Medicaid Section 1115 Monitoring Report

North Carolina - North Carolina Medicaid Reform Demonstration

DY6Q2 – Feb. 1 through April 30, 2024

Submitted on June 28, 2024

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

Contents

DEMONSTRATION YEAR 6 QUARTER 2 REPORT

Executive Summary

This report covers Demonstration Year 6, Quarter 2 (DY6Q2) of the North Carolina Medicaid Reform Demonstration, Feb. 1, 2024 through April 30, 2024.

The state fiscal year 2024 budget contained language directing the Secretary for the North Carolina Department of Health and Human Services (NCDHHS) to reduce the number of Local Management Entities/Managed Care Organizations (LME/MCOs). In November 2023, the Secretary directed Sandhills Center to dissolve and Eastpointe to consolidate with Trillium Health Resources, resulting in four remaining LME/MCOs – Alliance Health, Partners Health Management, Trillium Health Resources and Vaya Health. Consolidation and member realignment went into effect Feb. 1, 2024. LME/MCOs will operate the Behavioral Health Intellectual/Developmental Disability Tailored Plans (Tailored Plans) at their launch on July 1, 2024.

On April 12, the Department issued formal notices to the Tailored Plans notifying them of the Department's intent to move forward with Tailored Plan launch on July 1, 2024. The Department analyzed the performance of each plan across six key areas of performance – claims testing, readiness, network adequacy, end-to-end testing, technology operations and help center, and primary care provider (PCP) contracting – and determined that plans were ready to provide managed care services on behalf of the Department. Through the auto-enrollment process, the Department assigned 183,944 Tailored Plan-eligible members to a Tailored Plan based on their administrative county. The PCP Choice Period began April 15, allowing Tailored Plan members to choose their PCP and Tailored Care Management (TCM) provider from providers who are in network with their assigned Plan.

This quarter the Healthy Opportunities Pilot (HOP) team continued implementation efforts for the launch of the pilot with both the Tailored Care Management (TCM)-eligible NC Medicaid Direct beneficiary population and the Tailored Plans. Additionally, the Department finalized an approach for HOP fee schedule modifications and began coordination with the prepaid health plans (PHPs) to implement those changes. The draft HOP Interim Evaluation Report (IER), authored by the Sheps Center for Health Services Research, was submitted to CMS April 16, 2024. The Sheps team also prepared dissemination materials for other audiences and presented report findings in multiple venues, including a presentation to the Department's executive team and a presentation during the Medicaid Deep Dive series, a weekly presentation series to which all Department employees are invited.

Medicaid Managed Care

Operational Updates

Tailored Plan Consolidation

The state fiscal year 2024 budget contained language directing the Secretary for NCDHHS to reduce the number of Local Management Entities/Managed Care Organizations (LME/MCOs) to no more than five, and at least four. In November 2023, the Secretary issued Secretarial Directive 2023-001 directing Sandhills Center to dissolve and Eastpointe to consolidate with Trillium Health Resources. These changes resulted in four remaining LME/MCOs – Alliance Health, Partners Health Management, Trillium Health Resources and Vaya Health. Consolidation and member realignment went into effect Feb. 1, 2024, and was implemented in accordance with the approved consolidation agreement between Trillium and Eastpointe, and the approved consolidation plans from Alliance, Partners, Trillium and Vaya.

Tailored Plan Launch

The Department is preparing for the July 1, 2024 launch of Tailored Plans through regular meetings with the Plans. These include weekly status meetings with each Plan to track development and address business issues and risks, business unit-specific one-on-one meetings with each Tailored Plan, and bi-weekly calls with Tailored Plan executive leadership teams to address key issues and risks. As part of these weekly status calls, the Department has been engaging with the future Tailored Plans on system development and integration efforts and monitoring progress closely.

