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).*

Medicaid Section 1115 Monitoring Report
North Carolina - North Carolina Medicaid Reform Demonstration

Demonstration Year 3 – Nov. 1, 2020 through Oct. 31, 2021
Quarter 3 Measurement Period – May 2021- July 2021

Submitted: September 29, 2021

Contents

Executive Summary

On July 1, 2021, North Carolina launched the first phase in Medicaid Managed Care (MMC): Standard Plans. The State transferred 1.6 million Medicaid beneficiaries from fee-for-service (FFS) 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.

During the reporting period, the State laid the foundation for a successful transition to MMC. To make the transition between FFS and MMC as seamless as possible for beneficiaries, the State provided each PHP with all of their beneficiaries' historical claims and enrollment data. The State ensured that 95% of beneficiaries were assigned to plans that had the respective beneficiary's primary care provider (PCP) in network. As of June 1, 2021, the State stood up an ombudsman program, which will equip each beneficiary with knowledge and resources to understand the new Medicaid program. The State also established key processes to enable both providers and beneficiaries to escalate concerns related to MMC and to ensure that those concerns are delivered to key vendors and other responsible parties.

Leading to the Standard Plans launch, the State quickly mitigated and resolved anticipated challenges. The State addressed issues about Non-Emergency Medical Transportation (NEMT) that impacted beneficiaries' transportation to medical appointments. Providers' claims payment/processing concerns were dealt with through an established help center process. The State clarified provider hardship payment processes with the PHPs should the need arises. The open enrollment period was extended to allow beneficiaries more time to select a PHP and PCP prior to auto-enrollment.

With the launch of Standard Plans, the State is monitoring several 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. The quality measures included in this report provide the State and CMS a baseline view of processes and performance within these categories to monitor these areas moving forward. The metrics are derived from a variety of sources, including HEDIS® measures; National Committee for Quality Assurance (NCQA) health plan accreditation requirements, including a requirement for Long-Term Services and Supports (LTSS) distinction; and Centers for Medicare and Medicaid Services (CMS) Adult and Child Core measure set.

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 Dogwood Health Trust (Impact Health). The State distributed the first pilot capacity-building dollars to Network Leads in June 2021. See Appendix A for a map of the counties covered by each Network Lead.

Medicaid Managed Care

Operational Updates

In May and June, the State finalized preparation for Medicaid Managed Care Standard Plans launch including auto-enrollment activities. On July 1, 2021, North Carolina launched the Standard Plans with approximately 1.6 million Medicaid beneficiaries transitioning from fee-for-service to capitated managed care.

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

Standard Plans

1. Auto-enrollment was successful in assigning 1,234,782 beneficiaries to a prepaid health plan (PHP) if they did not actively select a PHP. See Appendix B for a detailed accounting of the managed care auto-enrollment.
2. Comprehensive operational readiness reviews were completed to confirm Standard Plans were prepared for operations on July 1.
3. PHPs sent beneficiaries welcome packets and ID cards.
4. The State continued established Help Center and Technical Operations processes to handle issues as they arose. Teams met daily to address these issues and maintain a closure rate.
5. The State implemented beneficiary and provider call centers, standing up 28 call lines across 8 vendors.
6. Pharmacy claim payments were successful on Day 1 and other claim payments were successful shortly after launch.
7. Beneficiaries experienced limited disruption to their assigned PCPs with most being able to stay with their preferred provider.
8. The PHPs met network adequacy and readiness goals with plans achieving 100% beneficiary access to providers in the five key service categories across all regions except region 6.

Tailored Plans

1. Following a competitive selection process, the following organizations were awarded a contract to serve as regional Behavioral Health I/DD Tailored Plans (TPs) when they launch July 1, 2022:
    - Alliance Health
    - Eastpointe
    - Partners Health Management
    - Sandhills Center
    - Trillium Health Resources

- Vaya Health
- Cardinal Innovations Healthcare[1]

2. The Tailored Plan team continues to move forward with TP program set-up activities and preparations for August 2021 kick-off presentations with all TP organizations.

