Medicaid Section 1115 Monitoring Report

North Carolina - North Carolina Medicaid Reform Demonstration

DY6 – Nov. 1, 2023 through Oct. 31, 2024

Submitted on Feb. 14, 2025

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

Contents

DEMONSTRATION YEAR 6 REPORT

Executive Summary

This annual report covers Demonstration Year 6 (DY6) of the North Carolina Medicaid Reform Demonstration, Nov. 1, 2023 through Oct. 31, 2024. Included in this report, following the annual updates, is a section specific to activities that occurred in Quarter 4, Aug. 1 to Oct. 31, 2024.

Medicaid Expansion

Medicaid Expansion went live on Dec. 1, 2023, making an estimated additional 600,000 North Carolinians eligible for NC Medicaid. Close to 300,000 North Carolinians receiving limited Medicaid Family Planning benefits were automatically enrolled to receive full health care coverage on day one of expansion. As of October 2024, over 550,000 people had enrolled in NC Medicaid through expansion, with roughly 90% of members enrolled in a Standard Plan and 10% in a Tailored Plan.

LME/MCO Consolidation and Tailored Plan Launch

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

On April 12, the Department issued formal notices to the Behavioral Health Intellectual/Developmental Disability Tailored Plans (Tailored Plans) notifying them of the Department's intent to move forward with launch on July 1, 2024. The Department analyzed the performance of each plan across six key areas of performance – claims testing, readiness, network adequacy, end-to-end testing, technology operations and help center, and primary care provider (PCP) contracting – and determined that plans were ready to provide managed care services on behalf of the Department. At launch, 219,517 members were enrolled in a Tailored Plan. The Department met the CMS requirement that 90% of members be assigned to their historical PCP to avoid care disruption. To ease administrative burden on providers and members during the transition period, the Department implemented temporary policy flexibilities related to prior authorizations, non-participating/out-of-network provider payment, and the timeframe for members to switch PCPs without cause. There have been no significant widespread issues since Tailored Plan launch.

On Sep. 26, 2024, Hurricane Helene made landfall, resulting in devastating floods in western North Carolina. The Department immediately enacted temporary flexibilities intended to support members and providers across NC Medicaid Managed Care and NC Medicaid Direct. Two Tailored Plans, Vaya and Partners, are based within the disaster area. The Department quickly established contact with both plans to understand high-level impacts on staff, communications, and operations within the organizations.

Children and Families Specialty Plan (CFSP)

In September 2023, the North Carolina legislature authorized NCDHHS to issue a Request for Proposals (RFP) to procure the Children and Families Specialty Plan (CFSP), a single, statewide NC Medicaid Managed Care plan that will support Medicaid-enrolled children, youth, and families served by the child welfare system in receiving seamless, integrated and coordinated care. The Department released a revised CFSP Policy Paper on Jan. 16, 2024. This paper, an update to the July 2022 CFSP policy paper, summarized the latest CFSP design for eligibility and enrollment, care management, provider network and quality. The RFP was released in early February 2024, and the contract was awarded to Blue Cross and Blue Shield of North Carolina (Blue Cross NC) Aug. 15, 2024. Blue Cross NC will operate the plan under the name Healthy Blue Care Together (HBCT). After the end of this demonstration year, the Department announced the CFSP will launch Dec. 1, 2025.

Healthy Opportunities Pilot (HOP)

In May 2024, the HOP program was implemented with the Pre-paid Inpatient Health Plans (PIHPs), which expanded HOP eligibility to the Tailored Care Management (TCM)-eligible NC Medicaid Direct beneficiary population. Additionally, HOP launched with the Tailored Plans simultaneously with their July 1, 2024 launch. The HOP team recently began implementation activities to launch HOP with the CFSP. HOP is also working with the Eastern Band of Cherokee Indians (EBCI) Tribal Option to launch the program with the Tribal Option as a HOP administrator.

The HOP Interim Evaluation Report, prepared by the independent evaluator for North Carolina's 1115 demonstration waiver, was submitted to CMS July 10, 2024 and approved November 5, 2024. The report included promising findings on the impact of the HOP model, including that the program: a) reduced members' health-related social needs; b) reduced adverse healthcare utilization, and; c) lowered cost per HOP-enrolled member per month when accounting for service delivery costs (compared to expected cost without the program).

A key challenge for the HOP program in DY6 was the possibility that the amount of state funding available for HOP services may not be sufficient to meet the projected service delivery spend through October 31, 2024. To mitigate the impact of this challenge, the Department changed the operational approach for reimbursing PHPs for service delivery funding from retrospective to prospective, which improved the health plans' management of their capped allocation budgets. The Department also developed a long-term strategy for tiered HOP service operations to ensure the most critical services would remain available to members.

Demonstration Year 6 Report

Operational Updates

Key Achievements

Standard Plans

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

   Beginning in January 2024, the Department began reviewing these proposals using a new, formalized process that involves close review by a small group of key reviewers, providing feedback to the Standard Plans, and a review and vote from a cross-functional working group.
3. The second annual Standard Plan Network Adequacy submission analysis was completed, and outstanding appeals have been resolved. The Department completed time/distance and non-time/distance analysis of the third annual Network Adequacy submissions. The fourth annual Network Adequacy submissions were received at the end of July 2024, and analysis of time/distance and non-time/distance network files is in progress.

Tailored Plans

1. With confirmation of the July 1, 2024 launch date for Tailored Plans, the Department's business units proposed adjusted dates for major Tailored Plan program milestones starting in early November 2023. The business units also worked with the remaining four Tailored Plan vendors and related external vendors to revise timelines for work supporting the program milestones. On Dec. 14, 2023, the Department's executive leadership team unanimously approved the adjusted milestone dates for the July launch date of the Tailored Plans.

2. LME/MCO consolidation and member realignment went into effect Feb. 1, 2024. The Department executed contract amendments with all four LME/MCOs to support changes related to consolidation. Additionally, the Department utilized existing Medicaid Help Center and Technology Operations Monitoring processes to resolve business and technology issues relating to Consolidation. There was not a significant increase in Medicaid Help Center or Technology Operations ticket volume related to consolidation.
3. On April 12, the Department issued formal notices to the Tailored Plans notifying them of the Department's intent to move forward with Tailored Plan launch on July 1, 2024. The Department analyzed the performance of each plan across six key areas of performance – claims testing, readiness, network adequacy, end to end testing, technology operations and help center, and PCP contracting – and determined that plans were ready to provide managed care services on behalf of the Department.
4. During March and April 2024, Tailored Plans completed 32 total virtual Onsite Readiness Review Sessions focused on 12 functional topic areas. These sessions resulted in the collection of 92 open items across all plans, which were monitored for resolution by the Readiness Review Team through iterative rounds of assessing plan responses and providing feedback.
5. Starting April 13, 2024, the Department began running the auto-enrollment process to assign Tailored Plan-eligible members to a Tailored Plan based on administrative county. By the end of the initial bulk enrollment, 183,944 members were assigned to a Tailored Plan. The Primary Care Provider (PCP) Choice Period began April 15, allowing Tailored Plan members to choose their PCP and TCM from providers who are in network with their assigned Plan.
6. The Department and the Enrollment Broker hosted multiple County Department of Social Services (DSS) virtual training sessions to familiarize Medicaid County DSS caseworkers with the Tailored Plans. The trainings were attended by over 2,000 Medicaid County DSS caseworkers and supervisors across the state.
7. The Department met the CMS requirement that all Tailored Plans have at least 90% of members assigned to their historical PCP. All PCP assignments were submitted to NCFAST by May 22, 2024. The overall historical PCP retention rate was 91%, meeting the CMS requirement. On the July 1 launch, one plan's retention rate had dipped below 90%, but the plan came into compliance by July 15.
8. Over 12 post-launch technology integrations were successfully deployed across five vendors, serving the needs of the Care and Quality business units. Throughout this process, both pre- and post-production meetings were conducted to validate the success and functionality of the integrations. These meetings played a critical role in identifying and addressing potential issues, ensuring a smooth deployment process. Additionally, the team collaborated closely with the Privacy and Security Office to guarantee that all required security deliverables were addressed and met the necessary compliance standards. This proactive approach underscores the Department's commitment to maintaining robust security protocols while delivering high-quality integration outcomes.

Children and Families Specialty Plan (CFSP)

1. The Department released a revised CFSP Policy Paper on Jan. 16, 2024. This paper, an update to the July 2022 CFSP policy paper, summarized the latest CFSP design for eligibility and enrollment, care management, provider network and quality.
2. The CFSP RFP was released in early February 2024. The contract was awarded to Blue Cross and Blue Shield of North Carolina Aug. 15, 2024, and the Contract Award Kickoff Series was held shortly after.
3. HBCT submitted their implementation plan to the Department Oct. 10, 2024. Department business units completed individual reviews, and the Department provided feedback to HCBT on Nov. 6. HBCT resubmitted the implementation plan after addressing Department feedback, and the Department expects to send any additional requested changes by early December. Additionally, HBCT began meeting with the North Carolina Association of County Directors of Social Services (NCACDSS) in October.

Key Challenges

Tailored Plans

1. In the leadup to Tailored Plan launch, provider network coverage and its impact on PCP choice and assignment was a key area of concern across the program. The original target for PCP contracting required no more than 20% disruption to members' historical PCP assignments, but this was updated by CMS to no more than 10%. When the LME/MCOs consolidated in February 2024 and members were reassigned to the remaining four Plans, the Department completed a new analysis of potential historical PCP disruption. Three of the four LME/MCOs did not meet the CMS threshold of no more than 10% disruption to members' historical PCPs. The Department reissued Notices of Concern to the plans that had not met the target. The Plans were required to increase reporting frequency to monitor PCP contracting progress against the CMS target leading up to critical milestones such as Plan auto-enrollment, PCP choice period and PCP auto-assignment.

   The Department closed the Notices of Concern around provider contracting on May 13, 2024, after all Plans met the CMS requirement that 90% of their members could keep their historically assigned PCP. The Department continued to track PCP contracting leading up to the PCP auto-assignment period to ensure Plans remained above the requirements. Following bulk PCP auto-assignment, the Department found that two Tailored Plans, Alliance and Vaya, dropped below the 90% threshold, although the program overall remained above 90%. Both plans were able to contract with providers and meet the 90% threshold in advance of July 1, 2024. The Department performed one final analysis on July 1, 2024, and found Partners was the only plan below the 90% requirement. Partners worked with the Department to make corrections to their assignments, and they were able to meet the 90% threshold by July 15, 2024.
2. PCP auto-assignment testing was scheduled to run from February 14 through April 1, 2024. The testing was delayed, and plans had to do multiple runs due to the number of defects identified.

