Medicaid Section 1115 Monitoring Report

North Carolina - North Carolina Medicaid Reform Demonstration

Demonstration Year 3 – November 1, 2020 through October 31, 2021

Submitted on Jan. 28, 2022

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

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ANNUAL REPORT - DEMONSTRATION YEAR 3

Executive Summary

This annual report covers Demonstration Year 3 (DY3) of the North Carolina Medicaid Reform Demonstration, Nov. 1, 2020, through Oct. 31, 2021.

In the first two quarters of DY3, the Department prepared for the July 1, 2021, launch of Standard Plans, the first phase in NC Medicaid Managed Care. Preparations for launch included standing up an Ombudsman program, awarding a contract to a Prepaid Health Plan (PHP) External Quality Review Organization (EQRO), and ensuring the Enrollment Broker completed development of a mobile application, website, and call center. The Department conducted extensive outreach to both beneficiaries and providers, launching a television and digital advertisement campaign on the transition to NC Medicaid Managed Care for beneficiaries and creating a Provider Playbook webpage for providers to access information and resources.

Member open enrollment for the Standard Plans began March 15, 2021, and ended May 21, 2021. Following the open enrollment period, the Department automatically assigned a PHP for the approximately 1.2 million beneficiaries who did not select one. On the July 1, 2021, launch of the Standard Plans, North Carolina transferred 1.6 million Medicaid beneficiaries from NC Medicaid Direct (fee-for-service Medicaid) to five PHPs: AmeriHealth Caritas, Healthy Blue of North Carolina, UnitedHealthcare of North Carolina, WellCare of North Carolina and Carolina Complete Health.

Following the Standard Plan launch, the Department focused on addressing post-implementation concerns, including continuing to work with providers as they move through contracting and claims processing with the PHPs. The Department completed the initial 90-day choice period for members to change their PHP without cause.

The Department continues to work toward the launch of the Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Plan (Tailored Plans). Following a competitive selection process, the Department announced in July 2021 that seven organizations were awarded a contract to serve as regional Tailored Plans. One of the selected Tailored Plan organizations, Cardinal Innovations Healthcare, announced a merger with another selected Tailored Plan organization, Vaya Health. Consolidation will occur on Jan. 1, 2022, and thus there are expected to be six Tailored Plan organizations. Kick-off meetings were conducted in August with the organizations awarded contracts, and the Tailored Plans have submitted 30-day and 60-day contractual deliverables. In November 2021, the Department postponed the Tailored Plan launch from July 1, 2022, to Dec. 1, 2022. As this announcement was made after the end of DY3, details will be provided in the next quarterly report.

In May 2021, North Carolina awarded contracts to three organizations that will act as Healthy Opportunities Network Leads, formerly called Lead Pilot Entities, for the Healthy Opportunities Pilots: Access East, Community Care of the Lower Cape Fear and Impact Health/Dogwood Health Trust. Collectively, the three Network Lead Pilot regions cover 33 of North Carolina's 100 counties. The Department distributed the first Pilot capacity-building dollars to Network Leads in June 2021.

The Department continued to work with the Healthy Opportunities Network Leads to prepare them for the Spring 2022 Pilot launch by holding regular engagement sessions, releasing model contracts to facilitate Network Lead contracting with PHPs and Human Service Organizations (HSOs), and overseeing the Network Leads' HSO application process. The second issuance of capacity building funds was provided to Network Leads in September 2021. Additionally, the Department executed key technology contracts to begin development of Pilot-specific functionality in NCCARE360 and began Pilot implementation activities with the PHPs, Network Leads and Clinically Integrated Networks (CINs).

The Department engaged with CMS on development of an amendment to the approved 1115 waiver, which would:

- Extend the end date of the current demonstration period to reflect implementation delays and provide sufficient time to evaluate key components of the demonstration
- Adjust which populations will be covered by Tailored Plans
- Expand eligibility for and modify certain implementation details relating to the Healthy Opportunities Pilots
- Re-open discussions with CMS around a previous request to establish a Tribal Uncompensated Care Pool

The Department plans to complete the tribal consultation and public notice and submit the amendment to CMS during the next demonstration quarter.

Medicaid Managed Care

Operational Updates

Key achievements and to what conditions and efforts successes can be attributed

Standard Plans Lead-up to Launch

- The Department engaged in extensive outreach to beneficiaries and providers. In March, the Department launched television and digital advertisement campaigns to inform beneficiaries of the transition to NC Medicaid Managed Care. The Department also created a Provider Playbook webpage for providers to access information and resources.
- The enrollment broker completed development for and launched the enrollment mobile application, website and call center in March 2021. At that time the enrollment broker also began conducting virtual outreach events with beneficiaries.
- The NC Medicaid Ombudsman became fully operational on June 1, 2021, following the website launch in February. The Ombudsman helps NC Medicaid beneficiaries understand the Medicaid program and changes occurring throughout the transition.
- The Department completed the Standard Plan open enrollment period, which ran from March 15 to May 21. After the completion of the open-enrollment period, auto-enrollment was successful in assigning 1,234,782 beneficiaries to a PHP if they had not selected one. Beneficiaries experienced limited disruption to their assigned PCPs, with 97% enrolled in a plan that included their current PCP in-network.

- The EQRO contract was awarded and approved by CMS in May 2021. The EQRO is tasked with reporting Standard Plan and Tailored Plan performance in required and optional areas under 42 CFR 438.352 and 438.364.

Standard Plans Post-Launch

- At Standard Plan launch, the PHPs achieved network adequacy and readiness goals, with 100% member access to providers in the five key service categories across all regions except Region 6. Plans reported less than 100% access to hospitals and OB/GYNs in Region 6, although most still met the compliance standard of 95% member access. Network adequacy will continue to be monitored for compliance.
- Over 98% of beneficiaries were enrolled with a primary care physician. 80% of those members are enrolled with an Advanced Medical Home (AMH) Tier 3, the Department's highest level of primary care, focused on care management and quality, as of the end of DY3. This reflects efforts earlier in 2021 to finalize AMH/Primary Care Provider (PCP) assignment flexibilities. PHPs were directed to use the policy as guidance for developing their AMH/PCP assignment processes.
- The Department had a successful Point of Sale (POS) pharmacy launch, and pharmacy claim payments were successful on day one. The Department ensured a successful transition through the following efforts:
    - Initial twice weekly monitoring of POS claims/denials: The Department worked with PHPs to monitor and understand denials at POS to ensure issues were raised and researched for quick resolution.
    - Establishment of a clinical dyad model, which included assigning a pharmacist and nurse to each PHP.
- The Department completed the initial 90-day choice period for members to change their health plan without cause on Sept. 30, 2021. Beginning October 1, beneficiaries could change their PHP at their Medicaid recertification date or "with cause" by contacting the enrollment broker.
- The Department began merit reviews of network adequacy exception requests as part of the overall network evaluation for Standard Plans. This is the result of efforts to reach agreement with PHPs on when an exception request is necessary.
- The Department is continuing to transition to a provider data management/credentialing verification organization (PDM/CVO) model for provider enrollment and credentialing through an NCQA-certified vendor. The new PDM/CVO model is slated for implementation by July 2023.

Tailored Plans

- In November 2020, the Department issued a Request for Applications (RFA) for Tailored Plans as part of the transition to NC Medicaid Managed Care. Following a competitive selection process, the Department announced in July 2021 that seven organizations were awarded a contract to serve as regional Tailored Plans:
    1. Alliance Health
    2. Eastpointe

3. Partners Health Management
4. Sandhills Center
5. Trillium Health Resources
6. Vaya Health
7. Cardinal Innovations Healthcare (Cardinal Innovations announced June 1, 2021 that it will merge with Vaya Health Care.)

- The Department held kick-off presentations in August 2021 for all organizations awarded a Tailored Plan contract.
- The Department rolled out a capacity building funds program to ensure the successful implementation of Tailored Care Management. Tailored Care Management will be the vehicle through which Tailored Plan members receive comprehensive care management support. All Tailored Plan members will be offered choice of a Tailored Care Management entity, and members will be assigned to an entity if one is not selected. Under Tailored Care Management, members will have a single care manager who will be equipped to manage all their needs, spanning physical health, behavioral health, I/DD, traumatic brain injury (TBI), pharmacy, long-term service and supports (LTSS) and unmet health-related resource needs. The Department conducted desk reviews of round one Advanced Medical Home Plus (AMH+) practices/Care Management Agencies (CMAs) provider applications and advanced 54 providers to the site review stage in August 2021. Approximately $90 million in capacity building support will be distributed across the state to Tailored Care Management providers who pass a standardized certification process. The desk reviews are part one of the certification process.