Key Achievements

Standard Plans

1. The Department partnered with Health Services Advisory Group (HSAG) to develop a Total Cost of Care (TCOC) dashboard tool that shows total cost and resource use. Separate dashboards are available to the Department, Standard Plans, and Advanced Medical Homes (AMHs). The dashboards were launched in a staggered rollout from February to April 2024. The goal of the dashboards is to enhance providers' understanding of cost and resource use to enable them to make informed decisions when entering value-based payment arrangements with PHPs and to help providers and PHPs understand potential drivers of overuse or inefficiency.
2. The Healthy Opportunities/Health Equity PHP Reinvestment Initiative creates opportunities for investments in health-related resources that impact health outcomes, community engagement, and/or the cost-effectiveness of care delivery. Standard Plans can participate in this program by investing in community-based projects that address the social drivers of health or health care disparities. The investment proposals must align with North Carolina's Medicaid Managed Care Quality Strategy, incorporate data-informed evidence, and involve a partnership with a community-based organization, among other requirements outlined in contractual language. Upon review and approval from the Department, approved investments can qualify for a Standard Plan's medical loss ratio or in lieu of remittance.

Beginning in January 2024, the Department began reviewing these proposals using a new, formalized process that involves close review by a small group of key reviewers, providing feedback to the Standard Plans, and a review and vote from a larger, cross-functional working group. Seventeen proposals were approved from January to the end of this quarter in April.

Tailored Plans

1. LME/MCO consolidation and member realignment went into effect Feb. 1, 2024. The Department executed contract amendments with all four LME/MCOs to support changes related to consolidation. Additionally, the Department utilized existing Medicaid Help Center and Technology Operations Monitoring processes to resolve business and technology issues relating to Consolidation. There was not a significant increase in Medicaid Help Center or Technology Operations ticket volume related to consolidation.
2. On April 12, the Department issued formal notices to the Tailored Plans notifying them of the Department's intent to move forward with Tailored Plan launch on July 1, 2024. The Department analyzed the performance of each plan across six key areas of performance – claims testing, readiness, network adequacy, end to end testing, technology operations and help center, and PCP contracting – and determined that plans were ready to provide managed care services on behalf of the Department.
3. During March and April 2024, Tailored Plans completed 32 total virtual Onsite Readiness Review Sessions focused on 12 functional topic areas. These sessions resulted in the collection of 92 open items across all plans, which are being monitored for resolution by the Readiness Review Team through iterative rounds of assessing plan responses and providing feedback.
4. Starting April 13, 2024, the Department began running the auto-enrollment process to assign Tailored Plan-eligible members to a Tailored Plan based on administrative county. By the end of the initial bulk enrollment, 183,944 members were assigned to a Tailored Plan. The Primary Care Provider (PCP) Choice Period began April 15, allowing Tailored Plan members to choose their PCP and TCM from providers who are in network with their assigned Plan. The Enrollment Broker completed bulk mailings of transition notices to members on April 23.
5. The Department and the Enrollment Broker hosted multiple County Department of Social Services (DSS) virtual training sessions to familiarize Medicaid County DSS caseworkers with the Tailored Plans. The trainings were attended by over 2,000 Medicaid County DSS caseworkers and supervisors across the state.
6. The Department completed an off-cycle Tailored Plan contract amendment specifically for contract items related to the Transitions to Community Living (TCL) program. TCL provides long-term housing, community-based services, supported employment and community integration to eligible adults living with serious mental illnesses.

