North Carolina January 2022 Quarterly Report for the Implementation of the American Rescue Plan Act of 2021, Section 9817 – 10% FMAP Increase for HCBS

Table of Contents

Introduction

Home and Community-Based Services (HCBS) are forms of care offered to individuals in a home or community setting rather than in an institution or isolated setting. Typically, HCBS are provided to older adults or individuals with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses. HCBS promote the health and well-being of individuals with functional limitations while also enabling them to live at home and alongside other community members.

North Carolina, like much of the country, has a growing need for HCBS. Over the last ten years, while the North Carolina population saw a 10 percent increase, there was a 41.9 percent increase in the population over 65 years old.[1] Geographically, all 100 counties in the state have experienced increases in the population over 65 years old. The need for direct care workers to provide HCBS is expected to increase dramatically over the next decade with more than an additional 20,000 positions expected by 2028.[2] The direct care workforce has high rates of turnover and low retention rates, in part due to limited wages and promotion opportunities. The workforce has been on the frontlines of the COVID-19 pandemic, ensuring that people with heightened risk of COVID-19 receive services and keeping people out of facilities, including those that had higher rates of infection. North Carolina provides HCBS through a variety of programs including 1915(c) waiver programs, PACE, state plan services, and several programs focused on people with disabilities and older adults.

The American Rescue Plan Act (ARPA), signed by President Biden on March 11, 2021, provides increased funding for HCBS through Medicaid to enhance, expand, or strengthen these services. In the face of heightened challenges due to the COVID-19 pandemic, the goal of financial incentives to support HCBS is to promote community living, improve quality of life, and enhance access to services that enable independence, productivity, integration, inclusion, and self-determination for older adults and individuals with disabilities. Section 9817 of ARPA temporarily increases the Federal Medical Assistance Percentage (FMAP) for HCBS by 10 percentage points. The increased FMAP will be in place from April 1, 2021 to March 31, 2022. The additional federal funds must be used to supplement, not supplant, existing state funds for Medicaid HCBS in effect as of April 1, 2021. States are required to use state funds equivalent to the increased federal funds towards HCBS improvements by March 31, 2024. States also must submit an initial spending plan and narrative, followed by quarterly submissions to demonstrate how the funds will be used or are being used.

North Carolina submitted the initial spending plan in July, 2021 and received comments from CMS in September, 2021. The first quarterly submission in November 2021 included initial

[1] 2019 Population estimates, U.S. Census Bureau

[2] https://static1.squarespace.com/static/5dcb76da7d6813437e91aab8/t/60b95dcacbd00325bd9402c0/1622760908342/Support-our-Direct-Care-Workforce.pdf

updates to the original initial submission. This submission includes additional detail on the progress for certain spending plan initiatives and updates the financial information from the previous report.

North Carolina engaged with stakeholders in the state to develop the plan outlined here. Early in drafting the plan, North Carolina (NC) Medicaid put out a request for comment with an email box that any stakeholder could submit comments. NC Medicaid also held a listening session to gather additional input using a webinar-based platform to allow input from across the state. The Department of Health and Human Services (the Department) has worked with the NC General Assembly to provide analysis of proposed legislation that impacts Medicaid HCBS and to allocate additional funding for these services. Much of this input is reflected in this spending plan or will be reflected in quarterly reports as additional stakeholder feedback is gathered.

North Carolina is committed to incorporating health equity into this work to ensure that all beneficiaries have access to the services necessary to their health.

The following spending plan and narrative will describe the proposed ways in which North Carolina will use the enhanced FMAP for Medicaid HCBS, organized by the following categories of initiatives:

- Workforce: Retaining and Building a Network of HCBS Direct Care Workers
- HCBS Transitions: Expanding Waiver Capacity
- Services: Enhancing HCBS Capacity and Models of Care
- HCBS Infrastructure and Support

The Department intends to continue working closely with stakeholders, the legislature, and divisions of the state government that are working on these issues to continue to develop the plan, as will be reflected in future quarterly submissions. The state intends to direct these resources to have the maximum positive effect for Medicaid beneficiaries and people who require HCBS in the state.

Spending Plan & Narrative

North Carolina is committed to strengthening, enhancing, and expanding HCBS. Using these funds, we intend to strengthen and enhance the current direct care workforce which is essential to providing beneficiaries with high quality care. Additional resources are needed for people to transition into the home and community setting and to begin to receive person-centered HCBS. Under the existing HCBS waivers, North Carolina intends to increase the number of people who receive HCBS waiver services. This action will reduce HCBS waiver waitlists while enhancing services and reducing barriers to care, thereby promoting transitions to the community. Other additional services can help enhance and strengthen HCBS, improving the quality of care and reducing the "churn" of beneficiaries in and out of facilities. For example, providing specialized therapy services as medically indicated can ease the transition into community settings. Offering additional training about infection control can help reduce diseases that may impair health. Additional services such as behavioral health initiatives and other supports can assist populations that previously did not have access to these services. Finally, we intend to strengthen the existing HCBS program infrastructure to provide additional training and to improve data collection so that beneficiaries can be connected to appropriate services and the NC Medicaid program can direct funding to areas in need of improvement.

NC Medicaid currently measures beneficiaries' quality of life, rebalancing, and community integration activities through quality measures and surveys for individuals receiving Long-Term Services and Supports (LTSS) as outlined in the aims, goals, and objectives of the Quality Strategy. Expansion of the current surveys, as well as population-specific surveys, will generate targeted patient and provider-reported outcomes and LTSS population-specific outcomes allowing for comparison between Health Plans for quality and population health improvements for those receiving HCBS and LTSS services.

Our proposal is divided into four key areas for improvement, based on feedback from stakeholders. The accompanying spending plan includes details of current HCBS spending projections and details of these proposals. Several of the proposals were dependent on legislative changes and cost neutrality projections for 1915(c) HCBS waivers. The North Carolina General Assembly passed a budget bill that included several specific uses for the HCBS funds. The North Carolina Department of Health and Human Services (DHHS) has revised the proposals and will continue to revise the HCBS spending plan as changes occur at the legislature and during the waiver amendment process. Several proposals are included that will require additional development; future plans will include these details.

Unless otherwise noted, projected costs are annual estimates and we expect to implement the proposals each state fiscal year between 2021-22 and 2023-24.

