Medicaid Section 1115 Monitoring Report

North Carolina - North Carolina Medicaid Reform Demonstration

DY6Q3 – May 1 through July 31, 2024

Resubmitted on Dec. 9, 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 3 REPORT

Executive Summary

This report covers Demonstration Year 6, Quarter 3 (DY6Q3) of the North Carolina Medicaid Reform Demonstration, May 1 through July 31, 2024.

The Department launched the Behavioral Health Intellectual/Developmental Disability Tailored Plans (Tailored Plans) July 1, 2024 with four Plans: Alliance Health, Partners Health Management, Trillium Health Resources and Vaya Health. At launch, 219,517 members were enrolled in a Tailored Plan. The primary care provider (PCP) choice period for members ended May 15, 2024, and members who did not choose a PCP were assigned to a PCP in-network with their Plan. The Department met the CMS requirement that 90% of members be assigned to their historical PCP to avoid care disruption. To ease administrative burden on providers and members during the transition period, the Department implemented temporary policy flexibilities related to prior authorizations, non-participating/out-of-network provider payment, and the timeframe for members to switch PCPs without cause.

There have been no significant widespread issues since Tailored Plan launch. Issues are being reported and resolved through the Technology Operations and Medicaid Help Center processes, and few issues have had to be escalated to Priority 1 (P1) Medicaid Help Center cases. For pharmacy point of sale (POS) claims, the pharmacy team has noted a higher-than-expected rate of denials due to prior authorizations and has issued additional guidance to Tailored Plans to address the issue. The pharmacy team is monitoring the effect this guidance has on denial rates through daily reporting.

In May, the Healthy Opportunities Pilot (HOP) program was implemented with the Pre-Paid Inpatient Health Plans (PIHPs), which expanded HOP eligibility to the Tailored Care Management (TCM)-eligible Medicaid Direct beneficiary population. HOP was implemented with the Tailored Plans simultaneously with Tailored Plan launch July 1. HOP enrollment for the Tailored Plan and PIHP populations exceeded initial projections, which can be attributed to communication and engagement efforts to raise awareness of the program. Additionally, modifications to the HOP fee schedule were implemented to clarify service descriptions and align the service caps and rates with increases in the costs of service delivery. The updates also clarify service descriptions to ensure Care Managers and Human Service Organizations understand the intent of each service and how to deliver it to members effectively. Finally, several enhancements were deployed to the HOP technology platform, NCCARE360, to streamline workflow and improve usability for stakeholders.

Medicaid Managed Care

Operational Updates

Tailored Plan Launch

The Department launched the Behavioral Health Intellectual/Developmental Disability Tailored Plans (Tailored Plans) July 1, 2024. The four Tailored Plans are Alliance Health, Partners Health Management, Trillium Health Resources and Vaya Health. Throughout May and June, the Department focused on monitoring key areas to support the launch. The PCP choice period for members concluded May 15, 2024, and members who did not choose a PCP were assigned to a PCP who was in-network with their Plan. Tailored Plans began mailing welcome packet to their members May 29, 2024, following PCP auto-assignment.

The Department published several policy flexibilities to ease administrative burden on providers and members during the transition period, including:

- Relaxing pharmacy and medical prior authorization requirements
- Paying non-participating/out-of-network providers at in-network rates for 91 days after launch
- Permitting uncontracted, out-of-network providers to follow in-network prior authorization rules until Jan. 31, 2025
- Extending the timeframe for members to switch PCPs without cause until Jan. 31, 2025
- Establishing continuity of care requirements for ongoing courses of treatment

There have been no significant widespread issues since Tailored Plan launch. Teams are reporting, tracking and resolving issues through the Technology Operations and Medicaid Help Center processes. The process to escalate questions or concerns is working and few issues have had to be escalated to Priority One (P1) Medicaid Help Center cases. The Department was closely monitoring non-emergency medical transportation (NEMT) rides and pharmacy point of sale (POS) claims as areas of risk at launch based on lessons learned from Standard Plan launch. The Department has noted only localized issues in NEMT and Plans have resolved any issues within expected timeframes. For pharmacy POS Claims, the pharmacy team has noted a higher-than-expected rate of denials due to prior authorizations and has issued additional guidance and expectations to Tailored Plans to address the issue. The team is monitoring the effect this guidance is having on denial rates.

