Medicaid Section 1115 Monitoring Report

North Carolina - North Carolina Medicaid Reform Demonstration

Demonstration Year 4 – November 1, 2021 through October 31, 2022

Submitted on Feb. 1, 2023

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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ANNUAL REPORT - DEMONSTRATION YEAR 4

Executive Summary

This annual report covers Demonstration Year 4 (DY4) of the North Carolina Medicaid Reform Demonstration, Nov. 1, 2021, through Oct. 31, 2022.

Standard Plans

On July 1, 2021, North Carolina transferred most Medicaid beneficiaries from NC Medicaid Direct (fee-for-service Medicaid) to five Prepaid Health Plans (PHPs): AmeriHealth Caritas, Healthy Blue of North Carolina, UnitedHealthcare of North Carolina, WellCare of North Carolina and Carolina Complete Health. Referred to as Standard Plans, the transition to these PHPs marked the launch of NC Medicaid Managed Care. Following Standard Plan launch, the Department has focused on addressing post-implementation concerns and supporting providers and members in the transition to managed care. The Department extended or made permanent numerous COVID-19 policy flexibilities in areas such as telehealth and prior authorizations and extended some temporary provider rate increases. The Department continues to monitor Standard Plan performance closely and address issues through formal notification, corrective action plans, and the assessment of liquidated damages, when applicable.

The Department has partnered with Standard Plans to drive clinical improvements in areas with existing health inequities. In DY4, workgroups were created to address integrated care, sickle cell disease and gender affirming care.

Tailored Plans

The Department has moved the launch of the Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Plans (Tailored Plans) from the original date of July 1, 2022, to April 1, 2023. In November 2021, the launch was delayed until Dec. 1, 2022. Several factors contributed to the date change, including that Tailored Plan contracts were awarded later than originally planned and numerous counties chose to disengage from Cardinal Innovations Healthcare and partner with new Local Management Entities-Managed Care Organizations (LME-MCOs). At the end of September 2022, the Department further delayed launch until April 1, 2023. The delay will allow Tailored Plans more time to contract with additional providers and to validate that data systems needed for launch are working. 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.

While the launch of Tailored Plans was delayed to April 1, 2023, the Department and LME-MCOs supported providers of Tailored Care Management to launch their services on Dec. 1, 2022. Through the innovative Tailored Care Management program, eligible beneficiaries have a single designated care manager supported by a multidisciplinary team to provide integrated care management that addresses whole-person health needs. To account for the increased burden this coordination will potentially place on medical homes, the Department increased the per member per month payment during this period of transition. Please see Appendix A for the NC Medicaid bulletin on this change.

Healthy Opportunities Pilots

Healthy Opportunities Pilot (HOP) service delivery began on March 15, 2022. HOP launched in three regions that collectively cover 33 counties in North Carolina. To ensure system and partner readiness and a successful launch for members, the Department adopted a phased launch approach in which service domains launched over a period of several months. Services launched on the following schedule:

- March 15, 2022: Food services
- May 1, 2022: Housing and transportation services
- June 15, 2022: Toxic stress and cross-domain services

Over 24,000 services addressing unmet social needs have been delivered to eligible Standard Plan members to date. Due to legal and technical challenges, interpersonal violence (IPV) services are not yet available. The Department is working on design and technical modifications for these sensitive services that will safeguard HOP enrollee safety and data. Additionally, the Department is preparing to launch HOP services with the Tailored Plans in the second quarter of 2023.

Medicaid Managed Care

Operational Updates

Standard Plans

Following the launch of Standard Plans on July 1, 2021, the Department has focused on addressing post-implementation concerns and supporting providers and members in the transition to managed care. Following launch, the Department extended or made permanent numerous COVID-19 policy flexibilities regarding telehealth, prior authorizations and the extension of some temporary provider rate increases. The Department has closely monitored Standard Plans' compliance with network adequacy standards. In February 2022, the Department issued the results of its review of Standard Plans networks. All five PHPs had gaps in compliance, which resulted in the issuance of corrective action plans (CAPs) that are being monitored by the Department.

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 extension does not affect NCQA Accreditation requirements for Tailored Plans.

The Department holds a monthly public meeting for providers that brings together Standard Plan and Tailored Plan leadership and addresses topics related to NC Medicaid Managed Care. In addition to providing timely updates, these sessions usually result in over 100 provider questions being answered in real time and approximately 500 people attend per month on average.

Tailored Plans

The Department has moved the launch of Tailored Plans from the original date of July 1, 2022, to April 1, 2023. On November 15, 2021, the Department initially delayed the launch to Dec. 1, 2022. Several factors contributed to this announcement, including:

- 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.

On Sep. 30, 2022, the Department announced that Tailored Plan launch would be further delayed until April 1, 2023. The delay will allow Tailored Plans more time to contract with additional providers to support member choice and to validate that data systems needed for launch are working. While the launch of Tailored Plans will be delayed, the Department and LME-MCOs will support providers of Tailored Care Management to launch their services on Dec. 1, 2022. Through Tailored Care Management, eligible beneficiaries will have a single designated care manager supported by a multidisciplinary team to provide integrated care management that addresses the beneficiary's whole-person health needs.

Tailored Plan operational readiness reviews officially kicked off March 17, 2022. The Department began the onsite portion of the readiness review process with Tailored Plans in July 2022. Representatives from each business and technology area across the Department were hosted by Tailored Plans at their home office locations to provide an overview of their implementation progress, participate in interviews with Department representatives and provide live system demonstrations.

In August 2022, the Department began the enrollment process for beneficiaries who will be eligible for Tailored Plans at launch, known as Tailored Plan Criteria Review. The Department confirmed approximately 150,000 members to be eligible at launch. An initial group of individuals received notices regarding their eligibility in August, while others will enroll throughout the year. The Department expects enrollment to continue to grow up to launch and through the year following launch until the end of the federal public health emergency unwinding. Following the eligibility criteria review, beneficiaries will be mailed a notice informing them of their health care choices and how to change their health care option. The Tailored Plan choice period will begin on Jan. 15, 2023.

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

Standard Plan Achievements

1. In collaboration with the Standard Plans and in alignment with the Department's values of proactive communication and transparency, in DY4Q1 the Department began publishing 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.
    - 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.

2. In December 2021, 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.
3. 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%)
4. In January 2022, the Department released the Quality Measurement Technical Specifications Manual for Standard Plans and Tailored Plans. The manual provides an overview of the Department's plans for promoting high-quality care through NC Medicaid Managed Care and provides technical details related to the measurement of the goals and objectives of the Department's Quality Strategy.
5. Health Services Advisory Group (HSAG), the Department's External Quality Review Organization, completed the validation of performance measures for Year 1.
6. The North Carolina Integrated Care for Kids (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 21 years of age 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 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 Medicaid Direct.

    InCK beneficiaries in need of greater supports are identified through service integration level (SIL) assignments based on a child and family's health, healthcare utilization, socioeconomic factors, and the risk of being placed out-of-home. Higher risk beneficiaries are assigned a Family Navigator, a care management role unique to the InCK program. The Department released the InCK Performance Measure Technical Specifications Manual outlining the 10 performance measures to be included in the InCK alternative payment model (APM).
7. The Department hosted the PHP Health Equity Quarterly Workgroup Kickoff meeting on Oct. 12, 2022, with Standard Plans and Tailored Plans. This was the first of planned quarterly PHP Health Equity workgroup sessions. At the kickoff, the Department provided an introduction on the purpose and objectives of the workgroup as well as an update to PHP Health Equity Leads on the Department's work on health equity.

8. The Department partnered with PHPs to drive clinical improvements in several areas of existing health inequity.
    - In January 2022 the Department partnered with PHPs to launch a Collaborative Care Consortium, a multipayer, multistakeholder initiative to drive integrated care for persons with mild to moderate behavioral health needs in the medical home.
    - In August 2022 the Department partnered with PHPs to launch a Sickle Cell Disease (SCD) Workgroup to better understand barriers to meeting care goals for members with SCD.
    - In January 2022 the Department partnered with PHPs to launch a Gender Affirming Services Workgroup to understand the unmet needs of beneficiaries living with gender dysphoria.

Tailored Plan Achievements

1. Tailored Plan operational readiness reviews officially kicked off 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.
2. The Department developed a weekly scorecard tracking Tailored Plan progress and began issuing it to Tailored Plans in April 2022. 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 inbound deliverables, readiness review, provider network coverage, end to end and system integration testing, and technology operations/Help Center.
3. Certified Care Management Agencies (CMAs) and Advanced Medical Home + (AMH+) providers from rounds one and two of the certification process completed their readiness reviews and started providing Tailored Care Management on Dec. 1, 2022. Tailored Care Management is the vehicle through which Tailored Plan members receive comprehensive care management support. All Tailored Plan members will be offered choice of a Tailored Care Management entity, and members will be assigned to an entity if one is not selected. Under Tailored Care Management, members have a single care manager who will be equipped to manage all their needs, spanning physical health, behavioral health, I/DD, traumatic brain injury (TBI), pharmacy, long-term services and supports (LTSS) and unmet health-related resource needs.
4. In August 2022, the Department used the Tailored Plan Criteria Review to determine that approximately 150,000 beneficiaries will be eligible for Tailored Plans at launch.
5. 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

6. In response to the delay of Tailored Plan launch, the Department completed re-alignment activities, including updating the timeline for implementation milestones, determining required contract changes, re-evaluating the proposed non-critical items flexibilities from Tailored Plans, and publishing a quick reference guide on delay impacts based on Tailored Plan questions. In November 2022, the proposed re-baselining changes will be submitted to Department executive leadership for approval.

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

Standard Plan Challenges

1. Throughout DY4, the Enrollment Broker has experienced call center staffing shortages and high attrition rates that reflect broader trends in the call center industry. While this largely impacted Standard Plans in the beginning of the year, there is also concern that there may not be enough agents to meet demand during the Tailored Plan choice period. To mitigate the issue, the Enrollment Broker is increasing hiring class sizes and holding weekly meetings with the Department until the issue is resolved. The Enrollment Broker began training 35 new agents on Oct. 31, 2022.
2. The Department addressed an issue where some nursing facilities were not accepting Standard Plan members upon hospital discharge due to delays in the long-term care financial eligibility determination process. After reviewing information provided by PHPs and consulting with representatives from the NC Healthcare Association and NC Health Care Facilities Association, the Department took the following actions:
    - Published a memo to Standard Plan CEOs on nursing facility payment that encourages PHPs to use existing flexibilities – such as rates, delivery models, and interim payments (or hardship advancements) to facilitate timely care. NC Medicaid strongly encourages PHPs to support providers with interim payments/hardship advances when there are delays in paying nursing facilities due to the long-term care financial eligibility determination process.
    - Created a new standardized form for PHPs and nursing facilities to communicate with local Departments of Social Services (DSS), streamlining processes for nursing facility admissions and the determination of long-term care financial eligibility.
    - Created stakeholder-specific fact sheets for counties, health plans, and providers (including hospitals and nursing facilities). The fact sheets outline the information flow, timelines and requirements for the long-term care financial eligibility determination process.
    - Are pursuing payment modifications to align with Medicare to create an incentive for SNFs to accept Medicaid members.
3. Corrective Action Plans (CAPs) were created for four Standard Plans in Spring 2022 to address errors on the PHP Network Files (PNFs), which required the plans to submit monthly self-audits to report on their errors and progress. Although one of the four plans is now in compliance, the

other three CAPs must be extended and will now include a liquidated damage (LD) for failure to remove providers not active in NC Medicaid from their PNFs.