This created a risk in plans' ability to complete PCP Assignment testing by the production go-live of May 16, 2024. As a mitigation, the Department aligned on an updated scope and extended the overall timeline. The mitigation allowed plans to focus on meeting 90% accuracy for bulk assigning members to their historical PCPs and then resolve remaining open defects and complete reassignment testing. Bulk PCP auto-assignment in production demonstrated the plans could accurately assign members to their historical PCP by meeting the 90% target. PCP auto-assignment testing was completed June 13, and plans were given approval to run their assignment process daily effective June 14.

TCM auto-assignment testing was scheduled to run from March 25 through April 26. This testing was also delayed, and plans had to do multiple runs due to the number of defects identified. This created a risk in plans' ability to complete TCM assignment testing by the production go-live date of May 23, 2024. Following a similar mitigation approach as was used for PCP auto-assignment, the Department aligned on an updated scope and extended the overall timeline, allowing plans to focus on meeting 95% accuracy for bulk-assigning members to their historical Tailored Care Managers, and then resolving remaining open defects and completing reassignment testing. Bulk TCM auto-assignment in production demonstrated the plans could accurately assign members to their historical TCM by meeting the 95% target. TCM auto-assignment testing was completed on June 13 and plans were given approval to run their assignment process daily effective June 14.

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

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

4. After launch, all Tailored Plans saw higher volumes of pharmacy denials based on prior authorization (PA), which was unexpected based on the relaxed PA flexibilities in place for the first 90 days following Tailored Plan launch. These flexibilities did not always function as intended (e.g., plans were not actively monitoring PA denials with claims data, issues with out of network providers, auto PA processes were not robust). During the first 30 days of launch, the Department shared updated guidance and expectations with the Tailored Plans around managing pharmacy point of sale (POS) denials, including adding a clarification as part of claims rejection messages that a 72-hour supply be provided to the member and directing Tailored

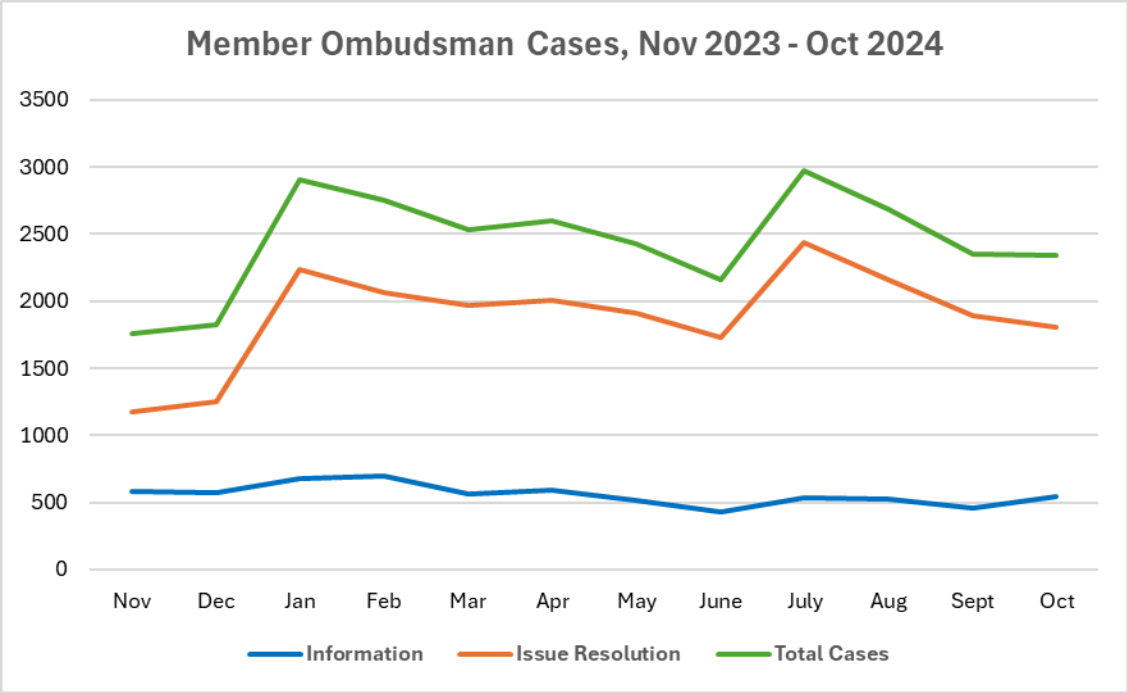
Plans to conduct proactive reviews of claims denials and process for a 30-day PA override, if appropriate.

The Department monitored pharmacy POS claims processing through daily reporting from Tailored Plans throughout July to assess if the guidance was having the expected effect on denial rates. After seeing improvement throughout July, the Department shifted to receiving weekly reporting from Tailored Plans throughout August. The additional guidance shared with Plans had the intended effect and this issue is no longer being monitored by the Department as an area of concern for Tailored Plans.

5. North Carolina declared a state of emergency due to Hurricane Helene less than three months following Tailored Plan launch. Two Tailored Plans, Vaya and Partners, are based within the Hurricane Helene disaster area. The Department quickly established contact with Vaya and Partners to understand high-level impacts on staff, communications, and normal operations within the organizations. NC Medicaid leadership met daily with all Tailored Plan CEOs to ensure they had the supports needed during the rapidly changing disaster response period. The Department evaluated deferment on operational reports and deliverables due between September 30 and November 1, 2023 to allow Tailored Plans to prioritize hurricane response.
6. The Department successfully launched Electronic Visit Verification (EVV) for Personal Care Services (PCS) for the Tailored Plans, at Tailored Plan Launch, with minimal programmatic challenges. For EVV Home Health (HH), the Tailored Plans went live in a soft launch state and continue to experience issues with HH provider connections and EVV system configuration. The Tailored Plans are addressing provider connection issues through increased outreach, including expanded office hours and education. The Plans are working closely with their providers, associations, and other PHPs on the overall implementation for EVV HH. The Department continues to monitor progress through weekly reporting and biweekly meetings.

Issues or complaints identified by beneficiaries

The Department receives beneficiary complaints primarily from the Office of Administration and the NC Medicaid Member Ombudsman. The NC Medicaid Ombudsman is an independent organization that provides education, guidance and referrals to NC Medicaid beneficiaries. Not all Ombudsman calls should be interpreted as complaints, as many involve educating beneficiaries or connecting them to the entity that can provide the service they need. The number of informational cases, issue resolution cases, and total cases throughout DY6 are shown in the graph below.



The Office of Administration largely handles cases referred from state legislative offices. Prior to DY5Q1, all constituent concerns handled by the Office of Administration were reported, including those from non-beneficiaries (such as providers). As of DY5Q1, the monitoring reports only include concerns from NC Medicaid beneficiaries. There were 51 recorded constituent concerns in DY6.

Office of Administration Member Concerns, DY6

Issue Category	Number of Issues
Behavioral health	24
Claims	5
Clinical/medical health	1
Durable Medical Equipment	2
Eligibility	13
LTSS	1
NEMT	1
Pharmacy	4
Total	**51**

Lawsuits or legal actions

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

Legislative updates

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

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

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

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

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

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

Post-award public forums

On June 21, 2024, the Department held a Section 1115 Demonstration Waiver post-award public forum during the Medical Care Advisory Committee meeting. There were no questions or comments.

Performance Metrics

Outcomes of care

The Department originally planned to report three outcome measures in its monitoring reports: Comprehensive Diabetes Care, Low Birth Weight, and Rating of Personal Doctor. Rating of Personal Doctor, a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measure, is provided below for 2019 to 2023. The Low Birth Weight Measure, included below for 2021 and 2022, was reported for the first time in DY6Q3. Hemoglobin A1c (HbA1c) Control for Patients with Diabetes rates are not available yet, as the Department does not receive A1c values through claims and encounters. The Department is working to obtain accurate A1c data through NC HealthConnex, North Carolina's statewide health information exchange, in order to report this measure in the future.

Low Birth Weight

The Low Birth Weight Measure is a modified version of the CDC's Live Births Weighing Less Than 2,500 Grams measure (CMIT #413), and was developed to assess, monitor, and support PHP efforts in North Carolina. In addition to following the technical specifications associated with the CDC measure, this modified metric considers only singleton, live birth deliveries. This modified metric also excludes babies born weighing less than 300 grams, to exclude births that are pre-viable but may be classified as live births in birth certificate records. Both low birth weight (<2,500 grams) and very low birth weight (<1,500 grams) are assessed, the latter being a subset of overall low birth weight births. Results for calendar years 2021 and 2022 for Medicaid Direct and Standard Plans in aggregate are below. For future plan-level assessment, the Department intends to only consider deliveries where the birth parent had continuous coverage with the same health plan from 16 weeks gestation or earlier, to ensure that plans and providers have adequate opportunity to impact outcomes.

Notably, rates of low and very low birth weights appear to increase dramatically in the Medicaid Direct/Tribal Option population between 2021 and 2022. The most likely cause of this trend is the

change in the Medicaid Direct population. Most Medicaid beneficiaries were moved to Standard Plans at the July 2021 launch, while beneficiaries with severe SUD or behavioral health issues, who are more likely to have poor birth outcomes, remained in Medicaid Direct. In the first half of 2021, all beneficiaries who gave birth would have been in Medicaid Direct, but by 2022 most beneficiaries were in Standard Plans the full calendar year. This is evidenced by the change in the Medicaid Direct rate denominator from 22,451 in 2021 to 1,257 in 2022.

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

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

Rating of Personal Doctor (CAHPS measure)

The calendar year (CY) 2023 CAHPS survey was administered between July 28, 2023, and Oct. 20, 2023. Beneficiaries were asked to think about their healthcare experiences *in the past 6 months* when answering survey questions.

Measure	Description	2019	2020	2021	2022	2023
Rating of Personal Doctor	Percentage of adult respondents who rated their personal doctor positively, measured as a rating of 8 or above (on a scale of 0-10)	83.2%	NA*	86.3%	87.2%	86.63%
	Percentage of child respondents** who rated their child's personal doctor positively, measured as a rating of 8 or above (on a scale of 0-10)	93.69%	NA*	91.15%	89.4%	90.70%

*The CAHPS survey was not administered in 2020

**Parents/caretakers are asked to complete the survey for beneficiaries under age 18

Quality of care

Measurement year 2023 quality measure results for all of NC Medicaid, except dually eligible beneficiaries and beneficiaries aged 65 and older, are reported below along with results from previous years. All measures reflect the calendar year. Calendar year 2023 CAHPS measure results for all of NC Medicaid are also reported, along with results from previous years. Because NC Medicaid Managed Care launched July 1, 2021, quality measure results for 2021 and CAHPS results for 2022 represent the last six months of fee-for-service and the first six months of managed care for North Carolina's Standard Plan population.

