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).*

Table of Contents

Table of Contents 2
ANNUAL REPORT - DEMONSTRATION YEAR 5 4
Executive Summary 4
Medicaid Managed Care 7
Operational Updates 7
Key achievements 7
Standard Plans 7
Tailored Plans 8
Key challenges 9
Standard Plans 9
Tailored Plans 10
Issues or complaints identified by beneficiaries 11
Unusual or unanticipated issues 12
Lawsuits or legal actions 12
Legislative updates 13
Descriptions of post-award public fora 16
Performance Metrics 17
Outcomes of care 17
Quality of care 18
Access to care 22
Results of beneficiary satisfaction surveys 26
Budget Neutrality and Financial Reporting Requirements 27
Evaluation Activities and Interim Findings 27
Healthy Opportunities Pilots 28
Operational Updates 28
Introduction 28
Legislative updates 30
Performance Metrics 30
Pilot Enrollee Costs 30

Healthy Opportunities Pilot Evaluation Activities and Interim Findings 32
DEMONSTRATION YEAR 5 QUARTER 4 REPORT 33
Executive Summary 33
Medicaid Managed Care 34
Operational Updates 34
Key Achievements 35
Standard Plans 35
Tailored Plans 35
Key Challenges 35
Standard Plans 35
Tailored Plans 35
Issues or complaints identified by beneficiaries 36
Lawsuits or legal actions 37
Legislative updates 38
Performance Metrics 41
Outcomes of care 41
Quality of care 41
Access to care 41
Results of beneficiary satisfaction surveys 44
Budget Neutrality and Financial Reporting Requirements 44
Evaluation Activities and Interim Findings 44
Healthy Opportunities Pilot 45
Operational Updates 45
Unusual or unanticipated trends 46
Performance Metrics 46
Healthy Opportunities Pilots Evaluation Activities and Interim Findings 46
Residential and Inpatient Treatment for Individuals with a Substance Use Disorder 47

ANNUAL REPORT - DEMONSTRATION YEAR 5

Executive Summary

This annual report covers Demonstration Year 5 (DY5) of the North Carolina Medicaid Reform Demonstration, Nov. 1, 2022, through Oct. 31, 2023.

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) referred to as Standard Plans: AmeriHealth Caritas, Healthy Blue of North Carolina, UnitedHealthcare of North Carolina, WellCare of North Carolina and Carolina Complete Health. Standard Plans are now in their third contract year, and the Department's focus is on closely monitoring plan performance and ensuring compliance with contract agreements. Identified issues are addressed through formal notification by the Department and the imposition of remedial actions (e.g., corrective action plans, audits), intermediate sanctions, and/or liquidated damages, as appropriate.

North Carolina passed Medicaid expansion in March 2023, with the provision that expansion could not take effect until the state budget passed. The state budget was enacted on Oct. 3, 2023, and the Department announced that Medicaid expansion would go live on Dec. 1, 2023, making an additional 600,000 North Carolinians eligible for NC Medicaid. The Department issued a Medicaid Expansion Impact document to the Standard Plans to provide an overview of expansion and identify the steps needed prior to implementation and downstream impacts. It's expected that 90-95% of the expansion population will be enrolled in a Standard Plan.

Tailored Plans

The original July 1, 2022 launch date for the Behavioral Health Intellectual/Developmental Disability Tailored Plans (Tailored Plans) has been delayed several times to allow Local Management Entities-Managed Care Organizations (LME/MCOs) more time to contract with additional providers and validate that data systems needed for launch are working. Beneficiaries who will be covered by the Tailored Plans continue to receive behavioral health, intellectual/developmental disability (I/DD), traumatic brain injury (TBI) and physical health care through NC Medicaid Direct.

On Feb. 27, 2023, the Department delayed the launch of Tailored Plans until Oct. 1, 2023. On July 11, 2023, the Department announced that the launch would be further delayed, with a new date to be determined, in part due to uncertainty around passage of the state budget. Now enacted, the state budget requires the launch of Tailored Plans no later than July 1, 2024. The Department is re-baselining implementation activities for the new launch date. The legislation also requires that the Children and Families Specialty Plan (CFSP) is launched by Dec. 1, 2024.

While the launch of Tailored Plans was delayed, the Department and LME/MCOs supported providers of Tailored Care Management (TCM) to launch their services on Dec. 1, 2022. Through the innovative TCM

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.

The state budget contained language directing the Secretary for the North Carolina Department of Health and Human Services to reduce the number of LME/MCOs to either four or five organizations. Shortly after, Sec. Kinsley announced that Sandhills Center would be dissolved, and Eastpointe and Trillium Health Resources would consolidate. The consolidation will result in four LME/MCOs – Alliance Health, Partners Health Management, Trillium Health Resources and Vaya Health – and will take effect Feb. 1, 2023.

Healthy Opportunities Pilot

Healthy Opportunities Pilot (HOP) service delivery began on March 15, 2022. HOP operates in three regions that collectively cover 33 counties in North Carolina. As of the end of September 2023, HOP had served 8,491 members who received a total of 121,166 services.

Most service domains – food services, housing and transportation, and toxic stress and cross-domain services – launched in 2022. On April 5, 2023, HOP launched the remaining interpersonal violence (IPV) and cross-domain IPV services, including IPV case management, violence intervention services, holistic high intensity case management, and linkages to health-related legal supports for IPV. The launch of IPV services was the culmination of a two-year process through which the Department worked with the NC Coalition Against Domestic Violence, their legal counsel, and additional stakeholder groups to develop programmatic and technical modifications for the safe delivery of IPV services to eligible members.

At the beginning of this DY, HOP member enrollment was trending behind the initial estimates established at the beginning of the Pilot. In response, the Department developed a strategic improvement plan to increase enrollment that focused on reducing the administrative burden for care management teams and members, improving referral pathways to allow community-based organizations to make referrals to the Standard Plans, developing a more robust communications strategy, and implementing a direct-to-consumer enrollment model with one human service organization (HSO) for a small subset of services. Member enrollment increased substantially in DY5Q4 and is now in line with original estimates.

The HOP team is currently conducting implementation activities with the LME/MCOs, Advanced Medical Home Plus (AMH+) practices and Care Management Agencies (CMAs) to launch HOP for the TCM-eligible NC Medicaid Direct beneficiary population.

Changes to the 1115 Demonstration

On July 7, 2023, CMS approved an amendment to North Carolina's Medicaid Reform Section 1115 Demonstration. The demonstration amendment authorizes North Carolina to make changes to the Tailored Plan design to ensure Tailored Plan members maintain access to critical residential services and clarifies that only dually eligible individuals enrolled in the Innovations or TBI waivers will enroll in Tailored Plans.

On October 31, 2023, North Carolina submitted its final application to renew its 1115 demonstration for another five-year period to CMS. North Carolina is requesting the following in its application:

- Extensions of ongoing managed care authorities
- An expansion of and refinements to the HOP program, building on successes to date
- Implementation of four new initiatives in line with the state's overarching goals focused on streamlining Medicaid enrollment for children and youth, improving care for justice-involved individuals, investing in behavioral health technology, and bolstering the behavioral health and long-term services and supports (LTSS) workforce

Medicaid Managed Care

Operational Updates

Key Achievements

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 Medicare 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.
3. The Department issued a Medicaid Expansion Impact document to the Standard Plans to provide an overview of Expansion and identify the steps needed prior to implementation and the downstream impacts.
4. Among Standard Plan members, 22% received care management services by the end of the contract year (June 2023), meeting the Department's target. The percentage of members receiving care management increased steadily quarter over quarter throughout the contract year. (Detailed information is available in the Performance Metrics section of this report.)
5. The Department approved a withhold program for Standard Plans to encourage them to perform beyond minimum performance compliance thresholds in priority areas. In a withhold program, a portion of plans' expected capitation payment is withheld, and plans must meet quality performance targets to receive the withheld funds from the state at the end of the performance period. The withhold program will begin in 2024 and includes the following measures:
   - Childhood Immunization Status: Percentage of children receiving 10 recommended vaccines by their second birthday. 70% of the withheld dollars for this rate are dedicated to reducing the disparity in immunization rates for Black members. To earn back the full amount of withheld funds, the plan must improve performance for the priority population by a relative 10%.
   - Prenatal and Postpartum Care:

    - Timeliness of Prenatal Care: Percentage of deliveries in which women had a prenatal care visit within the first trimester
    - Postpartum Care: Percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery
  - Screening for Health-Related Resource Needs: Unlike the above measures, for which performance will be used to determine withholds, designation of whether the data reported for this measure is valid determines withholds for this measure.

6. To increase the capacity for Non-Emergency Medical Transportation (NEMT), the Department conducted a review process with Managed Care plans and Lyft which resulted in the successful addition of Lyft as an NC Medicaid NEMT provider.
7. The state budget enacted Oct. 3, 2023 adds several SUD services (substance abuse comprehensive outpatient treatment, substance abuse intensive outpatient treatment, and social setting detox) to the services covered by Standard Plans. This was a recommendation from a workgroup convened by the Department with Standard Plans and LME/MCOs to ensure that Standard Plan members can obtain intensive SUD services without delay before moving to a Tailored Plan.