4. Two of the five Standard Plans did not meet the preferred drug list (PDL) compliance benchmark of 95% during all four quarters of State Fiscal Year 2022. The Department issued Notice of Deficiency memos on October 31, 2022, requesting liquidated damages for both plans. Additionally, one Standard Plan did not meet the compliance benchmark in the first quarter of SFY22. This plan was given a Notice of Deficiency, but liquidated damages were not assessed. Q1 was the first quarter of Standard Plan implementation.
5. In response to provider concerns about on-going member assignment and panel management issues for AMHs, the Department is working with Standard Plans to analyze errors and create easier pathways for providers to reach Standard Plans and resolve panel issues:
    - Standard Plans have identified one lead contact for each plan, and the Department distributed this information to providers.
    - Standard Plans are working to ensure their member and provider call lines are equipped to respond to calls related to AMH assignment.
    - Providers can also discuss panel limits with Standard Plans so they understand their panel limits with the plan based on initial contracting and can update limits as needed.
6. In response to concerns raised by the North Carolina Hospital Association (NCHA) regarding how Standard Plans approve and pay for newborn care, the Department convened a workgroup with NCHA and PHPs to align on a standardized approach to healthy normal newborns including:
    - Allowing providers one year to adjust to new newborn notification requirements by requiring plans to pay for medically necessary newborn claims through Year 1 of Managed Care.
    - Aligned on newborn event statuses and their triggers, which would result in notification to plans to promote care management support.
    - Aligned on a threshold for post-payment reviews for newborn claims for assurance purposes.
7. Providers have expressed concern that some Standard Plan members in need of intensive substance use disorder recovery services can't obtain these services while in a Standard Plan. These members will be eligible for Tailored Plans at launch, which cover these services. The Department convened a workgroup with the Standard Plans and LME-MCOs to avoid adverse outcomes for members in Standard Plans. Solutions from that work group included:
    - Allowing Standard Plans to submit In Lieu of Service (ILOS) requests as a bridge for members until they are moved to Tailored Plans
    - Prioritizing legislative change to allow Standard Plans to cover these services in some instances to enable timely service provision before moving to a Tailored Plan

Tailored Plan Challenges

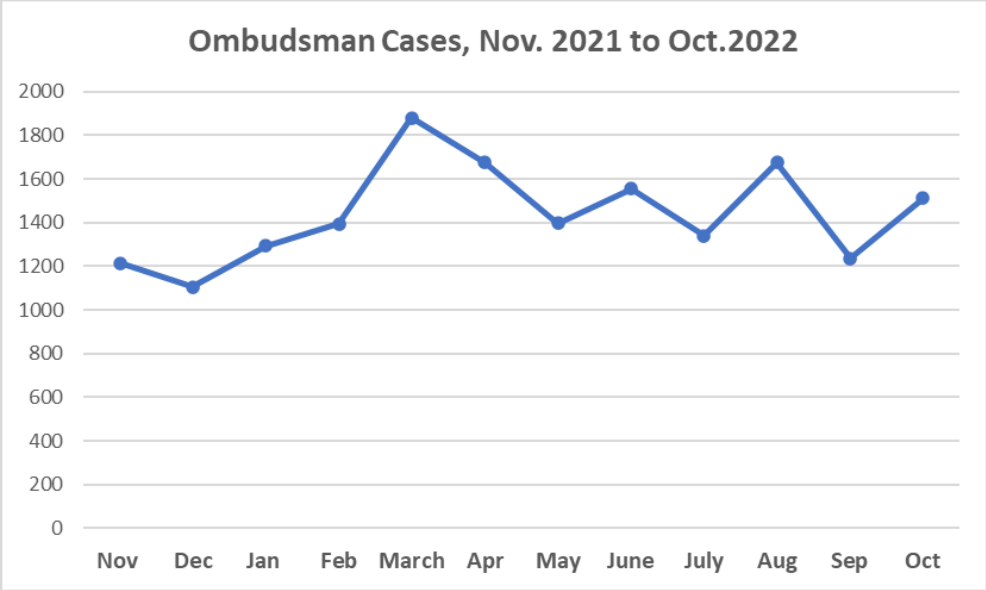
1. Adequate provider network coverage continues to be a risk across all Tailored Plans due to lower than expected provider contracting. Since the Tailored Plans started submitting provider contracting reports in early May, the results have not met network adequacy standards across the various provider categories. This could result in a lack of providers for primary care provider (PCP) auto-assignment beginning in February. The Department has worked to mitigate this risk through the following activities:
    - Close tracking of provider contracting data in the Weekly Tailored Plan Scorecards
    - Monitoring monthly AMH/PCP contracting submissions and other specialties from the monthly network submission
    - Monitoring bi-weekly contracting data submitted in response to a Notice of Concern issued to the plans
    - One-on-one calls with the Tailored Plans to get more frequent updates on contracting progress and challenges
    - Working through the Provider Engagement and Communications team to clarify the process to contract with Tailored Plans and the changes coming with Tailored Plan launch
2. End-to-end testing continued trending behind schedule for both the PCP Auto-Enrollment and plan launch milestones. The End-to-End team is meeting weekly with the Tailored Plans and escalating plan-specific delays and challenges through bi-weekly calls with the Tailored Plans' executive leadership teams. The main drivers of the delay have been:
    - Incorrect provider data setup by the Tailored Plans
    - Incorrect claim submissions
    - Enrollment Broker open defects on ongoing notices
    - Medicaid PIHP end-to-end testing overlapping with the Tailored Plan end-to-end testing schedule has added complexity and risk to the current end-to-end schedule.
3. Providers in the Tailored Care Management certification process have been slow to complete more advanced levels of the certification. A low number of certified Tailored Care Management providers could create less capacity in provider-based care management than the current target. The Department continues to provide coaching support to potential Tailored Care Management providers and has also published a second roll-out timeline of Feb. 1, 2023, to launch the service if providers are not ready for a Dec. 1, 2022 launch. Members can still receive Tailored Care Management from their Tailored Plan, so all members will have a source of Tailored Care Management at launch.
4. Tailored Plans are developing new claims processing engines to handle physical and behavioral health claims, as Tailored Plans, functioning as LME-MCOs, previously only handled behavioral health claims. The Department established a Tailored Plan claims processing mitigation strategy to prepare Tailored Plans for launch, including comparative claims testing entry criteria, comparative claims testing, provider claims testing entry criteria, provider claims testing, copay

exemption documentation initiative, weekly calls with Tailored Plans for claims special topics and a covered code initiative**.**

5. Some Tailored Plans demonstrated higher than expected turnover in key leadership positions over the past year, including difficulty hiring and retaining Chief Medical Officers (CMOs) and Deputy CMOs.

Issues or complaints identified by beneficiaries

The Department receives beneficiary complaints primarily from the 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. Not all Ombudsman calls should be interpreted as complaints, as many involve educating beneficiaries or connecting them to the entity that can provide the service they need. In DY4, the Ombudsman handled 17,280 total cases. Of these, 6,979 cases involved members seeking information and 10,301 involved issue resolution. The Office of Administration largely handles cases referred from state legislative offices. The Office handled 70 complaints in DY4.



Office of Administration Member/Constituent Concerns, DY4

Issue Category	Issue Count
Beneficiary/Member Eligibility	16
Clinical Policy - Medical Health	9
Dental	1
Durable Medical Equipment (DME) and Prosthetics Orthotics & Supplies	2
Electronic Visit Verification	3
Finance/PHP Claims Issues	17
Long-Term Services & Supports	1
Non-Emergency Medical Transportation (NEMT)	7
Outpatient Specialized Therapies (Prior Approvals) Leadership Escalation	3
Plan Administration	1
Program Integrity	1
Provider Operations	14
TOTAL	**70**

Unusual or unanticipated trends

1. In late November 2021, Envolve RX, the pharmacy benefit manager (PBM) vendor for three of the Tailored Plans - Eastpointe, Trillium Health Resources and Vaya Health - indicated that the company would be exiting the PBM market nationally in April 2022. Consequently, these three Tailored Plans underwent a re-procurement 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. There was concern that this would negatively impact the end-to-end testing timeline and Tailored Plan launch. To mitigate this risk, the Department decided that Pharmacy Point of Sale (POS) claims for Tailored Plan members would be temporarily managed by NCTracks from Dec. 1, 2022 through March 31, 2023. This will no longer be necessary due to the delay of Tailored Plan implementation, and Tailored Plans will manage pharmacy claims at launch.
2. In early December 2021, OneCall, the NEMT vendor for Eastpointe and Vaya Health indicated that it will be exiting the national marketplace. As a result, Eastpointe and Vaya Health had to identify and contract with a new vendor, and subsequently assess any potential impact to the development timeline.

3. 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 for Tailored Plans and the potential impact on member provider choice. Department leadership met with the groups and discussed their concerns. The Department continues to monitor contracting across Tailored Plans for both physical and behavioral health providers and to analyze how contracting progress will impact provider choice and access for members. The Department issued a notice of concern to all Tailored Plans around network adequacy and provider contracting in August 2022 to allow for more frequent reporting on Plans' progress. One of the contracting targets set by the notice of concern specifically addresses limiting member disruption and maximizing the number of members who retain their historical PCP at Tailored Plan launch.

Lawsuits or legal actions

All Standard Plan protests/cases were 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 2022. As such, there are no pending legal actions.

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.

S.L. 2022-46, enacted July 7, 2022, makes various changes and clarification to insurance laws:

- § 5 requires a PHP's solvency plans to allow continuation of health care services until the PHP's contract is terminated, and enrollees are transitioned to another PHP in the event of insolvency.