Key Challenges

1. **Network Adequacy and Provider Contracting:** Provider network coverage and its impact on PCP choice and assignment has been an area of concern across the Tailored Plan program and was a major factor in the decision to delay the program launch to July 1, 2024.
    - In February 2024, the Department issued new notices of concern to three Tailored Plans – Alliance, Trillium and Vaya – notifying them that their PCP provider network must allow for 90 percent of their members to keep their historically aligned PCP, per CMS requirements. The notices required Plans to submit weekly reports on PCP contracting based on new consolidation catchment areas to enable the Department to monitor progress in advance of Tailored Plan auto-assignment and the PCP Choice Period.
    - Partners was issued a letter of readiness notifying them that although they met the retention requirements for historically aligned PCPs, they would be required to submit weekly reporting on PCP contracting based on their new consolidation catchment area to enable monitoring and maintenance of the retention requirements.
    - The Department continued to see PCP contracting progress across all four Plans, and as of reporting submitted on March 20, all Plans exceeded the 90 percent retention requirement. The Department is continuing to receive weekly reporting on PCP contracting from all Plans to monitor this area and intends to close the notices of concern.
2. **Primary Care Provider and 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, when LME/MCOs began running this process for members in Medicaid Direct. The goal is to reach a point where all LME/MCOs can do the following daily without direction from the Department: 1) Correctly identify and assign newly eligible members and 2) Identify and reassign members who have had a change in eligibility or overall care needs.
    - As of April 2024, all four LME/MCOs have been approved to submit daily assignments directly to North Carolina Families Accessing Services through Technology (NC FAST) for their Medicaid Direct members. The Department continues to monitor the TCM assignments monthly to ensure no major issues are occurring. This is an important milestone for Plans, as they will need to run the TCM auto-assignment process for the Tailored Plan population starting in May. The Department included additional testing of the TCM auto-assignment process as part of the Tailored Plan end-to-end test plan that restarted in January.
    - TCM Auto-Assignment testing was scheduled to run March 25 to April 26, 2024. The testing was delayed, and plans had to do multiple runs due to the number of defects identified. This created a risk in plans' ability to complete TCM Assignment testing by the production go-live date of May 23. Following a mitigation approach similar to the one used for PCP auto-assignment, the Department aligned on an updated scope and extended the overall timeline, allowing Plans to focus on meeting 90% accuracy for bulk-assigning members to TCMs, and then work on resolving remaining open defects and completing reassignment testing.

- Due to the delays described above, PCP and TCM reassignment testing will continue beyond the PCP and TCM bulk auto-assignment production dates of May 16 and May 23 respectively. As a mitigation, the Department has requested all Plans pause reassignments until the testing is complete. This mitigation presents a low risk as the volume of members requiring reassignment is expected to be low and reassignments would not be effective until July 1. Therefore, plans can reassign once testing is complete prior to the effective date.

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. (See Appendix A for a full list of cases by category type this quarter.) Due to a data issue, Ombudsman data for January 2024 was not available at the time of the previous quarter's report and is included here. There were 7,880 Member Ombudsman cases in DY6Q2, an increase of approximately 21% over last quarter.

NC Medicaid Member Ombudsman Cases

	Information	Issue Resolution	Total
January 2024	675	2,235	2,910
February 2024	695	2,061	2,756
March 2024	561	1,967	2,528
April 2024	587	2,009	2,596

The Office of Administration largely handles cases referred from state legislative offices. Prior to DY5Q1, all constituent concerns handled by the Office of Administration were reported, including those from non-beneficiaries (such as providers). As of DY5Q1, the monitoring reports only include concerns from NC Medicaid beneficiaries. There were 13 recorded constituent concerns last quarter, and 9 in this quarter.

Office of Administration Member Concerns

Issue Category	Number of Issues
Behavioral health	5
Claims	1
Eligibility	1
Long-term Services and Supports	1
Durable Medical Equipment	1
Total	**9**

Lawsuits or legal actions

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

Legislative updates

There are no legislative updates to report this quarter.

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. Results for Rating of Personal Doctor is an annual measure and was provided in DY5Q4.

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 but will be included in the Q3 report.

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 NC HealthConnex, North Carolina's statewide health information exchange, in order to report this measure.

Quality of care

There are no quality of care metrics to report this quarter. Annual quality measure results were provided in DY5Q4.

Access to care

Network Time/Distance Standards

The percentage of members with access to provider types that meet network adequacy standards is shown below for each Standard Plan by region and type of service provider. The state's time or distance network adequacy standards generally require that at least 95% of the membership meet the access standard.

AmeriHealth Caritas									
Region	# of Counties	# of Members*	Hospitals	OB/GYN	Primary Care (Adult)	Primary Care (Child)	Pharmacy	Outpatient Behavioral Health (Adult)	Outpatient Behavioral Health (Child)
			% Members	% Members	% Members	% Members	% Members	% Members	% Members
1	19	144,579	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2	13	301,714	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
3	12	426,328	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
4	14	347,131	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
5	15	289,152	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
6	27	220,932	99.3%	99.6%	100.0%	100.0%	99.8%	100.0%	100.0%