Key challenges, underlying causes of challenges, and how challenges are being addressed

- The Department has had difficulty ensuring adequate non-emergency medical transportation (NEMT) contracting with PHPs. PHPs have contracted with two transportation brokers that work with public and private transportation providers to arrange and provide transportation for members. The brokers are:

    - ModivCare, used by: AmeriHealth Caritas of North Carolina, Carolina Complete Health, Healthy Blue and UnitedHealthcare of North Carolina
    - One Call, used by: WellCare of North Carolina

  To help ensure continuity and access to care during this transition, if a provider failed to schedule NEMT transportation through the broker for the first 60 days after Standard Plan launch (through Aug. 30, 2021), the PHPs and their transportation brokers honored those trips and paid NEMT providers equal to that of in-network providers. This flexibility has been extended through November 2021.

- In Quarter 4, the Department focused on addressing post-implementation concerns, including continuing to work with providers as they moved through contracting and claims processing with the Standard Plans. To support the provider community, the Department and the PHPs have agreed to extend the policy for out-of-network flexibilities to providers who have not yet contracted with a PHP through Nov. 30, 2021. This allowed for the following flexibilities:

  - Permits uncontracted, out-of-network providers enrolled in NC Medicaid to follow in-network provider prior authorization rules and continue to obtain a prior authorization retroactively. (This exception does not apply to concurrent reviews for inpatient hospitalizations).
  - Reimburses out-of-network providers at the in-network rate of 100% of the Medicaid fee schedule
  - Delays implementation of the 90% rate reduction following good faith contracting provision
  - Allows beneficiaries to change their PCP for any reason

- The Department experienced a high volume of work related to the review of Standard Plans' networks, network adequacy exception requests and other network aspects. The volume of work has prolonged the finalization of the review. The issue has been addressed through improved organization, upfront planning and sharing of expectations, and the addition of staff.
- The Department's Medicaid pharmacy unit resolved an issue where coverage for seizure medications through Standard Plans was being improperly denied. The Department responded quickly to ensure all PHPs were providing appropriate access to seizure medications.

Issues or complaints identified by beneficiaries

The Department receives member complaints from the Office of Program Integrity, Office of Administration and NC Medicaid Member Ombudsman. This report includes complaints from only Quarters 3 and 4, as Standard Plans were not operational during the first two quarters of the demonstration year.

The Office of Program Integrity did not receive any beneficiary concerns during Quarters 3 or 4. In Quarter 3, The Office of Administration received 13 total complaints: two related to member eligibility; three related to electronic visit verification; three related to NEMT; two related to clinical policy; one related to provider operations enrollment and two related to provider operations issues.

In Quarter 4, the Office of Administration received 24 complaints from managed care members: seven related to finance/PHP claims issues; three related to provider operations; three related to beneficiary/member concerns; one related to long-term services and supports; two related to medical health clinical policy; two related to behavioral health clinical policy and three related to durable medical equipment/prosthetics and orthotics.

In Quarter 3, the Member Ombudsman managed 2,115 cases. The most common case issues related to changing plans; eligibility, coverage, and referrals; and benefits and services. In Quarter 4, the Member Ombudsman handled 3,649 cases. Most calls involved educating beneficiaries or connecting them to the proper entity to help get the service they need (i.e., if a caller has a question on how to change health plans, they would be transferred to the enrollment broker). Aside from general inquiries, the most common issues were related to eligibility, coverage, and referrals; benefits and services; and access to care.

Unusual or unanticipated trends

- Prior to Standard Plan launch, 3,000 members who should have remained in NC Medicaid Direct were incorrectly assigned to PHPs. Corrections were made and members were reassigned to NC Medicaid Direct prior to launch.
- Prior to launch, there were 410 beneficiaries exempt from mandatory Standard Plan enrollment due to meeting Tailored Plan eligibility standards who chose to enroll in a Standard Plan. The Department researched the claims history of these individuals and identified that some of them were at risk of losing needed behavioral health benefits not covered by Standard Plans. To avoid the potential loss of needed benefits, the Department moved these individuals back into NC Medicaid Direct at launch and required that they speak to an enrollment broker prior to being able to opt into a Standard Plan.
- Formal notices of deficiencies were issued to two PHPs related to unscheduled customer service system outages.

Lawsuits or legal actions

At the beginning of the demonstration year the contract awards for the Standard Plans remained under protest. The Office of Administrative Hearings ruled in favor of the State in all cases. The following entities then sought judicial review: Aetna Better Health of North Carolina, Inc.; Optima Family Care of North Carolina; and My Health by Health Providers.

My Health has appealed the North Carolina Superior Court dismissal of its petition for judicial review to the North Carolina Court of Appeals. In addition, Aetna appealed both the Feb. 22, 2021, North Carolina Superior Court order limiting Aetna's participation in the My Health case to My Health's issues and the April 12, 2021, order denying My Health's petition for judicial review. The record on appeal has been finalized, briefs have been filed, and oral arguments are scheduled for Jan. 26, 2022.

My Health's second case before the Office of Administrative Hearings challenging the award of a third regional contract to Carolina Complete Health is awaiting ruling on the State's motion to dismiss filed in early 2020. The case is before Judge Ward.

Aetna's petition for judicial review was dismissed on Nov. 18, 2020. Aetna appealed the North Carolina Superior Court's dismissal of its petition for judicial review for failure to timely serve the State pursuant to N.C.G.S. 150B-46. The North Carolina Court of Appeals held oral arguments on May 26, 2021, and on Sept. 21, 2021, upheld the dismissal of the petition by the Superior Court. The deadline for further appeal was October 26; no appeal was filed.

Both of Optima's petitions filed in Wake and Pasquotank counties have been dismissed.

Legislative updates

S.L. 2021-3, enacted March 11, 2021, ends the required 5% provider rate increase on the earlier of the end of the federal public health emergency: rescission of executive order 116 declaring a North Carolina State of Emergency or on June 30, 2021.

S.L. 2021-26, enacted on May 27, 2021, allows flexibility for the State to submit mandatory encounter and claims data to the statewide Health Information Exchange network on behalf of PHPs and local management entity/managed care organizations (LME/MCOs).

S.L. 2021-61, enacted on June 29, 2021, revises hospital assessments to support the financing necessary for managed care.

S.L. 2021-62, enacted on June 29, 2021, makes a variety of changes for the successful implementation of managed care. It revises managed care entity grievance and appeal procedures, establishes procedure for expedited contested case hearings on disputed adverse benefit determinations, modifies the array of behavioral health services in Standard Plans, updates the populations and services that are excluded from managed care, including expanding the carve out of services provided by Children Development Service Agencies to include their contracted providers, addresses the transfer of area authority fund balances in the event of a dissolution of an LME/MCO, and amends durable medical equipment reimbursement under managed care to ensure it is at least equal to NC Medicaid Direct rates among other changes.

S.L. 2021-132, enacted on Sept. 1, 2021, amends the juvenile code to permit MCOs or PHPs to make a limited appearance in emergency motions for placement and payment for children in need of mental health services.

Descriptions of post-award public fora

No public fora occurred during the demonstration year. Post-award public fora were being planned for the first quarter of demonstration year four.

Performance Metrics

Impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population

No metrics to report in this category for the reporting period.

Outcomes of care

No metrics to report in this category for this reporting period.

Quality of care

North Carolina measurement year 2021 quality measure data will be available beginning in July 2022. Data on 2020 NC Medicaid Direct performance, including Adult and Child CMS Core Set reporting, is available in the report section specific to DY3Q4.

Cost of care

No metrics to report in this category for this reporting period. Cost metrics will become available for the November 2021 to January 2022 reporting period.

Access to care

To evaluate the influence of NC Medicaid Managed Care on primary care and obstetrics/gynecology (Ob/Gyn) practices that contract with Medicaid, the North Carolina Provider Experience Survey was developed and administered across all North Carolina primary care practices or their corporate parent. Please see the attachment labeled Appendix A for the full report.

Survey responses were collected between May 10 and Sept. 3, 2021. Stratified analyses were conducted to draw comparisons between rural versus non-rural provider groups, small/medium versus large provider groups, and groups delivering obstetrics and gynecology. The goal of these stratified analyses is to understand provider experience and satisfaction with the traditional Medicaid system and their thoughts about the transition to the PHPs.

Providers were asked what considerations were most important to them in contracting with PHPs. Independent groups and medical practices rated administrative items more important for contracting with PHPs than support for quality and population health (e.g., case management, coaching, data sharing, social determinants of health support). Over 95% of independent groups and medical practices surveyed said they either plan to or are likely to continue seeing Medicaid beneficiaries after they are enrolled in PHPs. Among health systems, education and training related to billing, prior authorizations or other administrative activities were less important than other factors in PHP contracting. Practices with rural presence tended to emphasize administrative processes, access to children's developmental services and care management. Small practices identified access to medical specialists, access to behavioral health prescribers, access to needed drugs and timeliness of data sharing as high priorities.

The most recent quarterly access to care metrics are available in the report section specific to DY3Q4.

