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Understanding Medicaid Transformation for Community Leaders: How to Prepare Today for Tomorrow

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NC's Roadmap to "Buy Health"

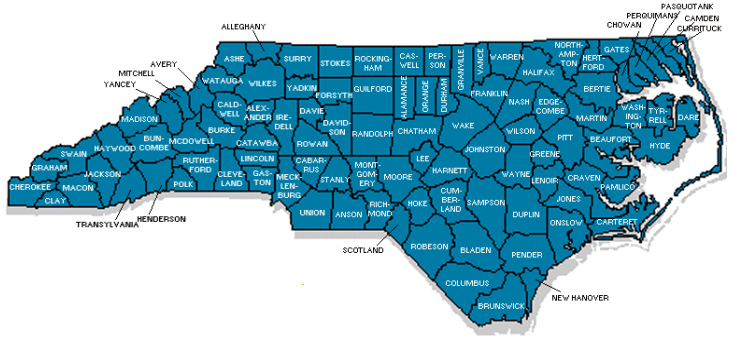
Mandy Cohen, MD, MPH

Secretary, NC Department of Health and Human Services

December 3, 2019

Vision for “buying health”

“We envision a North Carolina that optimizes health and well-being for all people by effectively stewarding our resources that bridge our communities and our health care system.”



DHHS Releases Vision for Future of Behavioral Health

Raleigh, NC

Feb 1, 2018

Our Vision: "North Carolinians will have access to integrated behavioral, developmental, and physical health services across their lifespan. Efforts within this plan will enhance the quality and capacity of services and supports in partnership with providers, clients, family members, and communities to **promote hope and resilience and achieve wellness and recovery."**

Behavioral Health and IDD is critical to our vision for buying health. This isn't separate, it is fully integrated to our work in the Department.

The NC Behavioral Health & IDD Strategic Plan outlines two key objectives that clearly connects to our broader "buying health" strategy.

1. Timely access to high-quality services

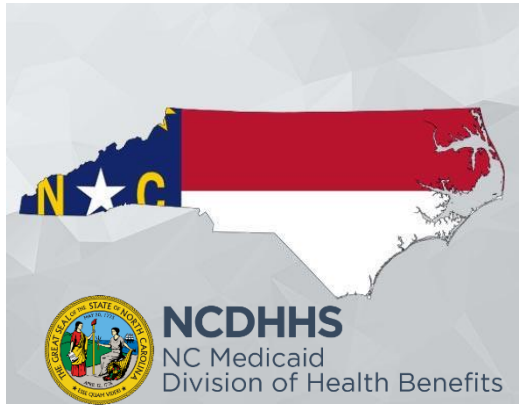
- Close the coverage gap
- Develop community-based services that match existing needs
- Strengthen community collaboration to develop, assess, and improve services

2. Whole Person Focus and Investment

- Integrated Behavioral Health, I/DD, and Physical Health Services with one insurance card
- Routine screening for children and adults
- Robust communication practices between behavioral and physical health providers
- Improve data and measurement to drive accountability and encourage innovation

“Buying Health” Across Our Department

Early Childhood Action Plan ⟷ **Medicaid Transformation** ⟷ **Opioid Action Plan**



“To improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care that addresses both the medical and non-medical drivers of health.”

Medicaid Transformation

- **Whole-Person Focus**
  - Physical and Behavioral Health Integration – Payment and Delivery
  - Addressing Unmet Social Needs – Healthy Opportunities
- **Primary Care and Local Care Management Investment**
  - Advanced Medical Home Program
  - Behavioral Health Home and Care Management
- **Value-Based Payments**
  - By end of Year 2 in managed care, health plan expenditures must:
    - Increase by 20 percentage points, OR
    - Represent at least 50% of total medical expenditures
- **Unified Quality Strategy**
  - Aligned physical and behavioral health metrics; focus on total cost of care

NCCARE360 Coordinated Network

A coordinated network that connects providers (such as health care providers, insurers, or community organizations) through a shared technology platform to:

- **Communicate in real-time**
- **Make electronic referrals**
- **Securely share client information**
- **Track outcomes together**

Foundation for Health Leadership & Innovation
Moving people and ideas into action.

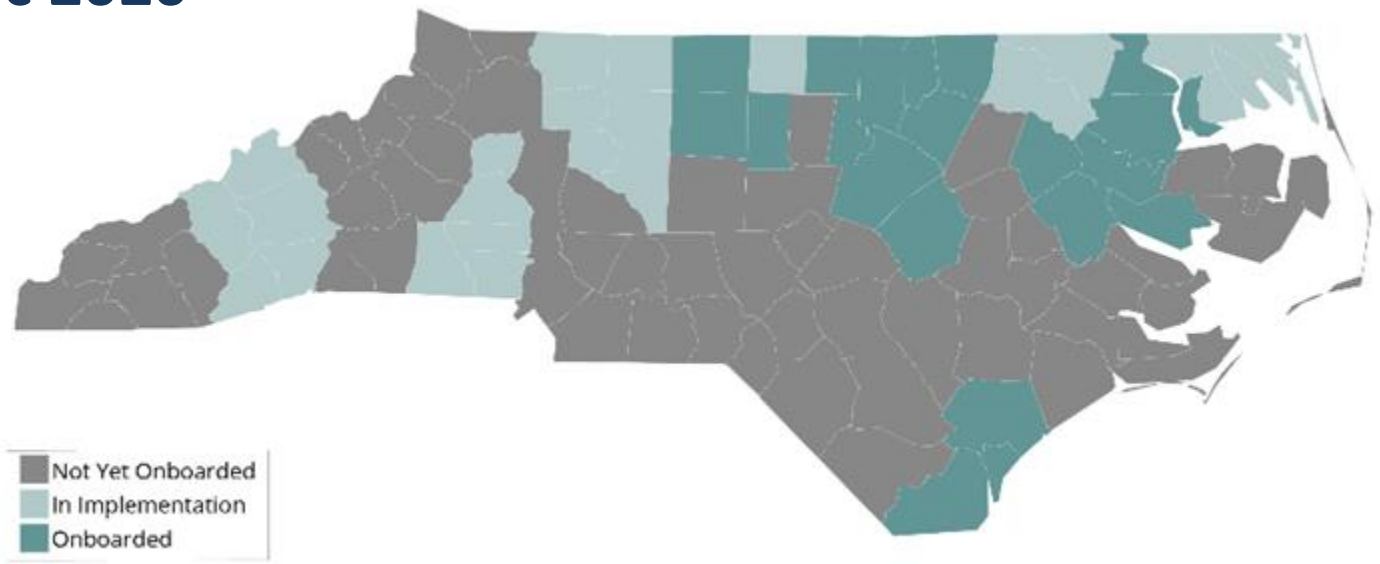
United Way of North Carolina

NCDHHS

Expound

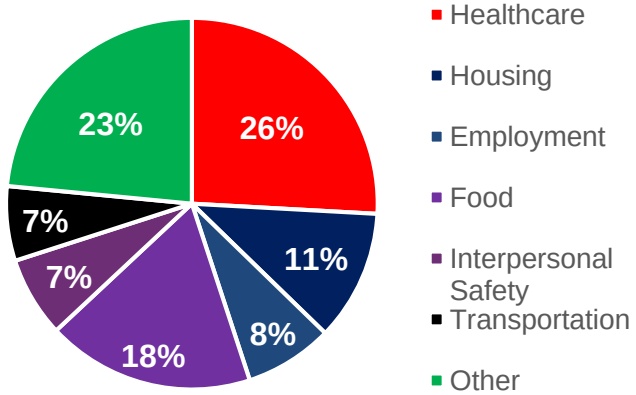
NORTH CAROLINA 211

NCCARE360 State Coverage (as of 11/18/19) – to be statewide by Dec 2020



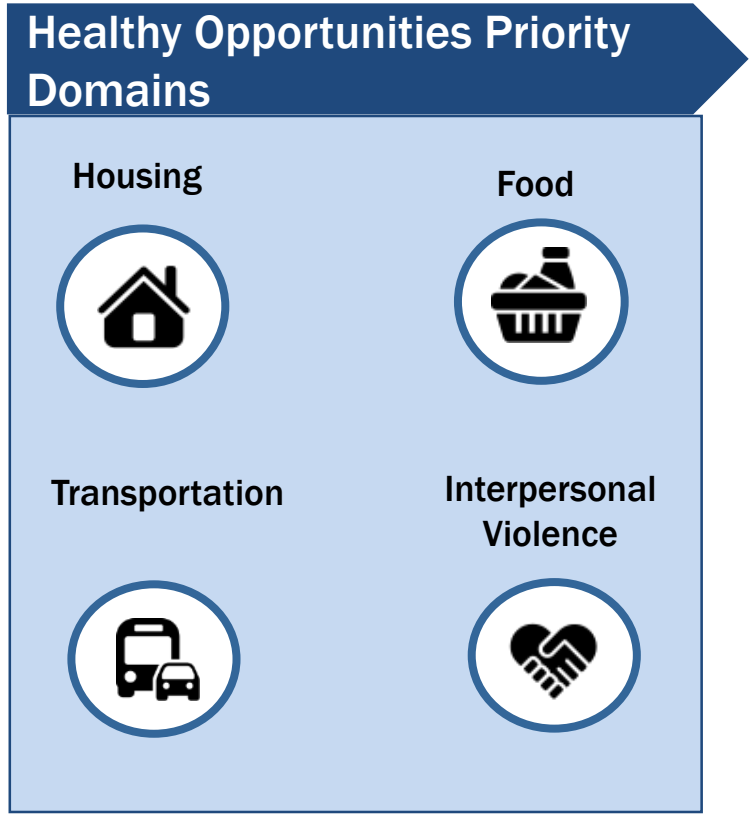
- 21 counties launched
- 29 counties started on implementation
- 2464 organizations engaged in socialization process
- 479 organizations with NCCARE360 licenses
- 1864 active users
- 1532 referrals sent
- 2,954 organizations verified in Resource Repository
- 10,736 programs verified in Resource Repository

Engaged Organizations by Service Type



Medicaid Pilots to "Buy Health"

- Up to $650M investment from Medicaid
- Unique opportunity for data and evidence generation.
- Embedded in the new managed care structure
- Detailed service definitions and pricing model
- RFP released November 5th



Eligible Pilot Services

Housing

- Tenancy support and sustaining services
- Housing quality and safety improvements
- One-time securing house payments (e.g., first month's rent and security deposit)

Food

- Linkages to community-based food services (e.g., SNAP/WIC application support)
- Nutrition and cooking coaching/counseling
- Healthy food boxes
- Medically tailored meal delivery

Transportation

- Linkages to existing public transit
- Payment for transit to support access to pilot services, including:
  - Public transit
  - Taxis, in areas with limited public transit infrastructure

Interpersonal Violence (IPV)

- Linkages to legal services for IPV related issues
- Evidence-based parenting support programs
- Evidence-based home visiting services

Opioid Action Plan 2.0 pushes us to broaden our approach.

- Infrastructure Investments
- Whole-Person care focused
- Value-Based Pilots
- SUD 1115 Medicaid Waiver
- Justice-Involved Populations
- Upstream to Prevention
- Data Modernization

2025 Goals At-A-Glance

1. Healthy Babies
2. Preventive Health Services
3. Food Security
4. Safe and Secure Housing
5. Safe and Nurturing Relationships
6. Permanent Families for Children in Foster Care
7. Social-Emotional Health and Resilience
8. High Quality Early Learning
9. On Track for School Success
10. Reading at Grade Level

2019-2020 Priority Goals

1. Healthy Babies
2. Preventive Health Services
3. Food Security
4. Safe and Secure Housing
5. Safe and Nurturing Relationships
6. Permanent Families for Children in Foster Care
7. Social-Emotional Health and Resilience
8. High Quality Early Learning
9. On Track for School Success
10. Reading at Grade Level

Medicaid Expansion

500,000	**New projected enrollees due to expansion, including a disproportionate number of rural North Carolinians**
90%	**Share of costs paid by the federal government – no new state appropriation needed to fund the state share**
43,000+	**Jobs created in the first five years of expansion**

Create a sustainable infrastructure to fight the opioid crisis

•

Improve health in NC, reduce rural health disparities

•

Put downward pressure on premiums

Challenges Ahead

- **Political uncertainty**
- **Change management across many organizations**
- **Data infrastructure modernization**
- **Culture change takes commitment and time**

Recognizing our Shared Commitment:

- To the vision of “buying health”
- To partnership and alignment
- To the children, families and communities that we serve