Measure/Measure Steward	**Description**	**2019**	**2020**	**2021**	**2022**	**2023**
Child and Adolescent Well-Care Visits (WCV)/ NCQA[1]	Members ages 12-21 who had at least one comprehensive well-care visit with a primary care physician or an OB/GYN during the measurement year.	NA	45.6%	47.8%	48.49%	51.29%
Childhood Immunization Status (CIS) (Combination 10)/ NCQA	Children age 2 who had four diphtheria, tetanus and acellular pertussis; three polio; one measles, mumps and rubella; three haemophilus influenza type B; three Hep B; one chicken pox; four pneumococcal conjugate; one hepatitis A; two or three rotavirus; and two influenza vaccines by their second birthday.	35.0%	36.2%	34.3%	28.65%	24.54%
Immunizations for Adolescents (IMA) (Combination 2)/ NCQA	Adolescents age 13 who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and a cellular pertussis vaccine, and have completed the HPV vaccine series.	31.6%	31.2%	30.3%	29.63%	29.66%
Use of First-Line Psychosocial care for Children and Adolescents on Antipsychotics (APP)/ NCQA	Children and adolescents ages 1-17 who had a new prescription for an antipsychotic medication, but no US Food and Drug Administration primary indication for antipsychotics and had documentation of psychosocial care as first-line.	52.1%	50.8%	45.0%	44.18%	43.07%
Well-child visits in the first 30	Percent of children who received six or more well-child visits in the first 15 months	NA	62.3%	62.1%	61.56%	63.46%

Measure/Measure Steward	Description	2019	2020	2021	2022	2023
months of life (W30)/ NCQA[2]	Percent with two or more well-child visits from 15 to 30 months	NA	70.8%	66.4%	66.75%	68.84%
Total Eligibles Receiving at Least One Initial or Periodic Screening/ NCDHHS[3]	Rate of preventive dental service use by children and adolescents in NC. Higher rates are better on this measure.	53%	44.5%	NA	54.58%	54.87%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)/ NCQA	Initiation phase rate: Percentage of children ages 6-12 as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.	50.1%	51.8%	53.7%	48.15%	49.78%
	Continuation rate: Percentage of children ages 6-12 with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	63.5%	62.9%	64.9%	60.10%	54.78%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)/ NCQA	The percentage of children ages 1 to 17 who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: Percentage of children and adolescents on antipsychotics who received blood glucose testing	53.7%	47.4%	51.1%	51.41%	54.46%
	Percentage of children and adolescents on antipsychotics who received cholesterol testing	37.7%	34.1%	35.4%	34.25%	37.78%
	Percentage of children and adolescents on antipsychotics who	34.9%	31.0%	32.61%	32.05%	35.21%

Measure/Measure Steward	Description	2019	2020	2021	2022	2023
	received blood glucose and cholesterol testing					
Prenatal and Postpartum Care (PPC)/ NCQA[4]	Timeliness of Prenatal Care: The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.	35.5%	40.0%	39.5%	41.86%	43.90%
	Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	68.8%	64.5%	53.7%	60.79%	60.66%
Cervical Cancer Screening (CCS)/ NCQA	Women ages 21-64 who had cervical cytology performed every 3 years.	43.82%	42.83%	40.7%	38.47%	39.16%
Chlamydia Screening in Women (CHL)/ NCQA	Women ages 16-24 who were identified as sexually active and who had at least one test for chlamydia during the measurement period.	58.22%	57.19%	56.79%	56.61%	59.27%
Breast cancer screening (BCS)/ NCQA	Women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years.	41.4%	35.4%	31.6%	29.05%	28.18%
Flu vaccinations for adults (FVA, FVO)/ NCQA	Adults ages 18 years and older self-report receiving an influenza vaccine within the measurement period.	42.9%	N/A	51.86%	50.1%	42.51%
Plan All-Cause Readmission – Observed Versus Expected Ratio (PCR)/NCQA	Adults ages 18 years and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and predicated probability of an acute readmission.	N/A	N/A	0.99	.7674	.7672
Controlling High Blood Pressure (CBP)/NCQA[5]	Percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood	N/A	4.58%	24.62%	40.92%	50.32%

Measure/Measure Steward	Description	2019	2020	2021	2022	2023
	pressure (BP) was adequately controlled (<140/90) during the measurement year.					
Antidepressant Medication Management (AMM)/NCQA	Adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications. Effective Acute Phase Treatment: Adults who remained on an antidepressant medication for at least 84 days (12 weeks).	58.2%	60.1%	54.1%	58.11%	60.48%
	Effective Continuation Phase Treatment: Adults who remained on an antidepressant medication for at least 180 days (6 months).	39.3%	41.6%	33.9%	36.43%	37.42%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)/NCQA	Percentage of adults 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	80%	75%	77%	76.69%	80.65%
Asthma Medication Ratio (AMR)/ NCQA	Percentage of adults 19-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	53.9%	60.3%	60.6%	60.85%	61.06%
Customer Service/ CAHPS[6]	**Composite measure (adult)**: Adult respondents were asked, "In the last 6 months, how often did your health plan's customer service give you the information or help you needed?" and "In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?" on a scale of "Never",	83.3%+	NA	86.5%	90.3%	91.90%

Measure/Measure Steward	Description	2019	2020	2021	2022	2023
	"Sometimes", "Usually", or "Always." This measure looks at the percentage of respondents who answered "Usually" or "Always."					
	Composite measure (child): Child respondents were asked, "In the last 6 months, how often did customer service at your child's health plan give you the information or help you needed?" and "In the last 6 months, how often did customer service staff at your child's health plan treat you with courtesy and respect?" on a scale of "Never", "Sometimes", "Usually", or "Always." This measure looks at the percentage of respondents who answered "Usually" or "Always."	81.0%+	NA	85.9%	82.5%	88.73%
Coordination of Care/CAHPS	Percentage of **adult** respondents who answered "Usually" or "Always" to the question, "In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?" on a scale of "Never", "Sometimes", "Usually", or "Always."	86.6%	NA	85.8%	88.2%	87.66%
	Percentage of **child** respondents who answered "Usually" or "Always" to the question, "In the last 6 months, how often did your child's personal doctor seem informed and up-to-date about the care your child got from these doctors or other health providers?" on a scale of "Never", "Sometimes", "Usually", or "Always."	81.9%	NA	85.4%	83.0%	84.71%

[1]This measure specification changed in 2020.

[2]This measure specification changed in 2021. The Well-Child Visits in the First 15 Months of Life (W15-CH) measure was modified by the measure steward. It now includes two rates: (1) six or more well-child visits in the first 15 months and (2) two or more well-child visits from 15 to 30 months.

[3]The 2022 rate for this measure is the Standard Plan aggregate rate.

[4]Rates for this measure are artificially low due to bundled payment for prenatal and postpartum care.

[5]NC Medicaid does not get blood pressure values via claims and encounters, but in recent years has begun receiving values from NC HealthConnex, the North Carolina Health Information Exchange. **Consequently**, **results from earlier years are to be interpreted with caution.**

[6]Composite measures are calculated as an average score across all questions within the composite measure.

[+] Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Access to care

Network Time/Distance Standards

The state's time or distance network adequacy standards generally require that at least 95% of the membership meet the access standard. In each of the past four quarters, all Standard Plans met the state's time or distance standards for the five key service categories: hospitals, OB/GYN, primary care (adult and child), pharmacy, and outpatient behavioral health (adult and child). Network adequacy metric tables for each Standard Plan in the most recent quarter can be found in the DY6Q4 section of this report.

Care Management Penetration

These data represent members enrolled in Standard Plans receiving care management through a Standard Plan or Tier 3 AMH practice, and Care Management for At-Risk Children (CMARC) and Care Management for High-Risk Pregnancies (CMHRP) from local health departments (LHDs) in Contract Year 3 (July 2023 – June 2024).

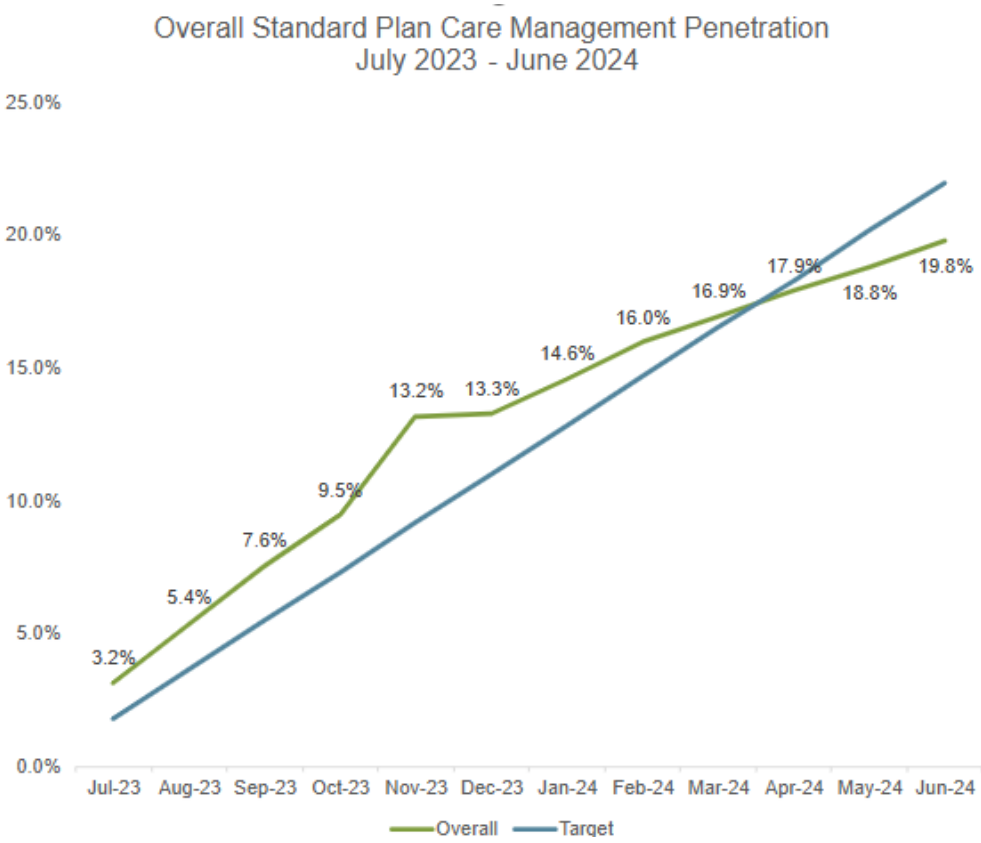
CMHRP is the Department's primary vehicle to deliver care management to pregnant women who may be at risk for adverse birth outcomes. CMARC offers a set of care management services for at-risk children ages 0 to 5. Care management provided through a Standard Plan, Tier 3 AMH, or LHD to members enrolled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

Among Standard Plan members, 19.8% received care management interactions in Contract Year 3, below the Department's target of 22%. Data on Contract Year 4 Care Management Penetration is available in the DY6Q4 section of this report.

