NC MEDICAID

ANNUAL TECHNICAL REPORT

March 2022

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES







HSAG
HEALTH SERVICES ADVISORY GROUP

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EXECUTIVE SUMMARY

Introduction to the Annual Technical Report

Title 42 of the Code of Federal Regulations (42 CFR) at §438.364 requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that provides a description of how the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the Medicaid managed care organizations (MCOs). Appendix A lists the required and recommended elements for the external quality review (EQR) technical report.

The North Carolina (NC) Department of Health and Human Services' (DHHS') Division of Health Benefits (the Department) is the state agency responsible for the overall administration of NC's Medicaid managed care program. This state fiscal year (SFY) 2021 (July 1, 2020, to June 30, 2021) EQR technical report was prepared for the Department by Health Services Advisory Group, Inc. (HSAG), the Department's EQRO. HSAG contracted with the Department as of May 24, 2021.

For a list of acronyms used in this report, please reference Appendix B.

Overview of NC's Managed Care Program

Statewide Medicaid Managed Care

In September 2015, the NC General Assembly enacted Session Law 2015-245, directing the transition of the State's Medicaid program from a predominantly fee-for-service (FFS) structure to a capitated managed care structure. Since that time, the Department has collaborated with the General Assembly and stakeholders to plan the implementation of this directive. The Department is committed to transitioning NC to Medicaid managed care to advance high-value care, improve population health, engage and support beneficiaries and providers, and establish a sustainable program with predictable costs. Implementation of managed care is occurring over a three-phased schedule: Phase 1—July 1, 2021; Phase 2—December 1, 2022; and Phase 3—projected no later than December 2023.

On July 1, 2021, the Department transitioned most beneficiaries to fully capitated prepaid health plans (PHPs) called "Standard Plans." Most enrollees, including adults and children with low to moderate intensity behavioral health (BH) needs, receive integrated physical health, BH, and pharmacy services through Standard Plans.

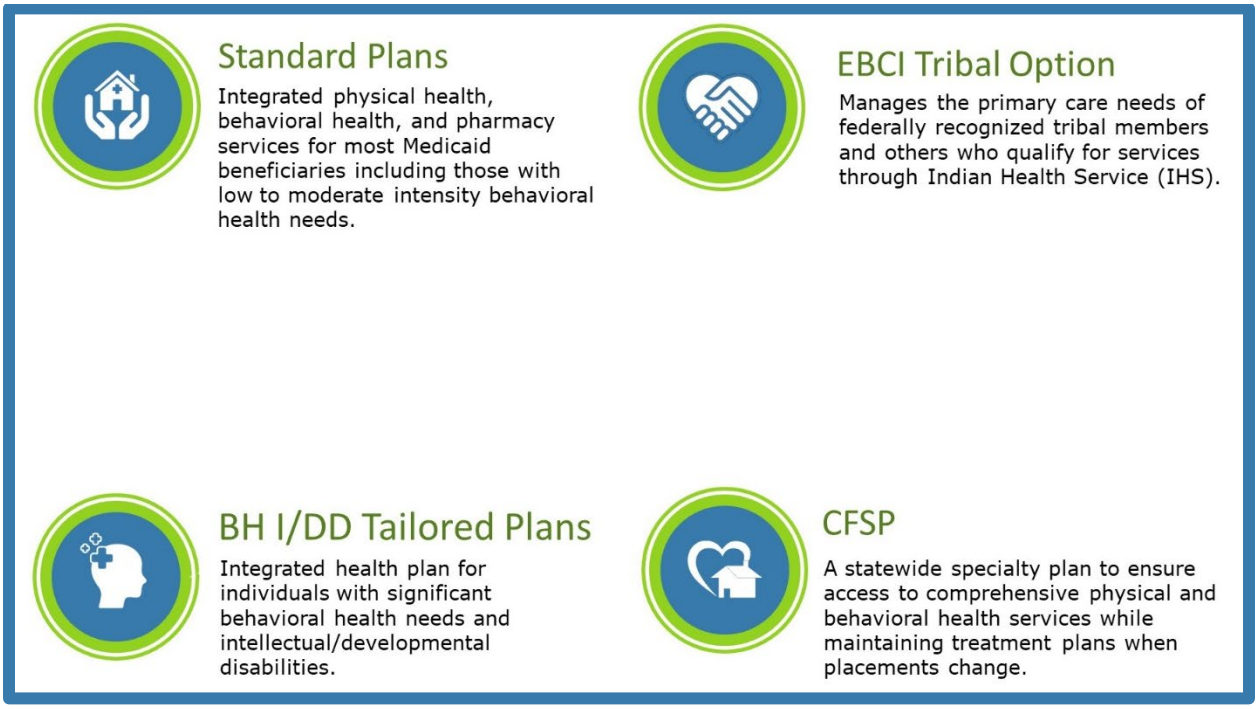
A new delivery system called the Eastern Band of Cherokee Indians (EBCI) Tribal Option was also launched on July 1, 2021. The Department's contract with the Cherokee Indian Hospital Authority (CIHA) established an Indian Managed Care Entity (IMCE), the first of its kind in the nation, to address the health needs of American Indian/Alaskan Native Medicaid beneficiaries. The EBCI Tribal Option is a non-risk bearing managed care option for federally recognized tribal members and other individuals eligible to receive Indian Health Service under 42 CFR §438.14(a). The EBCI Tribal Option has a strong focus on primary care, preventive health, and chronic disease management; provides care management for all members and care management service plans for high needs members; and coordinates all medical, BH, and pharmacy services.

