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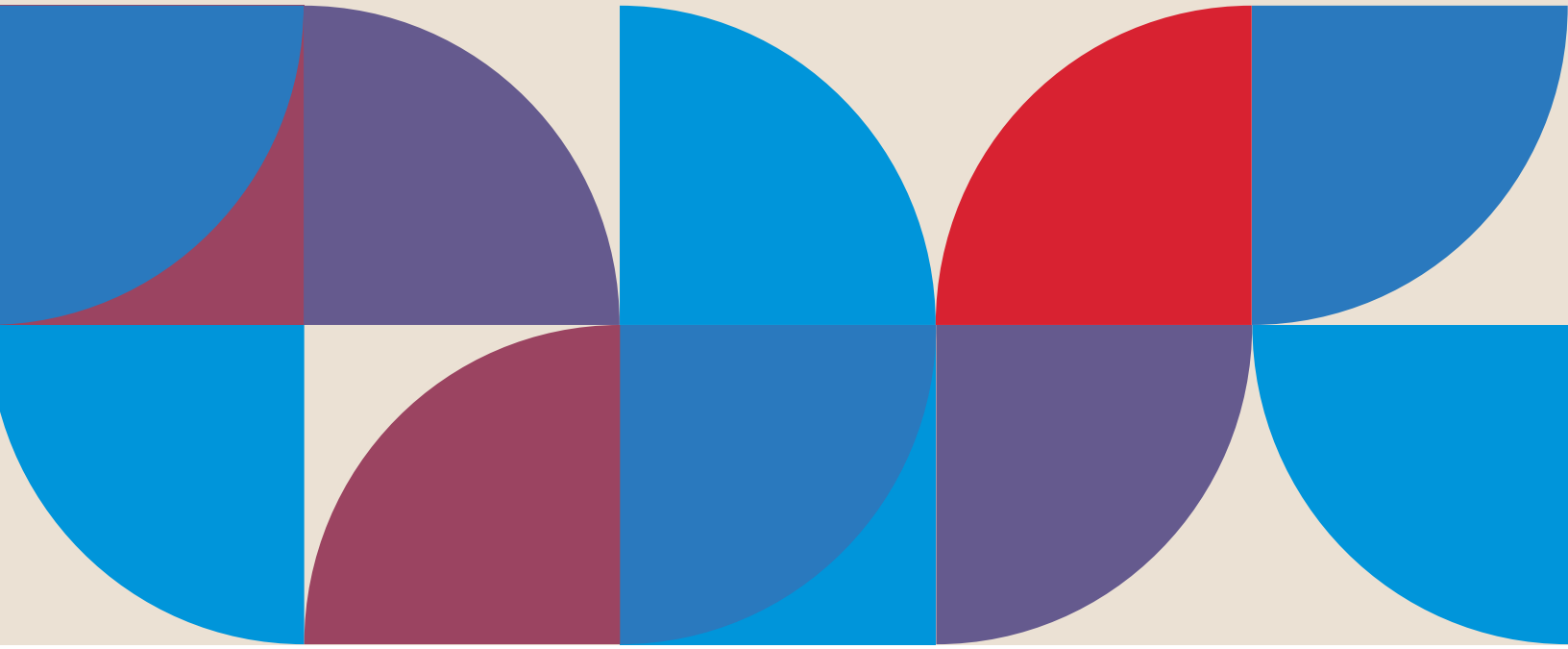
North Carolina's experience as the first state in nation to offer interpersonal violence services in Medicaid



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The North Carolina Healthy Opportunities Pilot (HOP) launched coverage of health-related non-medical services in three predominantly rural regions of the state (two in eastern North Carolina and one in western North Carolina) in March of 2022. Subsequently, the state phased in several additional services including services that address interpersonal violence. This paper will provide helpful insights for all states addressing social drivers of health. In particular, it will shine a light on North Carolina's offering of services to address interpersonal violence in HOP and lay out a road map for other states, including California, interested in covering these critical non-medical services and supports through Medicaid.

