North Carolina Medicaid Reform
Section 1115 Demonstration Renewal Application

State of North Carolina
Department of Health and Human Services

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This draft is intended for public comment. Based on public input and continuing analyses, all figures and descriptions may be subject to refinement prior to submission to CMS.
Contents

SECTION I – PROGRAM OBJECTIVES AND VISION ................................................................. 4

INTRODUCTION .................................................................................................................. 4

HISTORICAL SUMMARY OF THE MEDICAID REFORM DEMONSTRATION: 2019-2024 ................................................................................................................................... 5

VISION AND GOALS FOR 1115 DEMONSTRATION RENEWAL ........................................... 6

SECTION II – CONTINUING DEMONSTRATION FEATURES AND CHANGES REQUESTED TO THE DEMONSTRATION ....................................................................................................... 7

OBJECTIVE 1: ENSURE SMOOTH TRANSITION TO MANAGED CARE .................................. 8

INITIATIVE 1A: CONTINUED IMPLEMENTATION OF STANDARD PLANS .................................. 8

INITIATIVE 1B: LAUNCH OF TAILORED PLANS ..................................................................... 9

INITIATIVE 1C: LAUNCH OF CHILDREN AND FAMILIES SPECIALTY PLAN ......................... 10

OBJECTIVE 2: STRENGTHEN ACCESS TO WHOLE-PERSON, COORDINATED CARE ........... 11

INITIATIVE 2A: HEALTHY OPPORTUNITIES PILOT .............................................................. 11

INITIATIVE 2B: CONTINUOUS ENROLLMENT FOR CHILDREN ............................................. 16

INITIATIVE 2C: COVERAGE FOR PRE-RELEASE SERVICES FOR JUSTICE-INVOLVED INDIVIDUALS ................................................................................................................. 18

OBJECTIVE 3: STRENGTHEN BEHAVIORAL HEALTH AND I/DD DELIVERY SYSTEM ....... 20

INITIATIVE 3A: PROVIDING MEDICAID COVERAGE FOR INDIVIDUALS OBTAINING SHORT-TERM SUD TREATMENT IN IMDS ................................................................. 20

INITIATIVE 3B: INVESTMENTS IN BEHAVIORAL HEALTH AND I/DD TECHNOLOGY ................................................................................................................................. 21

INITIATIVE 3C: BOLSTERING THE BEHAVIORAL HEALTH AND LTSS WORKFORCE ................................................................................................................................. 22

INITIATIVE 3D: CHANGES TO 1915(I) ELIGIBILITY .................................................................. 24

DESIGNATED STATE HEALTH PROGRAMS ........................................................................ 24

SECTION III – BENEFITS, ELIGIBILITY, DELIVERY SYSTEM, AND COST SHARING ............. 25

BENEFITS .......................................................................................................................... 25

ELIGIBILITY ...................................................................................................................... 25

DELIVERY SYSTEM .......................................................................................................... 28

COST SHARING ................................................................................................................ 29
Section I – Program Objectives and Vision

Introduction

North Carolina Medicaid provides comprehensive health care coverage to over two million state residents. Since receiving federal approval for the North Carolina Medicaid Reform Demonstration1 on October 19, 2018, North Carolina has undertaken significant efforts to transform its Medicaid program in line with its overarching goal of improving health and well-being for all North Carolinians through a whole-person, well-coordinated system of care that addresses both medical and non-medical drivers of health and advances health access by reducing disparities for historically marginalized populations. Specifically, North Carolina is in the midst of implementing a significant managed care transition, affecting the majority of Medicaid enrollees. Ultimately, eligible, non-dually enrolled individuals will be enrolled in managed care through three types of managed care plans, or Prepaid Health Plans (PHPs): Standard Plans (currently available), Behavioral Health and Intellectual/Developmental Disabilities (Tailored Plans), and a Children and Families Specialty Plan, all of which offer or will offer comprehensive physical health, behavioral health, LTSS, and pharmacy services, in addition to care management programs serving enrollees with the most intensive needs. Members of federally recognized tribes, including members of the Eastern Band of Cherokee Indians (EBCI), may voluntarily enroll in PHPs on an opt-in basis. Individuals who are not enrolled in PHPs will continue to receive services through NC Medicaid Direct or the EBCI Tribal Option. North Carolina also instituted reforms to strengthen its substance use disorder (SUD) delivery and launched the nation’s first Medicaid-funded health-related social needs (HRSN) pilot program, called the Healthy Opportunities Pilot.

During this demonstration period, North Carolina also learned important lessons as it navigated the COVID-19 Public Health Emergency (PHE), which significantly disrupted ongoing implementation efforts and diverted key agency resources towards emergency response, resulting in delays to the launch of all of the managed care reforms noted above. In addition to these notable transformation efforts, during this demonstration period, North Carolina also obtained initial legislative authorization in March 2023 to expand Medicaid eligibility to childless adults under the Affordable Care Act (ACA), once a State budget has been enacted. Once implemented on October 1, 2023, this measure is expected to result in health coverage for over 600,000 North Carolinians.

North Carolina is now seeking to renew its Section 1115 demonstration for another five-year period to continue the important work underway and pursue select new opportunities to advance the State’s goal of improving health and well-being for all North Carolinians through a whole-person, well-coordinated system of care that addresses both medical and

1 North Carolina Demonstration Approval October, 19 2018 (link)
non-medical drivers of health and advances health access by reducing disparities for historically marginalized populations.

**Historical Summary of the Medicaid Reform Demonstration: 2019-2024**

On October 19, 2018, North Carolina received federal approval for the North Carolina Medicaid Reform Demonstration. The goals of this demonstration are to:

- Measurably improve health outcomes with the implementation of a new delivery system;
- Maximize high-value care to ensure sustainability of the Medicaid program; and
- Reduce substance use disorder (SUD).

Over the demonstration period, North Carolina has made significant strides towards achieving these goals by:

- **Launching Standard Plans:** On July 1, 2021, North Carolina transitioned most of its non-dually eligible Medicaid enrollees to fully capitated and integrated managed care plans called Standard Plans. Standard Plan members receive integrated physical health, behavioral health, long term services and supports (LTSS), and pharmacy services. As of July 2023, approximately 1.9 million Medicaid enrollees receive care across the five Standard Plans. North Carolina has also launched its Advanced Medical Home (AMH) program to provide community-based care management to higher need Standard Plan enrollees.

- **Preparing to Launch Behavioral Health and Intellectual / Developmental Disabilities (Tailored Plans):** North Carolina is planning to launch specialized managed care plans for approximately 160,000 individuals with intensive behavioral health conditions (including serious mental illness, serious emotional disturbance, and severe SUD), intellectual and developmental disabilities (I/DD), traumatic brain injury (TBI), called Tailored Plans.

  Tailored Plan members will have access to all Standard Plan services, in addition to specialized behavioral health and I/DD services to meet their needs, including, but not limited to, Innovations and TBI waiver and 1915(i) services. The specialized services will include Tailored Care Management, a health home benefit designed to address Tailored Plan members’ whole-person needs across physical health, behavioral health, I/DD, TBI, pharmacy, LTSS, and unmet HRSNs.

- **Preparing to Launch the Children and Families Specialty Plan (CFSP):** North Carolina is preparing to launch the CFSP. The CFSP, formerly referred to as the “Specialized Foster Care Plan,” will be a single statewide managed care plan that seeks to mitigate disruptions in care and coverage for children, youth, and families
served by the child welfare system.

Designed to meet the unique health care needs of this population and maintain treatment plans across placement changes, the CFSP will offer all benefits available in Standard Plan and nearly all benefits covered by Tailored Plans. The CFSP will include a robust, integrated care management model that helps coordinate a member’s needed health and health-related services and support transitions between treatment settings or health plans to ensure continuity of care and transition planning, and serve as the central entity accountable for the care of these members.

- **Implementing the SUD Component of the Demonstration:** The current demonstration includes expenditure authority for the state to obtain Medicaid match for services provided to short-term residents of institutions for mental diseases (IMDs) who are obtaining SUD treatment. Concurrently, North Carolina is expanding its continuum of SUD services available and fully aligning with American Society of Addiction Medicine (ASAM) standards. Since beginning implementation on May 1, 2019, North Carolina has observed a 26 percent increase in the number of Medicaid enrollees with SUD who accessed medication-assisted treatment.

  The SUD expenditure authority expires on October 31, 2023. Therefore, North Carolina is preparing to submit a five-year extension request to CMS through a separate application, and intends to align effective and expiration dates across all demonstration components during the next demonstration period.

- **Implementing Healthy Opportunities Pilot (HOP):** On March 15, 2022, North Carolina began delivering the first of a broad array of services intended to address unmet Health Related Social Needs (HRSNs). HOP is the nation’s first comprehensive program under Medicaid to test and evaluate the impact of providing select evidence-based, non-medical interventions related to housing, food, transportation, and interpersonal safety and toxic stress. To date, North Carolina has built networks of community-based providers, enrolled over 9,000 enrollees, launched 28 services across three largely rural regions, and delivered 70,025 services.²

**Vision and Goals for 1115 Demonstration Renewal**

During the first demonstration period, North Carolina began its transition to managed care and invested in novel programs to better respond to the diverse needs of North Carolinians who are enrolled in Medicaid. North Carolina is now ready to build on early successes and lessons learned to continue this progress over the next 5-year 1115 demonstration period, while also implementing select new targeted initiatives in line with the State’s overall goal

² North Carolina Department of Health and Human Services. Healthy Opportunities Pilots at Work (link)
to improve health and well-being for all North Carolinians through a whole-person, well-coordinated system of care that addresses both medical and non-medical drivers of health and advances health access by reducing disparities for historically marginalized populations.

Section II – Continuing Demonstration Features and Changes Requested to the Demonstration

North Carolina’s overarching goal for its 1115 demonstration renewal is to improve health and well-being for all North Carolinians through a whole-person, well-coordinated system of care that addresses both medical and non-medical drivers of health and advances health access by reducing disparities for historically marginalized populations.

The 1115 demonstration renewal will advance this goal through the following specific objectives and related initiatives:

Objective 1: Support a continued, smooth transition to managed care with a focus on improving care for enrollees with the most complex needs:

- Initiative 1a. Provide integrated whole-person, well-coordinated care for the majority of Medicaid enrollees through continued implementation of Standard Plans.
- Initiative 1b. Provide integrated care for individuals with serious mental illness, serious emotional disturbance, severe SUD, I/DD, and/or TBI, through the launch of Tailored Plans.
- Initiative 1c. Provide integrated care to address the complex needs of children and families served by the child welfare system and former foster youth through the implementation of the CFSP.

Objective 2: Strengthen access to a person-centered and well-coordinated system of care which addresses both medical and non-medical drivers of health:

- Initiative 2a. Build on HOP infrastructure investment and experience to expand HRSN services to North Carolinians across the state.
- Initiative 2b. Promote continuity of care by offering continuous enrollment in Medicaid to children and former foster care youth.
- Initiative 2c. Improve health outcomes and support reentry into the community for justice-involved individuals by providing targeted pre-release Medicaid services.

Objective 3: Strengthen the behavioral health and I/DD delivery system:

- Initiative 3a. Reduce incidence of OUD/SUD by providing Medicaid coverage for individuals obtaining short-term residential services for SUD in an IMD.
• **Initiative 3b.** Improve the coordinated system of care for people with behavioral health and I/DD needs through targeted new investments in technology.

• **Initiative 3c.** Bolster the behavioral health and LTSS workforce.

• **Initiative 3d.** Expand access to critical supports offered under 1915(i) authority.

**Objective 1: Ensure Smooth Transition to Managed Care**

**Objective 1:** North Carolina seeks to ensure a continued, smooth transition to managed care, with a focus on improving care for Medicaid enrollees with the most complex needs through the following initiatives:

• **Initiative 1a.** Provide integrated whole-person, well-coordinated care for the majority of Medicaid enrollees through continued implementation of Standard Plans.

• **Initiative 1b.** Provide integrated care for individuals with serious mental illness, serious emotional disturbance, severe SUD, I/DD, and/or TBI, through the launch of Tailored Plans.

• **Initiative 1c.** Provide integrated care to address the complex needs of youth and families served by the child welfare system through the implementation of the CFSP.

North Carolina is broadly requesting continued authority across its managed care initiatives to (1) allow for phase-in of managed care programs as set forth in this application; (2) continue mandatory enrollment in managed care; and (3) enable the State to vary the amount, duration, and scope of services offered to individuals in managed care under this demonstration, regardless of eligibility category. More information on the initiative-specific demonstration requests is outlined below.

**Initiative 1a: Continued Implementation of Standard Plans**

**Background**

In July 2021, North Carolina completed the first phase of managed care implementation with the launch of Standard Plans. This program provides integrated physical health, behavioral health, long-term services and supports (LTSS), and pharmacy services for the majority of North Carolina’s Medicaid enrollees.

**Standard Plan Renewal Request**

Under the next demonstration period, North Carolina requests to extend the authority to implement Standard Plans for the next 5-year 1115 demonstration renewal period. The

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3 Enrollees have choice with respect to network providers once enrolled in a managed care plan.
Standard Plans will continue to serve the majority of enrollees by providing integrated physical health, behavioral health, long-term services and supports (LTSS), and pharmacy services. See Section III for additional information on benefits, eligibility, delivery system changes, and cost sharing for Standard Plans.