Results of beneficiary satisfaction surveys

North Carolina conducts an annual "Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey" for the North Carolina Medicaid population. For calendar year 2019, the adult survey found that 82% of respondents reported being able to get the care they needed and 80.9% reported being able to get the care they needed quickly. Adult surveys for the following year showed improvement on these measures, with 85.3% being able to get the care they needed and 82.7% being able to get the care they needed quickly. For calendar year 2019, the child survey found that 89% of respondents reported being able to receive the care they needed and 93.9% reported being able to get needed care quickly. The following year, the child survey found that 87.3% of respondents reported being able to receive the care they need and 89.6% reported being able to get needed care quickly.

The Department's 2020 CAHPS implementation oversampled several populations so results could be stratified by race, ethnicity and receipt of telehealth services. The latter is intended to provide insight into the impact of telemedicine policies implemented during the Public Health Emergency.

The Department intends to oversample extensively in its upcoming CAHPS implementation with sample size not to exceed 63,165 sampled members. Strata will include the five participating PHPs, the tribal option population, the NC Medicaid Direct population, NC Medicaid Direct beneficiaries who will be eligible for Tailored Plans, and Standard Plan members receiving behavioral health services. This will be the first opportunity to compare results across NC Medicaid Direct and NC Medicaid Managed Care. The survey will be fielded from February 4 to April 29, 2022, with results available in July 2022.

Budget Neutrality and Financial Reporting Requirements

Since Standard Plans launched on July 1, 2021, DY3Q4 marks the first time the Department submitted budget neutrality data for both NC Medicaid Managed Care and SUD. In the budget neutrality workbook due to CMS on Dec. 31, 2021, the Department submitted budget neutrality information through Sept. 30, 2021. The workbook was uploaded to the DY3Q4 Budget Neutrality deliverable folder with the file name *DY3Q4_Budget_Neutrality_Workbook(thru_09-30-2021).xlsm*. This submission reflects the most recent information available based on quarterly CMS-64s. North Carolina appears to be within budget neutrality limits for the demonstration.

Evaluation Activities and Interim Findings

During Demonstration Year 3, there were several activities related to the waiver evaluation. The Sheps Center team at UNC continued to implement the evaluation design by increasing the number of quantitative metrics examined from the pre-implementation period, beginning in November 2015, through the present. The team is working with measures from HEDIS and other quality measure custodians, including but not limited to the Medicaid Adult and Child Core Set measures, to monitor the milestones of the NC Medicaid transformation. The evaluation team has been examining the use of Marketplace enrollees from a NC-based insurer as a potential comparison group for the difference-in-differences analysis through the comparison in trends in seven identified measures.

The evaluation team worked closely with the Department as the implementation of Standard Plans began on July 1, 2021, near the end of the DY, especially on issues related to the new encounter data that Standard Plans would be generating that would replace most of the fee-for-service claims data files that the Sheps Center has received for the evaluation. Utilization of services by NC Medicaid beneficiaries who were enrolled in Standard Plans is now packaged into encounter data rather than traditional claims data when it arrives at the Department, and the data has continued to be quickly made available to the Sheps Center team. Sheps has begun incorporating the different file formats and newly created variables into their analytic structure and is carefully monitoring the quality and usability of the encounter data as it arrives.

The transition in data formats has generally gone smoothly. One issue that affected data reporting post-implementation is a difference in the algorithm used for encrypted beneficiary identifiers, which has created a barrier in linking data on recipients over time and precludes the quantitative analysis from linking enrollment information to utilization. The Department has been responsive to these issues and has arrived at a solution that should be implemented by February 2022.

The evaluation uses a mixed-methods approach, combining analysis of administrative data with qualitative data to obtain detailed insights into the transformation that are not easily captured through claims and surveys; for example, how providers are prepared for the transformation and what can be done to improve their satisfaction with NC Medicaid. The qualitative component of the evaluation includes interviews with a heterogeneous panel of NC Medicaid providers and practices, including administrative personnel (e.g., practice managers, billing managers), direct providers (e.g., physicians, psychologists, registered nurses), leadership (e.g., executive directors), and health system representatives (e.g., Atrium, WakeMed, UNC, Cone Health) regarding key components of the waiver. Additionally, the qualitative team has scheduled interviews with staff from NC DHHS to better capture

perspectives of the transformation with respect to consumer engagement, provider participation, relationships with the Standard Plans, and rollout and implementation. This mixed method approach allows the triangulation of the quantitative and qualitative findings for a robust waiver evaluation.

During the DY, the evaluation team has formed a panel of approximately 50 practices statewide, completed a round of key information interviews with representatives from these practices and begun a second round of interviews. A first draft of the codebooks for each of the two interview guides has been developed and will undergo review and refinement before being uploaded to the coding software. The transcribed and coded interviews will address the major goals and research questions for the evaluation.

Enhanced Case Management (ECM) and Other Services Pilot Program

Operational Updates

Introduction

Throughout DY3, the Department has been preparing for the Health Opportunities Pilots launch in Spring 2022. At the beginning of DY3, the Department developed a detailed project plan and timeline incorporating a revised schedule that accounted for the delay in NC Medicaid Managed Care launch and a set of implementation-related tasks necessary to ensure Pilot development was on track. The RFP evaluation committee restarted its work to evaluate proposals and award contracts to Network Leads (formerly called Lead Pilot Entities), which would begin the capacity building period.

In May 2021, North Carolina awarded contracts to three organizations to serve as Healthy Opportunities Network Leads. Each Network Lead covers one Pilot region. The Department began working with Network Leads to prepare them for Pilot launch by holding engagement sessions, distributing capacity building funding and facilitating contracting. The Department also engaged with PHPs and CINs on Pilot implementation and worked with technology vendors to develop technology systems to support the Pilots.

Key achievements and to what conditions and efforts successes can be attributed

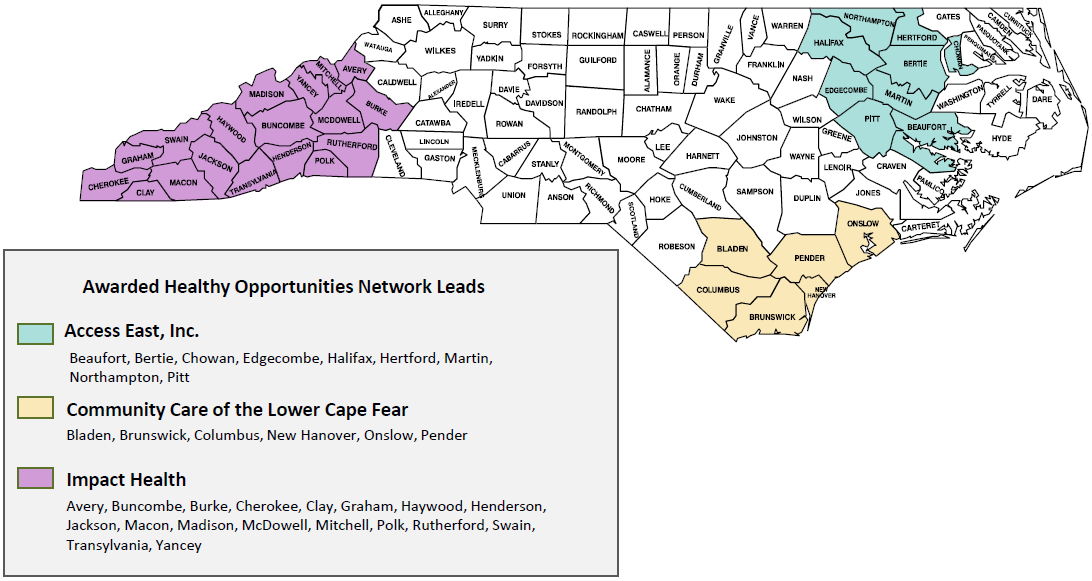
Network Lead Award and Engagement

In May 2021, following a competitive procurement process, the Department announced three Network Leads and the counties included in their Pilot regions:

1. **Access East Inc.:** Beaufort, Bertie, Chowan, Edgecombe, Halifax, Hertford, Martin, Northampton, Pitt
2. **Community Care of the Lower Cape Fear:** Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender
3. **Dogwood Health Trust (Impact Health):** Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey

Awarded Healthy Opportunities Network Leads and Regions

NCDHHS has procured Network Leads (NLs) with deep roots in their communities, which will facilitate collaboration across health care and human service providers.



In June 2021, the Department distributed the first round of capacity building payments to Network Leads and began frequent individual and group engagement sessions to provide training, share learnings and track implementation progress. Network Leads formed organizational structures to support the Pilots, including hiring staff and forming governing bodies, and submitted policies, procedures and operational plans to the Department, including implementation plans, final geographic footprints, board charters and Pilot governance policies.

In Quarter 4 the Network Leads continued submitting key deliverables to the Department, including HSO Network Applications, HSO Assessment Processes, HSO Provider Manuals, Training and Technical Assistance Plans, and Capacity Building Funding Distribution Approaches. The Network Leads began establishing their HSO networks by accepting and reviewing applications from HSOs within their Pilot region. The Department distributed a second issuance of capacity building funds to Network Leads on Sep. 21, 2021.