In a survey of state Medicaid programs, Manatt found that addressing social drivers of health is commonplace now because of the growing evidence that it will improve health, promote health equity and reduce costs.[1] Most states require their managed care organizations (MCOs) — through care management obligations — to screen for social needs, refer members to social services, and connect members to federal programs like the Supplemental Nutrition Assistance Program (SNAP) and the Women Infants and Children (WIC) program. Manatt found that housing tends to be at the top of the list of non-medical services addressed in contracts, followed by food and employment.

North Carolina is the only state, however, to address interpersonal violence (IPV). North Carolina defines IPV— including intimate partner violence, domestic/family violence, and community violence— as a social driver of health. IPV is often overlooked as a social driver despite its pervasiveness especially among low-income populations and communities of color. By overlooking this and other social drivers of health, state Medicaid programs (which serve many individuals in these same populations) are missing a huge opportunity to improve the delivery of health care and overall health outcomes.

This paper provides: background on North Carolina's HOP and its ongoing work to address IPV; identifies the accelerators that facilitated offering interpersonal safety services especially focused on community-based organizations (CBOs) and survivor needs and what the state needed to do to implement the pilot; and discusses the challenges that needed to be resolved for the state to safely offer these services to its Medicaid members.

[1] "In pursuit of Whole Person Health: Leveraging Medicaid Managed Care and 1115 Waivers to Address SDOH. Manatt on Health: Medicaid Edition. Oct. 28, 2020.

I. Background on North Carolina Healthy Opportunities Pilot (HOP)

In 2018, the North Carolina Department of Health and Human Services (NCDHHS) received approval from the Centers for Medicare & Medicaid Services (CMS) for a Section 1115 Medicaid transformation waiver to transition its state Medicaid program from fee-for-service to managed care. The state viewed this transition to managed care as an opportunity to address "whole person health" for all North Carolinians. They believed that embedding key assets and infrastructure into Medicaid would serve as a foundation on which other payers and providers could build.

As part of this waiver, CMS authorized the state to spend a portion of the savings gained from this transition ($650 million in state and federal Medicaid funds over the 5-year waiver period) on the HOP program. The state was authorized to spend up to $100 million (of the $650 million) on building the capacity of local CBOs)[2], and the rest to pay for the delivery of 29 evidence-based, federally-approved, non-medical services in the domains of housing/utilities, food/nutrition, transportation and interpersonal violence or toxic stress and accompanying administrative costs and value-based payments[3]. To reimburse for these services, the State defined and priced each service to create Medicaid's first fee schedule for non-medical services. As part of HOP, care managers at both health plans and providers use State-standardized, non-medical screening questions, as well as analytics (e.g., encounters, care management data) and outreach campaigns, to identify Medicaid members eligible for the program. HOP services are available to North Carolina Medicaid members who live in a pilot region and have at least one qualifying physical or behavioral health condition and one qualifying social risk factor. Care managers then use North Carolina's statewide, closed-loop referral platform, NCCARE360, to connect eligible members to community resources. The state procured three community care hubs, called Network Leads, to create and manage a network of high-performing CBOs to participate in HOP. These CBOs enroll as Medicaid providers through a customized Medicaid atypical provider type with a taxonomy classification of either individual "prevention professionals" or "public health" agencies. Medicaid health plans reimburse these participating CBOs for HOP services rendered and billed according to HOP's fee schedule. The services are provided at no cost to members. By integrating evidenced-based, non-medical services into Medicaid, the state hopes to:

- **Improve health outcomes for Medicaid enrollees**
- **Reduce health and economic disparities in the communities served by the pilots; and**
- **Reduce costs in the Medicaid program.**

Restoring a family's feeling of safety:

A family experiencing homelessness due to interpersonal violence-related challenges was living in a North Carolina shelter. A HOP-participating organization, with the shelter's assistance, was able to help the family find safe, affordable housing. The coordination of supports, including HOP services, was used to assist the guardian with securing a job and child care within two weeks of living in the shelter.