BH Intellectual/Developmental Disability (I/DD) Tailored Plans are integrated health plans for individuals with significant BH needs and I/DDs. BH I/DD Tailored Plans will also serve other special populations, including 1915(c) Innovations and traumatic brain injury (TBI) waiver enrollees, as well as manage several specialized BH and I/DD services. BH I/DD Tailored Plans will launch in December of 2022.

The final phase is a Children and Families Specialty Plan (CFSP) the Department intends to launch in December 2023. The CFSP will be a statewide specialty plan to ensure access to comprehensive physical and BH services while maintaining treatment plans when placements change. The CFSP will include care management services to improve coordination among service providers, families, involved entities (e.g., Department of Social Services, Division of Juvenile Justice, schools), and other stakeholders involved in serving the CFSP's members.

Figure 1 displays the state's health plan types.

Figure 1—NC Health Plan Types



Innovative Features

NC's Section 1115 waiver provides federal authority to incorporate the following innovative features into its new managed care delivery system.

Advanced Medical Homes (AMHs). The Department developed the AMH model as the primary vehicle for care management as the state transitions to Medicaid managed care. High-quality primary care with the capacity to manage population health is foundational to the success of NC's Medicaid transformation, supporting the delivery of timely care in the appropriate setting to meet each member's needs. The AMH model supports the Department's transformation vision by maintaining the strengths of NC's legacy care management structure and promoting delivery of care management in the community. The AMH model was designed to spur development of modernized, data-driven primary care that aligns with the Department's vision for advancing value-based payments over time.

Healthy Opportunities Pilots. Three organizations were selected to serve three regions of the state to test evidence-based, non-medical interventions designed to promote community engagement, reduce costs, and improve the health of Medicaid beneficiaries. These public–private regional pilots support and strengthen work already underway in communities and at the state level to maximize efficiencies and effectiveness within the managed care program, focusing on housing, food, transportation, interpersonal safety, and cross-domain services. The Department's goal is to create a systematic approach to integrating and financing non-medical services that address social determinants of health.

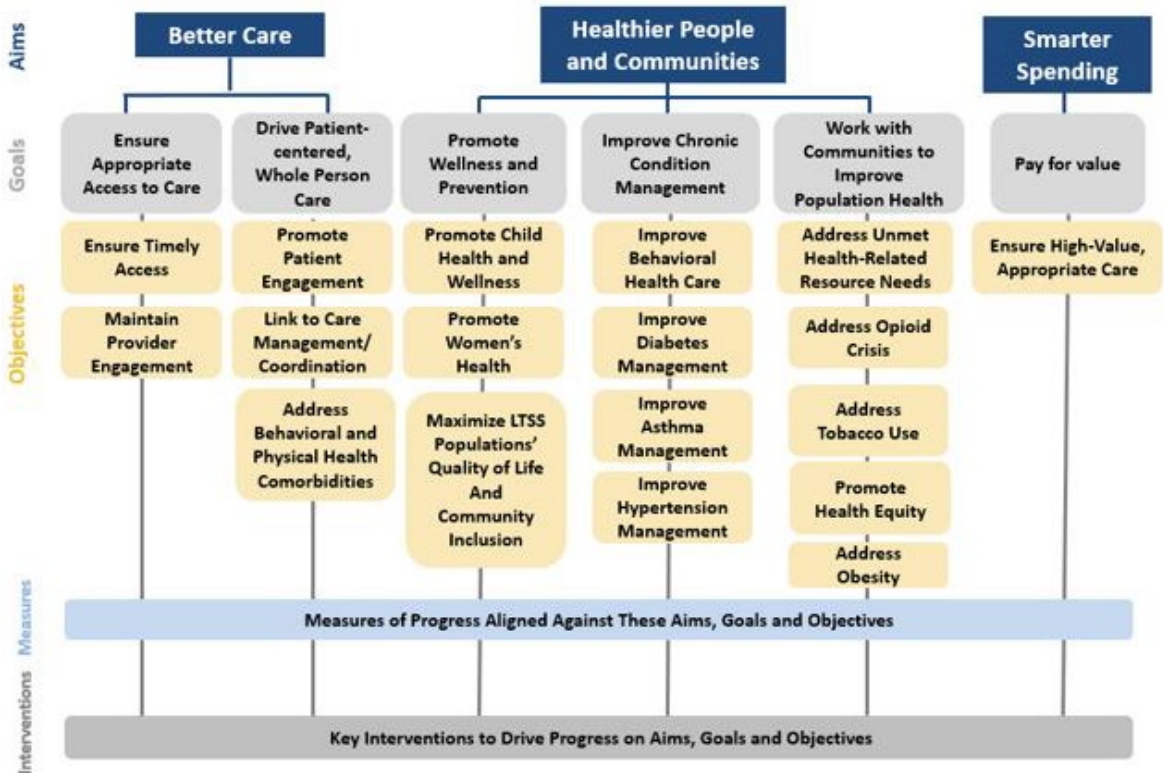
Opioid Strategy. To support broader state efforts to combat the opioid crisis, NC DHHS received federal authority to increase access to inpatient and residential substance use disorder treatment through reimbursement for services in institutions of mental disease.