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

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

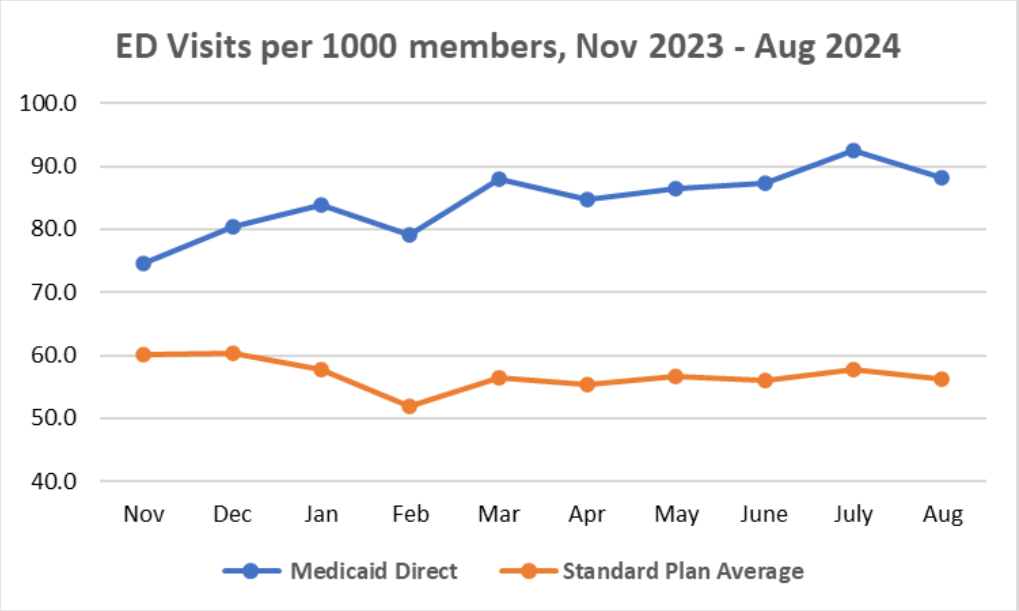
***Source**: All data in table are derived from BCM051 Care Management Interaction report prepared by SPs and submitted to DHB. Some members may be receiving CM from multiple entities and may be counted in multiple categories.*

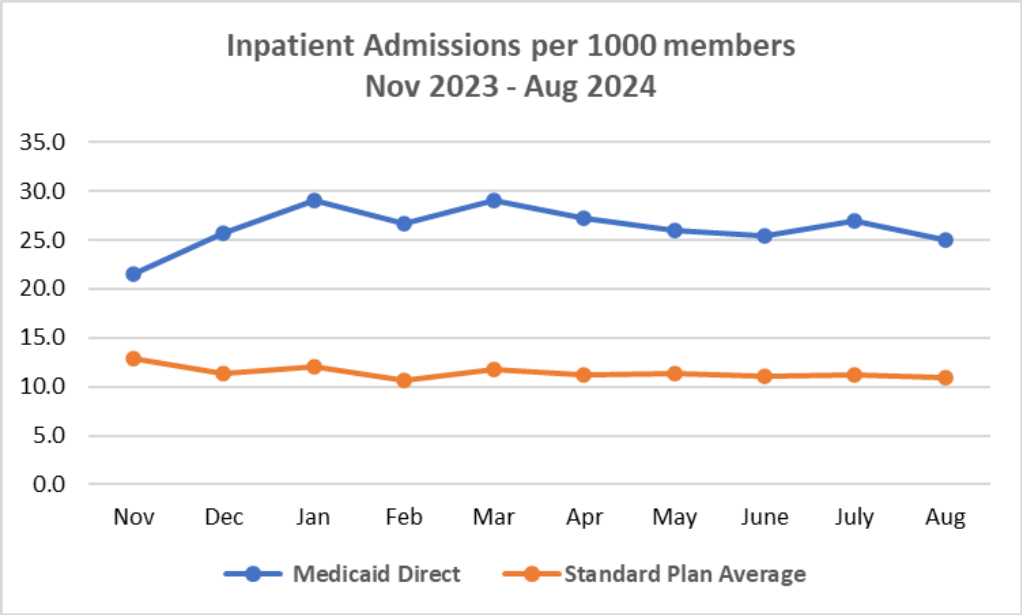


Emergency Department Visits and Inpatient Admissions Rates

Emergency department visits per 1,000 members and inpatient admissions per 1,000 members are measured for the adult NC Medicaid population (age 21 and older) and broken out by Standard Plan and NC Medicaid Direct/Tribal Option. Medicaid beneficiaries not eligible for hospital coverage (e.g., family planning participants) are excluded from NC Medicaid Direct calculations. The quarterly monitoring reports, including the DY6Q4 report, provide individual rates for each of the five Standard Plans. For the purposes of the annual report, rates in the graphs below are shown for Medicaid Direct/Tribal Option and the average across Standard Plans.

To better reflect claims lag and provide more accurate data, the Department reports these rates with a two-month lag. Therefore, we do not yet have data for all of DY6 (November 2023 – October 2024), and data is presented only through August 2024. It should be noted that higher rates are expected for NC Medicaid Direct, as members with substantial behavioral health issues remained in NC Medicaid Direct until the launch of Tailored Plans on July 1, 2024.





Results of beneficiary satisfaction surveys

In 2023, the CAHPS survey was administered to beneficiaries of the five Standard Plans, members of the Eastern Band of Cherokee Indians (EBCI) Tribal Option, NC Medicaid Direct beneficiaries, NC Medicaid Direct child beneficiaries who were currently in Foster Care, and those in NC Medicaid Direct who would qualify for Tailored Plans upon their launch. (Tailored Plans had not yet launched at the time of survey administration.) Adult and child (parents/caretakers completing the survey on behalf of their child) respondents provided feedback on their experiences with health plans and health care by mail or online between July 28 and October 20, 2023. The full report was released in August 2024 and is available on the NC Medicaid webpage. Key findings are highlighted below:

- Overall, adult respondents' positive experiences with their health plan, getting care quickly, and health plan's customer service have consistently increased from 2019 to 2023. Differences between 2022 and 2023 were tested for significance, and no significant differences were found for these measures.
- Adult respondents' experiences with their health care, specialist seen most often, getting needed care, getting care quickly, and how well their doctors communicate increased from 2022 to 2023, although the increases were not found to be statistically significant.
- The percentage of adult respondents whose provider sometimes, usually, or always advised them to quit smoking or discussed cessation medications and cessation strategies decreased from 2021 to 2023. Differences between 2022 and 2023 were tested for significance, and no significant differences were found for these measures.

- Parents'/caretakers' of child beneficiaries positive experiences with communication with their child's personal doctor and their child's health plan's customer service significantly increased from 2022 to 2023.
- Parents'/caretakers' of child beneficiaries positive experiences with their child's specialist they see most often decreased from 2021 to 2023. Differences between 2022 and 2023 were tested for significance, and no significant differences were found for this measure.

Race/Ethnicity Stratifications

Race and ethnicity were categorized as self-selected responses to the race and ethnicity questions. Race was categorized as White, Multi-Racial, Black, Native American, and Other (Asian, native Hawaiian or other Pacific Islander, and Other). Ethnicity was categorized as Hispanic and non-Hispanic. Racial and ethnic demographics were compared against their opposite aggregate; for example, Black respondents were compared to non-Black respondents and Hispanic respondents were compared to non-Hispanic respondents. Differences in experience of care varied by race and ethnicity within the NC Medicaid population:

- Adult and child respondents who identified as Hispanic ethnicity reported significantly more positive experiences across several measures, including Rating of Health Plan and How Well Doctors Communicate.
- Child beneficiaries who identified as Other race reported significantly worse positive experiences across several measures, including Getting Needed Care, Getting Care Quickly, and Coordination of Care.
- Adult and child beneficiaries who identified as Other race both reported significantly worse positive ratings for How Well Doctors Communicate.

Rural/Urban Stratifications

Respondents were categorized as rural or urban using county residency information. While very few significant differences were found between beneficiaries that live in urban counties compared to those that live in rural counties, the following significant differences were found:

- Adult respondents living in rural counties reported significantly lower positive experiences with their personal doctor when compared to respondents living in urban counties.
- Child respondents living in rural counties reported significantly more positive experiences with their child's ability to get needed care when compared to respondents living in urban counties.

Overall NC Medicaid and Standard Plan Aggregate Ratings

The table below shows the star ratings for each measure for the NC Medicaid Program and NC Standard Plan Aggregate when the positive ratings were compared to NCQA national percentiles. Positive ratings were compared to NCQA's Quality Compass Benchmark and Compare Quality Data to determine which NCQA national percentile range the scores fell within. Using the percentile distributions, a star rating was assigned from one (★) to five (★★★★★) stars, where one star is below the national 25th percentile and five stars is greater than or equal to the national 90th percentile. Please note this table

primarily serves the purpose of comparing NC Medicaid's performance to the national percentiles – no statistically significant differences are reported in this table.

NC Medicaid Program and NC Standard Plan Aggregate Star Ratings
When Positive Ratings Results Were Compared to NCQA National Percentiles (2023)

Measures	NC Medicaid Program Compared to National Percentiles		NC SP Aggregate Compared to National Percentiles	
	Adult	Child	Adult	Child
Global Ratings				
Rating of Health Plan	★★ 76.75%	★★ 84.43%	★ 73.96%	★★ 85.94%
Rating of All Health Care	★★★★ 78.16%	★★★ 88.04%	★★★★ 78.57%	★★★ 88.05%
Rating of Personal Doctor	★★★★ 86.63%	★★★ 90.70%	★★★ 83.97%	★★★ 90.63%
Rating of Specialist Seen Most Often	★★★★ 86.37%	★★★ 87.03%	★★★ 84.26%	★★★ 87.15%
Composite Measures				
Getting Needed Care	★★★★ 85.95%	★★★ 85.96%	★★★ 82.96%	★★★ 85.74%
Getting Care Quickly	★★★★ 85.19%	★★★ 87.95%	★★★ 83.72%	★★★ 87.72%
How Well Doctors Communicate	★★★ 93.83%	★★★★★ 96.14%	★★★ 93.60%	★★★★ 95.91%
Customer Service	★★★★ 91.90%	★★★ 88.73%	★★ 88.19%	★★★ 89.18%
Individual Item Measures				
Coordination of Care	★★★★ 87.66%	★★★ 84.71%	★★★ 86.02%	★★★ 84.64%
Flu Vaccination Received	★★★ 42.51%	NA	★ 34.69%	NA
Medical Assistance With Smoking and Tobacco Use Cessation Items				
Advising Smokers and Tobacco Users to Quit	★★★★ 78.87%	NA	★★★ 76.16%	NA
Discussing Cessation Medications	★★★ 54.14%	NA	★★ 49.11%	NA

Measures	NC Medicaid Program Compared to National Percentiles		NC SP Aggregate Compared to National Percentiles	
	Adult	Child	Adult	Child
Discussing Cessation Strategies	★★★ 47.15%	NA	★★ 43.15%	NA

NA *Indicates the measure is not applicable for the population.*
Positive rating is equivalent to the top-box score used by other states that contribute to national data. For further details, please refer to the Methodology Section within the Reader's Guide beginning on page 33.