The Department continues to hold regular meetings with the Tailored Plans, including weekly status meetings to track post-launch work and address business issues and risks, business unit-specific one-on-one meetings with each Plan, and bi-weekly calls with Tailored Plan executive leadership teams. The Department will evaluate the cadence and structure of these meetings as program operations stabilize and adjust meetings as needed to support effective oversight.

Standard Plans

In this quarter the Department is monitoring Standard Plan compliance related to provider welcome kits, call center metrics, and Advanced Medical Home data. To address continued concerns related to claims processing, the Department developed an informal process to address potential claims

operational issues that have been identified by internal and external stakeholders and will resolve issues by utilizing the Medicaid Help Center.

Key Achievements

Standard Plans

1. The Calendar Year 2 Standard Plan Network Adequacy submission analysis is complete, and outstanding appeals have been resolved. The Department completed time/distance and non-time/distance analysis of the CY3 Network Adequacy submissions.

Tailored Plans

1. During March and April, the 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 were monitored to resolution by the Department's Readiness Review team. The Tailored Plans worked to close out open items from these reviews throughout May and June, and by June 28, 2024, all open items were resolved across all Plans.
2. The Department created a "What to do if your NC Medicaid moved to a Tailored Plan" webpage. The page features helpful information for members and stakeholders, including a Tailored Plan Toolkit for stakeholders. The toolkit includes a presentation on Tailored Plans; flyers on NEMT, what happens if providers are not in network, and 1915(i) Medicaid home and community-based services; and social media posts. In June the team hosted a Community Partners webinar on Tailored Plans.
3. The Department completed validation on PCP assignments and all assignments were submitted to NCFAST by May 22, 2024. The overall historical PCP retention rate was 91%, meeting the CMS requirement of having at least 90% of members assigned to their historical PCP.
4. Tailored Plans began sending ID cards and welcome packet mailings on May 29, 2024. The Department also validated TCM assignments from Plans from May 23, 2024, through May 31, 2024.
5. The Tailored Plan Nurse and Pharmacy Lines were successfully launched June 1, 2024. Each line was tested and verified to be functioning properly after launch.

Key Challenges

Tailored Plans

1. **Network Adequacy and Provider Contracting** - The Department closed the notices of concern around provider contracting on May 13, 2024, after all Plans met the CMS requirement that 90% of their members could keep their historically assigned PCP. The Department continued to track PCP contracting leading up to the PCP auto-assignment period to ensure Plans remained above the requirements.

   Following bulk PCP auto-assignment, the Department ran an analysis and found two Tailored Plans, Alliance and Vaya, dropped below the 90% threshold, although the program as a whole remained above 90%. Both Plans were able to contract with providers and meet the 90% threshold in advance of July 1, 2024. The Department performed a final analysis on July 1, 2024,

and found Partners was the only Plan below the 90% requirement. Partners worked with the Department to make corrections to their assignments, and they were in compliance with the 90% threshold by July 15, 2024.

2. **PCP and Tailored Care Management (TCM) Auto-Assignment Testing -** PCP auto-assignment testing was scheduled to run from February 14 through April 1. 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 PCP assignment testing by the production go-live of May 16, 2024. As a mitigation, the Department aligned on an updated scope and extended the overall timeline. The mitigation allowed Plans to focus on meeting 90% accuracy for bulk assigning members to their historical PCPs, and then work to resolve remaining open defects and complete reassignment testing. Bulk PCP auto-assignment in production demonstrated the Plans could accurately assign members to their historical PCP by meeting the 90% target. PCP auto-assignment testing was completed June 13, and Plans were given approval to run their assignment process daily effective June 14.

   TCM auto-assignment testing was scheduled to run from March 25 through April 26. This testing was also 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, 2024. Following a similar mitigation approach as mentioned above, the Department aligned on an updated scope and extended the overall timeline, allowing plans to focus on meeting 95% accuracy for bulk-assigning members to their historical Tailored Care Managers, and then resolving remaining open defects and completing reassignment testing. Bulk TCM auto-assignment in production demonstrated the plans could accurately assign members to their historical TCM by meeting the 95% target. TCM auto-assignment testing was completed on June 13 and plans were given approval to run their assignment process daily effective June 14.

3. **NEMT Call Line Scheduling Issues -** On June 24, 2024, the NEMT team opened Priority 1 (P1) Help Center tickets for each Plan following analysis that there was a lack of scheduled trips effective July 1, 2024, for the high-utilization population. Early reports showed that many members were not successfully contacted, and trips were not being scheduled. There were also concerns that the ModivCare virtual agent scheduling line was difficult to navigate for members, impacting their ability to schedule rides.