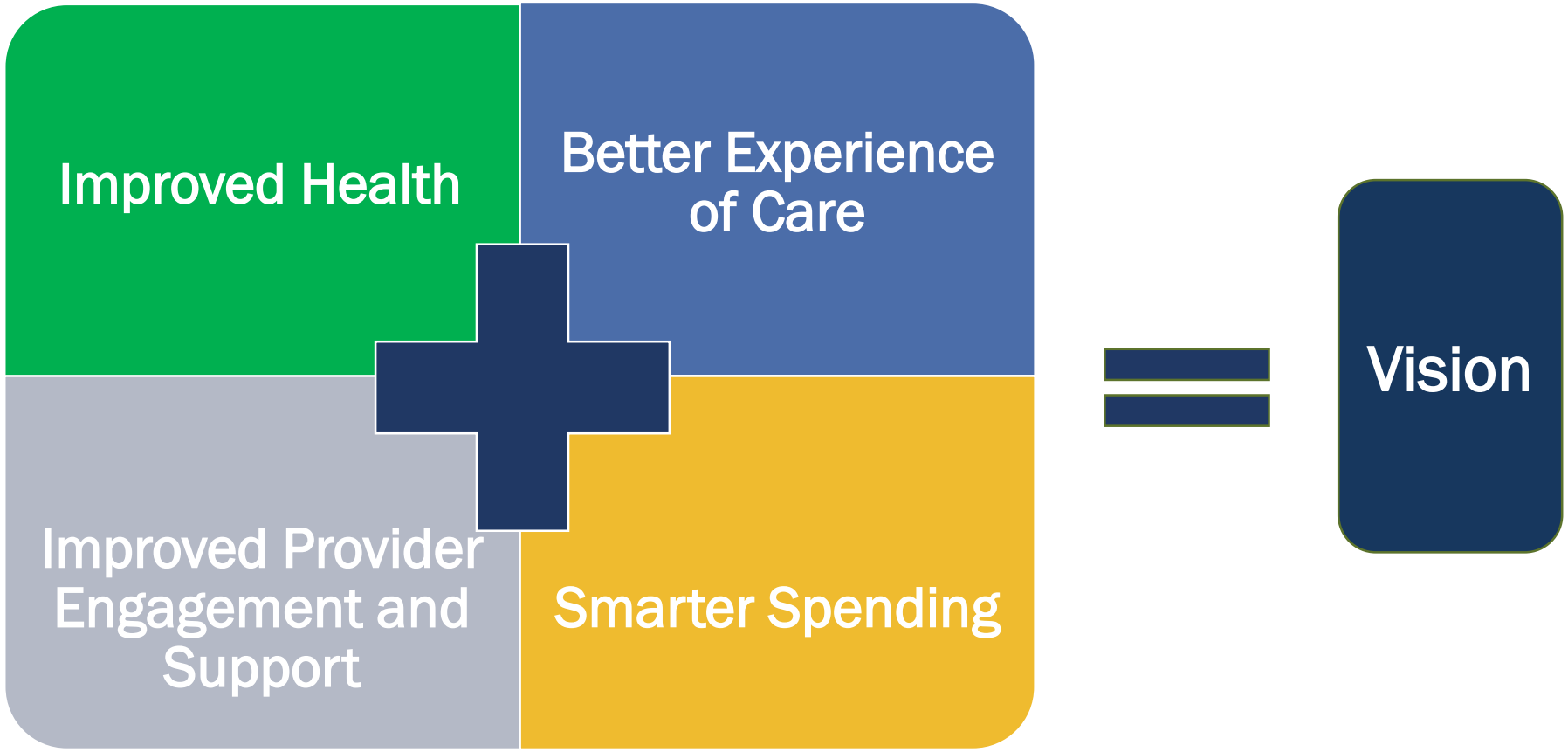
Creating and Implementing a System That Works

Dave Richard
Deputy Secretary
North Carolina Medicaid

i2i Pre-Conference Symposium

December 3, 2019

A System That Works for Beneficiaries & Providers



North Carolina Medicaid

Improving the quality of life for our most vulnerable citizens

2.1

million

people covered by Medicaid





Images: Thinkstock by Getty Images

Opportunities for Improved Health

53% of beneficiaries are children

50% of NC births covered by Medicaid

Opportunities to Improve Health

70% of health outcomes are tied to non-medical social determinants

16% households in NC are food insecure

33rd NC's ranking in overall health relative to other states

73% receiving food assistance have had to choose between paying for food or health care or medicine

1.2M North Carolinians, rural and urban, cannot find affordable housing

USDA Economic Research Service, "Food Security status of U.S. Households in 2015"
ncfoodbanks.org/hunger-in-north-carolina/
Robert Wood Johnson, County Health Rankings, countyhealthrankings.org/app/north-carolina/2017/overview
https://www.healthaffairs.org/do/10.1377/hblog20190206.576299/full/ American Health Rankings a composite index of over 30 metrics that give an annual snapshot of.

Opportunities for Improved Health

DHHS will

- Focus on Population Health
- Focus on Quality
- Address Unmet Social Needs
- Pilot new initiatives i.e. Telemedicine, access to SUD and behavioral health treatment through IMD, in-lieu and value added services

Integration Is Necessary For Improved Health

- Integration of all aspects of care including primary, behavioral health and pharmacy services
- Services will be managed Health Plans (health plan “products”:
  - **Standard Plans**
  - **BH I/DD Tailored Plans**
  - **Statewide Foster Care Plan**

- All three types of products will offer a robust set of behavioral health benefits; however, certain more intensive behavioral health benefits will only be available through BH I/DD Tailored Plans

- Continued focus on high-quality, local care management in all three types of products

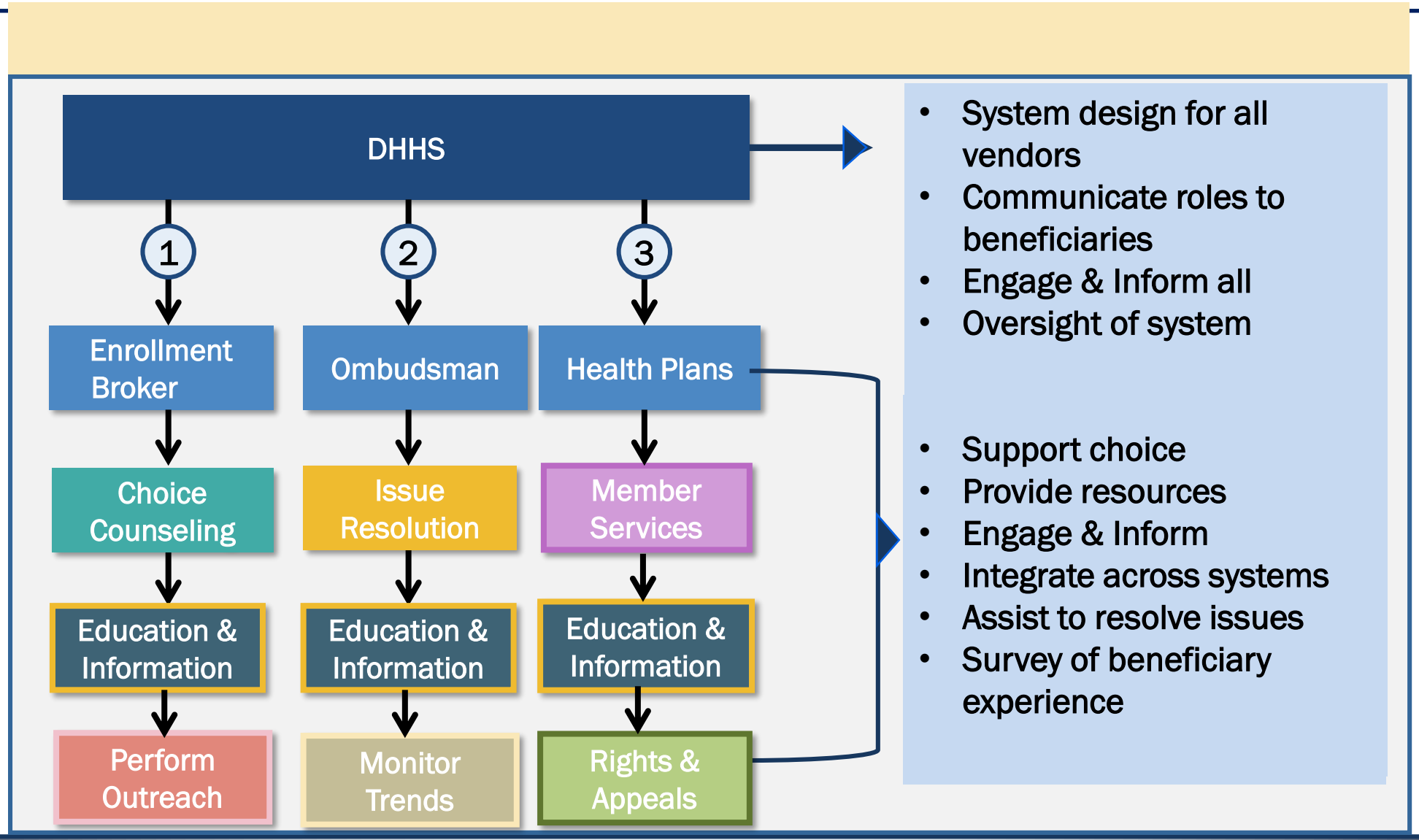
Tailored Plans

- Whole person, fully integrated care
- Implemented 1+ year after Standard Plan go live
- Operated by LME-MCOs which are successfully responsive to RFA
  - 5-7 entities
  - Must contract with licensed PHP that covers services required under a Standard Plan contract
  - After the first four-year period, non-profit prepaid health plans (PHPs) may also operate BH I/DD Tailored Plans
- Regions may mirror existing LME-MCOs
- Tailored Plan only services
- Manage state-funded behavioral health, IDD And TBI services for underinsured and uninsured

Who is served by Tailored Plans?

- 115-135K NC Medicaid and Health Choice beneficiaries with serious mental illness, serious emotional disturbance, substance use disorder, I/DD, or traumatic brain injury;
- Individuals on Innovations, TBI waivers

Better Experience Of Care For Beneficiaries



Improved Provider Engagement & Support

Managed Care Design will

- **Create new opportunities**
- **Minimize provider burden**
- **Sustain current crisis system**

New Opportunities for Providers	
• Contract with Plans • Rate Negotiation • Value Based Payments	• Addressing unmet social needs • Interface with new entities i.e. enrollment broker, ombudsman (member and provider) • Becoming a Care Management Agency

Improved Provider Engagement & Support

Standardization in Managed Care

- Incorporating a centralized, streamlined enrollment and credentialing process
- Standardizing and simplifying processes and standards across Health Plans
- Ensuring transparent payments for Health Plans and fair contracting and payments for clinicians
- Standardizing quality measures across Health Plans
- Using standard prior authorization forms
- Establishing a single statewide preferred drug list that all Health Plans will be required to use
- Covering the same services as Medicaid Fee-for-Service (except select services carved out of managed care)
- Requiring Health Plans to use DHHS' definition of "medical necessity" when making coverage decisions and set FFS benefit limits as a floor in managed care
- Transition of Care Requirements related to data exchange, honoring authorizations

Improved Provider Engagement & Support

- Provider Ombudsman
  - Provider ombudsman service available where a provider may submit a complaint about a PHP
  - Provider manual must include information on ombudsman service and instructions on how providers can submit complaints
- Detailed Requirements of DHHS for PHPs
  - Provider Appeals including
    - timeframes for how PHPs must handle provider appeals
    - DHHS review of PHPs' provider appeals policies
    - Appeals of Suspension or Withhold of Payment

Improved Provider Engagement & Support

Input and Information

- Engagement through MCAC subcommittees, AMH Technical Advisory Group
- Feedback on Design
- Experience Surveys
- Health Plan Provider Line

Training & Technical Assistance

- Training offered by
  - AHEC
  - DHHS
- Health Plan resources incl. manual, directory, portals

https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care

Smarter Spending in Managed Care

- DHHS focus on buying health
- Design incentivizes innovation
- Fully capitated Health Plan contracts which manages full cost of care
- Financial Penalties applied to Health Plans when appropriate
- Introduce value-based payments
- Care Management PMPMs
- Explore additional innovations i.e. address direct care workforce
- Tribal Option available to members of EBCI

Questions/Discussion

The Role of Standard Plans

Department of Health and Human Services
Sarah Gregosky, Deputy Director of Standard Plans

December 3, 2019

North Carolina's Vision for Standard Plans

- Delivering whole-person care
- Utilizing cost-effective resources and uniting communities and health care systems
- Performing localized care management
- Streamlining the Medicaid Managed Care Member experience
- Maintaining broad provider participation
- Supporting the Department's overall vision of creating a healthier North Carolina.

Who is served by Standard Plans?

- 1.5 million NC Medicaid and Health Choice beneficiaries
- TANF (families, children, pregnant women) and ABD (aged, blind or disabled) populations not otherwise excluded or eligible for TPs

Standard Plans for NC Medicaid Managed Care

Statewide contracts

- AmeriHealth Caritas North Carolina, Inc.
- Blue Cross and Blue Shield of North Carolina, Inc.
- UnitedHealthcare of North Carolina, Inc.
- WellCare of North Carolina, Inc.

Regional contract – Regions 3, 4 & 5

- Carolina Complete Health, Inc.