**Initiative 1b: Launch of Tailored Plans**

**Background**

Due to the COVID-19 pandemic and other factors, including organizational consolidation among local management entity/managed care organizations (LME/MCO), North Carolina has yet to implement Tailored Plans, which were authorized during the initial demonstration period.

**Tailored Plan Renewal Request**

Under the next demonstration, North Carolina requests to extend the authority to launch and implement Tailored Plans for the next 5-year 1115 demonstration renewal period. Managed care-eligible Medicaid enrollees with serious mental illness, serious emotional disturbance, severe SUD, I/DD, and/or TBI will be enrolled in Tailored Plans, which will be regional, specialized managed care products focused on the needs of these populations. The State is requesting to continue the ability to offer a set of specialized behavioral health and I/DD services in the Tailored Plans that are not offered in the Standard Plans; specifically Tailored Plans will offer Innovations and TBI waiver services, 1915(i) services, and North Carolina’s Tailored Care Management Health Home benefit, in addition to the most intensive State Plan behavioral health and I/DD services. In addition to managing Medicaid services, Tailored Plans will be responsible for managing state-funded behavioral health, I/DD and TBI services.

North Carolina is requesting to continue its existing expenditure authority that permits the State to limit the choice to a single Tailored Plan in each county for individuals meeting one of the following criteria:

- Individuals who reside in an intermediate care facility for individuals with intellectual disabilities (ICF-IID)
- Individuals who participate in North Carolina’s Transitions to Community Living
- Individuals who are enrolled in the Innovations or Traumatic Brain Injury 1915(c) waiver
- Individuals who receive services/supports in state-funded residential treatment (i.e., individuals receiving services to support them in their residence/house setting, including services provided in group homes or non-independent settings such as Group Living, Family Living, Supported Living, and Residential Supports).

See Section III for additional information on benefits, eligibility, delivery system changes, and cost sharing for Tailored Plans.
Initiative 1c: Launch of Children and Families Specialty Plan

Background

North Carolina has yet to implement the Children and Families Specialty Plan (CFSP) for which it previously obtained authority.

Children and Families Specialty Plan Renewal Request

Under the next demonstration period, North Carolina requests to extend the authority to launch and implement the CFSP for the 5-year 1115 demonstration period. The CFSP, formerly referred to as the “Specialized Foster Care Plan,” will be a single statewide managed care plan that seeks to mitigate disruptions in care and coverage for the following groups:

- Children in foster care;
- Children receiving adoption assistance;
- Former foster youth up to age 26;
- Parents and caretaker relatives of children/youth in foster care who are making reasonable efforts to comply with a court-ordered plan of reunification;
- Siblings of children/youth in foster care;
- Minor children and certain family members receiving Child Protective Services In-Home Services; and
- Minor children of children/youth in foster care, of children/youth receiving adoption assistance, or of former foster youth.

This plan is designed to meet the unique health care needs of this population and enable children, youth and families served by the child welfare system across the state to access a broad range of physical health, behavioral health, pharmacy, LTSS, and I/DD services and resources to address unmet HRSNs and maintain treatment plans even if placement changes occur. The State is requesting to continue its authority to offer a specialized set of services for the CFSP in comparison to the Standard Plans. Specifically, the CFSP will offer all of the specialized behavioral health and I/DD State Plan benefits besides ICF-IID that will be available through Tailored Plans, in addition to 1915(i) services. The CFSP must meet a set of requirements ensuring robust care management and medication management specifically for this vulnerable population. See Section III for additional information on benefits, eligibility, delivery system changes, and cost sharing for CFSP.
Objective 2: Strengthen Access to Whole-Person, Coordinated Care

Objective 2: North Carolina seeks to strengthen access to a person-centered and well-coordinated system of care which addresses both medical and non-medical drivers of health through the following initiatives:

- **Initiative 2a.** Build on Healthy Opportunities Pilots (HOP) infrastructure investment and experience to expand HRSN services to North Carolinians across the state.
- **Initiative 2b.** Promote continuity of care by offering continuous enrollment in Medicaid to children and former foster care youth.
- **Initiative 2c.** Improve health outcomes and support reentry into the community for justice-involved individuals by providing targeted pre-release Medicaid services.

Initiative 2a: Healthy Opportunities Pilot

Background

In October 2018, North Carolina received federal 1115 demonstration authority to implement the Healthy Opportunities Pilot (HOP). HOP is a comprehensive program to test and evaluate the impact of providing evidence-based, non-medical interventions that address housing instability, transportation insecurity, food insecurity, interpersonal violence (IPV) and toxic stress to qualifying Medicaid enrollees. Through HOP, North Carolina is dedicated to ensuring enrollees can access necessary HRSN services in a way that meets their needs and improves their health. At the same time, HOP has strengthened community capacity to provide HRSN services, enabled a diverse ecosystem of stakeholders to work together, and pursued the elimination of health disparities across the Pilot regions.

Today, Medicaid enrollees must live in one of the three regions where HOP operates and have at least one qualifying physical or behavioral health condition and one qualifying social risk factor to receive Pilot services.

Pilot services include 29 HRSN services defined and priced in the State’s Pilot fee schedule, 28 of which have been launched. The fee schedule was originally approved by CMS in December 2019. These services were selected based on their potential to improve health outcomes and/or lower health care costs and address the needs of qualifying enrollees. To ensure system readiness, HOP was launched in March 2022 with a purposefully limited scope and scale, focusing first on food and nutrition services, before expanding to housing and transportation, toxic stress, and most recently, services targeted to address IPV. The phased approach allowed the Department to work closely with a wide range of partners, quickly address issues that arose and focus on emerging best practices—thereby ensuring a smooth launch. Despite the challenges associated with launching the program during the COVID-19 pandemic, HOP began delivering services in March 2022 and as of May 31, 2023, has provided over 82,000 services to over 10,000 enrollees across the three Pilot regions.
A diverse set of stakeholders across the health and human services continuum work together to implement and operate HOP. Key Pilot entities and respective responsibilities include:

- **North Carolina Department of Health and Human Services (NCDHHS):** North Carolina is responsible for designing, establishing and overseeing HOP, and is accountable to CMS for all aspects of the program.

- **HOP Administrators⁴:** HOP Administrators are responsible for approving which individuals qualify for the HOP, and which services they receive. HOP Administrators also manage a capped allocation of funding to pay for Pilot services delivered by HSOs and other administrative expenses.

- **Care Managers:** Care Managers work with Medicaid enrollees on their full range of physical, behavioral and non-medical needs and work with the HOP Administrators to identify people who would benefit from and qualify for Pilot services. Care managers are responsible for proposing services that may benefit the individual, and coordinate, track and manage their Pilot services over time.

- **Network Leads:** Network Leads serve as a single point of accountability for HSOs and HOP Administrators, effectively bridging the gap between the healthcare and social services industries. Network Leads develop and manage a high-quality network of HSOs, provide technical assistance and distribute capacity-building funds to ensure HSOs are able to participate in the HOP.

- **Human Service Organizations (HSOs):** HSOs, comprised of community-based organizations and social service agencies, contract with Network Leads to deliver high-quality Pilot services in a culturally competent manner to qualifying individuals. HSOs develop capabilities to participate in the health care delivery system, including tracking, reporting and invoicing for Pilot services delivered to Pilot enrollees.

**Healthy Opportunities Pilot Renewal Request**

Under the next demonstration period, North Carolina requests to renew all prior features of HOP, in addition to implementing new Pilot-related program changes during the demonstration period. Specifically, North Carolina is requesting $1.7 billion in total computable expenditure authority for HOP services, allowing the State to expand HOP statewide, scale services, and make other program improvements over the course of the next demonstration. North Carolina is also requesting $300 million in total computable HOP capacity building funding to support expansion of these services across the State. North Carolina currently has the authority to operate HOP in select regions of the State, with one

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⁴ HOP Administrators include Prepaid-Health Plans (PHP) and other non-PHP Managed Care Entities including Primary Care Case Management Entities (PCCM-Es), Primary Care Managers (PCCMs), Prepaid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs) as defined in the State’s special terms and conditions.
Network Lead per region. To support statewide HOP operations, the State intends to procure additional Network Leads who will in turn develop HSO networks statewide. These requested changes build on the lessons learned and successes of HOP to date. Central to HOP is the Department’s commitment to continuous improvement, transparency and learning. HOP is the first initiative of its kind, a large-scale undertaking reliant on partnerships between organizations with different cultures, missions and business practices that have not historically worked together. Continuous improvement is vital to promoting an environment of shared learning and evolution based on these organizations’ experiences on-the-ground. The State intends to continue its practice of gathering and analyzing real time data about Pilot enrollment, service delivery and partnership development between organizations via Rapid Cycle Assessments (RCAs). North Carolina’s recent RCA revealed that North Carolina has been successful in implementing Pilot infrastructure and establishing effective collaborations between the State, HOP Administrators, healthcare systems, and HSOs to enable the delivery of Pilot services in current Pilot regions. This includes development of a statewide technology platform that allows Pilot entities to leverage a single system for exchanging Pilot data and operationalizing HOP, implementation of required legal and regulatory systems, and effective relationship-building with stakeholders. The RCA preliminarily found that Pilot enrollees receiving services are reporting decreased needs in respective domains. While this data is based on a limited period of Pilot service delivery, these early findings highlight the potential for HOP to meaningfully address the HRSN of enrollees. North Carolina is well positioned to scale these early successes from the first demonstration period to broaden the reach of HOP and impact population health. North Carolina remains committed to continuous improvement, transparency and learning as HOP expansion proceeds in the demonstration period.

**Eligibility**

Under the current waiver, to be eligible for and receive Pilot services, Medicaid enrollees must live in one of the three Pilot regions and have at least one qualifying physical or behavioral health condition and one qualifying social risk factor, as defined in Attachment G of the existing demonstration. Based on experience to date, the State is seeking authority to expand the geographic reach of HOP statewide and expand Pilot eligibility criteria to allow additional high-need individuals to access Pilot services.

Requested changes HOP eligibility that build on the state’s existing criteria include:

- For adults 21+, presence of one or more chronic conditions
- Individuals “at risk of” a chronic condition across all eligibility categories
- All pregnant women enrolled in Medicaid
- All Tailored Plan enrollees and individuals eligible for Tailored Care Management in
Prepaid Inpatient Health Plans (PIHPs)
- Individuals who are currently or have recently been impacted by natural disasters
- Individuals who have recently been released from incarceration
- Children/youth who receive adoption assistance

Services
North Carolina currently has authority to provide 29 Pilot services across four domains (housing, food, transportation and interpersonal violence/toxic stress) in Pilot regions. North Carolina will determine which services are scaled in new regions of the State based on service effectiveness, regional and population-based readiness to participate, and HSO capacity to provide select Pilot services. The State requests to continue offering and testing the efficacy of all existing services in current Pilot regions:

Housing
- Housing Navigation, Support and Sustaining Services
- Inspection for Housing Quality
- Housing Move-In Support
- Essential Utility Set-Up
- Home Remediation Services
- Home Accessibility and Safety Modifications
- Healthy Home Goods
- One-Time Payment for Security Deposit and First Month’s Rent
- Short-Term Post Hospitalization Housing

Interpersonal Violence (IPV) and Toxic Stress
- IPV Case Management Services
- Violence Intervention Services
- Evidence-Based Parenting Curriculum
- Home Visiting Services
- Dyadic Therapy

Food
- Food and Nutrition Access Case Management Services
- Evidence-Based Group Nutrition Class
- Diabetes Prevention Program
- Fruit and Vegetable Prescription
- Healthy Food Box (For Pick-Up)
- Healthy Food Box (Delivered)
- Healthy Meal (For Pick-Up)
- Healthy Meal (Home Delivered)
- Medically Tailored Home Delivered Meals
Transportation
- Reimbursement for Health-Related Public Transportation
- Reimbursement for Health-Related Private Transportation
- Transportation PMPM Add-On for Case Management Services

Cross-Domain
- Holistic High Intensity Enhanced Case Management
- Medical Respite
- Linkages to Health-Related Legal Supports

The State is also seeking authority to modify the Pilot services as follows:
- Allow up to three meals per day for key Pilot services within the food domain, including Healthy Food Boxes, Healthy Meals and Medically Tailored Meals
- Adapting existing service to provide six months of rental assistance (including payment of arrears) for high-needs enrollees
- Add a new “firearm safety” service that provides, at a minimum, locks and/or safes to support firearm safety.

In addition, the State wishes to retain its existing ability to remove Pilot services as appropriate, based on experience, service effectiveness, and HSO capacity to provide services across the State.

Other Program Improvements

Central to the existing Pilot model is the essential role of the Network Lead as a bridge between health care (HOP Administrators and care management entities) and social services (HSOs). Network Leads contract with HOP Administrators on behalf of their networks of HSOs, providing a level of standardization and consistency to both entities. Existing and new Network Leads will continue to play an essential role in Pilot administration. At the same time, the State wishes to foster innovation and flexibility with contracting relationships among HOP entities that are ready and prepared to do so. The State is seeking authority to allow HOP Administrators and HSOs to contract directly with one another where both parties have demonstrated readiness to do so.