Quality Strategy

The Centers for Medicare & Medicaid Services (CMS) Medicaid managed care regulations at 42 CFR §438.340 require state Medicaid agencies operating Medicaid managed care programs to develop and implement a written quality strategy for assessing and improving the quality of healthcare services offered to their enrollees.

The Department's Medicaid Managed Care Quality Strategy (Quality Strategy) outlines the Department's goals for accessible, high-quality care and smarter spending, and describes plans for achieving those goals.[1] The Quality Strategy Framework is structured around three central aims: Better Care Delivery; Healthier People and Healthier Communities; and Smarter Spending. These aims are depicted in Figure 2.

Figure 2—Overview of the Quality Strategy Framework



[1] North Carolina Department of Health and Human Services, Department of Health Benefits. *North Carolina's Medicaid Managed Care Quality Strategy*, June 16, 2021. Available at: https://medicaid.ncdhhs.gov/media/9968/download?attachment. Accessed on: Jan 28, 2022.

Each of the 18 objectives are tied to a series of focused interventions used to drive improvements within and, in many cases, across the goals and objectives set forth in the Quality Strategy. To assess the impact of these interventions and continue to identify opportunities for improving the quality of care delivered under Medicaid managed care, these interventions are tied to a set of metrics to assess progress. As baseline data for health plan performance becomes available, the Department intends to further refine the objectives to target specific improvement goals, including additional metrics that address health disparities.

Scope of External Quality Review Activities

As the Department implements managed care, HSAG will conduct mandatory and optional EQR activities, as described in 42 CFR §438.358, in a manner consistent with the associated *CMS External Quality Review (EQR) Protocols, October 2019* (CMS EQR Protocols).[2] The purpose of these activities, in general, is to improve states' ability to oversee and manage health plans they contract with for services and help health plans improve their performance with respect to the quality of, timeliness of, and access to care. Effective implementation of the EQR-related activities will facilitate State efforts to purchase high-value care and to achieve higher-performing healthcare delivery systems for their Medicaid and Children's Health Insurance Program (CHIP) members.

For SFY 2021, HSAG conducted preparatory activities with the Department for the mandatory EQR activities displayed in Table 1 and the optional activities described in the Optional EQR Activities section.

Table 1—EQR Activities

Activity	Description	CMS EQR Protocol
Mandatory Activities*		
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by a health plan used sound methodology in its design, implementation, analysis, and reporting.	**Protocol 1.** Validation of Performance Improvement Projects
Performance Measure Validation (PMV)	This activity assesses whether the performance measures (PMs) calculated by a health plan are accurate based on the measure specifications and State reporting requirements.	**Protocol 2.** Validation of Performance Measures
Compliance With Standards	This activity determines the extent to which a Medicaid and CHIP plan is in compliance with federal standards and associated state-specific requirements, when applicable.	**Protocol 3.** Review of Compliance With Medicaid and CHIP Managed Care Regulations

* Until the CMS network adequacy validation protocol is issued, health plans will only be subject to three mandatory EQR-related activities.

[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 28, 2022.

Aggregating and Analyzing Statewide Data

As HSAG, the Department, and the health plans conduct EQR activities, HSAG will analyze the results obtained from each EQR activity. From these analyses, HSAG will determine which results were applicable to the domains of quality of, access to, and timeliness of care and services. HSAG will then analyze the data to determine if common themes or patterns exist that allow conclusions about overall quality of, access to, and timeliness of care and services to be drawn for each health plan independently and the overall program. These conclusions will be presented in the SFY 2022 EQR technical report.

Quality, Access, Timeliness

CMS identified the domains of quality, access, and timeliness as keys to evaluating MCO performance. HSAG used the following definitions for these domains.



Quality

as it pertains to the EQR, means the degree to which an MCO, prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement.[1]

Access

as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services). Under §438.206, availability of services means that each state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner.[2]

Timeliness

as it pertains to EQR, is described by the National Committee for Quality Assurance (NCQA) to meet the following criteria: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[3] It further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care).

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.

[2] Ibid.

[3] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs.*

NC Managed Care Program Findings and Conclusions

In the SFY 2022 report, HSAG will utilize its analyses and evaluations of EQR activity findings from SFY 2022 to assess the health plans' performance in providing quality, timely, and accessible healthcare services to beneficiaries. For each health plan reviewed, HSAG will provide a summary of its overall key findings, conclusions, and recommendations based on the health plan's performance. The overall findings and conclusions for all health plans will be compared and analyzed to develop overarching conclusions and recommendations for the NC managed care program.

Recommendations for Targeting Goals and Objectives in the Quality Strategy

In the SFY 2022 report, HSAG will highlight substantive findings and actionable state-specific recommendations, when applicable, for the Department to further promote its Quality Strategy goals and objectives.

REVIEW OF COMPLIANCE

Introduction

According to federal requirements located within 42 CFR §438.358, the state, an agent that is not a Medicaid managed care entity, or its EQRO must conduct a review within a three-year period to determine an MCO's compliance with the standards set forth in 42 CFR Part 438—Managed Care Subpart D and the quality assessment and performance improvement (QAPI) requirements described in 42 CFR §438.330. These standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR Part 438.