Milestones

1. Over 80% of beneficiaries were enrolled in an Advanced Medical Home.
2. The member Ombudsman program became fully operational on June 1, 2021.
3. Oversight processes went into development in May 2021 to track PHP non-compliance with contractual requirements, including service level agreements, liquidated damages and general contract provisions.
4. The External Quality Review Organization (EQRO) contract was awarded and approved by CMS in May 2021. The EQRO is tasked with reporting Standard Plans and Behavioral Health I/DD Tailored Plans' performance in required and optional areas under 42 CFR 438.352 and 438.364.
5. The State obtained 2020 results for managed care quality measures.
6. The State fielded a baseline provider survey to determine providers' experience with the respective PHPs.
7. The State published the Medicaid Managed Care Quality Strategy on June 16, 2021.

Issues or complaints identified by beneficiaries

The State receives beneficiary complaints from three sources: 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 reporting period. The Office of Administration received 13 total complaints from a few different areas during this reporting period. Two were related to member eligibility, three related to electronic visit verification, three related to non-emergency medical transportation (NEMT), one related to clinical policy (prior approval/imaging services), one for clinical policy optical, one for provider operations enrollment, and two for provider operations NCTracks issues. See Appendix C for a detailed list.

The Ombudsman received 2,115 total service provider complaints and 2,223 service level complaints during the reporting quarter. Some of these complaints crossed all three months. Service level complaints included issues related to changing plans, eligibility, coverage or referrals, and general inquiries. Service provider complaints included issues related to the enrollment broker, providers and NC Medicaid Direct. See Appendix D for a complete list.

[1] Cardinal Innovations merged with Vaya Health Care on June 1, 2021.

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. All parties are working to finalize the record on appeal. Once finalized, all parties will file briefs and arguments will be scheduled.

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.S.S. 150B-46. The North Carolina Court of Appeals held oral arguments on May 26, 2021, and is awaiting the Court's ruling.

Optima has agreed to dismiss both of its petitions filed in Wake and Pasquotank counties.

Unusual or unanticipated trends

1. Addressed key issues prior to go-live
    a. Three thousand 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.

    b. The finance and clinical policy teams have worked closely to research claims processing concerns and provide clarification to PHPs and providers.

2. Addressing key issues post go-live
    a. Four hundred and ten beneficiaries exempt from mandatory Standard Plan enrollment due to meeting TP eligibility standards have chosen to enroll in a Standard Plan. When they chose to move to a Standard Plan, they received choice counseling and were provided all information necessary for informed consent. These beneficiaries could be at risk of losing behavioral health benefits not covered by the Standard Plan.

    b. Formal notices of deficiencies were issued to two PHPs related to unscheduled customer service system outages.

Legislative updates

Operational Legislative Updates May 1, 2021 to June 30, 2021

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 on June 30, 2021.
https://www.ncleg.gov/Sessions/2021/Bills/Senate/PDF/S105v6.pdf

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 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, amends durable medical equipment reimbursement under managed care to ensure it is at least equal to fee-for-service rates among other changes.

Descriptions of post-award public fora

No public fora occurred during this reporting quarter.

Summary of all public comments received through post-award public fora regarding the progress of the demonstration

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 the reporting period.

Quality of care

North Carolina 2021 quality measure data will be available to submit in 2022. The data provided below is from the 2020 Annual Quality Report and reflects fee-for-service Medicaid for calendar years 2016 - 2019.

