Medicaid Section 1115 Monitoring Report

North Carolina - North Carolina Medicaid Reform Demonstration

DY5Q1 – Nov. 1, 2022 through Jan. 31, 2023

Submitted on March 31, 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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DEMONSTRATION YEAR 5 QUARTER 1 REPORT

Executive Summary

This report covers Demonstration Year 5, Quarter 1 (DY5Q1) of the North Carolina Medicaid Reform Demonstration, Nov. 1, 2022, through Jan. 31, 2023.

Last quarter, the Department announced that the launch of Behavioral Health I/DD Tailored Plans (Tailored Plans) would be delayed until April 1, 2023 to allow Tailored Plans more time to contract with additional providers and validate that data systems needed for launch are working. On Feb. 27, 2023, the Department further delayed the launch of Tailored Plans until Oct. 1, 2023. As this occurred after DY5Q1, activities related to the delay will be included in next quarter's report.

This quarter, the Department implemented a policy change to ensure financial parity between NC Medicaid Direct and Standard Plans in payment of nursing facilities. This change requires prepaid health plans (PHPs) to pay no less than 95% of the facilities' adjusted Medicaid rate for the first 20 days of the nursing facility stay, and then pay no less than 80% of the facilities' adjusted Medicare rate for the remainder of the nursing facility stay covered under managed care. Additionally, plans have the ability to pay above the rate floor set by the Department.

Following the conclusion of Tailored Plan onsite readiness reviews in August, the Department flagged over 350 open items as a result of the plans' live system demonstrations and staff interviews. Between November and January, the Department facilitated 35 additional live demonstrations across various functional areas (e.g., claims and encounters processing and oversight, pharmacy point of sale, call center service line operations). By the end of January, the Department was able to resolve over 300 of the open items based on Tailored Plan demonstrations and written responses. The Department continues to monitor any items that require additional action. Additionally, the Department executed Departmental Readiness Reviews to evaluate internal operational readiness for Tailored Plan launch. The internal reviews focused on validating that Department staff had the tools and training needed to effectively oversee Tailored Plan operations. The Department reported readiness outcomes to CMS monthly through submission of the CMS Readiness Gateway document and responded to CMS-directed questions.

While the start of Tailored Plans was delayed, Tailored Care Management (TCM) launched on Dec. 1, 2022. TCM is a new care management model that reflects the goal of whole-person care management in NC Medicaid Managed Care.

The Healthy Opportunities Pilots (HOP) team worked this quarter to prepare for the launch of care management activities for select Local Health Departments (LHDs) and to implement an enrollment improvement strategy. The Department is reporting enrollee service cost metrics for the first time this quarter.

Medicaid Managed Care

Operational Updates

This quarter the Department executed an amendment to the Standard Plan Contract to make clarifications, technical corrections and updates to Section III (Definitions, Contract Terms, General Terms and Conditions, Other Provisions and Protections), Section V (Scope of Services), Section VI (Contract Performance), Section VII (Attachments) and Section X (Revised and Restated Summary of Contractual Payments and Risk Sharing Terms).

To improve care of NC Medicaid members related to gaps and delays in the delivery of substance use disorder (SUD) services, specifically American Society of Addiction Medicine (ASAM) Levels 2.1 and 2.5 for Standard Plan members, the Department recommended that Standard Plans develop In Lieu of Services (ILOS) consistent with ASAM Levels 2.1 and 2.5 as an interim step while legislative changes are pursued. Current legislation mandates that these are not covered services in Standard Plans and are only reimbursed in Tailored Plans. After completing a root cause analysis with stakeholders and reviewing clinical harm scenarios under the current coverage, a risk was identified where members could be delayed in accessing these critical services while transitioning to a Tailored Plan. While the implementation of an ILOS consistent with ASAM Levels 2.1 and 2.5 is optional for all Standard Plans, rapidly available SUD care meeting ASAM Levels 2.1 and 2.5 is a critical need for NC Medicaid members and would support members still enrolled with a Standard Plan and awaiting transfer to Medicaid Direct (or future Tailored Plan). Therefore, the Department issued a memo to the Standard Plans recommending that Standard Plans consider implementing these ILOSs, ensuring members can receive necessary care without delay while enrolled in a Standard Plan.

