Medicaid Section 1115 Monitoring Report

North Carolina - North Carolina Medicaid Reform Demonstration

DY7Q1 – Nov. 1, 2024 through Feb. 28, 2025

Submitted on April 29, 2025

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

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DEMONSTRATION YEAR 7 QUARTER 1 REPORT

Executive Summary

1115 Waiver Renewal

On Oct. 23, 2024, CMS approved a 43-day temporary extension of the NC Medicaid Reform Demonstration to continue negotiations on the extension application. On Dec. 10, 2024, CMS approved NC Medicaid's 1115 Waiver for another five years. This allows the opportunity for many key improvements in the health and well-being of North Carolinians, including:

- Allows the option for the state-wide expansion of the Healthy Opportunities Pilots that invest in non-medical drivers of health like food, transportation and housing
- Opens access for people who are incarcerated to get NC Medicaid coverage for select services up to 90 days prior to their release, providing them critical health services and helping to break the expensive cycle of incarceration
- Enables more behavioral health resources for North Carolinians and boosts the behavioral health workforce
- Extends federal authority for North Carolina's Medicaid Managed Care program
- Makes it possible for children to remain covered by NC Medicaid for longer periods of time before redetermination is required, reducing burdensome paperwork for families and counties, and
- Continues availability of substance use disorder treatment for Medicaid beneficiaries while they are in an Institution for Mental Disease (IMD)

In order to cover the temporary extension period and the first quarter of the renewed Demonstration period (DY7Q1), this report covers activities from Nov. 1, 2024 to Feb. 28, 2025.

Tailored Plans

The Behavioral Health Intellectual/Developmental Disability Tailored Plans (Tailored Plans) launched July 1, 2024. There were no widespread issues at launch, and the Department continues to work closely with the Tailored Plans to monitor and address potential issues and risks. The Department's Data Quality Initiative has standardized operational reporting, improving data accuracy.

Children and Families Specialty Plan

The Department continues to make progress on key project milestones for the Dec. 1, 2025 launch of the statewide Children and Families Specialty Plan (CFSP) with the selected vendor, Healthy Blue Care Together (HBCT). The CFSP will support Medicaid-enrolled children, youth, and families served by the child welfare system in receiving seamless, integrated and coordinated care. The end-to-end testing plan was approved this quarter, and technical development is progressing appropriately to support beginning testing at the end of May 2025.

Justice Involved Reentry Initiative

The Department has begun operational updates in preparation for implementation of the Reentry Demonstration Initiative authorized under the 1115 Waiver. This initiative will allow people who are incarcerated to receive NC Medicaid coverage of select services up to 90 days prior to their release, providing access to critical health care services and case management.

Effective Jan. 1, 2025, Medicaid beneficiaries whose Medicaid coverage was suspended during a period of incarceration will be enrolled in NC Medicaid Direct (or the Eastern Band of Cherokee Indians Tribal Option, if eligible) upon release. Keeping these beneficiaries in fee-for-service Medicaid for one year post-release (rather than enrolling them in a prepaid health plan) ensures that they will have access to the full array of behavioral health services and a statewide physical health network, reducing health plan changes and confusion during the post-release period.

Healthy Opportunities Pilot (HOP)

In this quarter, the HOP team worked on implementation of HOP services for the Eastern Band of Cherokee Indians (EBCI) Tribal Option and continued implementation activities with the CFSP. The Department and EBCI Tribal Option leadership aligned on an approach to phase-in the launch of services beginning July 1, 2025. In this initial phase, the EBCI Tribal Option will complete all required readiness activities, onboard to the HOP program's technology platform, and offer only HOP food domain services to eligible members. Additionally, the Department began efforts this quarter to determine the strategic design of the program for the next five-year demonstration period.

Medicaid Managed Care

Standard Plans

This quarter the Department's Standard Plan team reviewed operational reports and analytics related to provider welcome kits, call center metrics, AMH data, appeals and grievances, and NEMT to address Standard Plan compliance in these areas. Two initial notices of deficiency (NOD) were issued to Standard Plans in this quarter.

Key Achievements

Contract Amendments
The Department executed Standard Plan Amendment 21(22) and Amendment 22(23) which revised and restated capitation rates from the period of January 1, 2025 – June 30, 2025. The Department continues to work on the upcoming biannual amendment update 2025-1 through contract and legal review and amendment update 2025-2 through collection of amendment items from business units.