Tailored Plans

1. Tailored Care Management (TCM) launched on December 1, 2022 with 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 could change their TCM provider or opt out of the service.
2. The Department closed out all remaining open items that were identified during the onsite readiness reviews in July and August 2022. Due to the delay of Tailored Plan launch, The Department postponed a second round of on-site readiness reviews with the Tailored Plans scheduled for July 2023. Now that a new launch date is established, the previously identified focus areas for the reviews will be revalidated.
3. The Department met with all Tailored Plans on specific amendment item language to be included as part of the second amendment to the Tailored Plan Contract. The amendment was completed with all six plans by June 27, 2023. Changes in the amendment included but were not limited to:
   - Revisions to scope of services in areas including claims and encounters; value-based payments; provider payments, grievances, appeals and contracting; TCM; overall benefits package, including pharmacy benefits; AMHs as Primary Care Providers (PCPs) for members; and member grievances and appeals
   - Revisions to quality metrics
   - Revisions to operational reporting requirements

- Revisions to performance metrics, service level agreements and liquidated damages

4. To date, Tailored Plans have submitted a total of 3,088 deliverables. This quarter, Tailored Plans submitted 243 deliverables, with 302 Inbound Deliverables finalized. Reviewers from across the Department have gone through iterative reviews of each submitted deliverable and provided feedback to individual plans to address questions or unmet requirements prior to submitting final versions for approval.
5. After the July 2023 announcement that Tailored Plan launch would be delayed, the Department implemented the necessary changes to pause go-live. Business units worked with Tailored Plans to establish a Tailored Plan Delay FAQ process that addressed impacts to implementation work. Through this process, the Department addressed all questions and communicated responses back to the Tailored Plans.
6. Technology Deployment Status Trackers were implemented by the Department to aggregate pre- and post-technology deployment activities and feedback more efficiently from each Tailored Plan. The Trackers provide each Tailored Plan a full list of technology integrations that are part of their scope and a weekly inventory based on all approved Change Requests involving technology integrations and deployments. The Trackers also allow the Tailored Plans to provide the Department real-time updates on the plan's ability to go live with a technology integration. Overall, the Trackers have reduced the number of meetings required while achieving better oversight and transparency between the Department and Tailored Plans.

Key Challenges

Standard Plans

1. The Department continues to review Standard Plans' Provider Network Files (PNFs) for accuracy and completeness, which is necessary to ensure provider directory accuracy and appropriate assignment of NC Medicaid beneficiaries. Corrective Action Plans (CAPs) were opened for four Standard Plans in Spring 2022 to address PNF errors, which included a requirement that plans submit monthly self-audits to report on their errors and progress. Three of the four plans had Additional Action NODs sent, with liquidated damages assessed for failure to remove providers not active in NC Medicaid from the PNFs. Additional Action NODs are issued when a previous notice has been issued to the Plan on the same issue of non-compliance and the Department has determined that additional actions are required to ensure compliance. After multiple working sessions, significant improvements were made with Standard Plans who struggled with timely removal of non-active providers from their PNFs. Additionally, the Department included a new liquidated damage in the most recent contract amendment for plans that do not submit missing PNFs to the Department daily.

2. Additional Action Notices of Deficiencies (NODs) were issued for Annual Network Adequacy Deficiencies and for Network File Discrepancies for three of the five Standard Plans in DY5Q2. In February 2022, each of the five Standard Plans was issued an initial 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.
3. In DY5Q4, NODs were issued to three Standard Plans for Privacy and Security and to four Standard Plans for Call Center SLA Noncompliance for the period of January – June 2023. Plans are required to submit a Corrective Action Plan (CAP) when a NOD is issued, if requested by the Department. A CAP must include a description of how the issue will be remediated and the timeline for the implementation of the corrective actions. Once a Plan submits a CAP and it is approved by the Department, the Department will monitor the actions identified until the issue has been resolved.

Tailored Plans

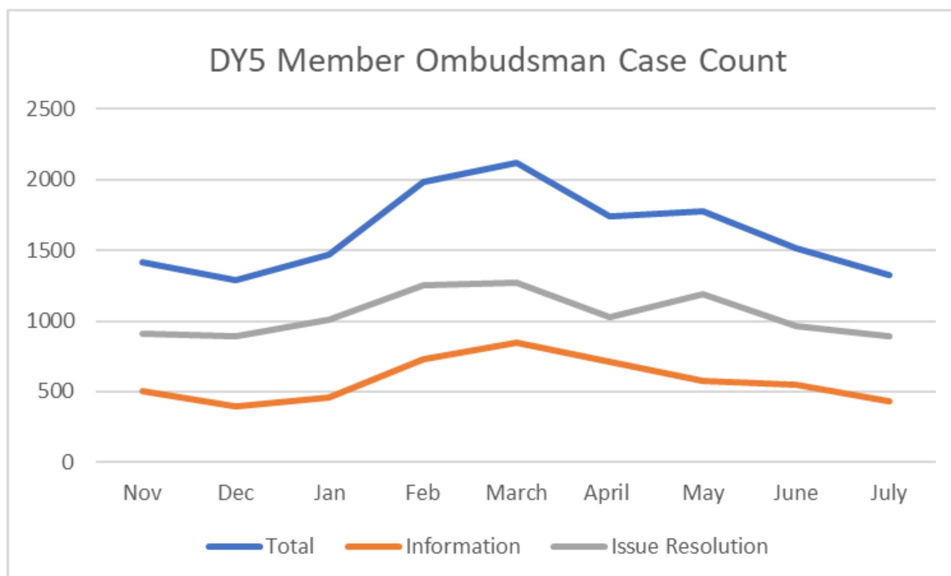
1. Network Adequacy and Provider Contracting: Provider network coverage and its impact on PCP choice and assignment is an area of concern across the Tailored Plan program and was a major factor in the decision to delay the Tailored Plan launch. Since Tailored Plans started submitting monthly reporting on provider contracting in early May 2022, results have not met network adequacy standards across all the required provider categories. The Department issued a Provider Contracting Notice of Concern that was sent to the plans in August 2022 to provide greater visibility into how Tailored Plans are addressing this challenge. Tailored Plans have shown improvement across provider categories tracked in the Notice, although one Plan still has not met PCP contracting targets. The Notice was closed for the remaining five plans in August 2023 as they met preliminary contracting targets set forth in the Notice. The Department continues to work to mitigate risk through the following methods:
    - Close tracking of provider contracting data in the Weekly Scorecards
    - Monitoring of monthly AMH/PCP and hospital contracting submissions, and other specialties from the monthly network submission
    - Monitoring monthly contracting data submitted in response to the Notice of Concern still in place for one of the plans
    - One-on-one calls with the Tailored Plans to get more frequent updates on both contracting progress and challenges
    - Utilizing the Provider Engagement and Communications team to clarify 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

2. Tailored Care Management Auto-Assignment: The Department has been working closely with the LME/MCOs to improve their readiness to independently support TCM Auto-Assignment since April 2023, a process that they will continue to perform for the Tailored Plan population upon Tailored Plan launch. The goal is to reach a point where all LME/MCOs, without direction from the Department, can correctly identify and assign newly eligible members and identify and reassign members who had a change in eligibility or overall care needs.

   Currently, there are three LME/MCOs that have been approved to submit daily assignments directly to NC FAST. Of the remaining LME/MCOs, two are required to submit reassignments to the Department for pre-approval prior to NC FAST submission, and one submits assignments to NC FAST on a bi-weekly basis with Department oversight. With the Department's guidance these LME/MCOs have improved the accuracy of their reassignments, but they must show further progress before being approved to submit directly to NC FAST.

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 Member Ombudsman is an independent organization that provides education, guidance and referrals to NC Medicaid beneficiaries. Not all Ombudsman cases should be interpreted as complaints, as many involve educating beneficiaries or connecting them to the entity that can provide the service they need. In DY5, the Ombudsman handled 19,830 cases, an increase of approximately 15% from DY4. Out of the total cases, roughly one third were for members seeking information and two thirds were for issue resolution. (See Appendix A for a full list of cases by category type.)



The Office of Administration largely handles cases referred from state legislative offices. In previous monitoring reports, all constituent concerns handled by the Office of Administration were reported, including those from non-beneficiaries (such as providers). As of DY5Q1, only concerns from NC Medicaid beneficiaries are included. This change significantly lowers the number of reported concerns compared to the previous DY.

Office of Administration Member Concerns, DY5

Issue Category	Number of Issues
Behavioral Health	3
Clinical/Medical Health	9
Claims	5
Eligibility	7
NEMT	2
Pharmacy	1
PHP Auto-Assignment	1
PHP Physician Search	1
Total	**29**

Unusual or unanticipated issues

1. In November 2022, 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 approximately 27,000 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. This corrected notice was mailed November 21- 23, 2022. Additionally, the Enrollment Broker conducted an outbound dialer campaign from November 18-23, 2022 to inform beneficiaries of this error and to let them know they will receive a confirmation notice in the mail correctly showing the enrollment with the LME/MCO.

Lawsuits or legal actions

Samantha R., et al. v North Carolina and the Department of Health and Human Services, is a lawsuit by Disability Rights NC (DRNC) which was filed in 2017 alleging that the state failed to make sure people

with intellectual and developmental disabilities could get essential services in their communities. A ruling in November 2022 required the state to expand services to the 16,314 people on the waiting list for Innovations Waiver slots; address and resolve the shortage of direct care workers who provide community-based support; assist 3,000 people who want to leave or avoid institutional settings, and cease new admissions to institutions after 6 years except for respite or short-term stabilization; and provide quarterly reports about each measure and post data regarding the State's progress. After the State appealed the ruling and following mediation, the parties agreed to work on a proposed consent order to submit to the Court that would resolve the appeal. Proceedings are stayed pending submission of the proposed consent order.

Legislative updates

Legislative updates for DY5 are listed below:

S.L. 2023-7, enacted March 27, 2023, makes various financing changes related to managed care:

- Section 1.4 establishes a healthcare access and stabilization program as a directed payment program that provides acute care hospitals with increased reimbursements funded through hospital assessments.
- Section 1.7.(d) revises the managed care component of the Hospital Assessment Act due to adoption of Medicaid expansion.