Shortly after being housed, the family was given a donated car with new tires and full insurance coverage paid for six months by a local church. The HOP organization was also able to find an individual willing to teach the member basic self-defense at no charge. Currently, the family is happily housed, employed, and no longer has a fear of feeling unsafe.

[2] North Carolina refers to community-based organizations as "Human Service Organizations"
[3] These included prepaid health plan (PHP) administrative payments, network lead payments, administrative payments, and value-based payments; they came out of the bucket of "the rest" of the $650 million, not the $100 million for capacity building.

Successful coordination of IPV and housing services:

After surviving an abusive marriage that ended with an attempt on her life, a North Carolina resident secured her own home where she lived independently for many years. Over time, her home became progressively less habitable and, by the time she enrolled in HOP, she was in severe need of housing services. Her roof was leaking badly, her ceiling was riddled with holes that let in cold and wet weather, and physical challenges made her bathroom difficult to use. Her HOP service provider coordinated with local contractors who replaced her roof, repaired and insulated her ceiling, and installed a new toilet, making it possible for her to continue living safely and independently.

A critical element of this initiative is evaluating which services are highest value and impact for specific subpopulations served. NCDHHS' ultimate goal is to "create accountable infrastructure, sustainable partnerships and payment vehicles that support integrating the highest value non-medical services into the Medicaid program at scale." [4]

The pilot strategically phased in services starting with food services in March of 2022, housing and transportation in May of 2022, toxic stress in June of 2022 and interpersonal violence services in April of 2023. This pilot is the first in the nation to identify IPV as a social driver of health and to offer interpersonal safety services to address this issue. The services specifically designed to address interpersonal violence and toxic stress include: interpersonal violence case management and holistic high-intensity case management (addressing housing, food, and IPV needs); violence intervention services; evidence-based parenting curriculum; home visiting services; and linkages to health-related legal supports. Importantly, other HOP services, such as housing navigation and move-in support, may also be provided to members because they are at risk of, or experiencing, IPV. Therefore, the enhanced privacy, security and safety requirements used specifically for IPV services also apply to all HOP services when an individual has an IPV need.

The pilot is authorized to run through the end of North Carolina's current Section 1115 waiver, which expires on October 31, 2024. However, in October of 2023, the state submitted a request to CMS to renew its 1115 waiver, including HOP, for another five years. North Carolina expects to use what they have learned (through rapid cycle and interim evaluations as well as through stakeholder engagement and tactical learning) to expand HOP services statewide and procure additional network leads in the next waiver period.

[4] Van Vleet, Amanda. Presentation on 10.4.23 to Princeton conference.

II. Factors leading to success in offering services to address IPV through Medicaid

This section highlights the tactical lessons learned in implementing interpersonal safety services that will be helpful to other states considering this type of innovative initiative. They are categorized into (1) design features; (2) standardization of technology and policies; and (3) coordination across health care and social service sectors. The following accelerators enabled North Carolina to successfully launch services to address interpersonal safety in Medicaid.

Pilot design features:

Early and regular collaboration across health and interpersonal safety sectors: soliciting early feedback in design phase and listening to IPV providers and advocates throughout the pilot

Prior to implementation of HOP, officials at North Carolina Department of Health and Human Services (NCDHHS), including NC Medicaid, and the North Carolina Coalition Against Domestic Violence (the Coalition) had already been collaborating closely and regularly for several years. (The Coalition is comprised of domestic violence agencies, community partners, colleges and individuals and leads the state's movement to end domestic violence and enhance work with survivors through collaborations, trainings, prevention, technical assistance, state policy development and legal advocacy.) NCDHHS had been working with the Coalition and NCCARE360 partners to ensure that the NCCARE360 platform met the needs of IPV survivors and of organizations providing IPV services. Both NCDHHS and the Coalition indicate that this strong relationship, which includes proactive communication and transparency, facilitated the state's ability to offer interpersonal safety services in the pilot.