Capacity Building Funds

North Carolina is requesting $300 million in total computable HOP capacity building funding to support expansion of the Pilot statewide. The State’s first RCA indicated that access to capacity building funding was critical to developing the necessary systems, relationships and infrastructure to deliver Pilot services. Capacity building funds will build on the investments made during the prior demonstration by further building the necessary infrastructure to deliver Pilot services statewide. This funding will support HOP-related capacity building activities, including but not limited to: building the capabilities necessary to execute Pilot responsibilities, conducting stakeholder engagement and training/technical assistance,
community engagement activities, hiring and training new staff, strengthening health information technology systems, essential overhead costs, and establishing operational workflows processes necessary participate in HOP.

Initiative 2b: Continuous Enrollment for Children

Background

Nationally, approximately four in ten children eligible for Medicaid/CHIP who are disenrolled, are re-enrolled within one year, also known as “churn.” In North Carolina, of youth who lose coverage, one in four regained coverage within the year. This temporary loss in coverage can lead to gaps in care during critical periods of child development as well as administrative confusion and complexity. Continuous enrollment can help reduce churn, prevent disruptions in care, and promote access to healthcare, while also reducing administrative burden for the state, counties, and families.

North Carolina currently offers a 12-month period of continuous enrollment for children ages 0 to 18.

Continuous Eligibility Renewal Request

Under the next demonstration, North Carolina is requesting authority to implement continuous enrollment for young children through age five and extend the continuous enrollment period to 24 months for children and youth ages six through 18. North Carolina is also requesting to offer continuous enrollment to youth who aged out of foster care prior to January 1, 2023 until age 26, aligning eligibility determination practices for these former foster care youth with other former foster care youth who aged out of foster care after January 1, 2023.

For children and youth, these continuous enrollment changes will be a valuable tool to help ensure that individuals receive critical screenings, vaccinations, and preventative services early in life. Moreover, providing continuous enrollment during vulnerable periods, such as when an individual ages out of the foster care system, can help promote access to much-needed services that address physical health, behavioral health, and HRSNs. North Carolina expects that more than 140,000 children and youth will benefit from these continuous enrollment changes annually, once fully implemented.

5 Medicaid and CHIP Payment and Access Commission. An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP. 2021 (link)
7 Kaiser Family Foundation. Medicaid Enrollment Churn and Implications for Continuous Coverage Policies. December 2021 (link)
8 Kaiser Family Foundation. Implications of Continuous Eligibility Policies for Children’s Medicaid Enrollment Churn. December 2022 (link)
9 Child Welfare and Foster Care Statistics. May 2023 (link)
Eligibility

Under the demonstration renewal, except for individuals eligible for Medicaid on the basis of 42 CFR 435.217, section 1902(a)(10)(C) of the Act and 42 CFR 435.301, or individuals eligible for Medicaid under the non-MAGI or aged, blind, and disabled categories, the following groups of children and youth will be eligible for the following extended periods of continuous enrollment:

- Children ages zero through five who enroll in Medicaid shall qualify for continuous enrollment beginning on the effective date of the child’s most recent eligibility determination or redetermination and extending through the end of the month in which their sixth birthday falls;
- Individuals ages six through 18 who enroll in Medicaid shall qualify for a 24-month continuous enrollment period beginning on the effective date of the individual’s most recent eligibility determination or redetermination; and
- Individuals under age 26 who aged out of foster care prior to January 1, 2023 and were enrolled in Medicaid at the time they aged out shall qualify for continuous enrollment period beginning on the effective date of the individual’s most recent eligibility determination or redetermination extending through the end of the month in which their twenty-sixth birthday falls. This will align eligibility determination practices for these former foster care youth with other former foster care youth who aged out of foster care after January 1, 2023.

If any of the following circumstances occur during an individual’s designated continuous eligibility period, the individual’s Medicaid eligibility shall be redetermined or terminated:

- The individual is no longer a North Carolina resident;
- The individual requests termination of eligibility;
- The individual dies; or
- The agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual.

North Carolina will establish procedures designed to ensure that enrollees can make timely and accurate reports of any changes in circumstances that may affect their eligibility as outlined in this demonstration. For all continuous enrollment periods longer than 12 months, North Carolina will establish procedures and processes to accept and update enrollee contact information on an annual basis and to check for the exceptions defined above and as required by CMS.
Initiative 2c: Coverage for Pre-Release Services for Justice-Involved Individuals

Background

Approximately 57,000 adults and youth in North Carolina were incarcerated as of May 2023. Stark racial disparities are reflected across the state’s justice-involved population; Black adults are nearly six times as likely and Hispanic adults are approximately three times as likely to be incarcerated as individuals of other races. Individuals leaving incarceration are particularly at risk of experiencing poor health outcomes. Compared to individuals who have never been incarcerated, justice-involved individuals have higher rates of physical and behavioral health needs. Among justice-involved individuals who were recently released from a correctional setting in North Carolina, approximately 30% are identified as having physical health needs, approximately 75% are identified as having substance use disorder (SUD), and approximately 50% are identified as having other mental health needs. Those recently released from a correctional setting in the state also have significant health-related social needs: 29% are identified as having housing needs, 71% are identified as having transportation needs, and around 45% are identified as having vocational or employment needs.

Moreover, justice-involved individuals are particularly vulnerable during the period immediately following release from a correctional setting, with one study reporting that the risk of death is over 10 times greater during this period for justice-involved individuals as compared to community members who are not involved with the justice system. In North Carolina, individuals recently released from correctional settings are 40 times more likely to suffer an opioid overdose compared to individuals who have never been incarcerated.

Justice-Involved Reentry Request

Ensuring continuity of health coverage and care and improving health outcomes for justice-involved populations is a high priority for North Carolina. In line with this goal, and with CMS guidance, North Carolina is requesting authority for federal Medicaid matching funds to provide a set of targeted Medicaid services to eligible justice-involved populations within the 90-day period prior to release, and to provide $315 million total computable in capacity

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10 Prison Policy Initiative (link)
11 Governor Cooper Establishes Task Force to Address Racial Inequity in the State Criminal Justice System. June 2020 (link)
12 The Commonwealth Fund. September 2022 (link)
13 Correctional Program Evaluation. 2019 (link)
14 Correctional Program Evaluation. 2019 (link)
15 The Commonwealth Fund. September 2022 (link)
16 NCDHHS Announces Funding Opportunity to Serve Justice-Involved Individuals as COVID-19 Impacts Overdoses. October 2021 (link)
17 North Carolina Department of Health and Human Services 2021-2023 Strategic Plan (link)
18 CMS State Medicaid Directors Letter on Justice-Involved Reentry. April 2023 (link)
building funding to support service delivery. These services will be available to individuals incarcerated in the State’s prisons as well as to individuals incarcerated in select county- and tribal-operated jails and youth correctional facilities.

Eligibility

North Carolina aims to implement this initiative in its 53 State prisons over the course of the demonstration, as well as in a subset of county- and tribal-operated jails and youth correctional facilities that meet Department-defined readiness standards (e.g., have automated enrollment and suspension services, have agreed to participate in the initiative, and have appropriate operational capacity).

North Carolina will phase in participating correctional facilities based on readiness over the course of the demonstration period.

All adults and youth who are incarcerated in a participating correctional setting and are enrolled in Medicaid will be eligible to access pre-release services. Services will be available to individuals both pre- and post-adjudication. North Carolina estimates that approximately 39,000 individuals will receive pre-release services under this demonstration.

Benefits

North Carolina seeks public comment on the scope of pre-release services that should be offered beginning up to 90-days prior to release from a participating correctional setting. Eligible individuals will, at a minimum, be able to access the following three services:

- **Case Management** under which case managers will establish client relationships, conduct a needs assessment, develop a person-centered care plan, and make appropriate linkages and referrals to post-release care and supports.

- **Medication Assisted Treatment (MAT)** including medication in combination with counseling/behavioral therapies, as clinically appropriate.

- **At a Minimum, a 30-Day Supply of Prescription Medication** in hand upon release, consistent with Medicaid State Plan coverage.

In addition to the above three services, the following additional services will be phased in over the course of the demonstration period based on readiness to implement:

- **Physical and Behavioral Health Clinical Consultation Services** that are intended to support the creation of a comprehensive, robust, and successful reentry plan, such as clinical screenings and pre-release consultations with community-based providers.

- **Laboratory and Radiology Services** as clinically appropriate, consistent with Medicaid State Plan coverage.

- **Medications and Medication Administration** as clinically appropriate, consistent with Medicaid State Plan coverage.
- **Tobacco Cessation Treatment Services** as clinically appropriate.
- **Durable Medical Equipment Upon Release** in hand upon release, consistent with Medicaid State Plan coverage.

Capacity Building Funds

To support cross-system implementation efforts for this initiative, North Carolina is requesting $315 million total computable in capacity building funds. Capacity building funds will be available to entities partnering with DHHS to implement the initiative, including correctional facilities. This funding will support planning and implementation activities, including but not limited to: conducting stakeholder engagement, hiring and training new staff, strengthening health information technology systems, and establishing new operational workflows, processes, and space modifications needed to implement this initiative across participating correctional settings.

**Objective 3: Strengthen Behavioral Health and I/DD Delivery System**

**Objective 3:** Strengthen the behavioral health and I/DD delivery system through the following initiatives:

- **Initiative 3a.** Reduce incidence of OUD/SUD by providing Medicaid coverage for individuals obtaining short-term residential services for SUD in an IMD.
- **Initiative 3b.** Improve the coordinated system of care for people with behavioral health and I/DD needs through targeted new investments in technology.
- **Initiative 3c.** Bolster the behavioral health and LTSS workforce.
- **Initiative 3d.** Expand access to critical supports offered under 1915(i) authority.

**Initiative 3a: Providing Medicaid Coverage for Individuals Obtaining Short-Term SUD Treatment in IMDs**

**Background**

The current demonstration permits North Carolina to obtain Medicaid reimbursement for individuals obtaining short-term SUD treatment in an IMD, regardless of whether they are enrolled in Medicaid managed care or NC Medicaid Direct, North Carolina’s fee-for-service delivery system. Concurrently, North Carolina is expanding its SUD service array to include the full ASAM continuum of care and aligning care with the ASAM standards. Under the demonstration, North Carolina is required to aim for a statewide average length of stay of 30 days in residential treatment settings to ensure short-term residential treatment stays.

The SUD component of the demonstration is effective January 1, 2019, through October 31, 2023. North Carolina is preparing to submit a separate request to extend the SUD component of the 1115 demonstration for an additional five years and intends to align
expiration dates across demonstration components during the next demonstration period.

Initiative 3b: Investments in Behavioral Health and I/DD Technology

Background

Behavioral health concerns—further exacerbated by the COVID-19 pandemic—are a significant and growing issue in North Carolina that has been identified as a key priority for increased investment. Nearly one in five North Carolinians has a mental illness. During the COVID-19 pandemic, approximately one in three North Carolinians surveyed reported symptoms of depression and/or anxiety. However, more than half of North Carolinians and nearly three out of four children with a behavioral health condition have not received needed treatment for their condition. In fact, more than half of North Carolina’s counties have no child and adolescent psychiatrist. Nationally, North Carolina is ranked within the bottom ten states for youth mental health, largely due to inadequate access to care and lack of adequate insurance coverage for mental health.

Nearly half of all children in North Carolina have endured at least one Adverse Childhood Experience (ACE). ACES are traumatic experiences, such as neglect or exposure to violence, which can contribute to toxic stress, exacerbate physical and mental health conditions, and negatively affect educational and employment outcomes later in life. In 2022, 68% of teachers in North Carolina reported that their students had greater needs for social, emotional, and mental health support than in a typical school year.

In recognition of the state’s behavioral health crisis, Governor Roy Cooper released a $1 billion plan to bolster key aspects of the State’s behavioral health system. The plan prioritizes investment in data and technology to improve health access and outcomes through increased use of technology and data-driven decision-making. In particular, supporting under-resourced behavioral health providers’ access and use of electronic health records to share data and connect with the North Carolina Health Information Exchange, HealthConnex, is a key priority to ensure access to integrated, whole-person care as North Carolina continues its managed care transition. In addition, in recognition of the important role that schools play in identifying and addressing students’ health and health-related

22 American Academy of Child and Adolescent Psychiatry. Workforce Maps by State. 2022 (link)
23 Reinert, M., T. Nguyen, and D. Fritze, The State of Mental Health in America 2022. 2022, Mental Health America: Alexandria VA (link)
24 Child Welfare. The prevalence of adverse childhood experiences, nationally, by state, and by race or ethnicity. 2018 (link)
25 North Carolina Teacher Working Conditions Survey. 2022 (link)
social needs and addressing adverse childhood experiences that impact behavioral health, North Carolina is seeking to invest in technology to support schools to appropriately document and bill for services delivered and make connections to external providers and other community-based resources and supports.

**Behavioral Health and I/DD Technology Request**

In the 1115 demonstration renewal, North Carolina is seeking $45 million in expenditure authority to allow Medicaid match for health information technology and related technical assistance for behavioral health, I/DD and TBI providers and schools to improve access to behavioral health services and promote care integration and whole-person care.

