Medicaid Section 1115 Monitoring Report

North Carolina - North Carolina Medicaid Reform Demonstration

DY5Q3 – May 1, 2023 through July 31, 2023

Submitted on Sep. 29, 2023

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 5 QUARTER 3 REPORT

Executive Summary

This report covers Demonstration Year 5, Quarter 3 (DY5Q3) of the North Carolina Medicaid Reform Demonstration, May 1, 2023 through July 31, 2023.

On July 11, 2023, the Department announced that the previous launch date of Oct. 1, 2023 for the Behavioral Health I/DD Tailored Plans (Tailored Plans) would be delayed, and a new launch date is to be determined. The delay will allow Tailored Plans more time to contract with additional providers to ensure a smooth transition for members and their care providers. Uncertainty with the state budget, which will fund transformation costs and update available funds for the Medicaid program, created additional needs for launching Tailored Plans. Tailored Care Management (TCM), which launched on Dec. 1, 2022, will continue to support these members leading up to the new implementation date. TCM is a care management model that reflects the goal of whole-person care management in NC Medicaid Managed Care.

On July 7, 2023, CMS approved an amendment to North Carolina's Medicaid Reform Section 1115 Demonstration. The demonstration amendment authorizes North Carolina to make changes to the Tailored Plan design that ensure Tailored Plan members maintain access to critical residential services and clarify that only dually eligible individuals enrolled in the Innovations or TBI waivers will enroll in Tailored Plans.

This quarter, the Department finalized a plan for implementing the Healthy Opportunities Pilots for the TCM-eligible Medicaid Direct population, pending CMS approval. Additionally, the Department is preparing to include Advanced Medical Home Pluses (AMH+s) and Care Management Agencies (CMAs) in Pilot care management. Previously, the Department reported that the Pilots were launching an Expedited Enrollment with one human services organization (HSO) and one Standard Plan to deliver fruit and vegetable prescriptions to members. This direct-to-consumer model utilizes a member texting campaign and beneficiary-facing portal to quickly enroll members for services. Initial analyses of the approach found that it is highly effective as a pathway for initial enrollment, and Pilot stakeholders have formed a working group to provide recommendations for the next phase of the Expedited Enrollment program.

Medicaid Managed Care

Operational Updates

Tailored Plan Delay

On July 11, 2023, the Department announced that the previous launch date of Oct. 1, 2023 for the Tailored Plans would be delayed, and a new launch date was to be determined. In February 2023, when the Department made the decision to delay launch to October 1, Department leadership identified three key areas that needed to show progress before Tailored Plans could be implemented:

- The Local Management Entity/Managed Care Organization (LME/MCO) provider network and technical capability readiness needed to improve. (LME/MCOs will serve as the Tailored Plans at launch.)
- The Department needed the appropriate legal tools to ensure the well-being and safety of beneficiaries if an LME/MCO is failing to provide services.
- The LME/MCOs were focused on providing services for the populations they are best positioned to manage successfully.

While gaps remain in provider networks, progress has been made by the LME/MCOs on technical capabilities. The Department has been working collaboratively with the legislature to achieve the necessary tools to administer the Tailored Plans on par with other managed care plans. At the time of this writing, North Carolina does not yet have a state budget, which will fund transformation costs and update available funds for the Medicaid program. Because it remains uncertain when these issues will be fully resolved, the Department announced the delay in Tailored Plans but is not able to announce a certain go-forward date at this time.

Beneficiaries who will be covered by the Tailored Plans will continue to receive behavioral health, intellectual/developmental disability (I/DD), traumatic brain injury (TBI) and physical health care through NC Medicaid Direct. North Carolina's Tailored Care Management model, which launched Dec. 1, 2022, continues to support beneficiaries by providing a care team to coordinate care across providers. Additionally, on July 1, 2023, the LME/MCOs began to provide 1915(i) services, offering an array of home and community-based services (HCBS) to Medicaid beneficiaries with serious mental health diagnoses, severe substance use disorders, I/DD and traumatic brain injury.