As SFY 2022 is NC's first year of operation for statewide managed care, it will initiate the compliance review process in subsequent years.

PERFORMANCE MEASURES

Introduction

Federal regulations at 42 CFR §438.330(c) require states to specify standard PMs for health plans to include in their comprehensive QAPI programs. Each year, the health plans must measure and report to the state the standard PMs specified by the state and submit specified data to the state that enables the state to calculate the standard PMs.

To ensure that all NC Medicaid managed care beneficiaries receive high-quality care, the Department requires the health plans report on, and ultimately be held accountable for, performance against measures aligned to a range of specific goals and objectives used to drive quality improvement (QI) and operational excellence. The Department's use of specific quality requirements to advance toward these goals and objectives will evolve as the health plans' and providers' infrastructure and experience increase, with greater rewards for excellence and more significant penalties for poor performance.

In its Quality Strategy, the Department developed standard PMs, as required by 42 CFR §438.330(c), some of which Standard Plans and Tailored Plans are required to measure and report to the Department. Others will be directly measured by the Department. Consistent with the Department's desire to benchmark its progress against other states' performance and assess key priorities to drive continuous QI efforts, nearly all the measures are nationally recognized. For the first two years of managed care implementation, the Department will set a benchmark for each measure (with the exception of measures of contraceptive care) of 105 percent of the Standard Plan average from the prior year. The benchmark for the BH I/DD Tailored Plans will be set at 105 percent of the prior year's performance average of the BH I/DD Tailored Plans. For the third plan year and beyond, the Department will monitor performance and may adjust the benchmarking methodology.

Quality Strategy Measures

The Department requires the Standard Plans to monitor and evaluate the quality of care through the use of Healthcare Effectiveness Data and Information Set (HEDIS®)[3] and Department-defined PMs. Table 2 lists PMs that are outlined in the Quality Strategy for priority focus for Standard Plan accountability. The table also shows HSAG's assignment of the PMs into the domains of quality, timeliness, and access. As activities and data are produced, the Department will continue to assess the assignment of measures by quality, timeliness, and access.

Table 2—Assignment of PMs to the Quality, Timeliness, and Access Domains

Performance Measure	Quality	Timeliness	Access
Pediatric Care			
Child and Adolescent Well-Care Visits	✓	✓	✓
Well-Child Visits in the First 30 Months of Life	✓	✓	✓
Childhood Immunization Status	✓	✓	✓
Immunization for Adolescents	✓	✓	✓
Total Eligibles Receiving at Least One Initial or Periodic Screen	✓		✓
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics	✓		
Adult Care			
Cervical Cancer Screening	✓		✓
Chlamydia Screening in Women—Total	✓		✓
Comprehensive Diabetes Care—Hemoglobin A1C (HbA1c) Testing	✓		
Controlling High Blood Pressure	✓		
Flu Vaccinations for Adults	✓		✓
Medical Assistance with Smoking and Tobacco Use Cessation	✓		
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	✓	✓	✓
Screening for Depression and Follow-Up Plan	✓		
Use of Opioids at High Dosage in Persons Without Cancer	✓		
Use of Opioids from Multiple Providers in Persons Without Cancer	✓		
Concurrent Use of Prescription Opioids and Benzodiazepines	✓		
Plan All-Cause Readmissions	✓	✓	✓
Total Cost of Care	✓		✓

[3] HEDIS® is a registered trademark of the NCQA.

Performance Measure	Quality	Timeliness	Access
Rate of Screening for Unmet Resource Needs	✓		✓
Maternal Care			
Low Birth Weight	✓		✓
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Rate of Screening for Pregnancy Risk	✓	✓	✓

Health Plan Names

A full list of health plans can be found in Appendix C.

Results

The HEDIS measurement year (MY) is one year following the year reflected in the data; for example, HEDIS MY 2022 refers to the analyses of data collected from January 1, 2021, through December 31, 2021. HEDIS measures require one full year of data; however, the Standard Plans' contracts did not go into effect until July 1, 2021. Considering the Standard Plan mid-measurement year launch into managed care operations, HSAG and the Department worked closely with the Standard Plans to understand several nuances and complexities in the Standard Plans' abilities to produce future MY 2021 PM rates for review and validation. HSAG ensured that calendar year (CY) 2021 PMV methods aligned with CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019;[4] however, final MY 2021 PM rates will not be available until mid-CY 2022 and will, therefore, be subsequently integrated into the EQR technical report produced in SFY 2023.

[4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 28, 2022.

PERFORMANCE IMPROVEMENT PROJECTS

Introduction

According to federal requirements located within 42 CFR §438.330, the state must require, through its contracts, that each health plan establish and implement an ongoing comprehensive QAPI program for the services it furnishes to its enrollees. The Department requires each health plan to conduct PIPs in accordance with 42 CFR §438.330.

The purpose of a PIP is to achieve, through ongoing measurement and intervention, significant improvements in clinical and nonclinical areas of care that are sustained over time. This structured method of assessing and improving health plan processes can have a favorable effect on health outcomes and member satisfaction. Federal requirements for PIPs include:

- Measurement of performance using objective quality indicators.
- Implementation of interventions to achieve improvement in the access to and quality of care.
- Evaluation of the effectiveness of the interventions based on the PMs.
- Planning and initiation of activities for increasing or sustaining improvement.