NCDHHS officials also attribute their efforts in soliciting early and frequent feedback from partners to the success of the overall Medicaid transformation process and specifically to enabling the launch of IPV services in HOP. The state solicited input from focus groups and stakeholder meetings in both the design phase and throughout implementation that continuously shaped the design of the pilots. The state listened and learned during early focus group sessions from domestic violence providers and the Coalition on the types of IPV services that should be covered, how to define the services, and the types of payment (e.g., fee-for-service vs. per-member-per-month) that would align with their work. The state is continuing to have conversations with the Coalition since the launch of interpersonal safety services and intends throughout the duration of the pilot to get feedback on what's working, what's not and what issues still need to be resolved.

Pilot centered on IPV survivor experience and needs

The state embedded IPV survivor experience and needs into the design and operations of the pilot. The state formed an IPV workgroup that included state staff, the Coalition, and Legal Aid of North Carolina to discuss how the State, MCOs, and care management entities could identify eligible members, how MCOs and care management entities could make referrals to IPV providers, how MCOs could pay for IPV services, and how the State and its independent evaluator could conduct an evaluation of HOP in a safe way for survivors. The IPV workgroup consulted the Department of Justice (DOJ) and CMS about governing laws and regulations as well as legal, operational and safety challenges faced by the IPV community and Medicaid community. In every step of the process, the IPV workgroup considered what was needed to ensure survivor safety.

Pilot services were launched in phases

As noted in the introduction, the state phased in services over a period of one year. The phasing in of services allowed the state to identify and troubleshoot any early issues before the pilot was at scale. Additionally, phasing service implementation allowed the state to begin delivering food, housing, transportation, and toxic stress services while they worked with the Coalition to determine how best to deliver and pay for IPV services to ensure survivor safety.

Standardization of technology and policies

One shared technology platform

The state prioritized using one shared technology system for most HOP functions, which is used by all pilot entities including health plans, providers, Network Leads, and CBOs. The platform, NCCARE360, is a state-wide, closed loop referral system. Prior to HOP, North Carolina Medicaid already required its managed care plans to use this closed loop referral system for any Medicaid enrollee with a social need. As a result, most health plans, providers, and CBOs were already using NCCARE360 at the time of HOP launch. This created the technological foundation on which to build HOP-specific functionality, including the delivery of IPV services. The main IPV-related functionality added was to capture more detailed contact information, additional response options for providers, and a revised consent form.

The state and Unite Us, the technology vendor for NCCARE360, worked together to add enhanced functionality into NCCARE360 to support HOP, including eligibility and enrollment documentation, service authorization, and a method for CBOs to submit invoices/claims. The health plans, providers, Network Leads and CBOs all use this single platform to share data. Additionally, NCCARE360 shares claims and encounters data with the state and its managed care plans, and it is integrated with the state's member enrollment system to check eligibility. The state uses NCCARE360 data to track member eligibility and enrollment in HOP, HOP service authorizations, referral outcomes, service delivery outcomes, and invoices. The state receives encounter data, originating from NCCARE360, through its Encounters Processing System, which enables the state to aggregate all HOP (non-medical) data with its medical data in the same analytics platform. Additionally, as previously mentioned, the state also enrolls participating CBOs as Medicaid providers through its Medicaid Management Information System.

Some policies that were added for IPV survivors were applied across all members participating in HOP

As noted earlier, HOP services became available in April of 2023 to individuals at risk or experiencing IPV. Those individuals could request IPV services (the set of services noted earlier) as well as any other HOP service. Since the state could not predict what needs these individuals would have, they made all systems and processes safe for these individuals regardless of what services they needed. This positively impacted survivors as well as those at risk of IPV. For example, the state captures member consent to participate in the pilot through a standardized consent form. When launching IPV services, the state worked with the Coalition to add elements to the consent form to improve the safety of IPV survivors and created a job aid to assist care managers in collecting consent.