The Department has regular meetings with the Tailored Plans to move forward on key project milestones for launch. This includes weekly status meetings with each Plan to track development work and address business issues and risks, business unit-specific meetings with each Tailored Plan, and bi-weekly calls with the Tailored Plan executive leadership teams to address key issues.

The Department has implemented the necessary changes to pause go-live. Business units worked with Tailored Plans to establish a Tailored Plan Delay FAQ process that addresses impacts to implementation work. Through this process, Department addressed all questions and communicated responses back to the Tailored Plans. The Department postponed a second round of on-site readiness reviews with the

Tailored Plans scheduled for July. The previously identified focus areas for the reviews will be re-validated when a new Tailored Plan launch date is established.

Waiver Amendment

On July 7, 2023, CMS approved an amendment to North Carolina's Medicaid Reform Section 1115 Demonstration that makes changes to the Tailored Plan design. As Tailored Plans will cover certain residential services that are not covered by Standard Plans, the Department wants to ensure that members maintain access to these vital services. North Carolina now has authority to require that Tailored Plan members falling into certain groups obtain their Medicaid benefits through a Tailored Plan, with no option to enroll in a Standard Plan.

Additionally, the demonstration amendment clarifies that among members who are dually eligible for Medicare and Medicaid, only those enrolled in the Innovations or TBI waivers will enroll in Tailored Plans. All other dually eligible individuals, including those with significant behavioral health needs and I/DD, will remain in NC Medicaid Direct.

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

Standard Plans (serve majority of members receiving services through NC Medicaid Managed Care)

1. 22% of Standard Plan members received care management services by the end of the contract year (June 2023), meeting the Department's target. The percent of members receiving care management increased steadily quarter over quarter throughout the contract year. (Detailed information is available in the Performance Metrics section of this report.)

2. The Department approved a withhold program for Standard Plans to encourage them to perform beyond minimum performance compliance thresholds in priority areas. In a withhold program, a portion of plans' expected capitation payment is withheld, and plans must meet quality performance targets to receive the withheld funds from the state at the end of the performance period. The withhold program will begin in 2024 and include the following measures:

    - Childhood Immunization Status: Percentage of children receiving 10 recommended vaccines by their second birthday. Performance measured in two ways:
        - 5% relative overall improvement
        - 10% relative improvement in the Black population. (The Black population in NC Medicaid has historically received these vaccines at lower rates than non-Black members.)
    - Prenatal and Postpartum Care:
        - Timeliness of Prenatal Care: Percentage of deliveries in which women had a prenatal care visit within the first trimester
        - Postpartum Care: Percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery

- Screening for Health-Related Resource Needs: Unlike the above measures, for which performance will be used to determine withholds, designation of whether the data reported for this measure is valid determines withholds for this measure. Payout for the measure is based on the results of data validation by the Department's External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG).

Tailored Plans (intended to serve individuals with behavioral health needs and intellectual/developmental disabilities)

1. Phase 3 Comparative Claims Testing started May 15, 2023, and was scheduled to end July 14, 2023. Due to the Tailored Plan launch delay, the end date for Phase 3 testing was extended to Aug. 8, 2023. During Phase 3 testing, Department subject matter experts created 88 specific scenarios that tested Tailored Plans on the following:
    - Edits which consisted of claims requiring a prior authorization, health check, secondary codes, pharmacy claims for clinical policy and duplicate checks, adjustments, uploading documents and electronic visit verification (EVV) for operations/processes.
    - Rates which consisted of claims paying using ACA, FQHC/RHC Fee Schedules in addition to confirming maintenance and ingestion of fee schedules along with different claim types that worked with Tailored Plans and their vendors for durable medical equipment, vision, NEMT, pharmacy and dental.
    - Processes for transition of claims, provider matching, prior authorization process, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and National Correct Coding Initiative (NCCI).
2. The Department met with all Tailored Plans on specific amendment item language to be included as part of the second amendment to the Tailored Plan Contract. The amendment was completed with all six plans by June 27, 2023. Changes in the amendment included but were not limited to:
    - Revisions to scope of services in areas including claims and encounters; value-based payments; provider payments, grievances, appeals and contracting; Tailored Care Management; overall benefits package, including pharmacy benefits; AMHs as Primary Care Providers (PCPs) for members; and member grievances and appeals
    - Revisions to quality metrics
    - Revisions to operational reporting requirements
    - Revisions to Medicaid policies, including the COVID-19 Public Health Emergency managed care policy
    - Revisions to performance metrics, service level agreements and liquidated damages