S.L. 2023-65, enacted June 29, 2023, makes technical changes to various statutes that intersect with managed care:

- Section 5.1 replaces a list of Medicaid recipients that LME/MCOs temporarily continue managing services for after Standard Plan launch, but before Tailored Plans launch, with a category of recipients who are not enrolled in a Standard Plan. The legislation also makes conforming changes and technical changes to various definitions.

S.L. 2023-134, the Current Operations Appropriations Act of 2023, enacted October 3, 2023, makes various changes related to the structure of managed care in NC Medicaid:

- Section 9E.16.(a1)-(a2) requires BH/IDD tailored plans to begin no later than 07/01/2024; repeals the planned 12/01/2022 start date.
- Section 9E.16.(b1) requires DHB to submit a proposal to open LME/MCO networks by the time BH/IDD tailored plans begin.
- Section 9E.16.(b2)-(b6) amends Article 3 of G.S. 108D to permit Medicaid Direct and Tailored Plans to have a closed network until Tailored Plans begin for MH/IDD/SUD and TBI services, unless DHHS identifies services that need improved access. Permits closed network for LME/MCOs operating 1915(b)/(c) or 1915(i) services.
- Section 9E.16.(c) requires the Department of Health Benefits (DHB) to submit a proposal to transition CAP/DA to Tailored Plans by 01/01/2025.
- Section 9E.16.(d) requires DHB to apply to expand TBI waiver across the state on 01/01/2025 or any later date approved by CMS.

- Section 9E.16.(e) requires DHB to submit a proposal to seek 1115 waiver to provide services to the adult incarcerated population, to be managed under Tailored Plans, by 01/01/2025.
- Section 9E.18 directs DHB to seek CMS approval to amend the Innovations Waiver CCP to allow Community Living and Support services to be provided by a relative living in the same home as a beneficiary under 18 years of age when no other provider is available.
- Section 9E.19.(a) amends Section 9D.9 of SL 2022-74 to require that DHB submit State Plan amendments necessary for new Medicaid coverage of behavioral health services by LME/MCOs to beneficiaries awaiting hospital discharge with proposed start date of March 1, 2023. Directs DHB to implement services and rates as soon as operationally feasible after CMS approval and to retroactively implement services and rates to the date approved by CMS. (Note: DHB withdrew the state plan amendment on June 26, 2023, upon receiving CMS communication that it would be recommended for disapproval.)
- Section 9E.19.(a1) exempts Standard Plans from covering behavioral health services provided to beneficiaries awaiting hospital discharge. Extends the start date of LME/MCO coverage to 03/31/2023.
- Section 9E.20 directs DHB to develop performance standards and metrics for claims payment within a set number of days for PHPs and to annually report to the General Assembly on each PHP's performance.
- Section 9E.22 et seq. establishes the start of Children and Families Specialty Plan (CFSP) on December 1, 2024; codifies the specifics of CFSP eligibility, enrollment/disenrollment, services, and networks; and identifies entities that can bid on the contract and other details.
- Section 9E.22.(d) permits Tailored Plan enrollees to request disenrollment without cause at any time.
- Section 9E.22.(g) amends G.S. 108D-35(b) to limit 1915(b)(3), 1915(b) and (c) waiver and 1915(i) services to be covered only under the LME/MCOs; adds SACOT, SAIOP, and social setting detox to services to be covered by Standard Plans.
- Section 9E.23.(a1)-(a2) amends G.S. 108A-68.2 to require each PHP to develop a lock-in program for beneficiaries who obtain controlled substance prescriptions from 4 or more providers, or 10 or more covered substance prescriptions in two consecutive months when not medically necessary. Requires the beneficiary receive written notice and appeal rights before being locked-in to up to two prescribers and two pharmacies that they choose from the PHP network. Lock-in period is two years.
- Section 9E.23(b) Amends G.S. 150B-1(e)(25) to exclude from Office of Administrative Hearings disputes arising under the PHP, PIHP, or PCCME contract.
- Section 9G.7A.(a1) enacts G.S. 122C-115.5 to authorize the Secretary to direct dissolution of an area authority upon Tailored Plan termination or noncompliance under 122C-124.2. Other subdivisions of this section make confirming changes and address the details of the dissolution of an area authority. Only the most important ones are reflected below:
  - Section 9G.7A.(a6) amends 122C-115 to require a minimum catchment area population of 1.5 million; repeals reduced funding or reassigned management for noncompliance

with minimum population requirements; repeals authority to adopt rules for county disengagement and approval; repeals ability to add counties by resolution and Secretary approval.

- Section 9G.7A.(a7) repeals 122C-115.2 (LME/MCO business plans) and conforming sections, 122C-115.3 (Dissolution of area authority), 122C-124.1 (Actions by the Secretary when area authority or county program is not providing minimally adequate services). Other sections make confirming changes throughout the North Carolina General Statutes.
- Section 9G.7A.(a9)-(a10) repeals 122C-125 (Area Authority financial failure; state assumption of financial control) and 122C-125.2 (LME/MCO solvency ranges; formula; corrective action plan).
- Section 9G.7A.(a11) enacts G.S 122C-125.3 to require contracts with LME/MCOS establish solvency standards and a corrective action plan where not met; requires monthly financial reports from LME/MCOs; directs the Department to publish to its website LME/MCO solvency and corrective action plan information each quarter.
- Section 9G.7A.(a14) amends G.S. 108D-60 to repeal ability for counties of an area authority to change LME/MCOs or for LME/MCOs to merge or be acquired prior to Tailored Plan start. Also amends this section to permit enrollees of dissolved area authority to be served by another Tailored Plan, area authority being dissolved under a capitated or other arrangement authorized by G.S. 108D-60(b), fee-for-service, Standard Plan or other system allowed under State law for Medicaid delivery.
- 9G.7A.(a20) directs the Secretary to reduce the number of LME/MCOs to 4 or 5 by dissolution, merger, or consolidation which is to be effective within 90 days of the effective date of this legislation (10/03/2023). Reserves authority for further consolidation in the future.
- 9G.7A.(b3) enacts G.S. 108D-46 to permit counties to request realignment with a different area authority no earlier than 6 months before RFP issuance for the next Tailored Plans contract term.
- Section 9G.7A.(c1)-(c3) amends various statutes to enhance Secretarial authority to have an area authority’s subcontractor’s staff removed to achieve compliance with State and federal law.

Aside from the Current Operations Appropriations Act of 2023, other session laws were enacted that impact how NC Medicaid has structured managed care:

- Section 15 of S.L. 2023-125, enacted September 29, 2023, requires standard plans and Tailored Plans to cover HCPCS procedure code G0330 because it is a surgical procedure and not a traditional dental procedure.
- Section 5.1.(a)-(b) makes technical change to G.S. 122C-115(e) to require LME/MCOs to stop managing services for beneficiaries enrolled in Standard Plans except that until Tailored Plans

begin they may continue managing services under the combined 1915(b)/(c) if the beneficiary is not enrolled in a Standard Plan.

Additional sections of various session laws summarized below have an incidental impact on managed care implementation but do not change the structure of managed care:

- Sections 1 and 2 of S.L. 2023-115, enacted Aug. 24, 2023, prohibit reduction in services provided at Adult Developmental and Vocational Programs or Community Rehabilitation Program without stakeholder input and funding a robust array of services that reflect choice. Also prohibits reduction in admissions until current services are reviewed and new services are approved.
- Section 9E.10 of S.L. 2023-134 increases Innovations Waiver slots by 350. It also repeals S.L. 2021-180, s. 9F.14 (group home stabilization) but allows services developed under this 9F.14 to continue if the program stays on budget.
- Section 9E.11 of S.L. 2023-134 continues skilled nursing facility rates that were in place on March 15, 2023.
- Section 9E.12A of S.L. 2023-134 increases private duty nursing rates to $13.00/15 minutes.
- Section 9E.13 of S.L. 2023-134 increases durable medical equipment rates so long as the increase does not exceed $1 million over twelve months.
- Section 9E.15 of S.L. 2023-134 increases rates for Medicaid enrolled provider and approved financial manager/financial support agencies under self-directed option so that Innovations Waiver direct care workers receive wages of $6.50/her above the state's industry average. Requires the capitation rate paid to LME/MCOs to be increased. Requires LME/MCOs to secure attestation/verification that the rate increase will be used for increasing hourly wages and any payroll costs.
- Section 9E.24 of S.L. 2023-134 directs DHB to set and adjust rates for licensed ambulatory surgical centers to 95% of the Medicare Ambulatory Surgical Center fee schedule in effect on January 1 of each year.

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

Outcomes of care

The Department planned 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. Hemoglobin A1c (HbA1c) Control for Patients with Diabetes 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 HealthConnex, North Carolina's statewide health information exchange, in order to report this measure.

CAHPS measures do not reflect a full calendar year, as the survey was administered June 7, 2022, and Oct. 11, 2022. Members were asked to think about services received *in the past 6 months* when answering survey questions.

Measure/Measure Steward	**Description**	**2019**	**2020**	**2021**	**2022**
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%	87.2%
	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%	89.4%

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

Quality of care

North Carolina measurement year 2022 quality measure results are reported below, along with results from previous years. 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.

The Department continues to work on statewide performance improvement projects with the Standard Plans related to increasing Immunizations in Children, Early Access to Prenatal Care, Postpartum Care, Diabetes Control for Adults and Screening for Health Related Resource Needs.