Standard & Tailored Plans Side by Side Comparison

- Many similarities exist between Standard and Tailored Plans
- Providers who deliver outpatient services encouraged to contract with both

Similarities	Key Differences
• Fully Integrated Care • Operate under 1115 waiver • Consistent Departmental Oversight • Provider Contracting and Rates Negotiation • Community Based Care Management • Network Adequacy Requirements	• Regions • Entry into Open Network (open vs. closed) • State Funded, Block Grant, current (b)(3) services • Procurement method RFP vs. RFA

Standard Plan Oversight Approach

The Department has developed a comprehensive oversight approach with the PHPs

- Consistent Communication (daily standups, weekly meetings with key business areas and PHP leadership)
- Contract Compliance
  - Clear expectations on Contract Performance (CAPs, Liquidated Damages, and Service Level Agreements)
  - Ongoing reporting, onsite reviews and audits
  - Assessment of PHP network adequacy
- Other oversight mechanisms
  - Procurement of EQRO
  - NCQA Accreditation
  - Infrastructure to monitor ongoing technology operations
  - Feedback from member and provider ombudsman
  - Development of business level oversight playbooks

PHP Network Adequacy

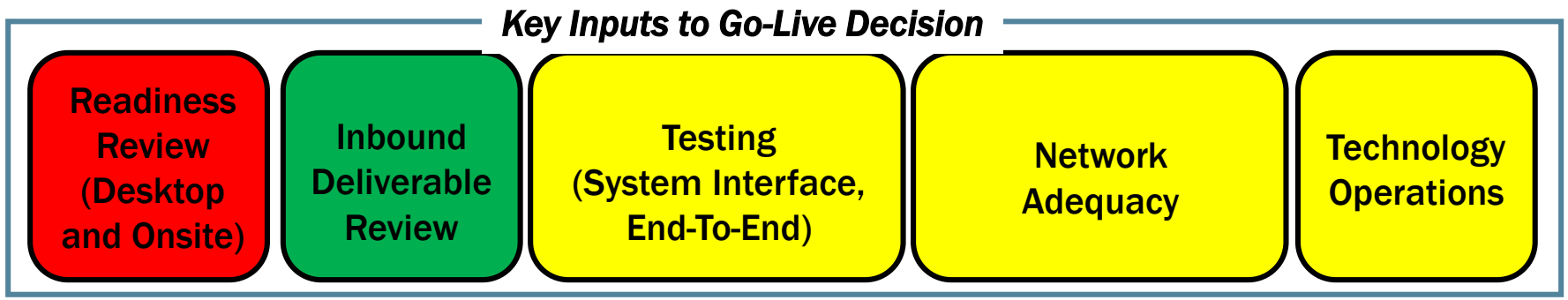
- The Department has continued to monitor PHP network adequacy across a variety of provider types/specialties.
- This information is used to ensure readiness, assess access and support beneficiary choice counseling and PHP selection.

Standard Plan Network Adequacy Standard Provider Types	
Primary care	Outpatient Behavioral Health
Specialty care	Crisis Services
Hospitals	IP Behavioral Health
Pharmacies	LTSS
OB/GYN	Nursing facilities
Occupations, Physical or Speech Therapy	

Standard Plan Readiness Assessment

Prior to the suspension, the Department was assessing PHP readiness across 5 key areas. Some of these assessments will continue, while others are slowed or suspended until a later date:

- **CMS Readiness Review:** Assess ability/capacity to operationalize Managed Care
- **Inbound Deliverables:** Review and/or approve contractual deliverables as part of DHHS oversight (e.g., clinical coverage policies, annual compliance plans, etc.)
- **System Testing:** Assess ability to ingest, process and transmit data and information with DHHS and vendors
- **Network Adequacy:** Ensure we have sufficient providers contracted to provide services to Medicaid beneficiaries
- **Technology Operations:** Monitor call center/website issues and technology-related defects/issues (e.g., daily file exchanges, file defects)



DHHS' Priorities during suspension

- **Beneficiaries:** Ensure beneficiaries have a clear message on what to do know and what to do when managed care restarts
- **Providers:** Continue provider engagement and training and encourage provider contracting with the PHPs
- **PHP Readiness:** Require PHPs to engage in testing and readiness assessments to a place of logical pause or conclusion
- **Procurement:** Move forward with managed care related procurements (Ombudsman, EQRO, and Healthy Opportunities Pilots)

Opportunities for Innovation in Integrated Care

Department of Health and Human Services
Deputy Secretary for Behavioral Health & IDD
Kody Kinsley

December 3, 2019

New Opportunities for Integration in Behavioral Health

- Healthy Opportunities Initiative
- New Grant Opportunities – PIPBHC
- Additional Opportunities with Peer Support
- Using MAT to promote integration

Focus of Today's Discussion

Using new grant opportunities and DMH Innovations to Promote Integration

Healthy Opportunities Initiative Addresses Unmet Social Needs

"Healthy Opportunities," commonly referred to as the social determinants of health, are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

- Access to high-quality medical care is critical, but research shows up to 80 percent of a person's health is determined by social and environmental factors and the behaviors that emerge as a result.
- Addressing the factors that directly impact health is a key component of meeting DHHS's mission to improve the health, safety and well-being of all North Carolinians while being good stewards of resources.

North Carolina's Healthy Opportunities Priority Domains

Housing

Food

Transportation

Interpersonal Safety

Promoting Integration of Primary and Behavioral Healthcare (PIPBHC) in NC

- **Five (5) year SAMSHA grant awarded January 2019**
- **Promotes integration of primary and behavioral care services in high need communities in behavioral health settings to improve the overall wellness and physical and behavioral health of adults with serious mental illness (SMI), children with serious emotional disturbance (SED), and adults and children with substance use disorders (SUD) and/or co-occurring disorders (COD).**
- **Based in 3 providers agencies**
  - **Coastal Horizons**
  - **Daymark Recovery Services**
  - **UNC-Wakebrook**
- **Scope changed to align with the NC Medicaid Transformation**

How does this fit with Medicaid Transformation?

PIPBHC

- Promoting full integration and collaboration between primary and behavioral health care
- Support the improvement of integrated care models for primary care and behavioral health care, improve overall wellness/physical health status of adults with SMI and children with SED
- Promote and offer integrated care services related to screening, diagnosis, prevention and treatment of MH/SU and physical health

Care Management

- Team-based, person-centered approach to effectively managing medical, social, and behavioral conditions
- A strong basis in primary care and connections to specialty care/community-based resources
- Directly link individuals to programs and services that address unmet health-related resource needs
- Involves a multidisciplinary care team

The Opportunity

- **Leverage the PIPBHC grant to pilot both the Tier 3 Advance Medical Home Plus (AMH+) model of care management and the Care Management Agency (CMA) approach**
- **Partner with UNC Greensboro to consider the following:**
  - **Whether the two models result in the improvement of overall wellness and physical health in the individuals served?**
  - **Which model works best for which individuals under which circumstances?**
  - **What is the estimated return on investment for care management?**

Additional opportunities

- **Examine the effectiveness of Certified Peer Support Specialists delivering interventions that focus on whole health integration**
- **Examine the effectiveness of evidence based or promising practices to determine which should be recommended or required as part of the care management model.**

Substance Use Disorder (SUD) Waiver

As part of the State's multifaceted Opioid Action Plan, DHHS is in the process of implementing its waiver of the institution for mental diseases (IMD) exclusion for SUD treatment to expand access to and Medicaid reimbursement for critical services.*

Key Activities

- Adding four SUD benefits to further expand access to SUD treatment and residential services and offer a complete continuum of services according to the American Society of Addiction Medicine (ASAM):**
  - Substance abuse halfway house (ASAM 3.1)
  - Clinically managed population-specific high intensity residential services (ASAM 3.3)
  - Ambulatory withdrawal management with extended on-site monitoring (ASAM 2-WM)
  - Social setting detoxification withdrawal management (ASAM 3.2-WM)
- Building provider capacity for new and existing SUD services
- Providing training for SUD providers on ASAM criteria

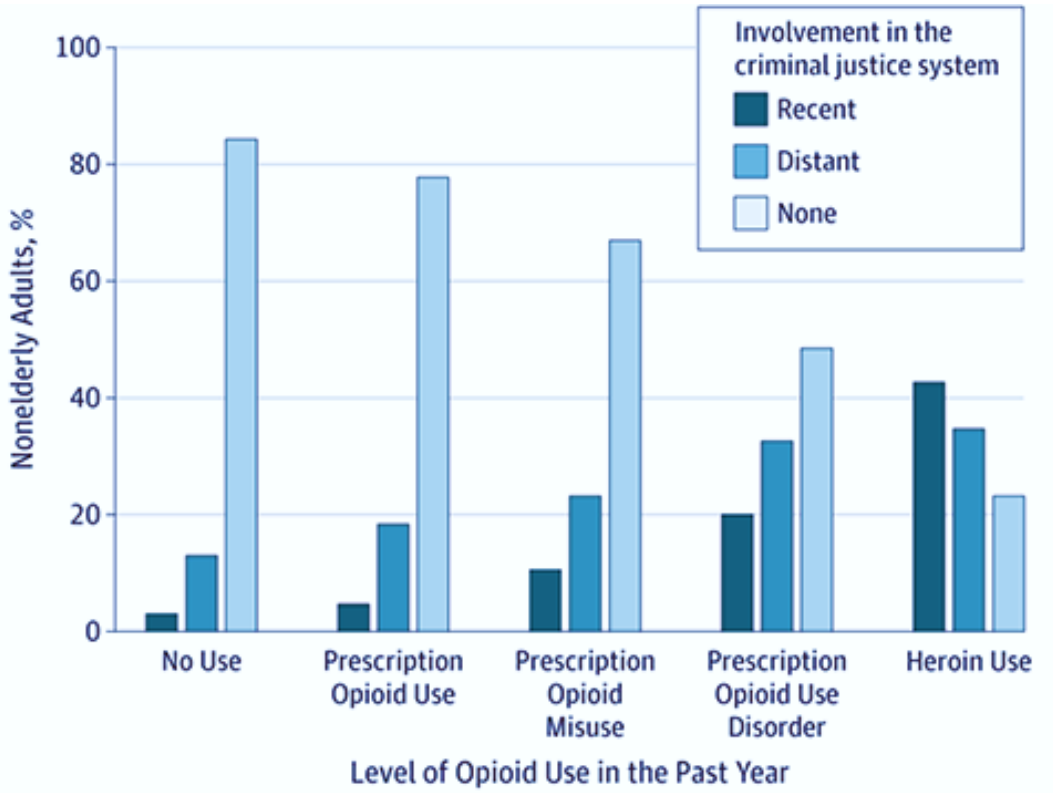
SUD waiver implementation includes working with the Division of Health Services Regulation (DHSR) to update administrative licensure rules for SUD providers to align with ASAM criteria.

*Medicaid law precludes payment for services delivered to individuals ages 21-64 residing in facilities classified as institutions for mental diseases (IMDs). This provision of Medicaid law is commonly referred to as the IMD exclusion. SSA Section 1905(a)(B).

**The waiver of the IMD exclusion applies to both Standard Plans and BH I/DD Tailored Plans, but certain SUD services will only be offered in BH I/DD Tailored Plans.

NC Opioid Action Plan and The Justice System

- People released from NC prisons are 40 times more likely to die from an opioid overdose in the two weeks after release from incarceration than the general population.
- The risk of a heroin overdose death is 74 times higher.



Criminal Justice Involvement by Level of Opioid Use in the United States, 2015-2016

Recent involvement in the criminal justice system refers to involvement within the past 12 months.

Distant involvement in the criminal justice system refers to involvement within an individual's lifetime but not within the past 12 months.

Medication Assisted Treatment (MAT)

- The purpose of the MAT Program is to provide pre-release treatment and post-release treatment referrals for opioid-addicted inmates at select sites.
- TARGET POPULATION
  - Eligibility prioritizes those who have completed or are enrolled in prison based substance use disorder treatment and meet the inclusion criteria including a documented opioid use disorder.





Quality Care: Outcomes and Value Proposition

Jaimica Wilkins, MBA, CPHQ, ICP

Senior Program Manager - Quality Management

Amanda Van Vleet, MPH

Senior Program Analyst

The Care Manager: Connecting the Consumer to Services

Kelsi Knick, MSW, LCSW

Senior Program Manager – Population Health

i2i Pre-Conference Symposium

December 3, 2019

Quality Care: Outcomes

Jaimica Wilkins, MBA, CPHQ, ICP
Senior Program Manager - Quality Management
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Quality Care: Governance

State Medicaid Managed Care Quality Strategy

States are required to implement a Quality Strategy to assess and improve the quality of managed care services offered within the state.