Quarterly Update for January 2022

Activity	Status of Activity	State Readiness for Activity	Intended Start Date for Activity
Workforce: Recruitment, Retention and Building the Network of HCBS Direct Care Workers			
Direct Care Worker Wage Increase	Remains under CMS Review	State legislative requirement	3/1/22
New Activity in January 2022 Quarterly Update: Private Duty Nursing Wage Increase	New Activity Proposed	State legislative requirement	11/1/21
New Activity in January 2022 Quarterly Update: Rate Increase for Mobile Crisis Services	New Activity Proposed	Implementation Work Ongoing	8/11/21
New Activity in January 2022 Quarterly Update: Rate Increase for PACE	New Activity Proposed	Implementation Work On Target	TBD
Employment Training for Direct Care Workers	Remains under CMS Review	Additional Design Work Required	TBD
Direct Care Workforce Survey	Partial Approval Received on September 24, 2021	Implementation Work On Target	4/1/22
HCBS Transitions			
Waiver Expansion and Waitlist Reduction	Remains under CMS Review	State legislative requirement	3/1/22
Services: Enhancing HCBS Capacity and Models of Care			
New for January 2022 Quarterly Update: Reimbursement Increase for the TBI and Innovations Waiver services subject to EVV requirements	New Activity Proposed	Implementation Work On Target	2/1/22
Home Health Enhancements	Partial Approval Received on September 24, 2021	Dependent on Budget Availability	TBD

Activity	Status of Activity	State Readiness for Activity	Intended Start Date for Activity
Additional Specialized Therapies for Certain Individuals	Remains under CMS Review	Dependent on Budget Availability	TBD
Social Isolation and Loneliness	Partial Approval Received on September 24, 2021	Implementation Work On Target	3/1/22
Healthy Opportunities Care Needs Screenings to HCBS Beneficiaries	Under Development	Additional Design Work Required	TBD
Expand CAP/DA Services (Home Adaptation)	Under Development	Additional Design Work Required	TBD
Special Assistance – In Home Spending Plan Projection	Remains under CMS Review	Dependent on Budget Availability	TBD
Expand Research-Based Behavioral Health Treatment to Provide Autism-Specific Supports to People Over 21	Remains under CMS Review	Implementation Work On Target	10/1/22
Unified Waitlist	Under Development	Additional Design Work Required	TBD
Retainer Payments	Remains under CMS Review	Implementation Work On Target	TBD
HCBS Infrastructure and Support			
Infection Control	Under Development	Additional Design Work Required	TBD
Bridge Housing Supports	Remains under CMS Review	Additional Design Work Required	TBD

Activity	Status of Activity	State Readiness for Activity	Intended Start Date for Activity
Remote Technology Support	Remains under CMS Review	Additional Design Work Required	TBD
Employment Training for Beneficiaries	Under Development	Additional Design Work Required	TBD
CAHPS Survey for HCBS (CAP/C, CAP/DA, Medicaid Direct)	Partial Approval Received on September 24, 2021	Implementation Work On Target	4/1/22
LTSS HEDIS Measure Calculation as Part of NCQA LTSS Distinction	Partial Approval Received on September 24, 2021	Implementation Work On Target	4/1/22
National Core Indicators Survey Expansion	Partial Approval Received on September 24, 2021	Implementation Work On Target	4/1/22

Workforce: Recruitment, Retention and Building the Network of HCBS Direct Care Workers

Direct Care Worker Wage Increase

Projected Cost: $210 million annually

One of NC Medicaid's highest priorities for improving HCBS is ensuring there is a well-trained, high-quality workforce to provide these services. North Carolina has more than 123,000 direct care workers, and the need for these workers is anticipated to increase significantly in the coming years.[3] The direct care workforce is projected to increase by at least 20,000 jobs by 2028.[4] In addition, 53 percent of the state's direct care workforce live at or near poverty level.[5] In order to recruit and retain high-quality direct care workers, it is essential to ensure that direct care workers have an adequate wage. Wage improvements have been associated with increased rates of retention, reduce shortages and turnover, improve productivity, and stimulation of local economies. Wage increases are essential to improved quality of care.[6]

Average wages for direct care workers in North Carolina are approximately $10-13 an hour which is cited as a significant cause of workforce shortages in the state.[7] Several approaches have been proposed as methods to increase wages, from setting a minimum hourly rate to increasing rates by a fixed percentage to providing temporary payments. DHHS is proposing a solution for long-term, sustainable wage increases, rather than a temporary increase that could cause additional worker shortages after the temporary wage increases end. An increase in the rate that is paid for HCBS would allow a wage increase to be operationalized quickly and sustainably.

North Carolina intends to increase rates for HCBS providers and include instructions that a majority (i.e. 80 percent) of these rate increases are used to increase direct care worker wages.[8] This initiative will also include the strengthening of data collection on the direct care workforce. Through a bonus payment that was included in legislation, not using HCBS ARPA funds, DHHS would ensure that the Department has accurate information on the direct care workforce and the payment rates of these workers. This additional data collection is necessary to allow the Department to continue efforts to improve recruitment, retention, training, and career path development in future years. As the Department continues to enhance its quality strategy and

[3] https://www.northcarolinahealthnews.org/2018/11/29/demand-for-nc-direct-care-workers-mounts-but-wages-decline/

[4] https://www.northcarolinahealthnews.org/2021/02/17/as-the-long-term-care-industry-shifts-covid-19-shafts-ncs-frontline-workers/

[5] https://phinational.org/essential-jobs-essential-care-a-conversation-with-north-carolina/

[6] https://www.healthaffairs.org/do/10.1377/hblog20201202.443239/full/

[7] https://www.salary.com/research/salary/posting/direct-care-worker-salary/nc

[8] The efforts to increase direct worker wages and improve data collection on the direct care workforce are supported by key stakeholders, including the Paraprofessional Healthcare Institute (PHI) and the North Carolina Coalition on Aging.

commitment to value-based care, data collection will also inform future efforts to increase value in the HCBS programs and direct payments to high performing HCBS providers.

This proposed wage increase is contingent on authority and funding of non-Federal share by North Carolina's legislature. Should NC Medicaid receive legislative funding of non-Federal share, North Carolina plans to sustain the wage increase for direct care workers after the enhanced FMAP period ends with further legislative appropriations as part of the state legislative process.

The Division of Health Benefits (DHB) plans to implement this provision of the HCBS plan through increasing rates for certain HCBS services including the following services, pending NC General Assembly funding of non-Federal share:

- Home Health Care
- Personal Care Services
- Case Management Services (as defined under 1905(a)(19) and 1915(g))
- School based services
- Rehabilitative Services
- Private Duty Nursing

Update for January 2022: The State has undertaken a thorough review of each of the HCBS service categories to identify services delivered by lower wage direct care workers. Services within each of these categories may have different service titles depending on the Medicaid program and authority under which they are approved. A table has been added below to clearly identify which waiver or State Plan services are impacted by the proposed direct care worker wage increase. These increases will be relative to reimbursement rates in effect prior to any temporary rate increases implemented in response to the COVID-19 pandemic.

These services are outlined by CMS in (SMDL) #21-003, Appendix B where a stable direct care workforce is crucial to providing high quality HCBS services and increasing rates would enhance, expand, and strengthen HCBS. These services are available to beneficiaries participating in the four 1915(c) waivers that North Carolina currently operates, state plan services under managed care arrangements, and 1115 authority.

The State continues to work on developing documents to provide public notice of these changes and to obtain Medicaid authority, including SPAs, Appendix K amendments, 1915(c) waiver amendments, and any necessary managed care directed payments, to effectuate these increases. At this time, these wage increases have not been implemented and no funds have been expended. Once the increases are implemented, the State will communicate with providers and other stakeholders through stakeholder engagement meetings and provider bulletins published to the State's website to advise of the changes.

These wage increases will be sustained through an appropriation from the legislature after the funds generated by the enhanced FMAP are expended, as part of the approved 2021 Appropriations Act, Senate Bill 105.