Measure/Measure Steward	Description	2019	2020	2021	2022
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%	48.49%
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%	28.65%
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%	29.63%
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%	44.18%

Measure/Measure Steward	Description	2019	2020	2021	2022
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%	61.56%
	Percent with two or more well-child visits from 15 to 30 months	NA	70.8%	66.4%	66.75%
Total Eligibles Receiving at Least One Initial or Periodic Screening/ NCDHHS[3]	Rate of preventive dental service use by children and adolescents in NC. Higher rates are better on this measure.	53%	44.5%	NA	54.58%
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%	48.15%
	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%	60.10%
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%	51.41%
	Percentage of children and adolescents on antipsychotics who received cholesterol testing	37.7%	34.1%	35.4%	34.25%

Measure/Measure Steward	Description	2019	2020	2021	2022
	Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	34.9%	31.0%	32.61%	32.05%
Prenatal and Postpartum Care (PPC)/ NCQA[4]	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%	41.86%
	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%	60.79%
Cervical Cancer Screening (CCS)/ NCQA	Women ages 21-64 who had cervical cytology performed every 3 years.	43.82%	42.83%	40.7%	38.47%
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%	56.61%
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%	29.05%
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	50.1%
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%	.7674
Controlling High Blood Pressure (CBP)/NCQA[5]	Percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was	N/A	4.58%	24.62%	40.92%

Measure/Measure Steward	Description	2019	2020	2021	2022
	adequately controlled (<140/90) during the measurement year.				
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%	58.11%
	Effective Continuation Phase Treatment: Adults who remained on an antidepressant medication for at least 180 days (6 months).	39.3%	41.6%	33.9%	36.43%
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%	76.69%
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%	60.85%
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%	90.3%
	Composite measure (child): Respondents were asked, "In the last 6 months, how	78.8%	NA	85.9%	82.5%

Measure/Measure Steward	Description	2019	2020	2021	2022
	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?"				
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%	88.2%
	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%	83.0%

[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]The 2022 rate for this measure is the Standard Plan aggregate rate.

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

[5]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.

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).

Care Management Penetration

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).

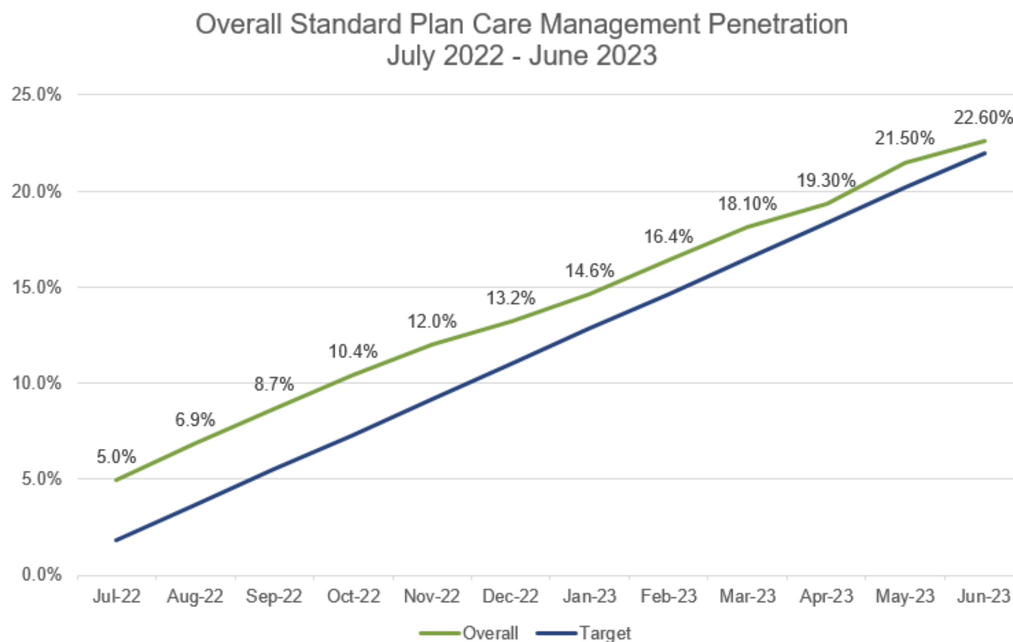
CMHRP is the Department's primary vehicle to deliver care management to pregnant women who may be at risk for adverse birth outcomes. CMARC offers a set of care management services for at-risk children ages 0 to 5. Both services are performed by local health departments (LHDs) as delegates of the Standard 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 the CMARC and CMHRP programs.

As the Standard Plan contract year does not align with the waiver demonstration year, rates are provided below for the most recently completed contract year, Contract Year 2 (July 2022 – June 2023). Rates for the first three months of Contract Year 3 (July 2023 – September 2023) are provided in the DY5Q4 section of this report. The target of 22% of Standard Plan members receiving care management services in Contract Year 2 was achieved. This is a significant improvement over the previous contract year, in which the overall care management rate was 17%, below the Department's target rate of 20% for that year.

Care Management Penetration by Entity, Contract Year 2

Period: July 1, 2022 - June 30, 2023			
Total Members Reported:	*2,005,602*		
Overall CM Penetration	**22.6%**	**453,971 Members**	
	Percent of care management provided by each entity:		
	SP	**AMH3**	**LHD**
Percent of members	18.6%	78.8%	14.4%
Number of members receiving at least one care management interaction with entity	84,240	357,842	65,312

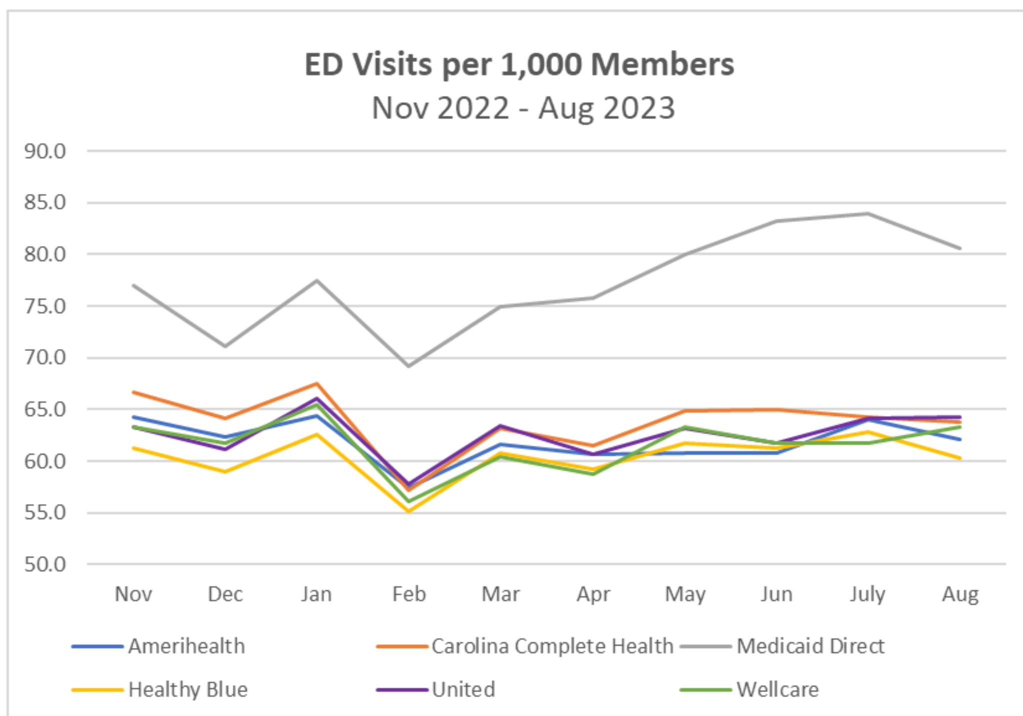
Overall Care Management Penetration, Contract Year 2

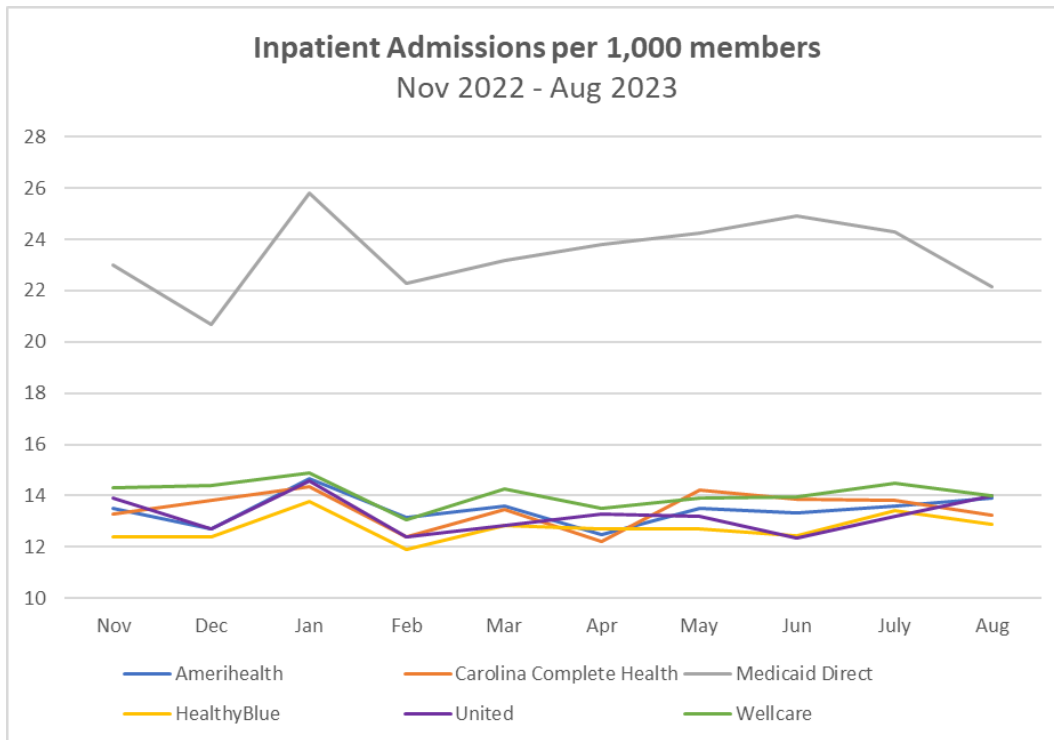


Emergency Department Visits per 1,000 Members and Inpatient Admissions per 1,000 Members

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 two months behind the quarterly monitoring schedule. Therefore, the rates below cover November 2022 to August 2023. 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.