Following the conclusion of Tailored Plan onsite readiness reviews in August, the Department flagged over 350 open items as a result of the plans' live system demonstrations and staff interviews. Between November and January, the Department facilitated 35 additional live demonstrations across various functional areas (e.g., claims and encounters processing and oversight, pharmacy point of sale, call center service line operations). By the end of January, the Department was able to resolve over 300 of the Open Items based on Tailored Plan demonstrations and written responses. The Department continues to monitor any items that require additional action. Also in January, the Department executed Departmental Readiness Reviews to evaluate internal operational readiness for Tailored Plan launch. The internal reviews focused on validating that Department staff had the tools and training needed to effectively oversee Tailored Plan operations. The Department reported readiness outcomes to CMS monthly through submission of the CMS Readiness Gateway document and responding to CMS-directed questions.

By Nov. 2, 2022, the Enrollment Broker completed mailing notices to all Tailored Plan eligible beneficiaries, and their authorized representatives, notifying them of changes in Tailored Plan launch. Additionally, the Department conducted an Enrollment Broker Tailored Plan readiness review for the vendor Maximus from November 2022 to January 2023. No major issues were found as result of the review. End to End testing was also completed with the Enrollment Broker to verify all Tailored Plan ongoing notices were generated correctly.

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

Standard Plans

1) To create financial parity, and improve hospital throughput and member experience, beginning Jan. 1, 2023 NC Medicaid required health plans to pay nursing facilities no less than 95% of the facilities' adjusted Medicaid rate for the first 20 days of the nursing facility stay, and then pay no less than 80% of the facilities' adjusted Medicare rate for the remainder of the nursing facility stay covered under managed care. Standard Plans were required to update their systems within 45 calendar days of receiving the updated rates and reprocess claims retroactively back to Jan. 1, 2023 within 75 days of receiving the updated rates.
2) Standard Plan CMOs have been critical participants in two statewide efforts to improve health access and outcomes. The Sickle Cell Disease (SCD) Workgroup has identified opportunities to remove barriers to timely care and improve outcomes for members with SCD through a menu of improvements. The Collaborative Care Consortium has created policy levers to make the provision of collaborative care in the primary care setting more accessible and financially feasible for practices. Both initiatives were undertaken in partnership with the Standard Plans.

Tailored Plans

1) Tailored Care Management (TCM) launched on December 1, 2022 with Local Management Entities/Managed Care Organizations (LME/MCOs) and TCM providers. TCM is a new care management model that reflects the goal of whole-person care management in NC Medicaid Managed Care. Letters were mailed beginning Nov. 14, 2022, to TCM-eligible beneficiaries and authorized representatives with the name and contact information of their TCM provider. The letter also explained TCM services and provided information on how beneficiaries can change their TCM provider or opt out of the service. Beneficiaries can change their TCM provider at any time, without limits, prior to April 1, 2023, by calling their LME/MCO.
2) In response to the Department's decision to move the launch of the Tailored Plans to April 1, 2023, the Department's business units proposed adjusted dates for all major Tailored Plan program milestones. In early November, Department executive leadership approved the proposed adjusted dates, and the adjustments were communicated to the Tailored Plans. (These dates will be adjusted again in response to the additional Tailored Plan delay.)
3) The Department assumed responsibility for running the TCM Auto-Assignment (AA) algorithm during the TCM soft-launch period between Dec. 1, 2022 and April 1, 2023. There were two runs completed in November to specifically make new assignments to TCM-eligible members. Following the December launch, the Department shifted its focus to complete monthly operational runs. For December, along with assigning newly eligible members, extra scope was added to reassign members due to changes in their eligibility or provider eligibility. Additionally, reassignments were made to resolve an issue related to honoring historical relationships. The Department also worked with LME/MCOs to reassign members to prevent member harm scenarios. Additional scope was added for January to give LME/MCOs the one-time opportunity

to reassign members away from the LME/MCOs to providers who were deemed to have low or no assignments.

4) In December, all Tailored Plans successfully completed Phase 1 of Tailored Plans claims testing by reaching 100% execution and pass rates for the entire scope of the testing. Phase 1 scope included comparison of Tailored Plans/Prepaid Inpatient Health Plan (PIHP) processing of historical claims from 837 files supplied by providers against historical results from NCTracks and LME/MCOS.