As SFY 2022 is NC's first year of operation for statewide managed care, HSAG worked with the Department in SFY 2021 to conduct preparatory activities as described below.

Preparatory Activities

For validation, the Department is requiring the Standard Plans to submit PIPs for the following topics: *Childhood Immunization Status Combo 10, Timeliness of Prenatal Care,* and *HbA1c Poor Control (>9%)*. Additionally, each Standard Plan will submit a nonclinical PIP topic for validation. The PIP topics submitted by the Standard Plans address CMS' requirements related to the quality of, access to, and timeliness of care and services.

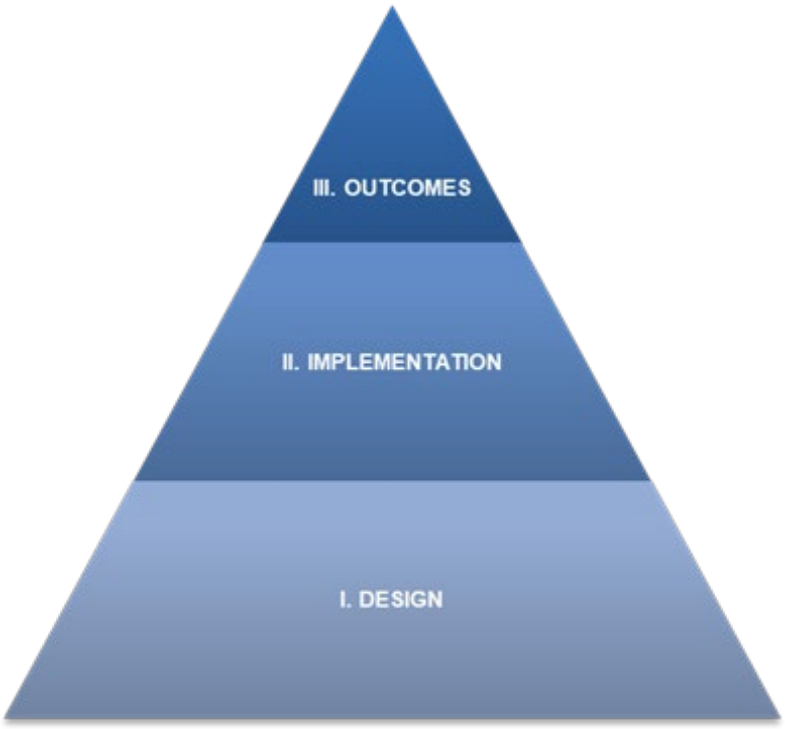
In SFY 2022, HSAG will complete the annual validation of the Standard Plans' PIPs, which includes the assessment of the Standard Plans' methodology for conducting PIPs and the evaluation of the overall PIP validity and reliability. In its PIP evaluation and validation, HSAG uses CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019 (EQR Protocol 1).[5] HSAG's evaluation of the PIP includes two key components of the QI process:

1. HSAG evaluates the technical structure of the PIP to ensure the Standard Plans design, conduct, and report the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling techniques, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the Standard Plans improve their rates through the implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results). The goal of HSAG's PIP validation is to ensure the Department and key stakeholders can have confidence that any reported improvement in outcomes is related to a given PIP.

Figure 3 illustrates the three stages of the PIP process—i.e., Design, Implementation, and Outcomes. Each sequential stage provides the foundation for the next stage. The Design stage establishes the methodological framework for the PIP. The activities in this section include development of the PIP topic, Aim statement, population, sampling techniques, performance indicator(s), and data collection processes. To implement successful improvement strategies, a strong methodologically sound design is necessary.

[5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 28, 2022.

Figure 3—Stages of the PIP Process



Data Collection

Methods and Tools

HSAG obtains the data needed to conduct the PIP validation from the Standard Plans' PIP Summary Forms. This form provides detailed information about the Standard Plans' completed PIP activities. In SFY 2022, the Standard Plans will be required to complete the design of the PIP, steps 1 through 6.

To monitor, assess, and validate PIPs, HSAG also developed a PIP Validation Tool to ensure uniform assessment of PIPs. This tool is used to evaluate each of the PIPs for the following nine EQR Protocol 1 steps:

Step 1—Review the Selected PIP Topic
Step 2—Review the PIP Aim Statement
Step 3—Review the Identified PIP Population
Step 4—Review the Sampling Method
Step 5—Review the Selected Performance Indicator(s)
Step 6—Review the Data Collection Procedures
Step 7—Review Data Analysis and Interpretation of Results
Step 8—Assess the Improvement Strategies
Step 9—Assess the Likelihood that Significant and Sustained Improvement Occurred

Each evaluation element within a given step will be given a score of *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed* based on the PIP documentation. HSAG's methodology for assessing and documenting PIP findings provides a consistent, structured process and a mechanism for providing the PHPs with specific feedback and recommendations for the PIP. Using its PIP Validation Tool and standardized scoring, HSAG will report the overall validity and reliability of the findings as one of the following:

- *Met* = high confidence/confidence in the reported findings.
- *Partially Met* = low confidence in the reported findings.
- *Not Met* = reported findings are not credible.