As part of the 2021 Appropriations Act, a wage increase was also approved for direct care workers providing services in an Intermediate Care Facility (ICF). While NC Medicaid is aware that such increases would not be eligible to be paid for as part of a Spending Plan activity, it is important to note that some local management entities (LMEs)-managed care organizations (MCOs) have opted to provide HCBS in lieu of ICF services. Specifically, one LME-MCO (Trillium) chooses to cover a service titled Community Living Facilities and Supports to support adults with developmental disabilities. The service is intended to bridge the gap for participants who have unmet needs while on the waiting list for the Innovations Waiver, as an attempt to divert them from institutional placement. The service includes support to choose direct support professionals or housemates, acquire household furnishings, complete common daily living activities and acquire support in emergencies, choose and learn to use appropriate assistive technology to reduce the need for staffing supports, become a participating member in community life, and manage personal financial affairs. Depending upon the needs of the individual, the service can also include integrated health care, nutrition supports, and nursing. It is provided based on a person-centered plan completed with the individual, their family, and other chosen members of their team. Each participant must receive this service while living in their own home, their family home, or in a rental property for which they hold the lease. This service does not provide any payment for room or board. Two other LME-MCOs (Vaya and Partners) provide the same service but title it Long-Term Community Supports. A fourth LME-MCO (Eastpointe) will also be adding this service.

In the interest of providing equitable wage increases for direct care workers of similar education and experience and to prevent unhealthy competition for workers in the LTSS continuum of care in North Carolina, NC Medicaid is seeking CMS approval to include a wage increase for direct care workers providing HCBS in lieu of ICF services as part of the HCBS Spending Plan.

New Activity in January 2022 Quarterly Update: Private Duty Nursing Wage Increase

Projected Cost: $27 to 40 million annually

The 2021 Appropriations Act updated the fee schedule for private duty nursing services from $9.90 to $11.25 per 15 minute unit. By April 1, 2021, the State had provided an increase to the private duty nursing rates to $10.40 per 15 minute unit, as per the Disaster SPA. Starting November 1, 2021, because of a COVID surge, the rate has been increased to $11.96 per 15 minute unit, consistent with the Disaster SPA. The funds earned from the enhanced FMAP will be used to pay these increases retroactive to November 1, 2021. The rate will become $11.25 per 15 minute unit at a future date to be determined.

From November 1, 2021 to December 31, 2021, the total computable expenditures for this initiative are estimated to be $5M, with the State share of this cost estimated to be $1.3M, to be funded by the monies available from the enhanced FMAP.

This wage increase reflects the State's investment in maintaining a highly trained and well-qualified nursing staff to provide ongoing care in a participant's home or community setting.

The State continues to work on developing documents to provide public notice of these changes and to obtain and maintain Medicaid authority to effectuate these increases, including but not limited to a future SPA submission and necessary state directed payment preprints for services provided through managed care. The State will continue to communicate with providers and other stakeholders through stakeholder engagement meetings and publish provider bulletin(s) to advise of the changes.

These wage increases will be sustained through an appropriation from the legislature after the funds generated by the enhanced FMAP are expended, as part of the approved 2021 Appropriations Act, Senate Bill 105.

New Activity in January 2022 Quarterly Update: Rate Increase for Mobile Crisis Services

Projected Cost: $6 million annually

The State proposes to include the rate increase for Mobile Crisis Management to $90.00 per 15 minute increment. The State Plan to accompany such an increase received CMS approval on December 14, 2021, with an effective date of August 11, 2021 (SPA NC-21-0019). The State's managed care organizations are also currently required to apply this rate as a minimum fee schedule. This activity is now being added to the HCBS Spending Plan, in order to use the funds earned from the enhanced FMAP for the State share of this rate increase.

From August 11, 2021 to December 31, 2021, the total computable expenditures for this initiative are estimated to be $2.3M, with the State share of this cost estimated to be $0.6M, to be funded by the monies available from the enhanced FMAP.

As of April 1, 2022, the State also plans to pursue the 85% FMAP available for Mobile Crisis Services, to decrease the State share funded through the HCBS Spending Plan. Any revisions to the projected cost for this activity will be evaluated and included in future quarterly updates.

After the funds from the HCBS Spending Plan are exhausted, this rate increase will be sustained through State appropriations.

New Activity in January 2022 Quarterly Update: Rate Increase for PACE Organizations

Projected Cost: The State continues to work with our actuarial partner on the PACE rate increase and an accurate cost projection. This information will be added to the next quarterly update, due in April 2022.

Demonstrating a commitment to the PACE model serving participants in North Carolina, a permanent rate increase is proposed as part of the HCBS Spending Plan, to be implemented using funds earned from the enhanced HCBS FMAP.

This rate increase for PACE will provide ongoing and permanent support to PACE organizations for the varied daily services they provide to each member and the associated wages paid to their high school educated direct care workers.

The State will update the PACE methodology letter to confirm this increased rate remains under the amount states would have otherwise paid, with an effective date to be determined. To date, these rate increases have not yet been implemented and no funds expended.

Once HCBS Spending Plan funds are exhausted, these rate increases will be sustained through State appropriations.

Employment Training for Direct Care Workers

Projected Cost: Specifics under development and to be determined based on remaining funds after expenditures for more developed HCBS efforts.

The Department plans to work collaboratively with the NC higher education system and Department of Labor to coordinate additional workforce development activities to further enhance the direct care workforce. These include additional training and educational opportunities, as well as partnering on job fairs to increase outreach to potential direct care workers. These funds would provide community college credits to individuals, potentially for on-the-job competency-based training, and allocate financial incentives to providers that offer additional credentialing or training. The funds would also be used to support county hiring fairs and other marketing and recruitment strategies to help connect people with direct service work opportunities. The goal of these efforts is to increase the recruitment pool of direct care workers and develop competencies and skills for existing workers. Additional work is needed to further develop these proposals and NC Medicaid plans to incorporate additional details on the use of funds for these activities into further quarterly reports.

Another way that North Carolina intends to enhance the direct care worker employment is by creating a Direct Care Jobs Innovation Fund. This fund would be dedicated funding for projects that improve recruitment and retention for direct care workers. Some activities that this fund could focus on would be improvements to technology systems to improve worker communication; job supports such as childcare, educational opportunities, and transportation support; and career advancement such as retention payments or career coaching. This fund would allow the state to test the best approaches to achieving the goals of supporting direct care workers that will be expanded throughout the state.

This plan would use funds to improve training for direct care workers that provide HCBS. Currently, the direct care workforce is facing staffing shortages due in part to limited job growth in the direct care field. By expanding training, this could help increase the number of

individuals that stay in the direct care worker field, improving job expertise. More workers with training in best practices for care delivery would not only increase the number of direct care workers available to provide services to beneficiaries outlined in Appendix B but would have the effect of improving the quality of care provided to these beneficiaries, thereby enhancing and strengthening the existing services that are provided to beneficiaries.