Budget Neutrality and Financial Reporting Requirements

North Carolina is within budget neutrality limits for the Demonstration. The Department will provide CMS with updated budget neutrality information in the next budget neutrality workbook submission.

Evaluation Activities and Interim Findings

The Sheps Center for Health Services Research (Sheps) at the University of North Carolina is the independent evaluator for the 1115 waiver. The evaluation uses a mixed-methods approach, combining analysis of administrative data with qualitative data to obtain detailed insights into Medicaid transformation that are not easily captured through claims and surveys.

In Quarter 4 the Sheps team received comments and feedback from CMS on the Managed Care Interim Evaluation Report that was submitted in September 2023. The Sheps team began working on revising the report and will continue to work on revisions through the beginning of next quarter.

Transition to Capitated Encounter Data from PHPs

Sheps analysts have now been working with the encounter data from beneficiaries enrolled in Standard Plans for more than two years. Beginning in April 2023, the Sheps evaluation team began receiving encounter data from the State's LME/MCOs through a new encounters processing system. For some time after this transition, Sheps was not receiving all encounters data. The complete data set was received in Quarter 3, and the team is working to revise reports that were affected by this issue, including the quarterly SUD monitoring reports. Additionally, because the July launch of Tailored Plans brought medical services for the Tailored Plan-eligible population under Tailored Plan contracts, there may be an additional transitional period for processing these medical claims that could result in a longer claims run-out period beginning July 1.

Quantitative Update

The quantitative team continues to use NC Medicaid claims and encounter data along with new data from the NC Division of Public Health, including updates to birth and death certificate and immunization data, and new files on care management data, value-based payment data and NCCARE360, the database that tracks Healthy Opportunities Pilot services and referrals. The team is working with the Division of State Operated Healthcare Facilities to gain access to data on institute of mental disease (IMD)

utilization not available from Medicaid claims due to state-only payments prior to and during the waiver. However, to date, neither the IMD data nor the Prescription Drug Monitoring Program (referred to as the Controlled Substances Reporting System in North Carolina) data have been received.

All data sources used for the Medicaid transformation evaluation are ingested into the University of North Carolina's secure data warehouse and are linked to NC Medicaid member information to generate metrics that are updated and tracked during the evaluation period. The team continues to update many of the metrics from established custodians for new time periods and updated technical specifications consistent with the NC Medicaid Managed Care Quality Strategy, Adult and Child Core measures, and other metrics that will address the study hypotheses. The evaluation team has decided to use Arizona Medicaid data as a comparison site after comparing trends in a selected set of metrics from prior to the demonstration period (2016-2019). While Arizona and North Carolina are geographically separated, both states have considerably large non-White populations. In addition, Arizona was the first state in the nation to implement managed care in Medicaid, and thus its system represents a mature managed care program that may have implications for the future of North Carolina's program.

The quantitative team is also developing new methodology to account for the complex dynamics of the COVID-19 pandemic. Once these have been finalized, Sheps will share these methods with NC Medicaid and CMS.

Qualitative Update

Sheps has completed transcription, cleaning, and coding of the interviews with PHPs, the North Carolina Association of Health Plans, and the state. They have drafted a two-page report on the interviews intended for NC Medicaid and related stakeholders. Work on outreach efforts and interviews with beneficiaries concluded in September 2024. In total, 35 interviews were completed with beneficiaries from both Standard Plans and Tailored Plans from July 2024 to September 2024. The process for analyzing the beneficiary interview data is ongoing. The documentation of findings is being drafted and will be completed in the next quarter.

Healthy Opportunities Pilot

Introduction

In May, the HOP program was implemented with the Pre-paid Inpatient Health Plans (PIHPs), which expanded HOP eligibility to the TCM-eligible NC Medicaid Direct beneficiary population. Additionally, HOP launched with the Tailored Plans at Tailored Plan launch on July 1, 2024. The HOP team began implementation activities for the future launch of HOP with the CFSP, which will require changes to the program design to serve youth and families involved in the child welfare system. HOP is also working with the Eastern Band of Cherokee Indians (EBCI) Tribal Option to launch the program with the Tribal Option as a HOP administrator in July 2025.

The HOP Interim Evaluation Report, prepared by the independent evaluator for the 1115 demonstration waiver, was submitted to CMS July 10, 2024. The report included promising findings on the positive impact of HOP services, including that the program reduced members' health-related social needs,

reduced adverse healthcare utilization, and lowered cost per HOP-enrolled member per month (compared to expected cost without the program).

Key achievements

HOP Implementation with PIHPs and Tailored Plans

The HOP program was implemented with the Pre-paid Inpatient Health Plans (PIHPs) on May 1, 2024, expanding HOP eligibility to the TCM-eligible Medicaid Direct beneficiary population. In the leadup to this implementation, the LME/MCOs that operate the PIHPs completed onsite readiness reviews to demonstrate their understanding of and ability to complete HOP processes. The Department also had to finalize regression testing with the LME/MCOs and HOP technology vendor and contract execution for both the LME/MCOs and HOP Network Leads (NLs). The implementation experienced several delays due to competing Department priorities, but the Department mitigated any potential confusion associated with the shifting timelines through consistent communication with program stakeholders.

In July, the HOP program was implemented with the Tailored Plans simultaneously with Tailored Plan Medicaid managed care launch. The Department made changes based on lessons learned from previous HOP implementations, enabling a successful launch with minimal issues reported by stakeholders. Early HOP enrollment for the Tailored Plan and PIHP populations exceeded the projections, which we attribute to communication and engagement efforts led by the Department to raise awareness of the program.

HOP Fee Schedule improvements

The Department updated the existing HOP Fee Schedule in response to feedback received from the field. Feedback indicated that there was confusion over the requirements for service delivery and that the cost of delivery had increased over time, causing undue burden for Human Services Organizations (HSOs). The Fee Schedule updates increased the service rates and caps to ensure HSOs are compensated appropriately for service delivery. The updates also clarify some service descriptions to ensure Care Managers and HSOs understand the intent of each service and how it should be delivered to members.

Technology Improvements

Based on stakeholder feedback, enhancements were deployed to the HOP technology platform, NCCARE360, to improve workflow efficiency. This included updating HOP reason codes to assist HOP care coordinators in providing a transparent identification of the cause of a member's disenrollment. Another improvement was the integration of NCCARE360, the platform used for HOP referrals, with the state's Medicaid Management Information System (MMIS). This allows for in-platform verification of Medicaid eligibility for HOP enrollees. Following integration, improvements were made to ensure HOP care coordinators and utilization managers are able to access a member's most current insurance record and Medicaid Managed Care status.

Sharing lessons learned from HOP

The Department finalized work with state partners to author and publish an article about North Carolina's approach to providing housing support services in *Health Affairs*. Additionally, to ensure that

the state is sharing lessons learned and technical assistance with other state partners, the Department participated in two national convenings, the Housing and Services Partnership Accelerator and the Medicaid Health-Related Social Needs Implementation Learning Series hosted by the Center for Health Care Strategies.

Key challenges

Delays in launching HOP with PIHPs

On May 1, 2024, the HOP program was implemented with PIHPs, which expanded HOP eligibility to the TCM-eligible Medicaid Direct beneficiary population. The program was initially expected to launch February 1, but launch was delayed due to capacity concerns and to provide more time to develop and execute contracts. Multiple ongoing initiatives, including LME/MCO consolidation and preparation for Tailored Plan launch, created capacity constraints across the Department. To resolve this issue, the Department and HOP stakeholders collaborated to adjust development timelines to mitigate further delays for the launch of HOP for this population. The Department held collaborative working sessions with the PIHPs to finalize the remaining items in negotiation, expediting contract execution.

State funding uncertainty

In this DY there was concern that the amount of state funding available for HOP services may not be sufficient to meet the projected needs for service delivery spend through the remainder of the waiver period. The Department developed strategies for mitigating the impact to HOP members which included:

- Addressing the budget challenges with PHPs and providing real-time guidance how to address budget shortfalls.
- Implementing changes to the Department's operational approach for reimbursing PHPs for service delivery funding, from retrospective to prospective payments, which improved the health plans' management of their capped allocation budget.
- Developing a long-term strategy for tiered HOP service operations to ensure that health plans management of their capped allocation

Higher than expected Tailored Plan enrollment

Following the July 1 launch, the Tailored Plans experienced higher than expected HOP enrollment. By the end of July, over 1,300 Tailored Plan members had enrolled in HOP, which was 40% more than initial enrollment estimates. This could be due to public anticipation based on the widely publicized successes of HOP with the Standard Plan population and improved pre- and post-launch communications and care manager readiness compared to Standard Plan HOP launch. The Department held recurring working sessions with the Tailored Plans to resolve questions and address challenges as their care managers and utilization management teams handled the higher than anticipated enrollment volume. As expected, enrollment slowed in the subsequent months and began to align with original projections. The program will continue to monitor the pace of HOP enrollment and take appropriate action to increase enrollment if needed.

Hurricane Helene impacts

An unexpected challenge was the impact of Hurricane Helene on the western region of North Carolina. The disaster significantly affected the HOP member population serviced by the Impact Health Network Lead and its network of HSOs. An initial assessment found that 58 of the 61 HSOs in the region were either not operational or were operating with limited capacity. The Department coordinated with the Network Leads, PHPs, and other community organizations to conduct outreach to the providers and members in this region to ensure that HSOs and members could receive the appropriate recovery assistance. In the weeks following the hurricane, the Department continued frequent engagement with HOP stakeholders and coordinated resources to restore operational capacity in the region.

Performance Metrics

Enrollee Service Costs

The most recent enrollee service cost data is provided in the DY6Q4 section of this report.

Incentive Payments to PHPs, NLs, and Pilot providers

There were no incentive payments in this DY.

Pilot Capacity Building Funding

On June 18, 2024, the three Network Leads received the capacity building funding amounts listed below. This funding was not originally reported in the quarter in which it occurred (DY6Q3) due to delays related to staff turnover.