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

Carolina Complete Health									
Region	# of Counties	# of Members*	Hospitals	OB/GYN	Primary Care (Adult)	Primary Care (Child)	Pharmacy	Outpatient Behavioral Health (Adult)	Outpatient Behavioral Health (Child)
			% Members	% Members	% Members	% Members	% Members	% Members	% Members
1	19	144,579							
2	13	301,714							
3	12	426,328	100.0%	100.0%	100.0%	100.0%	97.8%	100.0%	100.0%
4	14	347,131	100.0%	100.0%	100.0%	100.0%	99.2%	100.0%	100.0%
5	15	289,152	100.0%	100.0%	100.0%	100.0%	94.3%	100.0%	100.0%
6	27	220,932							

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

Healthy Blue/Blue Cross Blue Shield of NC									
Region	# of Counties	# of Members*	Hospitals	OB/GYN	Primary Care (Adult)	Primary Care (Child)	Pharmacy	Outpatient Behavioral Health (Adult)	Outpatient Behavioral Health (Child)
			% Members	% Members	% Members	% Members	% Members	% Members	% Members
1	19	144,579	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2	13	301,714	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
3	12	426,328	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
4	14	347,131	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
5	15	289,152	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
6	27	220,932	99.1%	99.4%	99.5%	99.1%	99.9%	100.0%	100.0%

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

United Healthcare									
Region	# of Counties	# of Members*	Hospitals	OB/GYN	Primary Care (Adult)	Primary Care (Child)	Pharmacy	Outpatient Behavioral Health (Adult)	Outpatient Behavioral Health (Child)
			% Members	% Members	% Members	% Members	% Members	% Members	% Members
1	19	144,579	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2	13	301,714	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
3	12	426,328	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%
4	14	347,131	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
5	15	289,152	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
6	27	220,932	99.6%	99.5%	99.7%	99.9%	99.8%	100.0%	100.0%

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

Wellcare									
Region	# of Counties	# of Members*	Hospitals	OB/GYN	Primary Care (Adult)	Primary Care (Child)	Pharmacy	Outpatient Behavioral Health (Adult)	Outpatient Behavioral Health (Child)
			% Members	% Members	% Members	% Members	% Members	% Members	% Members
1	19	144,579	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2	13	301,714	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
3	12	426,328	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
4	14	347,131	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
5	15	289,152	96.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
6	27	220,932	86.5%	99.4%	97.9%	95.9%	99.6%	100.0%	100.0%

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

Provider Enrollments by PHP

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

Provider Enrollment by PHP – Select Categories

Ambulatory Health Care Facilities by PHP

AmeriHealth	Healthy Blue	CCH*	United	WellCare
938	1,158	850	941	1,035

*CCH only operates in regions 3, 4 and 5. The other PHPs operate in all 6 regions.

Behavioral Health and Social Service Providers by PHP

AmeriHealth	Healthy Blue	CCH*	United	WellCare
8,738	9,041	7,521	5,568	8,436

*CCH only operates in regions 3, 4 and 5. The other PHPs operate in all 6 regions.

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	Carolina Complete Health*	Healthy Blue	United	WellCare	Total
No PCP Tier	26,190	11,433	49,076	50,433	26,639	**163,771**
Tier 1	5,691	3,756	6,194	5,256	2,062	**22,959**
Tier 2	64,961	57,604	85,865	94,269	49,808	**307,687**
Tier 3	293,137	202,217	451,017	311,176	403,366	**1,660,913**

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

Member Proportion by PHP and AMH Tier

	AmeriHealth	Carolina Complete Health	Healthy Blue	United	WellCare
No PCP Tier	6.72%	4.16%	8.29%	10.94%	5.53%
Tier 1	1.46%	1.37%	1.05%	1.14%	0.43%
Tier 2	16.66%	20.95%	14.50%	20.44%	10.34%
Tier 3	75.17%	73.53%	76.17%	67.48%	83.71%

AMH Provider Enrollment

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

	AmeriHealth	CCH**	Healthy Blue	United	WellCare
Tier 1	51.82%	74.14%	64.96%	62.04%	57.66%
Tier 2	63.63%	76.51%	89.47%	74.23%	69.32%
Tier 3	85.93%	91.94%	75.36%	82.19%	94.95%

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

**CCH's proportions are based on providers in regions 3, 4 and 5.

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 (DY6Q2 ends April 2024; however, data are available only through March 2024.)