Importantly, the Department worked with stakeholders over a series of months to develop, and in September 2021 distribute, a set of model contracts to govern the responsibilities and relationships between Networks Leads, PHPs and HSOs. Network Leads will use one model contract to contract with each PHP, and one model contract to contract with each HSO in its network. (Please see Appendices B and C.) The Department found significant value in developing these standardized contracts to define clear roles and responsibilities, streamline contracting and reduce burden on Network Leads and HSOs, and to maintain clear oversight while not “over-medicalizing” HSOs.

Health Plan and Clinically Integrated Network (CIN) Engagement

In Quarter 4, the Department accelerated implementation activities with PHPs and CINs to ensure that these entities would be ready for Pilot launch. The Department met regularly with PHPs to track implementation progress and develop a set of operational protocols, technology companion guides, and reporting templates for PHPs. The Department also engaged regularly with key CINs in Pilot regions that provide care management to NC Medicaid members to overview Pilot care management responsibilities.

Technology Development

The Department made significant progress on technology development for the Pilots in Quarter 4. Specifically, the Department executed contracts with key NCCARE360 vendors (Unite Us and the Foundation for Health Leadership and Innovation) to cover NCCARE360 licenses and develop additional functionality in NCCARE360 to support the Pilots.[1] The Department worked with Unite Us to define Base Pilot Functionality, or core functionality that will be ready at Pilot launch. The Department continues to work with Unite Us to define Advanced Pilot Functionality, which will improve and automate technology processes in the months after launch. In September and October, Unite Us began developing Base Pilot Functionality and demonstrating key functionality to the Department.

Also in Quarter 4, the Department worked with its Medicaid Management Information System (MMIS) vendor to continue developing technology to support the Pilots in the NC MMIS. Specifically, the Department developed functionality for HSOs to enroll as Medicaid providers in the MMIS, which went live in September 2021. The Department created and defined two new taxonomy codes for individuals and organizations to enroll as HSOs and worked on training curriculums tailored to HSOs, most of which are not familiar with enrolling as a Medicaid provider. The Department also worked with its MMIS vendor in Quarter 4 to develop affiliations in the MMIS for PHP-Network Lead and Network Lead-HSO affiliations.

The Department made significant progress on Pilot implementation in DY3, particularly in Quarter 4, due to a strong commitment from the Department and its partners to the success of the Healthy Opportunities Pilots.

Key challenges, underlying causes of challenges, how challenges are being addressed

A key challenge for the Healthy Opportunities Pilot has been the condensed implementation timeline. To meet the planned February 2022 launch date, business and technical requirements were drafted in parallel to implementing the Pilot when possible. The Department also focused on the core, necessary infrastructure to stand up the Pilot, with the intent to enhance functionality, HSO networks and service array in the months following launch. This approach allowed the team to leverage existing processes and technical functions and minimize technology changes and associated timeframes for development and testing. Additionally, Network Leads planned to launch services in February with HSOs that volunteered to start first, adding additional HSOs to their networks over time as they built capacity.

[1] The Foundation for Health Leadership and Innovation (FHLI) jointly oversees NCCARE360 with the North Carolina Department of Health and Human Services through a public-private partnership. Unite Us is the software development company that builds NCCARE360, which is North Carolina's statewide, closed-loop referral system.

The Department, however, continued to hear concerns from partners that a February launch date may not yield a successful launch. As a result of these conversations with partners, the Department decided to shift to the following phased Pilot launch approach:

- **Feb. 1, 2022: Engagement and NCCARE360 Functionality**
  - Newly developed "Base Pilot Functionality" in NCCARE360 available. Pilot-participating entities (PHPs, CINs, Network Leads, HSOs) will have access to an NCCARE360 training environment.
  - Additional time for engagement between PHPs and Network Leads/HSOs
- **March 15, 2022: Launch food services and three CINs**
  - Launch delivery of food services
  - Medicaid members to be assessed for Pilot eligibility and enrolled into Pilots through the three CINs that provide care management for most Medicaid-covered lives in Pilot regions
- **May 1, 2022: Launch housing and transportation services and additional CINs**
  - Launch delivery of housing and transportation services
  - Medicaid members to be assessed for Pilot eligibility and enrolled through additional interested CINs and Tier 3 AMHs
- **June 15, 2022: Launch toxic stress and cross-domain services**
  - Launch delivery of toxic stress and cross-domain services. Due to legal and technical challenges, interpersonal violence and certain cross-domain services may not yet be available.
  - Medicaid members to be assessed for Pilot eligibility and enrolled through Standard Plans, in addition to CINs and Tier 3 AMHs

The Department is also exploring a technical solution to translate Pilot invoices into a standard claims format.

Additionally, the Department is facing challenges with determining how to include interpersonal violence services in the Pilot. Federal laws such as the Violence Against Women Act, Victims of Crime Act, and Family Violence Prevention and Services Act rightfully restrict the sharing of a violence survivor's personal data to protect their safety. However, the Healthy Opportunities Pilots evaluation relies on linking a member's personal data on Pilot services received to health care utilization and outcomes. Additionally, since Pilot services operate essentially as temporary Medicaid benefits, a PHP must know if a member is covered by their plan to reimburse for the service. As a result, the Department has been engaging regularly for almost a year with the NC Coalition Against Domestic Violence and Legal Aid on how to modify processes to allow the incorporation of interpersonal violence and other sensitive Pilot services. The group is coming to agreement on potential operational modifications to allow coverage of these services. Next the group will need to explore technical solutions.

The Department continues to monitor the establishment of Network Leads' HSO networks. Pilot regions consist of mostly rural counties where HSOs capable of providing Pilot services may be limited. The

Department is exploring ways to ensure that enough Medicaid members are enrolled in the Pilots to support a meaningful evaluation.

Issues or complaints identified by beneficiaries

No issues or complaints identified by beneficiaries for this reporting quarter.

Lawsuits or legal actions

Three entities that were not awarded a contract to be a Network Lead submitted formal protests of the award in July. Two of these protests were dropped and one entity elected to move forward with legal action.

Unusual or unanticipated trends

No unusual or unanticipated trends during this reporting period.

Legislative updates

No legislative updates during this reporting period.

Descriptions of post-award public fora

No post-award public fora this reporting period.

Performance Metrics

No performance metrics to report for the Pilots this reporting period as services have not launched yet.

Incentive Payments to PHPs, NLs, and Pilot Providers

No incentive payments to report for the Pilots this reporting period.

ECM Capacity Building

The Department has made two distributions of capacity building funds to Network Leads during DY3, the first on June 22, 2021, and the second on Sept. 21, 2021. Network Leads could request up to $10 million in capacity building funds for the May 27, 2021– May 26, 2022 budget period and up to $10 million for the May 27, 2022–May 26, 2023 budget period. Network Leads must disburse at least 51% of their capacity building funds to HSOs in their Pilot network. Additionally, the Department permitted Network Leads to invoice up to 50% of their annual capacity building budget up front in their initial invoice. Each Network Lead requested 50% of their annual budget. In the second invoice, Network Leads could invoice up to 25% of their annual capacity building budget, and each Network Lead requested the full amount allowable.

Healthy Opportunities Pilots Evaluation Activities and Interim Findings

No Pilot services have been delivered yet, which limited the evaluation to preparation activities.

On July 1, 2021, the Department executed an implementation contract with the Cecil G. Sheps Center for Health Service Research to serve as the Healthy Opportunities Pilots external evaluator. Dr. Seth Berkowitz, the lead evaluator of the Healthy Opportunities Pilots, has begun meeting with Network Leads to explain their roles and responsibilities in Pilot data collection for evaluation.

During this demonstration year, evaluation consisted of two main activities. The first was providing technical assistance to the Department regarding planning for evaluation once Pilot services begin. For example, to appropriately comply with the Violence Against Women and Victims of Crime Acts, there have been ongoing meetings with stakeholder groups around data availability and collection for members who will receive services for interpersonal violence. The second set of evaluation activities has focused on preparing for primary data collection for Pilot service delivery. Activities have included obtaining Institutional Review Board (IRB) approval for interviews and surveys with Network Lead and HSO staff members, and development of an interview guide and survey for data collection. The evaluators are well-positioned to evaluate the delivery of Pilot services once they launch.

Residential and Inpatient Treatment for Individuals with a Substance Use Disorder

The Department will provide detailed information in the Substance Use Disorder annual submission that is due to CMS Feb. 28, 2022.

DEMONSTRATION YEAR 3 QUARTER 4 REPORT

Executive Summary

In the August to October 2021 reporting period, North Carolina continued to build on the launch of the Medicaid Managed Care Standard Plans. As of the July 1, 2021, launch, the Department transferred 1.6 million Medicaid beneficiaries to five PHPs: AmeriHealth Caritas, Healthy Blue of North Carolina, UnitedHealthcare of North Carolina, WellCare of North Carolina and Carolina Complete Health. The August to October reporting period is the first full quarter in which the Standard Plans have been operational.