The Quality Strategy is "intended to serve as a blueprint or road map for states and their contracted health plans in assessing the quality of care beneficiaries receive, as well as for setting forth measurable goals and targets for improvement" (Medicaid.gov)

Source: State Quality Strategies. https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/state-quality-strategy/index.html

Committees

Medical Care Advisory Committee - Quality Subcommittee

- Advisory group comprised of Board-certified physicians in internal medicine/family practice, pediatrics, obstetrics and gynecology, and Behavioral Health Psychiatrist and chaired by MCAC members
- Provide guidance on processes to promote evidence-based medicine, coordination of care and quality of care for health and medical care services that may be covered by the NC Medicaid Program.
- Review and advise on Quality Strategy (QS), Metrics - Priorities, quality policies, measures reporting and timeline, targeted quality initiatives approach for special populations and/or conditions, Performance Improvement Projects (PIPs)

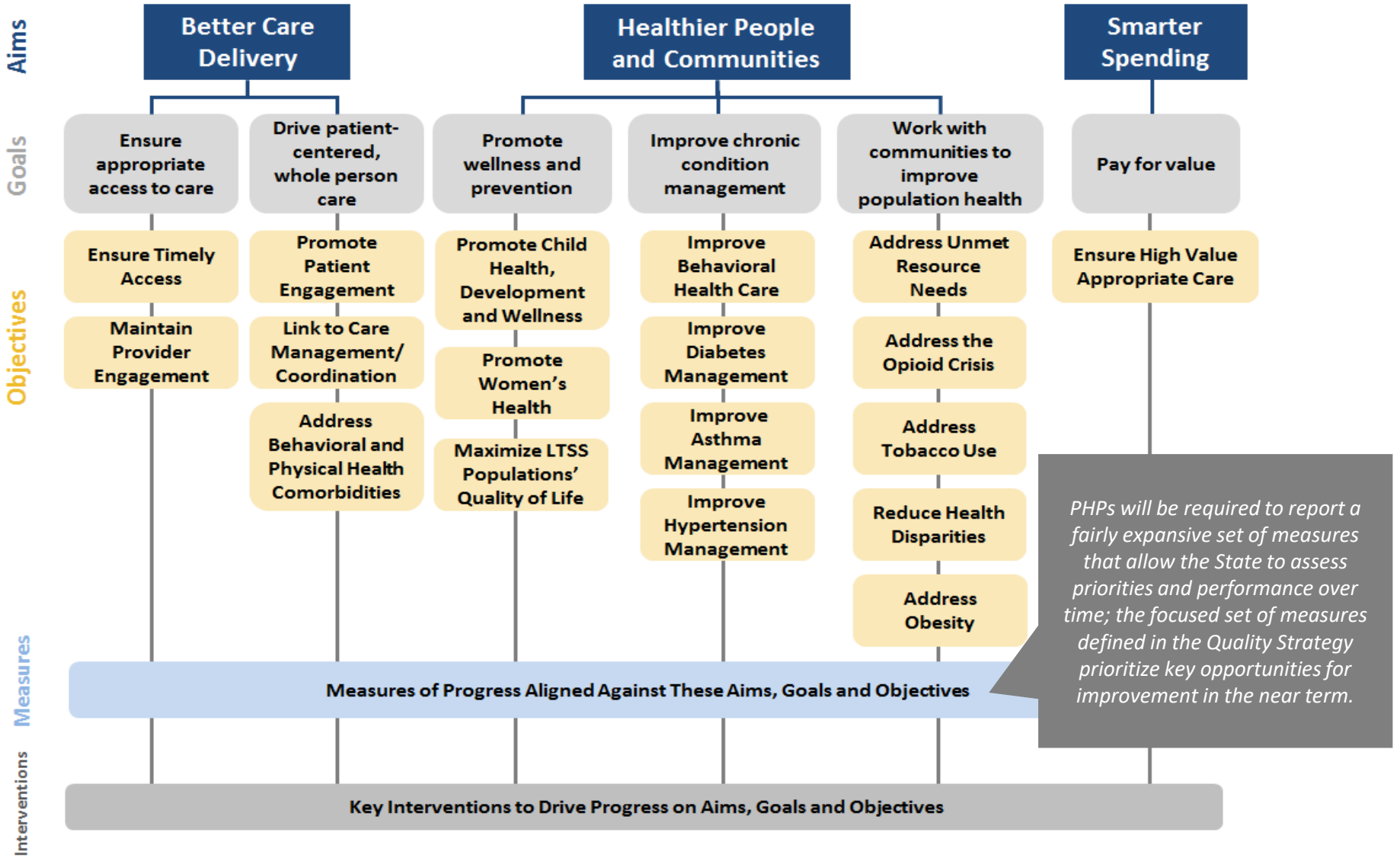
Advanced Medical Home Technical Advisory Group (AMH TAG)

- An advisory body made up of a group of invited representatives from PHPs, AMH practices, and other AMH stakeholders (e.g. CINs), and chaired by NC Medicaid.
- The AMH TAG will monitor for and identify strategic operational and implementation issues in the AMH program and will develop recommendations for NC Medicaid to respond to and resolve those challenges.

MCAC BH/I/DD/Tailored Plan Subcommittee

- Advisory group comprised of LME-MCOs, Provider Associations, Advocates/Advocacy organizations, Family Members, Individual Practitioners
- Review and provide feedback on Tailored Plans (TP) design elements −Care Management, Health Homes, Eligibility & Enrollment, Network Adequacy, Credentialing, State Plan services exclusively in Tailored Plans, Other services managed by Tailored Plans including State funded, TBI waiver, Innovations waiver, 1915(b)(3), and the TP Roll out schedule

Overview of the Quality Framework



Tailored Plan Measures, Structure, and Process

Measure Set Structure

Based on current recommendations, Tailored Plans will be required to report 67 measures (standard plan) plus additional measures for the TP set.

Confirmed/Required Measures for TP Reporting

67
Measures from SP Set
Includes the 38 measures required for NCQA Health Plan Accreditation, and adult and child core set measures.
*Note, if all SP measures are included, TPs would be required to report 94+ measures

+

27
Additional Measures Required for SUD Monitoring Protocol
There are 27 total SUD protocol measures; 1 is required for Health Plan Accreditation

+

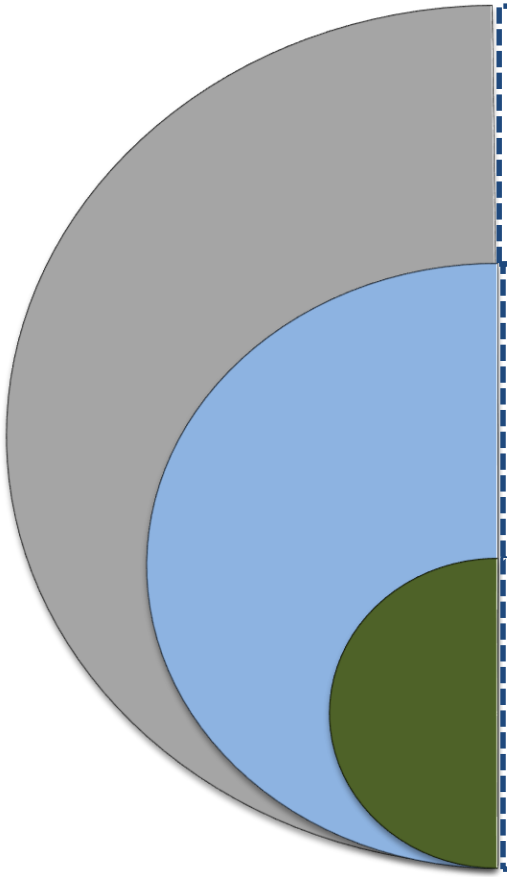
10
CMS Health Home Measures
10 total measures, 4 of which are required for Health Plan Accreditation

Additional Measures Under Consideration

- Chronic Condition Management
- Utilization Measures
- Post-Utilization Follow-up Measures
- Screening Measures
- Satisfaction with Care and Waiver Measures
- Survey Measures: Quality of life, consumer experience and functional status surveys to meet block grant reporting requirements and assess treatment outcomes

Measure Subsets

The TP measure set will include priority, AMH+/CMA and withhold measures.



Quality Measures Aligned with National, State and PHP Reporting & Select Administrative Measures

- *Quality measures are used by the DHHS to baseline PHP performance and set priorities in future years; DHHS may also elect to report on these measures publicly*
- *PHPs must report on all quality measures*

***Vision*: Report on quality measures broadly in initial years, and streamline the measure set over time to priority areas**

Priority Measures Aligned with DHHS Policies

- *Priority measures are aligned with the Quality Strategy and reflect NCIOM stakeholder input*
- ***DHHS will select AMH measures and quality withhold measures from the priority set***
- *PHPs must select measures from priority set to use in non-AMH performance improvement projects and value-based contracting arrangements*
- *Priority measures will be the minimum set of measures used for public reporting*

***Vision*: Leverage Priority Measures to Promote DHHS' Key Quality Areas**

Quality Withhold Measures

- *Quality withhold measures are used to financially reward and hold PHPs accountable against a sub-set of measures included in the **priority measure set***
- *Quality measures are the only component of the measure universe where performance (as opposed to reporting) is tied to PHP financial outcomes.*

***Vision*: Make annual updates and changes to Quality Withholds Measures based on assessment of PHP readiness to move from process measures to outcome and population health measures**

Quality Assurance & Quality Improvement

Quality Assurance

- EQRO: DHB will procure (federally required) External Quality Review Organization (EQRO) to assess the quality of care provided by PHPs
- Accreditation: PHPs are required to achieve NCQA Health Plan Accreditation by Year 3

Quality Improvement

- QAPI: PHP must develop an annual Quality Assessment and Performance Improvement (QAPI) program for measure areas that need improvement.
- PIPs: PHPs must have targeted clinical/non-clinical Performance Improvement Projects (PIPs) each year.

Medicaid Quality: Public Reporting of Performance

- ***Accreditation Progress and Results***—DHHS will publish PHP progress toward receiving this accreditation, and will report the accreditor's findings for each PHP during its accreditation process.
- ***Annual Quality Measures at Plan Level/Report Cards***—DHHS will share plan-level rates for the quality measures, to facilitate comparison among plans. Members and the public should have access to a reliable report on how PHPs are performing.
- ***Health Equity Report***—DHHS will assess disparities in care and outcomes and publish a report summarizing areas or care in which disparities have improved, persisted, or developed.
- ***Provider Survey Results***—DHHS, in partnership with a third party, will field a survey to providers assessing their satisfaction with the PHP(s) with which they have contracted. The Department will publish overall satisfaction rates and other findings from this survey.
- ***CAHPS Results***—DHHS, in partnership with a third party, will field the CAHPS (Consumer Assessment of Healthcare Providers and Systems) to assess patient experience in receiving care. The Department will publish overall ratings of plans, overall ratings of all care received and other findings from this survey.
- ***Network Accessibility Reports-***- DHHS, in partnership with a third party, will evaluate network adequacy—a combination of provider availability, realized member utilization, and patient perception of availability. DHHS will publish PHP Access reports.

Measure Selection Approach

For Consideration When Reviewing Measures

Standardized vs. non-standardized measures

For some services and conditions, there are both standardized and non-standardized (e.g. NC - developed) measures under consideration. Standardized measures offer greater flexibility to compare NC's performance to other states or entities. Further, standardized measures are maintained by external organizations, relieving NC of measure-maintenance responsibilities.

Consistency with SP measures

While there may be compelling reasons to use separate measures in each set, using consistent measures for the same service/condition in each set will reduce burden and allow more flexibility to analyze care across TP and SP.

Measure set size

While a large measure set allows the State to gather a wide range of data, it may increase reporting burden among plans and providers.

Paying for Value in North Carolina's Medicaid Managed Care Transformation

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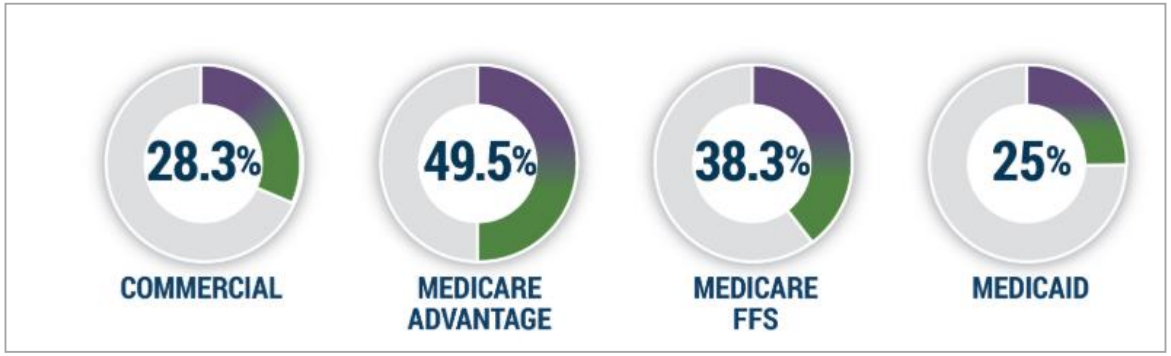
Shift to Paying for Value is Well Underway Nationally and in North Carolina

North Carolina Medicaid's focus on value-based payment is part of a broader shift in payment models across payers.

National Landscape

- **34%** of U.S. healthcare payments were "value-based" in 2017, up from **23%** in 2015, according to research conducted by the Healthcare Payment Learning and Action Network (HCP-LAN).*
- Value-based arrangements were most common in Medicare but are widespread across payers.

Percentage of Healthcare Payments in Level 3 or 4 Payment Models by Payer (2017)



*Payments categorized as level 3 (alternative payment models built on FFS architecture with upside/downside risk) or 4 (population based payment) under the Healthcare Payment Learning and Action Network (HCP-LAN) alternative payment model framework.

North Carolina

- Major NC health systems are signing value-based arrangements across payers.