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.

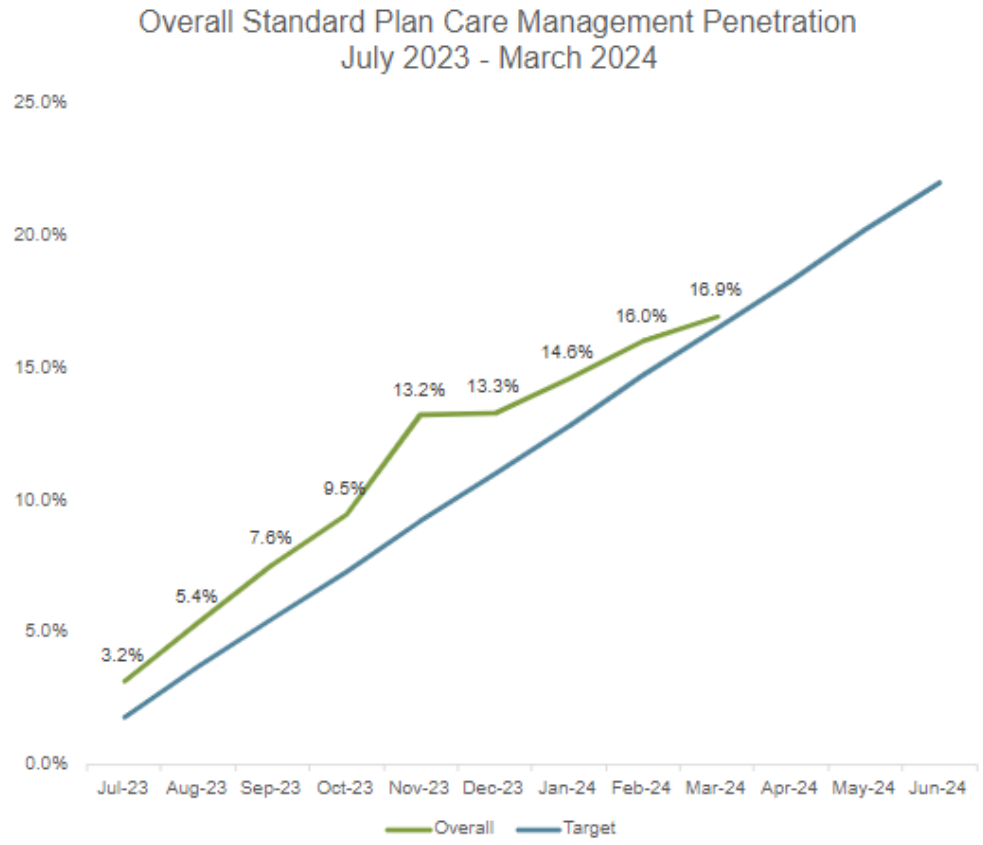
The Department has set a target of 22% of Standard Plan members receiving care management services in Contract Year 3. Standard Plans are currently on track to meet the target.

Care Management Penetration (defined as at least one interaction with care manager within one year) by Entity, Contract Year 3

Period: July 1, 2023 –March 31, 2024

	SP	AMH3	LHD	Overall
Total Number of Members Care Managed	79,956	304,271	39,285	395,748
Care Management Rate	**5.5%**	**23.7%**	**65.9%**	**16.9%**
Total Number of Members	1,444,675	1,283,169	59,577	2,335,436

***Source**: All data in table are derived from BCM051 Care Management Interaction report prepared by SPs and submitted to DHB. Some members may be receiving CM from multiple entities and may be counted in multiple categories.*



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

Emergency department visits per 1,000 members and inpatient admissions per 1,000 members are measured for the adult NC Medicaid population (age 21 and older) and broken out by Standard Plan and NC Medicaid Direct. Claims denied because they were erroneously billed to NC Medicaid Direct instead of a Standard Plan were excluded from measurement calculations to avoid duplication. Medicaid beneficiaries not eligible for hospital coverage (e.g., family planning participants) were excluded from NC Medicaid Direct calculations.