Direct Care Workforce Survey

Projected Cost: $500 thousand one-time

The direct care workforce has high rates of turnover and lower rates of employee retention. The evaluation of workforce experience and satisfaction will facilitate root cause analysis and clarify challenges and areas for improvement. A Direct Care Workforce Survey will produce actionable results to support systemic improvements in the experience of providing direct care to HCBS beneficiaries in the community. The survey would target workforce experience factors impacting the provision of care to HCBS beneficiaries such as workforce recruitment and retention strategies, training, and communication support. DHHS intends to contract with an external entity that has extensive experience in evaluating and performing provider surveys to complete this initiative.

HCBS Transitions

Waiver Expansion & Waitlist Reduction

Projected Cost: $103 million annually after full implementation

NC Medicaid is prioritizing the joint expansion of waiver slots and reduction of waitlists for four of NC Medicaid's HCBS programs. North Carolina has four 1915(c) waiver programs that include:

- Community Alternatives Program for Disabled Adults (CAP/DA), participants are adults age 18 and older with disabilities and seniors age 65 and older;
- Community Alternatives Program for Children (CAP/C), participants are children, including foster children, from birth through age 20 who are medically fragile;
- Traumatic Brain Injury (TBI) Waiver Program; and
- NC Innovations, designed to meet the needs of Individuals with Intellectual or Development Disabilities (I/DD).

Community alternatives programs (CAPs) supplement formal and informal services and supports already available to a beneficiary. The programs are for situations where no household member, relative, caregiver, landlord, community agency, volunteer agency or third-party payer is fully able or willing to meet all medical, psycho-social and functional needs of the Medicaid beneficiary, thereby putting that person at risk for institutionalization. The Innovations waiver provides an array of person-centered services that help with daily living activities like bathing, getting dressed and meal preparation. But the waiver is much more than assistance with daily activities; Innovations can also provide a combination of physical assistance, organization and decision-making supports, and community-based supports to volunteer at a local non-profit or engage in paid employment.

North Carolina has a waiver slot allocation system for beneficiaries to access these programs. When the number of slots is full, eligible individuals are placed on a waitlist for receiving the waiver services they need to support community living. Increasing the unduplicated participant count for these waivers will allow more people to access these HCBS programs. This will minimize the risk of exacerbation of the beneficiaries' conditions, promote inclusion and integration into the community, and is a key step in improving health and wellbeing in this population. In order to expand access to HCBS services, NC Medicaid is proposing expanding the unduplicated participant count in each of the HCBS waivers. The North Carolina General Assembly has proposed expanding the participant counts in the Innovations waiver by 1,000 with 800 of these slots available by January 1, 2022 pending legislation. The North Carolina legislature has also proposed to add 114 slots to the CAP/DA Waiver, pending legislation.

Currently, there are approximately 2,100 people on the CAP/DA Waiver waitlist and 15,000 people on the Innovations Waiver Registry of Unmet Needs (waitlist). The TBI waiver does not have a waitlist, and although the CAP/C waiver does not have a waitlist, the maximum participant count of 4,000 is reaching its limit. The state intends to expand the maximum participant count in the CAP/C Waiver to 5,000 to be effective in 2022; legislative approval is not required. The goal of this effort is to add a total of 2,114 more participants to these programs to increase access to 1915(c) services. This initiative is contingent on approval from the North Carolina state legislature. Should NC Medicaid receive legislative approval, expanded waiver slots and anticipated waitlist reductions will be sustained after the enhanced FMAP period ends. In sum DHHS intends to work with the legislature to make these increases in waiver slots permanent and correspondingly continue to fund services for the added population.

Under the estimates that were drafted we assumed that the waitlist reductions would both bring more people already eligible for Medicaid to obtain waiver services and would increase the number of people who are not currently in the Medicaid program to begin to obtain Medicaid physical health and HCBS services. The financial assumptions made in the initial spending plan assume a mix in the population. Under these assumptions, DHB assumes 85% of the people that would be newly eligible for waiver services already receiving Medicaid and the estimates only account for the enhanced HCBS waiver services. For the remaining 15% of the population that would be newly eligible for waiver services and Medicaid services, the financial projections include both HCBS waiver services and underlying community-based Medicaid costs under the state plan. None of these assumptions include institutional services.

Update for January 2022: In the 2021 Appropriations Act, the legislature approved an additional 114 slots for the CAP/DA waiver and 1000 slots for the Innovations waiver starting March 1, 2022. The State is working through the waiver amendments to incorporate the expanded slots and will be submitting to CMS by June 2022. The State is also working through the renewal of the CAP/C which will include additional slots.

The State continues to engage in planning activities around effectuating the waiver slot increases through the amendment process. Additionally, the State continues to develop the appropriate tracking mechanisms, to track those newly eligible for Medicaid as a result of a waiver slot and to ensure that the funds earned through the enhanced FMAP are not spent on institutional services. To date, these waiver slot increases have not been implemented and no funds expended. The state anticipates beginning to implement these additional slots starting in March 2022. NC intends to submit 1915(c) waiver amendments prior to the end of the waiver year to make these changes.

Services: Enhancing HCBS Capacity and Models of Care

New for January 2022 Quarterly Update: Reimbursement Increase for the TBI and Innovations Waiver services subject to EVV requirements

Projected Cost: $37 million annually

NC Medicaid intends to implement rate enhancements for in-home daily supports providers delivering services to participants in the TBI and Innovations Waivers, as well as through 1915(b)(3) services, to further support providers' efforts to enhance service delivery and program integrity through the use of electronic visit verification (EVV). These rate enhancements will be identical to those already implemented in the CAP/DA and CAP/C Waivers and the State Plan Personal Care Services. In particular, the rate increases will be 10% for the following services, subject to EVV requirements.

Table 2: Services Receiving Fee Schedule Increases for EVV

Innovations Waiver Services
Community Living and Supports
Supported Living (periodic)
TBI Waiver Services
Life Skills Training
Supported Living (periodic)
Personal Care
In-home Intensive Services
1915(b)(3) Waiver Services
Personal Care
In-home Skill Building
Community Living and Supports
Supported Living (periodic)

The State intends to develop appropriate public notice and waiver amendments to obtain Medicaid authority to effectuate these increases to the service rates considered in the LME-MCO capitation rates as well as any necessary directed payment preprints. These rate enhancements will be effective February 1, 2022.

Once HCBS Spending Plan funds are exhausted, these rate increases will be sustained through State appropriations.

Home Health Enhancements

Projected Cost: $29 million annually

NC Medicaid plans to further use this funding to increase Home Health services. Home Health will be expanded beyond the current criteria to include persons who are transitioning from institutions to the community and who have three or more chronic conditions of any type. This effort will enable more people to receive services to better manage their conditions and improve their quality of life. This improvement to Home Health will be sustained after the enhanced FMAP period ends by requesting recurring state funding for these services through our annual budget process.

Additional Specialized Therapies for Certain Individuals

Projected Cost: $3 million annually

The FMAP increase will be further used to support the provision of specialized therapies, which is allowed currently in the NC Medicaid program. This proposal would add specialized therapies to the array available for person-centered planning for persons transitioning from institutional and congregate living settings to homes in the community. Expanding specialized therapies will enable increased self-care capacity and facilitate smooth transitions into community settings. This increase in specialize therapies will be sustained after the enhanced FMAP period ends by requesting recurring state funding for these services in our annual budget process.