In this reporting period the Department was focused on addressing post-implementation concerns, including working with providers as they moved through contracting and claims processing with the PHPs. To support the provider community, an extension was granted to the Out-of-Network and Prior Authorization period. Additionally, the Department completed the initial 90-day choice period for beneficiaries to change their health plan without cause.

With the launch of Standard Plans, the Department will be monitoring metrics related to outcomes of care, quality of care, cost of care, access to care, results of beneficiary satisfaction surveys, and member and provider grievances and appeals. For the August to October reporting period, only access to care metrics are available for Standard Plans. Cost of care metrics will become available for the DY4Q1 period. This submission includes quality of care measures from 2020 NC Medicaid Direct performance, including Adult and Child CMS Core Set reporting.

North Carolina continues to prepare for the launch of Tailored Plans. Recently, the Department announced that the launch will be postponed from July 1, 2022, to Dec. 1, 2022. As this announcement was made after the end of the DY3Q4 reporting period, details will be provided in next quarter's report. Kick-off meetings were conducted in August with the seven organizations awarded Tailored Plan contracts, and the Tailored Plans have submitted 30-day and 60-day contractual deliverables.

The Department continued preparing for the Spring 2022 launch of the Healthy Opportunities Pilots. Specifically, the Department continued working with Healthy Opportunities Network Leads by holding regular engagement sessions, releasing model contracts to facilitate Network Lead contracting with PHPs and HSOs, and overseeing the Network Leads' HSO application process. The second issuance of capacity building funds was provided to Network Leads in September 2021. Additionally, the Department executed key technology contracts to begin development of Pilot-specific functionality in NCCARE360 and began Pilot implementation activities with the PHPs, Network Leads, and CINs.

The Department engaged with CMS on development of an amendment to the approved 1115 waiver to:

- Extend the end date of the current demonstration period to reflect implementation delays and provide sufficient time to evaluate key components of the demonstration
- Adjust which populations will be covered by the Tailored Plans
- Expand eligibility for and modify certain implementation details relating to the Healthy Opportunities Pilots

- Re-open discussions with CMS around a previous request to establish a Tribal Uncompensated Care Pool

The Department plans to complete the tribal consultation and public notice and submit the amendment to CMS during the next demonstration quarter.

Medicaid Managed Care

Operational Updates

On July 1, 2021, North Carolina launched the Standard Plans with approximately 1.6 million Medicaid beneficiaries transitioning from fee-for-service Medicaid to managed care. The August to October reporting period is the first full quarter in which managed care Standard Plans have been operational.

In this reporting period the Department was focused on addressing post-implementation concerns, including working with providers as they moved through contracting and claims processing with the standard plans. To support the provider community, an extension was granted to the Out-of-Network and Prior Authorization period. This allowed for the following flexibilities:

- Permits uncontracted, out-of-network providers enrolled in NC Medicaid to follow in-network provider prior authorization rules and continue to obtain a prior authorization retroactively. (This exception does not apply to concurrent reviews for inpatient hospitalizations.)
- Reimburses out-of-network providers at the in-network rate of 100% of the Medicaid fee schedule
- Delays implementation of the 90% rate reduction following good faith contracting provision
- Allows beneficiaries to change their PCP for any reason
- Extends flexibility for Non-Emergency Medical and Non-Emergency Ambulance Transportation providers through November 2021

The Department continues to prepare for the launch of Tailored Plans on Dec. 1, 2022.

Key achievements and to what conditions and efforts successes can be attributed

Standard Plans

- Requests were processed from 1,993 beneficiaries mandatorily enrolled in a PHP to move to NC Medicaid Direct.
- The Department created a process to address issues with PHPs as they are identified and address concerns via formal notification and corrective action. The Department will continue to refine this process to ensure adequate oversight of the Standard Plans.
- The Department is beginning to monitor and validate PHP network file errors and operational reports related to claims payments.
- The Department began merit reviews of network adequacy exception requests as part of the overall network evaluation for Standard Plans. This is the result of efforts to reach agreement with PHPs on when an exception request is necessary.

- The Department continues to build on the successful POS pharmacy launch through the following efforts:
  - Initial twice weekly data monitoring of POS claims/denials: The Department worked with PHPs to monitor and understand denials at POS to ensure issues were raised and researched for quick resolution.
  - Established a clinical dyad model, which included assigning a pharmacist and nurse to each PHP.
  - Established monthly clinical benefits meetings with Standard Plans to allow opportunity for Benefits team to report to the Standard Plans on any upcoming policy changes and to communicate key information to the Standard Plans.
- The Department is continuing efforts to transition to a PDM/CVO model for provider enrollment and credentialing through an NCQA-certified vendor. The new PDM/CVO model is slated for implementation by July 2023.
- The Department supported the implementation of an early respiratory syncytial virus (RSV) season for both NC Medicaid Direct and the Standard Plans, which started August 15. This allows earlier than usual coverage of the evidence-based prophylaxis Palivizumab.

Tailored Plans

- The Department held kick-off presentations in August for all organizations awarded a Tailored Plan contract.
- The Department began facilitating weekly status meetings with each plan to track development work and address any potential technical or business issues and risks.
- PHPs moved forward with the submission of contract deliverables. 133 30-day and 16 60-day contract deliverables were submitted for the Department to review and approve.
- The Department completed drafts of Tailored Plan enrollment notices for the 2022 launch.

Key challenges, underlying causes of challenges, and how challenges are being addressed

Standard Plans

- The Department experienced a significant increase in work volume due to the review of Standard Plan networks, network adequacy exception requests and other network aspects. The volume of work prolonged the finalization of review. The issue has been addressed through improved organization, upfront planning and sharing of expectations, and the addition of staff.
- The Department's pharmacy unit resolved an issue where coverage for seizure medications was being improperly denied. The Department responded quickly to ensure all PHPs were providing appropriate access to seizure medications.

Tailored Plans

There are no significant challenges to report for this quarter.

Milestones

- The Department completed the initial 90-day choice period for beneficiaries to change their health plan without cause.
- The Department finalized a process for making Standard Plan contract amendment changes.
- The NC Area Health Education Centers (AHEC) made over 2,000 contacts to providers, focusing on advanced medical home providers, community health workers, and providers interested in Tailored Care Management education. This represents a 56% increase in the number of outreach encounters from DY3Q3.

Issues or complaints identified by beneficiaries

The Department receives beneficiary complaints from the Office of Program Integrity, Office of Administration, and NC Medicaid Member Ombudsman.

The Office of Program Integrity did not receive any beneficiary concerns during this quarter. The Office of Administration received 24 complaints from managed care beneficiaries: seven related to finance/prepaid health plan claims issues; three related to provider operations; three related to beneficiary/member concerns; one related to long-term services and supports; two related to medical health clinical policy; two related to behavioral health clinical policy and three related to durable medical equipment/prosthetics and orthotics.

The Member Ombudsman handled 3,649 cases. Aside from general inquiries, the top issues by quantity of interactions were in the following categories: eligibility, coverage and referrals; benefits and services; and access to care. See Appendix D for a full list.

Lawsuits or legal actions

My Health has appealed the North Carolina Superior Court dismissal of its petition for judicial review to the North Carolina Court of Appeals. In addition, Aetna appealed both the Feb. 22, 2021, North Carolina Superior Court order limiting Aetna's participation in the My Health case to My Health's issues and the April 12, 2021, order denying My Health's petition for judicial review. The record on appeal has been finalized, briefs have been filed and oral arguments are set for January 26, 2022.

My Health's second case before the Office of Administrative Hearings challenging the award of a third regional contract to Carolina Complete Health is awaiting ruling on the State's motion to dismiss filed in early 2020. The case is before Judge Ward.

Aetna appealed the North Carolina Superior Court's dismissal of its petition for judicial review for failure to timely serve the State pursuant to N.C.G.S. 150B-46. The North Carolina Court of Appeals held oral arguments on May 26, 2021, and on Sept. 21, 2021, upheld the dismissal of the petition by the Superior Court. The deadline for further appeal was October 26; no appeal was filed.

Unusual or unanticipated trends

No unusual or anticipated trends to report for this reporting period.

Legislative updates

S.L. 2021-132, enacted on Sept. 1, 2021, amends the juvenile code to permit managed care organizations or prepaid health plans to make a limited appearance in emergency motions for placement and payment for children in need of mental health services.

Descriptions of post-award public fora

No public fora occurred during this reporting quarter.

Performance Metrics

Impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population

No metrics to report in this category for the reporting period.

Outcomes of care

No metrics to report in this category for this reporting period.