The State selected a few key quality metrics from the NC Medicaid Quality Strategy that drive interventions that advance health, performance improvement and quality outcomes:

Measure/Measure Steward	Description	Performance CY 2019
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%
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%
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%
Total eligible receiving at least one initial or periodic screen (Federal Fiscal Year)/CMS 416-EPSDT	Eligible children under age 21 who received at least one initial or periodic screening.	52.98%
Use of First-Line Psychosocial care for children and adolescents on antipsychotics/NCQA	Children and adolescents ages1-17 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.	52.09%
Well-child visits in the first 15 months of life/NCQA	Children who turned age 15 months during the measurement year who had six well-child visits with a primary care practitioner (PCP) during their first 15 months of life.	65.71%
Well-Child visits in the third, fourth, fifth, and sixth years of life/NCQA	Children ages 3-6 who had one or more well-child visits with a primary care physician during the measurement year.	70.48%
Cervical cancer screening/NCQA	Women ages 21-64 who had cervical cytology performed every 3 years.	43.82%
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%
Breast cancer screening/NCQA	Women ages 50-74 who had a mammogram to screen for breast cancer.	41.35%
Flu vaccinations for adults	Adults ages 18 years and older self-report receiving an influenza vaccine within the measurement period.	42.9%
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%

Cost of care

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

Access to care

Four of the prepaid health plans, WellCare, Healthy Blue, United Healthcare and AmeriHealth Caritas, ensured 100% network adequacy in the five key service categories[2] in all regions except region 6. These four plans reported reduced access to hospitals in region 6. Three of the health plans, AmeriHealth Caritas, Healthy Blue and United Healthcare, reported reduced access to OB/GYNs in region 6. Carolina Complete Health reported 100% access in the 3 regions it covers. The State is currently in the midst of reviewing each Standard Plan's network for compliance across all network adequacy standards and with all state and federal laws and regulations.

Access to Primary Care and Care Management

The State developed the AMH model as the primary vehicle for primary care and care management as the State transitions to MMC. High-quality primary care with the capacity to manage population health is foundational to the success of North Carolina's transformation to MMC, supporting the delivery of timely care in the appropriate setting to meet each member's needs. The AMH model supports the State's transformation vision by maintaining the strengths of North Carolina's legacy care management structure and promoting delivery of care management in the community.

The AMH program is integrated with the State's broader quality strategy under which the PHPs must meet population health targets. The AMH model was designed to spur development of modernized, data-driven primary care that aligns with the State's vision for advancing value-based payments over time. To promote care management that is well integrated with primary care, the AMH program requires PHPs to work closely with AMH practices and regularly share data in specific ways. The AMH model will evolve over time as practices gain data-driven capabilities and the market gains experience in managed care.

The State views the AMH program as the vehicle for promoting data-enabled primary care that will assume responsibility for the whole-person health of populations. This transition takes time, and the initial AMH Tier 3 set of requirements is a starting point that intentionally prioritizes the use of data for the management of population needs. The State expects to evolve the AMH program requirements after one to two years of experience in managed care. One particularly fast-moving area, both nationally and in North Carolina, is primary care's increasing role in addressing healthy opportunities, or social needs that impact individuals' health. In the planning for MMC, North Carolina is building capacity for the Medicaid delivery system to better integrate health care with addressing social needs, including preparation for North Carolina's Healthy Opportunities initiative and the deployment of the NCCARE360 platform, a statewide, coordinated care network to electronically connect those with identified needs with community resources. In year 1 of MMC, AMH practices are encouraged (but not formally required)

[2] Primary Care, Hospitals, Pharmacies, OB/GYN, and Outpatient Behavioral Health

to screen patients for unmet resource needs and use the information from the screening to refer patients to community-based resources to address their unmet needs. The State is considering adding more explicit healthy opportunities requirements after the first year of managed care experience.

The State recognizes that some practices and CINs/Other Partners may be interested in moving beyond the current AMH Tier 3 model toward more advanced value-based contracts that include increased accountability for total cost of care and/or shift payments to practices to a primary care capitated model (HCP-LAN level 3A or above). The State strongly encourages these developments, which align with the State's Value-Based Payment Strategy. PHPs and practices that want to enter into payment arrangements beyond Tier 3 in the HCP-LAN taxonomy may elect to do so at any time, with prior approval of the State.

