and child Medicaid beneficiaries to understand the Medicaid beneficiary experience and inform improvements in care.

Medicaid respondents were contacted for participation in the 2021 CAHPS survey between April 9, 2021, and August 15, 2021, and were asked to think about services received in the past six months when answering survey questions. Data from the 2019 survey were compared to 2021 to see how responses have changed from pre- to mid-COVID-19 pandemic. When this survey was administered, almost all respondent's health plans would be NC Medicaid Direct. For many individuals who responded to the survey between July 1, 2021, and August 15, 2021, their current health plan would have been a Standard Plan, but most of their experience in the past six months would have been while they were enrolled in NC Medicaid Direct. **Thus, the survey results largely do not reflect the experience of Medicaid members in NC Medicaid Managed Care.**

Key findings include:

- Overall health and mental health ratings did not change appreciably between 2019 and 2021, with the exception of child mental health, which declined slightly during the federal Public Health Emergency.
    - In 2021, 56.57% of adult respondents rated their overall health as good, very good or excellent compared to 54.72% of 2019 respondents
    - 97.21% of adult respondents in 2021 rated their child's overall health as good, very good or excellent, compared to 95.50% in 2019
    - 87.10% of adult respondents in 2021 rated their child's overall mental or emotional health as good, very good or excellent, compared to 91.09% in 2019
- Both adults and children were less likely to use non-emergency care in 2021, but there were no differences across years in the ability to access care when needed.
    - 34.31% of adults in 2021 reported that they did not use non-emergency health care in the previous six months, compared to 20.99% in 2019
    - 84.77% of adult respondents usually or always received care right away when needed in 2021, compared to 81.25% in 2019

- Approximately 41.79% of 2021 adult respondents reported their child did not use non-emergency health care in the previous six months, compared to 27.87% in 2019
- 95.95% of adult respondents reported their child usually or always received care right away when needed in 2021, compared to 95.07% in 2019

Budget Neutrality and Financial Reporting Requirements

The Department will provide CMS with updated budget neutrality information through April 30, 2022, in the next budget neutrality workbook submission.

Evaluation Activities and Interim Findings

The Sheps Center for Health Services Research continued its evaluation work in DY4Q2. The evaluation uses a mixed-methods approach, combining analysis of administrative data with qualitative data to obtain detailed insights into North Carolina Medicaid 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. The evaluation activities during this quarter are described below.

Transition to Capitated Encounter Data from Standard Plans

Sheps Center data scientists and analysts have begun working with the encounter data that tracks utilization by Medicaid beneficiaries enrolled in Standard Plans, which was received by the Sheps Center during DY4Q2. Sheps is providing feedback on the quality and completeness of these data to the Department and is in the process of revising code on metrics to include services, medications and diagnoses received through either claims or encounter data.

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 Set measures and other metrics that will address the study hypotheses. The Sheps Center has completed an evaluation of the use of Marketplace enrollees from a North Carolina-based insurer as a potential comparison group for the difference-in-differences analysis through the comparison in trends in seven identified measures. These measures showed generally similar trends between Medicaid and Blue Cross Blue Shield of North Carolina Marketplace plans in the pre-implementation period, although there were concerns about small sample sizes for some of the metrics that look at specific subsamples (such as well-child visits for children and adolescents due to the relatively modest number of children in Marketplace plans). The evaluation anticipates using this group as a control group for a limited number of metrics while simultaneously seeking other options for a comparison group, such as through other states' Medicaid data.

The Sheps Center is working with the Department to develop and field a new dashboard to track other behavioral health metrics that are not included in the Substance Use Disorder dashboard. This dashboard will increase the rapid monitoring of metrics that may have been influenced by Standard Plan implementation and other milestones. An additional dashboard on physical or general health metrics is also being planned.