   The Department met with all four Tailored Plans and ModivCare to resolve the issue. All Plans and ModivCare completed outreach to the high-utilization population in advance of launch, and a significant number of rides were scheduled. The virtual agent scheduling line was updated to improve member navigation. The general P1 Medicaid Help Center tickets for each Plan were closed and the Department opened individual tickets upon reports of any members having issues with NEMT rides.

4. **Pharmacy Claims Denials** - After launch, all four Plans saw higher volumes of pharmacy claims denials based on prior authorization (PA), which was unexpected due to the relaxed PA flexibilities in place for the first 90 days post-launch. The flexibilities did not always function as intended; for example, plans were not actively monitoring PA denials with claims data, there were issues with out-of-network providers, and auto-PA processes were not robust. Within the

first 30 days of launch, the Department shared updated guidance with the Tailored Plans on managing pharmacy POS denials, including modifying the claims rejection message to say that a 72-hour supply be provided to the member and adding the expectation that Plans implement proactive reviews of claims denials and process for a 30-day PA override when appropriate. The Department is continuing to monitor pharmacy POS claims processing to assess if the guidance is improving denial rates.

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.) There were 7,569 Member Ombudsman cases in DY6Q3, a decrease of approximately 4% from last quarter.

NC Medicaid Member Ombudsman Cases

	Information	Issue Resolution	Total
May 2024	519	1,911	**2,430**
June 2024	433	1,730	**2,163**
July 2024	535	2,441	**2,976**

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 9 recorded constituent concerns last quarter and 16 in this quarter.

Office of Administration Member Concerns

Issue Category	Number of Issues
Behavioral health	7
Claims	2
Durable Medical Equipment	1
Eligibility	6
Total	**16**

Lawsuits or legal actions

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

Legislative updates

S.L. 2024-34, enacted July 8, 2024, makes technical changes to various laws that intersect with managed care:

- Section 12.1 amends G.S. 108D-40(9) to provide that inmates of prisons are exempt from managed care for the lesser of 365 days from release or their initial Medicaid eligibility certification after release. Enacts new subdivision, G.S. 108D-40(9a), to provide a corresponding carve out for recipients residing in carceral settings other than prisons whose Medicaid eligibility has been suspended.
- Section 12.2 Makes technical correction to G.S. 122C-115(f) to clarify that LME/MCOs may continue managed BH/IDD, TBI services for Medicaid recipients who are not enrolled in managed care pursuant to a contract.
- Section 14 Encourages DHHS and LME/MCOs to enter into any intergovernmental agreements allowable under federal and State law with the Eastern Band of Cherokee Indians (EBCI) to facilitate the use of tribal health facilities by any residents of the State seeking voluntary admission or subject to involuntary commitment under State law.

S.L. 2024-25, enacted July 1, 2024, makes technical and clarifying changes to Hospital Assessment Act:

- Sections 5.1-5.4 add definition of rural emergency hospital and makes conforming changes throughout Article 7B of this Chapter (G.S. 108A-145.3). Updates figures used to calculate Health Advancement Assessments (G.S. 147.7).

S.L. 2024-1, enacted May 15, 2024, makes technical, clarifying and amendatory changes to the Current Appropriations Act of 2023.

Section 3.1 Section 9E.15(d) of S.L. 2023-134 to require LME/MCOs to recoup funds from providers who accepted rate increases earmarked to increase wages for Innovations direct care workers but failed to use the funds for the benefit of the applicable workers. Repeals recoupment requirements imposed on DHB.

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 will next be provided in DY6Q4. 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.

The Department is reporting the Low Birth Weight Measure for the first time this quarter. The Low Birth Weight Measure is a modified version of the CDC's Live Births Weighing Less Than 2,500 Grams measure (CMIT #413), and was developed to assess, monitor, and support prepaid health plan (PHP) efforts in North Carolina. In addition to following the technical specifications associated with the CDC measure, this modified metric considers only singleton, live birth deliveries. This modified metric also excludes babies born weighing less than 300 grams, to exclude births that are pre-viable but may be classified as live births in birth certificate records. Both low birth weight (<2,500 grams) and very low birth weight (<1,500 grams) are assessed, the latter being a subset of overall low birth weight births.