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, December 2023 – February 2024

AmeriHealth	CCH	Healthy Blue	Medicaid Direct	United	WellCare
55.58	57.45	55.95	81.14	58.72	55.73

Inpatient Admissions per 1,000 Members, December 2023 – February 2024

AmeriHealth	CCH	Healthy Blue	Medicaid Direct	United	WellCare
10.91	11.27	11.54	27.15	11.50	11.74

Results of beneficiary satisfaction surveys

There are no new beneficiary satisfaction survey results to report this quarter.

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 DY6Q2 reporting period activities have continued the evaluation work by the Sheps Center for Health Services Research (Sheps) team. The evaluation uses a mixed-methods approach, combining analysis of administrative data with qualitative data to obtain detailed insights into Medicaid transformation that are not easily captured through claims and surveys.

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. Beginning in April 2023, they began receiving encounter data from the State's LME/MCOs through a new claims processing system. As reported previously, the LME/MCOs changed the vendor through which their claims are submitted to align with Standard Plan data submission. As of last quarter, the data from this source is still not complete. Metrics that include services paid for through the LME/MCOs will be incomplete beginning on April 1, 2023, until the full data set is released. Additionally, because the July launch of Tailored Plans will bring medical services for the Tailored Plan-eligible population under Tailored Plan contracts, there may be an additional transitional period for processing these medical claims that could result in a longer claims run-out period beginning July 1.

Quantitative Update

The quantitative team continues to receive new data from the NC Division of Public Health, including updates to birth and death certificate and immunization data, and new files on care management data, value-based payment data and NCCARE360, the data base that tracks Healthy Opportunities Pilot services and referrals. We have also been in contact with the Division of State Operated Healthcare Facilities to revive the data request submitted years ago to receive data on institute of mental disease (IMD) utilization 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 the Controlled Substances Reporting System in North Carolina) have been received.

All data received sources are ingested into the University of North Carolina's secure data warehouse and are linked to NC Medicaid member information to generate metrics that are updated and tracked during the evaluation period. In addition, the team continues to update many of the metrics from established custodians for new time periods and updated technical specifications consistent with the NC Medicaid Managed Care Quality Strategy, Adult and Child Core measures, and other metrics that will address the study hypotheses. The evaluation team has been looking at Arizona Medicaid data as a potential comparison site. While Arizona and North Carolina are geographically separated, both states have considerably large non-White populations. In addition, Arizona was the first state in the nation to implement managed care in Medicaid, and thus its system represents a mature managed care program and may be a suitable comparison as a reflection of where North Carolina's system may be going. Sheps is in the process of 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.

The evaluation team has continued the development of a new member-level behavioral health dashboard. This new dashboard will include an expansion filter so users can view metrics based on pre-expansion and post-expansion populations. This should be released and made available to the Department in the upcoming quarter. Sheps also continues to update the aggregated behavioral health dashboard and the substance use disorder dashboard monthly.

The quantitative team is developing new methodology to account for the complex dynamics during the COVID-19 era. Once these have been finalized, we will share these methods with the state and CMS. Additionally, Sheps is developing a template for sharing quarterly updates on managed care to the Department. There is a benefit in providing quarterly updates on certain metrics to assess efficacy of various waiver components. This process should be fully scoped out by the end of next quarter.

Qualitative Update

This quarter's dissemination work includes finalizing drafts of the summary results for the 2023 provider interviews and beneficiary interviews after addressing reviewer comments. These summary reports will be posted on the Sheps' website. The first manuscript was resubmitted for review by the Department, and the revised version has been submitted to a scholarly journal for review and consideration. An abstract to present results from previous interviews to the AcademyHealth Annual Research meeting in June 2024 was accepted for presentation.

Work on PHPs and NCDHHS data collection this quarter included completing outreach materials, outreaching to organizations for interviews, and conducting four interviews with representatives from the North Carolina Association of Health Plans, PHPs, and the state. Outreach is ongoing, and the interviews for this data collection effort will be completed in the next quarter.

Concurrently, work on beneficiary data collection and interviews included finalizing all outreach tools and materials as well as interview logistics. Due to a pause to ensure the University of North Carolina and the state were in agreement around technology safety and security protocols in the evaluation contract, outreach to beneficiaries was paused to ensure the highest security. Outreach is now underway through multiple channels, including in coordination with the Department when applicable. In addition, a manuscript on caregiver data from 2023 interviews has been drafted and is being prepared for submission.