**HIT Grants**

North Carolina requests expenditure authority to provide health information technology (HIT) grants of up to $200,000 per practice ($30 million total computable) for providers who serve individuals with mental health conditions, substance use disorders, TBI, and/or I/DD located in North Carolina with a minimum of ten Medicaid patients and a Medicaid patient volume of at least 20%. Recipients of provider incentive payments under the Health Information Technology for Economic and Clinical Health (HITECH) Act who used funds to purchase or upgrade an electronic health record (EHR) system that can share real-time data with the North Carolina Health Information Exchange (NC HIE) would not be eligible for funding. Grants could cover costs of purchasing a new EHR system, making EHR system upgrades, and costs associated with enabling connectivity to NC HIE. Grants could also support training costs on EHR and NC HIE to enable providers to utilize technology to document and share patient data electronically and to utilize data to improve Medicaid enrollee health outcomes and identify and address disparities.

**School Health Technology Capabilities**

North Carolina requests expenditure authority to provide technology and related technical assistance to expand school's health and health-related capabilities for North Carolina Title I middle and high schools. Grants of up to $100,000 per school ($15 million total computable) could be used to purchase new technology and/or make upgrades to existing technology to support Medicaid functions, including to enable use of and data-sharing with Medicaid referral systems, support Medicaid billing, and provide related technical assistance.

**Initiative 3c: Bolstering the Behavioral Health and LTSS Workforce**

**Background**

North Carolina’s workforce lacks the capacity to address the state’s growing behavioral health crisis as well as fully meet the needs of people with intellectual and developmental disabilities (I/DD) and those in need of long-term services and supports (LTSS). Data indicate acute shortages with the state’s current behavioral health workforce. For example, psychiatrists serving in North Carolina are only meeting 13% of the need in the state
(compared to 28% nationally), and nearly a third of counties do not have any practicing psychologists. As of 2021, more than 2.6 million North Carolinians resided in a community without sufficient mental health professionals overall. In addition to community-based provider shortages, North Carolina lost more than nine percent of its direct care workforce between 2016 and 2021.

North Carolina has identified investment and support for the workforce within the behavioral health, I/DD and LTSS spaces as a key priority to reduce the current strain on the delivery system and improve access to behavioral health, LTSS, and other needed services.

**Behavioral Health and LTSS Workforce Request**

Under the renewed 1115 demonstration, North Carolina is seeking expenditure authority for $70 million in total computable funding to strengthen the behavioral health workforce, as well as providers and other professionals who serve individuals with intellectual and developmental disabilities (I/DD) and who provide long-term services and supports (LTSS). Studies have demonstrated that access to care is an important indicator of people’s abilities to remain in or join the labor market, with a strong focus on health care and home care workers in particular.

**Loan Repayment Program**

North Carolina requests $50 million in total computable expenditure authority to expand the state’s behavioral health student loan repayment program to support additional behavioral health professionals statewide who provide care to Medicaid enrollees, individuals who receive services via Indian Health Services (IHS), and other under-resourced populations. This includes up to $300,000 in loan repayments for psychiatrists, nurse practitioners, and physician assistants as well as loan repayments ranging from $25,000 to $50,000 (depending on the professional type) for master’s-level licensed clinicians (or above), bachelor’s level behavioral health professionals, and registered nurses, in exchange for a service commitment in a qualified setting that serves Medicaid beneficiaries, individuals who receive services via IHS, and uninsured individuals.

**Recruitment and Retention**

North Carolina requests $20 million in total computable expenditure authority to provide recruitment and retention payments for direct support professionals and other behavioral

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27 Kaiser Family Foundation. Mental Health in North Carolina (link)
29 National Alliance on Mental Illness. North Carolina Fact Sheet (link)
health professionals who provide Medicaid beneficiaries with behavioral health services, long term services and supports, and/or services and supports for individuals with I/DD, including: LTSS and BH/I/DD direct support professionals (DSPs), paraprofessionals as defined in North Carolina state administrative code, and other certified professionals (e.g., Peer Support Specialists, Family Partners, or Community Health Workers). The program would support recruitment and retention bonus payments, childcare subsidies, funding for training programs, and/or transportation subsidies. Payments for each category would be capped and would not exceed up to $15,000 per year in total for qualifying professionals. North Carolina would contract with one or more vendors to distribute and administer these payments.

**Initiative 3d: Changes to 1915(i) Eligibility**

**Background**

In July 2023, North Carolina began transitioning select critical home and community-based services (HCBS) for enrollees with significant behavioral health needs, I/DD and TBI previously covered under 1915(b)(3) authority to 1915(i) authority. The State initiated this transition to reflect when Tailored Plans launch, Tailored Plan members will no longer be enrolled in North Carolina’s prepaid inpatient health plans authorized under the State’s 1915(b) waiver, meaning that they will not be able to access 1915(b)(3) services. Under 1915(b)(3) authority, North Carolina has allowed certain flexibilities that are not permitted under 1915(i); specifically, the State has allowed individuals with incomes above 150% FPL to be eligible for 1915(i) services and pays for one-time transitional costs for individuals to move from an institution for mental diseases (IMD) into their own private residence in the community or to divert an enrollee from entering an adult care home.

**1915(i) Renewal Request**

In order to maintain the eligibility criteria for critical HCBS as North Carolina transitions services from 1915(b)(3) to 1915(i) authority, North Carolina is requesting authority under the 1115 demonstration to:

- Allow individuals with incomes above 150% FPL to be eligible for 1915(i) services
- Permit individuals transitioning out of an IMD to obtain North Carolina’s 1915(i) community transition benefit, if they otherwise meet the 1915(i) eligibility criteria. The community transition benefit provides up to $5,000 in one-time transitional costs for individuals to move from an institutional setting into their own private residence.

**Designated State Health Programs**

North Carolina is seeking expenditure authority to support the non-federal share of funding for pre-release services for justice-involved individuals and related capacity building and new HOP expenditures for the next demonstration period using Designated State Health Programs.
Program (DSHP) expenditures. North Carolina is requesting $610 million in total computable DSHP funding. North Carolina will work with CMS to finalize the demonstration initiatives that can be supported with DSHP funding, and to develop Special Terms and Conditions (STCs) and DSHP funding and reimbursement protocols for the demonstration period to reflect the demonstration’s goals and funding levels.

Section III – Benefits, Eligibility, Delivery System, and Cost Sharing

Benefits

Managed care benefits will continue to be defined under the State Plan or, where applicable, the 1915(c) waiver. The State is continuing to request an enhanced set of benefits for the Tailored Plans and Children and Families Specialty Plan in comparison to the Standard Plans as described in Section II.

Other changes to benefits proposed in the renewal are described in Section II above, and include:

- Expanding HOP statewide, reauthorizing the existing list of Pilot services, and modifying service definitions as proposed above
- Providing targeted pre-release services for justice-involved individuals in the 90 days prior to release
- Allowing individuals with incomes above 150% FPL to be eligible for 1915(i) services
- Permitting individuals transitioning out of an IMD to obtain North Carolina’s 1915(i) community transition benefit, if they otherwise meet the 1915(i) eligibility criteria.

Eligibility

This demonstration renewal proposes to continue managed care eligibility as authorized in the current demonstration with no changes. All eligibility is defined under the State Plan, including M-CHIP, or, where applicable, the 1915(c) waiver. This demonstration affects all eligibility groups other than those listed in Table B below. The groups listed in Table B below will not be affected by the demonstration and will continue to receive Medicaid benefits through the service delivery system under the approved state plan or under existing waivers.
Table A: Full Benefit Medicaid Beneficiaries in This Table Are Eligible for SUD and HOP (if they meet the HOP criteria and are served by a HOP Administrator consistent with these STCs)  

<table>
<thead>
<tr>
<th>GROUP NAME</th>
<th>CITATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duals Eligible for Full Medicaid, except those who are enrolled in the state’s Innovations and TBI 1915(c) waiver programs, which qualifies the beneficiary for enrollment in the Tailored Plans</td>
<td></td>
</tr>
<tr>
<td>Medically Needy</td>
<td>1902(a)(10)(C)</td>
</tr>
<tr>
<td>• Medically Needy Pregnant Individuals except those covered by Innovations or TBI waivers</td>
<td></td>
</tr>
<tr>
<td>• Medically Needy Children under 18 except those covered by Innovations or TBI waivers</td>
<td></td>
</tr>
<tr>
<td>• Medically Needy Children Age 18 through 20 except those covered by Innovations or TBI waivers</td>
<td></td>
</tr>
<tr>
<td>• Medically Needy Parents and Other Caretaker Relatives except those covered by Innovations or TBI waivers</td>
<td></td>
</tr>
<tr>
<td>• Medically Needy Aged, Blind, or Disabled except those covered by Innovations or TBI waivers</td>
<td></td>
</tr>
<tr>
<td>• Medically Needy Blind or Disabled Individuals Eligible in 1973 except those covered by Innovations or TBI waivers</td>
<td></td>
</tr>
<tr>
<td>Individuals Participating in the NC Health Insurance Premium Payment (HIPP) program except those covered by Innovations or TBI waivers</td>
<td>1906</td>
</tr>
<tr>
<td>Medicaid-only Beneficiaries Receiving Long-Stay Nursing Home Services</td>
<td>State Plan Eligibility</td>
</tr>
<tr>
<td>Community Alternatives Program for Children (CAP/C)</td>
<td>1915(c) waiver</td>
</tr>
<tr>
<td>Community Alternatives Program for Disabled Adults (CAP/DA)</td>
<td>1915(c) waiver</td>
</tr>
</tbody>
</table>

32 North Carolina, consistent with requirements in state statute, intends to enroll dual eligible and long-term stay nursing home populations into managed care in the future, and will update these tables as appropriate when more information is available on that change.
### Table B: Populations Excluded from Comprehensive Managed Care and This Demonstration

<table>
<thead>
<tr>
<th>GROUP NAME</th>
<th>CITATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals in any eligibility category not otherwise excluded during their period of retroactive eligibility or prior to the effective date of PHP coverage[^33]</td>
<td>1902(a)(34)</td>
</tr>
<tr>
<td><strong>Duals Eligible for Cost-Sharing Assistance</strong></td>
<td></td>
</tr>
<tr>
<td>- Qualified Medicare Beneficiaries</td>
<td>• 1902(a)(10)(E)(i)</td>
</tr>
<tr>
<td>- Qualified Disabled and Working Individuals</td>
<td>• 1905(p)(1)</td>
</tr>
<tr>
<td>- Specified Low Income Medicare Beneficiaries</td>
<td>• 1902(a)(10)(E)(ii)</td>
</tr>
<tr>
<td>- Qualifying Individuals</td>
<td>• 1902(a)(10)(E)(iii)</td>
</tr>
<tr>
<td>- Presumptively Eligible Pregnant Individuals</td>
<td>• 1902(a)(10)(E)(iv)</td>
</tr>
<tr>
<td>- Presumptively Eligible MAGI Individuals</td>
<td></td>
</tr>
<tr>
<td>- Incarcerated Individuals (Inpatient stays only), except for the provision of pre-release services to certain incarcerated individuals as described in this application</td>
<td>• Clause (A) following 1905(a)(29)(A)</td>
</tr>
<tr>
<td></td>
<td>• 42 CFR 435.1009, 1010</td>
</tr>
<tr>
<td>- Presumptively Eligible Pregnant Individuals</td>
<td>• 1902(a)(47)</td>
</tr>
<tr>
<td></td>
<td>• 1920</td>
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<tr>
<td></td>
<td>• 1920A</td>
</tr>
<tr>
<td></td>
<td>• 1920B</td>
</tr>
<tr>
<td></td>
<td>• 1920C</td>
</tr>
</tbody>
</table>

[^33]: Individuals in any eligibility category not otherwise excluded during their period of retroactive eligibility or prior to the effective date of PHP coverage are eligible for the SUD component of the demonstration but are not eligible for HOP.
Other eligibility-related changes proposed in the demonstration are described in more detail in Section II and include continuous enrollment to certain children and youth.

**Delivery System**

The delivery system will remain as proposed and authorized in the last demonstration with changes to implementation dates as described in Section III and in Table C below.

Beneficiaries, except those excluded or exempted, shall be enrolled to receive services through a PHP under contract with the state. All Medicaid populations except for those who are excluded or exempt are either currently enrolled in PHPs or will be phased in to PHPs according to the schedule detailed below in Table C. For these populations, Medicaid managed care enrollment is mandatory. Members of federally recognized tribes, including members of the EBCI, may voluntarily enroll in PHPs on an opt-in basis.

**Table C: Managed Care Phase-in Schedule**

<table>
<thead>
<tr>
<th>Managed Care Plan</th>
<th>Populations</th>
<th>Phase-In Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard Plan</strong></td>
<td>Medicaid and M-CHIP beneficiaries except those who are:</td>
<td>Complete; implemented on July 1, 2021</td>
</tr>
<tr>
<td></td>
<td>• Excluded as described in Table B of this application;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Exempted individuals who choose not to enroll in managed care;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Eligible to enroll in a Tailored Plan or the Children and Families Specialty Plan</td>
<td></td>
</tr>
<tr>
<td><strong>Tailored Plan</strong></td>
<td>Medicaid and M-CHIP beneficiaries eligible to enroll in Tailored Plans</td>
<td>Pending; anticipated to launch in 2024</td>
</tr>
<tr>
<td><strong>Children and Families Specialty Plan</strong></td>
<td>Medicaid and M-CHIP beneficiaries who are children in foster care; children receiving adoption assistance; former foster youth up to</td>
<td>Pending; anticipated to launch in late 2024 or 2025</td>
</tr>
</tbody>
</table>

34 North Carolina, consistent with requirements in state statute, intends to enroll dual eligible and long-term stay nursing home populations into managed care in the future, and will update these tables as appropriate when more information is available on that change.