Utilization Management and Mental Health Parity and Addiction Equity Act (MHPAEA)
In response to CMS' Notice to the Department on Oct. 23, 2024, informing the Department that NC Medicaid and its Managed Care Plans and Prepaid Inpatient Health Plans (PIHPs) must cease using non-compliant limits by Dec. 31, 2024, the Department issued a second notice to notify Standard Plans of utilization management ("UM") program changes necessary to comply with mental health parity requirements. The Department advised Standard Plans of the Quantitative Treatment Limitations (QTLs) and Non-quantitative Treatment Limitations (NQTLs) that they must remove from their UM program to ensure compliance. On Dec. 12, 2024, a revised notice was issued to the Standard Plans to provide additional clarification on removal and/or retention of QTLs and NQTLs from their UM Program.

Tailored Plans

The Department continues to monitor Tailored Plan operations through the Technology Operations and Medicaid Help Center processes, as well as regular meetings with the Plans. These meetings include weekly status meetings with each Plan to track post-launch work and address potential business issues and risks, Business Unit specific one-on-one meetings with each Tailored Plan, and biweekly calls with the Tailored Plan executive leadership teams to address key issues and risks.

Key Achievements

Contract Amendment
The Department successfully executed Amendment A5(7) and advanced the 2025-1 Amendment cycle, preparing the draft amendment and engaging in stakeholder and business unit discussions. The 2025-2 submission period closed, with submissions moving into processing and validation. The Department continues to refine amendment workflows, ensuring greater efficiency and alignment in future cycles.

Utilization Management and Mental Health Parity and Addiction Equity Act (MHPAEA)

In response to CMS' Notice to the Department on Oct. 23, 2024, informing the Department that NC Medicaid and its Managed Care Plans and PIHPs must cease using non-compliant limits by Dec. 31, 2024, the Department worked quickly to come into compliance. The Department issued a second Notice to the Tailored Plans on Nov. 1, 2024 advising Plans that the Department will remove all non-compliant limits from clinical coverage policies (CCPs) and the State Medicaid Plan by Dec. 31, 2024. The Notice instructed Tailored Plans to cease using all non-compliant limits by Dec. 31, 2024, submit required documentation by Dec. 20, 2024, and provide an attestation of compliance to the Notice by Jan. 3, 2025.

A revised version of the Notice was issued to the Tailored Plans on Dec. 12, 2024. The revision clarified that Tailored Plans could implement utilization management limits outside of the Department's CCPs after submitting documentation to the Department demonstrating the limits are compliant with MHPAEA. All Tailored Plans attested to removing all non-compliant limits by the required date. The Department is currently reviewing parity documentation submitted by the Tailored Plans that demonstrates the removal of the non-compliant limits and operational compliance with MHPAEA.

Key Challenges

Data Quality

Since December 2024, Tailored Plans have shown strong dedication to the Data Quality Initiative, leading to standardized operational reporting and improved data accuracy. Initially, reports contained tens of thousands of errors, but this has significantly decreased, to as low as 30 errors per submission. While scores remain in the 69-55% (orange) and 54% or lower (red) ranges, Tailored Plans are actively engaging with feedback and data quality processes. In February 2025, Tailored Plans received their first draft scorecard, with the official version expected in March 2025. Until then, the Department has continued providing detailed error feedback in monthly summaries.

Children and Families Specialty Plan (CFSP)

The state continues to make progress to prepare for the key project milestones for launching the statewide Children and Families Specialty Plan (CFSP) with the selected vendor, Healthy Blue Care Together (HBCT). The Department is having regular meetings with HBCT; including weekly status meetings with HBCT to track development work and address any potential business issues and risks, and bi-weekly calls with the HBCT's executive leadership to address key issues and risks. As part of these weekly status calls, the Department has been engaging with HBCT on system development and integration efforts and monitoring the progress closely. During this quarter, the Department also requested additional policy submissions for county engagement strategies from the CFSP.

Key Achievements

Inbound Deliverables

To date, HBCT has submitted a total of 142 deliverables. Reviewers from across the Department have gone through iterative reviews of each submitted deliverable and provided feedback to HBCT to address questions or unmet requirements prior to HBCT submitting final versions for approval.