Following the annual PIP validation, HSAG will provide the Department and each Standard Plan with an annual PIP Validation Report that includes background information for each PIP submitted, specific validation findings, identified strengths, opportunities for improvement, and recommendations.

Technical Assistance

In SFY 2021, HSAG provided a training for the Standard Plans to review the PIP submission requirements and validation process. Additionally, HSAG is available to provide technical assistance throughout the process to ensure PIPs are methodologically sound and meet CMS requirements. The Standard Plans may request technical assistance following the initial validation of the PIPs and prior to the resubmissions for the final validation. During technical assistance, the Standard Plans have the opportunity to ask HSAG questions, receive clarification on HSAG's validation feedback, and receive guidance on the PIP design and implementation.

Interventions

At the time of this report, the Standard Plans had not progressed to reporting interventions for their PIPs. In the next EQR technical report, the Standard Plans will report causal/barrier analysis activities, interventions, and the baseline performance indicator outcomes.

Conclusions

Strengths, Weaknesses, and Recommendations

Since the Standard Plans did not begin operations in SFY 2021, annual PIP validation had not been completed at the time of this report; therefore, HSAG had not yet identified strengths, weaknesses, why weaknesses exist, or recommendations.

OPTIONAL EQR ACTIVITIES

Introduction

EQR-related activities are the mandatory and optional activities, as set forth in 42 CFR §438.358, which produce the data and information that the EQRO analyzes when performing the EQR. EQR-related activities are intended to improve states' ability to oversee and manage the health plans they contract with for services and help improve their performance with respect to the quality of, timeliness, of and access to care. In addition to the mandatory sections described in the prior sections of this report, CMS designates six optional activities. The state has discretion to determine which optional EQR-related activities, if any, it wishes to conduct and include in the annual EQR. Upon implementation of managed care, the Department contracted HSAG to conduct the following five optional activities:

- Encounter data validation (EDV)
- Administration or validation of consumer or provider surveys of quality of care
- Calculation of PMs
- Focus studies on quality of care
- Rating of health plans

In addition to the mandatory and optional activities recognized by CMS, the Department also contracted HSAG to conduct the following tasks:

- Annual health plan performance reports
- Annual care management performance evaluation
- Collaborative QI forums

During SFY 2021, HSAG worked with the Department to prepare for the optional and additional EQR activities as described below.

Description of Optional Activities

Encounter Data Validation

Accurate and complete encounter data are critical to the success of any managed care program. State Medicaid agencies rely on the quality of the encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of the state's overall management and oversight of its Medicaid managed care program and in demonstrating its responsibility and stewardship. Federal regulations at 42 CFR Part 438 include several provisions related to encounter data, including:

- All providers must submit claims and/or encounters to states for all services regardless of the method by which a health plan pays its providers. (42 CFR §438.818[a])
- States must review and validate encounter data on initial receipt from their PHPs, and again when they submit the encounter data to CMS. (42 CFR §438.818[a][2])
- States must submit complete, accurate, and timely encounter data to CMS in a standardized format. (42 CFR §438.818[a][3])
- CMS may impose penalties on states for noncompliance by withholding Federal Financial Participation (FFP) funds. (42 CFR §438.818[c])

The EDV study proposed in the EQRO's scope of work is scheduled to begin in SFY 2023. In preparation, HSAG drafted a methodology in alignment with the CMS EQR *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, October 2019.[6]

The Department provided HSAG with a report produced by a previously contracted organization, and HSAG is considering that information to determine if revisions to the proposed methodology are needed. HSAG will continue to work with the Department and the PHPs throughout SFY 2022 in preparation for conducting an EDV study the following year.

Consumer Surveys

The Department contracted with HSAG to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[7] 5.1 Adult Medicaid Health Plan Survey and Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set in SFY 2022 to enrollees in

[6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 28, 2022.

[7] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

the PHPs and four statewide populations (i.e., EBCI Tribal Option, FFS, BH I/DD Tailored Plan-eligible, and BH populations).

The CAHPS surveys ask adult members or the parents/caretakers of child members to report on and evaluate their experiences with the healthcare services received in the last six months. These surveys cover topics that are important to members, such as the communication skills of providers and the accessibility of services.

During SFY 2021, HSAG conducted several survey preparation activities with the Department. HSAG finalized the text that will be used in the cover letters and reminder postcards, as well as finalized the supplemental questions that will be included in the CAHPS surveys.

HSAG will administer the survey in SFY 2022 and include the results in the SFY 2022 EQR technical report.

Calculation of Performance Measures

Regulations at 42 CFR §438.358(c)(3) specify that the EQRO may calculate PMs in addition to those specified by the state for inclusion in the PHPs' QAPI programs. Calculation of these additional PMs are an optional EQR-related activity. At the time of this report, the Department had not designated any additional measures for HSAG to validate. However, at the request of the Department in future years, HSAG will validate additional PMs in accordance with CMS EQR *Protocol 7. Calculation of Additional Performance Measures: An Optional EQR-Related Activity*, October 2019.[8]

Studies on Quality

States may direct their EQROs to conduct focus studies for QI, administrative, legislative, or other purposes. Focus studies may examine clinical or nonclinical aspects of care provided by health plans and assess quality of care at a specific point in time. HSAG's EQRO contract with the Department specifies the EQRO shall be requested to conduct reviews and studies to ensure that services provided to Medicaid members are medically necessary, appropriate, and provided at the most efficient level of care. When such a request is made by the Department, HSAG will conduct the focus study in accordance with CMS EQR *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*, October 2019.[9]

[8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 7. Calculation of Additional Performance Measures: An Optional EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 28, 2022.