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

Standard Plans

1) CAPs were created for three Standard Plans to address failure to comply with terms of conditions of confidentiality, privacy, and security protections of the contract. During this period, the Department reviewed and approved each of the Standard Plans' CAPs and closed the notices as all actions were complete and liquidated damages were paid.
2) Ongoing challenges with claims payment in hospital systems continue in specific areas: skilled nursing facilities (SNFs), Observation, Newborns and Outpatient Facility Pharmacy. The Department continues to mediate and seek resolution.
3) CAPs were opened for four Standard Plans in Spring 2022 to address errors on the PHP Network Files (PNFs), which included a requirement that PHPs submit monthly self-audits to report on their errors and progress. Although one of the four health plans is now in compliance and their CAP is closed, the other 3 CAPs must be extended. Notices of Deficiency (NODs) are being finalized and will now include a liquidated damage (LD) for failure to remove providers not active in NC Medicaid from their PNFs. Provider Operations continues to monitor the non-enrolled Medicaid provider data errors reported from PHPs on the PNF, as self-reported by the PHPs and validated on the Compiled Standard Plan Network Errors report, taking corrective actions as appropriate. The Provider Operations team continues to follow three trending issues within Standard Plans related to non-active Medicaid providers remaining on the PNF, missing PNFs, and delay in turnaround time between Standard Plans contracting with providers and sending the Provider Welcome Packets. Notices of Deficiencies and CAPs are in process.
4) In February 2022, each of the five Standard Plans were issued a NOD for annual network adequacy deficiencies. The notices detailed the Department's determination of plans' compliance with network adequacy standards and identified network gaps, denied exception requests and next steps to address gaps. The Notice required plans to provide a CAP to the Department and to submit monthly status reports. During this reporting period, two of the five Standard Plans were issued Notices of Closure as their CAPs have been reviewed and approved and no additional action is needed.

Tailored Plans

1) End-to-end testing continued trending behind schedule throughout this quarter for PCP Auto-Assignment, Capitation, Plan-to-Plan Transition of Care, TCM Claims and TCM interfaces. The main drivers of this trend have been:
    - Defect resolution turnaround times have gone up considerably, and
    - Resource constraint to support the Tailored Plan launch and testing

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

2) Provider network coverage is an area of risk across all Tailored Plans. Since the Tailored Plans started submitting monthly reporting on provider contracting in May 2022, results have not met network adequacy standards across the various provider categories. This could result in a lack of providers for PCP auto-assignment. The Department has worked to mitigate this risk through the following methods:
    - Close tracking of provider contracting data in the Weekly Scorecards
    - Monitoring of monthly Advanced Medical Home (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 all the Tailored Plans
    - One-on-one calls with the Tailored Plans to get frequent updates on contracting progress and challenges
    - Clarifying to providers the process to contract with Tailored Plans and the changes coming with Tailored Plan launch
    - Working with the North Carolina Healthcare Association (NCHA) to understand any contracting barriers and/or complexities occurring with the Tailored Plans

    3) As of December 21, 2022, all Tailored Plans successfully completed Phase 1 of Tailored Plans claims testing by reaching 100% execution and pass rates for the entire scope of the testing. Due to delays from the Tailored Plans, Phase 1 testing was not completed in late October as originally scheduled. Phase 2 Testing began on December 5, 2022, and Claims Portal Testing began January 6, 2023. Phase 2 Testing is slated for completion on February 10, 2023; however Tailored Plans are behind anticipated progress. The Department is meeting twice weekly with each Tailored Plan and holding daily end-to-end testing calls to provide support.

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 DY5Q1, the Ombudsman handled 4,176 cases. Case volume remained relatively stable, with an approximately 6% decrease in cases compared to last

quarter. (See Appendix A for a full list of cases by category type.) The Office of Administration largely handles cases referred from state legislative offices. Previously, all constituent concerns handled by the Office of Administration were reported, including those from non-beneficiaries (such as providers). Beginning this quarter, only concerns from NC Medicaid beneficiaries are included. This change significantly lowers the number of reported concerns compared to previous quarters. While only four concerns were reported this quarter, an average of 17 concerns were reported per quarter in DY4, under the old format.