End-to-End Testing Plan Approved

In the month of February, the end-to-end testing team met with individual business units to confirm scope of test paths and durations required to validate functionality. The team finalized the end-to-end testing plan and developed corresponding feature line items to track testing efforts upon commencement. The testing plan was approved through NC Medicaid governance on Feb. 20, 2025.

CFSP Technical Development
The Department continued to monitor Department system (e.g., EPS, NCTracks, NC FAST) and CFSP system development and independent testing. Business units coordinate with system teams for regular progression updates, and HBCT submits a weekly feature progression report documenting technical development efforts. As of the end of this quarter, development was progressing appropriately to support end-to-end testing beginning May 27, 2025.

Operational Report Templates and Report Guide
The Department reviewed and standardized operational reporting templates prior to sharing with HBCT to begin development. The Department has drafted the operational report guide and will be completing final review/approval of the guide and templates in March 2025. Once published, HBCT will use the Operational Report Guide as a reference document for first submission dates and processes for submission for operational reports required as part of the CFSP contract.

CFSP Contract Amendment
The Department met with HBCT on specific amendment item language to be included as part of the first standard cycle amendment to the CFSP Contract. The final draft amendment is currently under review with the Department's contracts and legal teams and is anticipated for execution during Q3.

Key Challenges

Network Adequacy and Provider Contracting
A key priority for the CFSP is preventing provider disruption for members and expanding the current network available to the CFSP population. HBCT's provider network coverage is being closely monitored throughout implementation. HBCT will need to contract with new behavioral health providers not included in their current network for the Standard Plan program. An underlying challenge in HBCT's provider contracting is that providers' current behavioral health rates are negotiated by the LME/MCOs and fee schedules have some ambiguity.

To address this challenge, the Department is conducting historical claims analysis to identify critical provider types for contracting based on CFSP-eligible population utilization. The Department is meeting bi-weekly with HBCT's contracting team for status updates and is receiving executive level updates on HBCT leadership calls. HBCT is providing specific details on contracting with new provider types outside of their Standard Plan network.

The Department will also leverage standard Network Adequacy Oversight measures applied in previous program implementations for the CFSP:

- CFSP submits monthly network data detail files formatted for time/distance and non-time/distance contractual standards analysis

- The Department analyzes submissions and measures progress towards meeting network adequacy contract standards on a minimum monthly basis
- Performance/progress is reported to stakeholders (scorecard, network adequacy tracker, gateway document)

County Department of Social Services (DSS) Readiness Approach
County Readiness represents a novel aspect of internal readiness that the Department has not overseen for County Child Welfare with previous Managed Care program launches. Across all 100 counties, DSS offices use different technical solutions and processes to manage child welfare information. This poses a challenge for designing consistent collaboration approaches between HBCT care managers and county child welfare workers and creating standardized readiness assessment methodologies.

The Department is leading regular engagement series with cross-divisional stakeholders, including DSS at both the state and county levels, to finalize the County Readiness approach. The team is considering the following approaches:

- Conducting surveys with counties to gain a better understanding of system and process differences
- Having HBCT and the Department conduct County "Roadshows" to provide program details across seven Child Welfare regions prior to readiness activities
- Engaging with HBCT to capture intersection points between health plan readiness and County Readiness
- Conducting onsite readiness reviews with a representative sample of counties and using a 100-county survey approach to validate County Readiness for launch

Additional 1115 Waiver Programs

Justice-Involved Reentry Initiative

The Department has begun making operational updates in preparation for implementation of the Reentry Demonstration Initiative authorized under the 1115 Waiver. This initiative will allow people who are incarcerated to receive NC Medicaid coverage for select services up to 90 days prior to their release, providing access to critical health care services and case management.

As part of program design planning, the Department has started holding monthly meetings with the NC Department of Adult Correction (DAC) and the Division of Juvenile Justice and Delinquency Prevention (DJJDP). DHB has also held initial conversations with the EBCI, NC Association of County Commissioners, the NC Formerly Incarcerated Transition Program (NC FIT), and the NC Community Health Center Association (along with representatives from local community health centers) on the reentry work and the various roles these stakeholders can play in supporting implementation.