35 These populations may opt to enroll in a Standard Plan.

36 These populations may opt to enroll in a Standard Plan.
age 26; parents and caretaker relatives of children/youth in foster care who are making reasonable efforts to comply with a court-ordered plan of reunification; siblings of children/youth in foster care; minor children and certain family members receiving Child Protective Services In-Home Services; minor children of children/youth in foster care, of children/youth receiving adoption assistance or of former foster youth.

Cost Sharing

There are no changes to cost sharing proposed under this demonstration. Cost sharing under this demonstration is consistent with the provisions of the approved state plan.

Section IV – Requested Waivers and Expenditure Authorities

Under the authority of Section 1115(a) of the Act, the following waivers and expenditure authorities shall enable North Carolina to implement the North Carolina Medicaid Reform Section 1115 demonstration from November 1, 2024, to October 31, 2029. To the extent that CMS advises the State that additional authorities are necessary to implement the programmatic vision and operational details described above, the State is requesting such waiver or expenditure authority, as applicable. North Carolina’s negotiations with the federal government, as well as State legislative/budget changes, could lead to refinements in these lists as we work with CMS to move this demonstration forward.

Table D. Requested Waiver and Expenditure Authorities

<table>
<thead>
<tr>
<th>Waiver/Expenditure Authority</th>
<th>Use for Waiver / Expenditure Authority</th>
<th>Currently Approved Waiver / Expenditure Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Waiver Authorities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statewideness:</td>
<td>To the extent necessary to enable the state to operate managed care on less than a statewide basis</td>
<td>Currently approved</td>
</tr>
<tr>
<td>Section 1902(a)(1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To the extent necessary to enable the state to implement the Healthy Opportunities</td>
<td>Currently approved</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Pilot</strong> in geographically limited areas of the state</td>
<td>To enable the state to provide pre-release services to qualifying beneficiaries on a facility limited basis, as outlined in this application</td>
<td>Not currently approved</td>
</tr>
<tr>
<td><strong>Freedom of Choice:</strong> Section 1902(a)(23)(A)</td>
<td>To the extent necessary to enable the state to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans for the receipt of covered services including individuals in the Innovations and TBI 1915(c) waivers NC 0423.RO2.00, NC1326.R00.00, respectively. No waiver of freedom of choice is authorized for family planning providers.</td>
<td>Currently approved</td>
</tr>
<tr>
<td></td>
<td>To enable the state to require qualifying beneficiaries to receive pre-release services, as described in this application, through only certain providers.</td>
<td>Not currently approved</td>
</tr>
<tr>
<td><strong>Amount, Duration, and Scope of Services:</strong> Section 1902(a)(10)(B)</td>
<td>To the extent necessary to enable the state to vary the amount, duration, and scope of services offered to individuals in managed care under this demonstration, regardless of eligibility category</td>
<td>Currently approved</td>
</tr>
<tr>
<td><strong>Comparability:</strong> Section 1902(a)(17)</td>
<td>To enable the state to provide Healthy Opportunities Pilot services as described in this application and that are not otherwise available to all beneficiaries in the same eligibility group.</td>
<td>Currently approved (Note: language is slightly modified from previous approval)</td>
</tr>
<tr>
<td></td>
<td>To enable the state to provide additional benefits to Medicaid beneficiaries who are enrolled in the Healthy Opportunities Pilot program.</td>
<td>Currently approved</td>
</tr>
<tr>
<td></td>
<td>To enable the state to provide only a limited set of pre-release services to qualifying beneficiaries, as described in this application, that is different than the services available to all other enrollees</td>
<td>Not currently approved</td>
</tr>
</tbody>
</table>
outside of carceral settings in the same eligibility groups authorized under the state plan or the demonstration

<table>
<thead>
<tr>
<th>Expenditure Authorities&lt;sup&gt;37&lt;/sup&gt;</th>
</tr>
</thead>
</table>

### Managed Care

<table>
<thead>
<tr>
<th>Tailored Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditures under contracts with managed care entities that do not meet the requirements in 1903(m)(2)(A) and 1932(a) of the Act as implemented in 42 CFR 438.52(a), to the extent necessary to allow the state to limit the choice to a single Tailored Plan in each county for Medicaid enrollees meeting one of the following criteria:</td>
</tr>
<tr>
<td>a. Residing in an ICF-IID</td>
</tr>
<tr>
<td>b. Participating in North Carolina’s Transitions to Community Living</td>
</tr>
<tr>
<td>c. Enrolled in the Innovations or Traumatic Brain Injury 1915(c) waiver</td>
</tr>
<tr>
<td>d. Receiving services/supports in state-funded residential treatment (i.e., individuals receiving services to support them in their residence/house setting, including services provided in group homes or non-independent settings such as Group Living, Family Living, Supported Living, and Residential Supports)</td>
</tr>
<tr>
<td>Currently approved</td>
</tr>
</tbody>
</table>

### Healthy Opportunities Pilot

<table>
<thead>
<tr>
<th>Expenditures Related to Healthy Opportunities Pilot Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditures to provide Healthy Opportunities Pilot services for individuals who meet the eligibility criteria and in accordance with this application.</td>
</tr>
<tr>
<td>Currently approved (Note: language is modified from previous approval to reflect statewide)</td>
</tr>
</tbody>
</table>

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<sup>37</sup> In the SUD waiver extension request submitted to CMS on [XXX], North Carolina requested to continue expenditure authority for Residential and Inpatient Treatment for Individuals with a Substance Use Disorder (SUD).
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditures Related to Healthy Opportunities Pilot Program Capacity Building Funding</td>
<td>Expenditures for capacity building funding to support implementation of HOP.</td>
<td>expansion and to remove October 31, 2024 expiration date)</td>
</tr>
<tr>
<td>Continuous Enrollment for Children</td>
<td>Expenditures for continued benefits for individuals who have been determined eligible for the applicable continuous eligibility period who would otherwise lose coverage during an eligibility determination.</td>
<td>Not currently approved</td>
</tr>
<tr>
<td>Coverage for Justice-Involved Reentry</td>
<td>Expenditures for pre-release services provided to qualifying demonstration beneficiaries who would be eligible for Medicaid if not for their incarceration status, for up to 90 days immediately prior to the expected date of release from a participating state prison, county jail, or youth correctional facility.</td>
<td>Not currently approved</td>
</tr>
<tr>
<td>Expenditures Related to Pre-Release Services Capacity Building Funding</td>
<td>Expenditures for capacity building funding to support implementation of Justice-Involved Reentry Initiative.</td>
<td>Not currently approved</td>
</tr>
<tr>
<td>Behavioral Health and I/DD Technology</td>
<td>Expenditures for the HIT Grants initiative.</td>
<td>Not currently approved</td>
</tr>
<tr>
<td>----------------------------------------------------------------</td>
<td>--------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Expenditures Related to Behavioral Health and I/DD HIT Infrastructure</td>
<td>Expenditures for the School Health and Health-Related Capabilities initiative.</td>
<td>Not currently approved</td>
</tr>
<tr>
<td>Behavioral Health and LTSS Workforce</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenditures Related to Clinical Loan Repayment Program</td>
<td>Expenditures for the Clinical Loan Repayment initiative.</td>
<td>Not currently approved</td>
</tr>
<tr>
<td>Expenditures Related to Recruitment and Retention</td>
<td>Expenditures for the Recruitment and Retention Payments for Direct Care Workers and Paraprofessionals initiative.</td>
<td>Not currently approved</td>
</tr>
<tr>
<td>1915(i) Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Transition Services</td>
<td>Expenditures to provide 1915(i) community transition services to Medicaid-enrolled individuals transitioning out of an IMD</td>
<td>Not currently approved</td>
</tr>
<tr>
<td>Expenditures Related to 1915(i) Services</td>
<td>Expenditures to provide 1915(i) services to Medicaid-enrolled individuals with incomes above 150% FPL</td>
<td>Not currently approved</td>
</tr>
<tr>
<td>Designated State Health Programs</td>
<td>Expenditures for Designated State Health Programs, as described in this application, which are otherwise fully state-funded, and not otherwise eligible for Medicaid matching funds.</td>
<td>Not currently approved</td>
</tr>
</tbody>
</table>

Section V – Summaries of External Quality Review Organization (EQRO) Reports, Managed Care

33
Organization (MCO), and State Quality Assurance Monitoring

External Quality Review Organization Reports

Health Services Advisory Group (HSAG), North Carolina’s EQRO, uses its analyses and evaluations of external quality review (EQR) activity findings to assess each Standard Plans’ (and later Tailored Plans’ and other managed care entities’) performance in providing quality, timely, and accessible healthcare services to beneficiaries as required in 42 CFR §438.364. In the latest EQR report, HSAG includes overall findings and conclusions regarding quality, timeliness, and access for all Standard Plans. High-level findings include:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Conclusion</th>
</tr>
</thead>
</table>
| Quality | • **Strength:** The Standard Plans demonstrated a member-centric, quality-driven approach to serving the Medicaid population.  
• **Strength:** The encounter data validation (EDV) information systems (IS) review assessed self-reported qualitative information from all five Standard Plans. Based on the Standard Plan contract and the Department’s requirements, Standard Plans demonstrated their capability to collect, process, and transmit encounter data to the Department, as well as develop data review and correction processes that can promptly respond to quality issues identified by Department.  
• **Strength:** The performance measure validation (PMV) activity identified that all five Standard Plans demonstrated extensive knowledge and experience in claims and encounter, membership/enrollment, data integration, rate production, and medical record procurement and abstraction processes.  
• **Strength:** All five Standard Plans achieved a PIP validation status of *Met* and 100 percent of the validation criteria for the first six steps submitted for validation. All PIPs were found to be methodologically sound.  
• **Opportunity for Improvement:** To improve the quality of encounter data submissions from the Standard Plans, the Department may want to assess whether there are common root cause(s) for Standard Plan encounter rejections.  
• **Opportunity for Improvement:** The Standard Plans did not consistently ensure that policies, procedures, processes, or committee materials |
satisfied program integrity (PI) requirements. These findings suggest that the Standard Plans may not have implemented processes to ensure all federal and Department requirements were met.

- **Opportunity for Improvement**: Results of the PMV activity indicated that two health plans had an opportunity to establish consistent data feeds with the State immunization registry. This finding may impact the Standard Plans’ ability to accurately assess enrollees for gaps in care.

### Access

- **Strength**: Provider participation in quality forums revealed interest in continuing discussions to address access to care and best practices to improve Healthcare Effectiveness Data and Information Set (HEDIS) access measures.

### Timeliness

- **Strength**: There was strong participation in EQRO activities, with consistent and timely submission of information that provided evidence of progress toward goals and continued improvement.

- **Opportunity for Improvement**: Results of the PMV activity indicated that two health plans had an opportunity to establish consistent data feeds with the State immunization registry. This finding may impact the Standard Plans’ ability to ensure that timely reporting of services is captured in quality measure reporting.

Note that reporting of the state’s HEDIS quality measure performance is one year following the year reflected in the data. HEDIS measures require one full year of data; however, the Standard Plans’ contracts did not go into effect until July 1, 2021. In consideration of this, HSAG and the Department worked closely with the Standard Plans to understand several nuances and complexities in the Standard Plans’ abilities to produce 2021 HEDIS performance rates for review and validation. HSAG ensured that calendar year (CY) 2021 PMV methods aligned with CMS EQR Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019; however, final measurement year (MY) 2021 rates were not available until mid-calendar year (CY) 2022 and will, therefore, be subsequently integrated into the EQR technical report produced in state fiscal year (SFY) 2023 (release pending).

The Standard Plans’ primary performance improvement project (PIP) activities in the first year of managed care were initiating new PIPs and completing the first six steps of the submission form. For the 2022 validation, the PIPs had not progressed to including baseline
data or initiating QI activities or interventions. These will also be reported in the next annual EQR technical report in 2023.

More information is available in the full 2021-2022 EQR report here. The Department will include in the October submission of the final waiver renewal the 2022-2023 EQR report and update this section, as needed.

In the October submission, the Department will include (with 2021 data):

- Managed Care Health Equity Report
- Annual Quality Report
- Access to Care Report

**Managed Care Organization and State Quality Assurance Monitoring**

North Carolina’s managed care contracts include robust requirements to ensure that managed care plans meet and, in many cases, exceed the standards outlined in 42 CFR Part 438, Subpart D, and as specified by the Department. These standards are detailed throughout the Quality Strategy and EQR report and include requirements for enrollee access to care, network adequacy, availability of services, access to care during transitions of coverage, assurances of adequate capacity and services, coordination and continuity of care and coverage, and authorization. Further, these requirements focus on the structure and operations that managed care plans and other entities delivering managed care must have in place to ensure the provision of high-quality care.