Network Lead	Capacity Building Funding	Purpose
Impact Health	$7,876,479	Make infrastructure and IT systems improvements, improve the capacity of HSOs, and support program administration, evaluation and oversite.
Community Care of the Lower Cape Fear	$4,500,000	Develop network adequacy by increasing staffing, improve technology, and build expertise through training
Access East	$ 7,729,336	Develop network adequacy by increasing staffing, improve technology, and build expertise through training

Healthy Opportunities Pilots Evaluation Activities and Interim Findings

Throughout DY6, the Sheps Center HOP team provided ongoing technical assistance and engagement with state of North Carolina program personnel to facilitate the HOP evaluation. Activities included bi-weekly meetings to discuss data goals and technical difficulties as well as continued participation in standing meetings to discuss other program updates and goals.

The initial HOP Interim Evaluation Report (IER) was submitted to CMS April 16, 2024. The final IER was submitted July 10, 2024, after making edits and clarifications in response to CMS comments on the draft

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

Other notable work in this DY included primary data collection for evaluation question 4 (patient-reported health outcomes). Sheps has continued collecting data via a longitudinal survey that launched at the end of May 2023. So far, they have recruited and completed 312 baseline surveys, 107 six-month surveys, and 13 twelve-month surveys with HOP participants. They have also begun interviews with eligible HOP participants, and 6 interviews have been conducted so far. An additional focus was conducting interviews with personnel at organizations within the pilot (Network Leads, HSOs, and PHPs). Interviews began in May 2024, and as of October 2024, Sheps had completed 70 interviews: 7 interviews with Network Lead personnel, 10 interviews across the five Standard Plans, and 43 interviews across 24 HSOs.

Sheps continued its work on dashboards that facilitate monitoring of Pilot implementation. Dashboard visualizations include enrollment, invoicing and payment, and service delivery. This work has also included developing definitions of data elements that will be visualized in dashboards, working with the Department to understand the prioritization of the data elements, and working on the design of the visualization dataset.

DEMONSTRATION YEAR 6 QUARTER 4 REPORT

Executive Summary

This section of the report covers Demonstration Year 6, Quarter 4 (DY6Q4) of the North Carolina Medicaid Reform Demonstration, Aug. 1 through Oct. 31, 2024.

The Department launched the Behavioral Health Intellectual/Developmental Disability Tailored Plans (Tailored Plans) July 1, 2024. There have been no significant widespread issues since Tailored Plan launch. Issues are being reported and resolved through the Technology Operations and Medicaid Help Center processes. In July, all Tailored Plans had higher than expected pharmacy claims denials based on prior authorization, despite relaxed PA flexibilities in place for the first 90 days following Tailored Plan launch. The Department issued additional guidance to Tailored Plans and increased monitoring in July and August. This successfully decreased pharmacy denials, and this issue is no longer being monitored by the Department as an area of concern.

On Sep. 26, 2024, Hurricane Helene made landfall, resulting in devastating floods in western North Carolina. The Department immediately enacted temporary flexibilities intended to support member access to care and providers' ability to provide services across NC Medicaid Managed Care and NC Medicaid Direct. Two Tailored Plans, Vaya and Partners, are based within the disaster area. The Department quickly established contact with Vaya and Partners to understand high-level impacts on staff, communications, and normal operations within the organizations.

The Children and Families Specialty Plan (CFSP) contract was awarded to Blue Cross NC Aug. 15, 2024, which will operate the plan under the name Healthy Blue Care Together (HBCT). The Contract Award Kickoff Series was held August 20 and 21, and HBCT submitted their implementation plan to the Department Oct. 10, 2024. The Department also began implementation activities to launch the Healthy Opportunities Pilot with the CFSP. The HOP team participated in engagement sessions with HBCT and is evaluating the program design changes that would be needed to implement HOP for youth and families served by the child welfare system.

Additionally, HOP continued to engage with the ECBI Tribal Option (TO) to review remaining design questions for launching HOP with the TO as a HOP Administrator. A key challenge for the Healthy Opportunities Pilot (HOP) this quarter was the possibility that the amount of state funding available for HOP services may not be sufficient for the projected service delivery spend through the remainder of the waiver period. To address this the Department changed the operational approach for reimbursing PHPs for service delivery funding, which improved the health plans' management of their capped allocation budget. The Department also developed a long-term strategy for HOP service reduction to ensure the most critical services would remain available to members.

Medicaid Managed Care

Operational Updates

This quarter the Department's Standard Plan team reviewed operational reports and analytics related to provider welcome kits, call center metrics, AMH data, appeals and grievances, and NEMT to address Standard Plan compliance in these areas. No Initial Notices of Deficiencies were issued this quarter. Additionally, the fourth annual Network Adequacy submissions were received at the end of July, and analysis of time/distance and non-time/distance network files is in progress.

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

On Sep. 26, 2024, Hurricane Helene made landfall, resulting in devastating floods in western North Carolina. Effective September 26, the Department enacted temporary flexibilities intended to support member access to care and providers' ability to provide services across NC Medicaid Managed Care and NC Medicaid Direct. In October the end date of the Hurrican Helene flexibilities was extended to Feb. 28, 2025. Some of the many policy flexibilities established include disaster relief applications available for health care providers not currently enrolled as a NC Medicaid provider, expanded ability for hospital swing beds, reimbursement for medically necessary services without prior authorization (PA), medication PA overrides due to Hurricane Helene, and early prescription refills during the Governor's state of emergency declaration.

Key Achievements

Standard Plans

1. The Department and Standard Plans executed an amendment for the revised and restated summary of contractual payment and risk sharing with an effective date of July 1, 2024. Another amendment was executed making updates related to provider payments for the Healthcare Access and Stabilization Program (HASP), including related technical changes, and SUD services.

Tailored Plans

1. The Department continued to work toward a finalized Tailored Plan contract amendment this quarter. In August and September, external working sessions were conducted with Tailored Plans to negotiate and address outstanding items. Following Sep. 26, communication with the Tailored Plans on non-critical work was temporarily paused due to disruptions caused by Hurricane Helene; this impacted ongoing amendment discussions and responses. By the end of October, the Department had completed its responses to all Tailored Plan feedback, resolved outstanding language issues, and prepared the amendment for final approval and routing for signature.

2. Over 12 post-launch technology integrations were successfully deployed across 5 vendors, serving the needs of the Care and Quality business units. Throughout this process, both pre- and post-production meetings were conducted to validate the success and functionality of the integrations. These meetings played a critical role in identifying and addressing potential issues, ensuring a smooth deployment process. Additionally, the team collaborated closely with the Privacy and Security Office to guarantee that all required security deliverables were thoroughly addressed and met the necessary compliance standards. This proactive approach underscores the Department's commitment to maintaining robust security protocols while delivering high-quality integration outcomes.

Children and Families Specialty Plan (CFSP)

1. The CFSP contract was awarded to Blue Cross and Blue Shield of North Carolina Aug. 15, 2024, and the Contract Award Kickoff Series was held shortly after.
2. HBCT submitted their implementation plan to the Department Oct. 10, 2024. Department business units completed individual reviews, and the Department provided feedback to HCBT on Nov. 6. HBCT resubmitted the implementation plan after addressing Department feedback, and the Department expects to send any additional requested changes by early December.
3. HBCT began meeting with the North Carolina Association of County Directors of Social Services (NCACDSS) in October.

Key Challenges

Tailored Plans

1. North Carolina declared a state of emergency due to Hurricane Helene less than three months following Tailored Plan launch. Two Tailored Plans, Vaya and Partners, are based within the Hurricane Helene disaster area. The Department quickly established contact with Vaya and Partners to understand high-level impacts on staff, communications, and normal operations within the organizations. NC Medicaid leadership met daily with all Tailored Plan CEOs to ensure they had the supports needed during the rapidly changing disaster response period. The Department evaluated deferment on operational reports and deliverables due between September 30 and November 1 to allow Tailored Plans to prioritize hurricane response.

2. After launch, all four plans saw higher volumes of pharmacy denials based on PA, which was unexpected based on the relaxed PA flexibilities in place for the first 90 days following Tailored Plan launch. These flexibilities did not always function as intended (e.g., plans were not actively monitoring PA denials with claims data, issues with out of network providers, auto PA processes were not robust). During the first 30 days of launch, the Department shared updated guidance and expectations with the Tailored Plans around managing pharmacy point of sale (POS) denials, including adding clarification as part of claims rejection messages that a 72-hour supply be provided to the member and directing Tailored Plans to conduct proactive reviews of claims denials and process for a 30-day PA override, if appropriate.

The Department monitored pharmacy POS claims processing through daily reporting from Tailored Plans throughout July to assess if the guidance was having the expected effect on denial rates. After seeing improvement throughout July, the Department shifted to receiving weekly reporting from Tailored Plans throughout August. The additional guidance shared with Plans had the intended effect and this is no longer being monitored by the Department as an area of concern for Tailored Plans.

3. North Carolina Medicaid successfully launched Electronic Visit Verification (EVV) for Personal Care Services (PCS) for the Tailored Plans, at Tailored Plan Launch, with minimal programmatic challenges. For EVV Home Health (HH), the Tailored Plans went live in a soft launch state and continue to experience issues with HH provider connections and EVV system configuration. The Tailored Plans are addressing provider connection issues through increased outreach, including expanded office hours and education. The Plans are working closely with their providers, associations, and other PHPs on the overall implementation for EVV HH. The Department continues to monitor progress through weekly reporting and biweekly meetings.

Issues or complaints identified by beneficiaries

The Department receives beneficiary complaints primarily from the Office of Administration and the NC Medicaid Member Ombudsman. The NC Medicaid Member Ombudsman is an independent organization that provides education, guidance and referrals to NC Medicaid beneficiaries. Not all Ombudsman calls should be interpreted as complaints, as many involve educating beneficiaries or connecting them to the entity that can provide the service they need. (See Appendix A for a full list of cases by category type this quarter.) There were 7,387 Member Ombudsman cases in DY6Q4, a decrease of approximately 2% from last quarter.

NC Medicaid Member Ombudsman Cases

	Information	Issue Resolution	Total
August	527	2,162	2,689
September	457	1,896	2,353
October	540	1,805	2,345

The Office of Administration largely handles cases referred from state legislative offices. Prior to DY5Q1, all constituent concerns handled by the Office of Administration were reported, including those from non-beneficiaries (such as providers). As of DY5Q1, the monitoring reports only include concerns from NC Medicaid beneficiaries. There were 16 recorded constituent concerns last quarter and 13 in this quarter.

Office of Administration Member Concerns, August – October 2024

Issue Category	Number of Issues
Behavioral health	4
Claims	1
Eligibility	4
NEMT	1
Pharmacy	3
Total	**13**

Lawsuits or legal actions

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

Legislative updates

There are no legislative updates to report this quarter

Performance Metrics

Outcomes of care

Results for Low Birth Weight and Rating of Personal Doctor metrics are available in the annual section of this report.