The State and the Coalition worked with Unite Us to make modifications to the NCCARE360 platform to limit information sharing for sensitive service types (such as IPV) and sensitive organizations (such as IPV service provider CBOs).

Some of these changes include:

- Limiting IPV-related information access for users at each entity in the pilot (care managers, other CBOs, Medicaid pre-paid health plans). Only users who send a referral, receive a referral, or receive billing information about a service provision are able to see information that confirms a member was referred to an IPV service provider or received IPV-related services.

- Adding options in the platform referral responses to allow CBOs receiving federal funds under the Violence Against Women Act (VAWA), the Victims of Crime Act (VOCA) and the Family Violence Prevention and Services Act (FVPSA) to limit information sharing about referral outcomes if a member has not also provided a separate VAWA-compliant release of information to the CBO.

This new consent form was then used for all HOP members, not just IPV survivors. Since all members were treated the same, there was no need to do a carve out or segment the population needing interpersonal safety services. Additionally, the state worked with the Coalition to develop a training on how to handle sensitive information of IPV survivors, and any staff member of a health plan, provider, Network Lead, or CBO that works on HOP must take this training.

Positive spillover

NC Medicaid health plans are required to screen members for medical and non-medical needs within 90 days of enrollment. They must try at least three times to reach members to determine if they have a social need. As part of HOP, care managers must collect detailed contact requirements for HOP enrollees, such as whether to call or text, time of day it is safe to call, and whether it is safe to leave a voicemail. These requirements were created for IPV survivors but must now be collected for all HOP enrollees, since an enrollee may be receiving a housing service, for example, but as a result of experiencing IPV. Although this requires new ways of operating, the health plans now have much better member contact information since the contracts require collection of this information for all members. This allows them to do better outreach for other services, as well, such as health promotion activities.

One standard screener

In its contracts with health plans, North Carolina requires the use of a standard screening tool for health-related social needs. This screener is essential for identifying needs and referring individuals to resources in their communities. Using the same screener across the pilots allows for all members to be treated equitably. It also facilitates collecting and analyzing data. The state hopes that if plans and providers are using this screening tool for their Medicaid population, then they will also use the same screener across all types of payer populations.

Coordination across health care and social service sectors

Network Leads promote equity in CBO networks

The state recognized that there was a need for direct financial support to under-resourced CBOs to help provide services that address social drivers of health. Thus, North Carolina created a new type of entity — Network Leads — that play a critical role in HOP by connecting the health care and social service sectors. The three Network Leads (one in each pilot region) each build and manage a network of HOP-participating CBOs and connect them to Medicaid health plans. (As of July 2024, there are 51 CBOs providing IPV/sensitive services in the three pilot regions. Most providers are local and only operate in one region with a small number of providers covering all three regions.) The network leads serve as a single point of accountability for the CBOs and as a single point of contact for health plans. They act as a local anchor to build the capacity of CBOs to participate in Medicaid by distributing capacity-building funds to strengthen CBO readiness and expand capacity to serve. They are also responsible for managing a high-quality network of CBOs and ensuring the network abides by efficiency, adequacy, and quality standards. (The state is responsible for reviewing the networks to ensure they include local organizations and organizations led by women and people of color that reflect members in the community.[5]) The Network Leads provide ongoing technical assistance and support to the CBOs. They receive, track and validate invoices from the CBOs and work with the managed care organizations to ensure payment. The state used this RFP for this new entity.[6]

[2] The state requires that Network Leads have a board of directors that is representative of the Medicaid population in their region and that Network Leads and CBOs make best efforts to employ staff that is representative of the Medicaid population in their region. The state also requires that all HOP-participating CBOs have a physical presence in the state to prioritize investments in local communities.