To ensure delivery of high-quality care under the MMC, the State developed an MMC Quality Strategy and identified a set of quality metrics that to assess PHP performance across their entire populations. The State has identified a subset of these measures for PHPs to use to monitor AMH performance and calculate AMH performance incentive payments.

The State will require PHPs to offer a contract to all AMH Tier 3 practices in each of their service areas. Over 80% of PHP members are enrolled in Advanced Medical Home Tier 3s.

Beneficiary Count by Plan and AMH Tier

	AmeriHealth	HealthyBlue	CCH	UHC	WellCare	Unassigned	Grand Total
No Assigned Tier	4,039	9,940	8,885	7,955	3,033	1,331	35,183
Tier 1	1,854	7,896	2,189	3,278	3,088	84	**18,389**
Tier 2	42,683	67,976	33,227	64,930	55,019	1,463	**265,298**
Tier 3	257,563	333,822	171,861	285,970	284,964	5,869	**1,340,049**

Beneficiary Proportion by Plan and AMH Tier

	AmeriHealth	HealthyBlue	CCH	UHC	WellCare	Unassigned	Grand Total
No Assigned Tier	1.32%	2.37%	4.11%	2.20%	0.88%	15.22%	**2.12%**
Tier 1	0.61%	1.88%	1.01%	0.91%	0.89%	0.96%	**1.11%**
Tier 2	13.94%	16.21%	15.38%	17.93%	15.90%	16.73%	**15.99%**
Tier 3	84.15%	79.59%	79.53%	78.99%	82.35%	67.10%	**80.78%**

*Providers that are not contracted at the State-designated AMH tier are not included in these counts.
**CCH only required to contract with providers in regions 3, 4 and 5. Proportion reflects updated denominator.

Providers Contracted by State-designated AMH Tier by Plan*

	Available Providers	AmeriHealth	HealthyBlue	CCH	UHC	WellCare
Tier 1	**275**	60	147	63	123	99
Tier 2	1,064	394	907	393	645	503
Tier 3	1,648	1,314	1,366	921	1,394	1,440

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

	Available Providers	AmeriHealth	HealthyBlue	CCH**	UHC	WellCare
Tier 1	N/A	21.82%	53.45%	50.00%	44.73%	36.00%
Tier 2	N/A	37.03%	85.24%	66.27%	60.62%	47.27%
Tier 3	N/A	79.73%	82.89%	90.03%	84.59%	87.38%

Results of beneficiary satisfaction surveys

North Carolina conducts an annual "Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey" for North Carolina child 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. For calendar year 2019, the child survey found that 89% of respondents reported being able to receive the care they need and 93.9% reported being able to get needed care quickly.

The State's 2020 CAHPS implementation oversampled several populations so results can be stratified by race, ethnicity and receipt of telehealth services. The latter is intended to provide insight into the impact of new telemedicine policies implemented to support continuity of care during the Public Health Emergency. The State intends to oversample even more extensively in its 2021 CAHPS implementation, which will be the first opportunity to compare results across PHPs.

Grievances and appeals

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

Budget Neutrality and Financial Reporting Requirements

Since the State went live with Standard Plans on July 1, 2021, there are no budget neutrality reporting updates for this period.

Managed Care Evaluation Activities and Interim Findings

The evaluation team continues to build the large number of metrics that are evaluated. The State had an increasing number of meetings with State IT staff to prepare for the receipt of the new encounter data from the July 1, 2021 implementation of the Standard Plans and the new variables available that reflect

provider participation in the networks of these plans. The State is examining whether Marketplace enrollees from a North Carolina-based insurer could serve as a potential comparison group for the difference-in-differences analysis through the comparison in trends in seven identified measures.