Quality of care

North Carolina measurement year 2021 quality measure results will be available beginning in July 2022. Because NC Medicaid Managed Care launched on July 1, 2021, quality measure results for 2021 will represent the last six months of fee-for-service and the first six months of managed care for North Carolina's Standard Plan population. The data provided below is from 2020 and 2019 NC Medicaid Direct performance, including Adult and Child CMS Core Set reporting. The Department selected a few key quality metrics that drive interventions that advance health, performance improvement, and quality outcomes:

Measure/Measure Steward	Description	Performance CY 2019	Performance CY 2020
Adolescent Well-Care Visits/NCQA	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.	43.4%	37.33%
Childhood Immunization Status (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.	35.02%	36.16%
Immunizations for Adolescents (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.	31.55%	31.21%
Use of First-Line Psychosocial care for children and	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	52.09%	50.82%

Measure/Measure Steward	Description	Performance CY 2019	Performance CY 2020
adolescents on antipsychotics/NCQA	antipsychotics and had documentation of psychosocial care as first-line.		
Well-child visits in the first 30 months of life/NCQA	The percentage of children who turned 30 months old during the measurement year and who had six well-child visits with a primary care practitioner (PCP) during their first 30 months of life.	NA	66.38%
Cervical cancer screening/NCQA	Women ages 21-64 who had cervical cytology performed every 3 years.	43.82%	42.83%
Chlamydia screening for women/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%
Breast cancer screening/NCQA	Women ages 50-74 who had a mammogram to screen for breast cancer.	41.35%	35.35%
Flu vaccinations for adults	Adults ages 18 years and older self-report receiving an influenza vaccine within the measurement period.	42.9%	49.89%
Plan All-Cause Readmission – Observed to expected ratio/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.	0.93%	0.99%

Cost of care

No metrics to report in this category for this reporting period. Cost metrics will become available for the DY4Q1 (November 2021 to January 2022) reporting period.

Access to care

Network Time/Distance Standards

Based upon network analyses submitted on Sept. 20, 2021, four of the prepaid health plans—AmeriHealth Caritas, Healthy Blue, UnitedHealthcare, and WellCare—were able to ensure 100% of members in all regions except Standard Plan regions five and six have access that complies with the network adequacy standards for the five key service categories (Primary Care, Hospitals, Pharmacies, OB/GYN, and Outpatient Behavioral Health). These four plans reported reduced access to hospitals in regions five and six. However, two of the plans, AmeriHealth Caritas and United Healthcare, showed increases in the percentage of members with access to hospitals in region 6 over the same statistic from the July 20, 2021, network analysis.

AmeriHealth Caritas, Healthy Blue, and United Healthcare reported reduced access to OB/GYNs in region 6. Carolina Complete Health reported 100% access in the three regions it covers. The Department's time or distance network adequacy standards require that at least 95% of the membership meet the access standard.

Provider Enrollments by PHP

As of this quarter, provider enrollment by provider type is available by PHP. There are 25 provider type categories. Provider enrollment for two categories, ambulatory health care facilities and behavioral health/social service providers, is provided below for illustration. See Appendix E for the full list.

Provider Enrollment by PHP – Select Categories

Provider Type	AmeriHealth	Healthy Blue	CCH	United	WellCare
Ambulatory Health Care Facilities	636	1,102	731	857	845
Behavioral Health & Social Service Providers	4,772	8,373	5,786	3,402	4,266

Beneficiaries Per AMH Tier

The Department developed the AMH model as the primary vehicle for care coordination in NC Medicaid Managed Care. 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

	Not Enrolled	AmeriHealth	CCH	Healthy Blue	United	WellCare	Total
No PCP Tier	313	4,118	3,462	7,568	5,851	3,918	25,230
Tier 1		1,879	2,259	8,218	3,446	3,142	18,944
Tier 2	3	43,206	34,229	71,794	66,152	55,299	270,683
Tier 3	12	254,875	176,807	343,639	287,798	288,320	1,351,451
							1,666,308

Member Proportion by PHP and AMH Tier

	Not Enrolled	AmeriHealth	CCH	Healthy Blue	United	WellCare	Total
No PCP Tier	95.43%	1.35%	1.60%	1.76%	1.61%	1.12%	1.51%
Tier 1		0.62%	1.04%	1.91%	0.95%	0.90%	1.14%
Tier 2	0.91%	14.21%	15.79%	16.65%	18.21%	15.77%	16.24%
Tier 3	3.66%	83.82%	81.57%	79.69%	79.23%	82.22%	81.10%

AMH Provider Enrollment

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

	AmeriHealth	Healthy Blue	CCH**	United	WellCare
Tier 1	21.53%	54.01%	50.40%	45.99%	36.86%
Tier 2	35.43%	84.54%	65.07%	63.82%	54.55%
Tier 3	82.32%	80.75%	90.56%	85.11%	87.05%

*Providers that are not contracted at the State-designated AMH tier are not included in these counts.

**CCH is only required to contract with providers in regions 3, 4 and 5. CCH's denominator only includes AMHs located in these three regions.

Care Management Penetration Rate

These data represent members enrolled in Standard Plans who are receiving care management through a PHP, AMH, the Care Management for At-Risk Children (CMARC) program, or the Care Management for High-Risk Pregnancies (CMHRP) program from July through October of 2021. Care management provided through a PHP or AMH is reported by PHPs on the BCM051 operational report. Care management provided for CMARC/CMHRP by local health departments is reported by Community Care of North Carolina (CCNC).

CMHRP is the State's primary vehicle for delivering 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 zero to five.

Care Management Penetration Rate

	PHP	AMH	CMARC	CMHRP	Overall
% of Total Members	2.4%	3.6%	0.6%	0.8%	6.3%
CM Distinct Member Count	41,774	60,890	10,125	13,181	106,616

Emergency Department Visits per 1,000 Members and Inpatient Admissions per 1,000 Members

Emergency department visits per 1,000 members and inpatient admissions per 1,000 members are measured for the adult NC Medicaid population (age 21 and older) and broken out by PHP and NC Medicaid Direct. The rates below are an average of the monthly rates for August to October. Claims denied because they were erroneously billed to NC Medicaid Direct instead of a PHP were excluded from measurement calculations to avoid duplication.

Emergency Department Visits per 1,000 Members, August – October

AmeriHealth	CCH	Healthy Blue	Medicaid Direct*	United	WellCare
92.91	93.49	89.39	68.21	92.28	94.95

*For Medicaid Direct, the calculation includes members who do not have access to hospital coverage

Inpatient Admissions per 1,000 Members, August – October

AmeriHealth	CCH	Healthy Blue	Medicaid Direct*	United	WellCare
25.72	20.03	20.36	18.41	22.07	23.56

*For Medicaid Direct, the calculation includes members who do not have access to hospital coverage

Results of beneficiary satisfaction surveys

North Carolina conducts an annual CAHPS® Health Plan Survey for the NC Medicaid population. For calendar year 2021, the adult survey found that 85.3% of respondents reported being able to get the care they needed and 82.7% reported being able to get the care they needed quickly. The child survey found that 87.3% of respondents reported being able to receive the care they need and 89.6% reported being able to get needed care quickly. Satisfaction for respondents who received at least some services through telemedicine did not vary significantly from those who only received in-person services.

The Department intends to oversample extensively in its upcoming CAHPS implementation with sample size not to exceed 63,165 sampled members. Strata will include the five participating PHPs, the tribal option population, the NC Medicaid Direct population, beneficiaries who will be eligible for Tailored Plans, and Standard Plan members receiving behavioral health services. This will be the first opportunity to compare results across NC Medicaid Direct and NC Medicaid Managed Care. The survey will be fielded from February 4 to April 29, 2022, with results available in July 2022.

Grievances and appeals

No metrics to report in this category for the reporting period.

Budget Neutrality and Financial Reporting Requirements

In the budget neutrality workbook due to CMS on Dec. 31, 2021, the Department submitted budget neutrality information through Sept. 30, 2021. This reflected the most recent information available based on quarterly CMS-64s. North Carolina appears to be within budget neutrality limits for the demonstration.

Evaluation Activities and Interim Findings

The DY3Q4 reporting period activities have both continued the mixed methods work by the Sheps Center team as well as involved a significant pivot in quantitative encounter data following the launch of the Standard Plans on July 1, 2021. The evaluation uses a mixed-methods approach, combining analysis of administrative data with qualitative data to obtain detailed insights into the transformation that are

not easily captured through claims and surveys; for example, how providers are preparing for the transformation and what can be done to improve their satisfaction with the Medicaid program. The evaluation activities conducted by the Sheps Center during this period are described below.

Transition to Capitated Encounter Data from Standard Plans

Sheps Center data scientists and analysts have been working closely with NC DHHS personnel to incorporate the substantially transformed data sources into the evaluation workflow. Utilization of services by Medicaid beneficiaries who were enrolled in Standard Plans is now packaged into encounter data rather than traditional claims data when it arrives at DHB, and the data has continued to be quickly made available to the Sheps Center team. The Sheps Center has begun the process of incorporating the different file formats and newly created variables into our analytic structure and is carefully monitoring the quality and usability of the encounter data as it arrives.