Qualitative Update

The qualitative team began recruitment for Year 2 interviews, starting with outreach to Year 1 participants to schedule second interviews. In March and April, eight interviews were conducted with Year 1 participants using an interview guide specific to repeat interviewees. Recruitment expanded to the survey team's non-respondent survey sample, and seven interviews were conducted with these participants. The qualitative team is also recruiting representatives from LHDs and federally qualified health centers (FQHCs). The team has a goal of incorporating approximately five FQHCs and five LHDs into the Year 2 sample. The team also aims to again interview most of the large health systems in the state in Year 2. The qualitative team is preparing a manuscript on patient engagement using the data from Year 1 interviews, and an abstract is being prepared for submission to the publications committee.

Enhanced Case Management (ECM) and Other Services Pilot Program

Operational Updates

Introduction

The Healthy Opportunities Pilots program launched Feb. 1, 2022, under a phased launch plan. In the first phase, newly developed "Base Pilot Functionality" in NCCARE360, North Carolina's statewide closed-loop referral system, became available. Food services launched on March 15, and housing and transportation services are scheduled to launch in May, followed by toxic stress and cross-domain services in June. The Department completed its readiness evaluation of the Network Leads and Standard Plans and delivered its proposed evaluation report submission schedule to CMS.

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

In the first Pilot launch phase, "Base Pilot Functionality" in NCCARE360 became available. Additional functionality in NCCARE360 also went live at that time, including an eligibility documentation system, an enrollment and service authorization system, referral enhancements, and invoicing. Due to the Department's focus on launching the Pilots quickly, these processes are currently somewhat manual, but will incorporate automation and integrations through "Advanced Pilot Functionality," which will roll out in phases and be completed by March 2023.

On March 15, food services launched, providing eligible members connections to services such as food and nutrition access case management; healthy food boxes/meals; fruit and vegetable prescriptions; and group nutrition classes. The first enrollment pathway opened on the same date, which allowed NC Medicaid Managed Care members assigned to three major Clinically Integrated Networks (CINs) for care management in Pilot regions to begin enrolling in the Pilot. These three CINs provide care management to the vast majority of NC Medicaid members receiving care management in Pilot regions. Enrollment pathways will continue to open in May and June.

Additionally, the Department continued weekly individual and group engagement sessions with the Standard Plans and Healthy Opportunities Network Leads to discuss the progress of their implementation activities. Both the Standard Plans and Network Leads continued implementing internal processes and updating policies during DY4Q2. The Department completed its readiness evaluation of the Network Leads and Standard Plans in February 2022. Additionally, the Department delivered its proposed evaluation report submission schedule to CMS in April 2022.

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

Key challenges for the Healthy Opportunities Pilots program during DY4Q2 included troubleshooting challenges experienced by Pilot entities as the program began to operationalize food service delivery, developing trainings for care management entities, and working with stakeholder groups to address any gaps in the program's equity approach.

The shift to a phased rollout resulted in task reprioritization and timeline adjustment of several implementation activities for Standard Plans and Network Leads. The Department worked with these entities to identify guidance needs, mitigate any difficulty with new processes, and ensure that services could begin for eligible beneficiaries. Additionally, the Department began to work with partners to develop trainings for care management entities. These trainings will address key topics including motivational interviewing, health equity and domain-specific trainings.

The Department also began to engage with community stakeholders and Pilot entities to identify and address any gaps in the program's equity strategy. Through multiple engagement sessions, the Department has begun to address questions about Human Services Organization (HSO) application timelines and requirements.

Lawsuits or legal actions

No lawsuits or legal actions this quarter.

Unusual or unanticipated trends

No unusual or unanticipated trends this quarter.

Legislative updates

No legislative updates this quarter.

Performance Metrics

Incentive Payments to Standard Plans, Network Leads, and Pilot providers

To ensure a successful Pilot launch, the Department determined milestones for each Network Lead and Standard Plan to reach during the Pilot Implementation Period (May 2021 through March 2022). These milestones were tied to meeting key Pilot implementation activities, including establishing an HSO network, providing training to HSOs and care management staff, establishing payment and reporting processes, and completing readiness testing. The Department developed an incentive payment fund for Network Leads and Standard Plans 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 Standard Plans can be found in Appendices C and D.