S.L. 2022-74, enacted July 11, 2022, adjusts base budget appropriations for the 2021-2023 biennium and enacts new programmatic, administrative and operational requirements for NC Medicaid:

- § 9D.4 authorizes NCDHHS to seek authority to extend Medicaid coverage of health care services that qualify for 100% FMAP when provided by an Indian Health Service provider or Eastern Band of Cherokee Indian facility to individuals with no other form of health coverage.
- § 9D.7 requires implementation of Tailored Plans by Dec. 1, 2022, and the initial contract to end on Dec. 1, 2026. It requires that Tailored Plans receive the equivalent extension of the contract that a PHP offering Standard Plan services may receive.
- § 9D.8 clarifies that the PHPs must reimburse ingredient costs and dispensing fees at 100% of the State Plan rate for pharmacy reimbursements. Establishes NADAC as primary method to calculate retail pharmacy reimbursement for non 340B drugs. This provision is in effect retroactively to Nov. 11, 2021, and expires June 30, 2026.
- § 9D.9 allows the agency until Dec. 31, 2022, to develop a new service and reimbursement rate to have LME/MCOs pay for emergency department bed holds.
- § 9D.13 (a) authorizes payment in fee-for-service for point-of-sale prescription drugs for Medicaid beneficiaries enrolled in a Tailored Plan for up to six months after launch. Requires Tailored Plans to cover prescription drugs submitted as medical outpatient professional claims through the Physician Administered Drug Program; (b) waives statutory solvency requirements for LME/MCOs with a Tailored Plan contract until Dec. 31, 2023, and replaces them with contractual solvency and capital reserve requirements; (c) requires LME/MCOs to include essential providers with respect to behavioral health, IDD, and TBI services in their closed network; (d) until Dec. 1, 2023, requires dissolution of an LME/MCO whose Tailored Plan contract is terminated and requires DHHS to submit a report on actions to be taken upon termination of any contract and LME/MCO holds.
- § 9G.6 grants primary care case management entities access to client-specific immunization information in the NC Immunization Registry.

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

Outcomes of care

The Department plans to report three outcome measures in its monitoring reports: Comprehensive Diabetes Care, Low Birth Weight, and Rating of Personal Doctor. Thus far, only Rating of Personal Doctor results are available.

The Low Birth Weight Measure is a modified version of the Live Births Weighing <2,500 grams measure (NQF #1382), and was developed to assess, monitor, and support PHP efforts in North Carolina. Currently, low Birth Weight rates are still under production. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) rates are not available yet, as the Department does not receive A1c values via claims and encounters. The Department is working to obtain accurate A1c data through the NC Health Information Exchange in order to report this measure.

CAHPS measures do not reflect a full calendar year, as the survey was administered April 9, 2021, to August 15, 2021. Members were asked to think about services received *in the past 6 months* when answering survey questions. At the time of survey administration, almost all respondents' 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 still have been while they were enrolled in NC Medicaid Direct.

Measure/ Measure Steward	Description	2019	2020	2021
Rating of Personal Doctor/CAHPS	Percentage of respondents who rated their personal doctor as an 8 or above (on a scale of 1-10)	83.2%	NA*	86.3%
	Percentage of respondents who rated their child's doctor as an 8 or above (on a scale of 1-10)	93.69 %	NA*	91.15 %

*CAHPS was not conducted during 2020 due to the Public Health Emergency

Quality of care

North Carolina measurement year 2021 quality measure results became available in July 2022. Because NC Medicaid Managed Care launched July 1, 2021, quality measure results for 2021 represent the last six months of fee-for-service and the first six months of managed care for North Carolina's Standard Plan population. All quality measures reflect the calendar year, except for CAHPS measures. These measures were originally reported in DY4Q3.

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.

Measure/Measure Steward	Description	2019	2020	2021
Child and Adolescent Well-Care Visits (WCV)/ NCQA[1]	Members ages 12-21 who had at least one comprehensive well-care visit with a primary care physician or an OB/GYN during the measurement year.	NA	45.6%	47.8%
Childhood Immunization Status (CIS) (Combination 10)/ NCQA	Children age 2 who had four diphtheria, tetanus and acellular pertussis; three polio; one measles, mumps and rubella; three haemophilus influenza type B; three Hep B; one chicken pox; four pneumococcal conjugate; one hepatitis A; two or three rotavirus; and two influenza vaccines by their second birthday.	35.0%	36.2%	34.3%
Immunizations for Adolescents (IMA) (Combination 2)/ NCQA	Adolescents age 13 who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and a cellular pertussis vaccine, and have completed the HPV vaccine series.	31.6%	31.2%	30.3%
Use of First-Line Psychosocial care for Children and Adolescents on Antipsychotics (APP)/ NCQA	Children and adolescents ages 1-17 who had a new prescription for an antipsychotic medication, but no US Food and Drug Administration primary indication for antipsychotics and had documentation of psychosocial care as first-line.	52.1%	50.8%	45.0%
Well-child visits in the first 30 months of life (W30)/ NCQA[2]	Percent of children who received six or more well-child visits in the first 15 months	NA	62.3%	62.1%
	Percent with two or more well-child visits from 15 to 30 months	NA	70.8%	66.4%

Measure/Measure Steward	Description	2019	2020	2021
Total Eligibles Receiving at Least One Initial or Periodic Screening/ NCDHHS	Rate of preventive dental service use by children and adolescents in NC. Higher rates are better on this measure.	53%	44.5%	NA
Follow-Up Care for Children Prescribed ADHD Medication (ADD)/ NCQA	Initiation phase rate: Percentage of children ages 6-12 as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.	50.1%	51.8%	53.7%
	Continuation rate: Percentage of children ages 6-12 with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	63.5%	62.9%	64.9%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)/ NCQA	The percentage of children ages 1 to 17 who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: Percentage of children and adolescents on antipsychotics who received blood glucose testing	53.7%	47.4%	51.1%
	Percentage of children and adolescents on antipsychotics who received cholesterol testing	37.7%	34.1%	35.4%
	Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	34.9%	31.0%	32.61%
Prenatal and Postpartum Care (PPC)/ NCQA[3]	Timeliness of Prenatal Care: The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.	35.5%	40.0%	39.5%

Measure/Measure Steward	Description	2019	2020	2021
	Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	68.8%	64.5%	53.7%
Cervical Cancer Screening (CCS)/ NCQA	Women ages 21-64 who had cervical cytology performed every 3 years.	43.82%	42.83%	40.7%
Chlamydia Screening in Women (CHL)/ NCQA	Women ages 16-24 who were identified as sexually active and who had at least one test for chlamydia during the measurement period.	58.22%	57.19%	56.79%
Breast cancer screening (BCS)/ NCQA	Women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years.	41.4%	35.4%	31.6%
Flu vaccinations for adults (FVA, FVO)/ NCQA	Adults ages 18 years and older self-report receiving an influenza vaccine within the measurement period.	42.9%	49.9%	N/A
Plan All-Cause Readmission – Observed Versus Expected Ratio (PCR)/NCQA	Adults ages 18 years and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and predicated probability of an acute readmission.	0.93%	0.99%	.99%
Controlling High Blood Pressure (CBP)/NCQA[4]	Percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.	N/A	4.58%	24.62%
Antidepressant Medication Management (AMM)/NCQA	Adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications. Effective Acute Phase Treatment: Adults who remained on an antidepressant medication for at least 84 days (12 weeks).	58.2%	60.1%	54.1%

Measure/Measure Steward	Description	2019	2020	2021
	Effective Continuation Phase Treatment: Adults who remained on an antidepressant medication for at least 180 days (6 months).	39.3%	41.6%	33.9%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)/NCQA	Percentage of adults 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	80%	75%	77%
Asthma Medication Ratio (AMR)/ NCQA	Percentage of adults 19-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	53.9%	60.3%	60.6%
Customer Service/ CAHPS	**Composite measure (adult):** Respondents were asked, “In the last 6 months, how often did your health plan’s customer service give you the information or help you needed?” and “In the last 6 months, how often did your health plan’s customer service staff treat you with courtesy and respect?”	83.3%	NA	86.5%
	Composite measure (child): Respondents were asked, “In the last 6 months, how often did customer service at your child’s health plan give you the information or help you needed?” and “In the last 6 months, how often did customer service staff at your child’s health plan treat you with courtesy and respect?”	78.8%	NA	85.9%
Coordination of Care/CAHPS	Respondents who answered “Usually” or “Always” to the question, "In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?"	86.6%	NA	85.8%

Measure/Measure Steward	Description	2019	2020	2021
	Respondents who answered "Usually" or "Always" to the question, "In the last 6 months, how often did your child's personal doctor seem informed and up-to-date about the care your child got from these doctors or other health providers?"	81.9%	NA	85.4%

[1]This measure specification changed in 2020.

[2]This measure specification changed in 2021. The Well-Child Visits in the First 15 Months of Life (W15-CH) measure was modified by the measure steward. It now includes two rates: (1) six or more well-child visits in the first 15 months and (2) two or more well-child visits from 15 to 30 months.

[3]Rates for this measure are artificially low due to bundled payment for prenatal and postpartum care.

[4]NC Medicaid does not get blood pressure values via claims and encounters. **Consequently**, **our results are to be interpreted with caution.** The Department is currently developing a process to receive accurate blood pressure data via the North Carolina Health Information Exchange.

Cost of care

No metrics to report in this category for this reporting period. The Department is working to develop these measures.

Access to care

Network Time/Distance Standards

The state's time or distance network adequacy standards require that at least 95% of the membership meet the access standard. In each of the past four quarters, 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). The most recent network adequacy rates by Standard Plan are available in the report section for DY4Q4.

Care Management Penetration Rate

These data represent members enrolled in Standard Plans who received care management through a Standard Plan, AMH, the Care Management for At-Risk Children (CMARC) program or the Care Management for High-Risk Pregnancies (CMHRP) program within the Standard Plan contract year (beginning July 1). These data are provided with a one-month lag (e.g., DY4Q4 ends Oct. 31; however, data are available only through September.)

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.

As the Standard Plan contract year does not align with the waiver demonstration year, rates are provided below for all of contract Year 1 (July 2021 – June 2022) and three months of Year 2 (July to September 2022) of Standard Plan operation. The tables below show the percent of Standard Plan members receiving any care management overall and the percent of care management provided by each entity. Care management rates were below the annual penetration target of 20% of members receiving care management by the end of Year 1 of NC Medicaid Managed Care. For Year 2, the Department has set a penetration target of 22%.

Standard Plan Care Management Rates, Year 1

Period:	*July 1, 2021 - June 30, 2022*		
Total Members Reported:	*1,853,442*		
Overall CM Penetration Rate	**17.0%**		**315,310 Members**
Percent of care management provided by each entity:			
SP	**AMH3**	**CMARC**	**CMHRP**
23.0%	78.1%	5.4%	6.0%
72,437	246,110	16,949	18,820

Source: Members in table are derived from BCM051 Care Management Interaction report prepared by PHPs and submitted to the Department.