Results of beneficiary satisfaction surveys

The Department released the results of the 2022 *Consumer Assessment of Healthcare Providers and Systems* (CAHPS) surveys in July 2023. NC Medicaid administers the CAHPS surveys to adult and child Medicaid beneficiaries to understand the Medicaid beneficiary experience and inform improvements in care. Results were used to assess the experience of three key member populations: adults, general children, and children with chronic conditions (CCC).

Respondents were contacted for participation in the survey between June 7, 2022, and Oct. 11, 2022, and were asked to think about services they/their child received in the past 6 months when answering all survey questions. The 2022 survey is the first CAHPS survey to capture members' experience with Standard Plans, as the 2021 survey period took place when members were still in Medicaid Direct or had just transitioned to a Standard Plan. The overall response rate was 8.7%, the adult response rate was 8.3% and the child response rate was 9.3%. It should be noted that response rates for CAHPS surveys have been declining nationally in recent years. Key findings include:

- Across the NC Medicaid population, a majority of respondents rated all their health care positively. When compared to the national average, however, different experiences emerged within groups. When compared to the national average:

 - Parent/caretaker respondents of children in Medicaid Direct reported significantly more positive experiences with *How Well Doctors Communicate*, but significantly worse experiences with *Rating of Health Plan*.
 - Parent/caretaker respondents of children with chronic conditions in the Tailored Plan Eligible population (i.e., those with more severe behavioral health conditions) reported significantly poorer experiences across measures such as *Rating of all Health Care* and *Rating of Health Plan*.
 - Parent/caretaker respondents of children who received enhanced behavioral health services while enrolled in a Standard Plan reported significantly poorer experiences with *Care Coordination*

- Overall, adult respondents' positive experiences with their health plan, personal doctor, health plan's customer service, and *getting care quickly* have consistently increased from 2019 to 2022 for the NC Medicaid Program.
- The percentage of parents/caretakers of general child members reporting a positive experience with their child's overall health care consistently increased from 2018 to 2022. However, their rating of their experiences with their child's personal doctor, receiving needed care for their child, and receiving care quickly for their child consistently decreased from 2019 to 2022.
- Parents'/caretakers' of CCC members rating for getting needed information for their child consistently increased from 2018 to 2022, while their experiences accessing specialized services and prescription medications for their child consistently decreased from 2018 to 2022.
- Medicaid Direct respondents reported significantly more positive experience with care when compared to the Standard Plans in Aggregate and the NC Medicaid program as a whole.
- When compared to NCQA national percentiles, the NC Medicaid Program as a whole and Standard Plans in Aggregate scored fairly well across the measure domains for the adult populations; however, both scored poorly across the measure domains for the general child and CCC populations. The *Rating of Health Plan* and *Getting Needed Care* measures were the lowest performing measures.

Budget Neutrality and Financial Reporting Requirements

The next budget neutrality workbook will be submitted to CMS by March 31, 2024.

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. This DY, Sheps completed the SUD Interim Evaluation Report, which was submitted to CMS June 8, 2023, and the Managed Care Interim Evaluation Report, which was submitted Oct. 5, 2023.

Transition to Capitated Encounter Data from PHPs

Sheps Center data scientists and analysts have now been working with the encounter data from beneficiaries enrolled in Standard Plans for more than two years. In April 2023, Sheps began receiving encounter data from the LME/MCOs. The LME/MCOs changed the platform through which their claims are submitted to align with Standard Plan data submission. Because of quality issues, the Department has not yet released data from at least two LME/MCOs. Metrics will be incomplete beginning on April 1, 2023, until the full data set is released.

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, in addition to files on care management data, value-based payments and NCCARES360, the database that tracks HOP services and referrals.

All data sources are ingested into the University of North Carolina's secure data warehouse and are beginning to 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 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 Blue Shield North Carolina data as a control group for a limited number of metrics in part because of sparse data. Sheps is considering Arizona's Medicaid data as a potential comparison site. While Arizona and North Carolina are geographically distant, both states have considerably large non-White populations, and Arizona was the first state in the nation to implement managed care in Medicaid. As a mature managed care program, it may be a suitable comparison as a reflection of where NC's system is going. Sheps is comparing 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.

Qualitative Update

The qualitative team completed its third round of provider interviews May 31, 2023. Additionally, the team conducted one Spanish language focus group (with four member participants), one Spanish language member interview, and 24 English language member interviews. The summary results for both the provider and beneficiary 2023 interviews have been disseminated. Interviews with PHPs and NCDHHS staff are planned for November/December 2023. Additional interviews with beneficiaries are planned for Spring 2024.

Healthy Opportunities Pilots

Operational Updates

Introduction

In DY5 HOP launched the remaining interpersonal violence (IPV) and cross-domain services, successfully increased enrollment after implementation of numerous enrollment strategies, and prepared to launch

the Pilots for NC Medicaid Direct members who are eligible for TCM. Additionally, the first HOP Rapid Cycle Assessment was submitted to CMS on Mar. 24, 2023.

Key achievements

Launch of Interpersonal Violence Services

On April 5, 2023, HOP launched interpersonal violence (IPV) and IPV-related cross-domain services, completing the implementation of all service domains. IPV services include IPV case management, violence intervention services, holistic high intensity case management, and linkages to health-related legal supports for IPV. The launch of IPV services was the culmination of a two-year process through which the Department worked with the NC Coalition Against Domestic Violence, their legal counsel, and additional stakeholder groups to develop programmatic and technical modifications for the safe delivery of IPV services to eligible members.

Strategic Plan to Increase Enrollment

At the beginning of this DY, HOP member enrollment was trending behind the initial estimates established at the beginning of the Pilot. In response, the Department developed a strategic improvement plan to increase enrollment. The Department successfully implemented several strategies for increasing enrollment across the three Pilot regions including:

- Launched a communication strategy utilizing bulletins, webinars, fliers and social media to increase awareness of the Pilot among members and providers.
- Launched the Outreach and Enrollment project which temporarily expands Human Service Organizations' (HSOs) roles to include direct community outreach. HSOs applied through their Network Leads to receive additional funding allowing them to conduct community outreach activities.
- Released a revised consent form and simplified Pilot Enrollment and Authorization (PESA) functionality within the NCCARE360 system, significantly reducing the administrative burden of enrollment for Care Managers.
- Implemented Expedited Enrollment with one HSO and one Standard Plan to deliver fruit and vegetable prescriptions to members. This direct-to-consumer model utilizes a member texting campaign and beneficiary facing portal to quickly enroll members for services. The implementation of this model resulted in 3,200 new enrollments within six months.
- Housing service modifications to the fee schedule were also implemented. This adjusted the documentation burden for Pilot services such as Payment of First Month's Rent and Security Deposit, which previously included prohibitive requirements, such as requiring HSOs to ensure a 24-month rent freeze for service delivery.

Member enrollment increased substantially in DY5Q4 and is now in line with original estimates.

Preparing for Pilot launch for NC Medicaid Direct members

The Department is working on implementation activities with the LME/MCOs, Advanced Medical Home Plus (AMH+) practices and Care Management Agencies (CMAs) to launch HOP for the TCM-eligible NC Medicaid Direct beneficiary population May 1, 2024. LME/MCOs have completed system integration testing (SIT) and operational process development required for launch. Additionally, the Department finalized updates to the operational reporting templates, guidance documents, and protocols. The LME/MCOs utilized these materials to finalize their operational processes and contractual deliverables, and to prepare for onsite readiness reviews completed in December. The Department continues work to finalize contract activities associated with HOP launch for the PIHP eligible populations.

Key challenges

Due to issues with invoicing and payment, several HSOs temporarily turned off their ability to receive new HOP referrals in NCCARE360, which has resulted in network adequacy gaps for some services across Pilot regions. In addition to the Department's efforts to resolve the invoice issues, Network Leads are closely monitoring the status of their regions. Network Leads are mitigating the service gaps by implementing strategies to contract with additional HSOs, expand the service offerings of existing HSOs and adjust capacity building funds to provide support to HSOs facing significant funding flow issues.

Unusual or unanticipated trends

Due to the substantial increase in enrollment in DY5Q4, the Standard Plans' capped allocation budget required review to account for the influx of service delivery funding. While some increase in enrollment was expected because of the enrollment strategies implemented earlier in 2023, the dramatic increase caused concerns that Standard Plans would not have enough capped allocation funding to reimburse HSOs for service delivery. The Department is working to ensure plans have the appropriate service delivery funding for the remainder of Fiscal Year 2024.

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

Pilot Enrollee Costs

The enrollee service cost analysis represents NCCARE360 data received by the Sheps Center on Oct. 25, 2023. This data contains information on services delivered March 15, 2022 through Sep. 30, 2023 that had an invoice status of "paid." There were 8,491 members that received a total of 121,166 services that had been both provided and paid for, totaling an amount invoiced of $21,271,831.30. Costs are calculated using "amount invoiced" within NCCARE360 as it is the most current and reliable data source.

It should be noted in analyses of spending by service domain that Interpersonal Violence (IPV) services only launched April 5, 2023, while the other service domains launched in 2022.