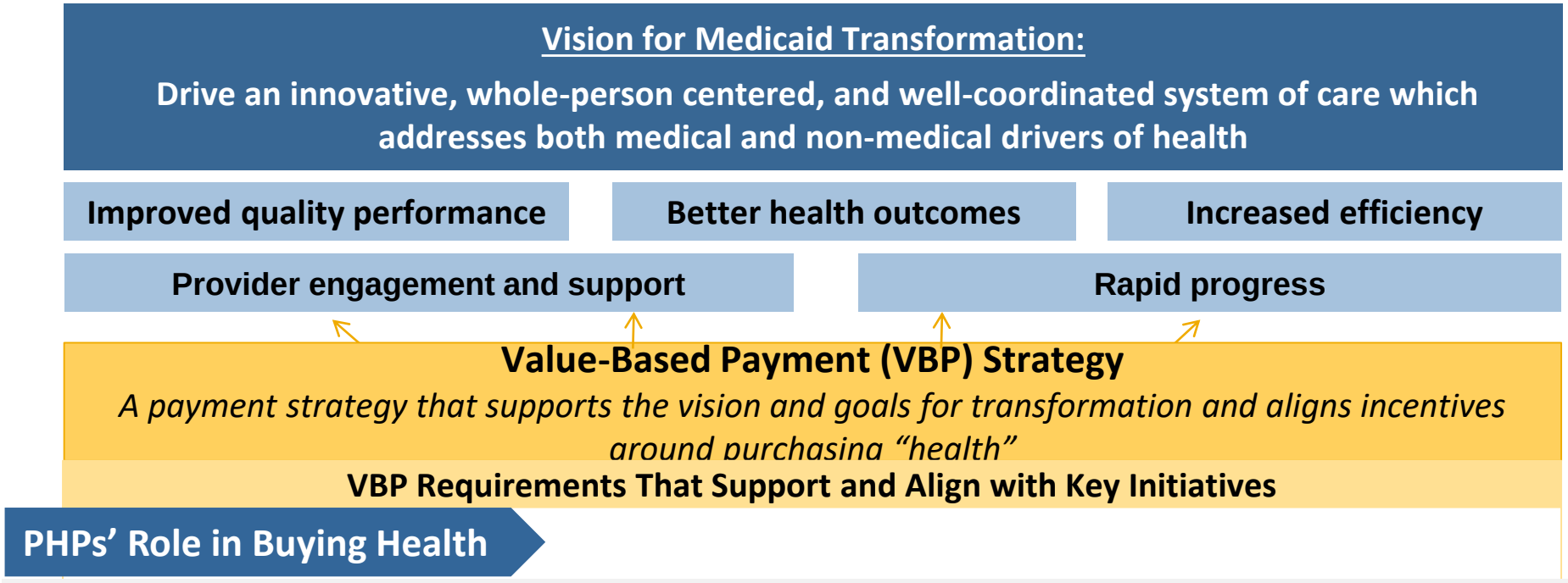
"Blue Cross NC and Five Major Health Systems Announce Unprecedented Move to Value-Based Care"
-BCBSNC, 1/2019

"Blue Cross NC, UNC Health Alliance Agreement Lowers Triangle ACA Rates by More Than 21 Percent"
- Business Wire, 8/2018

"Duke Physician-Led Network Exceeds Quality Standards, Saves Medicare Millions"
-Duke Health, 9/2018

Source: "APM Measurement: Progress of Alternative Payment Models", HCP-LAN, 2018. Survey responses were voluntary.

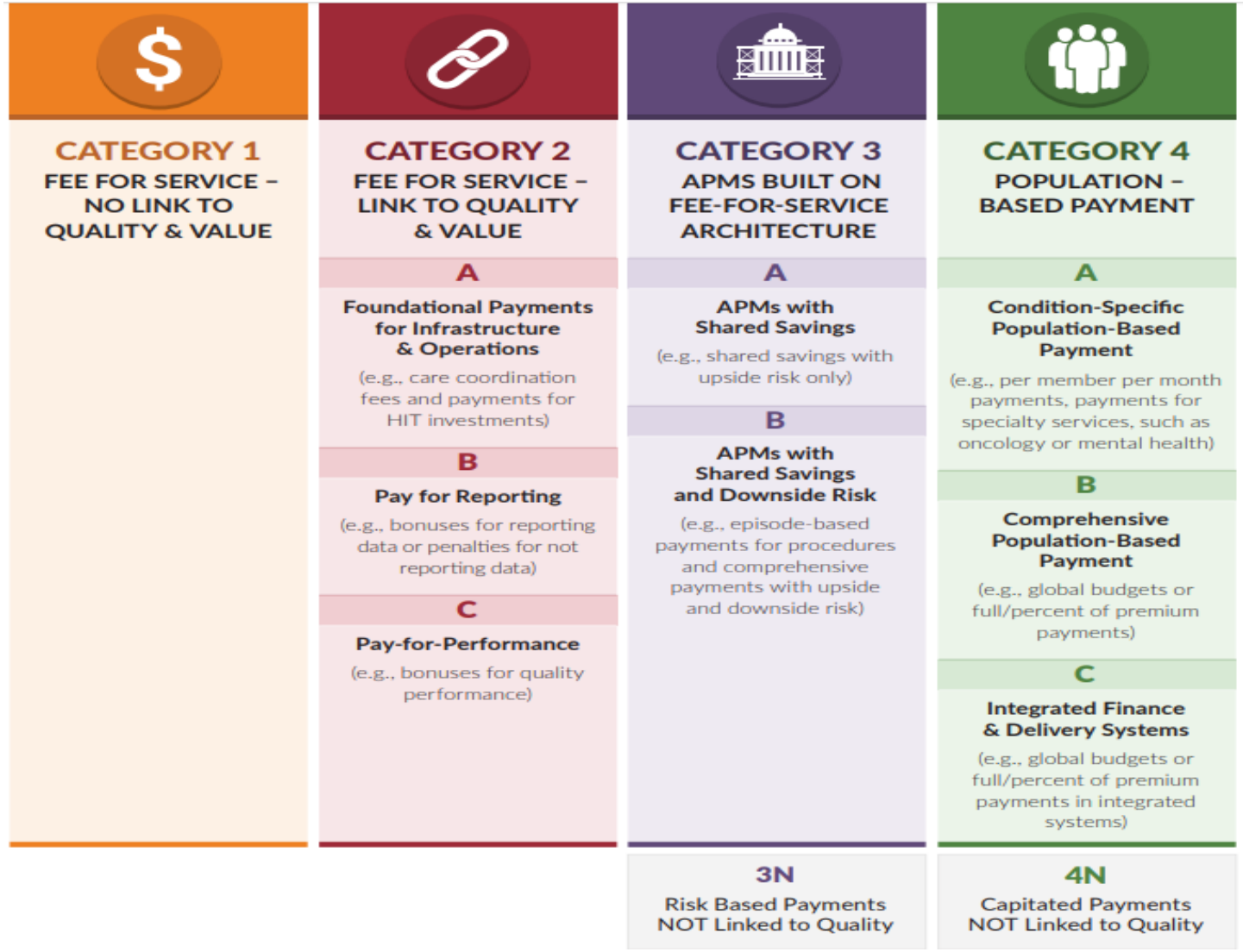
NC Medicaid's Strategy for Paying for Value



PHPs' Role in Buying Health

- Align financial incentives and accountability around total cost of care, overall health outcomes, and quality gains
- Incentivize integrated, whole-person care that coordinates physical and behavioral health, pharmacy, LTSS, and Opportunities for Health
- Support local care management and primary care (Standard Plans offer performance incentive payments to tier 3 Advanced Medical Homes, Pregnancy Medical Homes, and other providers)
- VBP arrangements must be aligned with DHHS' Quality Strategy and related measures
- Move increasingly toward value and risk over time

NC Medicaid will use the Health Care Payment-Learning and Action Network Framework to Shift to Value



HCP LAN
Health Care Payment Learning & Action Network

Value-Based Payment in Standard Plans

- **Department Defines VBP:** Any payment arrangement that falls in categories 2 through 4 of the HCP-LAN APM framework
- **Department Sets PHP targets:** By the end of contract year 2, the portion of a PHP's medical expenditures governed under VBP arrangements must either increase by twenty (20) percentage points or represent at least fifty percent (50%) of total medical expenditures. The Department may begin withholds in contract year 3 tied to meeting VBP targets.
- **PHPs and providers form value-based arrangements** that work for them and can meet providers where they are while moving toward value
- **Department will release more guidance** that will expand on NC's longer-term vision for paying for health, outline DHHS' approach to measuring and incentivizing the use of VBP arrangements in the coming years, and build on the AMH model for linking quality and outcomes to total cost of care

VBP strategies may look different for Tailored Plans and providers than for Standard Plans and providers in order to focus on physical and behavioral health integration and higher-need populations

The Care Manager: Connecting the Consumer to Services

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Care Management Guiding Principles

Care Management is Integral to Medicaid Transformation

Care management builds upon and intersects with DHHS's strategy for AMHs, Healthy Opportunities, and VBP.

Advanced Medical Homes and CMA

BH I/DD TPs will contract with Tier 3 AMHs and CMA certified by DHHS to provide integrated care management addressing the whole-person needs of populations with significant behavioral health or I/DD needs.

Healthy Opportunities

Care managers will assess beneficiaries for unmet health-related resource needs and manage social service referrals and coordination.

Value-Based Payment

Comprehensive care management has been shown to improve health outcomes and achieve positive returns on investment, making it an important piece of population health management.[1,2] Population health management provides the foundation for providers to be successful in a value-based payment environment.

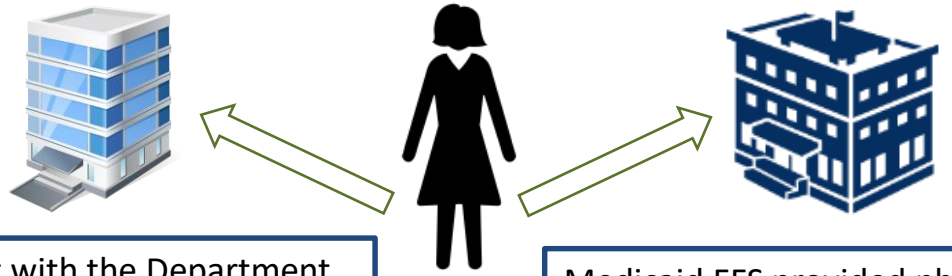
Health Home Care Management

[1]US DHHS. Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions. May 11, 2017.
[2]Long PV, Abrams M, Milstein A, et al. Effective care for high-need patients, opportunities for improving outcomes, value, and health. National Academy of Medicine; 2018.

Transition to Whole-Person Care

With the managed care transition, both types of managed care products—Standard Plans and BH I/DD Tailored Plans—will offer integrated, whole-person care.

Historical Environment

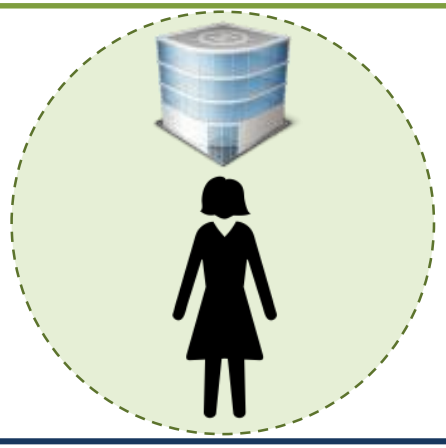


Per contract with the Department, LME-MCOs provided BH, I/DD and TBI services

Medicaid FFS provided physical health services

Managed Care Environment

PHPs will provide whole-person care



Care Management Model

Key Principle: Behavioral and physical health are integrated through the care team.

Overarching Principles

- Broad access to care management
- Single care manager taking an integrated, whole-person approach
- Person- and family-centered planning
- Provider-based care management
- Community-based care management
- Community inclusion
- Choice of care managers
- Consistency across the state
- Harness existing resources

Roles and Responsibilities of Care Managers

- Management of rare diseases and high-cost procedures
- Management of beneficiary needs during transitions of care
- High-risk care management
- Chronic care management
- Management of high-risk social environments
- Identification of beneficiaries in need of care management
- Development of care management assessments/care plans
- Development & deployment of prevention and population health programs
- Coordination of services

Advanced Medical Homes

Introduction to the AMH Program

The AMH program is a key vehicle for achieving integrated, whole-person care and local care management in North Carolina.

Vision for AMH in Managed Care

*Build on the Carolina ACCESS program to **preserve broad access to primary care services** for Medicaid enrollees and **strengthen the role of primary care in care management, care coordination, and quality improvement** as the state transitions to managed care*

Today's Carolina ACCESS primary care practices* have options:

- Current primary care practices in Carolina ACCESS program may **continue into AMH with few changes ("Tier 1" and "Tier 2")**
- Practices ready to take on more advanced care management functions may **attest into AMH "Tier 3"****
  - Tier 3 practices may rely on **in-house care management** capacity or **contract with a Clinically Integrated Network (CIN) or other partner of their choice**
  - Unlike in Carolina ACCESS, **practices ARE NOT be required to contract with Community Care of North Carolina (CCNC) to participate in AMH**

*Eligibility for AMH mirrors the legacy Carolina ACCESS program and includes general practice, family practice, internal medicine, pediatrics, OB/GYN, psychiatry and neurology

Overview of the AMH Program

The AMH Program will serve as the primary vehicle for delivery of local care management under Medicaid managed care.