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 prepared for the transformation and what can be done to improve their satisfaction with the Medicaid program. The qualitative team completed coding interviews with 46 individuals from practices across the state, 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). Additionally, the qualitative team has scheduled interviews with staff from the State (n = 5) to better capture perspectives of the transformation with respect to consumer engagement, provider participation, relationships with the PHPs, and rollout and implementation. Two of these interviews were completed, and the remaining three will take place in mid- to late-September. Once IRB approval is received for the PHP interview guide and email language, the qualitative team will also conduct outreach to representatives from each of the PHPs (n =5) to schedule interviews that will take place in September and October. The analysis of the practice interviews is underway via the qualitative coding program, Dedoose, which will allow the team to identify and report on key themes across interviews.

Enhanced Case Management (ECM) and Other Services Pilot Program

Operational Updates

Introduction

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. The State has begun working with Network Leads to prepare them for Pilot launch and distributed the first pilot capacity building dollars to Network Leads in June 2021.

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

Following a competitive procurement process, the three Network Leads and counties included in their current regions are:

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

A formal kickoff with the Network Leads was held on June 8, 2021, and weekly individual and group engagement sessions were subsequently held. Additionally, the Network Leads have submitted several deliverables, including their implementation plans, geographic footprints and Human Service Organization (HSO) network application processes.

Model contracts to be leveraged by the Network Leads in contracting with both HSOs and PHPs were provided for review and will be finalized for use during the next reporting period.

During the last period, the State conducted extensive work with Unite Us, the software development company that built NCCARE360, North Carolina's statewide, closed-loop referral system, to design additional NCCARE360 functionality for the Pilots. The State and Unite Us engaged in a detailed review of business and technology requirements through working sessions spanning the duration of the quarter. As a result of these sessions, the State intends to work with Unite Us to build Pilot-specific eligibility verification, service authorization and invoicing functionality into NCCARE360. This will allow entities participating in the Pilots, such as HSOs, Network Leads, care management entities and PHPs to use a single platform for most Pilot functions. The State and Unite Us are working on a contract to finalize requirements related to this scope of work.

The State has continued to engage PHPs throughout this period to review requirements and solicit feedback related to Pilot design and implementation. PHP feedback has been incorporated into design, implementation and technology considerations, and the engagement sessions continue to foster a positive working relationship between the State and PHPs regarding the Healthy Opportunities Pilot efforts.

Additionally, the State continued working closely with Unite Us to contract and onboard all PHPs onto NCCARE360 by the end of June 2021, prior to the launch of Standard Plans. All Standard Plans are now live on NCCARE360 using the platform to make referrals to non-medical services for their members.

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

Key challenges for the Healthy Opportunities Pilots program during the last period included finalizing the technical approach, business and technical requirements, and related vendor contracts necessary to develop and implement the solution for a Pilot launch date in early 2022. The State continues to work toward an early 2022 Pilot launch date by focusing on adopting critical functionality for Pilot launch, with the ability to develop the Pilot over time. This approach is factored into the technology that will need to be enabled to support the Pilots and by identifying potential program simplifications in the early Pilot years.

Additionally, the State is now closely monitoring and discussing the establishment of the HSO networks with the Network Leads. The Network Lead geographies consist of mostly rural counties where HSOs capable of providing Pilot services may be limited. The State is collaboratively exploring with the Network Leads and PHPs ways to ensure that enough Medicaid members are enrolled in the Pilots to support evaluation. Options under early consideration are for Network Leads to potentially expand their

Pilot geographies in later Pilot years and for PHPs to focus on member outreach and engagement of Pilot services.

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 (formerly Lead Pilot Entity) submitted formal protests of the award in July. It is unknown at this time if any subsequent lawsuits will be filed.

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.