Healthy Opportunities Pilot

Operational Updates

Introduction

This quarter, the Healthy Opportunities Pilot (HOP) continued implementation efforts for the launch of the pilot with both the Tailored Care Management (TCM)-eligible NC Medicaid Direct beneficiary population and the Tailored Plans. Additionally, HOP finalized an approach for HOP fee schedule modifications and began coordination with the PHPs to implement those changes. Finally, the HOP Interim Evaluation Report (IER) was finalized and submitted to CMS in April. The IER included promising findings on the positive impact of HOP services, including that the program reduced members' health-related social needs, reduced adverse healthcare utilization, and lowered cost per beneficiary per month (compared to expected costs without the program).

Key Achievements

The Department continued preparing to launch HOP for the TCM-eligible NC Medicaid Direct beneficiary population, which included finalizing regression testing with the LME/MCOs and HOP technology vendor and contract execution for both the LME/MCOs and HOP Network Leads (NLs). The implementation of HOP for the Medicaid Direct population has experienced several delays due to competing Department and health plan priorities, but the HOP team has mitigated any potential confusion associated with the shifting timelines through consistent communication with program stakeholders.

Additionally, HOP coordinated with the Department's actuary to design enhancements to the HOP Fee Schedule. These enhancements are a direct result of feedback received from the field which indicated that there has been confusion over the requirements for service delivery and that the cost of delivery has increased over time, causing undue burden for HOP Human Services Organizations (HSOs). The HOP Fee Schedule updates will increase the service rates and caps to ensure HSOs are compensated appropriately for HOP service delivery. The updates also clarify some service descriptions to ensure Care Managers and HSOs understand the intent of each service and how it should be delivered to members effectively.

Key Challenges

The Department's multiple ongoing initiatives, including the upcoming Tailored Plan launch and LME/MCO consolidation, have created capacity constraints across the Department resulting in delays for the development and execution of HOP contracts. The Department and HOP stakeholders collaborated to adjust development timelines to mitigate further delays for the launch of HOP for the TCM-eligible NC Medicaid Direct population.

Performance Metrics

Enrollee Service Costs

This enrollee service cost analysis represents NCCARE360 data received by the Sheps Center on April 30, 2024. This data contains information on services delivered March 15, 2022 through March 29, 2024 that had an invoice status of "paid." There were 15,460 members that received a total of 302,850 services that had been both provided and paid for, totaling an amount paid of $56,600,652.90.

Prior reports reported costs using the "amount invoiced" field within NCCARE360 due to errors found in the "amount paid" field, which made the former more accurate at the time. Recently, data quality improvements within NCCARE360 have resolved these issues. Given that "amount paid" is now a reliable measure of costs incurred, we have used it in this report. Both "amount paid" and "amount invoiced" will continue to be monitored for reliability, but going forward we plan to use "amount paid."

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.

Ten largest paid amounts per individual beneficiary

Order	Total Amount Paid	Types of Service(s) Received			
		Food	Housing	Transportation	Cross*
1	$ 62,432.59	✓	✓	✓	✓
2	$ 60,645.14	-	-	-	✓
3	$ 58,775.57	✓	✓	✓	✓
4	$ 48,574.16	✓	✓	-	✓
5	$ 38,733.90	✓	✓	✓	✓
6	$ 33,868.63	✓	✓	✓	-
7	$ 33,409.28	✓	-	✓	✓
8	$ 33,199.35	✓	✓	-	-
9	$ 32,702.08	✓	✓	-	-
10	$ 32,512.81	✓	✓	✓	✓

*Cross-domain services include holistic high intensity enhanced case management, medical respite and linkages to health-related legal supports

**There were no IPV services delivered to any of the beneficiaries with the ten largest invoiced totals. IPV services launched April 5, 2023.