These services will be available to provide outpatient physical therapy, occupational therapy and speech therapy to beneficiaries that require HCBS through state plan services. These benefits are currently available to beneficiaries but are limited. These funds would enhance the number of services available to help transition beneficiaries from institutional to community settings providing people with assistance to be mobile, work, speak, and more easily participate in community settings.

Social Isolation & Loneliness

Projected Cost: $1 million one-time

Social isolation and loneliness are important, pervasive, and often unrecognized, issues that impact people's physical and mental health. More than one in four adults live alone in the US and a recent survey reported three in five adults now struggle with feelings of loneliness.[9] This has increased 13 percent since 2018 and much of this growth is likely attributed to the COVID-19 pandemic and related statewide shutdowns, stay at home orders, and restricted

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7321652/

hospital and nursing home visitation.[9] Social isolation and/or loneliness has been associated with a 29 percent increase in coronary heart disease, a 32 percent increase in stroke, and a 50 percent increase in dementia.[10] Loneliness is also associated with higher rates of depression, anxiety, suicide, and poorer outcomes among heart disease patients.[10] Social isolation among older adults contributes to an estimated additional $6.7 billion in annual federal spending.[11] Although it is a significant and costly social determinant of health, health professionals rarely screen for social isolation.

National attention on this critical social determinant of health has sparked a proliferation of programs aimed at addressing social isolation and loneliness. The Division of Aging and Adult Services within the NC Department of Health and Human Services (DHHS) led a social isolation workgroup in response to the COVID-19 pandemic. Efforts included expanding access to virtual programming and training professionals in an evidence-based, mental health first aid program. DHHS is still learning what interventions are most needed in North Carolina, what initiatives are already underway, and what gaps exist. Instead of randomly selecting initiatives, we seek to thoughtfully implement effective, cutting-edge, evidence-informed, person-centered programs that will reach people across the lifespan. DHHS will use these funds to develop a plan to address social isolation by researching the best, promising, and evidence-based approaches to the issue, working across divisions to align and expand existing efforts, and ultimately developing and implementing three to four new programs to meet the diverse needs of those served by DHHS.

Healthy Opportunities Care Needs Screenings to HCBS Beneficiaries

Projected Cost: Specifics under development and to be determined based on remaining funds after expenditures for more developed HCBS efforts.

As part of North Carolina's innovative 1115 waiver approval in 2018, the state put an emphasis on whole person care. The Healthy Opportunities initiative has allowed North Carolina to focus on the need for covering services addressing social determinants of health and non-medical drivers of health. Additionally, the COVID-19 pandemic created a need to connect people to community resources statewide. In 2020 NCDHHS expedited the launch of NCCARE360, the first statewide coordinated care network to electronically connect those with identified needs to community resources and allow for a feedback loop on the outcome of that connection. The state has incorporated these goals of improving the non-medical drivers of health into many aspects of the Medicaid program, including requiring health plans to perform a care needs screening for all enrollees. This screening provides health plans with information about the beneficiaries' food, housing, transportation, and safety needs. Missing from that transformational change are the populations that will not be transitioning to managed care

[10] https://www.cdc.gov/aging/publications/features/lonely-older-adults.html

[11]

plans, for example the PACE population, 1915(c) waiver beneficiaries, and people eligible for Medicare and Medicaid.

North Carolina proposes incorporating the care needs screening to beneficiaries who will not be covered by managed care and do not receive this screening from primary care case management. Home health aides and other caregivers would be trained on completing the standard care needs screening and submit these responses to NC Medicaid. This would require funding to develop training for caregivers to properly ask the questions and to appropriately provide referrals to the NCCARE360 platform, as well as development of a method to report this information to NC Medicaid.

Expand CAP/DA services (home adaption)

Projected Cost: Specifics under development and to be determined based on remaining funds after expenditures for more developed HCBS efforts.

NC Medicaid plans to use this funding to increase the utilization limits for equipment, modification, and technology services for participants enrolled in the CAP/DA waiver. The CAP/DA waiver provides an array of person-centered services that help with activities of daily living and community integration to minimize the risk for exacerbation of health conditions and improve the health and wellbeing of this population. This increase in services will be sustained after the enhanced FMAP period ends by accounting for these services in our annual rebase.

Special Assistance-In Home Spending Plan Projection

Projected Cost: Specifics under development and to be determined based on remaining funds after expenditures for more developed HCBS efforts.

This proposal would provide a one-time payment to each active State County Special Assistance In-Home (SAIH) beneficiary, that will include spending parameters to focus the funds on the social drivers of health. This allocation will provide a one-time payment to active SAIH beneficiaries. The one-time payment will strengthen the services to this vulnerable population during the heightened challenges caused from the COVID-19 pandemic. The one-time payment will promote community living, improve quality of life, and enhance access to services that enable independence for older adults and individuals with disabilities.

SAIH provides a choice to those who are eligible for care in a licensed residential care facility but who desire to and can safely remain in a private living arrangement (PLA), by providing them with financial assistance and case management services. The purpose of the SAIH payment is to help eligible individuals meet their basic financial needs. The SAIH payment is an income supplement and is intended to assist with the provision of daily necessities such as food, shelter, clothing, utilities, transportation, in-home aide services, essential household

items, essential home repairs and modifications and other services that enable the client to live at home safely, rather than unnecessary institutionalization.

The county Department of Social Service (DSS) manages the operation of the SAIH Program in the county and assures that the policies and procedures for SAIH are followed. The county DSS and local LME/MCO are responsible for client assessment, case management and authorization of the SAIH payment that includes Medicaid. The Case Manager completes the functional and economic resource assessments. They determine whether or not the client has a need for services and financial assistance.

Funds will be utilized for:

- Technology purchases, to include laptops, tablets, cell phones and other technology and software that will facilitate socialization.
- Assist in buying transportation to allow an individual to enhance their quality of life and help to reobtain their own sense of "normality" prior to the pandemic.
- Enhance and increase services required for the individual to stay safely in the home, but not supplant existing funding and/or services.

This proposal would not pay for room and board with these allotted funds. The funds would be used to assist with promoting drivers of health and focus on the population's needs with facilitating socialization initiatives to eliminate or decrease social isolation and prevent isolation. The proposal does not pay for ongoing connectivity costs. This would be a one-time payment to assist vulnerable individuals through the COVID-19 pandemic. This payment will promote community living, improve quality of life and enhance access to services that enable independence for older adults and people with disability. SA-IH provides a choice to those who are eligible for care in a licensed residential care facility but who desire to and can safely remain in a private living arrangement, by providing them with financial assistance and case management services. The purpose of the SA-IH payment is to help eligible individuals meet their basic financial needs. The SA-IH payment is an income supplement and is intended to assist with the provision of daily necessities such as food, clothing, utilities, transportation, in-home aide services, essential household items, essential home repairs and modifications and other services that enable the client to live at home safely, rather than unnecessary institutionalization. It would not supplant existing funding and/or services.