**Other Quality Documentation**

The Department’s CMS 416 Form (2021) can be found here. The Department’s Consumer Assessment of Healthcare Providers and Systems (CAHPS) reflects reporting respondents’ experiences with their health care. Results from the 2022 report are here.

The Department administered a Medicaid Provider Experience Survey in the first year of managed care (2022), to assess the impact of the North Carolina Medicaid Transformation on primary care and obstetrics/gynecology (Ob/Gyn) practices that contract with NC Medicaid. The full report is available here; a baseline survey was conducted in 2021.
Section VI – Enrollment, Demonstration Financing and Budget Neutrality

This section describes the historical and expected enrollment impact, historical and expected financial expenditures, and budget neutrality considerations associated with the proposed demonstration renewal initiatives.  

Enrollment

Table E provides historical data on Member Months and estimated Person Count for North Carolina Medicaid Reform 1115 demonstration populations from November 1, 2019, to October 31, 2024. Note that a portion of the DY5 and all of the DY6 figures reflect continuation of reported experience through March 31, 2023.

Table E. Estimated Historical Person Count

<table>
<thead>
<tr>
<th>Medicaid Eligibility Group</th>
<th>Historical Member Months and Person Count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DY2&lt;sup&gt;39&lt;/sup&gt;</td>
</tr>
<tr>
<td>Aged, Blind, Disabled (ABD)</td>
<td>Member months</td>
</tr>
<tr>
<td></td>
<td>Person count</td>
</tr>
<tr>
<td>TANF &amp; Related Adults</td>
<td>Member months</td>
</tr>
<tr>
<td></td>
<td>Person count</td>
</tr>
</tbody>
</table>

<sup>38</sup> The calculations and figures included in this Section have been developed for purposes of illustrating 1115 demonstration budget neutrality as required by CMS. 1115 demonstrations must be budget neutral to the federal government, not to the State, according to the policies negotiated in each demonstration. The required approach, inputs and methods for CMS may not align with estimates performed by the State for other purposes. For example, the illustrated per capita caps and expenditures do not consider the impact of pharmacy rebates or other costs that are outside of the managed care programs and populations included in this document.

<sup>39</sup> Demonstration Year 1 was associated with SUD waiver implementation only. This table reflects the appropriate Demonstration years for the comprehensive Medicaid Reform Demonstration.
North Carolina has estimated enrollment for the next demonstration period for the purposes of public comment. Table F provides the estimated enrollment for the five years of the 1115 demonstration renewal from November 1, 2024, to October 31, 2029. The State will include final projections in the demonstration renewal request submitted to CMS; final numbers may differ as North Carolina continues to finalize enrollment data under the current 1115 demonstration, to determine the impact that the COVID-19 public health emergency has had on enrollment trends, to prepare to implement Medicaid expansion and to consider any new initiatives contemplated as part of the 1115 demonstration renewal.

Table F. Projected Member Months and Person Count Under Renewal

<table>
<thead>
<tr>
<th>Medicaid Eligibility Group</th>
<th>Projected Member Months and Person Count Under Renewal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DY7</td>
</tr>
<tr>
<td>Medicaid Eligibility Group</td>
<td>Nov 2024 to Oct 2025</td>
</tr>
<tr>
<td>ABD</td>
<td></td>
</tr>
<tr>
<td>Member months</td>
<td>2,217,445</td>
</tr>
</tbody>
</table>

*Launch of Medicaid expansion is pending given ongoing budget negotiations. Estimates in DY5 and DY6 are subject to change. North Carolina will update and include final projections in the demonstration renewal request submitted to CMS.
### Projected Member Months and Person Count Under Renewal

<table>
<thead>
<tr>
<th></th>
<th>DY7</th>
<th>DY8</th>
<th>DY9</th>
<th>DY10</th>
<th>DY11</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TANF &amp; Related Adults</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Person count</td>
<td>184,787</td>
<td>186,635</td>
<td>188,501</td>
<td>190,386</td>
<td>192,290</td>
</tr>
<tr>
<td>Member months</td>
<td>3,682,854</td>
<td>3,719,682</td>
<td>3,756,879</td>
<td>3,794,448</td>
<td>3,832,393</td>
</tr>
<tr>
<td>Person count</td>
<td>306,904</td>
<td>309,974</td>
<td>313,073</td>
<td>316,204</td>
<td>319,366</td>
</tr>
<tr>
<td><strong>TANF &amp; Related Children</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member months</td>
<td>15,642,839</td>
<td>16,212,785</td>
<td>16,792,565</td>
<td>16,960,491</td>
<td>17,130,095</td>
</tr>
<tr>
<td>Person count</td>
<td>1,303,570</td>
<td>1,351,065</td>
<td>1,399,380</td>
<td>1,413,374</td>
<td>1,427,508</td>
</tr>
<tr>
<td><strong>Innovations/TBI</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member months</td>
<td>168,000</td>
<td>168,000</td>
<td>168,000</td>
<td>168,000</td>
<td>168,000</td>
</tr>
<tr>
<td>Person count</td>
<td>14,000</td>
<td>14,000</td>
<td>14,000</td>
<td>14,000</td>
<td>14,000</td>
</tr>
<tr>
<td><strong>Medicaid Expansion</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member months</td>
<td>7,415,187</td>
<td>7,489,339</td>
<td>7,564,232</td>
<td>7,639,874</td>
<td>7,716,273</td>
</tr>
<tr>
<td>Person count</td>
<td>617,932</td>
<td>624,112</td>
<td>630,353</td>
<td>636,656</td>
<td>643,023</td>
</tr>
</tbody>
</table>

Continuously enrolled children and former foster youth are included in the TANF & Related Children Medicaid Eligibility Group projections noted above. Table G provides a summary of the estimated number of individuals impacted by these continuous enrollment changes.

**Table G. Estimated Continuous Enrollment Impacts**

<table>
<thead>
<tr>
<th></th>
<th>Estimated Number of Individuals Affected by Continuous Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DY7</td>
</tr>
<tr>
<td><strong>Continuous Enrollment Groups</strong></td>
<td></td>
</tr>
<tr>
<td>Nov 2024 to Oct 2025</td>
<td></td>
</tr>
<tr>
<td>Nov 2025 to Oct 2026</td>
<td></td>
</tr>
<tr>
<td>Nov 2026 to Oct 2027</td>
<td></td>
</tr>
<tr>
<td>Nov 2027 to Oct 2028</td>
<td></td>
</tr>
<tr>
<td>Nov 2028 to Oct 2029</td>
<td></td>
</tr>
</tbody>
</table>
Justice-involved individuals are not included in the Medicaid Eligibility Group projections noted above. Table H provides a summary of the estimated number of individuals who will receive pre-release services under this demonstration.

### Table H. Estimated Justice-Involved Reentry Initiative Impacts

| Estimated Number of Individuals Affected by Justice-Involved Reentry Initiative |
|---------------------------------|----------------|----------------|----------------|----------------|----------------|
|                                 | DY7            | DY8            | DY9            | DY10           | DY11           |
| Nov 2024 to Oct 2025            | 2,925          | 6,825          | 9,750          | 9,750          | 9,750          |
| Nov 2025 to Oct 2026            |                |                |                |                |                |
| Nov 2026 to Oct 2027            |                |                |                |                |                |
| Nov 2027 to Oct 2028            |                |                |                |                |                |
| Nov 2028 to Oct 2029            |                |                |                |                |                |

### Expenditures

Table I provides historical data on the total expenditures for the North Carolina Medicaid Reform 1115 demonstration services and populations from November 1, 2019, to October 31, 2024. Note that a portion of the DY5 and all of the DY6 figures are estimated based on reported experience through March 31, 2023.
### Table I. Historical Total Computable Expenditures

<table>
<thead>
<tr>
<th>Medicaid Eligibility Groups</th>
<th>Historical Expenditures (in $M)</th>
<th>DY2 2020</th>
<th>DY3 2021</th>
<th>DY4 2022</th>
<th>DY5 2023</th>
<th>DY6 2024</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABD</td>
<td>Nov 2019 to Oct 2020</td>
<td>0</td>
<td>$508,987,665</td>
<td>$2,046,744,665</td>
<td>$2,253,393,450</td>
<td>$2,253,393,450</td>
</tr>
<tr>
<td>TANF &amp; Related Adults</td>
<td>Nov 2020 to Oct 2021</td>
<td>0</td>
<td>$374,099,591</td>
<td>$2,287,582,053</td>
<td>$2,738,045,214</td>
<td>$2,738,045,214</td>
</tr>
<tr>
<td>TANF &amp; Related Children</td>
<td>Nov 2021 to Oct 2022</td>
<td>0</td>
<td>$620,287,515</td>
<td>$2,708,208,039</td>
<td>$2,863,757,092</td>
<td>$2,863,757,092</td>
</tr>
<tr>
<td>Innovations/TBI</td>
<td>Nov 2022 to Oct 2023</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medicaid Expansion</td>
<td>Nov 2023 to Oct 2024</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0*</td>
<td>0*</td>
</tr>
</tbody>
</table>

#### Healthy Opportunities Pilot

<table>
<thead>
<tr>
<th>ECM Capacity Building</th>
<th>ECM Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>$19,024,872</td>
<td>$16,660,324</td>
</tr>
<tr>
<td>$18,689,376</td>
<td>$5,010,877</td>
</tr>
<tr>
<td>$10,000,000</td>
<td>$84,000,000</td>
</tr>
<tr>
<td>0</td>
<td>$84,000,000</td>
</tr>
</tbody>
</table>

*Launch of Medicaid expansion is pending given ongoing budget negotiations. Estimates in DY5 and DY6 are subject to change. North Carolina will update and include final projections in the demonstration renewal request submitted to CMS.

For the purposes of public notice and comment, the State has summarized in the table below the projected expenditures for the renewal. The State will include final projections in the demonstration renewal request submitted to CMS; final numbers may differ as North Carolina continues to finalize financial data demonstrating the State’s historical expenditures under the current 1115 demonstration, to determine the impact that the COVID-19 public health emergency has had on enrollment and expenditure trends and consideration for new and emerging State...

40 Demonstration Year 1 was associated with SUD waiver implementation only. This table reflects the appropriate Demonstration years for the comprehensive Medicaid Reform Demonstration.
initiatives included in the 1115 renewal. For example, the anticipated distribution of capacity building funds for the justice-involved reentry initiative across the demonstration period reflects the current program implementation design; the distribution of costs may change as the design is refined.

Projected expenditures were developed using a blended approach of reported DY4 expenditure and enrollment levels and DY6 approved per capita caps, amongst other data sources. The blended approach considers estimated prospective trends intended to align with President’s Budget trend levels, adjustments for program adjustments as identified in the bullets below, and projected expenditures for new initiatives as outlined in this document.

Projected expenditures include new initiatives for which the State is requesting aggregate expenditure authority under the 1115 demonstration renewal as well as the following program adjustments which impacted the historical and/or future demonstration years:

- Continuous enrollment for children and former foster youth are included in expenditure projections for the TANF & Related Children MEG.
- Fee schedule increases for select service types including: hospital payment increases implemented July 1, 2021, HCBS direct care worker service rate increase implemented by DHHS in March 2022, and rate increases for Personal Care.
- Increased payments to SNFs based on a percent of Medicare payment approach required in managed care.
- Consideration for the impact of the public health emergency on future expenditures and enrollment.
- Tailored Plan and CFSP acuity and enrollment, once implemented.
- Expenditures to provide 1915(i) services to Medicaid-enrolled individuals.