Quantitative Update

The quantitative team continues to onboard new metrics that will be tracked during the evaluation period, drawing metrics from both established custodians consistent with the NC Medicaid Quality Strategy, many Adult and Child Core measures, and other metrics that will address the study hypotheses. Sheps continues to evaluate the use of Marketplace enrollees from a NC-based insurer as a potential comparison group for the difference-in-differences analysis through the comparison in trends in seven identified measures.

Qualitative Update

The qualitative team has completed coding and preliminary analysis of provider and practice interviews via Dedoose, identifying key themes across interviews. Initial findings of this qualitative analysis were presented to all qualitative team members during the week of November 15 for further discussion and review. Based on this discussion, the qualitative team outlined potential paper topics to guide more targeted analysis. In addition, the qualitative team conducted outreach to NC DHHS employees and representatives of the PHPs to gather their perspectives. Separate interview guides and email outreach language were developed and submitted for IRB approval for each of these groups. Based on this outreach, the qualitative team scheduled and completed interviews with five NC DHHS employees and six representatives from each of the five PHPs (AmeriHealth Caritas, Healthy Blue of North Carolina, UnitedHealthcare of North Carolina, WellCare of North Carolina and Carolina Complete Health). These interviews were transcribed and uploaded to Dedoose. A first draft of the codebooks for each of the two interview guides has been developed and will undergo review and refinement before being uploaded to the coding software. Once each codebook is finalized, NC DHHS and PHP interviews will be coded to identity themes across interviews, as well as to further inform findings from the provider and practice interview analysis.

Enhanced Case Management (ECM) and Other Services Pilot Program

Operational Updates

Introduction

The Department continued preparing for the Spring 2022 launch of the Healthy Opportunities Pilots. Specifically, the Department continued working with Healthy Opportunities Network Leads by holding regular engagement sessions, releasing model contracts to facilitate Network Lead contracting with PHPs and HSOs, and overseeing the Network Leads' HSO application process. The second issuance of capacity building funds was provided to Network Leads in September 2021. Additionally, the Department executed key technology contracts to begin development of Pilot-specific functionality in NCCARE360 and began implementation activities with the PHPs, Network Leads, and CINs.

Key achievements and to what conditions and efforts successes can be attributed

Network Lead Award and Engagement

The Department continued holding weekly individual and group engagement activities with each of the Healthy Opportunities Network Leads to provide training, share learnings, and track implementation progress. The Network Leads submitted several deliverables this period, including their HSO Network Applications (by which HSOs would apply to be in Pilot networks), HSO Assessment Processes (by which Network Leads would select HSOs), HSO Provider Manuals, Training and Technical Assistance Plans, and Capacity Building Funding Distribution Approaches (through which Network Leads would distribute at least half of their capacity building funds to their HSOs). Network Leads began establishing their HSO networks by accepting and reviewing applications from HSOs within their Pilot region. The Department distributed a second issuance of capacity building funds to Network Leads on Sept. 21, 2021.

Importantly, the Department worked with stakeholders over a series of months to develop, and in September 2021 distribute, a set of model contracts to govern the responsibilities and relationships between Networks Leads, PHPs and HSOs. Network Leads will use one model contract to contract with each PHP and one model contract to contract with each HSO in its network. The Department found significant value in developing these standardized contracts to define clear roles and responsibilities, streamline contracting and reduce burden on Network Leads and HSOs and maintain clear oversight while not over-medicalizing HSOs.

Health Plan and Clinically Integrated Network (CIN) Engagement

The Department began implementation engagement sessions with the PHPs in this reporting period to review program requirements and solicit feedback related to each technical and business process implementation activity that the PHPs are required to complete by Pilot launch. PHP feedback was used to align on the scope and completion timeframe of each implementation activity, to ensure a collaborative and positive working relationship is maintained between the Department and PHPs regarding the Healthy Opportunities Pilots efforts. The Department met regularly with PHPs to track implementation progress and developed a set of operational protocols, technology companion guides and reporting templates for the plans.

The Department also began engaging with key CINs in Pilot regions that provide care management to Medicaid members to overview Pilot care management responsibilities and solicit feedback from the CINs.

Technology Development

The Department made significant progress on technology development for the Pilots in Quarter 4. Specifically, the Department executed contracts with key NCCARE360 vendors (Unite Us and the Foundation for Health Leadership and Innovation) to cover NCCARE360 licenses and develop additional functionality in NCCARE360 to support the Pilots. The Department and Unite Us reviewed business and technology requirements through working sessions spanning the duration of the quarter to determine Base Pilot Functionality, or core functionality that will be ready at Pilot launch. As a result of these working sessions, the Department and Unite Us executed a contract to finalize these requirements and in October, Unite Us began developing Base Pilot Functionality and demonstrating key functionality to the Department. Additional working sessions with the Department and Unite Us are planned in the next reporting period to finalize requirements that will enhance technical capabilities and the overall user experience for the entities participating in the Pilot. These enhancements will be part of an Advanced Pilot Functionality, which will be deployed in a later release after Pilot launch.

Additionally, the Department worked with its MMIS vendor this quarter to continue developing technology to support the Pilots in NC's MMIS. Specifically, the Department developed functionality for HSOs to enroll as Medicaid providers in the MMIS, which went live in September 2021. The Department created and defined two new taxonomy codes for individuals and organizations to enroll as HSOs, and worked on training curriculums tailored to HSOs, most of which are not familiar with enrolling as a Medicaid provider. The Department also worked with its MMIS vendor in Quarter 4 to develop affiliations in the MMIS for PHP-Network Lead and Network Lead-HSO affiliations.

Key challenges, underlying causes of challenges, and how challenges are being addressed

Key challenges for the Healthy Opportunities Pilot program during this period included finalizing the technical approach, business and technical requirements, and related vendor contracts necessary for a Pilot launch date in February 2022. The Department continued to work toward a February 2022 Pilot service delivery launch date by focusing on adopting the core, necessary infrastructure to stand up the Pilot in February, with the intent to enhance functionality, HSO networks, and service array in the months following Pilot launch. This approach allowed the team to leverage existing processes and technical functions and minimize technology changes and associated timeframes for development and testing. Additionally, Network Leads planned to launch services in February with HSOs that volunteered to start first, adding additional HSOs to their networks over time as they built capacity.

The Department, however, continued to hear concerns from partners that a February launch date may not yield a successful launch. PHPs were concerned with the short timeline to build necessary technical solutions, the manual processes that would be required to process Pilot invoices rather than standard claim formats, and an increased care management workload resulting from the Pilot launch. CINs were concerned that they may not be able to onboard onto NCCARE360 and train care management staff sufficiently for launch. Network Leads were concerned that HSOs would need more time to practice invoicing through NCCARE360 and that Network Leads would have sufficient staff to process invoices.

As a result of these conversations with partners, the Department decided to shift to the following phased Pilot launch approach, which was communicated in December 2022:

- **Feb. 1, 2022: Engagement and NCCARE360 Functionality**
  - Newly developed "Base Pilot Functionality" in NCCARE360 available. Pilot-participating entities (PHPs, CINs, Network Leads, HSOs) will have access to an NCCARE360 training environment.
  - Additional time for engagement between PHPs and Network Leads/HSOs
- **March 15, 2022: Launch food services and three CINs**
  - Launch delivery of food services
  - Medicaid members to be assessed for Pilot eligibility and enrolled into Pilots through the three CINs that provide care management for the majority of Medicaid-covered lives in Pilot regions
- **May 1, 2022: Launch housing and transportation services and additional CINs**
  - Launch delivery of housing and transportation services
  - Medicaid members to be assessed for Pilot eligibility and enrolled into Pilots through additional interested CINs and Tier 3 AMHs
- **June 15, 2022: Launch toxic stress and cross-domain services**
  - Launch delivery of toxic stress and cross-domain services. Due to legal and technical challenges, interpersonal violence and certain cross-domain services may not yet be available
  - Medicaid members to be assessed for Pilot eligibility and enrolled into Pilots through Standard Plans, in addition to CINs and Tier 3 AMHs

The Department is also exploring a technical solution to translate Pilot invoices into a standard claim format.

Additionally, the Department continues to monitor the establishment of Network Leads' HSO networks. Pilot regions consist of mostly rural counties where HSOs may be limited. The Department, Network Leads and PHPs are exploring ways to ensure that enough Medicaid members are enrolled in the Pilots to support a meaningful evaluation. Options under early consideration are for PHPs to expand member outreach and engagement of Pilot services, and potentially for Network Leads to expand their Pilot geographies in later Pilot years.