Standard Plan Care Management Rates, Year 2 (SFY Q1 only)

Overall Care Management (CM) Rates

Period:	*July 1 - September 30, 2022*		
Total Members Reported:	*1,782,785*		
Overall CM Penetration Rate	**8.7%**		**154,818 Members**
Percent of care management provided by each entity:			
SP	**AMH3**	**CMARC**	**CMHRP**
13.4%	78.5%	1.7%	3.0%
20,783	121,569	2,708	4,572

Source: Members in table are derived from BCM051 Care Management Interaction report prepared by PHPs and submitted to the Department.

Care Management Rates by Entity, Year 2 (SFY Q1 only)

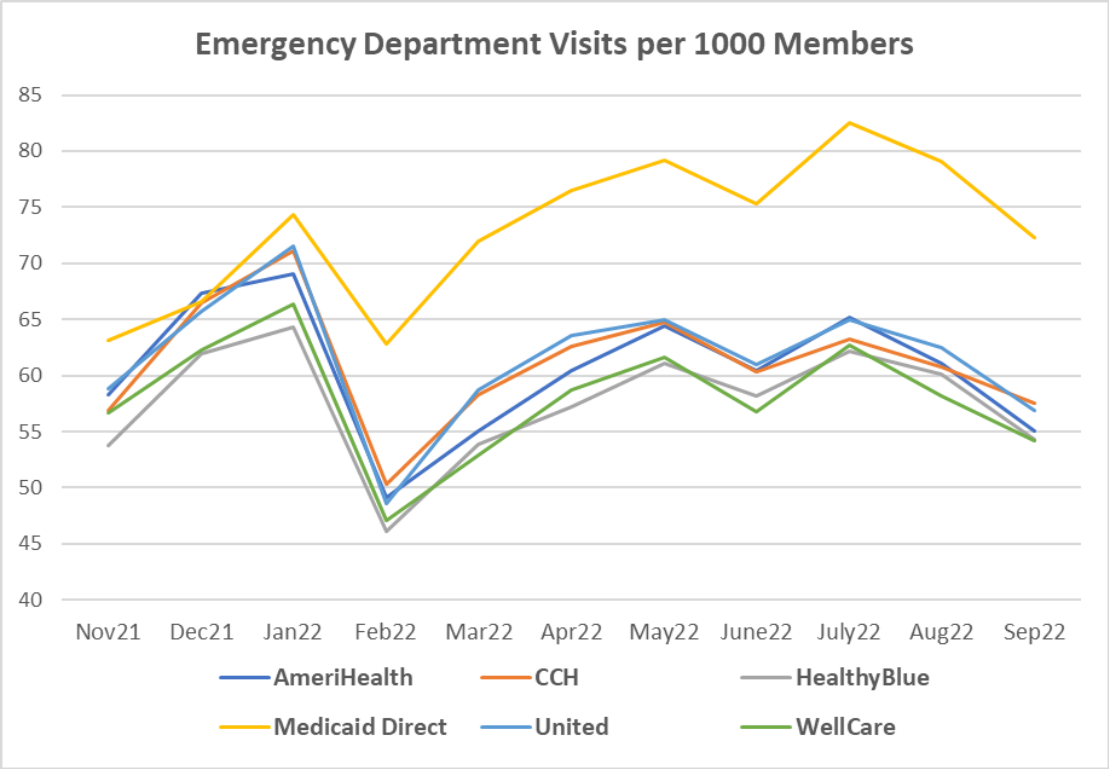
Period:	*July 1 - September 30, 2022*			
CM penetration rate by entity:				
	SP	**AMH3**	**CMARC**	**CMHRP**
Members with CM	20,783	121,569	2,708	4,572
Members assigned to entity	1,042,961	799,972	5,305	9,044
Penetration rate	**2%**	**15%**	**51%**	**51%**

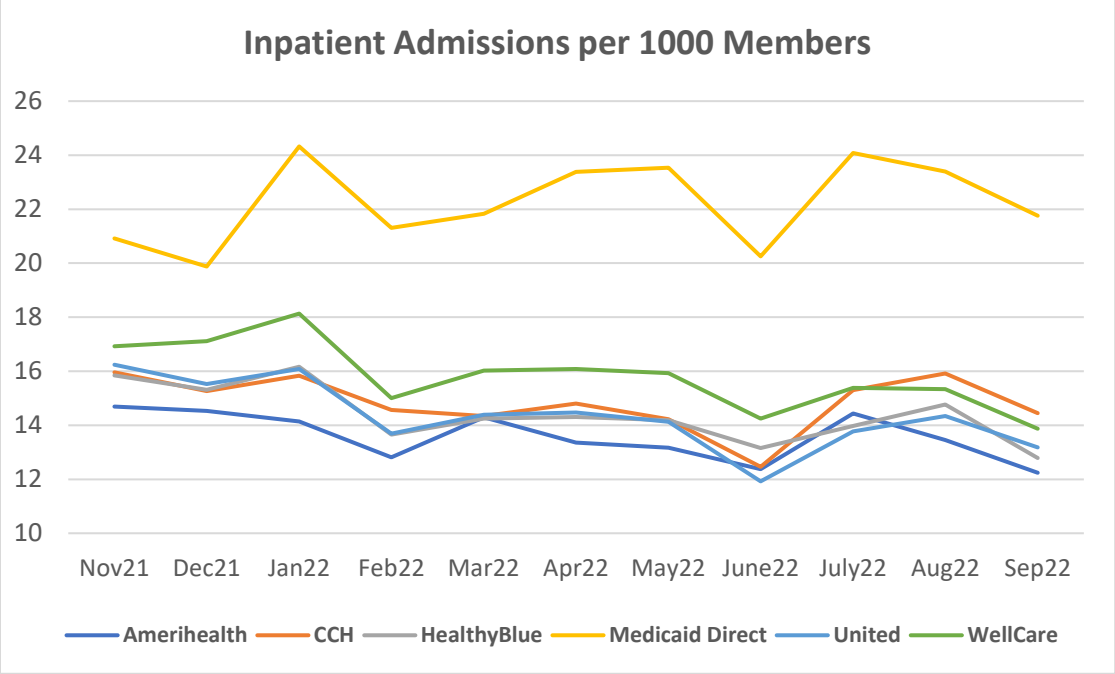
Source: Members in table are derived from BCM051 Care Management Interaction report prepared by PHPs and submitted to the Department. Some members may be receiving CM from multiple entities and may be counted in multiple categories.

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 are one month behind the quarterly monitoring schedule. Therefore, the rates below cover November 2021 to September 2022. It should be noted that higher rates are expected for NC Medicaid Direct, as members with substantial behavioral health issues to be enrolled in Tailored Plans currently remain in NC Medicaid Direct.


Emergency Department Visits per 1000 Members
85
80
75
70
65
60
55
50
45
40
Nov21
Dec21
Jan22
Feb22
Mar22
Apr22
May22
June22
July22
Aug22
Sep22
AmeriHealth
CCH
HealthyBlue
Medicaid Direct
United
WellCare


Inpatient Admissions per 1000 Members
26
24
22
20
18
16
14
12
10
Nov21
Dec21
Jan22
Feb22
Mar22
Apr22
May22
June22
July22
Aug22
Sep22
Amerihealth
CCH
HealthyBlue
Medicaid Direct
United
WellCare

Results of beneficiary satisfaction surveys

The Department released the results of the latest *Consumer Assessment of Healthcare Providers and Systems* (CAHPS) surveys in August 2022. 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 6 months when answering all survey questions. Data from the 2019 survey were compared to 2021 to see how responses have changed from pre- to mid-pandemic. At the time 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 still have been while they were enrolled in Medicaid Direct. **Thus, the survey results largely do not reflect the experience of Medicaid members in NC Medicaid Managed Care.** A summary of results from the 2022 CAHPS survey, reflecting beneficiary experiences after Standard Plan launch, will be available in the next quarterly report.

Key findings include:

- Overall health and mental health ratings did not change appreciably between 2019 and 2021, except for child mental health, which declined slightly during the Public Health Emergency.
  - In 2021, 56.57% of adults 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 adults reported they usually or always received care right away when needed in 2021, compared to 81.25% in 2019
  - Approximately 41.79% of 2021 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 next budget neutrality workbook will be submitted to CMS by Jan. 31, 2023.

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 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.

Transition to Capitated Encounter Data from Standard Plans

In DY4, Sheps analysts began working with encounter data that tracks utilization by NC Medicaid beneficiaries enrolled in Standard Plans. 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. Beginning at Standard Plan launch, the encounter data 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. Sheps worked closely with the Department to resolve this issue. Sheps also provided feedback on the quality and completeness of the data to the Department while continuing to revise code on metrics to include services, medications and diagnoses received through either claims or encounter data.

In DY4Q4, Sheps had to shift considerable focus to data quality issues caused by a faulty file sent by the state's data vendor for managed care. The file contained mismatched IDs for Standard Plan members. A replacement file was created, but this required a complete rebuild of Sheps's claims and encounter system, which delayed reporting by months. The issue is expected to be resolved by December 2022.

Quantitative Update

The Sheps quantitative team onboarded 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 Sheps to address the study hypotheses. Sheps has completed the evaluation of 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. These measures showed generally similar trends between Medicaid and Blue Cross and Blue Shield of North Carolina (BCBSNC) Marketplace plans in the pre-implementation period, although there were concerns about relatively small sample size for some of the metrics that look at specific subsamples (such as well-child visits for children and adolescents, due to the relatively small number of children in Marketplace plans). The evaluation will use BCBSNC data 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.

In the last year, Sheps began building a new dashboard to track behavioral health metrics that are not included in the substance use disorder dashboard that the evaluation team currently updates monthly. This new behavioral health dashboard will increase the rapid monitoring of metrics that may have been influenced by Standard Plan implementation and other milestones. Other dashboards specific to Foster Care plan members, individuals with intellectual and developmental disabilities, and physical/overall health metrics are also planned.

Qualitative Update

The qualitative team completed 40 interviews with 26 health systems and health care practices from March to July 2022. Of the 26 organizations, 10 were repeat participants from Year 1 (demonstration year 3, Nov 2020 to Oct 2021). The sample included three health systems, 14 independent practices, five

FQHCs, and four local health departments. Of the 14 independent practices, five were internal and/or family medicine, and nine were pediatric practices. The qualitative team reached out to 18 independent obstetric practices identified from the Year 1 provider file, survey respondents file, and NCDHHS website. They were either unavailable to participate or did not respond to the interview request. The Department included high-level findings from these interviews in the DY4Q3 monitoring report.