Results for calendar years 2021 and 2022 for Medicaid Direct and Standard Plans in aggregate are below. For future plan-level assessment, the Department intends to only consider deliveries where the birth parent had continuous coverage with the same health plan from 16 weeks gestation or earlier, to ensure that plans and providers have adequate opportunity to impact outcomes.

Notably, rates of low and very low birth weights appear to increase dramatically in the Medicaid Direct/Tribal Option population between 2021 and 2022. The most likely cause of this trend is the change in the Medicaid Direct population. Most Medicaid beneficiaries were moved to Standard Plans at the July 2021 launch, while beneficiaries with severe SUD or behavioral health issues, who are more likely to have poor birth outcomes, remained in Medicaid Direct. In the first half of 2021, all beneficiaries who gave birth would have been in Medicaid Direct, but by 2022 most beneficiaries were in Standard Plans the full calendar year. This is evidenced by the changed in the Medicaid Direct rate denominator from 22,451 in 2021 to 1,257 in 2022.

Low Birth Weight and Very Low Birth Weight, CY 2021-2022

Year	Measure	Line of Business	Rate
CY2021	Low Birth Weight (<2,500 Grams)	Medicaid Direct/Tribal Option	10.64% (2,389 / 22,451)
CY2021	Very Low Birth Weight (<1,500 Grams)	Medicaid Direct/Tribal Option	1.97% (442 / 22,451)
CY2021	Low Birth Weight (<2,500 Grams)	Standard Plans	10.18% (2,246 / 22,060)
CY2021	Very Low Birth Weight (<1,500 Grams)	Standard Plans	1.39% (307 / 22,060)
CY2022	Low Birth Weight (<2,500 Grams)	Medicaid Direct/Tribal Option	22.51% (283 / 1,257)
CY2022	Very Low Birth Weight (<1,500 Grams)	Medicaid Direct/Tribal Option	11.69% (147 / 1,257)
CY2022	Low Birth Weight (<2,500 Grams)	Standard Plans	10.21% (4,404 / 43,124)
CY2022	Very Low Birth Weight (<1,500 Grams)	Standard Plans	1.45% (627 / 43,124)

Quality of care

There are no quality of care metrics to report this quarter.

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	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	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

*Number of members mandated in Managed Care population as of 10/19/22. This is NOT representative of the 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%	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							

*Number of members mandated in Managed Care population as of 10/19/22. This is NOT representative of the 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	99.0%	99.0%	99.0%	99.0%	100.0%	100.0%	100.0%

*Number of members mandated in Managed Care population as of 10/19/22. This is NOT representative of the 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%	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	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

*Number of members mandated in Managed Care population as of 10/19/22. This is NOT representative of the 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	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	99.0%	99.0%	98.0%	97.0%	100.0%	100.0%	100.0%

*Number of members mandated in Managed Care population as of 10/19/22. This is NOT representative of the 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
960	1,155	884	944	1,060

*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
8,382	8,411	7,489	5,335	8,332

*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	29,630	11,516	52,955	50,267	30,220	174,588
Tier 1	5,860	4,241	6,149	5,478	2,135	23,863
Tier 2	65,527	58,009	86,767	98,828	51,118	360,249
Tier 3	294,265	205,133	458,082	316,789	408,107	1,682,376

*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	7.50%	4.13%	8.77%	10.66%	6.15%
Tier 1	1.48%	1.52%	1.02%	1.16%	0.43%
Tier 2	16.58%	20.80%	14.37%	20.97%	10.40%
Tier 3	74.44%	73.55%	75.85%	67.21%	83.02%

AMH Provider Enrollment

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

	AmeriHealth	CCH**	Healthy Blue	United	WellCare
Tier 1	51.85%	73.77%	64.44%	62.96%	45.19%
Tier 2	66.08%	67.57%	95.99%	75.62%	59.90%
Tier 3	84.60%	89.83%	80.17%	82.14%	90.29%

*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 for Standard Plan members

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 (DY6Q3 ends July 2024; however, data are available only through June 2024.)