NC Medicaid Member Ombudsman Cases, November 2022 – January 2023

November 2022		December 2022		January 2023		Total Cases
Information	Issue Resolution	Information	Issue Resolution	Information	Issue Resolution	
507	911	396	890	462	1,010	**4,176**

Office of Administration Member Concerns, November 2022 – January 2023

Issue Category	Number of Issues
PHP Physician Search	1
PHP Auto Assignment	1
Pharmacy	1
Beneficiary/Member Eligibility	1
Total	**4**

Lawsuits or legal actions

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

Unusual or unanticipated trends

1) In November, the Member Help Center received multiple reports that beneficiaries received letters stating that they were ineligible for LME/MCO services. The Enrollment Broker had inadvertently sent a letter notifying a cohort of beneficiaries that they were disenrolled from their LME/MCO. The Department worked with the Enrollment Broker to quickly send out a corrected notice to the cohort of beneficiaries stating they are enrolled in an LME/MCO.

Legislative updates

There are no legislative updates to report this quarter.

Descriptions of post-award public fora

On Jan. 30, 2023, the Department held a Section 1115 Demonstration Waiver post-award public forum during the Community Partners Webinar. The Department presented on progress in the implementation of the 1115 waiver and provided an overview of upcoming work and the timeline for implementation of future key aspects of the waiver. The presentation covered the transition to NC Medicaid Managed Care, Healthy Opportunities Pilots, and the SUD waiver.

Comments and questions were received on the following topics, with most questions focusing on Tailored Plans:

- NC counties served by the Integrated Care for Kids (InCK) program
- Updates on the 1915(i) option services
- NC Health Choice beneficiary transition to NC Medicaid
- Tailored Plan launch timeline
- Enrollment in Tailored Plans and notification of enrollment
- Services available in Tailored Plans
- Provider contracting with Tailored Plans
- Impact of Tailored Plan launch on Community Alternatives Program for Disabled Adults (CAP/DA). (CAP/DA beneficiaries will remain in Medicaid Direct.)
- Identifying Tailored Plan members when verifying member eligibility in NCTracks
- Grace period for services received by members during transition to Tailored Plans
- Ability for members enrolled in a Tailored Plan to move to NC Medicaid Direct (only possible for members of a federally recognized tribe)
- Impact of Tailored Plan launch on children in foster care (children in foster care will remain in Medicaid Direct following Tailored Plan launch, unless they are on the Innovations Waiver)
- Member Ombudsman and Tailored Plans (Member Ombudsman is currently available to help with Tailored Plan questions)
- Appealing Medicaid disenrollment
- Impact of the end of the Public Health Emergency on the NC Medicaid population

Performance Metrics

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

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

Outcomes of care

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

Quality of care

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

Access to care

Network Time/Distance Standards

At this time the Department is still working to compile the DY5Q1 Standard Plan compliance with network time/distance standards due to issues related to staff turnover. This information will be included in next quarter's report.

Provider Enrollments by PHP

At this time the Department is still working to compile the Standard Plan provider enrollment due to issues related to staff turnover. This information will be included in next quarter's report.

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	9,367	1,283	33,302	26,089	9,343	**79,384**
Tier 1	3,357	3,678	9,242	5,174	3,096	**24,547**
Tier 2	45,222	45,514	80,468	74,071	57,062	**302,337**
Tier 3	278,270	188,879	380,339	284,010	333,540	**1,465,038**

*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	2.79%	0.54%	6.62%	6.70%	2.32%	**4.24%**
Tier 1	1.00%	1.54%	1.84%	1.33%	0.77%	**1.31%**
Tier 2	13.45%	19.02%	15.98%	19.02%	14.16%	**16.16%**
Tier 3	82.77%	78.91%	75.56%	72.95%	82.76%	**78.29%**

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

AMH Provider Enrollment

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

	AmeriHealth	Healthy Blue	CCH**	United	WellCare
Tier 1	29.83%	58.82%	61.38%	45.80%	39.08%
Tier 2	51.85%	87.96%	84.64%	59.26%	57.15%
Tier 3	83.28%	83.28%	90.85%	73.29%	90.00%

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

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

Care Management Penetration Rate

These data represent members enrolled in Standard Plans receiving care management through a Standard Plan, AMH, Care Management for At-Risk Children (CMARC) program or Care Management for High-Risk Pregnancies (CMHRP) program since Standard Plan launch (July 2021). These data are provided with a one-month lag (e.g., DY5Q1 ends Jan. 31; however, data are available only through December.)