[9] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity,* October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 28, 2022.

Quality Rating of Health Plans

Regulations at 42 CFR §438.334 require the development of a Medicaid managed care quality rating system. The Department contracted HSAG to develop an annual Report Card that compares the PHPs to each other in key performance areas to help Medicaid beneficiaries select from the participating PHPs. Information in the Report Card shall include quality PMs, measures of provider and member satisfaction, and operational measures that relate to overall quality performance. During SFY 2022, HSAG will work with the Department to determine the strategy, approach, comparison measures, timing, and report format for the Report Card. HSAG will also stay abreast of CMS' development of a protocol for this activity. Currently, *Protocol 10. Assist With Quality Rating of Medicaid and CHIP Managed Care Organizations, Prepaid Inpatient Health Plans, and Prepaid Ambulatory Health Plans: An Optional EQR-Related Activity*, is reserved by CMS.

Annual Performance Reports

HSAG has also been contracted by the Department to annually produce a detailed performance report for each Standard Plan that includes the findings of its annual EQR and quality of care activities. HSAG held planning meetings with the Department in SFY 2021 to discuss the contents and format of the performance reports. In SFY 2022, HSAG will develop performance reports for each Standard Plan in accordance with the scope of work and the direction provided by the Department. The performance reports will be included in the SFY 2022 EQR technical report.

Annual Care Management Performance Evaluation

The health plans are required to offer care management services for Medicaid managed care members with chronic health conditions, or complex health issues or situations. The Department requires health plan reporting of data on care management services to determine the number of individuals, the types of conditions, and the impact care management services have on members receiving those services. HSAG is contracted to facilitate the annual collection and validation of data submitted by the health plans regarding their AMH, at-risk child, high-risk pregnancy, and long-term services and supports (LTSS) care management programs. HSAG will work with the Department throughout SFY 2022 to develop a methodology and report template to present findings for each health plan. In addition, HSAG will participate with the Department in an annual meeting with the health plans to review results from the care management data, identify opportunities for improvement, and determine efficient application of care management services to positively impact outcomes.

Collaborative Quality Improvement Forums

The Department may direct HSAG to organize and conduct at least one quality forum each contract year to promote the statewide goals of delivering high-quality, accessible care to members. The quality forum will be an interactive, face-to-face conference that includes the Standard Plans and Department stakeholders. HSAG will schedule the quality forums and create an agenda, subject to the approval of the Department, for day-to-day activities and will maintain minutes from each quality forum. During SFY 2022, HSAG will collaborate with the Department to finalize frequency and timing of quality forums, strategy and approach, and forum topics.

PRIOR EQRO RECOMMENDATIONS

Introduction

42 CFR §438.364(a)(6) requires that the EQR technical report include an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has addressed effectively the recommendations for QI made by the EQRO during the previous year's EQR. As SFY 2022 is NC's first year of operation for statewide managed care and, therefore, no prior EQR technical report was produced, follow-up on SFY 2022 EQR recommendations will be included in the SFY 2023 EQR technical report.

APPENDIX A. EQR TECHNICAL REPORT REQUIREMENTS

Table A-1 lists the required and recommended elements for the EQR technical report, per 42 CFR §438.364 and recent CMS technical report feedback received by states. Table A-1 also identifies the page number where the corresponding information that addresses each element is located in the EQR technical report, if applicable. In the table below, TBD represents "to be determined" to indicate that this information will be included in subsequent reports and page numbers will be able to be determined.

Table A-1—EQR Technical Report Elements

	Required Elements	Page Number
1	The state submitted its EQR technical report by April 30.	NA
2	All eligible Medicaid and CHIP plans are included in the report.	26
3	Required elements are included in the report:	
3a	Describe the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality of, timeliness of, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity.	6
3b	An assessment of the **strengths and weaknesses of each MCO, PIHP, PAHP and PCCM entity** with respect to (a) quality, (b) timeliness, and (c) access to the healthcare services furnished by each MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR §438.310[c][2]) furnished to Medicaid and/or CHIP beneficiaries. Contain specific recommendations for improvement of identified weaknesses.	7
3c	Describe how the state can **target goals and objectives in the quality strategy**, under 42 CFR §438.340, to better support improvement in the quality, timeliness, and access to healthcare services furnished to Medicaid and/or CHIP enrollees.	7
3d	Recommends improvements to the quality of healthcare services furnished by each MCO.	TBD
3e	Provides state-level recommendations for performance improvement.	TBD
3f	Ensures methodologically appropriate, comparative information about all MCOs.	TBD
3f	Assesses the degree to which each MCO has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR.	21
4	Validation of PIPs: A description of **PIP interventions** associated with each state-required PIP topic for the current EQR review cycle, and the following for the validation of PIPs: **objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.**	12
4a	**Interventions.**	15