Based on the interviews, Sheps created three findings briefs on the provider and PHP experience and presented findings to the Department during a "Deep Dive" session in October 2022. All Department employees are encouraged to attend weekly Deep Dive sessions that cover a specific topic of interest to the Department and provide employees an opportunity to ask the presenters questions.

Sheps plans to conduct beneficiary focus groups in early 2023 via Zoom. This will include recruiting up to 24 family caregivers of pediatric patients on Medicaid and up to 24 adult Medicaid beneficiaries. The two groups will each be divided into no more than eight groups of three to six caregivers/adult beneficiaries. Discussions are underway regarding the possibility of offering at least one Spanish language focus group. Staff are developing recruitment materials and focus group guides. Once details have been finalized for this additional qualitative work, IRB approval will be sought.

The rapid analysis of the DY4 health system and health care practices data is complete. The report has been drafted and shared with the advisory committee. It will be updated if new insights are gained from additional health system interviews. The qualitative team is preparing a manuscript on patient engagement using the data from Year 1 interviews. An abstract is being prepared for submission to the publications committee.

Proposed Changes to Evaluation Design

The Sheps Center, in collaboration with NC Medicaid, has updated the evaluation design to address changes to the implementation environment such as the Covid-19 Public Health Emergency, implementation delays and adjustments to programs and policies. A summary of evaluation design changes was included in the DY4Q3 monitoring report. Please see Appendix B for a document with waiver evaluation design changes.

Healthy Opportunities Pilots (previously Enhanced Case Management and Other Services)

Operational Updates

Introduction

In December 2021, the Department announced that HOP would adopt a phased launch approach to allow additional time for testing technical systems, training key staff, and ensuring partner readiness. Though readiness reviews were not required for the Healthy Opportunities Pilot, the Department determined that conducting the reviews would lead to a more successful pilot launch. Therefore, the Department conducted readiness reviews of Standard Plans and Network Leads that were completed in February 2022. Standard Plans and Network Leads, in turn, were required to ensure the readiness of their contracted Human Service Organizations (HSOs) and care management entities. All Standard Plans

and Network Leads met the minimum requirements for HOP launch. The Department phased in HSOs and care management entities that demonstrated readiness through the phased launch timeline, noted below.

Under the revised timeline, services, HSOs, and care management entities launched on the following schedule:

Feb. 1, 2022: HSO Engagement and NCCARE360 Technical Functionality

- Newly developed "Base Pilot Functionality" in NCCARE360 became available. Pilot-participating entities (PHPs, CINs, Network Leads, HSOs) gained access to an NCCARE360 training environment.
- Allowed for additional time for engagement between PHPs and Network Leads/HSOs and training key staff at Pilot-participating entities

March 15, 2022: Launch food services and three CINs

- Launched delivery of food services
- NC Medicaid Standard Plan members were assessed for Pilot eligibility and enrolled into HOP through the three CINs that provide care management for most Medicaid-covered lives in HOP regions

May 1, 2022: Launch housing and transportation services and additional CINs

- Launched delivery of housing and transportation services
- Members were assessed for Pilot eligibility and enrolled into HOP through additional interested CINs and Tier 3 AMHs

June 15, 2022: Launch toxic stress and cross-domain services

- Launched services to address toxic stress and multiple non-medical needs
- Members were assessed for Pilot eligibility and enrolled in HOP through Standard Plans, in addition to CINs and Tier 3 AMHs
- Due to legal and technical challenges, interpersonal violence services are not available yet.

Since March 2022, the Department has delivered over 24,000 services addressing unmet resource needs to over 3,000 Standard Plan members. Medicaid members have recounted numerous stories about how HOP services have impacted their lives. The Department is preparing to launch HOP services for Tailored Plans members in 2023 and is adapting lessons learned from Standard Plans to the Tailored Plan model.

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

Generated Partnerships and Collaboration Across Health and Human Service Sectors

HOP relies on an ecosystem of multiple medical and non-medical partners to address whole-person health, including unmet social needs. Currently, five Standard Plans, 23 care management organizations, three Network Lead organizations, and over 100 HSOs are participating in HOP across North Carolina. All these organizations are taking on new responsibilities and adapting their business models to change how they fundamentally address health. North Carolina has seen significant collaboration develop through regular HOP engagement. Additionally, in 2022, the Department developed first-of-their-kind model contracts to govern relationships between PHPs and Network Leads, and Network Leads and

HSOs. The model contracts clearly define the roles and responsibilities of each entity to ensure clear accountability.

Built a Single, Statewide Technology Platform (NCCARE360) to Facilitate HOP Activities and Created Standardized, Electronic Non-Medical Encounters

In 2020, NCCARE360, the first statewide technology platform to connect the health and human service sectors, went live in all 100 of North Carolina's counties. In 2022, the Department worked with NCCARE360 partners to build additional functionalities into NCCARE360 to facilitate HOP-specific processes. These additional functionalities include the ability to document HOP eligibility and enrollment, facilitate HOP service authorization, refer 29 standardized HOP services to HOP-participating HSOs, and invoice for HOP services. Considering the array of stakeholders involved in HOP, having a single technology platform that most HOP participants were already using reduced the technological barriers to participation, especially for HSOs. The Department prioritized using invoicing, which most HSOs were already familiar with, as opposed to claims to encourage HSO participation.

The Department then worked with technology and PHP partners to automatically translate invoices into standardized claims and encounters. PHPs receive non-medical service invoices through NCCARE360, translate them into encounters, and submit them to the Department. We believe that North Carolina is the first state in the nation with the ability to receive non-medical encounters, which the Department can analyze within the same data warehouse as medical encounters to assess whole-person health.

The Department has worked with the Sheps Center to begin transmitting both NCCARE360 and encounter data, which is now available for Pilot monitoring and evaluation. Developing, testing and launching these system functionalities is a result of months of partnership between NC Medicaid, the NCDHHS Information Technology Division and numerous technical partners. There were extensive engagement efforts to identify a solution that ensured HSOs and PHPs experienced minimal disruption to their current workflows.

Created Care Management Trainings on Non-Medical Needs and Services

Though care managers often address whole person health through their work with NC Medicaid members, HOP requires an in-depth understanding of complex non-medical needs and services. In 2022, the Department, in collaboration with NC Area Health Education Centers (AHEC), other NCDHHS divisions and HSOs, developed extensive training materials for care managers to better assess non-medical needs, determine which non-medical services are most appropriate for members, and conduct whole-person care management. These trainings provide detail on HOP services (e.g., when to refer a member to post-hospitalization housing vs. medical respite) and have led to greater collaboration between care managers at medical entities and HSOs. These trainings were the result of months of collaboration between multiple medical and non-medical, public and private partnerships.

Launch of Service Delivery

In the first HOP launch phase in February 2022, "Base Pilot Functionality" in NCCARE360 became available. This functionality included an eligibility documentation system, an enrollment and service authorization system, referral enhancements and invoicing. Due to the Department's focus on launching the Pilot quickly, these processes were somewhat manual, but are being improved to incorporate

automation and integrations through "Advanced Pilot Functionality," which will roll out in phases in 2022 and 2023.

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. The first enrollment pathway opened on the same date, which allowed NC Medicaid Managed Care members assigned to three major CINs for care management in Pilot regions to begin enrolling in HOP. These three CINs provide care management to the vast majority of NC Medicaid members receiving care management in Pilot regions. Enrollment pathways continued to open in May and June.

Transportation and housing services launched on May 1, 2022. Housing services include navigation support and sustaining services; inspection for housing safety and quality; move-in support; essential utility setup; home remediation services; and accessibility and safety modifications. Transportation services include reimbursement for health-related public or private transportation and transportation for case management services.

On June 15, 2022, toxic stress and cross-domain services launched. These services include evidenced-based parenting classes, home visiting services and medical respite. The Department intends to launch IPV services in 2023.

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

Low Referral Volume

Although the Department purposely launched the pilot slowly and in phases, there is still an unexpectedly low volume of enrollees in the Pilot. The Department worked with partner organizations to identify strategies to increase referral volume quickly and equitably. These strategies included initiatives to promote direct community outreach by HSOs, technical solutions to allow community organizations to make referrals to care managers within the technology system and working with Standard Plans to improve their processes for proactive outreach to potentially eligible members.

Payment challenges – Provider Remittance Advice

Both Network Leads and Standard Plans have worked to incorporate and improve upon new policies and processes as part of the implementation of the Pilots. A key process which both entities have continued to improve is ensuring that remittance advice is transmitted by the Standard Plan to the corresponding HSO and contains all necessary information for the HSO to accurately account for service payment. The Department is working with both entities to ensure that there are both short-term solutions that address any historical gaps in data and long-term solutions which ensure that all necessary information is transmitted and received by the corresponding entity.

Housing Services

There have been fewer than expected housing services delivered through the Pilots. This is partly due to limitations in the current housing support infrastructure, such as very limited affordable housing in rural areas, and funding limitations, especially for HSOs that had historically operated with a smaller budget. The funding challenges were addressed, in part, through capacity building funds which allow the HSOs flexibility to deliver higher cost housing services. This continues to be monitored to ensure appropriate

use of Pilot funds and that members receive necessary services in a timely manner. The limitations in affordable housing extend beyond the scope of the program. The Department continues to work with housing subject matter experts (SMEs) to ensure that challenges are addressed within the context of broader housing support infrastructure.

Delayed launch of IPV services

Due to legal and technical challenges, interpersonal violence services did not become available this year. The planned launch date for these services had been June 15, 2022. For services that are part of the IPV domain, the Department worked with domestic violence and IPV SMEs to determine design modifications necessary to ensure Pilot enrollee safety and data confidentiality for these sensitive services. Over the last year, the Department and its partners identified technology system, contract, and training modifications necessary to address safety considerations for individuals experiencing interpersonal violence. These modifications are intended to ensure that Violence Against Women Act (VAWA) and Victims of Crime Act (VOCA) regulatory considerations are met, as well as incorporate best practices for protecting the privacy and safety of individuals experiencing IPV. The Department continues to work toward the launch of this service domain while balancing federal regulations, industry best practices and survivor safety.

Issues or complaints identified by beneficiaries

Member reactions to HOP have been overwhelmingly positive. However, some members have said that the enrollment and consent process for HOP is too time consuming and detailed. The Department is currently working to address this feedback by shortening and streamlining both the enrollment and consent processes for participating in HOP.

Members have also communicated that many individuals are not aware of HOP services or how to access them. Some members also expressed confusion about what services are available to them through HOP, especially in the housing domain. The Department is currently developing a broad communications campaign to increase member, provider and community awareness of HOP services and how to access them, including the development of outreach materials for partners to distribute in their communities.