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 is 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	Types of Service(s) Received			
		Food	Housing	Trans.	Cross
1	$ 60,645.14	-	-	-	✓
2	$ 43,232.99	✓	✓	-	-
3	$ 27,088.90	-	✓	-	✓
4	$ 25,716.44	✓	✓	-	-
5	$ 22,716.17	✓	✓	-	-
6	$ 22,649.58	✓	✓	-	-
7	$ 21,975.06	✓	✓	-	-
8	$ 21,770.01	✓	✓	✓	-
9	$ 20,783.50	✓	-	✓	✓
10	$ 19,880.55	✓	✓	-	-

* There were no IPV services received to any of the beneficiaries with the largest invoiced total per beneficiary

Percentile amount paid and amount invoiced per enrollee

Percentiles	Amount Invoiced
90%	$ 5,715.66
75%	$ 3,407.92
50%	$ 1,671.63
25%	$ 733.89
10%	$ 307.88

Percent of amount paid by PHP and service category

PHP	Food Services	Housing Services	Transportation Services	Cross – Domain	IPV* Services
AmeriHealth Caritas North Carolina	10.21%	4.64%	0.24%	0.07%	0.01%
Blue Cross and Blue Shield of North Carolina	16.03%	7.65%	0.66%	0.18%	0.02%
Carolina Complete Health	3.65%	2.65%	0.05%	0.06%	0.00%
UnitedHealthcare of North Carolina	12.37%	6.41%	0.59%	0.52%	0.01%
WellCare of North Carolina	23.63%	9.25%	0.74%	0.35%	0.02%
Total	**65.89%**	**30.59%**	**2.28%**	**1.17%**	**0.07%**

** Interpersonal Violence / Toxic Stress*

Percent of amount paid by PHP by Enrollment Category

PHP	Children 0 - 20	Adults 21+	Pregnant Women*	Missing
AmeriHealth Caritas North Carolina	5.68%	8.80%	0.41%	0.70%
Blue Cross and Blue Shield of North Carolina	8.86%	14.03%	0.50%	1.66%
Carolina Complete Health	2.54%	3.45%	0.20%	0.41%
UnitedHealthcare of North Carolina	6.06%	12.52%	0.83%	1.32%
WellCare of North Carolina	12.54%	18.92%	0.60%	2.53%
Total	**35.68%**	**57.72%**	**2.52%**	**6.61%**

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

Healthy Opportunities Pilot Evaluation Activities and Interim Findings

The first HOP Rapid Cycle Assessment was submitted to CMS on Mar. 24, 2023. The Sheps Center team is working on the HOP Interim Evaluation Report, which will be submitted to CMS in April 2024.

DEMONSTRATION YEAR 5 QUARTER 4 REPORT

Executive Summary

This report covers Demonstration Year 5, Quarter 4 (DY5Q4) of the North Carolina Medicaid Reform Demonstration, Aug. 1, 2023 through Oct. 31, 2023.

The North Carolina state budget was enacted Oct. 3, 2023, and the legislation made important changes to NC Medicaid programs. The Department previously announced in July 2023 that the launch date of Oct. 1, 2023 for the Tailored Plans would be delayed, and a new launch date would be determined. The budget requires the launch of Tailored Plans no later than July 2024. The Department is re-baselining implementation activities for the new launch date. The legislation also requires that the Children and Families Specialty Plan (CFSP) is launched by Dec. 1, 2024.

North Carolina passed Medicaid expansion in March 2023, with the provision that expansion could not take effect until the state budget passed. On Sep. 25, 2023, anticipating passage of the budget, the Department announced that Medicaid expansion would go live Dec. 1, 2023, making an additional 600,000 North Carolinians eligible for NC Medicaid.

In August 2023, two of the six LME/MCOs, Sandhills Center and Eastpointe, announced their intention to merge. The state budget contained language directing the Secretary for the North Carolina Department of Health and Human Services to reduce the number of LME/MCOs to either four or five organizations. Shortly after, Sec. Kinsley announced that Sandhills Center would be dissolved, and Eastpointe and Trillium Health Resources would consolidate. The consolidation will result in four LME/MCOs – Alliance Health, Partners Health Management, Trillium Health Resources and Vaya Health – and will take effect Feb. 1, 2023.

On October 31, 2023, NC submitted its final application to renew its 1115 demonstration for another five-year period along with supporting budget neutrality materials to CMS. North Carolina is requesting the following in its application:

- Extensions of ongoing managed care authorities
- An expansion of and refinements to the Healthy Opportunities Pilot (HOP) program, building on successes to date
- Implementation of four new initiatives in line with the state's overarching goals focused on streamlining Medicaid enrollment for children and youth, improving care for justice-involved individuals, investing in behavioral health technology, and bolstering the behavioral health and LTSS workforce

Medicaid Managed Care

Operational Updates

The state budget was enacted Oct. 3, 2023, and made important changes related to NC Medicaid. The Department previously announced in July 2023 that the launch date of Oct. 1, 2023 for the Tailored Plans would be delayed, and a new launch date would be determined. The budget requires the launch of Tailored Plans no later than July 2024. The Department is re-baselining implementation activities for this launch date. The legislation also requires that the Children and Families Specialty Plan (CFSP) is launched by Dec. 1, 2024.

The state budget contained language directing the Secretary for the North Carolina Department of Health and Human Services to reduce the number of LME/MCOs to either four or five organizations. Shortly after, Sec. Kinsley announced that Sandhills Center would be dissolved with Eastpointe recognized as the surviving entity. Additionally, Eastpointe and Trillium Health Resources were directed to consolidate. The consolidation will result in four LME/MCOs – Alliance Health, Partners Health Management, Trillium Health Resources and Vaya Health – and will take effect Feb. 1, 2023. Additionally, the Secretary's directive specifies that:

- Catchment areas of Sandhills Center, Eastpointe, and Trillium Health Resources will be combined except for the counties of Davidson, Harnett, and Rockingham.
- Davidson County will align with Partners Health Management; Harnett County will align with Alliance Health; and Rockingham County will align with Vaya Health.

In anticipation of the Secretary's Directive in early November, the Department began pre-planning for consolidation activities based on lessons learned from previous consolidations and aligned to the following priorities:

- All impacted members are assigned to their new LME/MCO and can access services
- Impacted members do not experience any disruption of behavioral health, I/DD, TBI or TCM services
- LME/MCOs receiving members through consolidation have the capacity and historical background (Transition of Care details) to support each member
- Providers are aware of how to obtain payment and resolve payment disputes for service provided to impacted members prior to and after consolidation
- Community stakeholders and internal/external partners are engaged and aware of the consolidation process.

The Department continues to monitor and address any issues identified with the Standard Plans. Identified issues are addressed through formal notification by the Department and the imposition of remedial actions (e.g., corrective action plans, audits), intermediate sanctions, and/or liquidated damages, as appropriate. This quarter the Department focused on reviewing operational reports related

to automated claims processing for NEMT, call center metrics, and privacy and security to ensure plan compliance in these areas.

Key Achievements

Standard Plans

1. To increase the capacity for Non-Emergency Medical Transportation (NEMT), the Department conducted a review process with Managed Care Plans and Lyft which resulted in the successful addition of Lyft as an NC Medicaid NEMT provider.
2. Seven Notices of Closure were issued to Standard Plans this quarter for issues related to privacy and security, call center service level agreement (SLA) noncompliance, provider welcome packets, network file discrepancies, and preferred drug list (PDL) noncompliance. A Notice of Closure is issued if the plan has successfully completed all of the actions imposed under the Notice of Deficiency.

Tailored Plans

1. To date, Tailored Plans have submitted a total of 3,088 deliverables. This quarter, Tailored Plans submitted 243 deliverables, with 302 Inbound Deliverables finalized. Reviewers from across the Department have gone through iterative reviews of each submitted deliverable and provided feedback to individual plans to address questions or unmet requirements prior to submitting final versions for approval.

Key Challenges

Standard Plans

1. This quarter, Initial Notices of Deficiencies (NODs) were issued to three Standard Plans for Privacy and Security and to four Standard Plans for Call Center SLA Noncompliance for the period of January – June 2023.
2. To address continued concerns related to claims processing, the Department developed an informal process to address potential claim operational issues identified by internal and external stakeholders and will follow this process to resolve operational issues utilizing the Medicaid Help Center.

Tailored Plans

1. Network Adequacy and Provider Contracting: Provider network coverage and its impact on PCP choice and assignment is an area of concern across the Tailored Plan program and was a major factor in the decision to delay the Tailored Plan program beyond October 1, 2023. The Department issued a Provider Contracting Notice of Concern that was sent to the plans in

August 2022 to provide greater visibility into how Tailored Plans are addressing this challenge. Tailored Plans have shown improvement across provider categories tracked in the Notice, although one Plan still has not met PCP contracting targets. The Notice was closed for the remaining 5 plans in August 2023 as they met preliminary contracting targets set forth in the Notice. The Department continues to work to mitigate risk through the following methods:

- Close tracking of provider contracting data in the Weekly Scorecards
- Monitoring of monthly AMH/PCP and hospital contracting submissions, and other specialties from the monthly network submission
- Monitoring monthly contracting data submitted in response to the Notice of Concern still in place for one of the plans
- One-on-one calls with the Tailored Plans to get more frequent updates on both contracting progress and challenges
- Utilizing the Provider Engagement and Communications team to clarify 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

2. TCM Auto-Assignment: The Department has been working closely with the LME/MCOs to improve their readiness to independently support TCM Auto-Assignment since April 2023, a process that they will continue to perform for the Tailored Plan population upon Tailored Plan launch. The goal is to reach a point where all LME/MCOs, with oversight but limited direction from the Department, can correctly identify and assign newly eligible members and identify and reassign members who had a change in eligibility or overall care needs.

   Currently, there are three LME/MCOs that have been approved to submit daily assignments directly to NC FAST. Of the remaining LME/MCOs, two are required to submit reassignments to the Department for pre-approval prior to NC FAST submission, and one submits assignments to NC FAST on a bi-weekly basis with Department oversight. With the Department's guidance these LME/MCOs have improved the accuracy of their reassignments, but they must show further progress before being approved to submit directly to NC FAST.