There is ongoing development of materials to be shared with stakeholders, such as an 1115 Reentry Policy Paper, a stakeholder presentation, and an 1115 Waiver Fact Sheet. There are also working groups scheduled to make design decisions regarding eligibility and enrollment, benefits, capacity building, and facility readiness.

Key Achievements

Data Sharing Memorandum of Agreement

In January 2025, a memorandum of agreement (MOA) for automated data sharing between NCDHHS, DHB and the Department of Public Safety (DPS), DJJDP was executed. This agreement paves the way for data sharing between these entities, allowing for the automated suspension and unsuspension of benefits for individuals in DJJ facilities. Currently, this process relies on manual reporting.

Effective Jan. 1, 2025, Medicaid beneficiaries whose Medicaid coverage was suspended during a period of incarceration will be enrolled in NC Medicaid Direct (or the EBCI Tribal Option, if eligible) upon release. Keeping these beneficiaries in fee-for-service Medicaid for one year post-release (rather than enrolling them in a PHP) ensures that they will have access to the full array of behavioral health services and a statewide physical health network, reducing health plan changes and confusion during the post-release period.

Eligibility Changes for Incarcerated Individuals

Effective Jan. 1, 2025, Medicaid beneficiaries whose Medicaid coverage was suspended during a period of incarceration will be enrolled in NC Medicaid Direct (or the EBCI Tribal Option, if eligible) upon release. Session Law 2024-34 Part XII. Clarifying Medicaid Benefits for Inmates, Section 12.1.(a) G.S. 108D-40 states that beneficiaries who are incarcerated and whose Medicaid enrollment has been suspended will remain excluded from NC Medicaid Managed Care for up to 365 days following their release. Keeping these beneficiaries in fee-for-service Medicaid for one year post-release ensures that they will have access to the full array of behavioral health services and a statewide physical health network, reducing health plan changes and confusion during the post-release period.

Effective Feb. 1, 2025, Medicaid eligibility policy was updated so that benefits for individuals incarcerated in county jails are suspended instead of terminated. Systems changes are underway to facilitate automated suspension and unsuspension of benefits for individuals incarcerated in county jails. Implementation of automated suspension is planned for Spring 2025.

Key Challenges

State Funding for Reentry Services

The Department is waiting to begin engagement with jails and other stakeholders until state funding of reentry services is confirmed. To mitigate delays, the Department is preparing materials for stakeholder engagement and proactively identifying which stakeholders to engage as soon as legislative funding approval is granted. Any materials for engagement are approved by the Department and have appropriate messaging around the 1115 waiver implementation. Additionally, the Department continues to push forward with the implementation of CAA 5121 pre- and post-release services for youth, which will ultimately help prepare for the launch of the 1115 reentry program.

Continuous Eligibility for Children

The 1115 Waiver renewal provided federal authority to implement continuous eligibility (CE) for 0–18-year-olds. Teams have begun activities to implement CE for modified adjusted gross income (MAGI) children, which will go into effect July 1, 2025. Code development and testing is underway to implement new CE rules in the NC FAST system. Updates to policy, caseworker guidance, and training are also in progress. The state has been working to ensure there are no gaps for MAGI children as North Carolina

discontinues 12-month continuous coverage for children under e14 waiver authority and implements CE under 1115 waiver authority.

Issues or complaints identified by beneficiaries

Member Ombudsman Cases

The NC Medicaid Member 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 10,119 total Member Ombudsman cases from November 2024 to February 2025.

NC Medicaid Member Ombudsman Cases

	Information	Issue Resolution	Total Cases
November 2024	438	1,688	2,126
December 2024	449	1,948	2,397
January 2025	663	2,297	2,960
February 2025	599	2,037	2,636

Appeals and Grievances

Appeals and grievances data is provided by the most recent Fiscal Year quarter, broken out by Standard Plans and Tailored Plans. Currently, data on reasons for appeals and grievances is only collected for Tailored Plans, but will become available for Standard Plans after the launch of a new operational report to capture this information. At that time, we will add data on reason categories for Standard Plan appeals and grievances. Appeals for denial of benefits refers to an appeal filed regarding any denial of service, whether an initial service or continuation. It does not include payment denials.