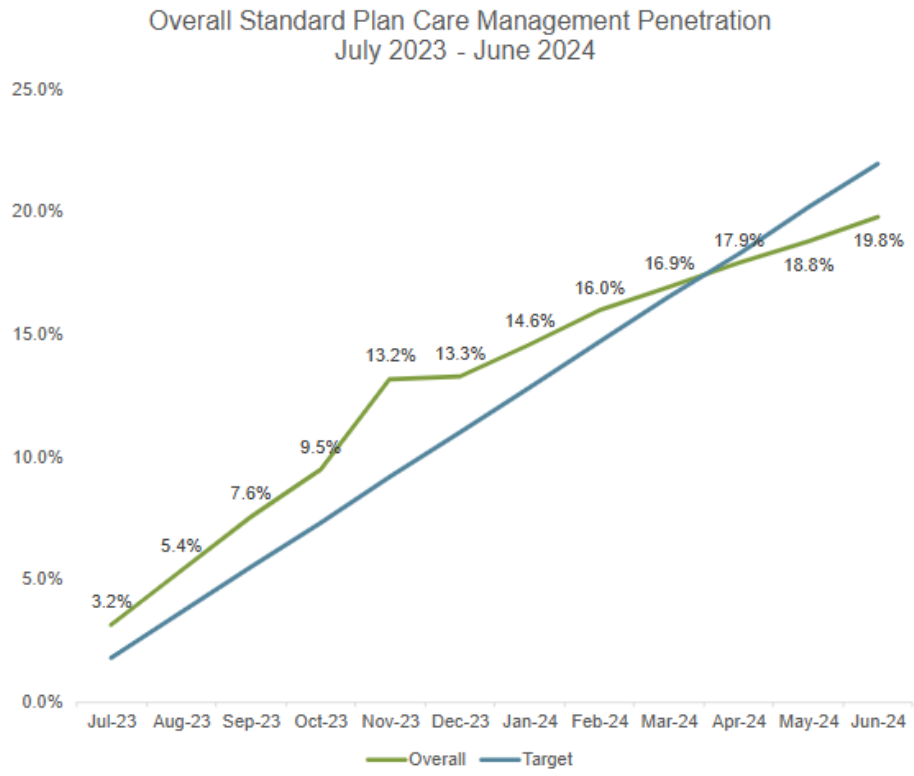
CMHRP is the Department's primary vehicle to deliver care management to pregnant women who may be at risk for adverse birth outcomes. CMARC offers a set of care management services for at-risk children ages 0 to 5. Care management provided through a Standard Plan, Tier 3 AMH, or LHD to members enrolled in Standard Plans is reported by Standard Plans on the BCM051 Care Management Interaction operational report.

In Contract Year 3, 19.8% of Standard Plan members received care management services, slightly below the Department's target of 22%.

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

Period: July 1, 2023 –June 30, 2024				
	SP	**AMH3**	**LHD**	**Overall**
Total Number of Members Care Managed	100,415	370,578	49,813	482,014
Care Management Rate	**6.4%**	**26.4%**	**69.9%**	**19.8%**
Total Number of Members	1,567,720	1,404,347	71,216	2,431,916

***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 remained in NC Medicaid Direct until the launch of Tailored Plans on July 1, 2024.

Emergency Department Visits per 1,000 Members, March – May 2024

AmeriHealth	CCH	Healthy Blue	Medicaid Direct	United	WellCare
55.48	55.78	56.05	86.35	57.91	55.46

Inpatient Admissions per 1,000 Members, March – May 2024

AmeriHealth	CCH	Healthy Blue	Medicaid Direct	United	WellCare
11.43	11.09	11.25	27.40	11.86	11.67

Results of beneficiary satisfaction surveys

Results from the 2023 Adult and Child Medicaid CAHPS Report will be provided next 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 DY6Q3 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, Sheps began receiving encounter data from the State's Local Management Entities/Managed Care Organizations (LME/MCOs) through a new encounter processing system. As reported previously, the LME/MCOs changed the vendor through which their encounters are submitted to align with Standard Plan data submission. Previously, metrics that include services paid for through the LME/MCOs were incomplete beginning on April 1, 2023, but Sheps is expected to receive the complete data in September 2024. 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 a 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. This quarter there were renewed discussions with the Division of State Operated Healthcare Facilities (DSOHF) on the data request to receive data on institute of mental disease (IMD) utilization not available from Medicaid claims due to state-only payments prior to and during the waiver. However, 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 decided to use Arizona Medicaid data as a comparison site after comparing trends in a selected set of metrics from prior to the demonstration period (2016-2019) and will begin the formal process to establish that relationship. 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.