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 DY5Q4, the Ombudsman handled 5,204 cases. Case volume increased approximately 13% from last quarter.

DY5Q4 NC Medicaid Member Ombudsman Cases

Aug. 2023		Sep. 2023		Oct. 2023		Total Cases
Information	Issue Resolution	Information	Issue Resolution	Information	Issue Resolution	
561	1,225	477	1,053	572	1,316	**5,204**

The Office of Administration largely handles cases referred from state legislative offices. In previous monitoring reports, all constituent concerns handled by the Office of Administration were reported, including those from non-beneficiaries (such as providers). As of DY5Q1, only concerns from NC Medicaid beneficiaries are included.

Office of Administration Member Concerns, August – October 2023

Issue Category	Number of Issues
Behavioral health	3
Clinical/medical health	4
Claims	1
Eligibility	6
Total	**14**

Lawsuits or legal actions

1. *Samantha R., et al. v North Carolina and the Department of Health and Human Services,* is a lawsuit by Disability Rights NC (DRNC) which was filed in 2017 alleging that the state failed to make sure people with intellectual and developmental disabilities could get essential services in their communities. A ruling in November 2022 required the state to expand services to the 16,314 people on the waiting list for Innovations Waiver slots; address and resolve the shortage of direct care workers who provide community-based support; assist 3,000 people who want to leave or avoid institutional settings, and cease new admissions to institutions after 6 years except for respite or short-term stabilization; and provide quarterly reports about each measure and post data regarding the State's progress. After the State appealed the ruling and following mediation, the parties agreed to work on a proposed consent order to submit to the Court that would resolve the appeal. Proceedings are stayed pending submission of the proposed consent order.

Legislative updates

S.L. 2023-134, the Current Operations Appropriations Act of 2023, enacted October 3, 2023, makes various changes related to the structure of managed care in NC Medicaid:

- Section 9E.16.(a1)-(a2) requires BH/IDD tailored plans to begin no later than 07/01/2024; repeals the planned 12/01/2022 start date.
- Section 9E.16.(b1) requires DHB to submit a proposal to open LME/MCO networks by the time BH/IDD tailored plans begin.
- Section 9E.16.(b2)-(b6) amends Article 3 of G.S. 108D to permit Medicaid Direct and Tailored Plans to have a closed network until Tailored Plans begin for MH/IDD/SUD and TBI services, unless DHHS identifies services that need improved access. Permits closed network for LME/MCOs operating 1915(b)/(c) or 1915(i) services.
- Section 9E.16.(c) requires the Department of Health Benefits (DHB) to submit a proposal to transition CAP/DA to Tailored Plans by 01/01/2025.
- Section 9E.16.(d) requires DHB to apply to expand TBI waiver across the state on 01/01/2025 or any later date approved by CMS.
- Section 9E.16.(e) requires DHB to submit a proposal to seek 1115 waiver to provide services to the adult incarcerated population, to be managed under Tailored Plans, by 01/01/2025.
- Section 9E.18 directs DHB to seek CMS approval to amend the Innovations Waiver CCP to allow Community Living and Support services to be provided by a relative living in the same home as a beneficiary under 18 years of age when no other provider is available.
- Section 9E.19.(a) amends Section 9D.9 of SL 2022-74 to require DHB submit State Plan amendments necessary for new Medicaid coverage of behavioral health services by LME/MCOs to beneficiaries awaiting hospital discharge with proposed start date of March 1, 2023. Directs DHB to implement services and rates as soon as operationally feasible after CMS approval and to retroactively implement services and rates to the date approved by CMS. (Note: DHB withdrew the state plan amendment on June 26, 2023, upon receiving CMS communication that it would be recommended for disapproval.)
- Section 9E.19.(a1) exempts Standard Plans from covering behavioral health services provided to beneficiaries awaiting hospital discharge. Extends the start date of LME/MCO coverage to 03/31/2023.
- Section 9E.20 directs DHB to develop performance standards and metrics for claims payment within a set number of days for PHPs and to annually report to the General Assembly on each PHP's performance.
- Section 9E.22 et seq. establishes the start of Children and Families Specialty Plan (CFSP) on December 1, 2024; codifies the specifics of CFSP eligibility, enrollment/disenrollment, services, and networks; and identifies entities that can bid on the contract and other details.
- Section 9E.22.(d) permits Tailored Plan enrollees to request disenrollment without cause at any time.

- Section 9E.22.(g) amends G.S. 108D-35(b) to limit 1915(b)(3), 1915(b) and (c) waiver and 1915(i) services to be covered only under the LME/MCOs; adds SACOT, SAIOP, and social setting detox to services to be covered by Standard Plans.
- Section 9E.23.(a1)-(a2) amends G.S. 108A-68.2 to require each PHP to develop a lock-in program for beneficiaries who obtain controlled substance prescriptions from 4 or more providers, or 10 or more covered substance prescriptions in two consecutive months when not medically necessary. Requires the beneficiary receive written notice and appeal rights before being locked-in to up to two prescribers and two pharmacies that they choose from the PHP network. Lock-in period is two years.
- Section 9E.23(b) Amends G.S. 150B-1(e)(25) to exclude from Office of Administrative Hearings disputes arising under the PHP, PIHP, or PCCME contract.
- Section 9G.7A.(a1) enacts G.S. 122C-115.5 to authorize the Secretary to direct dissolution of an area authority upon Tailored Plan termination or noncompliance under 122C-124.2. Other subdivisions of this section make confirming changes and address the details of the dissolution of an area authority. Only the most important ones are reflected below:
    - Section 9G.7A.(a6) amends 122C-115 to require a minimum catchment area population of 1.5 million; repeals reduced funding or reassigned management for noncompliance with minimum population requirements; repeals authority to adopt rules for county disengagement and approval; repeals ability to add counties by resolution and Secretary approval.
    - Section 9G.7A.(a7) repeals 122C-115.2 (LME/MCO business plans) and conforming sections, 122C-115.3 (Dissolution of area authority), 122C-124.1 (Actions by the Secretary when area authority or county program is not providing minimally adequate services). Other sections make confirming changes throughout the North Carolina General Statutes.
    - Section 9G.7A.(a9)-(a10) repeals 122C-125 (Area Authority financial failure; state assumption of financial control) and 122C-125.2 (LME/MCO solvency ranges; formula; corrective action plan).
    - Section 9G.7A.(a11) enacts G.S 122C-125.3 to require contracts with LME/MCOS establish solvency standards and a corrective action plan where not met; requires monthly financial reports from LME/MCOs; directs the Department to publish to its website LME/MCO solvency and corrective action plan information each quarter.
    - Section 9G.7A.(a14) amends G.S. 108D-60 to repeal ability for counties of an area authority to change LME/MCOs or for LME/MCOs to merge or be acquired prior to Tailored Plan start. Also amends this section to permit enrollees of dissolved area authority to be served by another Tailored Plan, area authority being dissolved under a capitated or other arrangement authorized by G.S. 108D-60(b), fee-for-service, Standard Plan or other system allowed under State law for Medicaid delivery.
    - 9G.7A.(a20) directs the Secretary to reduce the number of LME/MCOs to 4 or 5 by dissolution, merger, or consolidation which is to be effective within 90 days of the

effective date of this legislation (10/03/2023). Reserves authority for further consolidation in the future.
  - 9G.7A.(b3) enacts G.S. 108D-46 to permit counties to request realignment with a different area authority no earlier than 6 months before RFP issuance for the next Tailored Plans contract term.
  - Section 9G.7A.(c1)-(c3) amends various statutes to enhance Secretarial authority to have an area authority's subcontractor's staff removed to achieve compliance with State and federal law.

Aside from the Current Operations Appropriations Act of 2023, other session laws were enacted that impact how NC Medicaid has structured managed care:

- Section 15 of S.L. 2023-125, enacted September 29, 2023, requires standard plans and Tailored Plans to cover HCPCS procedure code G0330 because it is a surgical procedure and not a traditional dental procedure.
- Section 5.1.(a)-(b) makes technical change to G.S. 122C-115(e) to require LME/MCOs to stop managing services for beneficiaries enrolled in Standard Plans except that until Tailored Plans begin they may continue managing services under the combined 1915(b)/(c) if the beneficiary is not enrolled in a Standard Plan.

Additional sections of various session laws summarized below have an incidental impact on managed care implementation but do not change the structure of managed care:

- Sections 1 and 2 of S.L. 2023-115, enacted Aug. 24, 2023, prohibit reduction in services provided at Adult Developmental and Vocational Programs or Community Rehabilitation Program without stakeholder input and funding a robust array of services that reflect choice. Also prohibits reduction in admissions until current services are reviewed and new services are approved.
- Section 9E.10 of S.L. 2023-134 increases Innovations Waiver slots by 350. It also repeals S.L. 2021-180, s. 9F.14 (group home stabilization) but allows services developed under this 9F.14 to continue if the program stays on budget.
- Section 9E.11 of S.L. 2023-134 continues skilled nursing facility rates that were in place on March 15, 2023.
- Section 9E.12A of S.L. 2023-134 increases private duty nursing rates to $13.00/15 minutes.
- Section 9E.13 of S.L. 2023-134 increases durable medical equipment rates so long as the increase does not exceed $1 million over twelve months.
- Section 9E.15 of S.L. 2023-134 increases rates for Medicaid enrolled provider and approved financial manager/financial support agencies under self-directed option so that Innovations Waiver direct care workers receive wages of $6.50/her above the state's industry average. Requires the capitation rate paid to LME/MCOs to be increased. Requires LME/MCOs to secure attestation/verification that the rate increase will be used for increasing hourly wages and any payroll costs.