41 The following programs which have not yet been approved and are still pending given ongoing budget negotiations may have financial impact on the projected expenditures: Healthcare Access and Stabilization Program (HASP), Behavioral Health Fee Schedule increases, Innovations/TBI, Private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID). North Carolina will update and include final projections in the demonstration renewal request submitted to CMS.
### Table J. Projected Total Computable Expenditures Under Renewal

<table>
<thead>
<tr>
<th>Medicaid Eligibility Groups</th>
<th>DY7</th>
<th>DY8</th>
<th>DY9</th>
<th>DY10</th>
<th>DY11</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABD</td>
<td>$5,586,941,191</td>
<td>$5,896,737,080</td>
<td>$6,223,711,151</td>
<td>$6,568,815,934</td>
<td>$6,933,056,778</td>
</tr>
<tr>
<td>TANF &amp; Related Adults</td>
<td>$3,064,472,454</td>
<td>$3,234,397,451</td>
<td>$3,413,744,790</td>
<td>$3,603,036,938</td>
<td>$3,802,825,337</td>
</tr>
<tr>
<td>TANF &amp; Related Children</td>
<td>$5,188,185,940</td>
<td>$5,619,191,812</td>
<td>$6,082,044,107</td>
<td>$6,419,293,452</td>
<td>$6,775,243,274</td>
</tr>
<tr>
<td>Innovations/TBI</td>
<td>$1,561,052,272</td>
<td>$1,631,299,624</td>
<td>$1,704,708,107</td>
<td>$1,781,419,972</td>
<td>$1,861,583,871</td>
</tr>
<tr>
<td>Medicaid Expansion</td>
<td>$9,780,541,039</td>
<td>$10,372,263,772</td>
<td>$10,999,785,730</td>
<td>$11,665,272,767</td>
<td>$12,371,021,789</td>
</tr>
</tbody>
</table>

### Healthy Opportunities Pilots

| Services                             | $340,000,000      | $340,000,000      | $340,000,000      | $340,000,000      | $340,000,000      |
| Capacity Building*                    | $50,000,000       | $100,000,000      | $100,000,000      | $25,000,000       | $25,000,000       |

### Justice-Involved Reentry

| Services                             | $4,096,381        | $10,036,134       | $15,054,201       | $15,806,911       | $16,597,256       |
| Capacity Building*                    | $100,000,000      | $125,000,000      | $50,000,000       | $30,000,000       | $10,000,000       |

### Behavioral Health and I/DD Provider Technology

| $15,000,000                           | $15,000,000       | $0                | $0                | $0                |

### Behavioral Health and LTSS Workforce

| $35,000,000                           | $35,000,000       | $0                | $0                | $0                |

### Technology to Advance Schools

| $7,500,000                            | $7,500,000        | $0                | $0                | $0                |

### DSHP
Projected Total Computable Expenditures

<table>
<thead>
<tr>
<th>Year</th>
<th>Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>DY7</td>
<td>$122,000,000</td>
</tr>
<tr>
<td>DY8</td>
<td>$122,000,000</td>
</tr>
<tr>
<td>DY9</td>
<td>$122,000,000</td>
</tr>
<tr>
<td>DY10</td>
<td>$122,000,000</td>
</tr>
<tr>
<td>DY11</td>
<td>$122,000,000</td>
</tr>
</tbody>
</table>

*North Carolina has allocated the total requested capacity building funding for the Healthy Opportunities Pilot and the Justice-Involved Reentry Initiative across the demonstration years based on the State’s best estimates and requests flexibility on the timing of actual payments.

**Budget Neutrality**

As described above, North Carolina’s proposed demonstration renewal seeks to continue existing demonstration initiatives and proposes new demonstration features. The demonstration is expected to be budget neutral as measured by CMS. Budget neutrality will align with the projected expenditures for the demonstration proposal as described above in Table J. Below, Table K shows the requested budget neutrality treatment across initiatives in the renewal. North Carolina will continue to work with CMS to confirm and finalize budget neutrality during the demonstration negotiation and approval process.

**Table K. Budget Neutrality (BN)**

<table>
<thead>
<tr>
<th>Waiver Initiative</th>
<th>Per Capita or Aggregate</th>
<th>Proposed Budget Neutrality Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Care</td>
<td>Per Capita</td>
<td>Main BN Test</td>
</tr>
<tr>
<td>Healthy Opportunities Services</td>
<td>Aggregate</td>
<td>Capped Hypothetical</td>
</tr>
<tr>
<td>Healthy Opportunities Capacity Building</td>
<td>Aggregate</td>
<td>Capped Hypothetical</td>
</tr>
<tr>
<td>Continuous Enrollment for Children</td>
<td>Per Capita</td>
<td>Hypothetical</td>
</tr>
<tr>
<td>Justice Involved Pre-Release Services</td>
<td>Per Capita</td>
<td>Hypothetical</td>
</tr>
<tr>
<td>Justice Involved Pre-Release Capacity Building</td>
<td>Aggregate</td>
<td>Hypothetical</td>
</tr>
<tr>
<td>Behavioral Health (BH) and LTSS Workforce Investments</td>
<td>Aggregate</td>
<td>Main BN Test</td>
</tr>
</tbody>
</table>
Behavioral Health and I/DD Provider HIT | Aggregate | Main BN Test
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Technology to Expand Schools’ Health and Health-Related Capabilities | Aggregate | Main BN Test
1915(i) Benefit Changes | Per Capita | Hypothetical
Designated State Health Programs (DSHP) | Aggregate | Main BN Test

Section VII – Evaluation

Evaluation Results from the Current Demonstration

Background

The purpose of the previously approved North Carolina Medicaid Reform 1115 Demonstration is to improve Medicaid enrollee health outcomes through the implementation of a new delivery system, to enhance the viability and sustainability of North Carolina’s Medicaid program by maximizing the receipt of high-value care, and to reduce SUD statewide. As required under the special terms and conditions (STCs) of the North Carolina Medicaid Reform Section 1115 demonstration, the state engaged an independent research organization, the North Carolina University Cecil G. Sheps Center for Health Services Research (“Sheps Center”), to evaluate the performance of the demonstration initiatives, including, but not limited to, managed care transformation, expansion of SUD coverage, and HOP.

Because the many programs included in the demonstration have different time frames, structures, and funding streams, the evaluation designs and timelines for the programs also vary. The approved demonstration evaluation design, inclusive of the Department’s objectives and hypotheses, is available [here](#) (the separate HOP evaluation design is available [here](#)). For initiatives where interim evaluation reports, rather than final evaluation reports, have been completed, work on the final evaluations is continuing and will be provided to CMS as required by the demonstration STCs, unless otherwise discussed and agreed upon by the State and CMS. The State’s evaluation materials will be made available at specified areas of DHHS’ website, such as the Quality Management and Improvement [homepage](#), or are available upon request.

Demonstration Evaluation Findings to Date
Managed Care Evaluation

The Department’s annual report from Demonstration Year 4 is available in the Appendix and the interim evaluation report will be submitted to CMS in October. The Department will include in the final submission to CMS in October the most recent evaluation findings.42

Summaries of qualitative evaluation findings from Demonstration Year 3 are provided below for reference:

- Demonstration Year 3 Summary – Providers
- Demonstration Year 3 Summary – Standard Plans
- Demonstration Year 4 Summary – Providers

SUD Components of the Demonstration Evaluation

The Department, in collaboration with the Sheps Center, conducted an Interim Evaluation between October 1, 2015 – September 31, 2022, of the SUD components of the demonstration. May 1, 2019 is used as the official start of the SUD expenditure authority. Many SUD changes were phased in over time and thus estimates will be conservative since Sheps included months prior to each event. Two major events occurred during the SUD implementation period. First, the COVID-19 PHE began with stay-at-home orders in March 2020 and only ended in May 2023, after the study period for this report. Sheps developed a novel method of identifying the return-to-normal dates in our data. Second, the launch of Standard Plans occurred on July 1, 2021. While most of the population with an SUD has not yet enrolled in a managed care plan, but will be enrolled in a Tailored Plan, the launch of Standard Plans may have affected outcomes for people with SUD if Standard Plans’ benefit design affected access to care or if Standard Plans changed providers’ patterns of care, directly or indirectly. Sheps found that 25% of the population identified as having a SUD were enrolled in Standard Plans.

Sheps used interrupted time series models to examine the trends in metrics before the start of the SUD waiver and during the waiver implementation period. These models control for changes due to other factors, such the COVID-19 time period, Standard Plan implementation, month effects, county effects, and beneficiary-level controls for age, race/ethnicity, sex, and the Chronic Disease Payment System (CDPS- Rx) risk score. This evaluation does not incorporate a comparison group that was not exposed to the NC Medicaid transformation and thus the models will attribute

42 The Department is pending feedback from CMS for the following: SUD Mid-Point Assessment and the SUD Interim Evaluation Report.
any remaining factors that occurred during the SUD implementation period to the SUD waiver. Sheps takes this into account when describing results.

Below is a summary of findings by major hypothesis. The Department will include in the final demonstration renewal application to CMS updated evaluation findings, as available.

**Hypothesis 3.1: Expanding coverage of SUD services will result in improved care quality and outcomes for beneficiaries with SUD.**

Sheps examined 27 metrics reflecting quality of care and outcomes for Medicaid beneficiaries with substance use disorders to test hypothesis 3.1. Analysis of these variables found that only six metrics represented progress in improving outcomes and quality of care for people with SUD, one metric demonstrated no change, one had data issues and could not be analyzed, while the remaining 19 metrics demonstrated declines. The metrics that improved during the SUD waiver were important high-level reflections of the health of the population of Medicaid beneficiaries who struggle with substance use disorders. These include proportionately a greater percent of beneficiaries with diagnosed with SUD after a peak around the time of the COVID-19 pandemic, potentially indicating better access to care (although Sheps notes that it is impossible to tell whether this reflects a higher prevalence of SUD or a higher diagnosed prevalence), greater use of withdrawal management services, the growth in the availability of providers to provide SUD and medications for opioid use disorder (MOUD) treatments, continued low lengths of stay in inpatient or residential treatment facilities, often referred to as IMDs, and greater continuity of care for opioid use disorder (OUD). These are important metrics of the success of the SUD waiver. Many of the metrics demonstrating declines were measures of access to specific types of services, initiation and engagement in care. Most of these metrics declined during the COVID PHE, despite our effort to control these effects using trends from Medicaid beneficiaries without SUD diagnoses. The remaining metrics that did not demonstrate progress examined availability and use of specialty behavioral health services, which may reflect the fact that many of the expansions in benefits offered to meet American Society of Addiction Medicine (ASAM)’s levels of care have only been recently introduced or are still in process. In addition, the Tailored Plans had been envisioned as a major driver of improvements in care have still not been implemented and potentially caused disruption in care during the two prior delayed launches of this benefit plan.

**Hypothesis 3.2: Expanding coverage of SUD services will increase the use of MOUD and other appropriate opioid treatment services and decrease the long-term use of prescription opioids.**

Sheps examined the trends in 16 additional metrics reflecting medication and other treatments for OUD and long-term use of opioids in order to test Hypothesis 3.2 (Table 1). Four of the metrics demonstrated appreciable progress since the SUD waiver implementation,
one demonstrated no change, and the remaining 11 moved in the opposite direction as the waiver goals. The metrics that indicated appreciable progress during the SUD waiver implementation period included the use of pharmacotherapy for OUD, 30-day follow up after emergency department (ED) visit for mental health among beneficiaries with SUD diagnoses; two metrics reflecting the receipt of opioids from multiple providers. The use of non-medication services for OUD did not change. The eleven metrics that did not demonstrate progress included metrics reflecting follow up care after emergency and hospital visits for SUD, use of opioids at high doses, and the rate of ED and inpatient use per 1000 beneficiaries with SUD.

Hypothesis 3.3: Expanding coverage of SUD services will result in no changes in total Medicaid and out-of-pocket costs for people with SUD diagnoses and increases in Medicaid costs on SUD IMD services.

Sheps examined six measures reflecting total spending, per beneficiary spending, and out-of-pocket costs overall for SUD services and specifically for IMD services. Sheps found that total spending on SUD services increased after SUD waiver implementation, as expected. This reflects both the greater number of beneficiaries receiving benefits, especially after the start of the PHE, but also greater spending per capita, even after controlling for changes in case mix. Spending on SUD services in IMDs remained stable, although per capita spending on SUD services in IMDs grew slightly. A somewhat greater percent of beneficiaries with SUD had out-of-pocket spending after the SUD waiver was implemented, affecting 2% of beneficiaries with SUD. However, the average copay among beneficiaries with some out-of-pocket spending declined during the SUD implementation period.

Additional Hypothesis 4.1: The implementation of the SUD waiver will increase access to health care and improve the quality of care and health outcomes.

Sheps examined eight measures reflecting general health care quality and health outcomes in order to test the effect of the SUD waiver implementation on overall health. Sheps notes that the largest component of the SUD waiver intended to improve overall health among beneficiaries with SUD, Tailored Plans, were intended to launch earlier in the demonstration period, but have not yet launched, and thus the mechanisms for improving overall health outcomes for people with SUD are not strong. In this set of analyses, Sheps found an improvement in one measure of care – access to ambulatory / preventative visits. Sheps found that three of the measures did not have a measurable effect of the SUD waiver, and four of the measures showed worse outcomes associated with the SUD waiver implementation.

Additional Hypothesis 4.2: The implementation of the SUD waiver will increase the rate of use of behavioral health services at the appropriate level of care and improve the quality of
behavioral health care received.

This section mostly focuses on the impact of the SUD waiver on mental health measures. A high proportion of people with substance use disorders also qualify for mental health diagnoses. Sheps tested hypothesis 4.2 on access to and quality of behavioral health care for beneficiaries with SUD diagnoses using 18 measures, including 13 that had been used in prior hypotheses (see Table 1). One of the measures was unaffected by the Medicaid SUD transformation (antidepressant management during the acute phase), while all remaining 17 measures declined during SUD implementation. These estimates attempt to control for trends observed during the COVID-19 PHE in the Medicaid beneficiary population without SUD and not transitioned to standard plans, but these adjustments are not without limitations due to the differences in these populations.

Stratified analyses show important declines in several disparities in care across numerous dimensions and effects both directly from SP implementation as well as indirect effects in the beneficiary population with SUD diagnoses.

Conclusions

The results from this assessment reflect the tremendous sacrifices and pivots that North Carolina, like virtually all other states, had to make during the COVID-19 PHE. The components of the demonstration that affect SUD treatment were only beginning to gain traction as the PHE began, having been implemented only 10 months before its start. Most NC DHHS staff and providers worked under extraordinary conditions that lasted longer than anyone expected. Many professionals left the public health and medical workforce at a time of greater demand for substance use services. The findings in this evaluation do not in any way detract from the dedication of the thousands of dedicated public health professionals who accomplished daily miracles during this time. The SUD waiver is the most challenging demonstration component to evaluate because it is not a discrete event, like managed care launch, but comprised multitudes of policy changes and approvals, many of which are still in progress. For example, the launch of Tailored Plans has been postponed several times and may have limited the momentum of SUD waiver implementation.