Appeals and Grievances, October – December 2024

	Standard Plans	Tailored Plans
Appeals Total	3,204	323
Grievances Total	2,198	942
Appeals – denial of benefits		318

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 originally planned to report three annual outcome measures in its monitoring reports: Comprehensive Diabetes Care, Low Birth Weight, and Rating of Personal Doctor. Rating of Personal Doctor, a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measure, was reported in DY6Q4. The Low Birth Weight Measure for 2021 and 2022 was reported for the first time in DY6Q3. Hemoglobin A1c (HbA1c) Control for Patients with Diabetes rates are not available yet, as the Department does not receive A1c values through claims and encounters. The Department is working to obtain accurate A1c data through NC HealthConnex, North Carolina's statewide health information exchange, to report this measure in the future.

Quality of care

Annual quality measures were reported last quarter, in the DY6 report.

Access to care

Network Time/Distance Standards

Standard Plans
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. 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) as of the end of January 2025. In the next quarter, network adequacy metrics for Tailored Plans will also be provided.

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%	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	99.3%	99.4%	99.6%	99.6%	99.9%	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%
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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%	99.5%	99.5%	99.2%	99.8%	100.0%	100.0%

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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	99.5%	99.4%	99.8%	99.9%	99.8%	99.9%	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%
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Provider Enrollments by Standard Plan

Provider enrollment by provider type is available by Standard Plan. 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.

Ambulatory Health Care Facilities by Standard Plan

AmeriHealth	Healthy Blue	CCH*	United	WellCare
1,019	1,226	987	932	1,088

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

Behavioral Health and Social Service Providers by Standard Plan

AmeriHealth	Healthy Blue	CCH*	United	WellCare
9,642	9,709	8,031	6,297	9,047

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

Emergency Department Visits and Inpatient Admissions Rates

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/Tribal Option (TO). Medicaid beneficiaries not eligible for hospital coverage (e.g., family planning participants) are excluded from NC Medicaid Direct calculations.

To reflect claims lag and provide more accurate data, the Department reports these rates with a two-month lag.

Emergency Department Visits per 1,000 Adult Members, September – November 2024

AmeriHealth	CCH	Healthy Blue	Medicaid Direct/TO	United	WellCare
52.92	54.82	55.00	84.82	56.09	54.54

Inpatient Admissions per 1,000 Adult Members, September – November 2024

AmeriHealth	CCH	Healthy Blue	Medicaid Direct/TO	United	WellCare
10.02	9.71	10.66	23.74	11.17	10.73

Results of beneficiary satisfaction surveys

There are no 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

In DY7Q1 the University of North Carolina Sheps Center for Health Services Research (Sheps) continued its evaluation work for the 1115 waiver. 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. In this quarter the Sheps team revised the Managed Care Interim Evaluation Report based on comments from CMS received Oct. 8, 2024. The final report was submitted to CMS Dec. 18, 2024.

Quantitative Update

The quantitative team continues to utilize MC Medicaid claims and encounter data, along with data from the NC Division of Public Health (DPH). This quarter, the team began receiving new data sources, including:

- Division of State Operated Healthcare Facilities (DSOFH) Data
- Pregnancy Screening Data
- Health Information Exchange Authority (HIEA) Data

The team has begun integrating the new data into the monthly data ingestion process, and they expect to utilize this data in the Summative Evaluation Report. To date, they still have not received data from the Prescription Drug Monitoring Program (referred to as the Controlled Substances Reporting System in North Carolina).

The quantitative team has been developing new methodology to account for the complex dynamics during the COVID-19 era and expects this to be complete by the end of next quarter (DY7Q2). Once finalized, the methods will be shared with the Department and CMS. The team also continues to update the member-level behavioral health dashboard on a quarterly basis and is working on adding an additional filter.

On April 1, 2023, LME/MCOs transitioned to the same encounters processing vendor used by the Standard Plans, and for months after this transition not all encounters were being received in Sheps' data. This impacted the accuracy of the SUD monitoring metrics, which are run by Sheps. This issue has now been resolved, and the previously missing encounters are now included in the data. Sheps sent the Department revised metrics for the quarters affected, DY5Q3 through DY6Q3. The Department informed CMS that revised SUD monitoring reports for these quarters will be submitted by April 11, 2025.