Quality of care

Annual quality metrics are included in the annual section of this report.

Access to care

Network Time/Distance Standards

The percentage of members with access to provider types that meet network adequacy standards is shown below for each Standard Plan by region and type of service provider. The state's time or distance network adequacy standards generally require that at least 95% of the membership meet the access standard. All Standard Plans met the state's time or distance standards for the five key service categories of hospitals, OB/GYN, primary care (adult and child), pharmacy and outpatient behavioral health (adult and child) as of the end of this quarter.

AmeriHealth Caritas									
Region	# of Counties	# of Members*	Hospitals	OB/GYN	Primary Care (Adult)	Primary Care (Child)	Pharmacy	Outpatient Behavioral Health (Adult)	Outpatient Behavioral Health (Child)
			% Members	% Members	% Members	% Members	% Members	% Members	% Members
1	19	144,579	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2	13	301,714	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
3	12	426,328	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
4	14	347,131	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
5	15	289,152	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
6	27	220,932	99.1%	99.5%	99.8%	99.7%	100.0%	100.0%	100.0%

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

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

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

Healthy Blue/Blue Cross Blue Shield of NC									
Region	# of Counties	# of Members*	Hospitals	OB/GYN	Primary Care (Adult)	Primary Care (Child)	Pharmacy	Outpatient Behavioral Health (Adult)	Outpatient Behavioral Health (Child)
			% Members	% Members	% Members	% Members	% Members	% Members	% Members
1	19	144,579	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2	13	301,714	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
3	12	426,328	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
4	14	347,131	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
5	15	289,152	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
6	27	220,932	99.0%	99.0%	99.0%	99.0%	100.0%	100.0%	100.0%

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

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

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

Wellcare									
Region	# of Counties	# of Members*	Hospitals	OB/GYN	Primary Care (Adult)	Primary Care (Child)	Pharmacy	Outpatient Behavioral Health (Adult)	Outpatient Behavioral Health (Child)
			% Members	% Members	% Members	% Members	% Members	% Members	% Members
1	19	144,579	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2	13	301,714	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
3	12	426,328	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
4	14	347,131	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
5	15	289,152	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
6	27	220,932	99.2%	99.5%	98.2%	97.0%	99.8%	100.0%	100.0%

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

Provider Enrollments by Standard Plan

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

Ambulatory Health Care Facilities by Standard Plan

AmeriHealth	Healthy Blue	CCH*	United	WellCare
960	1,155	884	944	1,060

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

Behavioral Health and Social Service Providers by Standard Plan

AmeriHealth	Healthy Blue	CCH*	United	WellCare
8,382	8,411	7,489	5,335	8,332

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

Beneficiaries Per AMH Tier

The Department developed the AMH model as the primary vehicle for care management in Standard Plans. AMH Tier 3s are the Department's highest level of primary care, focused on care management and quality. The tables below show the count and proportion of beneficiaries in each AMH tier by PHP.

Member Count by PHP and AMH Tier

	AmeriHealth	Carolina Complete Health*	Healthy Blue	United	WellCare	Total
No PCP Tier	28,935	11,130	56,542	50,354	27,990	174,951
Tier 1	5,799	4,304	5,964	5,650	2,145	23,862
Tier 2	65,336	57,491	88,058	101,275	50,615	362,775
Tier 3	296,390	208,038	461,813	320,967	416,920	1,704,128

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

Member Proportion by PHP and AMH Tier

	AmeriHealth	CCH	Healthy Blue	United	WellCare
No PCP Tier	7.30%	3.96%	9.23%	10.53%	5.62%
Tier 1	1.46%	1.53%	0.97%	1.18%	0.43%
Tier 2	16.48%	20.46%	14.38%	21.18%	10.17%
Tier 3	74.76%	74.04%	75.41%	67.11%	83.77%

AMH Provider Enrollment

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

	AmeriHealth	CCH**	Healthy Blue	United	WellCare
Tier 1	53.38%	74.55%	64.66%	63.91%	45.86%
Tier 2	62.67%	81.60%	98.69%	79.90%	61.54%
Tier 3	84.57%	87.37%	78.89%	82.36%	91.27%

*Providers that are not contracted at a state-designated AMH tier are not included in these counts.
**CCH's proportions are based on providers in regions 3, 4 and 5.

Care Management Penetration

These data represent members enrolled in Standard Plans receiving care management through a Standard Plan or Tier 3 AMH practice, and Care Management for At-Risk Children (CMARC) and Care

Management for High-Risk Pregnancies (CMHRP) from local health departments (LHDs) since the start of the contract year (July 2024). These data are provided with a one-month lag (DY6Q4 ends October 2024; however, data are available only through September 2024.)

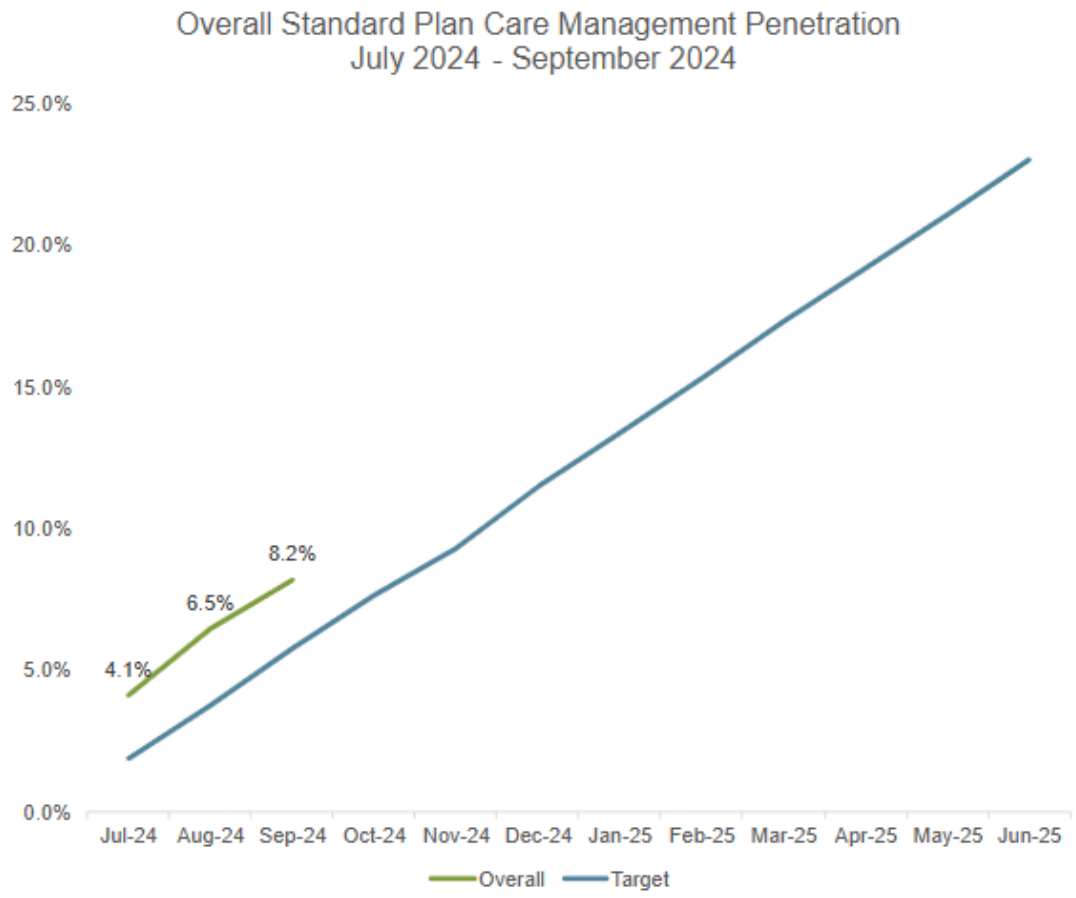
CMHRP is the Department's primary vehicle to deliver care management to pregnant women who may be at risk for adverse birth outcomes. CMARC offers a set of care management services for at-risk children ages 0 to 5. Care management provided through a Standard Plan, Tier 3 AMH, or LHD to members enrolled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

The Department has set a target of 23% of Standard Plan members receiving care management services in Contract Year 4.

Care Management Penetration (defined as at least one interaction with care manager within one year) by Entity, Contract Year 4

Period: July 1, 2024 –September 30, 2024				
	SP	**AMH3**	**LHD**	**Overall**
Total Number of Members Care Managed	37,374	128,552	28,454	185,557
Care Management Rate	**3.0%**	**11.2%**	**58.6%**	**8.2%**
Total Number of Members	1,236,492	1,145,998	48,524	2,259,130

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



Emergency Department Visits and Inpatient Admissions Rates

Emergency department visits per 1,000 members and inpatient admissions per 1,000 members are measured for the adult NC Medicaid population (age 21 and older) and broken out by Standard Plan and NC Medicaid Direct. Medicaid beneficiaries not eligible for hospital coverage (e.g., family planning participants) are excluded from NC Medicaid Direct calculations.

To better reflect claims lag and provide more accurate data, the Department reports these rates with a two-month lag. It should be noted that higher rates are expected for NC Medicaid Direct, as members with serious behavioral health issues remained in NC Medicaid Direct until the launch of Tailored Plans on July 1, 2024.

Emergency Department Visits per 1,000 Members, June – August 2024

AmeriHealth	CCH	Healthy Blue	Medicaid Direct	United	WellCare
56.68	55.77	56.86	89.30	58.10	56.01

Inpatient Admissions per 1,000 Members, June - August 2024

AmeriHealth	CCH	Healthy Blue	Medicaid Direct	United	WellCare
10.59	10.70	11.16	25.79	11.53	11.36

Results of beneficiary satisfaction surveys

Results from the 2023 Adult and Child Medicaid CAHPS Report are provided in the annual section of this report.

Budget Neutrality and Financial Reporting Requirements

The Department will provide CMS with updated budget neutrality information in the next budget neutrality workbook submission.

Evaluation Activities and Interim Findings

This quarter the Sheps Center team received comments and feedback from CMS on the Managed Care Interim Evaluation Report that was submitted in October 2023. The team began revising the report and will continue to work on revisions through the beginning of next quarter.

Transition to Capitated Encounter Data from PHPs

Sheps Center analysts have now been working with the encounter data from beneficiaries enrolled in Standard Plans for more than two years. Beginning in April 2023, Sheps began receiving encounter data from the State's LME/MCOs through a new encounter processing system, leading to issues receiving complete data. Following the resolution of this issue in Fall 2024, the Sheps team is revising reports that were affected by the incomplete data, including the SUD quarterly monitoring reports. Additionally, because the July launch of Tailored Plans brought medical services for the Tailored Plan-eligible population under Tailored Plan administration, there may be a transitional period for processing medical claims that could result in a longer claims run-out period beginning July 1.