Members have also noted gaps in the availability of certain services – especially housing services, due to a general housing shortage in North Carolina, and public transportation options in rural areas. The Department is continuing to work with Network Leads and HSOs to develop additional infrastructure for these services.

Lawsuits or legal actions

There are no legal actions to report for the demonstration year.

Legislative updates

Legislative updates are included in the Managed Care section of this report.

Descriptions of post-award public fora

Descriptions of post-award public fora are included in the Managed Care section of this report.

Performance Metrics

Incentive Payments to PHPs, NLs, and Pilot Providers (HSOs)

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 are 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 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 PHPs can be found as Appendices C and D.

Network Lead Incentive Payments - DY4

Network Lead	Milestone Achieved	Quarter Disbursed	Amount Paid
Access East	Established an HSO Capacity Building Payment Distribution Approach	DY4Q1	$17,857.00
Access East	Established data reporting processes	DY4Q1	$17,857.00
Community Care of the Lower Cape Fear	Established an HSO Capacity Building Payment Distribution Approach	DY4Q1	$17,857.00
Community Care of the Lower Cape Fear	Established data reporting processes	DY4Q1	$17,857.00
Impact Health	Established an HSO Capacity Building Payment Distribution Approach	DY4Q1	$17,857.00
Impact Health	Established data reporting processes	DY4Q1	$17,857.00
Access East	Disbursement of first capacity building funds to HSOs.	DY4Q2	$17,857.00

Network Lead	Milestone Achieved	Quarter Disbursed	Amount Paid
Access East	Received Department approval of HSO Network Report.	DY4Q2	$26,785.00
Community Care of the Lower Cape Fear	Disbursement of first capacity building funds to HSOs.	DY4Q2	$17,857.00
Community Care of the Lower Cape Fear	Received Department approval of HSO Network Report.	DY4Q2	$26,785.00
Impact Health	Disbursement of first capacity building funds to HSOs.	DY4Q2	$17,857.00
Impact Health	Received Department approval of HSO Network Report.	DY4Q2	$26,785.00
Access East	Completion of Implementation Year training, technical assistance, and engagement.	DY4Q3	$17,857.00
Access East	Completion of Department readiness evaluation; HSO network prepared to deliver services.	DY4Q3	$26,785.00
Impact Health	Completion of Implementation Year training, technical assistance, and engagement.	DY4Q3	$17,857.00
Impact Health	Completion of Department readiness evaluation; HSO network prepared to deliver services.	DY4Q3	$26,785.00
Community Care of the Lower Cape Fear	Completion of Implementation Year training, technical assistance, and engagement.	DY4Q3	$17,857.00
Community Care of the Lower Cape Fear	Completion of Department readiness evaluation; HSO network prepared to deliver services.	DY4Q3	$26,785.00

PHP Incentive Payments – DY4

PHP	Milestone Achieved	Quarter Disbursed	Amount Paid
AmeriHealth Caritas of NC	Execute contracts with all Network Leads that are operating in the PHP's region.	DY4Q2	$30,000.00
Blue Cross Blue Shield of NC	Execute contracts with all Network Leads that are operating in the PHP's region.	DY4Q2	$30,000.00
Carolina Complete Health	Execute contracts with all Network Leads that are operating in the PHP's region.	DY4Q2	$30,000.00
United Healthcare	Execute contracts with all Network Leads that are operating in the PHP's region.	DY4Q2	$30,000.00
WellCare	Execute contracts with all Network Leads that are operating in the PHP's region.	DY4Q2	$30,000.00
AmeriHealth Caritas of NC	Meet Department Pilot-related systems integration and end-to-end testing standards related to Pilot eligibility, service authorization, referral, invoice, and payment. Successful completion of DHB Readiness Review to implement Pilots.	DY4Q3	$70,000.00
Blue Cross Blue Shield of NC	Meet Department Pilot-related systems integration and end-to-end testing standards related to Pilot eligibility, service authorization, referral, invoice, and payment. Successful completion of DHB Readiness Review to implement Pilots.	DY4Q3	$70,000.00
Carolina Complete Health	Meet Department Pilot-related systems integration and end-to-end testing standards related to Pilot eligibility, service authorization, referral, invoice, and payment. Successful completion of DHB Readiness Review to implement Pilots.	DY4Q3	$70,000.00

PHP	Milestone Achieved	Quarter Disbursed	Amount Paid
United Healthcare	Meet Department Pilot-related systems integration and end-to-end testing standards related to Pilot eligibility, service authorization, referral, invoice, and payment. Successful completion of DHB Readiness Review to implement Pilots.	DY4Q3	$70,000.00
WellCare	Meet Department Pilot-related systems integration and end-to-end testing standards related to Pilot eligibility, service authorization, referral, invoice, and payment. Successful completion of DHB Readiness Review to implement Pilots.	DY4Q3	$70,000.00

Pilot Capacity Building Funding

Two rounds of capacity building funding were released over the demonstration year. On Jan. 4, 2021, $6,341,624 in capacity building funding was released to Network Leads. This was the third issuance of Capacity Building Funds for the May 27, 2021–May 26, 2022 budget period. In DY4Q3, $12,106,683.50 of capacity building funding was released to the Network Leads for Year 2 program activities.

The State permitted Network Leads to request up to $10,000,000 in capacity building funds for 2021-2022 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. Please see Appendix E for a breakdown of funding received by Network Lead by date and purpose.

Pilot Enrollee Costs

The Pilot evaluator ran the first enrollment cost report in December 2022, looking at services provided between March 17, 2022 and Oct. 28, 2022. Data were aggregated using NCCARE360 invoice data provided by the Department, containing 8,749 services provided for 1,208 unique enrollees. Unfortunately, the Department is unable to report the enrollment cost data at this time due to two issues. Firstly, discrepancies were noted between total paid amount and total invoiced amount for several services. The discrepancies were most pronounced in the category of food delivery services. The Department is working with the evaluator and the NCCARE360 vendor, Unite Us, to resolve this issue. Secondly, Medicaid encounter data were investigated as a potential data source for cost analysis of HOP-related claims, but this data source could not be used to calculate costs per enrollee due to a known data issue involving unique identifiers. (This issue is summarized in the Evaluation Activities and Interim Findings section of the report under “Transition to Capitated Encounter Data from Standard Plans” above). Currently this issue disproportionally affects members enrolled in the Pilots (34.5% of enrollees). This issue is actively being resolved, such that in future analyses Medicaid encounter claim data may be used for cost analysis. The Department intends to provide Pilot enrollee cost data in DY5Q1.

Healthy Opportunities Pilot Evaluation Activities and Interim Findings

Throughout DY4, the Sheps Center provided technical assistance in the operationalization of HOP to facilitate evaluation. This included meeting with the Department, Network Leads, HSOs and other stakeholders to engage with questions around workflows for Pilot service delivery, provision of IPV services, payment activities, eligibility criteria and types of services to emphasize. Additionally, Sheps documented emerging implementation themes to inform data collection and analysis and developed data collection procedures that ensure safety and confidentiality for Pilot members affected by IPV.

Sheps prepared the necessary information technology infrastructure to receive and analyze descriptive and quantitative data regarding Pilot activities. Preparation included identification of necessary data elements, planning to receive data when available, and creating staffing assignments to support analysis workflows across analysts and other research team members.

Sheps conducted primary data collection for evaluation question 1 (Network Lead service delivery networks). Team members completed quantitative and qualitative data collection with Network Leads and HSOs regarding their experiences preparing for and delivering early phase Pilot services. Team members analyzed qualitative data on service delivery to be compiled in reports to the Department. The Sheps team also conducted activities for evaluation question 4 (patient-reported health outcomes). Survey data collection planning is underway, and an initial IRB submission was completed in October 2022 for Pilot member telephone interviews with adults, parents and adolescents.

In response to a CMS request to include additional stratifications in the evaluation report, Sheps will report stratified data to examine differences in health across populations defined by categories of race and ethnicity, gender, primary language and rurality. A new equity analysis section has been proposed for Hypotheses 4, 5, and 6. These changes were first reported in DY4Q3.

Residential and Inpatient Treatment for Individuals with a Substance Use Disorder

The Department will provide detailed information in the Substance Use Disorder annual submission that is due to CMS Feb. 28, 2023.

DEMONSTRATION YEAR 4 QUARTER 4 REPORT

Executive Summary

This section of the report covers Demonstration Year 4, Quarter 4 (DY4Q4) of the North Carolina Medicaid Reform Demonstration, August 1, 2022, through October 31, 2022.

On September 30, 2022, the Department announced that the launch of Behavioral Health I/DD Tailored Plans would be delayed until April 1, 2023. The delay will allow Tailored Plans more time to contract with additional providers to support member choice and to validate that data systems needed for launch are working. Following announcement of the delayed Tailored Plan implementation, the Department's business units finalized proposed adjusted dates for all major Tailored Plan program milestones. In early November, the proposal will be submitted to Department executive leadership for approval. While the launch of Tailored Plans will be delayed, the Department and LME/MCOs will support providers of Tailored Care Management to launch their services on December 1, 2022. Through Tailored Care Management, eligible beneficiaries will have a single designated care manager supported by a multidisciplinary team to provide integrated care management that addresses the beneficiary's whole-person health needs.

Last quarter the Department reported that Pharmacy Point of Sale (POS) claims for Tailored Plan members would be temporarily managed by NCTracks from Dec. 1, 2022 through March 31, 2023, as a result of a key pharmacy benefit manager (PBM) unexpectedly leaving the NC Medicaid market in late 2021. This will no longer be necessary due to the delay of Tailored Plan implementation; Tailored Plans will manage pharmacy claims at launch.

In early August 2022, the Department began the enrollment process for those who will be eligible for Tailored Plans at launch, known as Tailored Plan Criteria Review. The Department confirmed that approximately 150,000 members will be eligible at launch. The Tailored Plan choice period will begin on Jan. 15, 2023.

The Department is preparing to launch Healthy Opportunities Pilot services with the Tailored Plans in the second quarter of 2023. Lessons learned from Standard Plans are being adapted to the Tailored Plan model in implementation activities.

Medicaid Managed Care

Operational Updates

Recognizing this is a time of substantial change for North Carolina Medicaid enrollees, providers, and health plans, the Department implemented temporary flexibilities and program changes in the lead-up to Tailored Plan launch. To focus resources on requirements that are critical for implementation, the Tailored Plans submitted a collective list of requests to the Department of requirements that they viewed as non-critical to go-live and recommended modifying. Department leadership evaluated the recommendations and either approved, approved with modification, or denied the requests. Following announcement of the implementation delay, the responses were re-evaluated and adjusted based on

the April 1, 2023, launch date. Mirroring the Standard Plan launch, the Department approved select temporary policy flexibilities to reduce provider burden during implementation. The policy flexibilities range in duration from 90 to 181 days following Tailored Plan launch.