Qualitative Update

Last quarter Sheps completed transcription, cleaning, and coding of the interviews with representatives from PHPs, the North Carolina Association of Health Plans, and the state. They drafted a two-page report intended for NC Medicaid and related stakeholders, which is now published on the Sheps website. In addition, from these data they continue to work on a short deliverable piece aimed at a broader health policy and practice audience, as well as a longer deliverable piece on facilitators of North Carolina's transition to managed care under the waiver.

The beneficiary engagement paper previously reviewed by the Department was resubmitted and accepted for publication at *Medical Care Research and Review*. A paper on provider contracting considerations using 2022 and 2023 provider data is currently being reviewed internally. Sheps is also working on a mixed methods manuscript about the participation of provider practices in the Advanced Medical Home Program. Both manuscripts will be sent to the Department for review next quarter. Planning for the next phase of data collection has begun, with preliminary discussions exploring a focus on various areas, including Tailored Plans.

Work on outreach efforts and interviews with beneficiaries concluded in September 2024. In total, 35 interviews were completed with beneficiaries from both Standard Plans and Tailored Plans from July 2024 to September 2024. The report on beneficiary interview data has been drafted and will be sent to the Department for review, to be published on the Sheps website once complete. Sheps is also planning a manuscript on the 2024 beneficiary data. A manuscript on the 2023 beneficiary data is currently under a second round of review with the Department before a journal submission anticipated in the next quarter. Sheps is in the early stages of planning for the next round of data collection in the Fall of 2025.

The beneficiaries report incorporated feedback from key stakeholders and was reviewed accordingly. It was then presented to the core evaluation team, where any additional feedback was addressed before submission to the state. The 2023 Medicaid Provider Experience Survey report was reviewed by the Department and published on the Sheps website in February 2025.

Healthy Opportunities Pilot

Operational Updates

In this quarter, the Healthy Opportunities Pilot (HOP) initiated the implementation of HOP services for the EBCI Tribal Option and continued implementation activities with the CFSP. Additionally, HOP began efforts to determine the strategic design of the program for the next 5-year demonstration period.

Key achievements

The determination was made this quarter to prioritize the implementation of HOP for the EBCI Tribal Option, to align with the Department's overarching goal of promoting access to HOP services to eligible NC Medicaid beneficiaries. The HOP program collaborated closely with the EBCI Tribal Option leadership to align on an approach to phase-in the launch of services beginning July 1, 2025. In this initial phase, the EBCI Tribal Option will complete all required readiness activities, onboard to the HOP technology

platform, and offer only HOP food domain services to eligible members. The remaining HOP service domains will be implemented in subsequent phases.

Additionally, implementation activities continued with the CFSP to launch HOP for youth and their families served by the child welfare system. The HOP team participated in stakeholder engagement sessions, developed supplemental materials to facilitate process and technical development, and monitored the CFSP's progress toward completing required implementation activities.

Finally, HOP began design sessions to discuss lessons learned from the previous demonstration period and review operational changes with the 1115 waiver renewal to develop a strategic vision for the next demonstration that aligns with the Department's goals and priorities.

Key challenges

The Impact Health Network Lead region continued to recover from the impacts of Hurricane Helene, which significantly affected the Human Services Organizations (HSOs) and beneficiary population in the western region of North Carolina. The Department continued coordinating with stakeholders to mitigate service disruption for members and to facilitate the process to help HSOs become operational as soon as possible.

In the initial months following the launch of HOP with the Tailored Plans and PIHPs, member enrollment and service delivery exceeded initial projections. Within this quarter, however, the plans are reporting a significant decrease in new HOP enrollees and delivery of services, which has resulted in the underutilization of their HOP capped allocation funding. The Department has taken steps to reduce the plans' funding for this Service Delivery Period and is collaborating with the plans to identify strategies for improving enrollment and service delivery.

Performance Metrics

Enrollee Service Costs

This enrollee service cost analysis represents NCCARE360 data received by the Sheps Center by Feb. 28, 2025. This data contains information on services delivered March 15, 2022 through Dec. 9, 2024 which had an invoices status of "paid." There were 28,614 members that received a total of 735,202 services that had been both provided and paid for, totaling an amount paid of $150,943,061.

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 have used it in this report. Both "amount paid" and "amount invoiced" will continue to be monitored for reliability.