Quantitative Update

The quantitative team continues to use NC Medicaid claims and encounter data along with new data from the NC Division of Public Health, including updates to birth and death certificate and immunization data, and new files on care management data, value-based payment data and NCCARE360, the database that tracks Healthy Opportunities Pilot services and referrals. Sheps has had renewed discussions with

the Division of State Operated Healthcare Facilities regarding their request to receive data on institute of mental disease (IMD) utilization not available from Medicaid claims due to state-only payments prior to and during the waiver. However, to date neither the IMD data nor the Prescription Drug Monitoring Program data have been received.

All data sources used for the Medicaid transformation evaluation are ingested into the University of North Carolina's secure data warehouse and are linked to NC Medicaid member information to generate metrics that are updated and tracked during the evaluation period. In addition, the team continues to update many of the metrics from established custodians for new time periods and updated technical specifications consistent with the NC Medicaid Managed Care Quality Strategy, Adult and Child Core measures, and other metrics that will address the study hypotheses. The evaluation team has decided to use Arizona Medicaid data as a comparison site after comparing trends in a selected set of metrics from prior to the demonstration period (2016-2019) and will begin the formal process to establish that relationship.

In this quarter Sheps completed a new member-level behavioral health dashboard. This dashboard includes an expansion filter so users can view metrics based on pre-expansion and post-expansion populations. Since it combines the previous SUD and behavioral health dashboards, Sheps has discontinued monthly updates for these older dashboards.

The quantitative team is developing new methodology to account for the complex dynamics during the COVID-19 era. Once these have been finalized, Sheps will share these methods with the Department and CMS. Additionally, Sheps is developing a template for sharing quarterly updates on managed care to the Department. Providing quarterly updates on a limited number of metrics will provide a quicker way to assess the efficacy of various waiver components in between formal evaluation reports.

Qualitative Update

Sheps has completed transcription, cleaning, and coding of the interviews with PHPs, the North Carolina Association of Health Plans, and the state. They have drafted a two-page report out of this data intended for NC Medicaid and related stakeholders. In addition, based on these interviews Sheps is developing a short deliverable piece aimed at a broader health policy and practice audience, as well as a longer piece on facilitators of NC Medicaid's transition to managed care under the waiver.

Work on outreach efforts and interviews with beneficiaries concluded in September 2024. In total, 35 interviews were completed with beneficiaries from both Standard Plans and Tailored Plans from July to September 2024. The interview audio recordings were sent to a transcription service and then the transcripts were reviewed, cleaned, and coded in NVivo. The analysis of the beneficiary interview data is ongoing, and findings will be drafted in the next quarter.

The manuscript on 2023 beneficiary data is currently under review and will be submitted to a journal next quarter. In addition, Sheps is revising a beneficiary engagement paper for resubmission to a scientific journal and working on a manuscript about provider contracting.

Healthy Opportunities Pilot

Introduction

This quarter, the Healthy Opportunities Pilot (HOP) continued to provide operational support for the Tailored Plans, which launched HOP with the TCM-eligible managed care population on July 1, 2024. This follows the launch of HOP with Prepaid Inpatient Health Plans (PIHPs) on May 1. Both the Tailored Plans and PIHPs are operated by the state's Local Management Entities/Managed Care Organizations (LME/MCOs). Additionally, HOP began implementation activities with the CFSP and continued working with the ECBI Tribal Option to review HOP program design. HOP experienced some challenges this quarter as the program needed to navigate the impact of state budget uncertainty and the response to Hurricane Helene, which severely affected the western region of North Carolina.

Key achievements

Following the July 1 launch, the Tailored Plans experienced higher than expected HOP enrollment which outpaced initial estimates for the month of July. By the end of July, over 1,300 Tailored Plan members had enrolled in HOP, which was 40% more than initial enrollment estimates. This could be due to public anticipation based on the widely publicized successes of HOP with the Standard Plan member population and improved pre- and post-launch communications and care manager readiness compared to Standard Plan HOP launch. The Department held recurring working sessions with the Tailored Plans to resolve questions and address challenges as their care managers and utilization management teams handled the higher than anticipated enrollment volume. As expected, enrollment slowed in the subsequent months of this quarter and began to align with the original projections. The program will continue to monitor the pace of HOP enrollment and take appropriate action to increase enrollment as needed.

In this quarter, the HOP team began implementation activities for the future launch of HOP with the CFSP, which will require changes to the program design to serve youth and families involved in the child welfare system. The HOP program participated in engagement sessions with the new health plan and evaluated the unique changes to program design that would be needed to implement HOP for youth and families served by the child welfare system. Additionally, HOP continued to engage with the ECBI Tribal Option (TO) to review remaining design questions for launching HOP with the TO as a HOP Administrator. Engagement with the TO will continue in the coming months as the Department and TO align on a target implementation date for the HOP.

Key challenges

One of the key challenges this quarter was navigating the uncertainty of available State funding for the program due to ongoing negotiations in the NC General Assembly. The negotiations resulted in a significant State funding reduction for HOP, so the Department developed strategies for mitigating the impact to HOP members which included:

- Addressing the budget challenges with the health plans and providing real-time guidance on pausing service authorizations.

- Implementing changes to the Department's operational approach for reimbursing PHPs for service delivery funding, which improved the health plans' management of their capped allocation budget.
- Developing a long-term solution for HOP service reduction to ensure the most critical services would be available for Medicaid members.

Additionally, an unexpected challenge was the impact of Hurricane Helene in the western region of North Carolina. The natural disaster significantly affected the HOP member population in this region, the Impact Health HOP Network Lead, and their network of HSOs. An initial assessment found that 58 of the 61 HSOs in the region were either not operational or were operating with limited capacity so the Department coordinated with the NLs, health plans, and other community organizations to conduct outreach to the providers and members in this region to ensure each issue was appropriately triaged and that HSOs and members could receive the appropriate recovery assistance. In the subsequent weeks after the disaster, the Department continued frequent engagement with HOP stakeholders and coordinated resources to restore operational capacity in the region.

Performance Metrics

Enrollee Service Costs

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

Prior to DY6Q2, costs were reported using the "amount invoiced" field within NCCARE360 due to errors found in the "amount paid" field, which made the former more accurate at the time. Data quality improvements within NCCARE360 have resolved these issues. Given that "amount paid" is now a reliable measure of costs incurred, we have used it in this report. Both "amount paid" and "amount invoiced" will continue to be monitored for reliability.

It should be noted in analyses of spending by service domain that Interpersonal Violence (IPV) services only launched April 5, 2023, while the other service domains launched in 2022.

Ten largest paid amounts per individual beneficiary

Order	Total Amount Paid	Types of Service(s) Received*			
		Food	Housing	Transportation	Cross**
1	$ 84,449.71	✓	✓	✓	✓
2	$ 72,500.15	✓	✓	✓	✓
3	$ 60,645.14	-	-	-	✓
4	$ 57,859.94	✓	✓	✓	✓
5	$ 50,435.19	✓	✓	-	✓
6	$ 40,724.19	✓	✓	✓	✓
7	$ 39,894.86	✓	✓	-	✓
8	$ 38,848.12	✓	✓	✓	✓
9	$ 38,149.62	✓	✓	-	✓
10	$ 35,857.81	✓	✓	✓	-

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

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

Percentile amount paid and amount invoiced per enrollee

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

Percent of amount paid by PHP and service category

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

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

Percent of amount paid by PHP by Enrollment Category*

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

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

Assessments found that members fell into disparate eligibility categories when completing multiple screening forms, even when the screenings were completed on the same day. Due to this, eligibility category is determined by age at time of enrollment for age-based categories. Updates were made to the data collection methods of the NCCARE360 platform during April 2023. Prior to this change the only way to collect information on pregnancy was through the screenings data. Following this change, this information was captured in the enrollment roster. Thus, the methodology for determining membership in the pregnant individual category differs in reports prepared using data before and after that date. Individuals that did not fall into the pregnant individuals category and for whom an age could not be calculated (because they had no date of birth provided) were coded as having a missing eligibility category.

Incentive Payments to PHPs, NLs, and Pilot providers

There were no incentive payments released this quarter.

Pilot Capacity Building Funding

There were no capacity building funds released this quarter.

Healthy Opportunities Pilots Evaluation Activities and Interim Findings

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

Sheps continues to work on dissemination of HOP IER results through the submission of conference abstracts and scientific manuscripts for peer-reviewed journals. The IER was submitted July 10, 2024 and approved by CMS in November 2024. Sheps is preparing for the Summative Evaluation Report by establishing data flows from the Health Information Exchange to receive data needed for Evaluation Question 4 analyses and establishing data sources needed for cost analyses (Evaluation Question 6). Due to the lack of data, some of these analyses could not be included in the interim evaluation report, and the plan is to include them in the summative report. The team plans to send a list to the Department of additional data sources needed by December 2024, particularly as it relates to HOP cost analyses.

Primary data collection for evaluation question 4 (patient-reported health outcomes) is ongoing. Sheps has continued collecting data via a longitudinal survey that launched at the end of May 2023. So far, they have recruited and completed 312 baseline surveys, 107 six-month surveys, and 13 twelve-month surveys with HOP participants. They have also begun interviews with eligible HOP participants, and six interviews with participants have been conducted. An additional focus was conducting interviews with personnel at organizations within the pilot (Network Leads, HSOs, and PHPs). Interviews began in May 2024, and as of October 2024, Sheps had completed 70 interviews: 7 interviews with Network Lead personnel, 10 interviews across the five Standard Plans, and 43 interviews across 24 HSOs.

Sheps is developing dashboarding that facilitates monitoring of Pilot implementation. Dashboard visualizations include enrollment, invoicing and payment, and service delivery. This work has also included developing definitions of data elements that will be visualized in dashboards, working with the Department to understand the prioritization of the data elements, and working on the design of the visualization dataset.

In this quarter Sheps has also worked on analyses for the Department on the expedited enrollment program and the No Wrong Door referral policy. The expedited enrollment program uses different data flows, compared with the standard program, which required new processes in order to extract and analyze relevant data. The completed report was provided to the Department in August. The No Wrong Door analysis was sent to the Department in September. This report looks at the total number of members referred to HOP through the No Wrong Door policy and the percent that went on to Social Care Coverage enrollment, with a breakdown of these metrics by demographic categories.

Finally, Sheps is preparing a new data set and analysis for HOP cost analyses to help inform discussions around a possible second iteration of HOP. This included preparing a new dataset and working on analyses to provide the state with information regarding heterogeneous treatment effects of HOP interventions for different outcomes and clinical populations.