	Required Elements	Page Number
4b	• **Objectives.**	12
4c	• **Technical methods of data collection and analysis.**	14
4d	• **Description of data obtained.**	14
4e	• **Conclusions drawn from the data.**	15
5	Validation of performance measures: A description of **objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.**	9
5a	• **Objectives.**	TBD
5b	• **Technical methods of data collection and analysis.**	TBD
5c	• **Description of data obtained.**	TBD
5d	• **Conclusions drawn from the data.**	11
6	Review for compliance: 42 CFR §438.358(b)(1)(iii) (cross-referenced in CHIP regulations at 42 CFR §457.1250[a]) requires the technical report include information **on a review, conducted within the previous three-year period**, to determine each MCO's, PIHP's, PAHP's or PCCM's compliance with the standards set forth in Subpart D and the QAPI requirements described in 42 CFR §438.330. Additional information that needs to be included for compliance is listed below:	8
6a	• **Objectives.**	8
6b	• **Technical methods of data collection and analysis.**	TBD
6c	• **Description of data obtained.**	TBD
6d	• **Conclusions drawn from the data.**	TBD
7	**Each remaining activity** included in the technical report must include a **description of the activity** and the following information:	16
7a	• **Objectives.**	TBD
7b	• **Technical methods of data collection and analysis.**	TBD
7c	• **Description of data obtained.**	TBD
7d	• **Conclusions drawn from the data.**	TBD

APPENDIX B. GLOSSARY OF ACRONYMS

42 CFR	Title 42 of the Code of Federal Regulations
AMH	Advanced Medical Home
BH	Behavioral Health
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCC	Children with Chronic Conditions
CFSP	Children and Families Specialty Plan
CHIP	Children's Health Insurance Program
CIHA	Cherokee Indian Hospital Authority
CMA	Care Management Agency
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
DHHS	Department of Health and Human Services
EBCI	Eastern Band of Cherokee Indians
EDV	Encounter Data Validation
EQR	External Quality Review
EQRO	External Quality Review Organization
FFP	Federal Financial Participation
FFS	Fee-for-Service
HEDIS	Healthcare Effectiveness Data and Information Set
HSAG	Health Services Advisory Group, Inc.
I/DD	Intellectual/Developmental Disability
IMCE	Indian Managed Care Entity
LME	Local Management Entity
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
MY	Measurement Year
NC	North Carolina
NCQA	National Committee for Quality Assurance
PAHP	Prepaid Ambulatory Health Plan
PCCM	Primary Care Case Management
PHP	Prepaid Health Plan
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project

PM ..... Performance Measure
PMV ..... Performance Measure Validation
QAPI ..... Quality Assessment and Performance Improvement
QI ..... Quality Improvement
SFY ..... State Fiscal Year
TBI ..... Traumatic Brain Injury

APPENDIX C. HEALTH PLAN LIST

NC Medicaid Managed Care Health Plans

Table C-1 displays the Medicaid managed care health plans in operation for SFY 2022.

Table C-1—NC Medicaid Managed Care Health Plans

Health Plan Name	Abbreviation	Health Plan Type	Regions
AmeriHealth Caritas North Carolina, Inc.	AmeriHealth	PHP	Statewide
Healthy Blue of North Carolina	Healthy Blue	PHP	Statewide
UnitedHealthcare of North Carolina, Inc.	UnitedHealthcare	PHP	Statewide
WellCare of North Carolina, Inc.	WellCare	PHP	Statewide
Carolina Complete Health, Inc.	Carolina Complete	PHP	Regions 3, 4, and 5

Table C-2 displays additional health plan types scheduled to operate in subsequent contract years.

Table C-2—Additional Health Plans for Subsequent Contract Years

BH I/DD Tailored Plans			
Health Plan Name	**Abbreviation**	**Health Plan Type**	**Counties**
Alliance Health	Alliance	Local Management Entity/Managed Care Organization (LME/MCO)	Cumberland, Durham, Johnston, Mecklenburg, Orange, Wake
Eastpointe	Eastpointe	LME/MCO	Bladen, Duplin, Edgecombe, Greene, Lenoir, Robeson, Sampson, Scotland, Warren, Wayne, Wilson
Partners Health Management	Partners	LME/MCO	Burke, Cabarrus, Catawba, Cleveland, Davie, Forsyth, Gaston, Iredell, Lincoln, Rutherford, Stanly, Surry, Union, Yadkin
Sandhills Center	Sandhills	LME/MCO	Anson, Davidson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond, Rockingham
Trillium Health Resources	Trillium	LME/MCO	Brunswick, Carteret, Columbus, Nash, New Hanover, Onslow, Pender, Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Gates, Halifax, Hertford, Hyde, Jones, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington
Vaya Health	Vaya	LME/MCO	Alamance, Alexander, Alleghany, Ashe, Avery, Buncombe, Caldwell, Caswell, Chatham, Cherokee, Clay, Franklin, Graham, Granville, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Person, Polk, Rowan, Stokes, Swain, Transylvania, Vance, Watauga, Wilkes, Yancey

EBCI Tribal Option			
Category	**Abbreviation**	**Health Plan Type**	**Regions**
EBCI Tribal Option	EBCI	IMCE	Cherokee, