Medicaid Section 1115 Monitoring Report

North Carolina - North Carolina Medicaid Reform Demonstration

DY4Q3 – May 1, 2021 through July 31, 2022

Submitted on Sep. 29, 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).*

Contents

DEMONSTRATION YEAR 4 QUARTER 3 REPORT

Executive Summary

This quarterly report covers Demonstration Year 4, Quarter 3 (DY4Q3) of the North Carolina Medicaid Reform Demonstration, May 1, 2022, through July 31, 2022.

This quarter, the Department marked one year since Standard Plans, the first phase of NC Medicaid Managed Care, became operational. On July 1, 2021, North Carolina transferred 1.6 million Medicaid beneficiaries from NC Medicaid Direct (fee-for-service Medicaid) to five Prepaid Health Plans (PHPs): AmeriHealth Caritas, Healthy Blue of North Carolina, UnitedHealthcare of North Carolina, WellCare of North Carolina and Carolina Complete Health.

The Department continues to monitor Standard Plan performance closely and address issues through formal notification, corrective action plans, and the assessment of liquidated damages, when applicable. In this quarter, the Department monitored Standard Plan performance related to non-emergency medical transportation (NEMT), provider network file discrepancies, network adequacy, and call center performance.

The Department continues to prepare for the launch of the Behavioral Health I/DD Tailored Plans (Tailored Plans) on Dec. 1, 2022. Tailored Plan operational readiness reviews began March 17, 2022. The Department began the onsite portion of the readiness review process with Tailored Plans in July. Representatives from each business and technology area across the Department were hosted by Tailored Plans at their home office locations to provide an overview of their implementation progress, participate in interviews with Department representatives and provide live system demonstrations. On June 15, 2022, Tailored Plan member and provider service lines went live, and the Tailored Plans began marketing activities.

Pharmacy Point of Sale (POS) claims for members enrolled in Tailored Plans will be temporarily managed by NCTracks when the plans launch on Dec. 1, 2022, through March 31, 2023. Beginning on April 1, 2023, these claims will be managed by the Tailored Plans. This change was made as a result of a key pharmacy benefit manager (PBM) unexpectedly leaving the NC Medicaid market in late 2021, which required some Tailored Plans to procure another PBM. There will be no impact to members' pharmacy benefits during this transition period.

Effective June 15, 2022, three new Healthy Opportunities Pilots services are available to qualified members to address toxic stress and multiple non-medical needs: evidenced-based parenting classes, home visiting services, and medical respite. The Department continues to prepare to launch Healthy Opportunities Pilots services with the Tailored Plans in 2023.

Medicaid Managed Care

Operational Updates

The Department continues to monitor Standard Plan performance closely and to address identified issues through formal notification, corrective action plans, and the assessment of liquidated damages, if applicable. In this quarter, the Department monitored Standard Plan performance related to non-

emergency medical transportation (NEMT), provider network file discrepancies, network adequacy, and call center performance.

Tailored Plan operational readiness reviews officially kicked off March 17, 2022. The Department began the onsite portion of readiness review process with Tailored Plans in July. Representatives from each business and technology area across the Department were hosted by Tailored Plans at their home office locations to provide an overview of their implementation progress, participate in interviews with Department representatives and provide live system demonstrations.

The Department onboarded the Tailored Plans into the Medicaid Help Center and TechOps processes to resolve business and technology related issues leading up to launch. The Medicaid Help Center process enables the Department to address business-related issues and questions from providers, members and stakeholders across all vendors. The Tailored Plans now participate in weekly status calls regarding cases submitted to the Medicaid Help Center that require their action to resolve. Similarly, the TechOps process enables the Department to address technology operations issues self-reported from stakeholders and vendors involved in technology processes critical to NC Medicaid Managed Care operations. The Tailored Plans participate in four TechOps status calls per week with the Department and other vendors to address production technology issues. Tailored Plans also attend ad hoc discussions to resolve high priority issues that require escalation and immediate attention.

The Department decided that pharmacy point of sale (POS) claims for members enrolled in Tailored Plans will be temporarily managed by NCTracks when the plans launch on Dec. 1, 2022, through March 31, 2023. Beginning on April 1, 2023, these claims will be managed by the Tailored Plans. This change was made because a key pharmacy benefit manager (PBM) unexpectedly leaving the NC Medicaid market in late 2021, which required some Tailored Plans to procure another PBM.

There will be no impact to members' pharmacy benefits during this transition period. From Dec. 1, 2022, through March 31, 2023, member identification cards will not include pharmacy information. New cards will be issued for April 1, 2023, with the new RxBin and PCN numbers for the Tailored Plans. The Department will reach out to members, pharmacists and providers in the coming months with additional information about the transition.

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

Standard Plans

1. The Advanced Medical Home (AMH) Technical Advisory Group continues to advise and inform the Department on key aspects of the design and evaluation of the AMH program. At its June meeting, the Data Subcommittee discussed the impact of and potential solutions for three priority data issues: beneficiary assignment, Clinically Integrated Network (CIN)-AMH relationship tracking, and the patient risk list.
2. The North Carolina Integrated Care for Kids (NC InCK) program aims to improve quality of care and reduce expenditures for children under age 21 covered by NC Medicaid through prevention, early identification, and treatment of behavioral and physical health needs. While the program is distinct from the 1115 waiver, beneficiaries in NC InCK are included in the transition to NC Medicaid Managed Care. The InCK Team has provided feedback on provider contract amendments from all Standard Plans regarding alternative payment model (APM)

implementation. The InCK team delivered finalized data specification documentation for the InCK APM reports to Standard Plans and CINs, and APM implementation is expected to begin in November.

Tailored Plans

1. Following the start of operational readiness reviews in March, the Department continued reviewing responses and documentary evidence on the desktop review tools that were shared with the Tailored Plans. The Desktop Review tools have gone through three review and response iterations between the Department and the Tailored Plans, and only a small number of issues remain open.
2. The Department began the onsite portion of the readiness review process with Tailored Plans in July. Representatives from each business and technology area across the Department were hosted by Tailored Plans at their home office locations to provide an overview of their implementation progress, participate in interviews with Department representatives and provide live system demonstrations.
3. The Department shared finalized operational report templates and an operational report guide with Tailored Plans. The Department's analytics team drove an effort across all business units to review and standardize the operational reporting templates prior to sharing with Tailored Plans. Tailored Plans will use the operational report guide as a reference document to understand first submission dates and processes for operational reports required as part of the Tailored Plan contract.
4. The Department has met with all Tailored Plans on amendment item language to be included in the first amendment to the Tailored Plan contract. The final draft amendment is currently under review with the Department's contracts and legal teams and is anticipated for execution during Quarter 4.
5. All Round 1 and Round 2 Advanced Medical Home Plus (AMH+) practices/Care Management Agencies (CMAs) candidates have completed certification, and readiness reviews are scheduled in August and September. A Provider Readiness Review Q&A session was held in July, and a second session will be held in August to prepare providers for the reviews. These organizations will be one vehicle through which Tailored Plan members receive comprehensive care management support, in addition to the Tailored Plans. All Tailored Plan members will be offered choice of a Tailored Care Management entity (plan or provider-based), and members will be assigned to an entity if one is not selected. Federal authority for the AMH+/CMA program is expected to come from a Medicaid Health Home SPA, which was submitted in September.

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

Standard Plans

1. The Enrollment Broker is experiencing call center staffing shortages and high attrition rates that reflect broader trends in the call center industry. To mitigate the issue, the Enrollment Broker is

increasing hiring class sizes and holding weekly meetings with the Department until the issue is resolved.

2. In February 2022, the Department published a review of the Standard Plans' networks for compliance across all network adequacy standards and with all state and federal laws and regulations. All five Standard Plans had gaps in compliance, resulting in the issuance of corrective action plans (CAPs). In this quarter, the Department monitored plans' progress under the CAPs and expects to close the CAPs and complete the annual review process in the next quarter.
3. The Department's pharmacy team identified that two of the five Standard Plans did not meet the preferred drug list (PDL) compliance benchmark of 95% during the first three quarters of State Fiscal Year 2022. The Department is preparing submissions for liquidated damages for both plans.

Tailored Plans

1. Provider network coverage is an area of risk across all Tailored Plans. Since the Tailored Plans started reporting monthly on provider contracting in early May, results have not met network adequacy standards across the provider categories. This could result in a lack of providers for PCP auto-assignment beginning in October. The Department is mitigating this risk through close tracking of provider contracting data in the Tailored Plan Weekly Scorecards, one-on-one calls with the Tailored Plans and by working through our provider engagement and communications teams to clarify the process for providers contracting with Tailored Plans.
2. Providers in the Tailored Care Management certification process have been slow to complete more advanced levels of the certification progress. A low number of certified Tailored Care Management providers could create less capacity in provider-based care management than the current NC Medicaid and Tailored Plan target. The Department continues to provide coaching support to potential Tailored Care Management providers and has also published a second roll-out timeline of Feb. 1, 2023, to launch the service if providers are not ready for a Dec. 1, 2022 launch. Members can still receive Tailored Care Management from their Tailored Plan, so all members will have a source of Tailored Care Management at launch.
3. Tailored Plans are developing new claims processing engines to handle physical and behavioral health claims, as Tailored Plans, functioning as LME/MCOs, previously only handled behavioral health claims. The Department established a Tailored Plan claims processing mitigation strategy to prepare Tailored Plans for launch, including comparative claims testing entry criteria, comparative claims testing, provider claims testing entry criteria, provider claims testing, copay exemption documentation initiative, weekly calls with Tailored Plans for claims special topics and a covered code initiative.
4. End-to-end testing for Tailored Plans started in May and has trended behind schedule throughout this quarter for both the Auto-Enrollment and Plan Launch milestones. This is largely due to long turnaround times in the defect resolution process for Tailored Plans and a delay in

obtaining Privacy Security Officer (PSO) documentation sign-off for the five technology vendors who are supporting the Tailored Care Management providers. The End-to-End team meets with the Tailored Plans weekly and escalates plan-specific challenges through biweekly calls with Tailored Plans' executive leadership teams. The Department is working with the providers and vendors participating in End-to-End testing and the PSO to obtain the correct documentation and has been able to get approval for three of the five providers and their technology partners.

Milestones

1. On July 1, 2022, the Department reached one year since the launch of NC Medicaid Managed Care with the Standard Plans.
2. The Tailored Plan member and provider service lines went live on June 15, 2022.
3. The Tailored Plans began marketing activities on June 15, 2022.

Issues or complaints identified by beneficiaries

The Department receives beneficiary complaints primarily from the Office of Compliance and Program Integrity, 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.

In DY4Q3, the Ombudsman handled 4,293 cases, an increase of approximately 29% from last quarter. Many calls involved educating beneficiaries or connecting them to the entity that could provide the service they need. (See Appendix A for a full list of cases by category type.) This quarter, the Office of Administration received 13 complaints, compared to 33 last quarter. There were no complaints reported to the Office of Compliance and Program Integrity.

NC Medicaid Member Ombudsman Cases

May 2022		June 2022		July 2022		Total Cases
Information	Issue Resolution	Information	Issue Resolution	Information	Issue Resolution	
518	879	522	1,033	364	977	**4,293**

Office of Administration Member/Constituent Concerns, May 2022 – July 2022

Issue Category	Number of Issues
Beneficiary/Member Eligibility	2
Clinical Policy	2
Electronic Visit Verification	3
Non-Emergency Medical Transportation (NEMT)	3
Provider Operations	3
TOTAL	**13**

Lawsuits or legal actions

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

Unusual or unanticipated trends

There are no unusual or unanticipated trends to report this quarter.

Legislative updates

The 2022 Short Session began May 18, 2022. The General Assembly has paused most activity but has not yet adjourned. During this reporting period the following legislation impacting managed care implementation was enacted.

S.L. 2022-46, enacted July 7, 2022, makes various changes and clarification to insurance laws:

- § 5 requires a PHP's solvency plans to allow continuation of health care services until the PHP's contract is terminated, and enrollees are transitioned to another PHP in the event of insolvency.

S.L. 2022-74, enacted July 11, 2022, adjusts base budget appropriations for the 2021-2023 biennium and enacts new programmatic, administrative and operational requirements for NC Medicaid:

- § 9D.4 authorizes NCDHHS to seek authority to extend Medicaid coverage of health care services that qualify for 100% FMAP when provided by an Indian Health Service provider or Eastern Band of Cherokee Indian facility to individuals with no other form of health coverage.
- § 9D.7 requires implementation of Tailored Plans by Dec. 1, 2022, and the initial contract to end on Dec. 1, 2026. It requires that Tailored Plans receive the equivalent extension of the contract that a PHP offering Standard Plan services may receive.
- § 9D.8 clarifies that the PHPs must reimburse ingredient costs and dispensing fees at 100% of the State Plan rate for pharmacy reimbursements. Establishes NADAC as primary method to

calculate retail pharmacy reimbursement for non 340B drugs. This provision is in effect retroactively to Nov. 11, 2021, and expires June 30, 2026.

- § 9D.9 allows the agency until Dec. 31, 2022, to develop a new service and reimbursement rate to have LME/MCOs pay for emergency department bed holds.
- § 9D.13 (a) authorizes payment in fee-for-service for point-of-sale prescription drugs for Medicaid beneficiaries enrolled in a Tailored Plan for up to six months after launch. Requires Tailored Plans to cover prescription drugs submitted as medical outpatient professional claims through the Physician Administered Drug Program; (b) waives statutory solvency requirements for LME/MCOs with a Tailored Plan contract until Dec. 31, 2023, and replaces them with contractual solvency and capital reserve requirements; (c) requires LME/MCOs to include essential providers with respect to behavioral health, IDD, and TBI services in their closed network; (d) until Dec. 1, 2023, requires dissolution of an LME/MCO whose Tailored Plan contract is terminated and requires DHHS to submit a report on actions to be taken upon termination of any contract and LME/MCO holds.
- § 9G.6 grants primary care case management entities access to client-specific immunization information in the NC Immunization Registry.

Descriptions of post-award public fora

No public fora this 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

The Department plans to report three outcome measures in its monitoring reports: Comprehensive Diabetes Care, Low Birth Weight, and Rating of Personal Doctor. Currently, only Rating of Personal Doctor results are available.

The Low Birth Weight Measure is a modified version of the Live Births Weighing <2,500 grams measure (NQF #1382), and was developed to assess, monitor, and support PHP efforts in North Carolina. 2020 Low Birth Weight rates will be available in October 2022, and 2021 rates are expected at the end of 2022. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) rates are not available yet, as the Department does not receive A1c values via claims and encounters. The Department is working to obtain accurate A1c data through the NC Health Information Exchange in order to report this measure.

CAHPS measures do not reflect a full calendar year, as the survey was administered April 9, 2021, to August 15, 2021. Members were asked to think about services received *in the past 6 months* when answering survey questions. At the time of survey administration, almost all respondents' health plans would be NC Medicaid Direct. For many individuals who responded to the survey between July 1, 2021,

and August 15, 2021, their current health plan would have been a Standard Plan, but most of their experience in the past six months would still have been while they were enrolled in NC Medicaid Direct.

Measure/Measure Steward	Description	2019	2020	2021
Rating of Personal Doctor/CAHPS	Percentage of respondents who rated their personal doctor as an 8 or above (on a scale of 1-10)	83.2%	NA*	86.3%
	Percentage of respondents who rated their child's doctor as an 8 or above (on a scale of 1-10)	93.69%	NA*	91.15%

*CAHPS was not conducted during 2020 due to the Public Health Emergency

Quality of care

North Carolina measurement year 2021 quality measure results became available in July 2022. Because NC Medicaid Managed Care launched July 1, 2021, quality measure results for 2021 represent the last six months of fee-for-service and the first six months of managed care for North Carolina's Standard Plan population. All quality measures reflect the calendar year, except for CAHPS measures.

The Department continues to work on statewide performance improvement projects related to increasing Immunizations in Children, Early Access to Prenatal Care, Postpartum Care and Diabetes Control for Adults.

Measure/Measure Steward	Description	2019	2020	2021
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%
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%
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%

Measure/Measure Steward	Description	2019	2020	2021
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%
Well-child visits in the first 30 months of life (W30)/ NCQA[2]	Percent of children who received six or more well-child visits in the first 15 months	NA	62.3%	62.1%
	Percent with two or more well-child visits from 15 to 30 months	NA	70.8%	66.4%
Total Eligibles Receiving at Least One Initial or Periodic Screening/ NCDHHS	Rate of preventive dental service use by children and adolescents in NC. Higher rates are better on this measure.	53%	44.5%	NA
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%
	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%
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%
	Percentage of children and adolescents on antipsychotics who received cholesterol testing	37.7%	34.1%	35.4%

Measure/Measure Steward	Description	2019	2020	2021
	Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	34.9%	31.0%	32.61%
Prenatal and Postpartum Care (PPC)/ NCQA[3]	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%
	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%
Cervical Cancer Screening (CCS)/ NCQA	Women ages 21-64 who had cervical cytology performed every 3 years.	43.82%	42.83%	40.7%
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%
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%
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%	49.9%	N/A
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.	0.93%	0.99%	.99%
Controlling High Blood Pressure (CBP)/NCQA[4]	Percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.	N/A	4.58%	24.62%

Measure/Measure Steward	Description	2019	2020	2021
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%
	Effective Continuation Phase Treatment: Adults who remained on an antidepressant medication for at least 180 days (6 months).	39.3%	41.6%	33.9%
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%
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%
Customer Service/ CAHPS	**Composite measure (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?”	83.3%	NA	86.5%
	Composite measure (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?”	78.8%	NA	85.9%

Measure/Measure Steward	Description	2019	2020	2021
Coordination of Care/CAHPS	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?"	86.6%	NA	85.8%
	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?”	81.9%	NA	85.4%

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

[4]NC Medicaid does not get blood pressure values via claims and encounters. **Consequently**, **our results are to be interpreted with caution.** The Department is currently developing a process to receive accurate blood pressure data via the North Carolina Health Information Exchange.

Cost of care

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

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 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 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	146,103	100%	100%	100%	100%	100%	100%	100%
2	13	306,492	100%	100%	100%	100%	100%	100%	100%
3	12	432,242	100%	100%	100%	100%	100%	100%	100%
4	14	351,755	100%	100%	100%	100%	100%	100%	100%
5	15	292,624	99%	100%	100%	100%	100%	100%	100%
6	27	223,552	99%	100%	100%	100%	100%	100%	100%

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	146,103							
2	13	306,492							
3	12	432,242	100%	100%	100%	100%	100%	100%	100%
4	14	351,755	100%	100%	100%	100%	100%	100%	100%
5	15	292,624	100%	100%	100%	100%	100%	100%	100%
6	27	223,552							

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	146,103	100%	100%	100%	100%	100%	100%	100%
2	13	306,492	100%	100%	100%	100%	100%	100%	100%
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5	15	292,624	100%	100%	100%	100%	100%	100%	100%
6	27	223,552	99%	99%	100%	100%	99%	100%	100%

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	146,103	100%	100%	100%	100%	100%	100%	100%
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4	14	351,755	100%	100%	100%	100%	100%	100%	100%
5	15	292,624	100%	100%	100%	100%	100%	100%	100%
6	27	223,552	100%	100%	100%	100%	100%	100%	100%

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	146,103	100%	100%	100%	100%	100%	100%	100%
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4	14	351,755	100%	100%	100%	100%	100%	100%	100%
5	15	292,624	100%	100%	100%	100%	100%	100%	100%
6	27	223,552	99%	100%	100%	100%	99%	100%	100%

Provider Enrollments by PHP

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 B for the full list.

Provider Enrollment by PHP – Select Categories

Provider Type	AmeriHealth	Healthy Blue	CCH	United	WellCare
Ambulatory Health Care Facilities	974	1,219	941	860	833
Behavioral Health & Social Service Providers	8,090	9,207	6,597	3,961	5,466

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	CCH*	Healthy Blue	United	WellCare	Total
No PCP Tier	7,819	1,180	18,637	16,570	4,866	**49,072**
Tier 1	2,500	3,204	9,110	3,863	3,366	**22,043**
Tier 2	42,437	39,956	76,392	67,631	55,035	**281,451**
Tier 3	260,657	180,029	358,739	288,094	308,643	**1,396,162**

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

Member Proportion by PHP and AMH Tier

	AmeriHealth	CCH	Healthy Blue	United	WellCare	Total
No PCP Tier	2.49%	0.53%	4.03%	4.41%	1.31%	**.03%**
Tier 1	0.80%	1.43%	1.97%	1.03%	0.91%	**.01%**
Tier 2	1354%	17.81%	16.50%	17.98%	14.80%	**16.09%**

Tier 3	83.17%	80.24%	77.50%	76.58%	82.99%	**79.84%**

AMH Provider Enrollment

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

	AmeriHealth	Healthy Blue	CCH**	United	WellCare
Tier 1	27.23%	56.03%	58.77%	47.86%	38.91%
Tier 2	45.80%	86.10%	79.69%	58.04%	53.85%
Tier 3	88.56%	84.53%	90.16%	79.83%	88.20%

*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 receiving care management through a Standard Plan, AMH, Care Management for At-Risk Children (CMARC) program or Care Management for High-Risk Pregnancies (CMHRP) program since Standard Plan launch (July 2021). These data are provided with a one-month lag (e.g., DY4Q3 ends July 31; however, data are available only through June.)

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. Both services are performed by local health departments (LHDs) as delegates of the Standard Plans. Care management provided through a Standard Plan or AMH is reported by Standard Plans on the BCM051 operational report. Care management provided for CMARC/CMHRP by LHDs is reported by Community Care of North Carolina (CCNC), the Department vendor that oversees CMARC and CMHRP programs.

Care management rates were below the annual penetration target of 20% of members receiving care management by the end of Year 1 of NC Medicaid Managed Care.

Care Management Penetration Rate, July 2021 – June 2022

	PHP	AMH	CMARC	CMHRP	Overall
% of Total Members	3.9%	13.3%	1.5%	1.6%	**17.9%**
Care Management Distinct Member Count	72,437	246,110	28,377	30,553	**331,977**

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 Standard Plan and NC Medicaid Direct. Claims denied because they were erroneously billed to NC Medicaid Direct instead of a Standard Plan were excluded from measurement calculations to avoid duplication. Medicaid beneficiaries not eligible for hospital coverage (e.g., family planning participants) were excluded from NC Medicaid Direct calculations

Due to the lag in claims and encounter reporting, the rates below are reported with a one-month lag. It should be noted that higher rates are expected for NC Medicaid Direct, as members with substantial behavioral health issues to be enrolled in Tailored Plans in December 2022 currently remain in NC Medicaid Direct.

Emergency Department Visits per 1,000 Members, April – June

AmeriHealth	CCH	Healthy Blue	Medicaid Direct	United	WellCare
61.7	62.6	58.8	77.0	63.2	59.0

Inpatient Admissions per 1,000 Members, April – June

AmeriHealth	CCH	Healthy Blue	Medicaid Direct	United	WellCare
13.0	13.8	13.9	22.4	13.5	15.4

Results of beneficiary satisfaction surveys

No results to report this quarter.

Budget Neutrality and Financial Reporting Requirements

The Department will provide CMS with updated budget neutrality information through July 31, 2022, in the next budget neutrality workbook submission.

Evaluation Activities and Interim Findings

The DY4Q3 reporting period activities have continued the evaluation work by the Sheps Center team. 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.

Transition to Capitated Encounter Data from Standard Plans

Sheps Center data scientists and analysts have continued working with the encounter data which tracks utilization from Medicaid beneficiaries enrolled in Standard Plans. We have been providing feedback on the quality and completeness of this data to the State and our team has continued to revise code on metrics to include services, medications, and diagnoses received through either claims or encounter data.

Quantitative Update

The quantitative team received new data from the NC Division of Public Health, including birth and death certificate and immunization data, and began linking that data to NC Medicaid member information to generate new metrics that will be tracked during the evaluation period. In addition, the team continues to update many of the metrics from established custodians consistent with the NC Medicaid Quality Strategy, Adult and Child Core measures, and other metrics that will address the study hypotheses. Sheps has completed the evaluation of 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. These measures showed generally similar trends between Medicaid and Blue Cross and Blue Shield of North Carolina (BCBSNC) Marketplace plans in the pre-implementation period, although there were concerns about relatively small sample size for some of the metrics that look at specific subsamples (such as well-child visits for children and adolescents due to the relatively modest number of children in Marketplace plans). The evaluation will use BCBSNC data as a control group for a limited number of metrics, while simultaneously seeking other options for a comparison group, such as through other states' Medicaid data.

The evaluation team is working with the Department to refine and field a new dashboard to track other behavioral health metrics that are not included in the substance use disorder dashboard that the evaluation team currently updates monthly. This new behavioral health dashboard will increase the rapid monitoring of metrics that may have been influenced by Standard Plan implementation and other milestones. Other dashboards specific to Foster Care plan members, individuals with intellectual and developmental disabilities, and physical/overall health metrics are planned.

Qualitative Update

The qualitative team completed 40 interviews with 26 health systems and health care practices from March to July 2022. Of the 26 organizations, 10 were repeat participants from year 1 (demonstration year 3, Nov 2020 to Oct 2021). The sample included 3 health systems, 14 independent practices, 5 FQHCs, and 4 local health departments. Of the 14 independent practices, 5 were internal and/or family medicine, and 9 were pediatric practices. The qualitative team reached out to 18 independent obstetric practices identified from the year 1 provider file, survey respondents file, and NCDHHS website. They were either unavailable to participate or did not respond to the interview request. The team is continuing to recruit representatives from health systems.

At the request of CMS, the Department is providing preliminary evaluation findings in its monitoring reports. Preliminary findings from these interviews represent the first qualitative data on the provider experience gathered after the launch of NC Medicaid Managed Care. Interview topics included the

organization's experience with PHPs, AMH status, referrals, member attribution, and Tailored Plan implementation. Key findings included:

- Of the 26 participating health systems and practices, 14 had contracted with all five PHPs. Three had contracted with two or fewer PHPs.
- Participants reported mixed experiences in working with PHPs. Common factors that the participants considered were responsiveness, claim processing, reworking denials, and ease of using the website.
- An overwhelming majority of participants described initial challenges with auto-assignment to a primary care provider, which improved over time. The concerns included difficulty accessing member assignment lists, correcting member assignment, attribution of performance to primary care providers for wrongly assigned members, and loss of revenue.
- 18 of the participating independent practices and health systems had an AMH Tier 3 status, of which 11 contracted with a CIN and 5 had an in-house care management infrastructure.
- 12 of the participating practices and health systems were unsure about their participation in the Tailored Plans, and four had no intention to participate due to their experience of implementing Standard Plans. Six were either gathering information or had contracts underway.

The rapid analysis of the year 2 (DY4, Nov 2021 to Oct 22) health system and health care practices data is complete. The report has been drafted and shared with the advisory committee. It will be updated if new insights are gained from additional health system interviews. The qualitative team is preparing a manuscript on patient engagement using the data from year 1 interviews. An abstract is being prepared for submission to the publications committee.

Proposed Changes to Evaluation Design

The Sheps Center, in collaboration with NC Medicaid, has updated the evaluation design to address changes to the implementation environment such as the Covid-19 Public Health Emergency, implementation delays and adjustments to programs and policies. CMS requested that evaluation design changes be presented in quarterly monitoring reports.

Major updates to the Waiver Evaluation Design document include:

- Updates to the dates of major milestones, including Standard and Tailored Plan implementation dates and SUD waiver implementation dates in Table 1 and throughout the document
- The addition of a Tribal Option is now noted
- Update to the design because of the statewide rather than regional implementation of Standard Plans
- Two hypotheses were added on the impact of value-based payments on access, quality of care, and outcomes (Hypothesis 1.6) and on services and Medicaid expenditures (Hypothesis 2.5) after the release of detailed information on VBP expectations in Standard Plans in January 2020.
- Updates to some of the metrics tracked due to metric discontinuation by measure custodians, new measures in use, updates to the NC Medicaid Quality Strategy and low rates of reporting for certain measures (such as flu shots or depression screening) that make analysis impractical.
- Detailed sections about how the design changed due to the COVID-19 Public Health Emergency (e.g., changes to the qualitative design, changes to the estimation approach to acknowledge the

lower rates of use during the stay-at-home orders and subsequent changes in care) as well as the ability to track populations with COVID-19 diagnoses and receiving COVID-19 vaccines.

- Changes to the strategy for qualitative analysis due to the difficulty obtaining responses from providers during the pandemic and lack of information from many providers about changes to NC Medicaid (a full panel will no longer be used, with some providers interviewed annually but new providers interviewed each year)
- We have slightly shortened the baseline period which initially begin Jan. 1, 2014, to now begin on Oct. 1, 2015, because ICD-10 diagnostics were in effect on this date, affecting most of the algorithms used for measures. This still yields just over a three-year baseline period for the SUD metrics (October 2015 – December 2018) and over a five-year baseline period for the non-SUD components of the waiver (October 2015 – June 2021).
- We have added a section on local or contextual variables that will be added to multivariate analyses to better model heterogeneity in response to waiver components
- We have added a section summarizing each of the data sources included and how they are integral to the analysis
- We have removed the NC Hospital Discharge data as a source of information due to significant deficits in the data and its duplication with other sources such as claims and encounter data

Enhanced Case Management (ECM) and Other Services Pilot Program

Operational Updates

Introduction

The Department continued to hold regular implementation meetings with AMH Tier 3s and their CINs, PHPs, and Network Leads to review pilot design questions and to align on the scope and timing of the implementation activities. The Department completed implementation of a phased launch approach to the Healthy Opportunities Pilots, with services from all domains going live between March 15 and June 15, 2022. Services to address toxic stress and multiple non-medical needs launched on June 15 and include evidenced-based parenting classes, home visiting services, and medical respite. There is ongoing design and technical development in progress for the launch of a subset of sensitive services.

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

The Department continued weekly individual and group engagement sessions with the Standard Plans and Network Leads to discuss the progress on implementation activities. This has allowed the Department to mediate key programmatic challenges. The Department also continued implementation efforts to launch Pilots services with the Tailored Plans in 2023. Ongoing implementation efforts are adapting lessons learned from Standard Plans to the Tailored Plan model.

The Department continued to engage with community stakeholders and Pilot entities to identify and address gaps in the program's equity strategy. Key findings from these sessions will be incorporated into a broader Healthy Opportunities Pilots health equity strategy.

Additionally, the Department continued to work with the technology vendor, Unite Us, to ensure that invoices that were converted into automated claims will be available to PHPs with minimal burden to Human Service Organization (HSO) providers. This was achieved after extensive engagement efforts to

identify a solution that ensured providers and PHPs experienced minimal disruption to their current workflows.

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

Key challenges for the Healthy Opportunities Pilots program included troubleshooting challenges experienced by Pilot entities as the program launched a more complete set of services. The Department worked to mitigate implementation challenges in the housing domain, payment challenges with the provision of provider remittance advice, and the delayed launch of IPV-related sensitive services.
Both Network Leads and PHPs have worked to incorporate and improve upon new policies and processes as part of the implementation of the Pilots. A key process which both entities have continued to work to improve is ensuring that remittance advice is transmitted by the PHP to the corresponding HSO and contains all necessary information for the HSO to accurately account for service payment. The Department is working with both entities to ensure that there are both short-term solutions that address any historical gaps in data and long-term solutions which ensure that all necessary information is transmitted and received by the corresponding entity.

The Department worked with partner organizations to address challenges that arose for each service domain throughout the implementation process. Housing services have presented a particular challenge, due in part to the intricacy of the housing landscape which has seen further exacerbations of existing challenges due to the COVID-19 Pandemic. The State has continued to work with subject matter experts to identify long-term solutions that will allow for implementation with a priority on simplicity for providers.
Additionally, the Department continued to work toward identifying design and technical solutions to allow for the implementation of interpersonal violence-related sensitive services. Stakeholder engagement with subject matter experts provided a framework to allow for the future launch of sensitive services. The Department continues to balance federal regulations, industry best practices, and the priority of survivor safety.

Issues or complaints identified by beneficiaries

No issues or complaints identified by beneficiaries to report this quarter.

Lawsuits or legal actions

No lawsuits or legal actions to report this quarter.

Unusual or unanticipated trends

No unusual or unanticipated trends to report this quarter.

Legislative updates

Descriptions of post-award public for a

No post-award public for a to report this quarter.

Performance Metrics

Incentive Payments to PHPs, NLs, and Pilot providers

To ensure a successful Pilot launch, the Department determined milestones for each Network Lead and Standard Plan to reach during the Pilot Implementation Period (May 2021 through March 2022). These milestones are tied to meeting key Pilot implementation measures, including establishing an HSO network, providing training to HSOs and care management staff, establishing payment and reporting processes, and completion of readiness testing. The Department developed an incentive payment fund for both Network Leads and Standard Plans during the implementation year and weighted each milestone based on importance to Pilot launch to determine the milestone payment amounts.

As of this quarter, the Department will begin reporting Network Lead incentive payments by the payment date, when the funds are disbursed to Network Leads, instead of by the deadline for Network Leads to achieve the milestone. This change aligns the reporting of payments with how payment reports are processed internally by the Department.

For consistency, a revised table of DY4Q2 Network Lead VBP Payments that follows the new reporting structure is included, outlining actual payments disbursed for incentive-based payment milestones in DY4Q2. The following incentive-based payment milestones were achieved in DY4Q2, but payment was issued in DY4Q3: "Completion of Implementation Year training, technical assistance, and engagement as outlined in the Network Lead's Pilot Entity Engagement, Training, and Technical Assistance Plan" and "Completion of Department readiness evaluation, including that HSO network is prepared to deliver services." Previously, these milestones were reported in DY4Q2, but they are now reported in DY4Q3 as payment was disbursed this quarter.

All three Network Leads submitted these deliverables on time and received the corresponding incentive payment for reaching each milestone. The details of each incentive payment made are listed in the following table:

DY4Q3 Network Lead VBP Payments			
Entity	**Milestone(s) Achieved**	**Payment Date**	**Amount Paid**
Access East	5. Completion of Implementation Year training, technical assistance, and engagement as outlined in the Network Lead's Pilot Entity Engagement, Training, and Technical Assistance Plan.	6/22/2022	$17,857.00
Access East	6. Completion of Department readiness evaluation, including that HSO network is prepared to deliver services.	6/22/2022	$26,785.00
Impact Health	5. Completion of Implementation Year training, technical assistance, and engagement as outlined in the Network	6/22/2022	$17,857.00

	Lead's Pilot Entity Engagement, Training, and Technical Assistance Plan.		
Impact Health	6. Completion of Department readiness evaluation, including that HSO network is prepared to deliver services.	6/22/2022	$26,785.00
Community Care of the Lower Cape Fear	5. Completion of Implementation Year training, technical assistance, and engagement as outlined in the Network Lead's Pilot Entity Engagement, Training, and Technical Assistance Plan.	6/22/2022	$17,857.00
Community Care of the Lower Cape Fear	6. Completion of Department readiness evaluation, including that HSO network is prepared to deliver services.	6/22/2022	$26,785.00

REVISED DY4Q2 Network Lead VBP Payments			
Entity	**Milestone Achieved**	**Payment Date**	**Amount Paid**
Access East	3. Disbursement of first capacity building funds to HSOs.	3/29/2022	$17,857.00
Access East	4. Received Department approval of HSO Network Report.	3/29/2022	$26,785.00
Community Care of the Lower Cape Fear	3. Disbursement of first capacity building funds to HSOs.	3/29/2022	$17,857.00
Community Care of the Lower Cape Fear	4. Received Department approval of HSO Network Report.	3/29/2022	$26,785.00
Impact Health	3. Disbursement of first capacity building funds to HSOs.	3/29/2022	$17,857.00
Impact Health	4. Received Department approval of HSO Network Report.	3/29/2022	$26,785.00

This reporting period, the Department disbursed incentive payments to the Standard Plans for completing end-to-end testing and readiness activities associate with Pilot launch by the established deadlines. All five Standard Plans completed these milestones on time and received the corresponding incentive payments. The details of each incentive payment made are listed in the following table:

Prepaid Health Plan VBP Payments			
Entity	**Milestone Achieved**	**Payment Date**	**Amount Paid**
AmeriHealth Caritas of NC	Meet Department Pilot-related systems integration and end-to-end testing standards related to Pilot eligibility, service authorization, referral, invoice, and payment. Successful completion of DHB Readiness Review to implement Pilots.	6/14/22	$70,000.00
Blue Cross Blue Shield of NC	Meet Department Pilot-related systems integration and end-to-end testing standards related to Pilot eligibility, service authorization, referral, invoice, and payment. Successful completion of DHB Readiness Review to implement Pilots.	6/14/22	$70,000.00
Carolina Complete Health	Meet Department Pilot-related systems integration and end-to-end testing standards related to Pilot eligibility, service authorization, referral, invoice, and payment. Successful completion of DHB Readiness Review to implement Pilots.	6/14/22	$70,000.00
United Healthcare	Meet Department Pilot-related systems integration and end-to-end testing standards related to Pilot eligibility, service authorization, referral, invoice, and payment. Successful completion of DHB Readiness Review to implement Pilots.	6/14/22	$70,000.00
WellCare	Meet Department Pilot-related systems integration and end-to-end testing standards related to Pilot eligibility, service authorization, referral, invoice, and payment. Successful completion of DHB Readiness Review to implement Pilots.	6/14/22	$70,000.00

ECM Capacity Building

In this reporting period, $12,106,683.50 of capacity building funding was released to the Network Leads for Year 2 program activities. The Network Leads were able to invoice up to 50% of their total Year 2 capacity building budget. The amounts and breakdown of the second capacity building invoices are:

Access East: $2,133,350.00

Description of Expense	Category of NL Allowable Use	Category of HSO Allowable Use	Amount
NL Salary Dollars	Staff Time: Establishing the LPE	N/A	$538,407.00
Program and General Supplies	Administrative Overhead costs	N/A	$15,000.00
Minor Equipment: Computer Package	Purchases for Functional Systems	N/A	$800.00
Minor Equipment: Conference Room Communications	Administrative Overhead costs	N/A	$ -
Minor Equipment: Phone System	Purchases for Functional Systems	N/A	$ -
Staff Training & Education	Staff Time: Establishing the LPE	N/A	$2,000.00
Staff Training & Education	Staff Time: Establishing the LPE	N/A	$ -
Lease Payments	Administrative Overhead costs	N/A	$43,750.00
Furnishings: Offices	Administrative Overhead costs	N/A	$ -
Furnishings: Conference Room	Administrative Overhead costs	N/A	$ -
Cell Phones	Purchases for Functional Systems	N/A	$300.00
Cell Service (annual)	Purchases for Functional Systems	N/A	$4,050.00
Mobile Hotspots	Purchases for Functional Systems	N/A	$2,100.00
HSO Network Educational Events/Outreach Activities	Other Use Approved by the Department	N/A	$3,080.00
Stakeholder Engagement	Other Use Approved by the Department	N/A	$11,250.00
Marketing	Marketing and Outreach Material	N/A	$5,000.00
Travel: Network Development & Onsite Assessment	Administrative Overhead costs	N/A	$36,540.00
HSO - Assessments (subcontract)	Administrative Overhead costs	N/A	$ -
System Development, Implementation/Network Integration	Administrative Overhead costs	N/A	$ -

Description of Expense	Category of NL Allowable Use	Category of HSO Allowable Use	Amount
HSO Staff Training & Education	Administrative Overhead costs	N/A	$2,090.00
HSO Travel	Administrative Overhead costs	N/A	$13,920.00
HSO Capacity Building Funding Distribution	Other Use Approved by the Department	N/A	$1,342,365.00
Board Training	Administrative Overhead costs	N/A	$ -
Shared Services Legal, HR, Financial	Administrative Overhead costs	N/A	$39,123.00
NL Travel	Administrative Overhead costs	N/A	$19,575.00
Learning Community Meetings	Administrative Overhead costs	N/A	$54,000.00

Community Care of the Lower Cape Fear: $5,000,000.00

Description of Expense	Category of NL Allowable Use	Category of HSO Allowable Use	Amount
Executive Director	Staff Time: Establishing the LPE	N/A	$3,533.00
Program Director	Staff Time: Establishing the LPE	N/A	$7,814.00
Recruiting	Administrative Overhead costs	N/A	$ -
Office Space/Rent	Administrative Overhead costs	N/A	$29,250.00
Office Supplies	Administrative Overhead costs	N/A	$6,500.00
Travel	Administrative Overhead costs	N/A	$6,500.00
Training and Development	Administrative Overhead costs	N/A	$3,250.00
Payroll Services	Administrative Overhead costs	N/A	$3,250.00
Liability Insurance	Administrative Overhead costs	N/A	$11,000.00

Description of Expense	Category of NL Allowable Use	Category of HSO Allowable Use	Amount
Misc. ROUNDING	Administrative Overhead costs	N/A	$(528.00)
Executive Director	Staff Time: Developing a Network of HSOs	N/A	$3,533.00
Program Director	Staff Time: Developing a Network of HSOs	N/A	$19,533.00
Care Council Leads	Staff Time: Developing a Network of HSOs	N/A	$47,559.00
QI Coordinator	Staff Time: Developing a Network of HSOs	N/A	$10,871.00
Program Managers	Staff Time: Developing a Network of HSOs	N/A	$50,956.00
Marketing	Administrative Overhead costs	N/A	$2,500.00
Misc.	Administrative Overhead costs	N/A	$1,250.00
Executive Director	Staff Time: Developing Infrastructure/Systems	N/A	$3,533.00
QI Coordinator	Staff Time: Developing Infrastructure/Systems	N/A	$5,435.00
Compliance Manager	Staff Time: Developing Infrastructure/Systems	N/A	$23,780.00
Program Managers	Staff Time: Developing Infrastructure/Systems	N/A	$50,956.00
Data Analyst	Staff Time: Developing Infrastructure/Systems	N/A	$39,067.00
Office Management	Administrative Overhead costs	N/A	$8,125.00
HR Management	Administrative Overhead costs	N/A	$11,375.00
IT Management	Administrative Overhead costs	N/A	$8,125.00
CRM Licenses	Administrative Overhead costs	N/A	$6,500.00
Software Licenses	Administrative Overhead costs	N/A	$3,250.00
CRM/ Cultural Competency Training	Administrative Overhead costs	N/A	$11,375.00

Description of Expense	Category of NL Allowable Use	Category of HSO Allowable Use	Amount
Computer and Communication Equipment	Administrative Overhead costs	N/A	$ -
Executive Director	Staff Time: Providing TA/Training to HSOs	N/A	$3,533.00
Program Director	Staff Time: Providing TA/Training to HSOs	N/A	$3,907.00
Care Council Leads	Staff Time: Providing TA/Training to HSOs	N/A	$47,559.00
QI Coordinator	Staff Time: Providing TA/Training to HSOs	N/A	$10,871.00
Program Managers	Staff Time: Providing TA/Training to HSOs	N/A	$50,956.00
Executive Director	Staff Time: Distributing Capacity Building Funding to HSOs	N/A	$3,533.00
Program Director	Staff Time: Distributing Capacity Building Funding to HSOs	N/A	$19,533.00
Accountant/Claims	Staff Time: Distributing Capacity Building Funding to HSOs	N/A	$40,765.00
CFO Services (by CCLCF)	Administrative Overhead costs	N/A	$20,000.00
Executive Director	Staff Time: Facilitating Collaboration and Governance	N/A	$3,533.00
Program Director	Staff Time: Facilitating Collaboration and Governance	N/A	$3,907.00
QI Coordinator	Staff Time: Facilitating Collaboration and Governance	N/A	$5,435.00
Team Consultant	Staff Time: Facilitating Collaboration and Governance	N/A	$10,191.00
Legal Services	Administrative Overhead costs	N/A	$5,000.00

Description of Expense	Category of NL Allowable Use	Category of HSO Allowable Use	Amount
Meetings, Facilitation and Travel	Administrative Overhead costs	N/A	$2,750.00
Cultural Competency Training (UNC-W)	Administrative Overhead costs	N/A	$26,225.00
Teambuilding, Coaching and Facilitation	Administrative Overhead costs	N/A	$ -
Collaboration and Teambuilding	Administrative Overhead costs	N/A	$ -
Communication	Administrative Overhead costs	N/A	$9,750.00
BOD Expenses	Administrative Overhead costs	N/A	$2,000.00
Executive Director	Staff Time: Reporting	N/A	$3,533.00
Program Director	Staff Time: Reporting	N/A	$11,720.00
Care Council Leads	Staff Time: Reporting	N/A	$47,559.00
QI Coordinator	Staff Time: Reporting	N/A	$21,741.00
Reporting (Audit & Tax Prep Fees)	Administrative Overhead costs	N/A	$6,250.00
Executive Director	Staff Time: Participating in Community Engagement	N/A	$3,533.00
Program Director	Staff Time: Participating in Community Engagement	N/A	$11,720.00
Care Council Leads	Staff Time: Participating in Community Engagement	N/A	$47,559.00
Team Consultant	Staff Time: Participating in Community Engagement	N/A	$10,191.00
Program Managers	Staff Time: Participating in Community Engagement	N/A	$50,956.00
HSO Funding	N/A	N/A	$4,137,500.00

Impact Health: $4,973,333.50

Description of Expense	Category of NL Allowable Use	Category of HSO Allowable Use	Amount
Network Lead Establishment	Staff Time	Establishing the LPE	$819,475.00
Network Lead Establishment	Administrative Overhead costs	Overhead	$409,114.00
Network Lead Establishment	Staff Time	Developing a Network of HSOs	$43,260.00
HSO Network Development	Other Use Approved by the Department	Convenings	$2,537.00
HSO technical assistance and training	Staff Time	HSO technical assistance and training	$115,875.00
HSO technical assistance and training	Other Uses Approved by the Department	HSO technical assistance and training	$163,148.00
Governance and Cross-Entity Collaboration	Staff Time	Governance and Cross-Entity Collaboration	$69,525.00
Governance and Cross-Entity Collaboration	Other uses approved by the department	Governance and Cross-Entity Collaboration	$62,500.00
Program administration, evaluation and oversight	Staff Time	Program administration, evaluation and oversight	$46,350.00
Program administration, evaluation and oversight	Staff Time	Program administration, evaluation and oversight	$7,725.00
HSO Capacity Building Fund Distribution	Other Use Approved by the Department	Modifications to Existing Physical Infrastructure	$590,000.00
HSO Capacity Building Fund Distribution	Administrative Overhead costs	Office Furnishings, Supplies, and Equipment	$590,000.00
HSO Capacity Building Fund Distribution	Staff Time: Developing Infrastructure/Systems	Staff Time: Developing Infrastructure/Systems	$375,000.00
HSO Capacity Building Fund Distribution	Staff Time: Developing Infrastructure/Systems	Staff Time: Developing Infrastructure/Systems	$600,000.00
HSO Capacity Building Fund Distribution	Staff Time: Developing Infrastructure/Systems	Staff Time: Developing Infrastructure/Systems	$400,000.00
HSO Capacity Building Fund Distribution	Staff Time: Developing Infrastructure/Systems	Staff Time: Developing Infrastructure/Systems	$375,000.00
HSO Capacity Building Fund Distribution	Staff Time: Developing Infrastructure/Systems	Staff Time: Developing Infrastructure/Systems	$300,000.00

Healthy Opportunities Pilots Evaluation Activities and Interim Findings

During this period, evaluation consisted of three main activities. The first was providing ongoing technical assistance and engagement with NC Medicaid staff to facilitate the Pilots evaluation. Activities included participating in weekly and monthly standing meetings, documenting emerging implementation themes to inform ongoing data collection and analysis planning, and communicating about operational questions as needed.

The second activity involved working with the data team at the Sheps Center to prepare the necessary information technology infrastructure to receive and analyze descriptive and quantitative data regarding Pilot activities, expected in September 2022. Activities included identification of necessary data elements, planning to receive data when available, and creating staffing assignments to support analysis workflows across analysts and other research team members.

The third focus of this quarter was primary data collection for evaluation question 1. Team members completed quantitative and qualitative data collection with Network Leads and HSOs regarding their experiences preparing for and delivering early phase pilot services. Analyses for these data are expected to be completed by next quarter.

Evaluation Design Changes

In response to a CMS request to include additional stratifications in the evaluation report, we will report stratified data to examine differences in health across populations defined by categories of race and ethnicity, gender, primary language, and rurality. A new equity analysis section has been proposed for Hypotheses 4, 5, and 6. These changes are outlined in detail in Appendix C.

Residential and Inpatient Treatment for Individuals with a Substance Use Disorder

The Department will provide detailed information in the Substance Use Disorder quarterly monitoring report due to CMS Oct. 28, 2022.