- Section 9E.24 of S.L. 2023-134 directs DHB to set and adjust rates for licensed ambulatory surgical centers to 95% of the Medicare Ambulatory Surgical Center fee schedule in effect on January 1 of each year.

Descriptions of post-award public fora

No public forums were held this quarter.

Performance Metrics

Outcomes of care

Please see the annual section of the report.

Quality of care

Please see the annual section of the report for 2022 quality measure results.

Access to care

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	19,414	7,466	47,765	39,320	23,303	**137,268**
Tier 1	4,245	4,446	8,482	4,571	2,404	**24,148**
Tier 2	43,884	45,996	75,602	73,473	44,931	**283,886**
Tier 3	270,331	184,304	386,884	276,965	344,393	**1,462,877**

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

Member Proportion by PHP and AMH Tier

	AmeriHealth	CCH*	Healthy Blue	United	WellCare
No PCP Tier	5.75%	3.08%	9.21%	9.97%	5.61%
Tier 1	1.26%	1.84%	1.64%	1.16%	0.58%
Tier 2	12.99%	18.99%	14.57%	18.635	10.83%
Tier 3	80.01%	76.09%	74.58%	70.24%	82.98%

AMH Provider Enrollment

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

	AmeriHealth	Healthy Blue	CCH**	United	WellCare
Tier 1	40.51%	61.02%	68.29%	55.90%	54.87%
Tier 2	66.76%	94.04%	78.40%	72.50%	70.74%
Tier 3	79.42%	79.59%	91.67%	80.23%	95.23%

*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

These data represent members enrolled in Standard Plans receiving care management through a Standard Plan or Tier 3 AMH practice, and Care Management for At-Risk Children (CMARC) and Care Management for High-Risk Pregnancies (CMHRP) from local health departments (LHDs) since the start of the contract year (July 2023). These data are provided with a one-month lag (DY5Q4 ends October 2023; however, data are available only through September). Care management penetration is defined as an interaction between a member and his or her care manager within a 12-month period.

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. Care management provided through a Standard Plan, Tier 3 AMH, or LHD to members enrolled in Standard Plans is reported by Standard Plans on the BCM051 Care Management Interaction operational report.

Care Management Penetration by Entity

Period: July 1, 2023 – September 30, 2023				
	SP	**AMH3**	**LHD**	**Overall**
Total Number of Members Care Managed	29,598	105,012	16,022	145,635
Care Management Rate	2.9%	10.6%	49.6%	7.6%
Total Number of Members	1,014,885	991,999	32,330	1,925,249

***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 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.

To better reflect claims lag and provide more accurate data, the Department is reporting these rates with a two-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, June – August 2023

AmeriHealth	Carolina Complete Health	Healthy Blue	Medicaid Direct	United	WellCare
62.27	64.33	61.52	82.58	63.41	62.26

Inpatient Admissions per 1,000 Members, June – August 2023

AmeriHealth	Carolina Complete Health	Healthy Blue	Medicaid Direct	United	WellCare
13.61	13.65	12.92	23.80	13.18	14.15

Results of beneficiary satisfaction surveys

See the annual section of this report for a summary of 2022 CAHPS survey results.

Budget Neutrality and Financial Reporting Requirements

The Department will provide CMS with updated budget neutrality information in the next budget neutrality workbook submission.

Evaluation Activities and Interim Findings

The Sheps Center has continued its evaluation work in DY5Q4. This quarter, the team's focus was writing the Managed Care Interim Evaluation Report, which was submitted to CMS in October 2023. The Sheps team also reviewed CMS' comments on the SUD Interim Evaluation Report and revised the report for resubmission prior to the 60-day deadline.

Transition to Capitated Encounter Data from Prepaid Health Plans

Sheps Center data scientists and analysts now been working with the encounter data from beneficiaries enrolled in Standard Plans for more than two years. In April 2023, Sheps began receiving encounter data from the LME/MCOs. As reported last quarter, the LME/MCOs changed the platform through which their claims are submitted to align with Standard Plan data submission. Because of quality issues, the Department has not yet released data from at least two LME/MCOs. Metrics will be incomplete beginning on April 1, 2023, until the full data set is released.

Quantitative Update

The quantitative team focused on generating and updating analyses for the Managed Care Interim Report during the last quarter. Additionally, the team contacted the Division of State Operated Healthcare Facilities to revisit a data request for Institute for Mental Disease (IMD) utilization data that is not available from Medicaid claims due to state-only payments prior to and during the waiver. To date, neither the IMD data nor the Prescription Drug Monitoring Program (referred to as Controlled Substances Reporting System in NC) is received by Sheps. All data received sources are ingested into UNC's secure data warehouse and are beginning to be linked to NC Medicaid member information to generate new metrics that will be tracked during the evaluation period.

Qualitative Update

The qualitative team's dissemination efforts this quarter include submission of the summary results for 2023 provider and beneficiary interviews. Revisions have been made to the team's first manuscript with

plans to resubmit for review in November 2023. The team is working on a second manuscript in addition to preparation of a poster for submission to AcademyHealth in early January 2024.

With the addition of a new graduate research assistant (GRA), recruitment materials and interview guides have been developed and submitted to the IRB in preparation for PHP and NCDHHS staff interviews in November and December 2023. Interviews with beneficiaries are planned for Spring 2024. The team plans to hire a bilingual GRA by the end of 2023 to assist with the Spanish language recruitment and interviews. Other new members of the qualitative team include a National Research Service Award fellow and a research scientist. Their experience with qualitative work in both patient populations as well as Hispanic communities in North Carolina will strengthen the qualitative work planned for 2024.

Healthy Opportunities Pilot

Operational Updates

Introduction

This quarter, the Healthy Opportunities Pilot (HOP) continued implementation activities with the LME/MCOs, AMH+ practices and CMAs to launch HOP for the TCM-eligible NC Medicaid Direct beneficiary population. LME/MCOs completed system integration testing and operational process development required for launch.

Initiatives launched earlier this year led to a substantial increase in Pilot enrollment during this quarter, bringing Pilot enrollment in line with original estimates. Additionally, the Department submitted its application for the 1115 waiver renewal which included an expansion of the Pilot. The proposed expansion will offer HOP services statewide, as well as expand the type and volume of certain services.

Key Achievements

The LME/MCOs completed systems integration testing on schedule for all Pilot file integrations. The delay of Pilot launch for the NC Medicaid Direct population from October 2023 to early 2024 created a significant gap in the timeline between the finalization of system testing and Pilot launch. The Department is requiring additional system testing activities to mitigate potential issues and to ensure all file integrations are operational at launch. The Department developed a regression testing plan and coordinated with the LME/MCOs to begin the test activity. Additionally, the Department finalized updates to the operational reporting templates, guidance documents, and protocols. The LME/MCOs are utilizing these materials to finalize their operational processes and contractual deliverables, and to prepare for onsite readiness reviews scheduled for early December.

The Department conducted an extensive public comment process to capture feedback about the 1115 waiver renewal. A majority of feedback received was associated with the Healthy Opportunities Pilot program and the Department factored this feedback into their application submitted in October.

Finally, member enrollment in HOP increased significantly during this quarter. The enrollment increase may be attributed to the Pilot improvement initiatives implemented by the Department in early 2023.

These initiatives focused on reducing the administrative burden for care management teams and members, improving referral pathways to allow community-based organizations to make referrals to the Standard Plans, developing a more robust communications strategy, and implementing a direct-to-consumer enrollment model with one HSO for a small subset of services.

Key Challenges

The Pilot continued to experience invoicing challenges which caused some HSOs to turn off the capability to receive referrals in the HOP platform until the issue is resolved. As a mitigation strategy, the Network Leads continued to facilitate weekly meetings with the Department, the Pilot referral platform vendor, and the Standard Plans to collaborate on solutions. The Department also implemented Pilot functionality enhancements to improve workflows for the Network Leads and PHPs. This included improvements to the invoice work queue, enabling system notifications for Network Leads when PHPs make changes to invoice status and adding the capability to see invoices aging for longer than the specified contractual service level agreement.

Unusual or unanticipated trends

Due to the substantial increase in enrollment this quarter, the Standard Plans' capped allocation budget required review to account for the influx of service delivery funding. While some increase in enrollment was expected because of the enrollment strategies implemented earlier in 2023, the dramatic increase caused concerns that Standard Plans would not have enough capped allocation funding to reimburse HSOs for service delivery. The Department is working to ensure plans have the appropriate service delivery funding for the remainder of Fiscal Year 2024.

Performance Metrics

Enrollee Service Costs

Please see the annual section of the report for the most recent Pilot enrollee cost metrics.

Healthy Opportunities Pilots Evaluation Activities and Interim Findings

The Sheps Center is the independent evaluator for the Pilot. Evaluation activities conducted this quarter by the Sheps team include:

- Provided ongoing technical assistance to NC Medicaid personnel to facilitate the Pilot evaluation. Activities included bi-weekly meetings to discuss data goals and technical difficulties.
- Submitted a qualitative manuscript based on interviews with staff at entities involved with Pilot implementation.
- Conducted primary data collection for evaluation question 4 (patient-reported health outcomes). Sheps is collecting data via a longitudinal survey that launched at the end of May 2023. Survey materials for Spanish speaking participants have been finalized and the team has begun to collect survey data for Spanish-speaking participants.
- Continued development of dashboards to monitor implementation of the Pilots. Dashboards regarding invoices have been developed and others are in progress.

- Continued development of metrics that will be used in the interim evaluation report that is scheduled to be submitted to CMS in April 2024.
- Worked with the Department to finalize value-based payment metrics of interest and coordinate a feasible delivery cadence for these analyses.

Residential and Inpatient Treatment for Individuals with a Substance Use Disorder

The Department will provide detailed information in the DY5Q4 Substance Use Disorder monitoring report.