Summary of all public comments received through post-award public fora regarding the progress of the demonstration

Performance Metrics

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

Amount and how incentive funds were dispersed to PHPs

Amount and how incentive funds were dispersed to LPEs

Amount and how incentive funds were dispersed to pilot providers

i. The enrollee cost for each of the top ten enrollees who received the most costly services across all ECMs cumulatively

The 90% percentile cumulative cost for an enrollee in ECM

The 75% percentile cumulative cost for an enrollee in ECM

The 50% percentile cumulative cost for an enrollee in ECM

The 25% percentile cumulative cost for an enrollee in ECM

The 10% percentile cumulative cost for an enrollee in ECM

ii. Incentive Payments. The State will provide a report on the amount and how incentive funds were dispersed to PHPs, LPEs, and pilot providers.

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

iii. ECM Capacity Building. The State will provide a report on the amount of capacity building provided to each LPE, the time frame the funding was provided, and what the funding was used for.

The first issuance of Capacity Building Funds for the May 27, 2021-May 26, 2022 budget period was provided to Network Leads on June 22, 2021. The State permitted Network Leads to request up to $10,000,000 in capacity building funds for the May 27, 2021-May 26, 2022budget period and up to $10,000,000 for the 5 May 27, 2022-May 26, 2023budget period. Network Leads must disburse at least 51% of their capacity building funds to HSOs in their Pilot network.

Additionally, the State 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. The amounts and breakdown of the first capacity building invoices are:

Access East: $2,700,494

Description of Expense	Category of Network Lead Allowable Use	Amount
LPE Salary Dollars	Staff Time: Establishing the Network Lead	$1,058,825
Minor Equipment: Computer Package	Purchases for Functional Systems	19,200
Minor Equipment: Conference Room Communications	Administrative Overhead costs	3,000

Description of Expense	Category of Network Lead Allowable Use	Amount
Minor Equipment: Phone System	Purchases for Functional Systems	5,000
Staff Training & Education	Staff Time: Establishing the Network Lead	56,000
Lease Payments	Administrative Overhead costs	87,500
Furnishings: Offices	Administrative Overhead costs	44,660
Furnishings: Conference Room	Administrative Overhead costs	3,700
Cell Phones	Purchases for Functional Systems	4,800
Cell Service (annual)	Purchases for Functional Systems	7,200
Mobile Hotspots	Purchases for Functional Systems	4,900
System Development, Implementation/Network Integration and Assessment	Purchases for Functional Systems	1,405,709

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

Description of Expense	Category of LPE Allowable Use	Amount
Executive Director (.25 FTE)	Staff Time: Establishing the Network Lead	$27,440.35
Healthy Opportunities Integration Program Director	Staff Time: Establishing the Network Lead	75,856.80
4 Care Council County Leads	Staff Time: Establishing the Network Lead	184,696.00
Health Opportunities QI Coordinator	Staff Time: Establishing the Network Lead	52,770.00
Compliance Manager	Staff Time: Establishing the Network Lead	46,173.71
4 Program Managers (Cape Fear Collective)	Staff Time: Establishing the Network Lead	197,888.00
Salesforce System Administrator (Cape Fear Collective)	Staff Time: Establishing the Network Lead	37,928.41
Implementation Team Consultants (.2 FTE from Novant)	Staff Time: Establishing the Network Lead	35,694.50
Accountant/Claims Processor	Staff Time: Establishing the Network Lead	39,577.47
Recruiting	Staff Time: Establishing the Network Lead	3,250.00
Office space/rent	Administrative Overhead costs	29,250.00
Office supplies	Administrative Overhead costs	6,500.00
Marketing and outreach material	Marketing and Outreach Material	26,250.00
Travel	Staff Time: Establishing the Network Lead	19,500.00
Training and development	Staff Time: Establishing the Network Lead	9,750.00
Accounting and financial reporting (audit & tax)	Staff Time: Reporting	10,000.00