Tiers 1 and 2

- PHP retains primary responsibility for care management
- Practice requirements are the same as for Carolina ACCESS
- **Practices will need to interface with multiple PHPs**, which may employ different approaches to care management

AMH Payments

- **PMPM Medical Home Fees**
  - Same as Carolina ACCESS
  - Minimum payment floors

Tier 3

- PHP delegates primary responsibility for care management to the AMH
- Practice must meet all Tier 1 and 2 requirements, plus additional Tier 3 care management responsibilities
- Practices will have the option to **provide care management in-house** or **through a single CIN/other partner** across all Tier 3 PHP contracts

*PHPs should **attempt to contract with all certified Tier 3 AMHs***

AMH Payments

- **PMPM Medical Home Fees**
  - Same as Carolina ACCESS
  - Minimum payment floors
- **PMPM Care Management Fees**
  - Negotiated between PHP and practice
- **Performance Incentive Payments**
  - Negotiated between PHP and practice
  - Based on AMH measure set

Practice Requirements: Tiers 1 and 2

Practice requirements for Tiers 1 and 2 are the same as requirements for Carolina ACCESS practices

Requirements for AMH Tiers 1 and 2

1. Perform **primary care services** that include certain preventive & ancillary services**
2. Create and maintain a **patient-clinician relationship**
3. Provide direct patient care a **minimum of 30 office hours per week**
4. Provide access to medical advice and services **24 hours per day, seven days per week**
5. **Refer to other providers** when service cannot be provided by PCP
6. Provide **oral interpretation for all non-English proficient beneficiaries and sign language** at no cost

Deep Dive on Tier 3 AMHs

Tier 3 AMHs are responsible for delivering care management at the practice level, including all Tier 1 and 2 requirements in addition to the following:

Tier 3 Responsibilities

- **Risk stratify** all empaneled patients
- Provide **care management to high-need patients,** which includes (but is not limited to):
  - Conducting a **comprehensive assessment** of enrollees' needs
  - Establishing a **multi-disciplinary care team** for each enrollee
  - Developing a **care plan** for each enrollee
  - **Coordinating all needed services** (physical health, behavioral health, social services, etc.)
  - Providing **in-person assistance securing unmet resource needs** (e.g. nutrition services, income supports, etc.)
  - Conducting medication management, including regular medication reconciliation and support of medication adherence
  - Providing **transitional care management** as enrollees change clinical settings
- **Receive claims data feeds** (directly or via a CIN/other partner) and meet state-designated **security standards** for their storage and use

Tailored Care Management Model

Overview of Tailored Care Management Approach

Department of Health and Human Services

Establishes care management standards for BH I/DD Tailored Plans aligning with federal Health Home requirements

The BH I/DD Tailored Plan will act as the Health Home and will be responsible for meeting federal Health Home requirements

BH I/DD Tailored Plan Health Home

Care Management Approaches

BH I/DD Tailored Plan beneficiaries will have the opportunity to choose among the care management approaches; all must meet the Department's standards and be provided in the community to the maximum extent possible.

Approach 1:
"AMH+" Primary Care Practice
Practices must be certified by the Department to provide Tailored Care Management.

Approach 2:
Care Management Agency (CMA)
Organizations eligible for certification by the Department as CMAs include those that provide BH or I/DD services.

Approach 3:
BH I/DD Tailored Plan-Employed Care Manager

The Department anticipates allowing—but not requiring—CMAs and AMH+ practices to work with a **CIN or other partner** to assist with the requirements of the Tailored Care Management model, within the Department's guidelines.

Resource Documents

North Carolina's Medicaid Managed Care Quality Strategy - Released April 18, 2019

https://files.nc.gov/ncdma/documents/Quality_Strategy_4.5.19.v2.pdf

Quality Measurement Technical Specifications - Released April 18, 2019

https://files.nc.gov/ncdma/documents/NC-Medicaid-Managed-Care-Quality-Measurement-Technical-Specifications-Public.pdf

Smarter Spending: Value-Based Purchasing under Managed Care
https://files.nc.gov/ncdma/NC-VBP-Initial-Guidance-Final-for-Comms-20190218.pdf

Care Management Strategy for Behavioral Health I/DD Tailored Plan Policy Paper

https://files.nc.gov/ncdhhs/TailoredPlan-CareManagement-PolicyPaper-FINAL-20180529.pdf

North Carolina's Data Strategy for Tailored Care Management

https://files.nc.gov/ncdhhs/medicaid/Tailored-CareMgmt-DataStrategy-PolicyPaper-FINAL-20190912.pdf

Websites

https://medicaid.ncdhhs.gov/quality-management-and-improvement

https://medicaid.ncdhhs.gov/behavioral-health-idd-tailored-plans





Healthy Opportunities in North Carolina Medicaid Managed Care

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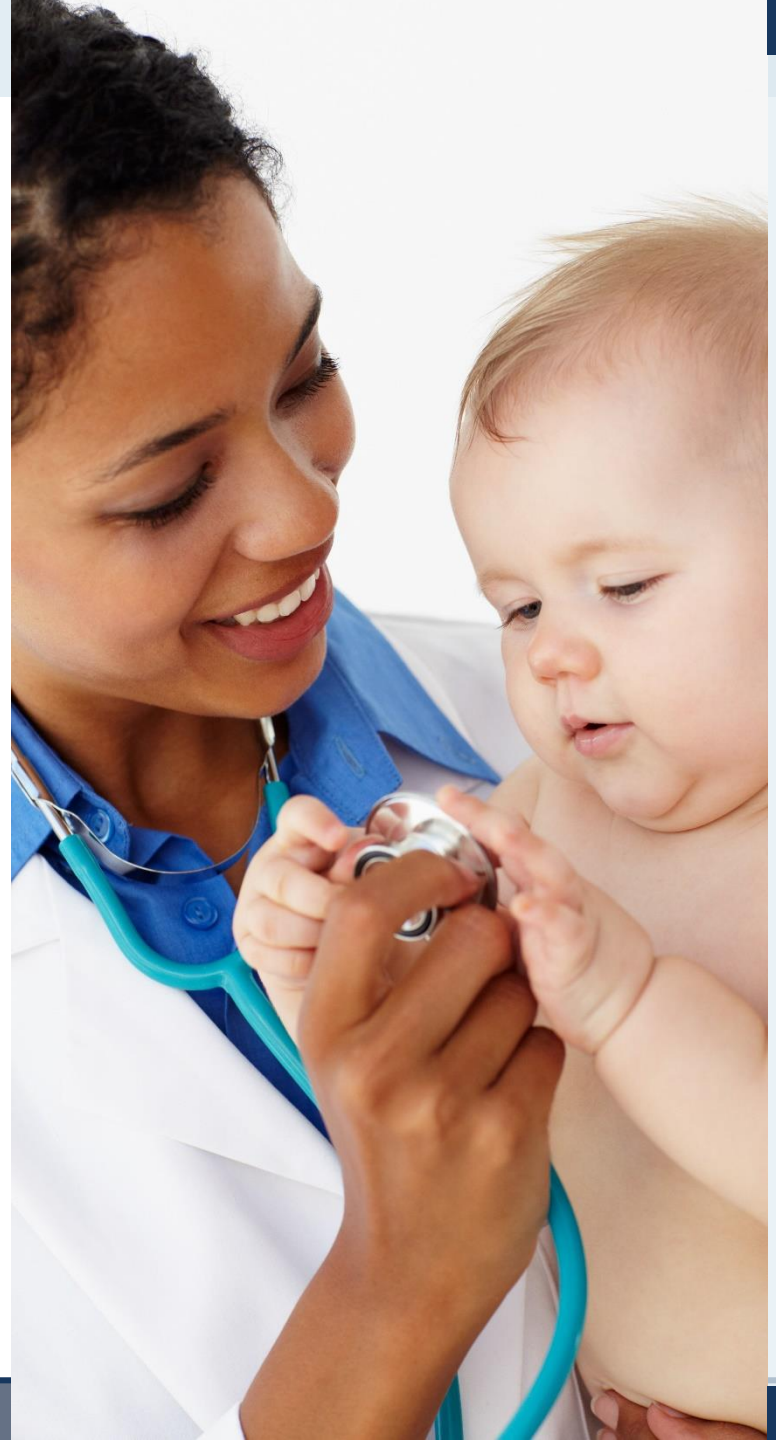
North Carolina Medicaid

i2i Pre-Conference Symposium

December 3, 2019



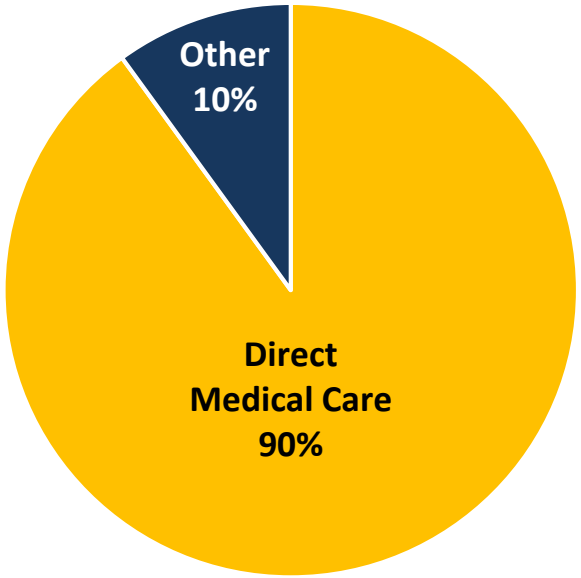
North Carolina's Vision for Medicaid Managed Care

"To improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care that addresses both the medical and non-medical drivers of health."

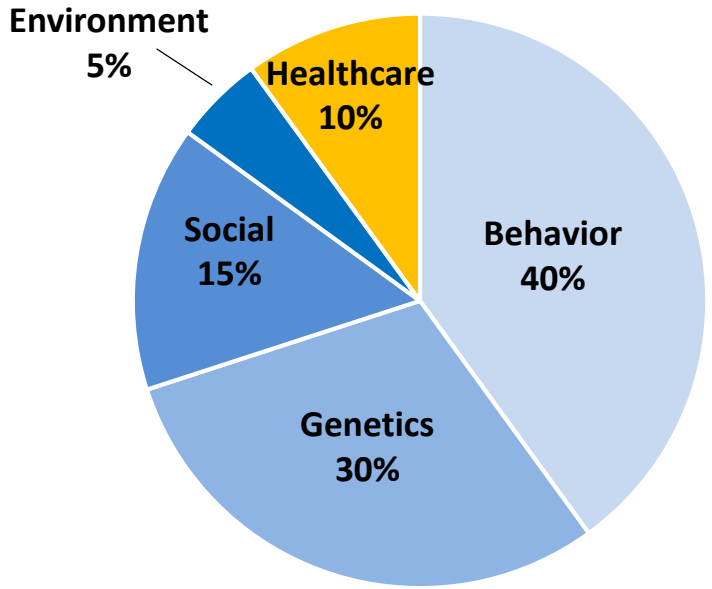
Why Emphasize Non-Medical Drivers of Health?

Mismatch: We are Currently Buying Healthcare, not "Health"

Healthcare Spending



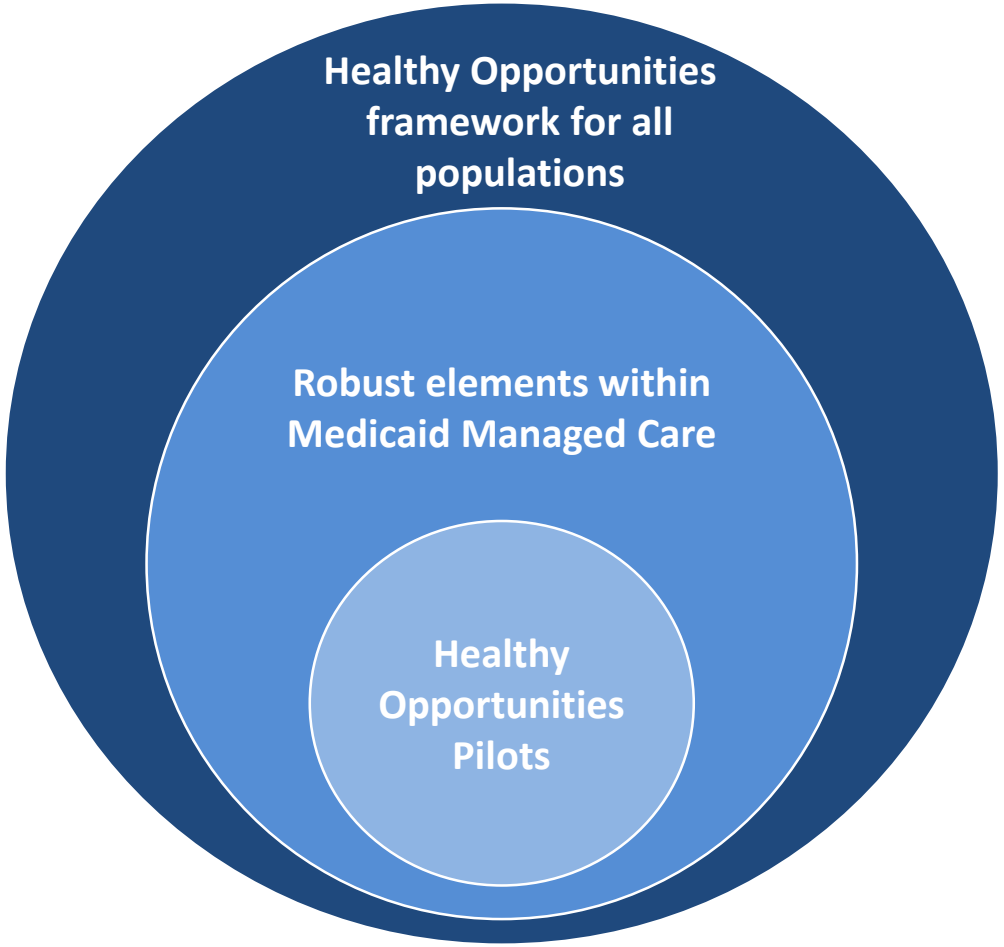
Drivers of Health



SOURCE: Schroeder SA. N Engl J Med 2007

Opportunities for Health

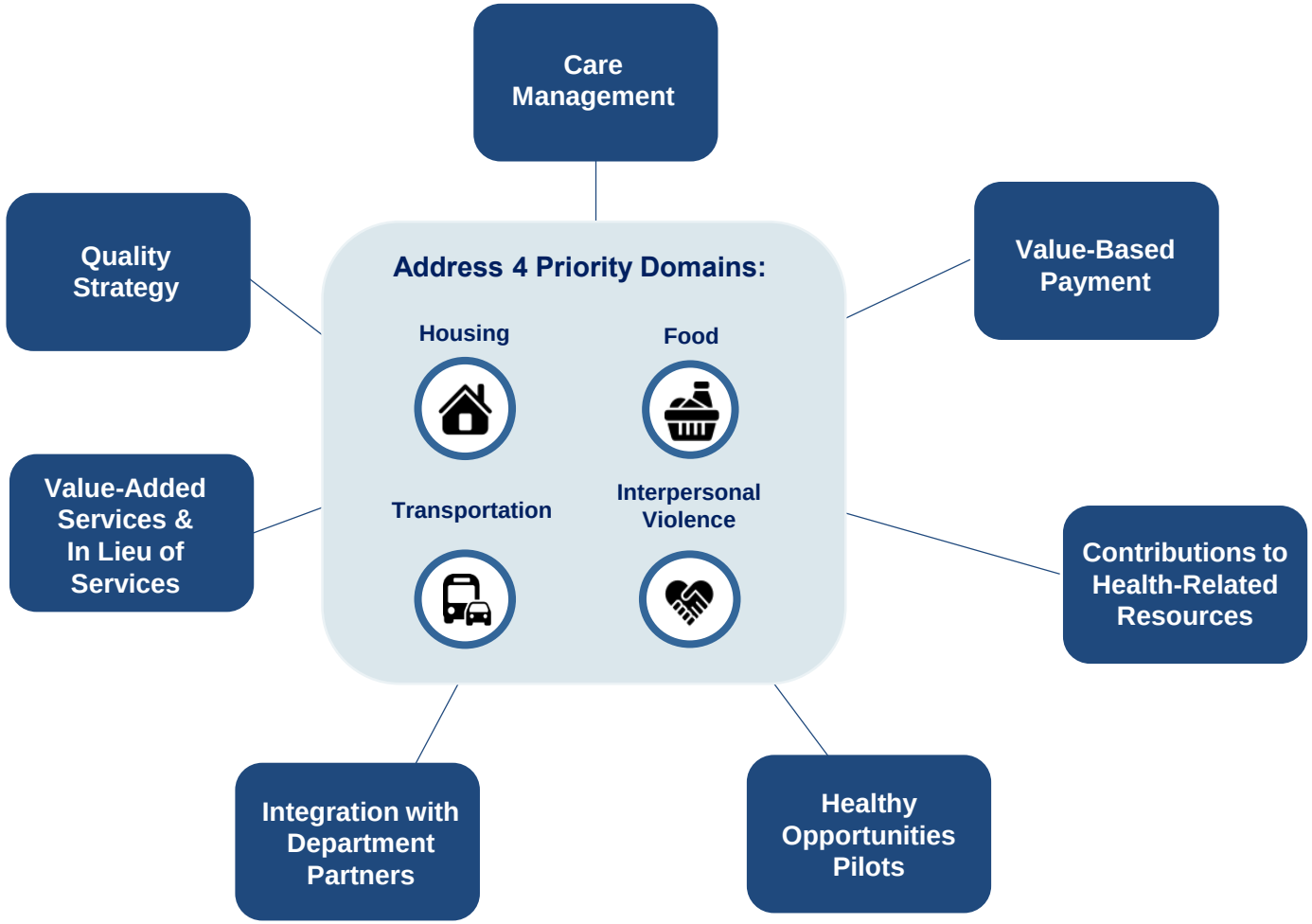
All North Carolinians deserve the opportunity for health. As such, we need to address the medical and non-medical drivers of health.



Statewide Infrastructure and Initiatives

Hot Spot Map	• Interactive GIS map of social determinants of health indicators at census tract level statewide
Screening Questions	• Statewide standardized SDOH screening questions
NCCARE360	• Statewide coordinated network with a robust data repository and electronic referral platform with close the loop functionality and outcome reporting
Workforce Development	• E.g., Community Health Workers core competencies, curriculum, and training

Robust Elements in Medicaid Managed Care



Addressing Social Needs Through Care Management

To focus on whole-person care, PHPs and care managers will address beneficiaries' unmet resource needs in a similar way they would address physical and behavioral health.

- **PHPs must identify and provide care management to beneficiaries with "high unmet resources needs."** PHPs will identify such individuals through:
  - Use of State-standardized SDOH screening
  - Analysis of claims, encounters and other available data;
  - Provider, patient and family referral.
- **Care managers will conduct a comprehensive assessment** with identified beneficiaries that addresses physical, behavioral, pharmacy, long term services and supports, and social areas of need.
- **PHPs are accountable for addressing identified needs**, including by:
  - Providing in-person assistance with select human service applications (e.g., TANF & Food and Nutrition Services);
  - Connecting beneficiaries to needed social resources and tracking outcomes using NCCARE360 once certified for statewide use;
  - Having a housing specialist;
  - Providing access to medical-legal partnerships for legal issues adversely affecting health.

High Unmet Resource Needs

Standard Plans must define high unmet resource needs to include beneficiaries who are:

- Homeless;
- Experiencing or witnessing domestic violence or lack of personal safety; and;
- Showing unmet needs in three or more SDOH domains

Providers will play a critical role in helping PHPs meet their obligations to address the unmet resource needs of beneficiaries

Care Management Deep Dive: Standardized SDOH Screening

Screening Questions

- PHPs will use DHHS' standardized SDOH screening questions as part of an initial Care Needs Screening to identify individuals eligible for care management due to high unmet resource needs.
- PHPs must ask these standardized SDOH screening questions across the four priority domains to every beneficiary within 90 days of enrollment.
- NC DHHS' standardized set of SDOH screening questions was developed by the Department with the assistance of a Technical Advisory Group, released for public comment, and field tested in 18 clinical sites. The screening questions are taken from evidence-based tools (e.g., Bright Futures Questionnaire, 9 Meaningful Use, Uniform Data Set (Community Health Centers), PRAPARE (Community Health Centers), Accountable Health Community, Pregnancy Medical Home Screen).

	Yes	No
Food		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
Housing/ Utilities		
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
Transportation		
6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
Interpersonal Safety		
7. Do you feel physically or emotionally unsafe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?		
9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
Optional: Immediate Need		
10. Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.		
11. Would you like help with any of the needs that you have identified?		

Care Management Deep Dive: NCCARE360

NCCARE360 is a statewide resource and referral platform that allows key stakeholders to connect individuals with needed community resources.

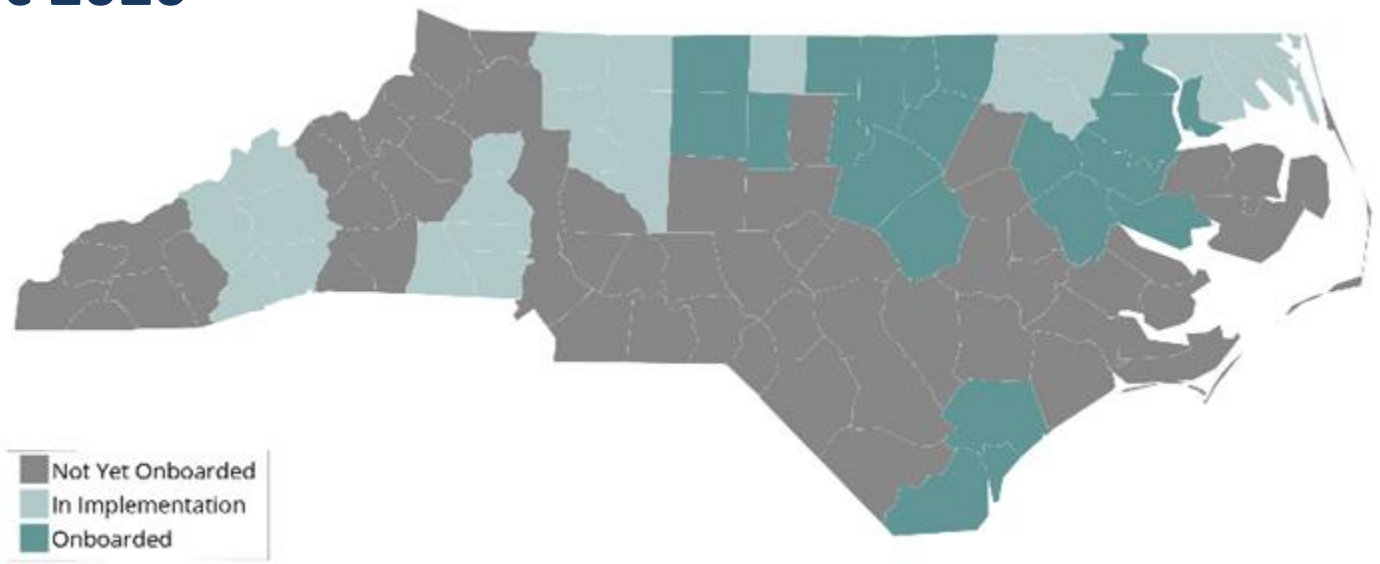
- NCCARE360 **(NC Resource Platform) is a telephonic, online and interfaced IT platform, providing:**
  - A robust **statewide resource repository** of community-based programs and services at community-based organizations, social service agencies and other organizations.
  - A **referral platform** that allows health care providers, insurers and human service providers to connect people to resources in their communities. It supports "closed-loop referrals," giving them the ability to track whether individuals accessed the community-based services to which they were referred.
- **PHPs will, at minimum, use NCCARE360 to:**
  - Identify community organizations to meet a beneficiary's needs
  - Make a referral on behalf of the beneficiary, and
  - Track closed-loop referrals.

NORTH CAROLINA 211

Expound

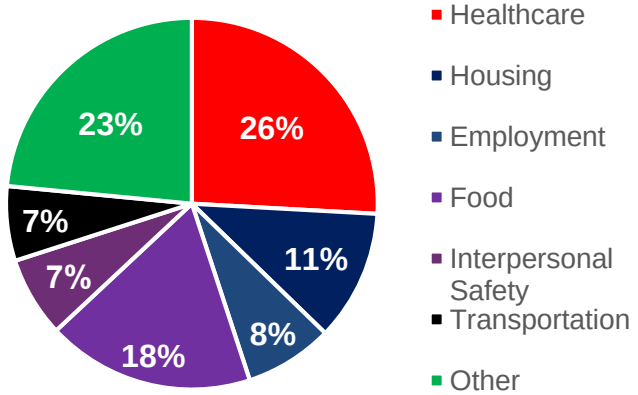
UNITE US

NCCARE360 State Coverage (as of 11/18/19) – to be statewide by Dec 2020



- 21 counties launched
- 29 counties started on implementation
- 2464 organizations engaged in socialization process
- 479 organizations with NCCARE360 licenses
- 1864 active users
- 1532 referrals sent
- 2,954 organizations verified in Resource Repository
- 10,736 programs verified in Resource Repository

Engaged Organizations by Service Type



Using the Quality Strategy to Promote Healthy Opportunities

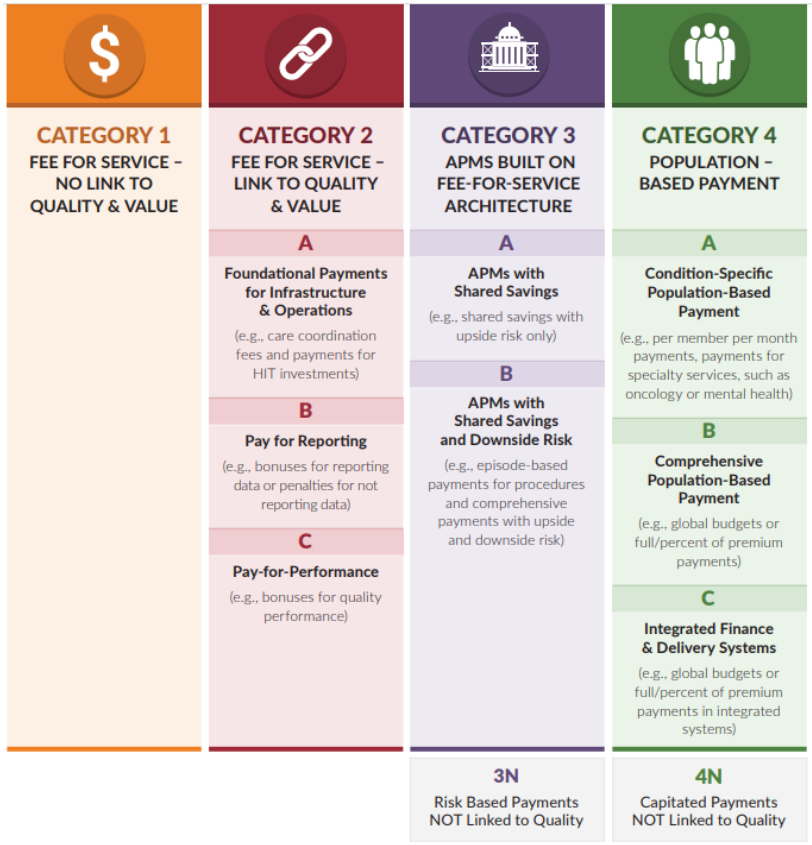
North Carolina's Quality Strategy details how PHPs are held accountable for achieving desired outcomes, including those linked to Healthy Opportunities.

- Addressing unmet resource needs is a critical component of the NC's Quality Strategy and approach to improving population health.
- PHPs must conduct at least one non-clinical Performance Improvement Project annually.
- PHPs will work with communities to improve population health, and promote the aim of healthier people and healthier communities within North Carolina.
- PHPs will report on rates of completed SDOH screenings in Year one of managed care. PHPs may be asked to report on referrals to services to address identified needs in future years.

Incorporating Healthy Opportunities into Value-Based Payment Strategies

VBP Overview

- Value-based payments give providers flexibility to decide how best to use payments, including by paying for health-related social supports that may be more cost-effective than traditional medical care.
- The State's VBP strategy will encourage PHPs and other providers to consider how they can incorporate and promote healthy opportunities into their VBP contracts.



Leveraging In Lieu of Services (ILOS) and Value Added Services (VAS) to Promote Healthy Opportunities

PHPs are encouraged to use ILOS and VAS to finance services that improve health by addressing unmet resource needs.

In Lieu of Services and Value Added Services are nontraditional services or settings that managed care plans can provide that are not covered in NC's State Plan.

In Lieu of Services

- Services or settings a PHP substitutes for a similar service covered under NC's State Plan.
- Must be both medically appropriate and a cost-effective substitute for a state plan service.
- **Funded by Medicaid dollars** (i.e. included in PHPs' capitation rates)
- **Example:** Offering medically tailored meals *in lieu of* a hiring a contracted home health aide

Value-Added Services

- Services a PHP can offer that are unrelated to NC's State Plan services.
- **Must be funded by the PHP** and *not* Medicaid dollars (i.e. not included in PHPs' capitation rates)
- **Example:** Carpet cleaning or mold remediation services, Boy Scout/Girl Scout memberships, educational support

Encouraging Voluntary PHP Contributions to Health-Related Resources

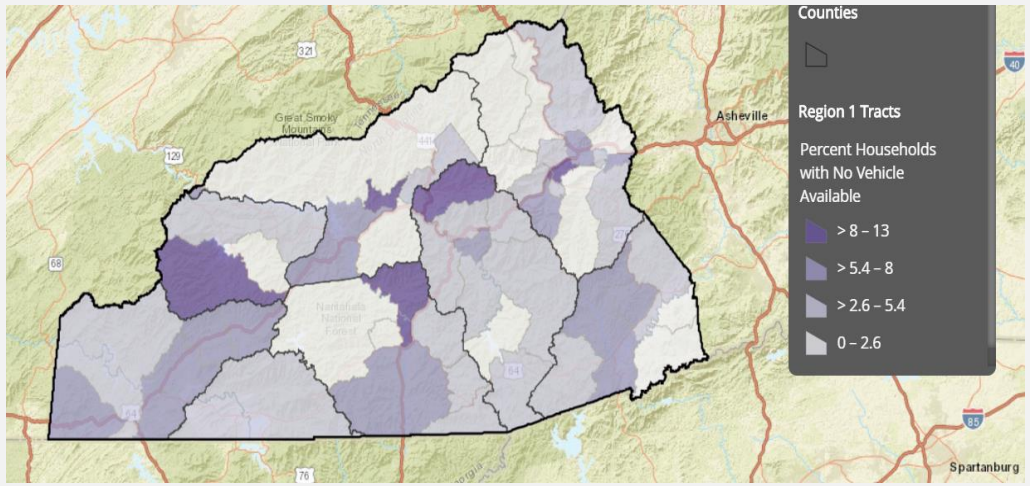
PHPs are encouraged to make contributions to health-related resources that help to address members' and communities' unmet health-related needs.

Contributions to Health-Related Resources

- PHPs are encouraged to contribute to health-related resources that improve health outcomes and cost-effective delivery of care in the communities they serve.
- PHPs that voluntarily contribute to health-related resources **may count the contributions in the numerator of their MLR.**
- A PHP that voluntarily contributes at least one-tenth percent (0.1%) of its annual capitation revenue in a region to health-related resources may be awarded a **preference in auto-assignment** to promote enrollment in each region in which the PHP contributes.

Providers may wish to give input to PHPs on how to direct their contributions in their communities.

Percent of Households Without Access to a Vehicle in Region 1



The NC "Hot Spot" Map uses geographic information system (GIS) technology and census data to map unmet resource needs across the state **and can strategically guide contributions to health-related resources.**

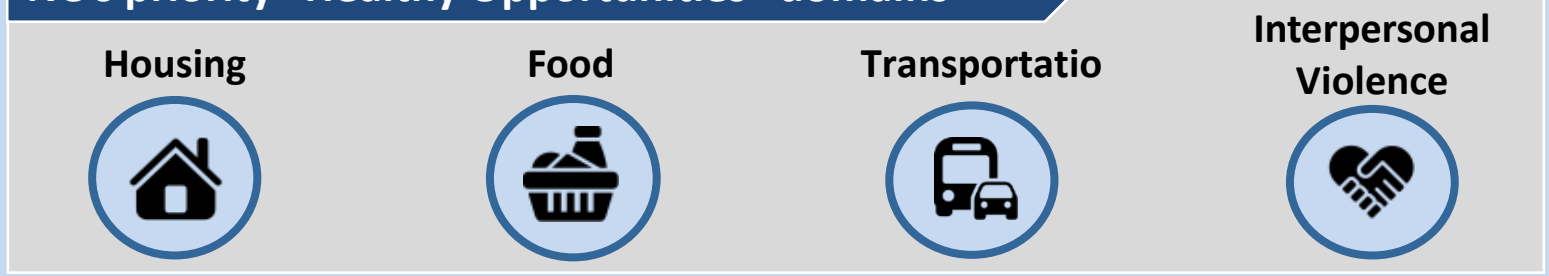
Healthy Opportunities Pilots

CMS authorized up to $650 million in state and federal Medicaid funding to test evidence-based, non-medical interventions designed to improve health outcomes and reduce healthcare costs for a subset of Medicaid enrollees.

Pilot funds will be used to:

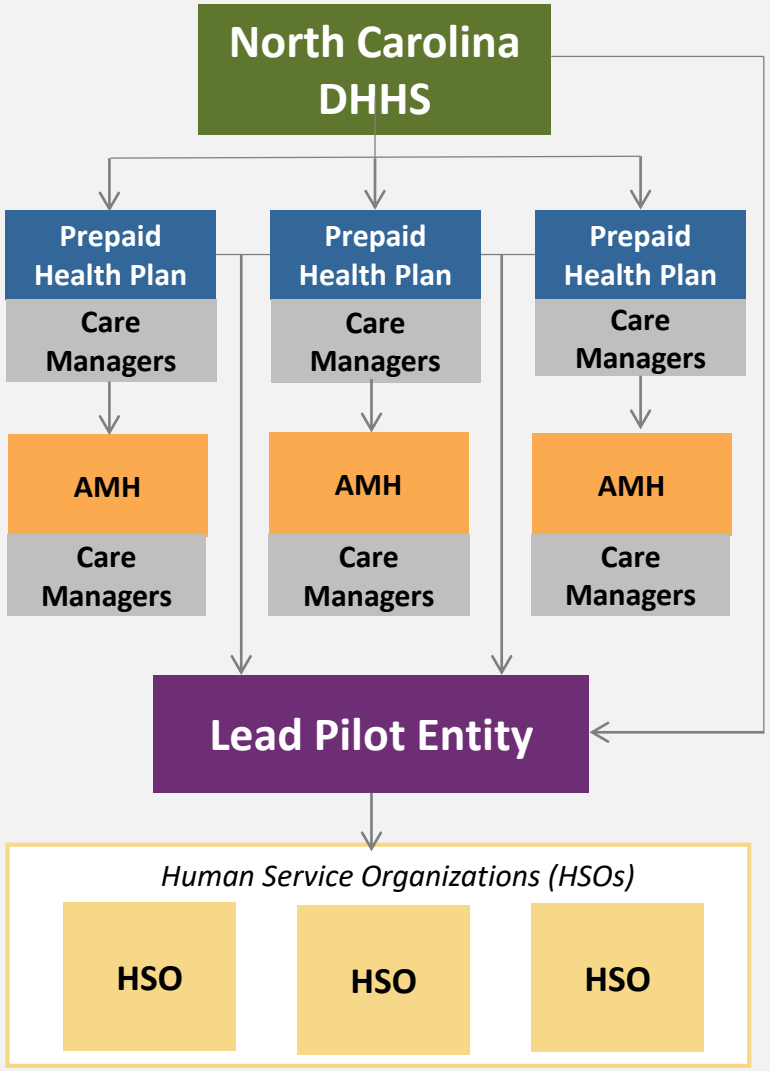
- **Cover the cost of federally-approved Pilot services**
  - *NC DHHS has developed service definitions and a fee schedule to reimburse entities that deliver these non-clinical services*
  - *The fee schedule will promote value and increasingly link payment to outcomes*
- **Support capacity building to establish "Lead Pilot Entities" and strengthen the ability of human service organizations (HSOs) to deliver Pilot services**
  - *NC DHHS will procure up to three Lead Pilot Entities with deep roots in their community that can facilitate collaboration across the healthcare and human service providers through building partnerships.*

NC's priority "Healthy Opportunities" domains



What Entities Are Involved in the Pilots?

Sample Local Pilot



Key Entities' Roles in the Pilots

- **PHPs:**
  - Manage a Pilot budget
  - Approve member eligibility for Pilot services
  - Ensure the provision of care management to members
  - Ensure individuals are enrolled in other federal/ state programs if eligible (e.g. SNAP and TANF)
  - Pay HSOs for pilot services delivered
- **Care Managers:**
  - Interface with members to conduct care management at PHPs, Tier 3 AMHs, AMH+s, LHDs, and CMEs/CMAs
  - Assess beneficiary eligibility for Pilot services (approved by PHP); track member progress
- **Lead Pilot Entities:**
  - Competitively procured by NC DHHS (define the geographic region they serve)
  - Develop, manage, and oversee a network of HSOs
  - Provide technical assistance to HSOs; convene Pilot entities to share best practices
  - Collect and report data to NC DHHS to assist in evaluation and oversight
- **Human Service Organizations:**
  - Frontline social service providers that contract with the LPE to deliver Pilot services to Pilot enrollees
  - Submit invoices and receive reimbursement for services delivered

What Services Can Members Receive Through the Pilots?

North Carolina's 1115 waiver specifies services that can be covered by the Pilot.

Housing

- Housing navigation, support and sustaining services
- Housing quality and safety inspections and improvements
- One-time payment for security deposit and first month's rent
- Short-term post hospitalization housing

Food

- Linkages to community-based food resources (e.g., SNAP/WIC application support)
- Nutrition and cooking education
- Fruit and vegetable prescriptions and healthy food boxes/meals
- Medically tailored meal delivery

Transportation

- Linkages to existing transportation resources
- Payment for transportation to support access to pilot services, (e.g., bus passes, taxi vouchers, ride-sharing credits)

Interpersonal Violence (IPV)

- Case management/ advocacy for victims of violence
- Evidence-based parenting support programs
- Evidence-based home visiting services

Pilot Evaluation

Hypotheses Tested:

- Lead Pilot Entities will enable **effective delivery of Pilot services**
- The Pilot program will increase rates of Medicaid enrollees **screened** for social risk factors and **connected to** services that address these risk factors
- The Pilot program **will improve the qualifying social risk factors, health outcomes, healthcare utilization, and healthcare costs of participants** (overall and by sub-populations)

Evaluation Phases:

- **Rapid cycle assessments** culminating in an interim evaluation submitted 2023
  - To enable real-time learning and to adapt pilot interventions based on these learnings
  - Comparisons made within intervention recipients, before and after they receive intervention, using interrupted time series designs
- **Summative Evaluation** submitted 2026
  - To test the effectiveness of the 'final' pilot interventions
  - **Randomization** of higher-intensity services (SMART design)
  - Within-participant comparison (enabled by adaptive randomized design) and comparison of pilot regions to other regions in NC (difference-in-difference analysis)

Estimated Timeline

- **Lead Pilot Entity RFP Released:** November 5, 2019
- **Proposals Due:** January 21, 2020
- **Award Contracts:** April 15, 2020
- **Implementation Period:** April 15, 2020 – March 2021
- **Pilot Service Delivery:** March 2021 – October 2024

For More Information

NC Medicaid Transformation:
https://www.ncdhhs.gov/assistance/medicaid-transformation

Healthy Opportunities:
https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities

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Questions/Discussion