This proposal would strengthen HCBS because it would prevent people that are at risk of moving to an institution because of a small cost, such as payment of a utility bill or another essential un-met need, to remain in the home rather than unnecessary moving to an institution. The one-time payment will promote community living, improve quality of life, and enhance access to services that enable independence for older adults and individuals with disabilities. SA-IH payments are considered non-countable income for the purposes of Medicaid eligibility. Those approved for the SA-IH program are eligible for Medicaid and an increase in their payments would not negatively impact their eligibility. SA-IH participants utilize the Medicaid

services outlined in SMDL #21-003 as to be eligible for the program beneficiaries must be 65 years or older or have disabilities and live in an HCBS setting.

Update for January 2022 Quarterly Update:

In addition, the legislature included an expanded SA-IH eligibility that would in turn allow more people to be eligible for Medicaid and proposed using ARPA HCBS funds for the purposes of the SA-IH payments and the Medicaid expenditures for those newly eligible for Medicaid. The expanded eligibility required DHHS to submit a SPA that accounts for the Medicaid eligibility increased number of people that would be eligible for Medicaid because of their new eligibility for the SA-IH payment. This SPA was submitted in MACPro on December 16, 2021. Discussions with CMS are ongoing to determine how the HCBS ARPA funds could be used to support the SA-IH payment increase without being in violation of the provision to ensure payments do not go toward rent.

Updated for January 2022 Quarterly Update:

Expand Research-Based Behavioral Health Treatment (RT-BTH) to provide Autism-specific supports to people over 21

Projected Cost: $3.9 million annually at full ramp up

NC Medicaid plans to use this funding to expand Research-Based Behavioral Health Treatment (RB-BHT) to people over 21 while maintaining the same services that are currently offered to people under the age of 21. This effort will enable more people who are currently aging out of RB-BHT to continue receiving RB-BHT services if they continue to meet the eligibility criteria. This age expansion will provide another tool to support people with Autism in their community. A state plan amendment has been approved for the implementation of this age expansion. This increase in services will be sustained after the enhanced FMAP period ends by accounting for these services in our annual rebase.

Expanding services to adults with Autism will enhance HCBS and would allow beneficiaries that receive HCBS to have more robust services to live in their communities. These benefits will be made available specifically to beneficiaries enrolled in our Innovations 1915(c) waiver services and to beneficiaries receiving services through LME-MCOs or 1915(b) services. RB-BHT falls under Rehabilitative Services section in the state plan. The SPA was submitted to make this change as 21-0023 on September 28, 2021 and approved on December 16, 2021 with an effective date of July 1, 2021.

Unified Waitlist

Projected Cost: Specifics under development and to be determined based on remaining funds after expenditures for more developed HCBS efforts.

The Unified Innovations and TBI Waiver Waitlist project seeks to develop a state waitlist database for intellectual and developmental disabilities (I/DD) and survivors of traumatic brain injury (TBI) services for both state operated and funded services and Medicaid waiver-funded services. This will provide beneficial information for the community to understand the demographics of people who require services and may shift between programs. This would be an operational change rather than addition of services or change in eligibility of these populations.

Retainer Payments

Projected Costs: Minimal

As part of the COVID-19 Appendix K waivers in 2020, North Carolina Medicaid provided the flexibility for retainer payments at the onset of the PHE. The State would like to further this flexibility into 2022 to allow beneficiaries and direct care workers that are participating in the 1915(c) waivers with the ability to respond to surges in the PHE and allow for retainer payments. These payments will have guardrails as specified in the CMS guidelines and are time-limited to 90 days.

<u>Update for January 2022 Quarterly Update</u>:

The State has submitted an Appendix K amendment to receive approval to implement the retainer payments. The capitation rates will not be increased for the purposes of these retainer payments, primarily because the capitation rates were developed assuming pre-PHE utilization levels of services. Because the utilization of services eligible for retainer payments has continued to be at decreased levels due to the PHE, there is sufficient funding in the existing capitation rate to allow for these new retainer payments without need for a capitation rate increase.

To date, these retainer payments have not been implemented and no funds have been expended. Due to delays in implementation because of approval uncertainty, the state intends to move forward with retainer payments for the CAP programs.

HCBS Infrastructure and Support

Infection Control

Projected Cost: Specifics under development and to be determined based on remaining funds after expenditures for more developed HCBS efforts.

The COVID-19 pandemic highlighted the vulnerability and limited capacity of HCBS care settings to implement and sustain effective infection control methods. It is important that HCBS providers have staffing and resources to prevent and control the spread of COVID-19 among those receiving HCBS services and those working in these care settings. As a part of this state's numerous efforts to respond to the pandemic, the DHHS Divisions of Public Health (DPH) and Division of Health Services Regulation (DHSR) developed a targeted response for HCBS settings called Infection Control Assessment and Response (ICAR) visits. These interventions proved to be an important step in the containment of COVID-19 in HCBS. The goal of an ICAR visits and training was to identify any infection control issues and help the provider resolve these problems. The "Infection Control Assessment Tool" in the COVID-19 infection prevention toolkit lists specific policies and practices to look for during a COVID-19 outbreak. This document provided information about how to conduct ICAR visits in general and serves as a helpful reference.

Adequate training and surveillance in these care settings is essential to mitigating the risk for future outbreaks caused by COVID-19 variants or other infectious diseases. Increased funding will go towards the provision of support mechanisms for infection control, training, and on-going surveillance. Specifically, these funds will be used to support the development of initial and on-going training and surveillance to sustain the effective policies and procedure for infection control learned through the ICAR program. Additionally, this effort will entail a partnership with county departments of public health to hire dedicated staff to carry out these infection control practices on a county level for the more than 600 family care homes and adult day health centers across the state. Details of this proposal are under development and additional details on sustainability and cost estimates will be included in future quarterly reports.

Bridge Housing Supports

Projected Cost: Specifics under development and to be determined based on remaining funds after expenditures for more developed HCBS efforts.

Bridge housing is an important tool to allow people to transition from an institutional setting to a community setting. North Carolina has piloted a model that provides temporary housing to help people improve their Activities of Daily Living (ADL) and Instrumental Activities of Daily

Living (IADL) as they wait to enter permanent supportive housing. This proposal would expand that model to provide more comprehensive 90 day to 6-month bridge housing and staffing to assist people with health needs. The funds would be used to pay for the high-quality staffing needed to assist people with skill building and tenancy training. The staffing would support approximately 10 beneficiaries at a time in 5 key regions of the state. This increase in services will be sustained after the enhanced FMAP period ends by accounting for these services in our annual rebase.

The funds for bridge housing supports will not pay for room and board. The funds would be used for support staff to provide HCBS services to people transitioning from an institutional setting to an HCBS setting. The support services would include care planning and assist with activities of daily living and instrumental activities of daily living.

Remote Technology Support

Projected Cost: Specifics under development and to be determined based on remaining funds after expenditures for more developed HCBS efforts.

This initiative includes the provision of remote service supports for technology, including devices and hotspots, to beneficiaries in order to increase access to the HCBS and telehealth services vital to maintaining community placement. Remote technology support will be added to the service definition of the approved goods and services in the CAP/C and CAP/DA 1915(c) HCBS waivers. These services would be available for people in CAP/C and CAP/DA 1915(c) waivers. This increase in services will be sustained after the enhanced FMAP period ends by accounting for these services in our annual rebase.