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

Standard Plans

1. This quarter, Notices of Deficiency (NODs) for non-compliance with the Preferred Drug List for Quarter 1 of Contract Year 2 were issued for two of the five Standard Plans. Plans are required to submit a Corrective Action Plan (CAP) each time a NOD is issued. A CAP must include a description of how the issue will be remediated and the timeline for the implementation of the corrective actions. Once a Plan submits a CAP and it is approved by the Department, the Department will monitor the actions identified until the issue has been resolved. Additionally, liquidated damages were assessed for these two NODs, which plans have the opportunity to appeal.
2. Four Standard Plans received NODs for failure to meet the required mailing timeframes for sending provider welcome packets between August 2021 to October 2022.

Tailored Plans

1. Network Adequacy and Provider Contracting: Provider network coverage and its impact on PCP choice and assignment is an area of concern across the Tailored Plan program and was a major factor in the decision to delay the Tailored Plan launch. Since Tailored Plans started submitting monthly reporting on provider contracting in early May 2022, results have not met network adequacy standards across all the required provider categories. The Department continues to hold open the Provider Contracting Notice of Concern that was issued in August 2022 to provide greater visibility into how Tailored Plans are addressing this challenge. Tailored Plans have shown improvement across provider categories tracked in the Notice, although one Plan still has not met PCP contracting targets.

   The Department has worked to mitigate this risk through close tracking of provider contracting data, monthly AMH/PCP contracting submissions and other specialties from the monthly network submission, and bi-weekly contracting data submitted in response to the Notice of Concern. The Department also holds one-on-one calls with the Tailored Plans to obtain frequent updates on contracting progress and challenges.

   While an updated PCP auto-assignment date will be contingent on the updated Tailored Plan launch date, the Department is continuing the mitigations described above to address hospital and PCP contracting concerns and their downstream impact on member choice.

2. End-To-End Testing Progress: End-to-End testing was paused when the Department delayed Tailored Plan launch. Prior to the pause, End-to-End testing was trending behind on PCP Auto Assignment, TCM Auto Assignment, Transition of Care interfaces, and Tailored Care Management interfaces. The main drivers of this trend have been high defect resolution turnaround time and limited resources to support both production and testing.

Prior to the delay, the End-to-End team was meeting weekly with the Tailored Plans on testing progress and escalating plan-specific delays and challenges through bi-weekly calls with the plans' executive leadership. End-to-End testing for Tailored Plans is scheduled to restart once the new Tailored Plan launch date is established.

3. TCM Certification and Contracting for Providers: To stabilize existing TCM providers and ensure they receive requested panels, the Department has divided the Round 3 applications into three cohorts. Providers were selected based on their ability to serve areas and populations with high need. Cohorts 3.2 and 3.3 include many AMH+s, which will increase the number of community-based providers in the TCM program. The cohorts have different timelines; 3.1 providers will enter the field this fall, and 3.3 providers will enter the field in early 2024.

4. TCM Auto-Assignment: The Department has been working closely with the LME/MCOs to improve their readiness to independently support TCM Auto-Assignment since April 2023, a process that they will continue to perform for the Tailored Plan population upon Tailored Plan launch. The goal is to reach a point where all LME/MCOs, without direction from the Department, can correctly identify and assign newly eligible members and identify and reassign members who had a change in eligibility or overall care needs.

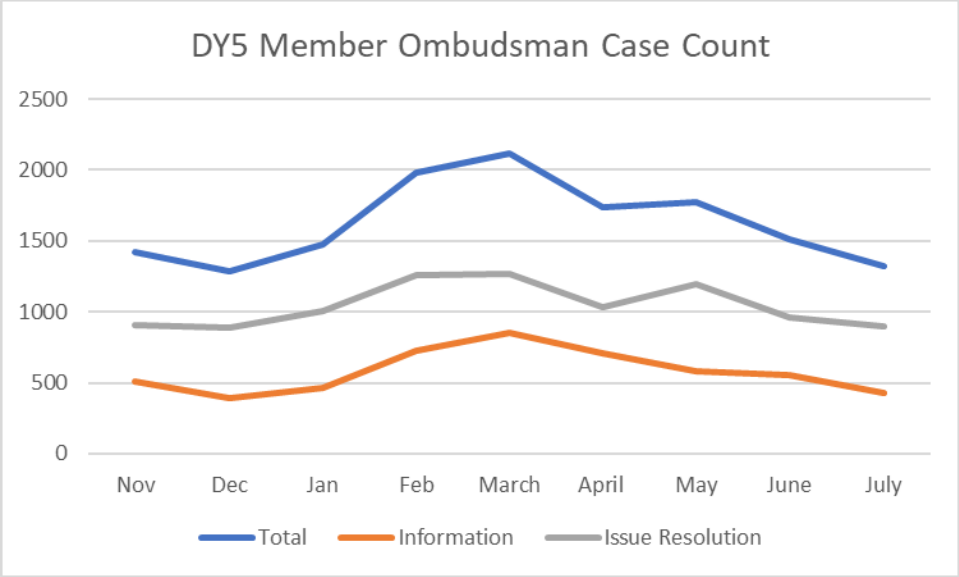
   The Department has scheduled individual working sessions with LME/MCOs to provide real-time feedback as they work toward this goal. Currently, one LME/MCO has been approved to submit daily assignments directly to NCFast. Of the remaining LME/MCOs, two are required to submit assignments to the Department for pre-approval prior to NCFast submission, and three submit assignments to NCFast on a bi-weekly basis with Department oversight.

Issues or complaints identified by beneficiaries

The Department receives beneficiary complaints primarily from the Office of Administration and the NC Medicaid Member Ombudsman. The NC Medicaid Ombudsman is an independent organization that provides education, guidance and referrals to NC Medicaid beneficiaries. Not all Ombudsman calls should be interpreted as complaints, as many involve educating beneficiaries or connecting them to the entity that can provide the service they need. In DY5Q3, the Ombudsman handled 4,609 cases. Case volume decreased approximately 21% from last quarter. (See Appendix A for a full list of cases by category type.)

NC Medicaid Member Ombudsman Cases

May 2023		June 2023		July 2023		Total Cases
Information	Issue Resolution	Information	Issue Resolution	Information	Issue Resolution	
580	1,193	551	960	430	895	**4,609**



The Office of Administration largely handles cases referred from state legislative offices. In previous monitoring reports, all constituent concerns handled by the Office of Administration were reported, including those from non-beneficiaries (such as providers). As of DY5Q1, only concerns from NC Medicaid beneficiaries are included. This change significantly lowers the number of reported concerns compared to previous quarters.

Office of Administration Member Concerns, May - July 2023

Issue Category	Number of Issues
Clinical health	2
NEMT	2
Claims	4
Total	**8**

Lawsuits or legal actions

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

Unusual or unanticipated trends

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

Legislative updates

S.L. 2023-65, enacted June 29, 2023, makes technical changes to various statutes that intersect with managed care:

- Section 5.1 replaces a list of Medicaid recipients that LME/MCOs temporarily continue managing services for after Standard Plan launch, but before Tailored Plans launch, with a category of recipients who are not enrolled in a Standard Plan. The legislation also makes conforming changes and technical changes to various definitions.

Descriptions of post-award public fora

There was no post-award public forum this quarter.

Performance Metrics

Outcomes of care

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

Quality of care

Quality of care metrics will be available next quarter, DY5Q4.

Access to care

Network Time/Distance Standards

At this time the Department is still working to compile the DY5Q3 Standard Plan compliance with network time/distance standards due to issues related to Department staff turnover. This information will be included in next quarter's report.

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	984	1,221	885	943	1,031
Behavioral Health & Social Service Providers	7,842	8,000	6,622	4,851	7,342

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

Beneficiaries Per AMH Tier

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

Member Count by PHP and AMH Tier

	AmeriHealth	CCH*	Healthy Blue	United	WellCare	Total
No PCP Tier	16,988	3,815	40,480	35,601	20,755	**117,639**
Tier 1	3,484	4,592	8,862	4,793	2,765	**24,496**
Tier 2	43,650	47,052	80,075	73,635	57,757	**302,169**
Tier 3	275,967	187,663	389,009	281,309	333,521	**1,467,469**

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

Member Proportion by PHP and AMH Tier

	AmeriHealth	CCH*	Healthy Blue	United	WellCare
No PCP Tier	5.00%	1.57%	7.81%	9.01%	5.00%
Tier 1	1.02%	1.89%	1.71%	1.21%	0.67%
Tier 2	12.83%	19.35%	15.45%	18.63%	13.92%
Tier 3	81.15%	77.19%	75.04%	71.16%	80.41%

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

AMH Provider Enrollment

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

	AmeriHealth	Healthy Blue	CCH**	United	WellCare
Tier 1	37.44%	59.03%	61.70%	51.54%	59.03%
Tier 2	71.74%	89.98%	83.38%	71.09%	65.15%
Tier 3	82.25%	85.99%	87.96%	80.33%	99.38%

*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

These data represent members enrolled in Standard Plans receiving care management through a Standard Plan or Tier 3 AMH practice, and Care Management for At-Risk Children (CMARC) and Care Management for High-Risk Pregnancies (CMHRP) from local health departments (LHDs) since the start of the contract year (July 2022). These data are provided with a one-month lag (DY5Q3 ends July 2023; 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. Care management provided through a Standard Plan, Tier 3 AMH, or LHD to members enrolled in Standard Plans is reported by Standard Plans on the BCM051 Care Management Interaction operational report.

Care Management Penetration by Entity

Period: July 1, 2022 - June 30, 2023

CM penetration by entity:				
	SP	**AMH3**	**LHD**	**Any entity (overall)**
Members with CM	84,240	357,842	65,312	*453,971*
Members reported with CM entity	*1,303,095*	*1,148,419*	*247,028*	*1,005,602*
Penetration rate	**6.5%**	**31.2%**	**26.4%**	**45.1%**

Overall = *Members with care management provided by any entity over the fiscal year period*

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

Percent of Total Care Management Provided by Entity

Period: July 1, 2022 - June 30, 2023

Total Members Reported:	*2,005,602*	
Overall CM Penetration	**22.6%**	**453,971 Members**

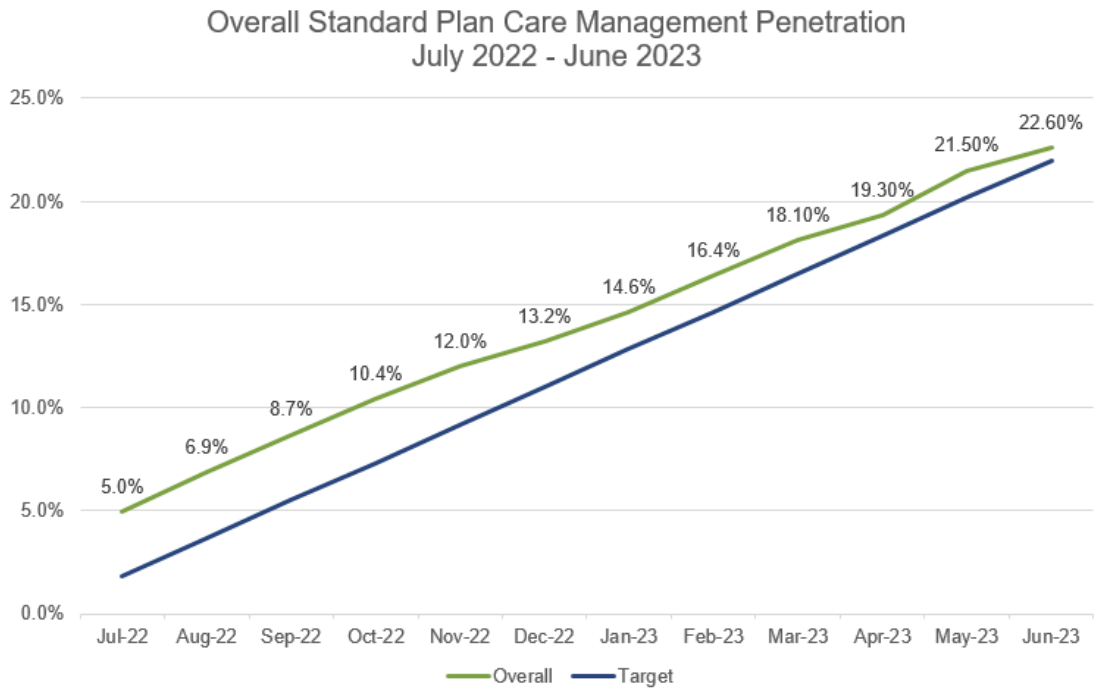
Percent of care management provided by each entity:

SP	**AMH3**	**LHD**
18.6%	78.8%	14.4%
84,240	357,842	65,312

Source*: Members in table are derived from BCM051 Care Management Interaction report prepared by SPs and submitted to DHB.*

Overall Care Management Penetration

The percent of members receiving care management has increased steadily quarter over quarter since July 2022. The target of 22% of Standard Plan members receiving care management services by June 2023 was achieved.



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.

To better reflect claims lag and provide more accurate data, beginning this quarter the Department is reporting these rates with a two-month (instead of one-month) lag. Due to this change, only April and May 2023 are included in this report. 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 currently remain in NC Medicaid Direct.

Emergency Department Visits per 1,000 Members, April – May 2023

AmeriHealth	CCH	Healthy Blue	Medicaid Direct	United	WellCare
60.8	63.2	60.5	78.0	61.9	61.0

Inpatient Admissions per 1,000 Members, April – May 2023

AmeriHealth	CCH	Healthy Blue	Medicaid Direct	United	WellCare
13.0	13.2	12.7	24	13.3	13.7

Results of beneficiary satisfaction surveys

There are no new beneficiary satisfaction survey results to report this quarter.

Budget Neutrality and Financial Reporting Requirements

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

Evaluation Activities and Interim Findings

The Sheps Center for Health Services Research (Sheps) is the independent evaluator for the NC 1115 waiver. 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.

This quarter, the Sheps Center completed the SUD Interim Evaluation Report, which has been submitted to CMS. Sheps also began work on the separate Managed Care Interim Evaluation Report, which is expected to be submitted to CMS in October 2023.

Transition to Capitated Encounter Data from PHPs

Sheps data scientists and analysts continued working with encounter data from members in Standard Plans, encounter data from LME/MCOs serving as the Tailored Plans, and fee-for-service claims data. Sheps has been providing feedback on the quality and completeness of these data to the Department while continuing to update code on metrics to include services, medications, and diagnoses received through claims or encounter data in response to new data challenges or metric versions.

As reported last quarter, the LME/MCOs changed the system through which their claims are submitted to align with Standard Plan data submission. Because of quality issues, the state has not released data that began coming through this system since April 1, 2023. Metrics will be incomplete beginning on April

1, 2023, until this data is released. Sheps is preparing to incorporate the new data format into its analyses.

Qualitative Update

The qualitative team completed its third round of provider interviews May 31, 2023. The analysis of the nearly 50 interviews is ongoing and expected to be finished in early fall 2023. Additionally, interviews with Medicaid beneficiaries were also completed during this period. The team is currently analyzing transcripts from one Spanish language focus group (with four member participants), one Spanish language member interview, and 24 English language member interviews. The goal is to complete this analysis by early fall 2023.

The qualitative team finished the patient engagement manuscript and submitted it to NC Medicaid for review on April 10, 2023. A poster presentation to AcademyHealth's Annual Research Meeting in June received a positive response from attendees. Additionally, the team has opened a graduate research associate position to start in the new academic year. For the next reporting quarter, the team plans to carry out dissemination work, which includes submitting Year 3 progress reports to NC Medicaid, posting a 2-page summary of results from both provider and beneficiary interviews on the Sheps website, and preparing a new manuscript.

Healthy Opportunities Pilots

Operational Updates

Introduction

In this quarter, the Healthy Opportunities Pilots (HOP) completed planning efforts to phase the Advanced Medical Home Plus (AMH+) practices and Care Management Agencies (CMAs) into Pilot care management and implement the Pilot for TCM-eligible NC Medicaid Direct beneficiaries.

Additionally, the Pilot team continued key design activities, including the development of value-based payments (VBP) for Year 3 of service delivery and the next phase of the direct-to-consumer expedited enrollment model.

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

As part of the 1115 waiver amendment, the Department requested approval to expand eligibility for Pilot services to Medicaid Direct beneficiaries. While awaiting approval for this request the Pilot team finalized the plan for implementing the Pilot for the TCM-eligible Medicaid Direct population. The LME/MCOs began their implementation work to ensure Pilot services could be delivered once the amendment was approved. Additionally, the Department finalized the workplan for including AMH+s and CMAs in HOP care management. The Department made the decision to launch the AMH+s and CMAs on February 1, 2023, to ensure that these delegated care management entities are prepared to conduct Pilot care management activities in addition to their TCM workload.

The Department continued work associated with VBP Period 3, focusing on developing a model to incentivize Pilot-participating entities to meet established performance targets that would advance the overall goals of the Pilot. Additionally, following CMS approval received this quarter, the Department posted the first HOP rapid cycle assessment to the NC Medicaid website.

Finally, the Department evaluated the first phase of the Expedited Enrollment implementation, a direct-to-consumer model that utilized a member texting campaign and beneficiary portal to enroll members to receive Pilot services. Initial analyses of the approach demonstrated that it is highly effective as a pathway for initial enrollment, but additional work is needed to ensure that members are connected to care management for long-term support. Pilot stakeholders, led by Network Leads, formed a working group that is currently meeting to assess recommendations for the next phase of expedited enrollment.

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

The Human Services Organizations (HSOs) continue to report delays in receiving timely payment for services delivered due to invoicing challenges. To mitigate these issues, the Network Leads have initiated working sessions with the Standard Plans and the Pilot technology vendor to expedite a resolution. This approach has yielded initial success for the resolution of issues and is providing a framework for the monitoring and resolution of future challenges.

Unusual or unanticipated trends

Due to the ongoing issues with invoicing and payment, several HSOs have temporarily turned off their ability to receive new HOP referrals in NCCARE360, which has resulted in network adequacy gaps for some services across Pilot regions. In addition to the Department's efforts to resolve the invoice issues, the Network Leads are closely monitoring the status of their regions. Network Leads are mitigating the service gaps by implementing strategies to contract with additional HSOs, expand the service offerings of existing HSOs and adjust capacity building funds to provide support to HSOs facing significant funding flow issues.

Performance Metrics

Enrollee Service Costs

The enrollee service cost analysis represents NCCARE360 data received by the Sheps Center on June 30, 2023. This data contains information on services delivered March 15, 2022 through April 30, 2023 that had an invoice status of "paid." There were 3,686 members that received a total of 38,920 services that had been both provided and paid for, totaling an amount invoiced of $6,565,622.07. Costs are calculated using "amount invoiced" within NCCARE360 as it is the most current and reliable data source. It should be noted in analyses of spending by service domain that Interpersonal Violence (IPV) services only launched April 5, 2023, while the other service domains launched in 2022.

Assessments found that members fell into disparate eligibility categories when completing multiple screening forms, even when the screenings were completed on the same day. Due to this, eligibility category is determined by age at time of enrollment for age-based categories. If a beneficiary indicated they were pregnant on their screening form at any point in their enrollment, they were also placed in the pregnant individuals eligibility category. Individuals that did not fall into the pregnant individuals category and for whom an age could not be calculated (because they had no date of birth provided) were coded as having a missing eligibility category.

Ten largest invoiced amounts per individual beneficiary

Order	Total Amount Invoiced	Types of Service(s) Received			
		Food	Housing	Transportation	Cross-domain*
1	$ 17,800.28	-	-	-	✓
2	$ 16,637.04	✓	✓	-	-
3	$ 16,428.45	✓	✓	-	-
4	$ 15,750.00	-	✓	-	-
5	$ 15,678.58	✓	✓	-	-
6	$ 15,041.64	✓	✓	-	-
7	$ 14,394.07	✓	✓	-	-
8	$ 14,126.81	✓	✓	✓	-
9	$ 12,028.08	✓	✓	-	-
10	$ 11,662.76	✓	✓	-	-

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

**There were no IPV services delivered to any of the beneficiaries with the ten largest invoiced totals. IPV services launched April 5, 2023 and only services delivered through April 30, 2023 are included here.

Percentile amount paid per enrollee

Percentiles	Amount Invoiced
90%	$ 4,013.63
75%	$ 2,419.75
50%	**$ 1,258.27**
25%	$ 533.13
10%	$ 267.87

Percent of amount paid by PHP and service category

PHP	Food Services	Housing Services	Transportation Services	Cross – Domain	IPV* Services
AmeriHealth Caritas North Carolina	9.58%	3.54%	0.14%	-	-
Blue Cross and Blue Shield of North Carolina	16.73%	6.89%	0.38%	0.07%	-
*Carolina Complete Health***	2.91%	1.76%	0.05%	0.01%	-
UnitedHealthcare of North Carolina	12.05%	5.24%	0.38%	0.32%	-
WellCare of North Carolina	29.32%	9.81%	0.74%	0.07%	0.01%
Total	**70.59%**	**27.24%**	**1.69%**	**0.47%**	**0.01%**

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

Percent of amount paid by PHP by Enrollment Category

PHP	Children 0 - 20	Adults 21+	Pregnant Women*	Missing
AmeriHealth Caritas North Carolina	4.58%	7.44%	0.29%	1.26%
Blue Cross and Blue Shield of North Carolina	7.49%	14.16%	0.38%	2.43%
*Carolina Complete Health***	1.45%	2.95%	0.17%	0.30%
UnitedHealthcare of North Carolina	4.40%	11.09%	0.38%	2.47%
WellCare of North Carolina	12.82%	23.30%	0.75%	3.82%
Total	**30.74%**	**58.94%**	**1.97%**	**10.28%**

*Pregnant beneficiaries will also appear in either children 0 – 20 or adults 21+

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

Incentive Payments to PHPs, NLs, and Pilot providers

There were no incentive payments released this quarter.

Pilot Capacity Building Funding

In this quarter, Access East received $2,133,347.36 in capacity building funds and Impact Health received $4,973,333.50.

Healthy Opportunities Pilots Evaluation Activities and Interim Findings

During this quarter, Sheps provided ongoing technical assistance and engagement with state program personnel to facilitate the Healthy Opportunities Pilots evaluation. Activities included participating in

newly added bi-weekly meetings to discuss data goals and technical difficulties as well as retaining weekly and monthly standing meetings.

Sheps prepared a qualitative manuscript to be submitted to peer reviewed journals based on results from the first rapid cycle assessment (RCA). This involved working with the qualitative team at Sheps and co-investigators to create and review the manuscript in preparation to send to NC Medicaid for review. The manuscript was sent to the Department on July 21, 2023.

Sheps continued primary data collection for evaluation question 4 (patient-reported health outcomes). This longitudinal survey launched at the end of May 2023, and data collection is ongoing. The team is also currently developing materials for Spanish speaking participants.

Preparation for dashboards to monitor implementation of the Pilots has also continued. Dashboards on invoices have been developed and visualized, and other dashboard visualizations are in progress. This project entails developing definitions of data elements that will be visualized in dashboards, working with NC Medicaid to understand the prioritization of the data elements, and developing the design of the visualization dataset.

Finally, Sheps worked on developing metrics that will be used in the Pilot interim evaluation report and determining a feasible timeline for that report in light of adjustments to delivery of Pilot services made in response to the Public Health Emergency. CMS approved a new deadline for the report of April 30, 2024.

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. 29, 2023.