In previous reports, Medicaid encounter claims had far fewer encounters than the NCCARE360 data. Thus, the quarterly cost reports have used NCCARE360 data as the data source for analyses. For continuity, we have continued to use NCCARE360 data for analyses presented in this report. However, contrary to what has previously been seen in the data, there are now more Medicaid encounters claims

than NCCARE360 invoices. This trend will be monitored and if Medicaid Encounter claims continues to be a more timely source it may be used in future reports in place of NCCARE360 data.

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.

Amount Paid per Enrollee

The below table contains values for the ten largest cumulative amounts paid on behalf of an individual beneficiary since HOP launch, along with an indicator of whether an individual has received any services in each specific service domain.

Ten largest paid amounts per individual beneficiary

Order	Total Amount Paid	Types of Service(s) Received*			
		Food	Housing	Transportation	Cross**
1	$ 92,864.72	✓	✓	✓	✓
2	$ 84,918.95	✓	✓	✓	✓
3	$ 60,645.14	✓	✓	✓	✓
4	$ 57,859.94	-	✓	✓	✓
5	$ 50,755.79	-	-	-	✓
6	$ 44,283.50	-	✓	✓	✓
7	$ 42,710.93	✓	✓	✓	✓
8	$ 42,133.33	✓	✓	-	✓
9	$ 41,939.10	✓	✓	✓	✓
10	$ 40,858.74	-	✓	✓	✓

**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 Costs per Enrollee

The percentiles of cumulative paid amounts per individual beneficiary are provided below.

Percentile amount paid per enrollee

Percentiles	Amount Paid
90%	$ 12,150.23
75%	$ 7,325.22
50%	$ 3,608.64
25%	$ 1,553.99
10%	$ 628.06

Amount Paid by PHP and Service Category

The distribution of the percentage of total spending by PHP and service category is presented in two tables below. HOP launched with PIHPs in May 2024 and with Tailored Plans at their launch on July 1, 2024. (Tailored Plans and PIHPs are operated by the LME/MCOs.) Since HOP launched with Standard Plans in March 2022, overall LME/MCO spending is only a small portion of cumulative PHP spending.

The first table breaks out cumulative spending by Standard Plan and all LME/MCOs combined since HOP launch. The following table breaks down spending by LME/MCO as a percentage of total LME/MCO spending. It should be noted that only three of the four LME/MCOs operate in HOP pilot regions.

Percent of amount paid by PHP and service category

PHP	Food Services	Housing Services	Transport. Services	Cross – Domain	IPV* Services
AmeriHealth Caritas North Carolina	9.30%	4.99%	0.26%	0.20%	0.02%
Blue Cross and Blue Shield of North Carolina	16.88%	9.20%	0.60%	0.62%	0.05%
*Carolina Complete Health***	3.38%	3.09%	0.15%	0.35%	0.03%
UnitedHealthcare of North Carolina	10.68%	6.94%	0.44%	0.49%	0.03%
WellCare of North Carolina	19.55%	9.63%	0.71%	0.51%	0.04%
Combined Total of All Tailored Plans/PIHPs	1.11%	0.62%	0.05%	0.07%	0.00%
Total	**60.90%**	**34.47%**	**2.21%**	**2.24%**	**0.17%**

** Interpersonal Violence/Toxic Stress*

***CCH only operates in one of the three Pilot regions*

Percent of amount paid by LME/MCOs by service category, out of spending by only LME/MCOs*

PHP	Food Services	Housing Services	Transport. Services	Cross – Domain	IPV** Services
Partners Health Management – PIHP	1.83%	-	-	0.04%	-
Partners Health Management – Tailored Plan	3.05%	1.18%	-	0.06%	-
Trillium Health Resources - PIHP	6.44%	6.32%	0.00032%	0.05%	-
Trillium Health Resources - Tailored Plan	19.53%	12.24%	0.006%	0.15%	0.03%
Vaya Health – PIHP	6.60%	2.52%	0.38%	1.88%	0.05%
Vaya Health – Tailored Plan	22.71%	10.72%	1.24%	1.57%	0.04%
Total	**60.16%**	**32.98%**	**2.25%**	**3.75%**	**0.12%**

** Sum of amount paid for all LME/MCOs was 1.85% of total amount paid for all PHPs*

*** Interpersonal Violence / Toxic Stress*

Amount Paid by PHP and Eligibility Category

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.