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.

Percent of Total Care Management Provided by Entity

Period:	*July 1, 2022 - Dec. 31, 2022*		
Total Members Reported:	*1,885,061*		
Overall CM Penetration Rate	**13.2%**	**249,023 Members**	
Percent of care management provided by each entity:			
SP	**AMH3**	**CMARC**	**CMHRP**
15.4%	78.3%	2.1%	2.8%
38,298	194,907	5,145	7,093

***Source**: Members in table are derived from BCM051 Care Management Interaction report prepared by SPs and submitted to DHB.*

Care Management Penetration Rate by Entity

Period:	*July 1 - December 31, 2022*				
CM penetration rate by entity:					
	SP	**AMH3**	**CMARC**	**CMHRP**	**Overall**
Members with CM	38,298	194,907	5,145	7,093	**249,023**
Members assigned to entity	1,156,034	940,207	12,958	12,389	*1,885,061*
Penetration rate	**3.3%**	**20.7%**	**39.7%**	**57.3%**	**13.2%**

***Source**: All data in table are derived from BCM051 Care Management Interaction report prepared by SPs and submitted to DHB. 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 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, November 2022 – January 2023

AmeriHealth	CCH	Healthy Blue	Medicaid Direct	United	WellCare
62.59	64.21	59.72	75.61	62.20	61.30

Inpatient Admissions per 1,000 Members, November 2022 - January 2023

AmeriHealth	CCH	Healthy Blue	Medicaid Direct	United	WellCare
13.02	13.53	12.44	22.43	13.15	14.25

Results of beneficiary satisfaction surveys

NC Medicaid administers the Consumer Assessment of Healthcare Providers and Systems (CAHPS) health plan surveys annually to adult and child Medicaid beneficiaries to understand the Medicaid beneficiary experience and inform improvements in care. NC Medicaid respondents were contacted for participation in the 2022 CAHPS survey between June 7 and Oct. 11, 2022. Respondents provided feedback on their/their child's experiences with care and services over the prior six months. The overall adult response rate was 8.3% (1,029 eligible responses of 12,527 sampled) and the overall child response rate was 9.3% (1,305 eligible responses of 14,145 sampled). Rates were calculated for respondents in NC Medicaid Direct, PHPs, and the NC Medicaid program overall. The 2022 CAHPS results are the first time that the PHPs and the targeted populations were evaluated independently. Findings shared here focus on respondents in a PHP; at the time of the survey this meant that the respondents were enrolled in one of the five Standard Plans.

Key findings based on aggregate PHP results include:

- 73.2% of adult respondents and 84.1% of respondents answering for their child rated their/their child's health plan positively. 77% of adult respondents and 88.8% of child respondents rated all their health care positively. 84.5% of adult respondents and 89.2% of child respondents rated their personal doctor positively.
- The percentage of adult respondents who usually or always got care they needed was 81.2%. The percentage of child respondents who usually or always got care they needed was 82.8%.
- 82.7% of adult respondents said they usually or always got care quickly, and 85.1% of child respondents said they usually or always got care quickly.

- 93.5% of adult respondents reported their personal doctors usually or always communicated well with them. 91.7% of child respondents said their child's personal doctor usually or always communicated well with them.
- 87.3% of adult respondents usually or always had a positive experience with their health plan's customer service. 82.0% of child respondents usually or always had a positive experience with their child's health plan customer service.
- 85.5% of adult respondents and 82.2% of child respondents said their personal doctor/their child's personal doctor usually or always seemed informed and up to date about the care they received from other doctors or health providers.

There is no indication in these survey data that the transition to managed care has significantly impacted the overall experience of care being provided to NC Medicaid members relative to the quality of care received prior to the transition. However, NC Medicaid Direct respondents reported a significantly more positive experience with their care when compared to respondents in Standard Plans and the overall NC Medicaid Program. These differences may be due to differences in the respondent population mix between NC Medicaid Direct and the PHPs. The findings presented are subject to limitations in the survey design, analysis and interpretation. The 2022 results represent a baseline assessment of members' experiences specific to the PHPs and targeted populations. Caution should be used when interpreting or generalizing the findings.

Budget Neutrality and Financial Reporting Requirements

The Department will provide CMS with updated budget neutrality information through Jan. 31, 2023 in the next budget neutrality workbook submission.