Remote technology support would enhance and strengthen HCBS. Internet connectivity will allow better collaboration and communication with the case manager and other healthcare providers for beneficiaries in remote areas to quickly address health and safety issues. It will also promote telephonic engagement with primary care providers to manage health care conditions when the beneficiary cannot physically see a provider or need a quick check-in or question answered.

Employment Training for Beneficiaries

Projected Cost: Specifics under development and to be determined based on remaining funds after expenditures for more developed HCBS efforts.

As an additional step to improving its HCBS array, NC Medicaid is planning to implement competitive integrated employment training programs to support community inclusion for its working age beneficiaries. Job coaching, self-advocacy training, job retention and advancement support strategies, and entrepreneurship opportunities would be supports provided to

beneficiaries in order to sustain and advance employment and community integration. Such training helps ensure that people with disabilities become productive members of the community and reduces risk of institutionalization.

CAHPS Survey for HCBS (CAP/C, CAP/DA, Medicaid Direct)

Projected Cost: $1.3 million one-time

HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a voluntary survey that would collect patient-reported outcomes for those receiving LTSS within Medicaid Direct and managed care and will allow for comparisons across HCBS programs at the health plan and state level. The survey evaluates quality of life and experience in care specific to HCBS, advancing quality of care and health outcome improvements. This proposal would enable NC Medicaid to administer, collect, and analyze the results of the beneficiary survey. The proposed expenditures would occur incident to a contract modification with the existing CAHPS survey administering entity. The survey results will better inform both policy and quality improvement efforts.

LTSS HEDIS Measure Calculation as part of NCQA LTSS Distinction

Projected Cost: $200 thousand one-time

The National Committee for Quality Assurance (NCQA) has developed Healthcare Effectiveness Data and Information Set (HEDIS) measures specific to LTSS activities to assess quality of life, beneficiary experience, program effectiveness, and processes for safe transitions. Performance on these measures will be evaluated within managed care and Medicaid Direct populations. Health Plans are required to attain LTSS Distinction by contract year three and will be held accountable for these measures. Expanding the measure calculation and reporting and using a contract modification of existing HEDIS activities to include total Medicaid population for LTSS will support comprehensive evaluation of LTSS across Medicaid.

National Core Indicators Survey Expansion

Projected Cost: $50 thousand one-time

National Core Indicators™ (NCI™) surveys provide a mechanism for states to assess their developmental disability service systems. The NCI provides a picture of individuals' overall quality of life and satisfaction with the services they are receiving. Further, it serves as a mechanism for North Carolina to be able to track progress and determine additional quality improvement efforts that may be needed across the service delivery system. For FY22, DHHS is

slated to complete 650 surveys out of a potential pool of 14,945 individuals accessing Medicaid HCBS services. (This does not include individuals that only receive state-funded surveys and may change as we pull concrete numbers from NC TRACKS before initiating the final NC NCI State Plan). This is capturing less than 7 percent of the potential population. The capacity to survey at or near 1,000 individuals will provide essential information about our service system, data that speaks to our state's alignment with our NC HCBS Statewide Transition Plan, and data that can be utilized to support or prompt LME-MCO/Tailored Plans' quality improvement plans. Further, the additional 330 surveys can be specifically designated to the Innovations Waiver to ensure we are diving deeper into analysis of our HCBS services, if needed or required. The cost per survey is $153. An additional 330 surveys would cost $50,430.

Stakeholder Feedback

North Carolina worked with key stakeholders in the state to create the initiatives in this spending plan and narrative. NC Medicaid sent out a request for feedback to stakeholders with an email box open for the submission of comments. In addition, NC Medicaid held a stakeholder listening session via webinar during which participants from across the state could express their feedback. Input from both of these manners of stakeholder engagement was considered in the development of this plan.

The email box was open to the public for feedback and received comments on current HCBS and suggestions on future HCBS development from people in North Carolina who receive HCBS, whose family or friends receive HCBS, or who provide services or work directly in HCBS settings. A common theme among many of the comments was concern about the direct care workforce, most often linked to insufficient pay for these essential workers and the limited hours in which direct care services are offered to beneficiaries. Comments about the direct care workforce pointed to the need for higher wages, increased and improved training and credentialing, and strengthened data collection to address these issues within HCBS. Another common theme was the desire for the provision of compensation, counseling, and respite to family caregivers. Other feedback suggested reductions in HCBS waiver waiting lists, expanded nursing facility transition programs, increased funding for physical adaptations to the homes of HCBS beneficiaries, and more funding for respite care services. Stakeholders who submitted feedback through the email box also highlighted the connections between HCBS and various social determinants of health, including the importance of bridging those who receive HCBS to resources for affordable and stable housing. Further emailed feedback emphasized the importance of the HCBS Innovations Waiver and also requested attention on the Innovations workforce and waitlist issues.

On June 22, 2021, North Carolina Medicaid hosted listening session via a webinar about the 10-percentage point Federal Medical Assistance Percentage (FMAP) increase for Medicaid Home and Community-Based Services (HCBS) provided in the American Rescue Plan Act (ARPA). The purpose of this listening session was to hear from key stakeholders about how to best allocate the funds from the enhanced FMAP.

Approximately 500 people registered for the event, more than 350 attended, and around 175 people submitted comments and questions verbally, or by typed submission during the session. Stakeholders who attended included parents and family members of children and adults who receive HCBS, representatives of the direct care workforce, engaged community members, and leaders of HCBS agencies and facilities. The listening session first consisted of a brief description of the enhanced HCBS FMAP and how the funds may be utilized. The subsequent time, more than hour and 45 minutes, was filled entirely by stakeholders sharing their experiences, concerns, and questions related to HCBS, along with concrete suggestions on how to best

spend the additional funds. The session facilitators also pointed to the email submission box for further questions and comments.

Though a wide variety of feedback was received on how to best enhance, expand, or strengthen HCBS, there were some suggestions that were mentioned consistently by many stakeholders. There was overwhelming desire from the participants to strengthen the direct care workforce through wage increases; the feedback referenced the lack of competitive wages and benefits as a key reason for why there is such a shortage in these essential workers. As a means of ensuring this issue is addressed, stakeholders repeatedly mentioned the importance of requiring that increased reimbursement rates are reflected in worker wages. Another common concern surrounded the extensive waitlists for HCBS waiver programs such as the Innovations Waiver. Multiple suggestions were made that additional services should be provided for those unable to get off these waitlists, even if the programs are expanded. An additional theme of the feedback was the necessity to expand HCBS simultaneously with the expansion of the workforce, in order to avoid an increase in services with no staff to provide the services. Many also requested adjustments to the regulations for relatives as caregivers to enable full time care of children in need, a service added to the waiver programs as part of the COVID-19 flexibilities. Stakeholders further emphasized the need for funds to provide home modifications, equipment for recreational and outdoor activities, and transportation support to improve the quality of life of HCBS recipients.

The participants in the listening session were extremely appreciative of the opportunity to share their thoughts on how to improve HCBS, reflecting the importance of these services for beneficiaries and their families and the necessity to make impactful changes.