The Department continues to have regular meetings with the Tailored Plans, including weekly status meetings with each Plan to track development work and address any potential business issues and risks, and bi-weekly calls with the Tailored Plan executive leadership teams to address key issues and risks.

Tailored Plan Criteria Review

In early August 2022, the Department began the enrollment process for those who will be eligible for Tailored Plans at launch, known as Tailored Plan Criteria Review. The Department confirmed approximately 150,000 members to be eligible at launch. An initial group of individuals received notices regarding their eligibility in August, while others will enroll throughout the year. The Department expects enrollment to continue to grow up to launch and through the year following launch until the end of the federal public health emergency unwinding.

Individuals are identified as eligible for Tailored Plans consistent with North Carolina statute. The start date for the lookback period for eligibility criteria that rely on service utilization has been updated to December 1, 2020. The original lookback period began January 2018 and was selected to identify beneficiaries who would be exempt from mandatory enrollment in Standard Plans due to their expected enrollment in Tailored Plans. With the delay of Tailored Plan launch, the original lookback period was determined to no longer be clinically appropriate for service-based criteria. Other eligibility criteria that rely on qualifying diagnoses or special program participation will continue with the original lookback period of January 1, 2018, in order to identify beneficiaries who are exempt from mandatory Standard Plan enrollment. Approximately 50,000 beneficiaries who previously qualified for an exemption from mandatory Standard Plan enrollment due to meeting Tailored Plan criteria will not be eligible to enroll in a Tailored Plan at launch because their qualifying services are now outside the look-back period or they do not meet the revised state-funded service use criteria. These beneficiaries will be auto-enrolled in a Standard Plan in November 2022, with coverage effective December 1, 2022.

Beneficiaries who utilized the Request to Move process, which allows Standard Plan members to move to NC Medicaid Direct or a Tailored Plan, in the past will continue to remain eligible for a Tailored Plan. The Request to Move process will also continue to be available for beneficiaries who may not be identified through the Tailored Plan Criteria Review process.

Following the eligibility criteria review, beneficiaries will be mailed a notice informing them of their health care choices and how to change their health care option. The Tailored Plan choice period will begin on Jan. 15, 2023. To disenroll from the Tailored Plan and enroll in a Standard Plan, Tailored Plan members must contact the Enrollment Broker to ensure they understand they will no longer receive enhanced services provided only by the Tailored Plan and provide informed consent. Individuals will be permitted to move back to the Tailored Plan at any time if they continue to meet the criteria.

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

Standard Plans

1. The Department hosted the PHP Health Equity Quarterly Workgroup Kickoff meeting on Oct. 12, 2022, with Standard Plans and Tailored Plans. This was the first of planned quarterly PHP Health Equity workgroup sessions. At the kickoff, the Department provided an introduction on the purpose and objectives of the workgroup as well as an update to PHP Health Equity Leads on the Department's work on health equity.

Tailored Plans

1. The Department began the enrollment process, known as Tailored Plan Criteria Review, for beneficiaries who will be eligible for Tailored Plans effective April 1, 2023. The Department confirmed approximately 150,000 members to be eligible at launch. An initial group of individuals received notices regarding their eligibility in August, with others enrolling throughout the year. The Department expects enrollment to continue to grow up to launch and throughout the year following launch until the end of the federal public health emergency.
2. In response to the delay of Tailored Plan launch, the Department conducted re-alignment activities, including updating the timeline for implementation milestones, determining required contract changes, re-evaluating the proposed non-critical items flexibilities from Tailored Plans, and publishing a quick reference guide on delay impacts based on Tailored Plan questions. In early November, the proposed re-baselining changes will be submitted to Department executive leadership for approval.
3. The Department's pharmacy business unit held a community pharmacist stakeholder summit with the Tailored Plans to provide an update on Tailored Plan implementation following the launch delay.

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

Standard Plans

1. The Department addressed an issue where some nursing facilities were not accepting Standard Plan members upon hospital discharge due to delays in the long-term care financial eligibility determination process. After reviewing information provided by PHPs and consulting with representatives from the NC Healthcare Association and NC Health Care Facilities Association, the Department took the following actions:
    - Published a memo to Standard Plan CEOs on nursing facility payment that encourages PHPs to use existing flexibilities – such as rates, delivery models, and interim payments (or hardship advancements) to facilitate timely care. NC Medicaid strongly encourages PHPs to support providers with interim payments/hardship advances when there are delays in paying nursing facilities due to the long-term care financial eligibility determination process.

- Created a new standardized form for PHPs and nursing facilities to communicate with local Departments of Social Services (DSS), streamlining processes for nursing facility admissions and the determination of long-term care financial eligibility.
- Created stakeholder-specific fact sheets for counties, health plans, and providers (including hospitals and nursing facilities). The fact sheets outline the information flow, timelines and requirements for the long-term care financial eligibility determination process.

2. Corrective Action Plans (CAPs) were created for four Standard Plans in Spring 2022 to address errors on the PHP Network Files (PNFs), which required the plans to submit monthly self-audits to report on their errors and progress. Although one of the four plans is now in compliance, the other three CAPs must be extended and will now include a liquidated damage (LD) for failure to remove providers not active in NC Medicaid from their PNFs.

3. Two of the five Standard Plans did not meet the preferred drug list (PDL) compliance benchmark of 95% during all four quarters of State Fiscal Year 2022. The Department issued Notice of Deficiency memos on October 31, 2022, requesting liquidated damages for both plans. Additionally, one Standard Plan did not meet the compliance benchmark in the first quarter of SFY22. This plan was given a Notice of Deficiency, but liquidated damages were not assessed. Q1 was the first quarter of Standard Plan implementation.

4. In response to provider concerns about on-going member assignment and panel management issues for AMHs, the Department is working with Standard Plans to analyze errors and create easier pathways for providers to reach Standard Plans and resolve panel issues:

    - Standard Plans updated their contact information for providers to contact them with panel questions or issues.
    - Standard Plans are working to ensure their member and provider call lines are equipped to respond to calls related to AMH assignment.
    - Providers can also discuss panel limits with Standard Plans so they understand any panel limits they currently have with the plan based on initial contracting and can update panel limits as needed.

Tailored Plans

1. Adequate provider network coverage continues to be a risk across all Tailored Plans due to lower than expected provider contracting. Since the Tailored Plans started submitting provider contracting reports in early May, the results have not met network adequacy standards across the various provider categories. This could result in a high rate of separation of Tailored Plan beneficiaries from the PCP they were assigned under fee-for service and a lack of providers for PCP auto-assignment beginning in February. The Department has worked to mitigate this risk through the following activities:

    - Close tracking of provider contracting data in the Weekly Tailored Plan Scorecards
    - Monitoring monthly AMH/PCP contracting submissions and other specialties from the monthly network submission

- Monitoring bi-weekly contracting data submitted in response to a Notice of Concern issued to the plans
- One-on-one calls with the Tailored Plans to get more frequent updates on contracting progress and challenges
- Working through the Provider Engagement and Communications team to clarify the process to contract with Tailored Plans and the changes coming with Tailored Plan launch

2. End-to-end testing continued trending behind schedule throughout this quarter for both the Auto-Enrollment and Plan Launch milestones. The main drivers of this trend have been:

    - Incorrect provider data setup by the Tailored Plans
    - Incorrect claim submissions
    - Enrollment Broker open defects on ongoing notices
    - Medicaid PIHP end-to-end testing overlapping with Tailored Plan end-to-end testing schedule adds complexity and risk to the current end-to-end plan and schedule.

    The End-to-End team is meeting weekly with the Tailored Plans and escalating plan-specific delays and challenges through bi-weekly calls with the Tailored Plans' Executive Leadership teams.

Milestones

1. The first Tailored Plan Contract Amendment was executed with the plans in early September.

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 DY4Q4, the Ombudsman handled 4,422 cases. Case volume remained relatively stable, with an increase of approximately 3% from last quarter. Many calls involved educating beneficiaries or connecting them to the entity that could provide the service they need. (See Appendix F for a full list of cases by category type.) This quarter, the Office of Administration received 20 complaints, compared to 13 last quarter. There were no complaints reported to the Office of Compliance and Program Integrity.

NC Medicaid Member Ombudsman Cases

August 2022		September 2022		October 2022		Total Cases
Information	Issue Resolution	Information	Issue Resolution	Information	Issue Resolution	
567	1,108	482	754	523	988	**4,422**

Office of Administration Member/Constituent Concerns, August 2022 – October 2022

Issue Category	Number of Issues
Beneficiary/Member Eligibility	4
Clinical Policy	2
PHP Claims/Finance	10
Non-Emergency Medical Transportation (NEMT)	1
Program Integrity	1
Provider Operations	2
TOTAL	**20**

Lawsuits or legal actions

There are no lawsuits or legal actions to report this quarter.

Unusual or unanticipated trends

There are no unusual or unanticipated trends to report this quarter.

Legislative updates

There are no legislative updates to report this quarter.

Descriptions of post-award public fora

There were no public fora this quarter.

Performance Metrics

Outcomes of care

Available outcomes of care measures are included in the annual section of this report.

Quality of care

North Carolina measurement year 2021 quality measure results were reported in DY4Q3 and are available in the annual section of this report.

Cost of care

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

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. Based upon networks submitted on Oct. 31, 2022, 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).