[2] This site has all of the HOP RFP documents. https://medicaid.ncdhhs.gov/requests-proposals-rfps-and-requests-information-rfis

Capacity building funds for CBOs to engage with the health care system

The state also determined that smaller, less resourced CBOs needed significant funding to build their capacity to participate in and engage with the health care system. Many CBOs substantially increased their caseloads to serve Medicaid beneficiaries once the pilots were launched, and they wanted to continue to effectively serve their existing clients. Moreover, some CBOs expanded into new counties to serve HOP members or expanded the array of services that they provided. In addition, many CBOs did not have experience performing traditional medical billing, Medicaid program integrity functions, data collection and analytics. The state provided capacity-building funds to help CBOs take on these new responsibilities. For CBOs providing IPV services, the funds are largely used for hiring additional staff to take on expanded capabilities. Some of the capacity-building funds also are used to purchase equipment (e.g., van for food delivery), technology, and infrastructure (temporary office space). CBOs apply to the network lead in their region to participate in the pilot. Network Leads could request up to $10 million in capacity building funds per year for the first two years — at least half of which went to the CBOs — and receive administrative funding for the remainder of the pilot.

IPV trainings for all staff involved with the pilots

When the state launched IPV services in April of 2023, IPV-specific trainings were required for all staff involved with the pilots. These trainings focused on how to interact with individuals experiencing or at risk of IPV and how to work with their data, regardless of which HOP services they were receiving. The trainings reviewed the five new IPV services in detail and provided information on topics such as trauma-informed care and maintaining data privacy and safety.

The state implemented two types of mandatory IPV trainings for all individuals working with the pilots. Care managers, who interact directly with HOP enrollees, must undergo specialized training on best practices in IPV response, creating a culture of care for IPV survivors, and how to recommend appropriate IPV services for a member. All non-patient facing staff at health plans, providers, Network Leads, and CBOs involved in the pilot (e.g., health plan billing and payment staff) must complete a training related to data privacy and safety for members needing interpersosnal safety services. This includes documenting the limited number of individuals who are allowed to access this data and times that the data was accessed.

Model contracts and staffing issues relating to IPV

The state established clearly defined roles for all pilot entities – health plans, care manaagement entities, Network Leads and CBOs -- by using model contracts. The model contracts specified the roles and responsibilities of each entity. Clearly defined roles and alignment of goals allowed for clarity among the many organizations involved in HOP. The model contracts between health plans and network leads can be found here; the model contract between network leads and CBOs can be found here.

The state also found it helpful to have a dedicated staff person with overall programmatic accountability for the IPV part of the initiative. In addition, they hired one staff person to focus on the legal issues relating to survivor protection.

III. Challenges to providing interpersonal safety services

The state felt passionately about including interpersonal safety services as part of the pilots but faced some daunting challenges. This section lays out some of these challenges and how North Carolina addressed these issues. The challenges fall into two categories: ensuring survivor safety and privacy; and developing effective partnerships between health plans and CBOs.

Ensuring survivor safety and privacy

Protecting the safety and confidentiality of individuals at risk of, or experiencing, interpersonal violence is imperative. If an abuser discovers that a survivor is seeking support or locates their address, for example, there could be dangerous and even deadly consequences. Therefore, laws such as the Violence Against Women Act (VAWA), the Victims of Crime Act (VOCA) and the Family Violence Prevention and Services Act (FVPSA) include strict requirements for organizations that serve IPV survivors to protect survivor information in order to receive federal funding, under these laws, on which many of these organizations rely. These laws ban organizations receiving federal funding from sharing any personally identifiable information of a survivor unless a narrow exception applies, such as when the survivor provides a voluntary, informed, written, time-limited consent to share their information. Conversely, the medical community relies on knowing personally identifiable information. Health insurers, for example, need to know if an individual is a covered member and what services they received to reimburse an organization for services provided. This is one of the primary reasons that services to address IPV have proved so challenging to implement in Medicaid.