The evaluation team has continued the development of a new member-level behavioral health dashboard. The dashboard includes an expansion filter so users can view metrics based on pre-expansion and post-expansion populations. It combines the previous SUD and behavioral health dashboards. The new dashboard has been sent to the Department for feedback, and once feedback has been received, should be released and made available to the Department in the upcoming quarter. Sheps has discontinued updating the aggregated behavioral health dashboard and the SUD dashboard, which were previously updated 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. The evaluation team presented information on this novel methodology to AcademyHealth and the American Society of Health Economists.

Qualitative Update

Summary results for the 2023 provider and beneficiary interviews were posted on the Sheps' website. Additionally, results were presented to the AcademyHealth Annual Research meeting in June 2024. Interviews with representatives from the North Carolina Association of Health Plans, PHPs, and the state were completed during this quarter, bringing the final interview count to nine. Audio recordings from all nine interviews were sent to a transcription service and transcripts were then reviewed, cleaned, and coded in Nvivo. Final analysis and documentation will be completed in the following quarter.

Interviews for beneficiary data collection also continued this quarter and are almost complete. In total, 25 interviews were complete at the close of the quarter. We anticipate two final interviews in the following quarter. Audio recordings from the completed interviews were also sent to a transcription service, reviewed, and cleaned. Tools for analyzing the data were drafted.

Healthy Opportunities Pilot

Operational Updates

Introduction

This quarter, the Healthy Opportunities Pilots (HOP) successfully launched for the Tailored Care Management (TCM)-eligible Medicaid Direct beneficiary population and the Tailored Plans. Additionally, necessary modifications to the HOP Fee Schedule were implemented to clarify service descriptions and align the service caps and rates with market increases in the costs of service delivery. Finally, several enhancements were deployed to the HOP technology platform to streamline workflow and improve usability for stakeholders.

Key achievements

In May, the HOP program was implemented with the Pre-Paid Inpatient Health Plans (PIHPs), which expanded HOP eligibility to the TCM-eligible Medicaid Direct beneficiary population. The implementation experienced some delays due to contract finalization timelines, but issues were mitigated promptly through collaborative working sessions between the Department and the PIHPs. These sessions helped finalize the remaining items in negotiation, expediting contract execution so that HOP services could be made available to this expanded group of potentially eligible beneficiaries. In July, HOP was implemented with the Tailored Plans simultaneously with Tailored Plan launch. The Department made changes based on lessons learned from previous HOP implementations, enabling a successful launch with minimal issues reported by stakeholders. HOP enrollment for the Tailored Plan

and PIHP populations exceeded the initial projections, which we attribute to communication and engagement efforts led by the Department to raise awareness of the program.

Additionally, updates to the HOP Fee Schedule were implemented to clarify service description requirements and revise service rates and caps to account for inflation and increases in administrative costs associated with HOP service delivery. 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 Human Service Organizations (HSOs) understand the intent of each service and how it should be most effectively delivered to members.

Finally, based on stakeholder feedback, enhancements were deployed to the HOP technology platform, NCCARE360, to improve workflow efficiency. This included updating HOP reason codes w to assist HOP care coordinators in providing a transparent identification of the cause of a member's disenrollment. Improvements were also made to the integration between the HOP technology platform and North Carolina's Medicaid Management Information System (MMIS) to ensure HOP care coordinators and utilization managers can access a member's most current insurance record and Medicaid Managed Care status.

Key challenges

As the North Carolina state legislature has not yet passed a budget, the amount of state funding available for HOP services may not be sufficient to meet the projected need for service delivery spend through the remainder of the current waiver period. The Department has modified capped allocation (set maximum amounts issued to each health plan) to allow them to plan as they enroll new members. To further mitigate the funding challenge, the Department has worked closely with the PHPs to identify budget flexibilities to mitigate the impact to beneficiaries and providers by improving transparency and consistency across plans. Additionally, as a long-term strategy, the Department is utilizing stakeholder feedback and previous service delivery spending data to develop a plan for scaling back certain services that are high cost with low utilization.

Performance Metrics

Enrollee Service Costs

This enrollee service cost analysis represents NCCARE360 data received by the Sheps Center on July 30, 2024. This data contains information on services delivered March 15, 2022 through June 21, 2024 that had an invoice status of "paid." There were 19,127 members that received a total of 430,623 services that had been both provided and paid for, totaling an amount paid of $82,758,679.10.

Prior to DY6Q2, costs were reported 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. Data quality improvements within NCCARE360 have resolved these issues. Given that "amount paid" is now a reliable measure of costs incurred, we will report this field moving forward. Both "amount paid" and "amount invoiced" will continue to be monitored for reliability.