Evaluation Activities and Interim Findings

The DY5Q1 reporting period activities have continued the evaluation work by the Sheps Center for Health Services Research. 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. The Sheps Center is working on an initial draft of the Interim SUD report, which will be submitted to the Department in early April. A summary of interim findings will be included in the DY5Q2 quarterly report.

Transition to Capitated Encounter Data from PHPs

Sheps Center data scientists and analysts have continued working with the encounter data which tracks utilization from NC Medicaid beneficiaries enrolled in Standard Plans. They have provided feedback on the quality and completeness of this data to the Department and continued to revise code on metrics to include services, medications and diagnoses received through either claims or encounter data. Sheps received a fix for the faulty file received previously from the state's data vendor for managed care and the revised data seems to meet most quality metrics.

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, and new files on care management data, value-based payment data and NCCARE360, the database that tracks HOP services and referrals. All data

sources are ingested into the University of North Carolina's (UNC) secure data warehouse and then linked to NC Medicaid member information to generate new metrics that will be tracked during the evaluation. 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. The evaluation will use Blue Cross and Blue Shield of North Carolina (BCBSNC) data as a control group for a limited number of metrics in part because of sparse data. Sheps is evaluating Arizona's Medicaid data as a potential comparison site. While Arizona and North Carolina are geographically distant, both states have large non-White populations. In addition, as the first state to implement managed care in Medicaid, Arizona has a mature managed care program, which may provide a suitable comparison as a reflection of where North Carolina's system is heading. Sheps is in the process of comparing some metrics between the two states to ensure that the trends in the metrics are moving in the same direction during the pre-implementation period, often referred to as the parallel trends assumption.

The evaluation team has continued refining the new dashboard on behavioral health metrics while updating the focused SUD dashboard monthly. Other dashboards specific to Foster Care plan members, individuals with intellectual and developmental disabilities, and physical/overall health metrics are planned.

Healthy Opportunities Pilot

Operational Updates

Introduction

This quarter, the Healthy Opportunities Pilots team prepared for the implementation of various programmatic initiatives, including the launch of Tailored Plans, the launch of care management activities for select Local Health Departments (LHDs) and an enrollment improvement strategy. There were multiple challenges with the implementation of these initiatives, and the Department and its partners executed mitigation strategies which have so far been highly effective.

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

The Department continued implementation activities with the four Tailored Plans participating in HOP. The Tailored Plans began development of the technical capabilities required to launch the program.

The Department also initiated activities with LHDs to onboard them to provide care management services within the pilot. This included routine check-ins and trainings on program operations and technology. LHDs began contracting with Standard Plans in this reporting period.

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

The number of enrolled members in HOP has trended behind the initial estimates established at the beginning of the Pilot. In response to this, the Department has developed a strategic improvement plan to increase enrollment and implemented several initiatives during this reporting period:

- Reduce Administrative Burden on Care Managers

    - Redesigned the Pilot consent process by creating a condensed consent form and an accompanying, detailed rights and responsibilities document.
- Improve the Pathways to Enrollment
    - Launched new NCCARE360 functionality, enabling a new pathway for NCCARE360 users who are not Care Managers to refer members for HOP services. This additional pathway is intended to provide community-based organizations and providers with a mechanism to directly refer members to their managed care organization.
    - Developed an expedited enrollment process with one PHP and one Human Services Organization (HSO). This process is expected to launch March 15, 2023, and significantly increase HOP enrollment numbers.
- Raise awareness of HOP
    - Began implementation of an iterative stakeholder engagement strategy. In partnership with the State's Area Health Education Center, the Department is providing HOP webinars for providers across Pilot regions. These webinars are meant to introduce the program and provide information on how to connect potentially eligible members to their care manager for screening and enrollment.

Additionally, due to competing priorities with Tailored Plan launch, the Tailored Plans notified the Department that they lacked capacity to complete the technical development needed to implement HOP at Tailored Plan launch. In coordination with the Tailored Plans, the Department developed a strategy that would enable Tailored Plans to launch the Pilot as expected. (These plans and the associated timeline will be revised due to the delay in Tailored Plan launch announced after this reporting quarter.)

Issues or complaints identified by beneficiaries

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

Unusual or unanticipated trends

No unusual or unanticipated trends to report this quarter.

Performance Metrics

Enrollee Service Costs

This is the first quarter in which the Department is reporting HOP enrollee service costs. Data contained within the enrollee service cost analysis represents invoices that had an invoice status of "paid" within NCCARE360 data received by the Sheps Center on Jan. 4, 2023. This data represents services delivered between March 15, 2022 and Nov. 30, 2022. In this timeframe there were 11,068 services provided at an amount invoiced of $1,754,102.67.

Previously we reported that there were discrepancies between the "amount paid" and "amount invoiced" in NCCARE360. Because of variances in the NCCARE360 amount paid, we calculated costs using NCCARE360 amount invoiced as it is the most current and reliable data source. NC Medicaid Encounter Claims data was considered but ultimately not used due to greater data lag.

Assessments found that members fell into disparate eligibility categories when completing multiple screening forms, even when the screenings were completed on the same day. Due to this, eligibility

category was determined by age at time of enrollment for age-based categories. If a beneficiary indicated they were pregnant on their screening form at any point in their enrollment, they were also placed in the pregnant individuals eligibility category. Individuals that did not fall into the pregnant individuals category and for whom an age could not be calculated (because they had no date of birth provided) were coded as having a missing eligibility category.

Ten largest invoiced amounts per individual beneficiary

Order	Total Amount Invoiced
1	$ 13,920.53
2	$ 12,481.38
3	$ 9,828.29
4	$ 9,700.05
5	$ 8,479.42
6	$ 6,900.14
7	$ 6,503.60
8	$ 6,054.15
9	$ 5,920.00
10	$ 5,478.23

Percentile amount invoiced per enrollee

Percentiles	Amount Invoiced
90%	$ 2,524.09
75%	$ 1,666.13
50%	**$ 950.88**
25%	$ 400.26
10%	$ 193.58

Percent of amount invoiced by PHP and service domain*

PHP	Food Services	Housing Services	Transportation Services
AmeriHealth Caritas North Carolina	13.30%	3.20%	0.28%
Blue Cross and Blue Shield of North Carolina	20.00%	10.57%	0.87%
*Carolina Complete Health***	3.60%	0.98%	0.02%
UnitedHealthcare of North Carolina	9.09%	2.17%	0.45%
WellCare of North Carolina	30.14%	4.73%	0.59%
Total	**76.13%**	**21.65%**	**2.21%**

* As of Jan. 4, 2023, no services for Interpersonal Violence/Toxic Stress had been paid

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

Percent of amount paid by PHP by Enrollment Category

PHP	Children 0 - 20	Adults 21+	Pregnant Women*
AmeriHealth Caritas North Carolina	6.65%	10.16%	0.15%
Blue Cross and Blue Shield of North Carolina	9.99%	21.38%	0.18%
*Carolina Complete Health***	1.59%	2.91%	0.10%
UnitedHealthcare of North Carolina	3.05%	8.67%	0.06%
WellCare of North Carolina	13.76%	21.71%	0.61%
Total	35.04%	64.83%	1.10%

Note: 0.11% of beneficiaries had enrollment category missing due to missing date of birth

*Pregnant beneficiaries will also appear in either children 0 – 20 or adults 21+

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

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

During this period, evaluation consisted of three main activities. The first was providing ongoing technical assistance and engagement to Department personnel to facilitate the HOP evaluation. Activities included participating in standing meetings and documenting emerging implementation themes to inform ongoing data collection and analysis.

The second key activity was working with the data team at Sheps to receive and analyze quantitative secondary data regarding Pilot activities. Data deliveries began in November 2022. Sheps data analysts established workflows and lines of communication across entities to support data processing for preparation of evaluation metrics to be used for dashboards and Rapid Cycle Assessment reports.

The third focus was primary data collection for evaluation questions 1 (lead pilot entity services delivery networks) and 4 (patient-reported health outcomes). For Evaluation Question 1, team members completed a final report for qualitative analysis of lead pilot entity interviews. Key findings will be integrated into the Rapid Cycle Assessment mixed methods report to be delivered to CMS in March 2023. For Evaluation Question 4, researchers obtained UNC IRB approval for pilot member telephone interviews for adults, parents and adolescents. Sheps also designed a data collection system for the longitudinal survey, which is expected to begin later this year after data workstreams are finalized.

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 May 1, 2023.