Acquiring requisite knowledge among Medicaid staff to protect survivors

In order to offer interpersonal safety services, North Carolina Medicaid officials faced a steep learning curve. The laws for sharing of data on survivors of domestic violence are even stricter than laws on health care data sharing. The health sector learned new terminology around safety, privacy, confidentiality and security. They also became steeped in the federal laws around data sharing that apply to CBOs that receive federal funding to serve IPV survivors. The state hired a staff member to do research on laws protecting the information of IPV survivors and Department of Justice (DOJ) requirements. The researcher identified requirements and issues the state needed to address and the state verified these requirements, issues and potential solutions with the Coalition. Medicaid officials worked closely with the Coalition as they developed policies to protect and ensure the safety of survivors.

Making modifications to protect survivors

North Carolina Medicaid enacted three types of modifications to protect survivors. These modifications took into account both federal requirements in the medical and social sectors and best practices for protecting survivor information and safety.

One of the main changes adopted by the state is that they began having HOP partners collect and abide by HOP enrollee's contact requirements that were modified to address survivor-related issues. Using up-to-date and detailed contact information on how to safely contact survivors of IPV is crucial to protecting their safety. For example, if an abuser hears a voicemail on the home answering machine or receives hard copy mail to the home indicating that the survivor is seeking help, the abuser could be encouraged to take action against the survivor with dangerous consequences. The Coalition indicated that this was a priority to safely including IPV services in HOP.

Modification 1

o Contact information captured

Since all HOP partners (health plans, providers, Network Leads, and CBOs) have access to NCCARE360, the state worked with Unite Us to create a method of documenting more detailed member contact information in the platform. Care managers, who screen Medicaid members for HOP eligibility and obtain their consent to participate, were also tasked with collecting up-do-date contact requirements for the member at the same time (see box). Care managers documented the contact requirements in NCCARE360, which are visible to and editable by all HOP-participating organizations serving the member. Contract amendments were made with all HOP-participating organizations, requiring them to abide by the member's contact requirements when reaching out to the member and, if requested by the member, update the contact requirements.

Another change resulting from the clear importance of safely contacting members is that the state decided not to send mailings of HOP service denial notices and rights and responsibilities documents to members through the mail. Instead, care managers inform members if their service request was denied and aim to connect the member to another service to meet their needs. While these are still waiver services, information on member rights and responsibilities and how the member can file a grievance if their service is denied is posted on each health plan's website.

Modification 2

o Consent

Member consent is required for at least three, and up to four, purposes during participation in the pilot. The state has streamlined the consent process as much as possible but acknowledges that this can still be a major barrier to members receiving care. First, CMS requires a member's consent to participate in the Medicaid pilot Second, the NCCARE360 platform requires consent since member data is shared across the platform. Third, the evaluator of the North Carolina pilots needs consent to include member information in the evaluation, per their internal review board. And fourth, if the member needs services to address domestic violence, domestic violence organizations that share survivor information must collect a separate VAWA-compliant consent to meet Department of Justice requirements. The state has developed a brief universal consent form to meet CMS requirements and streamline the consent process as much as possible. When a care manager is collecting consent from the member to participate in the pilot, they also document if the member consents to having their information included in the evaluation and can collect consent from the member to add their information into NCCARE360. North Carolina Medicaid takes the opportunity when asking for consent to participate in the pilot to inform the members about what data of theirs will be used, who it will be shared with and for what purpose.

Documenting more detailed contact information requirements

- *Establishing times when it is safe to contact*
- *Preferred contact method (e.g., phone, text, mail)*
- *Message to leave (e.g., when calling, say it's from the veterinarian)*

Modification 3

o Training on IPV services and survivor needs tailored based on the staff member's interaction with patients and with data

Finally, as noted in the previous section on accelerators, the state required training for all health plan, care management entities, Network Lead, and CBO staff involved in the pilots. The state worked closely with the Coalition to develop the trainings on best practices that protect privacy and confidentiality. The health care sector and the social service sector are both being asked to behave differently to achieve "whole person health" so training was essential. Separate trainings are provided for those individuals that are patient-facing and those that are non-patient facing (i.e., workers that mostly interacted with the patient's data/information). Requirements to complete these trainings were added into HOP-participating entities' contracts and made available online. The Coalition continues to provide input on additional training needed and proposes training modules in response to any implementation challenges arising as the IPV service providers continue under the pilot.