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	$ 84,449.71	✓	✓	✓	✓
2	$ 72,500.15	✓	✓	✓	✓
3	$ 60,645.14	-	-	-	✓
4	$ 57,859.94	✓	✓	✓	✓
5	$ 50,435.19	✓	✓	-	✓
6	$ 40,724.19	✓	✓	✓	✓
7	$ 39,894.86	✓	✓	-	✓
8	$ 38,848.12	✓	✓	✓	✓
9	$ 38,149.62	✓	✓	-	✓
10	$ 35,857.81	✓	✓	✓	-

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

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

Percentile amount paid and amount invoiced per enrollee

Percentiles	Amount Paid
90%	$ 9,425.76
75%	$ 5,909.35
50%	**$ 3,157.56**
25%	$ 1,420.00
10%	$ 590.00

Percent of amount paid by PHP and service category

PHP	Food Services	Housing Services	Transportation Services*	Cross – Domain	IPV** Services
AmeriHealth Caritas North Carolina	9.77%	4.88%	0.25%	0.21%	0.03%
Blue Cross and Blue Shield of North Carolina	16.92%	8.82%	0.06%	0.43%	0.03%
*Carolina Complete Health****	3.56%	3.22%	0.15%	0.26%	0.02%
UnitedHealthcare of North Carolina	10.90%	6.49%	0.50%	0.50%	0.02%
WellCare of North Carolina	21.36%	9.78%	0.79%	0.51%	0.04%
Total	**62.51%**	**33.19%**	**1.75%**	**1.90%**	**0.15%**

**One invoice for $57.81 found for a transportation service associated with a Tailored Plan was excluded from the transportation service breakdown reported in this table*
*** Interpersonal Violence/Toxic Stress*
***CCH only operates in one of the three Pilot regions*

Percent of amount paid by PHP by Enrollment Category*

PHP	Children 0 - 20	Adults 21+	Pregnant Beneficiaries**
AmeriHealth Caritas North Carolina	6.43%	8.52%	0.27%
Blue Cross and Blue Shield of North Carolina	11.49%	14.94%	0.65%
*Carolina Complete Health****	3.22%	3.89%	0.17%
UnitedHealthcare of North Carolina	7.12%	10.98%	0.46%
WellCare of North Carolina	13.91%	17.93%	0.51%
Total	**42.17%**	**56.26%**	**2.06%**

** There were 2% of beneficiaries with an enrollment category missing*
***Pregnant beneficiaries will also appear in either children 0 – 20 or adults 21+*
**** CCH only operates in one of the three Pilot regions*

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 in 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 NC Medicaid 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 final HOP Interim Evaluation Report in this quarter, making edits and clarifications in response to CMS comments on the draft report. The Department submitted the final report to CMS July 10, 2024. Additionally, the team drafted a manuscript focused on the cost analyses in the report. Additional sensitivity analyses are being conducted as it relates to these analyses included in the manuscript. The manuscript was sent to the Department and then to CMS for review.

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. So far, they have recruited and completed 267 baseline surveys, 47 six-month surveys, and 4 twelve-month surveys with HOP participants. They have also begun interviews with eligible HOP participants. Another focus was recruiting for and completing interviews with personnel at organizations within the pilot (Network Leads, HSOs, and PHPs). Sheps completed 17 interviews with Network Lead personnel. Five interviews have been completed across three of the five participating PHPs, and the team is working to schedule interviews with the remaining two PHPs. Twelve interviews have been conducted across 10 HSOs, and the team continues to recruit and schedule interviews with a diverse range of HSOs.

Sheps continued its work on dashboards that facilitate 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.

Sheps has worked on several analyses of different elements of HOP this quarter. The evaluation of the expedited enrollment program mentioned in the previous quarter is ongoing. This program uses different data flows compared to the standard program, requiring the design of new processes in order to extract and analyze relevant data. There is an additional analysis being developed around the “No Wrong Door” HOP referrals. The team plans to send results of this analysis to the Department by the end of the August. The report will look at the total number of members referred to HOP through the No

Wrong Door policy and the percent that were enrolled in HOP, with a breakdown of these metrics by demographic categories. Sheps also completed an ad-hoc report relating to transportation, which analyzed reimbursement relating to private transportation support and vehicle repair services. Findings were sent to the Department June 24, 2024.

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 Oct. 29, 2024.