In DY4Q2, the Department disbursed incentive payments to Network Leads for the completion of implementation year training, technical assistance and engagement activities, and for successfully completing the DHB readiness evaluation, which included ensuring their HSO network was prepared for service delivery. 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 below:

Network Lead VBP Payments			
Entity	**Milestone Achieved**	**Milestone Deadline**	**Amount Paid**
Access East	Complete Implementation Year training, technical assistance and engagement as outlined in the Network Lead's Pilot Entity Engagement, Training and Technical Assistance Plan.	3/14/2022	$17,857.00
Access East	Pass DHB readiness evaluation, including that HSO network is prepared to deliver services.	3/14/2022	$26,785.00
Community Care of the Lower Cape Fear	Complete Implementation Year training, technical assistance and engagement as outlined in the Network Lead's Pilot Entity Engagement, Training and Technical Assistance Plan.	3/14/2022	$17,857.00
Community Care of the Lower Cape Fear	Pass DHB readiness evaluation, including that HSO network is prepared to deliver services.	3/14/2022	$26,785.00
Impact Health	Complete Implementation Year training, technical assistance and engagement as outlined in the Network Lead's Pilot Entity Engagement, Training and Technical Assistance Plan.	3/14/2022	$17,857.00
Impact Health	Pass DHB readiness evaluation, including that HSO network is prepared to deliver services.	3/14/2022	$26,785.00

In DY4Q2, the Department disbursed incentive payments to the Standard Plans for executing contracts with each Network Lead operating in their respective regions by the established deadline. All five Standard Plans completed this milestone on time and received the corresponding incentive payment. The details of each incentive payment made are listed below:

Standard Plan VBP Payments				
Entity	**Milestone Achieved**	**Milestone Deadline**	**Documentation Submitted**	**Amount Paid**
WellCare	Execute contracts with all Network Leads that are operating in the Standard Plan's region.	11/22/2021	Copy of executed contract.	$30,000.00
AmeriHealth Caritas of NC	Execute contracts with all Network Leads that are operating in the Standard Plan's region.	11/22/2021	Copy of executed contract.	$30,000.00
Carolina Complete Health	Execute contracts with all Network Leads that are operating in the Standard Plan's region.	11/22/2021	Copy of executed contract.	$30,000.00
United Healthcare of NC	Execute contracts with all Network Leads that are operating in the Standard Plan's region.	11/22/2021	Copy of executed contract.	$30,000.00
Blue Cross Blue Shield of NC	Execute contracts with all Network Leads that are operating in the Standard Plan's region.	11/22/2021	Copy of executed contract.	$30,000.00

ECM Capacity Building

In DY4Q2, $1,925,000 of capacity building funding was released to Community Care of the Lower Cape Fear. This funding was disbursed as a correction because this amount was not released on Jan. 4, 2022, with the rest of the capacity building funding. No additional capacity building funds were released in DY4Q2.

Healthy Opportunities Pilots Evaluation Activities and Interim Findings

During DY4Q2, Pilot evaluation consisted of three main activities:

- Providing technical assistance to the Department regarding operationalization of the Healthy Opportunities Pilots to facilitate evaluation. This included meeting with the Department, Network Leads, HSOs and other stakeholders to engage with questions around workflows for delivery of pilot services, provision of interpersonal violence services, payment activities, eligibility criteria and types of services to emphasize. These activities include weekly and monthly standing meetings. The evaluation team also worked to set a new schedule for

delivering evaluation reports based on the current schedule of pilot services (which began with food insecurity services in March 2022).

- Working with the data team at Sheps to prepare the necessary information technology infrastructure to receive data regarding Pilot activities, expected in July 2022. This involved identification of the necessary data elements, owners of the needed data, and privacy protections, and making necessary arrangements to receive data when available.
- Primary data collection for evaluation question 1. This involved quantitative and qualitative data collection with Network Leads and HSOs regarding their preparations to deliver Pilot services.

Residential and Inpatient Treatment for Individuals with a Substance Use Disorder

The Department will provide detailed information in the Substance Use Disorder quarterly monitoring report due to CMS July 31, 2022.