The table below shows costs by the five Standard Plans for services which have been paid by the Plan by Enrollment Category. An aggregated total for Tailored Plan PHPs is also provided in this table for comparison purposes. More granular detail of amount paid by LME/MCOs by Enrollment Category is provided in the second table.

Percent of amount paid by PHP by Enrollment Category*

PHP	Children 0 - 20	Adults 21+	Pregnant Beneficiaries**
AmeriHealth Caritas North Carolina	5.91%	8.42%	0.28%
Blue Cross and Blue Shield of North Carolina	11.10%	15.42%	0.85%
Carolina Complete Health	2.95%	3.85%	0.19%
UnitedHealthcare of North Carolina	6.92%	11.07%	0.42%
WellCare of North Carolina	12.55%	16.85%	0.57%
Combined Total of All Tailored Plans/ PIHPs	0.51%	1.29%	0.03%
Total	**39.94%**	**56.90%**	**2.34%**

** There were 1% of beneficiaries with an enrollment category missing*

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

Percent of amount paid by LME/MCOs by Enrollment Category out of spending by only LME/MCOs*

PHP	Children 0 - 20	Adults 21+	Pregnant Beneficiaries**
Partners Health Management – PIHP	-	2.31%	0.05%
Partners Health Management – Tailored Plan	0.36%	3.87%	0.06%
Trillium Health Resources - PIHP	1.82%	11.12%	0.32%
Trillium Health Resources - Tailored Plan	9.21%	22.88%	0.68%
Vaya Health – PIHP	1.42%	9.86%	0.02%
Vaya Health – Tailored Plan	15.23%	20.54%	0.24%
Total	**28.04%**	**70.58%**	**1.37%**

** Sum of amount paid for all LME/MCOs was 1.85% of total amount paid for all PHPs*
***Pregnant beneficiaries will also appear in either children 0 – 20 or adults 21+*

Incentive Payments to PHPs, NLs, and Pilot providers

The following Value Based Payment incentive payments were made to the Tailored Plans. One payment was made in DY6Q4 but is being reported for the first time this quarter.

Tailored Plan	Checkwrite Date	Amount
Vaya	10/02/2024	$70,000.00
Trillium	12/10/2024	$70,000.00
Partners	12/10/2024	$70,000.00

Pilot Capacity Building Funding

There were no capacity building funds 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 Department personnel to facilitate the HOP 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 is disseminating results from the HOP Interim Evaluation Report, which was approved by CMS Nov. 5, 2024, through submission of scientific manuscripts to peer-reviewed journals. Their manuscript was published online by *JAMA* on Feb. 27, 2025.

Sheps also conducted primary data collection for Evaluation Question 4 (patient-reported health outcomes). They have continued collecting data via a longitudinal survey that launched at the end of May 2023. Recruitment for baseline surveys was completed Feb. 15, 2025, with a total of 335 total enrollees. Outreach for six- and twelve-month surveys is ongoing, with 140 six-month surveys and 34 twelve-month surveys completed so far with HOP participants. They have also conducted 26 interviews with HOP participants. Additionally, Sheps began qualitative coding and analysis of interviews completed with personnel at organizations within the pilot (Network Leads, Human Service Organizations, and PHPs). Results from the qualitative reports will be included in the Summative Evaluation Report.

An additional focus this quarter was on dashboards that facilitate monitoring of HOP implementation. Dashboard visualizations include enrollment, invoicing and payment, and service delivery. Sheps has been 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.

To prepare for the Summative Evaluation Report, Sheps is working on establishing data flows from the Health Information Exchange to receive data needed for Evaluation Question 4 analyses and Evaluation Question 6 cost analyses. They received the first batch of data from the Health Information Exchange in early January and are preparing the data for analysis while monitoring the continued monthly flow of data. This includes ensuring all the necessary data elements are present, working with the Department on delivery cadence, and developing timelines for completing necessary analyses. In this quarter, Sheps sent a list to the Department of additional data sources needed, particularly as it relates to HOP cost analyses.

Sheps is preparing a new data set and analysis for HOP cost analyses to inform discussions around the next iteration of HOP. This included preparing a new dataset and working on analyses to provide the state with information regarding heterogeneous treatment effects of HOP interventions for different outcomes and clinical populations. Sheps is also working with the Department to draft the Evaluation Design and metrics of interest for the 1115 Waiver renewal.