Finally, the Department is facing challenges with determining how to include interpersonal violence services in the Pilot. Federal laws such as the Violence Against Women Act, Victims of Crime Act, and Family Violence Prevention and Services Act rightfully restrict the sharing a violence survivor's personal data to protect their safety. However, the Healthy Opportunities Pilots evaluation relies on linking a member's personal data of Pilot services received to health care utilization and outcomes. Additionally, since Pilot services operate essentially as temporary Medicaid benefits, a PHP must know if a member is covered by their plan to reimburse for the service. As a result, the Department regularly engaged this quarter with the NC Coalition Against Domestic Violence and Legal Aid on how to modify Pilot processes to allow the incorporation of interpersonal violence and other sensitive services. The group collectively worked to identify key issues, align on workflows and discuss potential solutions.

Issues or complaints identified by beneficiaries

No issues or complaints identified by beneficiaries for this reporting quarter.

Lawsuits or legal actions

Three entities that were not awarded a contract to be a Network Lead submitted formal protests of the award in July. Two of these protests were dropped and one entity elected to move forward with legal action.

Unusual or unanticipated trends

No unusual or unanticipated trends during this reporting quarter.

Legislative updates

No legislative updates during this reporting quarter.

Descriptions of post-award public fora

No post-award public fora this reporting quarter.

Performance Metrics

No performance metrics to report for the Pilots this reporting quarter as service delivery has not launched yet.

Incentive Payments to PHPs, NLs, and Pilot providers

No incentive payments to report for the Pilots this reporting quarter.

ECM Capacity Building

The second issuance of capacity building funds for the May 27, 2021–May 26, 2022 budget period was provided to Network Leads on Sept. 21, 2021. The Department permitted Network Leads to request up to $10 million in capacity building funds for the May 27, 2021–May 26, 2022 budget period and up to $10 million for the May 27, 2022–May 26, 2023 budget period. Network Leads must disburse at least 51% of their capacity building funds to HSOs in their Pilot network.

Additionally, the Department permitted Network Leads to invoice up to 25% of their annual capacity building budget in their second invoice. Each Network Lead requested 25% of their annual budget. The amounts and breakdown of the second capacity building invoices are:

Access East: $1,350,247.00

Description of Expense	Category of Network Lead Allowable Use	Category of HSO Allowable Use	Amount
System Development, Implementation/Network Integration and Assessment	Purchases for Functional Systems	N/A	$285,918
Program and General Supplies	Administrative Overhead costs	N/A	$30,000
Staff Training and Education	Staff Time: Developing a Network of HSOs	N/A	$2,000
Education Events/Outreach Activities	Marketing and Outreach Material	N/A	$1,540
Stakeholder Engagement	Marketing and Outreach Material	N/A	$22,500
Marketing	Marketing and Outreach Material	N/A	$27,000
Travel: Network development & on-site HSO	Staff Time: Developing a Network of HSOs	N/A	$62,640
HSO assessments (subcontract)	Staff Time: Developing a Network of HSOs	N/A	$105,000
HSO Staff Training & Education	Staff Time: Providing TA/Training to HSOs	N/A	$11,475
HSO Travel	Other Use Approved by the Department	N/A	$19,720
Board Training	Administrative Overhead costs	N/A	$5,000
Learning Community Meetings	Marketing and Outreach Material	N/A	$81,000
Shared Services: Legal, HR, Financial Services	Administrative Overhead costs	N/A	$78,905
LPE Travel	Administrative Overhead costs	N/A	$52,200
HSO - System Implementation & Integration	Administrative Overhead costs	N/A	$317,190
HSO - Program Manager/Staff	Staff Time: Developing Infrastructure/Systems	N/A	$248,159

Community Care of the Lower Cape Fear: $2,500,000.00

Description of Expense	Category of Network Lead Allowable Use	Category of HSO Allowable Use	Amount
Executive Director (.25 FTE)	Staff Time: Establishing the LPE	N/A	$13,720
Healthy Opportunities Program Director	Staff Time: Establishing the LPE	N/A	$37,928
4 Care Council County Leads	Staff Time: Establishing the LPE	N/A	$92,348
Health Opportunities QI Coordinator	Staff Time: Establishing the LPE	N/A	$26,385
Compliance Manager	Staff Time: Establishing the LPE	N/A	$23,087
4 Program Managers (Cape Fear Collective)	Staff Time: Establishing the LPE	N/A	$98,944
Data Scientist/Salesforce System Administrator (Cape Fear Collective)	Staff Time: Establishing the LPE	N/A	$18,964
Implementation Team Consultants (.2 FTE from Novant)	Staff Time: Establishing the LPE	N/A	$17,847
Accountant/Claims Processor	Staff Time: Establishing the LPE	N/A	$19,789
Recruiting	Staff Time: Establishing the LPE	N/A	$1,625
Office space/rent	Administrative Overhead costs	N/A	$14,625
Office supplies	Administrative Overhead costs	N/A	$3,250
Marketing and outreach material	Marketing and Outreach Material	N/A	$13,125
Travel	Staff Time: Establishing the LPE	N/A	$9,750
Training and development	Staff Time: Establishing the LPE	N/A	$4,875
Accounting and financial reporting (audit & tax)	Staff Time: Reporting	N/A	$5,000
Software (exclude invoicing systems)	Purchases for Functional Systems	N/A	$1,625

Description of Expense	Category of Network Lead Allowable Use	Category of HSO Allowable Use	Amount
Computer equipment	Purchases for Functional Systems	N/A	$6,500
IT management (employee equipment)	Purchases for Functional Systems	N/A	$4,063
Legal services	Other Use Approved by the Department	N/A	$12,500
Meetings, Facilitation & Travel	Staff Time: Establishing the LPE	N/A	$50,000
Liability Insurance	Administrative Overhead costs	N/A	$5,500
Communication	Administrative Overhead costs	N/A	$4,875
Payroll service	Administrative Overhead costs	N/A	$1,625
Salesforce (not all will be in-kind)	Purchases for Functional Systems	N/A	$3,250
Cultural Competency Training (UNC-W)	Staff Time: Establishing the LPE	N/A	$25,000
Teambuilding, coaching and facilitation	Staff Time: Establishing the LPE	N/A	$8,125
Collaboration & & Teambuilding	Staff Time: Establishing the LPE	N/A	$16,250
External Board Members	Staff Time: Establishing the LPE	N/A	$1,000
Human Resource Administration (by CCLCF)	Staff Time: Establishing the LPE	N/A	$5,688
Office Management Services (by CCLCF)	Staff Time: Establishing the LPE	N/A	$4,063
CFO Services (by CCLCF)	Staff Time: Establishing the LPE	N/A	$18,750
CRM/Cultural Competency Training (by CCLCF)	Staff Time: Establishing the LPE	N/A	$5,688
Other LPE Expenses	N/A	N/A	$(763)
HSO Funding	N/A	N/A	$1,925,000

Dogwood Health Trust (Impact Health): $2,491,377.00

Description of Expense	Category of LPE Allowable Use	Category of HSO Allowable Use	Amount
Lead Pilot entity establishment	Staff Time: Establishing the LPE	N/A	$407,958
Lead Pilot entity establishment	Administrative Overhead costs	N/A	$146,450
Lead Pilot entity establishment	Administrative Overhead costs	N/A	$45,511
HSO network development	Staff Time: Developing a Network of HSOs	N/A	$22,255
Infrastructure/IT system development	Staff Time: Developing Infrastructure/Systems	N/A	$9,680
HSO technical assistance and training	Staff Time: Providing TA/Training to HSOs	N/A	$114,021
HSO capacity building funding distribution	N/A	Other Use Approved by the Department	$1,673,000
Governance and cross-entity collaboration	Staff Time: Facilitating Collaboration and Governance	N/A	$46,250
Program administration, evaluation and oversight	Administrative Overhead costs	N/A	$22,500
Community engagement	Staff Time: Participating in Community Engagement	N/A	$3,750

Healthy Opportunities Pilots Evaluation Activities and Interim Findings

No Pilot services were delivered during this period, which limited evaluation activities to preparation.

In the last quarter, the Pilot evaluation team has been involved in large project weekly meetings aimed at resolving issues, making decisions involving project set-up, and working with entities to set up data collection contracts. Dr. Berkowitz and Dr. Ricks attend monthly meetings with DHHS, and Dr. Ricks attends weekly meetings with network leads to keep abreast of new changes, Network Lead questions, and how HSO selection and other preparations for service delivery are progressing.

During this period, evaluation consisted of two main activities. The first was providing technical assistance to the Department regarding planning for evaluation once Pilot services begin. For example, to appropriately comply with the Violence Against Women and Victims of Crime Acts, there have been ongoing meetings with stakeholder groups around data availability and collection for members who will receive services for interpersonal violence. The second set of evaluation activities has focused on preparing for primary data collection for Pilot service delivery. Activities have included obtaining IRB

approval for interviews and surveys with Network Lead and HSO staff members, and development of an interview guide and survey for data collection. The evaluators are well-positioned to evaluate the delivery of Pilot services once they launch.

Residential and Inpatient Treatment for Individuals with a Substance Use Disorder

The Department will provide detailed information in the Substance Use Disorder annual submission that is due to CMS Feb. 28, 2022.