Spending Plan Projection

In our initial HCBS plan, we estimated drawing $274.8 million in receipts from the enhanced FMAP on qualifying HCBS services between April of 2021 and March of 2022. We assume that we can generate an additional $18 million by reinvesting receipts from the enhanced FMAP on qualifying HCBS in the first year of implementation. Based on estimated qualifying actuals for fee-for-service and capitation through April -September 2021, we now anticipate that the draw will be $279m, which is 1.5% higher than the previous estimate. We have not yet drawn enhanced FMAP, as we are working with our actuarial partner to ensure we apply the correct percentage to capitation claims that qualify for the enhanced FMAP. We expect to have this finalized and begin including these in projections for allotment requests during the remainder of calendar year 2021. Table 1 below reflects preliminary estimates (numbers for the fourth quarter of FFY20-21 may be refined due to transition to managed care and lags in data used for reporting).

Table 1: Preliminary Estimated Draw for 10% Enhanced FMAP

	FFY 21 Q3	FFY 21 Q4	FFY22 Q1	FFY 22 Q2	Total
Fee-for-Service (FFS)*	$29m	$31m	$314m	$19m	$110m
PACE*	$2m	$2m	$2m	$2m	$8m
LME-MCO Capitation**	$45m	$44m	$45m	$39m	$173
Managed Care Capitation***	$0.0m	$6m	$6m	$4m	$16m
Totals	**$76m**	**$83m**	**$84m**	**$64m**	**$307m**

**FFS and PACE estimates use actuals for FFY 21 Q3 and Q4 and FFY 2022 Q1 original HCBS plan estimates for FFY 22 Q2.*

*** LME-MCO Capitation uses a preliminary estimate of the percent of capitation payments qualifying for the 10% HCBS enhanced FMAP applied to actual capitation payments for April 2021-Decemberr 2021. These are subject to revision as the state receives updated data.*

****Managed Care Capitation uses a preliminary estimate of the percent of capitation payments qualifying for the 10% HCBS enhanced FMAP applied to actual capitation payments for July 2021-December 2021. These are subject to revision as the state receives updated data.*

Update for January 2022: The State has recently evaluated the FFS claims and capitation payments for the first three quarters of the improvement year, quarters ending 6/30/21, 9/30/21, and 12/31/21. The HCBS provided in that timeframe eligible for the 10% enhanced FMAP were higher than originally estimated in the Initial Spending Plan. As of 12/31/21, the State has drawn $230 million in enhanced FMAP for the first three quarters. With more current data regarding utilization, the State now estimates it will draw down approximately $307 million in total enhanced FMAP. As the State finalizes the rate adjustments for the direct care workers and updates the rates for the PDN services, we expect the ultimate claiming for the enhanced FMAP to increase from this $307 million estimate.

Table 2 outlines the estimated spending on policy items for which we have defined costs by state fiscal year and calculates the amount spent out of the receipts from the enhanced FMAP. At this point, we estimate that we would spend $293 million of the $307 million by the end of March 2024. As policy proposals noted in the spending narrative as currently under development are further defined and costed, this amount is expected to change.

Table 2: Spending by Year from Enhanced FMAP Receipts*

	SFY 2022	SFY 2023	SFY 2024
Estimated Total Cost of Policy Proposals	$255m	$425m	$425m
Estimated State Share (Federal HCBS funding)	$54m	$137m	$103m
Estimated State Share (Appropriations)	$0	$0	$34m*
Estimate Federal Share	$200m	$288m	$288m
Remaining HCBS Receipts	**$253m**	**$116m**	**$14m**

**The state fiscal year (SFY) for North Carolina runs from July1-June 30.*
***This covers the portion of the fiscal year following March 31, 2024.*

Tables 3-5 below outline estimated costs of proposals for each of the fiscal years covered under the program. We estimate an additional $22m in state spending will be spent by the proposals still under development.

Table 3: Estimated Total Cost for Proposal Items by State Fiscal Year

Services	SFY 2022*	SFY 2023	SFY 2024
Direct Care Worker Wage Increase	$88	$210	$210
Private Duty Nursing Rate Increase	$31	$27	$27
EVV Enhancements	$15	$37	$37
Mobile Crisis Response Rate Increase	$10	$12	$12
Waiver Expansion and Waitlist Reduction	$78	$103	$103
Expand Research-Based Behavioral Health Treatment (RT-BTH)	$4	$4	$4
Additional Specialized Therapies for Certain Individuals	$3	$3	$3

Home Health Enhancements	$23	$29	$29
Social Isolation and Loneliness	$1	$0	$0
CAHPS Survey for HCBS	$1	$0	$0
LTSS HEDIS Measure Calculation	$0	$0	$0
Direct Care Workforce Survey	$1	$0	$0
National Core Indicators Survey Expansion	$0	$0	$0
Total	**$255,000,000**	**$425,000,000**	**$425,000,000**

**SFY2022 assumes spending items began at various points specific to individual items, as indicated in the narrative above.*

Table 4: Estimated Federal Share of Cost for Proposal Items by State Fiscal Year

Services	**SFY 2022***	**SFY 2023**	**SFY 2024**
Direct Care Worker Wage Increase	$69	$142	$142
Private Duty Nursing Rate Increase	$25	$18	$18
EVV Enhancements	$12	$25	$25
Mobile Crisis Response Rate Increase	$8	$8	$8
Waiver Expansion and Waitlist Reduction	$61	$70	$70
Expand Research-Based Behavioral Health Treatment (RT-BTH)	$3	$3	$3
Additional Specialized Therapies for Certain Individuals	$2	$2	$2
Home Health Enhancements	$18	$20	$20
Social Isolation and Loneliness	$1	$0	$0
CAHPS Survey for HCBS	$1	$0	$0

LTSS HEDIS Measure Calculation	$0	$0	$0
Direct Care Workforce Survey	$0	$0	$0
National Core Indicators Survey Expansion	$0	$0	$0
Total	**$200**	**$288**	**$288**

**SFY2022 assumes spending items began at various points specific to individual items, as indicated in the narrative above.*

Table 5: Estimated State Share of Cost for Proposal Items by State Fiscal Year

Services	**SFY 2022***	**SFY 2023**	**SFY 2024**
Direct Care Worker Wage Increase	$19	$68	$68
Private Duty Nursing Rate Increase	$6	$9	$9
EVV Enhancements	$3	$12	$12
Mobile Crisis Response Rate Increase	$2	$4	$4
Waiver Expansion and Waitlist Reduction	$17	$33	$33
Expand Research-Based Behavioral Health Treatment (RT-BTH)	$1	$1	$1
Additional Specialized Therapies for Certain Individuals	$1	$1	$1
Home Health Enhancements	$5	$9	$9
Social Isolation and Loneliness	$0	$0	$0
CAHPS Survey for HCBS	$0	$0	$0
LTSS HEDIS Measure Calculation	$0	$0	$0
Direct Care Workforce Survey	$0	$0	$0
National Core Indicators Survey Expansion	$0	$0	$0
Total	**$54**	**$137**	**$137**

**SFY2022 assumes spending items began at various points specific to individual items, as indicated in the narrative above.*