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	144,579	100%	100%	100%	100%	100%	100%	100%
2	13	301,714	100%	100%	100%	100%	100%	100%	100%
3	12	426,328	100%	100%	100%	100%	100%	100%	100%
4	14	347,131	100%	100%	100%	100%	100%	100%	100%
5	15	289,152	100%	100%	100%	100%	100%	100%	100%
6	27	220,932	99%	99%	100%	100%	100%	100%	100%

**Number of members currently mandated in Managed Care population as of 10/19/22. This metric is NOT representative of each Standard Plan's membership.*

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	144,579							
2	13	301,714							
3	12	426,328	100%	100%	100%	100%	100%	100%	100%
4	14	347,131	100%	100%	100%	100%	100%	100%	100%
5	15	289,152	100%	100%	100%	100%	100%	100%	100%
6	27	220,932							

**Number of members currently mandated in Managed Care population as of 10/19/22. This metric is NOT representative of each Standard Plan's membership.*

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	144,579	100%	100%	100%	100%	100%	100%	100%
2	13	301,714	100%	100%	100%	100%	100%	100%	100%
3	12	426,328	100%	100%	100%	100%	100%	100%	100%
4	14	347,131	100%	100%	100%	100%	100%	100%	100%
5	15	289,152	100%	100%	100%	100%	100%	100%	100%
6	27	220,932	99%	100%	99%	99%	100%	100%	100%

**Number of members currently mandated in Managed Care population as of 10/19/22. This metric is NOT representative of each Standard Plan's membership.*

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	144,579	100%	100%	100%	100%	100%	100%	100%
2	13	301,714	100%	100%	100%	100%	100%	100%	100%
3	12	426,328	100%	100%	100%	100%	100%	100%	100%
4	14	347,131	100%	100%	100%	100%	100%	100%	100%
5	15	289,152	100%	100%	100%	100%	100%	100%	100%
6	27	220,932	100%	100%	100%	100%	100%	100%	100%

**Number of members currently mandated in Managed Care population as of 10/19/22. This metric is NOT representative of each Standard Plan's membership.*

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	144,579	100%	100%	100%	100%	100%	100%	100%
2	13	301,714	100%	100%	100%	100%	100%	100%	100%
3	12	426,328	100%	100%	100%	100%	100%	100%	100%
4	14	347,131	100%	100%	100%	100%	100%	100%	100%
5	15	289,152	100%	100%	100%	100%	100%	100%	100%
6	27	220,932	99%	100%	100%	100%	100%	100%	100%

**Number of members currently mandated in Managed Care population as of 10/19/22. This metric is NOT representative of each Standard Plan's membership.*

Provider Enrollments by PHP

Provider enrollment by provider type is available by PHP. 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 G for the full list.

Provider Enrollment by PHP – Select Categories

Provider Type	AmeriHealth	Healthy Blue	CCH	United	WellCare
Ambulatory Health Care Facilities	988	1,237	919	1,423	2,478
Behavioral Health & Social Service Providers	8,685	9,115	6,914	3,789	6,340

Beneficiaries Per AMH Tier

The Department developed the AMH model as the primary vehicle for care management in Standard Plans. 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	8,602	1,233	26,676	21,825	6,022	**64,358**
Tier 1	2,845	3,117	8,941	4,580	3,064	**22,547**
Tier 2	41,815	40,993	76,090	69,727	54,482	**283,107**
Tier 3	259,896	176,961	355,931	274,040	309,682	**1,376,510**

*CCH only operates in regions 3, 4 and 5.

Member Proportion by PHP and AMH Tier

	AmeriHealth	CCH	Healthy Blue	United	WellCare	Total
No PCP Tier	2.75%	0.55%	5.70%	5.90%	1.61%	**3.68%**
Tier 1	0.91%	1.40%	1.91%	1.24%	0.82%	**1.29%**
Tier 2	13.35%	18.44%	16.27%	18.84%	14.60%	**16.21%**
Tier 3	82.99%	79.60%	76.11%	74.03%	82.97%	**78.81%**

AMH Provider Enrollment

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

	AmeriHealth	CCH**	Healthy Blue	United	WellCare
Tier 1	28.92%	58.18%	56.63%	48.19%	35.74%
Tier 2	47.37%	66.67%	88.33%	62.51%	52.18%
Tier 3	86.15%	90.31%	85.67%	85.49%	88.96%

*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

Care management penetration rates for July to September, 2021 are located in the annual section of this report.

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 are expected for NC Medicaid Direct, as members with substantial behavioral health issues to be enrolled in Tailored Plans currently remain in NC Medicaid Direct.

Emergency Department Visits per 1,000 Members, July – September 2022

AmeriHealth	CCH	Healthy Blue	Medicaid Direct	United	WellCare
60.5	60.5	58.9	78.0	61.4	58.3

Inpatient Admissions per 1,000 Members, July – September 2022

AmeriHealth	CCH	Healthy Blue	Medicaid Direct	United	WellCare
13.38	15.22	13.84	23.08	13.77	14.86

Results of beneficiary satisfaction surveys

No results to report this quarter.

Budget Neutrality and Financial Reporting Requirements

The Department will submit the next budget neutrality workbook by Jan. 31, 2023.

Evaluation Activities and Interim Findings

The Sheps Center for Health Services Research (Sheps) is the independent evaluator for North Carolina's 1115 demonstration. 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, such as how providers are preparing for the transformation and what can be done to improve their satisfaction with NC Medicaid.

Transition to Capitated Encounter Data from Standard Plans

Sheps data scientists and analysts have continued working with the encounter data that tracks utilization by Standard Plan members. Sheps has provided feedback on the quality and completeness of this data to the Department while continuing to revise code on metrics to include services, medications and diagnoses received through either claims or encounter data. This quarter, Sheps had to shift considerable focus to data quality issues caused by a faulty file sent by the state's data vendor for managed care. The file contained mismatched IDs for Standard Plan members. A replacement file was created, but this required a complete rebuild of Sheps's claims and encounter system, which has delayed reporting by months. The issue is expected to be resolved by December 2022.

Quantitative Update

The quantitative team continues to receive new data from the NC Division of Public Health, including updates to birth and death certificate and immunization data. The team is also ingesting new files on care management data, value-based payment data and NCCARE360, the database that tracks Pilot services and referrals. All data sources are ingested into UNC's secure data warehouse and will be linked to NC Medicaid member information to generate new metrics that will be tracked during the evaluation period. In addition, the team continues to update many of the metrics from established custodians consistent with the NC Medicaid Quality Strategy, Adult and Child Core measures, and other metrics that will address the study hypotheses. Sheps has completed the evaluation of 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. These measures showed generally similar trends between Medicaid and Blue Cross and Blue Shield of North Carolina (BCBSNC) Marketplace plans in the pre-implementation period, although there were concerns about relatively

small sample size for some of the metrics that look at specific subsamples (such as well-child visits for children and adolescents, due to the relatively small number of children in Marketplace plans). The evaluation will use BCBSNC data 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 evaluation team has been refining the new dashboard on behavioral health metrics while updating the focused substance use disorder dashboard monthly; both dashboards have recently been delayed because of the data quality issue noted above. Other dashboards specific to Foster Care plan members, individuals with intellectual and developmental disabilities, and physical/overall health metrics are planned.

Qualitative Update

The qualitative team created three findings briefs on both the provider experience and PHP experience. The briefs will be posted on the Sheps Center website once they have been reviewed by the Department and appropriate stakeholders. The qualitative team also presented findings to the Department during a Deep Dive session in October 2022. All Department employees are invited to attend weekly Deep Dive sessions that cover a specific topic of interest to the Department and provides employees an opportunity to ask the presenters questions.

Sheps continues to work on the patient engagement manuscript, which focuses on the data from Year 1 interviews.

Sheps plans to conduct beneficiary focus groups in early 2023 via Zoom. This will include recruiting up to 24 family caregivers of pediatric patients on Medicaid and up to 24 adult Medicaid beneficiaries. The two groups will each be divided into no more than eight groups of three to six caregivers/adult beneficiaries. Discussions are underway regarding the possibility of offering at least one Spanish language focus group. Staff are developing recruitment materials and focus group guides. Once details have been finalized for this additional qualitative work, IRB approval will be sought.

Healthy Opportunities Pilots (previously Enhanced Case Management and Other Services)

Operational Updates

Introduction

The Healthy Opportunities Pilots (HOP) launched service delivery in March 2022. HOP launched in three regions that collectively cover 33 counties in North Carolina. The Pilot has resulted in over 20,000 services addressing unmet social needs being delivered to eligible Standard Plan members.

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

Further, the technology system developed to link medical and non-medical sectors has effectively allowed for program eligibility and service authorization, service referrals, and service invoicing. The Department has worked with the Pilots evaluator to begin to transmit service data which is now available for Pilot evaluation.

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

The Pilots have experienced challenges related to referral volume, service delivery implementation and system processes.

There was an unexpectedly slow ramp-up in referral volume. The Department worked with partner organizations to identify strategies to increase referral volume quickly and equitably. These strategies included initiatives to promote direct community outreach by HSOs, technical solutions to allow community organizations to make referrals to care managers within the technology system and working with Standard Plans to improve their processes for proactive outreach to potentially eligible members.

Service delivery for the IPV and housing domains has been particularly challenging. Challenges have in part been due to limitations in the current housing support infrastructure, such as very limited affordable housing in rural areas, and funding limitations, especially for HSOs that had historically operated with a smaller budget. The funding challenges were addressed, in part, through capacity building funds which allow the HSOs flexibility to deliver higher cost housing services. This continues to be monitored to ensure appropriate use of Pilot funds and that members receive necessary services in a timely manner. The limitations in affordable housing extend beyond the scope of the program. The Department continues to work with housing subject matter experts (SMEs) to ensure that challenges are addressed within the context of broader housing support infrastructure.

For services that are part of the IPV domain, the Department worked with domestic violence and IPV SMEs to determine design modifications necessary to ensure Pilot enrollee safety and data confidentiality for these sensitive services. Over the last year, the Department worked to modify the technology system to address safety considerations, such as having detailed contact information for members readily available, and make modifications needed to ensure that Violence Against Women Act (VAWA) and Victims of Crime Act (VOCA) regulatory considerations were met, such as ensuring that sensitive data is only visible to individuals who providing IPV services.

The Department continues to work to modify the technology system and build an advanced functionality which automates processes. At service delivery launch, there were various manual workflows which were put in place temporarily.

Issues or complaints identified by beneficiaries

No issues or complaints identified by beneficiaries to report this quarter.

Lawsuits or legal actions

No lawsuits or legal actions to report this quarter.

Unusual or unanticipated trends

No unusual or unanticipated trends to report this quarter.

Performance Metrics

Incentive Payments to PHPs, NLs, and Pilot providers

There were no incentive payments released this quarter.

Pilot Capacity Building Funding

There were no capacity building payments released this quarter.

Healthy Opportunities Pilots Evaluation Activities and Interim Findings

In this quarter, the Sheps Center provided ongoing technical assistance and engagement with the Department to facilitate the Pilots evaluation. Activities included participating in weekly and monthly standing meetings, documenting emerging implementation themes to inform data collection and analysis and developing data collection procedures that ensure safety and confidentiality for Pilot members affected by IPV.

Sheps staff prepared to receive and analyze data relating to Pilot activities. Sheps began to receive data on the Pilots enrollment roster and claims during this period and anticipates initial delivery of data necessary for the evaluation in the upcoming quarter. Associated activities included identification of necessary data elements, planning to receive data when it becomes available, and creating staffing assignments to support analysis workflows.

The final evaluation focus of this quarter was primary data collection for evaluation questions one (lead pilot entity services delivery networks) and four (patient-reported health outcomes). Team members analyzed qualitative data on services delivery to be compiled in reports to the Department. Survey data collection planning continued for patient-reported health outcomes, and an initial IRB submission was completed in October 2022 for Pilot member telephone interviews with adults, parents and adolescents.

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 Feb. 28, 2023.