There are some bright spots in this assessment: the number of beneficiaries diagnosed with a substance use disorder has started to decline, consistent with the stated goals of the demonstration, the number of people using evidence-based medication treatments for opioid use disorder is increasing, the continuity of pharmaceutical care for OUD is increasing, more providers are available to provide SUD services to beneficiaries, fewer beneficiaries without cancer are receiving opioid prescriptions from multiple providers, and beneficiaries with SUD diagnoses are accessing more ambulatory and preventative care.
However, Sheps clearly identified serious lack of access to many essential services for people with substance use disorders, even after the implementation of many of the components of the SUD waiver. Performance on most of the SUD metrics required by CMS for SUD 1115 waiver monitoring declined rather than improved during the demonstration period. The percent of beneficiaries with SUD receiving any type of care has stagnated at 35-40% of the population identified for treatment. This statistic alone indicates that more than 60% of people in the target population are not receiving any type of Medicaid-paid SUD service in a given month. The percent of beneficiaries with a diagnosed SUD condition receiving outpatient SUD services has dropped to levels below those experienced during the initial months of the PHE when the state was under stay-at-home orders. These levels indicate that in a typical month almost 75% of the eligible population is not receiving a single outpatient service. Finally, over 40% of non-elderly adults with opioid use disorder are not accessing evidence-based medication treatments for opioid use disorder, an essential tool to fight this deadly condition.

**HOP Evaluation**

The Department’s first Rapid Cycle Assessment (RCA) on the HOP program includes data regarding preparations for service delivery and delivery of services from March 15, 2022, to November 30, 2022. A subsequent RCA, interim evaluation and summative evaluation will be submitted to CMS by the end of the demonstration period. The Department will include in the final submission to CMS in October updated evaluation findings, if available.

The Pilot aims to test evidence-based, non-medical interventions for their direct impact on North Carolina’s Medicaid beneficiaries’ health outcomes and healthcare costs, with the purpose of incorporating findings into the Medicaid program. The three evaluation questions and hypotheses for HOP that are explored in the first Rapid Cycle Assessment are:

- **Evaluation Question 1 (“Effective Delivery of Pilot Services”)** analyses relate to activities undertaken by Network Leads and HSOs to establish the necessary infrastructure, workforce, and data systems needed to effectively contract with and build the capacity of a network of HSOs, and to deliver Pilot services once established. Overall, Evaluation Question 1 analyses help test the hypothesis that Network Leads will enable effective delivery of Pilot services.

- **Evaluation Question 2 (“Increased Rates of Social Risk Factor Screening and Connection to Appropriate Services”)** analyses relate to how the coordinated activities of HOP Administrators, Network Leads, and HSOs facilitate screening for social risk factors/needs in Pilot regions, and connect a higher proportion of those with social risk factors/needs to services to address those needs in Pilot regions, compared with non-Pilot regions that do not have these coordinated activities. Overall, Evaluation Question 2 analyses help test the
hypothesis that HOP will increase rates of Medicaid beneficiaries screened for social risk factors and connected to services that address these risk factors.

- Evaluation Question 3 (“Improved Social Risk Factors”) analyses relate to improving the social risk factors that Pilot enrollees experience, across all eligibility categories: adults, pregnant individuals, children ages 0 to 21, and the subset of children age 0 to 3. Evaluation Question 3 analyses help test the hypothesis that HOP will measurably improve the qualifying social risk factors in participants.

The findings of the assessment are largely positive:

- North Carolina’s goal of establishing effective multi-sector collaboration between the state, HOP Administrators, healthcare systems, and HSOs has been achieved. Although there are always areas of operations that can be improved, this was a major undertaking completed in a relatively compressed timeframe after unavoidable disruption due to the COVID-19 pandemic. In preparation to deliver services, staff at Network Leads and HSOs interviewed expressed concern about the scale of the task and the differences between the structure of HOP and their usual methods of operation, including interfacing with the Medicaid regulatory environment. Network Leads and HSOs began by collaborating with a core group of other organizations they had previously worked with, but substantially grew their collaborations so that a wide array of Pilot services could be offered.

- From the perspective of Network Leads and HSOs, benefits of participating in HOP include building networks of collaboration, supporting growth of HSOs, and improving community health and wellness. Components of HOP that Network Leads and HSOs thought were key to success included support for capacity building, facilitating of communication between HOP Administrators, Network Leads, and HSOs, and detailed planning for the complicated logistics of delivery Pilot services to a large number of participants.

- Operational data reveals that despite challenges, Pilot services are being delivered successfully. As of November 30, 2022 (seven months following launch), 2,705 unique individuals have been enrolled, and 14,427 services have been delivered across many different intervention types by 84 HSOs. Initial assessments of social needs occur quickly (most commonly at the time of enrollment). Within the data used for this report, 63% of those who enrolled—1,713 out 2,705 Pilot participants—had received at least one invoiced service, with more participants in the pipeline to receive services as time progresses. Further, there can be a lag between service delivery and invoicing for services. Services delivered typically began quickly—over 75% of services had a start of service date within 2 weeks of enrollment in HOP. The rate of service receipt varied across need types. 68% of individuals reporting a food need received an invoiced food service during this
period, while 40% of those reporting a housing need received an invoiced housing service, and 16% of those reporting a transportation need received an invoiced transportation service. This difference may reflect both the phased rollout of services, with food services preceding all other services, and the complexity of delivering services to address the varying needs. For example, housing shortages are common in many communities served by HOP, and the availability of transportation resources varies across communities as well. Very few cross-domain services were invoiced during this period, and no toxic stress services were invoiced during this evaluation period including IPV-related services, as these services were not yet offered. Food services constituted the majority (90%) of services delivered.

- Invoices for services were paid in a timely fashion. 56.2% of invoices were paid within 30 days, 90.3% within 60 days, and 97.9% within 90 days. This is important as a major goal of HOP was to ensure that HSOs, many of which historically depend on grant funding received prior to delivery of services, could operate successfully with a financing model that includes payments made after services were delivered.

- Overall, the evidence regarding the effectiveness of Pilot services at addressing social needs was mixed. As anticipated, Sheps observed an initial increase in recorded needs as needs are identified by detailed assessments around the time of enrolling in the Pilot, followed by a decrease in needs as Pilot services address them. However, the magnitude of the decrease in needs was small and may not be clinically meaningful. For example, Sheps estimated that soon after enrollment in HOP, individuals reported an average of 1.73 needs, which declined to 1.68 needs at 90 days after enrollment. While statistically significant, whether a decrease of this magnitude is likely to improve health, healthcare utilization, or healthcare cost is unclear. Although prior studies have shown that improvements in social needs can be seen within 90 days, this is still a very brief time period for assessment, and greater changes may become evident over longer periods of observation. At present, there have not been enough individuals with longer Pilot participation to examine needs at 180 or 365 days. Such analyses will be reported in subsequent assessments.

- When examining specific needs, Sheps estimated that the probability of an individual reporting a food need at 90 days after Pilot enrollment (0.85) was almost identical to the probability around the time of enrollment (0.86). Similarly, the probability of reporting a housing need was 0.55 around the time of enrollment and still 0.55 at 90 days after Pilot enrollment, and the probability of reporting a transportation need was 0.31 around the time of enrollment and 0.29 at 90 days after Pilot enrollment. IPV-related and toxic stress needs were not reported very frequently during this evaluation period, so Sheps cannot
draw conclusions about changes in those need types (and again, IPV-related services were not yet available in this time period. Two key limitations in interpreting these findings, however, are the relatively short enrollment time for most Pilot participants, and the possibility of bias owing to differential reassessment such that those whose needs went unmet were reassessed more frequently than those whose needs were met and required less contact with Pilot staff.

- Sheps observed interesting findings regarding specific services. A key rationale for conducting and evaluating HOP is that there are often different services that might plausibly address a need, without sufficient comparative effectiveness evidence to choose one over another. For example, both a food subsidy (such as a fruit and vegetable prescription) and delivery of healthy meals might address food needs, but which is more effective is not clear. Sheps did find suggestions of variations across intervention types. Healthy meal delivery was associated with lower probability of reporting a food need at 90 days of enrollment in HOP than other food services offered within HOP like fruit and vegetable prescriptions and food boxes, and these differences were large enough that they may be clinically meaningful. For example, the probability of reporting a food need at 90 days was 0.08 lower (95% Confidence Interval [CI]: 0.12 lower to 0.02 lower, p = .001) with delivered meals compared with fruit and vegetable prescriptions. Similarly, with regard to housing services, tenancy support and sustaining services (which provide one-to-one case management and/or educational services to prepare an enrollee for stable, long-term housing) were associated with lower probability of reporting a housing need after 90 days of Pilot enrollment than other types of housing services.

- These findings thus support the rationale of using HOP to develop evidence on the comparative effectiveness of social needs interventions, so that the State of North Carolina can make an evidence-informed decision as to what services to offer for all Medicaid beneficiaries in subsequent years. However, these findings should also be interpreted cautiously at this time, as receipt of services was not randomly assigned, and thus the association observed may be confounded. Subsequent stages of the evaluation will be better able to address this potential threat to the validity of the findings.

- The ability to address some questions of interest in this assessment was hindered by the number of individuals enrolled in HOP. HOP was designed to ramp up during this assessment period, and so the enrollment numbers may reflect that. Another explanatory factor could be that methods of social need assessment and enrollment require iteration. In any event, working to increase enrollment in HOP is a major goal going forward.
Plans for Evaluating Impact of Demonstration Renewal

North Carolina will continue to contract with an independent evaluator to assess the impact of proposed new demonstration features. North Carolina is proposing the research questions, hypotheses, and proposed evaluation approaches described below to include as part of its evaluation design.

North Carolina will continue to incorporate rapid cycle evaluation into its broader evaluation strategy to understand the impact of the services funded through managed care savings in real time. North Carolina will use the findings to adjust how it spends its savings to ensure that it is investing in models that advance the demonstration goals, while discontinuing initiatives that are not making an impact.

North Carolina will also continue to identify strategies to assess the extent to which the demonstration is addressing gaps in health outcomes and decreasing health disparities. During the demonstration period, North Carolina is working to improve its data systems and collaborate with community partners to strengthen the State’s ability to collect and analyze data related to health outcomes, disparities and gaps in care for populations which have marginalized. This demonstration seeks to test the hypotheses outlined in Table L below through its continuing and new initiatives. Specific evaluation methodology will be submitted upon approval of the application via the revised evaluation design. As appropriate, the State will work with CMS to refine the evaluation goals and the hypotheses described in Table L prior to submitting the proposed evaluation design.

Table L. Approach to Evaluation for Demonstration Renewal

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<thead>
<tr>
<th>Hypotheses</th>
<th>Evaluation Approach and Data Sources</th>
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<tr>
<td><strong>Managed Care</strong></td>
<td>Approach and data sources will be consistent with the North Carolina Medicaid Reform Demonstration Approved Evaluation Design, including:</td>
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<tr>
<td>• Improve health outcomes for Medicaid enrollees in managed care via a new delivery system</td>
<td>• Primary care/OB survey</td>
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<td>• Maximize high-value care to ensure sustainability of the Medicaid program</td>
<td>• Beneficiary interviews</td>
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<td>• Reduce Substance Use Disorder (SUD)</td>
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<td><strong>Healthy Opportunities</strong></td>
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- Improve health outcomes for Healthy Opportunities Pilot participants
- Improve the share of Medicaid enrollees receiving Pilot services that report improvements in unmet resource needs

Approach and data sources will be consistent with the Enhanced Case Management and Other Services Pilots Evaluation Design; Attachment H

**Continuous Enrollment**

- Reduce churn and gaps in Medicaid coverage for children and youth, including for racial and ethnic groups that experience disproportionately high rates of churn
- Improve health outcomes for children and youth

Analysis of enrollment and claims files

**Justice Involved Pre-Release Services**

- Increase Medicaid coverage for justice-involved individuals
- Improve health outcomes for justice-involved individuals, including by improving transitions into the community following release

Analysis of data files, including:
- Claims linked with criminal justice indicators
- Data on preventive and routine physical and behavioral health care
- Data on avoidable ED visits and inpatient hospitalizations

**Behavioral Health and I/DD Technology**

- Improve rates of real-time data sharing with the North Carolina HIE (HealthConnex) among participating behavioral health and I/DD providers
- Improve rates of schools equipped with technologies need to improve billing and tracking for delivery of services and referrals among participating school providers

- Analysis of Medicaid Enterprise Systems (MES) documentation
- Survey and/or analysis of providers

**Behavioral Health and LTSS Workforce**
<table>
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<th>Reduce workforce shortages</th>
<th>Analysis of administrative data such as Medicaid billing data, NC Health Professions Data System, and/or HCBS electronic visit verification</th>
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<tr>
<td>Increase provider retention and Medicaid participation among BH, I/DD and LTSS providers who serve Medicaid beneficiaries in North Carolina</td>
<td>Survey and interviews of providers</td>
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