Description of Expense	Category of LPE Allowable Use	Amount
Software(exclude invoicing systems)	Purchases for Functional Systems	3,250.00
Computer equipment	Purchases for Functional Systems	13,000.00
IT management (employee equipment)	Purchases for Functional Systems	8,125.00
Legal services	Other Use Approved by the State	25,000.00
Meetings, Facilitation & Travel	Staff Time: Establishing the Network Lead	100,000.00
Liability Insurance	Administrative Overhead costs	11,000.00
Communication	Administrative Overhead costs	9,750.00
Payroll service	Administrative Overhead costs	3,250.00
Salesforce (not all will be in-kind)	Purchases for Functional Systems	6,500.00
Cultural Competency Training (UNC-W)	Staff Time: Establishing the Network Lead	50,000.00
Teambuilding, coaching and facilitation	Staff Time: Establishing the Network Lead	16,250.00
Collaboration & & Teambuilding	Staff Time: Establishing the Network Lead	32,500.00
External Board Members	Staff Time: Establishing the Network Lead	2,000.00
Human Resource Administration (by CCLCF)	Staff Time: Establishing the Network Lead	11,375.00
Office Management Services (by CCLCF)	Staff Time: Establishing the Network Lead	8,125.00
CFO Services (by CCLCF)	Staff Time: Establishing the Network Lead	37,500.00
CRM/Cultural Competency Training (by CCLCF)	Staff Time: Establishing the Network Lead	11,375.00
Other LPE Expenses	N/A	-1,525.00
HSO Funding	N/A	3,850,000.00

Dogwood Health Trust (Impact Health): $4,982,754

Description of Expense	Category of Network Lead Allowable Use	Amount
Lead Pilot entity establishment	Staff Time: Establishing the Network Lead	$815,918
Lead Pilot entity establishment	Administrative Overhead costs	292,902
Lead Pilot entity establishment	Administrative Overhead costs	91,023
HSO network development	Staff Time: Developing a Network of HSOs	44,511
Infrastructure/IT system development	Staff Time: Developing Infrastructure/Systems	19,360
HSO technical assistance and training	Staff Time: Providing TA/Training to HSOs	228,042
HSO capacity building funding distribution		3,346,000

Description of Expense	Category of Network Lead Allowable Use	Amount
Governance and cross-entity collaboration	Staff Time: Facilitating Collaboration and Governance	92,500
Program administration, evaluation and oversight	Administrative Overhead costs	45,000
Community engagement	Staff Time: Participating in Community Engagement	7,500

Healthy Opportunities Pilots Evaluation Activities and Interim Findings

As Healthy Opportunities Network Lead contracts were awarded in May 2021 and the first Pilot capacity building dollars were dispersed in June 2021, the evaluation team began collecting data on Network Lead uses of Pilot capacity building funds in the last quarter. Additionally, the evaluation team continues to prepare for Pilot service delivery launch. The team has been involved in regular meetings focused on Pilot implementation and data collection, and has helped create contracts to design and implement system integrations necessary for Pilot data collection.

On July 1, 2021, the State executed an implementation contract with the Cecil G. Sheps Center for Health Service Research to serve as the Healthy Opportunities Pilot external evaluator. Dr. Seth Berkowitz, the lead evaluator of the Healthy Opportunities Pilot, has begun meeting with Network Leads to explain their roles and responsibilities in Pilot data collection for evaluation. Due to the Pilot program beginning in 2022, no Pilot services were delivered this reporting quarter.

The evaluation team had two main evaluation activities during this reporting period. The first was providing technical assistance to the Pilot implementation team regarding operationalizing the Healthy Opportunities Pilots to effectively facilitate evaluation once Pilot services begin. As examples, these activities consisted of advice regarding operationalizing eligibility criteria, workflows for delivery of Pilot services and selection of key monitoring metrics. The second main activity involved preparing the necessary information technology infrastructure to receive data regarding Pilot activities once they commence. This involved, for example, identification of necessary data elements, owners of the needed data and making necessary arrangements to receive and transfer data. As of this writing, the external evaluator is well poised to evaluate the delivery of Pilot services once they commence.

Residential and Inpatient Treatment for Individuals with a Substance Use Disorder (SUD)

The State will provide detailed information in the Substance Use Disorder quarterly submission that is due to CMS October 29, 2021.