Developing effective partnerships between health plans and CBOs

Balancing the rigor and extent of requirements for CBOs to become Medicaid providers with the desire/need for CBOs to participate in HOP

Because HOP is a Medicaid-funded pilot, it must abide by state and federal Medicaid regulations. The state recognized that while needing to maintain program integrity, if Medicaid requirements (e.g., program integrity, billing) were too rigorous then CBOs would simply not participate in HOP. The state sought to balance these objectives in multiple ways.

First, **they created a new Medicaid provider type specifically for CBOs participating in HOP.** They maintained federal requirements like background checks but were able to reduce some requirements like fingerprinting and to eliminate the registration fee (which was covered by capacity building funds). The state only required CBOs to be credentialed for what they otherwise need in their field (e.g. food, housing) with no new Medicaid credentialing required. This memo outlines the enrollment process and requirements for the new provider type.

Additionally, since Network Leads are responsible for overseeing their network of CBOs, **the state tasked them (as opposed to health plans) with overseeing the program integrity of CBOs** as well. Network Leads all contracted with an outside entity to assist them with conducting ongoing background checks of staff. Each Network Lead developed a process for ensuring that members were in fact receiving the HOP services that were authorized for the member. And if a Network Lead suspects any suspicious activity from a CBO, it works in close collaboration with the state to investigate and address the concern. It was important to the state to have Network Leads accountable for the program integrity of CBOs. Network Leads are the entity that works most closely with their local CBOs and can ensure that a tone of learning was set without overmedicalizing CBOs through the program.

Balancing rigorous regulations to maintain program integrity

- *A new Medicaid provider type specifically for CBOs participating in HOP was created*
- *Network Leads were tasked with overseeing their network of CBOs*

Developing pricing and billing methodology that works for CBOs

The state spent approximately one year developing the HOP fee schedule. First, they conducted research on evidence-based non-medical services — those that improved health outcomes and lowered costs. This informed a refined list of services and service definitions. Second, they conducted focus groups with CBOs by domain and sought input on CBOs' current payment methodologies, preferred payment methodologies, and pricing structures. There were different preferences by domain and type of service. For example, CBOs providing food and nutrition case management services preferred to be paid for that service in 15-minute intervals, similar to fee-for-service. Because housing needs can often take longer and be more complex to address, CBOs that provided housing case management services preferred to be paid for case management in per-member-per-month payments. Third, they convened a state and national advisory panel to provide feedback on the refined list of services, service definitions, and different payment methodologies. Fourth, they solicited public comments on the draft services, service definitions and rate methodology. Based on this input, the state finalized the initial fee schedule. The HOP Fee Schedule can be found here.

The state conducts an annual review of the HOP fee schedule which includes input from participating CBOs and an assessment of market changes for each service.

IV. Conclusion

North Carolina is a leader among states in addressing the range of social drivers and especially in its commitment to addressing interpersonal violence. The precedent set in North Carolina for covering IPV and the range of social drivers eases the way for other states to move forward. While CMS has approved Section 1115 waivers for other states such as Arizona, Massachusetts, and Oregon to offer additional financing and flexibilities to address unmet resource needs, IPV services are not currently included in CMS' health-related social needs (HRSN) framework, which focuses on food and housing-related needs. States may be able to offer IPV-related services through other mechanisms, such as state plans or other types of waivers, but including IPV services in CMS' national HRSN framework would encourage more states to offer IPV services and streamline their delivery with other HRSN-related services.

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