Percentile amount paid and amount invoiced per enrollee

Percentiles	Amount Paid
90%	$ 7,940.00
75%	$ 4,917.69
50%	**$ 2,655.76**
25%	$ 1,202.88
10%	$ 455.58

Percent of amount paid by PHP and service category

PHP	Food Services	Housing Services	Transportation Services	Cross – Domain	IPV* Services
AmeriHealth Caritas North Carolina	9.61%	4.30%	0.19%	0.19%	0.02%
Blue Cross and Blue Shield of North Carolina	16.79%	8.56%	0.51%	0.37%	0.03%
*Carolina Complete Health***	3.80%	3.42%	0.11%	0.17%	0.02%
UnitedHealthcare of North Carolina	11.30%	6.41%	0.45%	0.45%	0.02%
WellCare of North Carolina	22.26%	9.83%	0.73%	0.42%	0.03%
Total	**63.76%**	**32.51%**	**1.99%**	**1.61%**	**0.12%**

** Interpersonal Violence/Toxic Stress*

***CCH only operates in one Pilot region*

Percent of amount paid by PHP by enrollment category

PHP	Children 0 - 20	Adults 21+	Pregnant Women*	Missing
AmeriHealth Caritas North Carolina	5.76%	8.05%	0.33%	<1%
Blue Cross and Blue Shield of North Carolina	11.11%	14.53%	0.73%	<1%
*Carolina Complete Health***	3.32%	3.67%	0.23%	<1%
UnitedHealthcare of North Carolina	7.06%	11.10%	0.66%	<1%
WellCare of North Carolina	14.10%	18.24%	0.53%	<1%
Total	**41.35%**	**55.59%**	**2.48%**	**3.57%**

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

***CCH only operates in one Pilot region*

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. Updates were made to the data collection methods of the NCCARE360 platform during April 2023. Prior to this change the only way to collect information on pregnancy was through the screenings data. Following this change, this information was captured in the enrollment roster. Thus, the methodology for determining membership in the pregnant individual category differs in reports prepared using data before and after that date. 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.

Incentive Payments to PHPs, NLs, and Pilot providers

There were no incentive payments released this quarter.

Pilot Capacity Building Funding

There were no capacity building payments released this quarter.

Healthy Opportunities Pilots Evaluation Activities and Interim Findings

During this quarter, the Sheps Center HOP team provided ongoing technical assistance and engagement with state of North Carolina program personnel to facilitate the Healthy Opportunities Pilots evaluation. Activities included bi-weekly meetings to discuss data goals and technical difficulties as well as continued participation in standing meetings to discuss other program updates and goals.

Sheps completed the draft interim evaluation report in this quarter, and the Department submitted the report to CMS April 16, 2024. The IER included promising findings on the positive impact of HOP services, including that the program reduced members' health-related social needs, reduced adverse healthcare utilization, and lowered cost per beneficiary per month (compared to expected costs without the program). The Sheps team prepared briefer dissemination materials for other audiences and presented report findings in multiple venues, included a presentation to the Department's executive team and a presentation during the Medicaid Deep Dive series, a weekly presentation to which all Department employees are invited.

Primary data collection for evaluation question 4 (patient-reported health outcomes) is ongoing. Sheps has continued collecting data via a longitudinal survey that launched at the end of May 2023. Survey materials for Spanish speaking participants have been finalized and survey data collection for Spanish-speaking participants has begun. So far, Sheps has recruited and completed baseline surveys with 222 HOP participants. The team also prepared study materials to begin interviews with pilot participants that they anticipate launching in June 2024. An additional focus this quarter was finalizing materials for interviews with personnel at organizations within the pilot (NLs, HSOs, and PHPs). Outreach to personnel at these organizations is active and interviews began May 2024.

The Sheps team is working on dashboarding that facilitates monitoring of Pilot implementation. Dashboard visualizations include enrollment, invoicing and payment, and service delivery. This work has also included developing definitions of data elements that will be visualized in dashboards, working with

the Department to understand the prioritization of the data elements, and working on the design of the visualization dataset.

Finally, Sheps is working on an evaluation of the expedited enrollment program. This program uses different data flows compared to the standard program, requiring the design of new processes to extract and analyze relevant data.

Residential and Inpatient Treatment for Individuals with a Substance Use Disorder

The Department will provide detailed information in the Substance Use Disorder quarterly monitoring report due to CMS July 30, 2024.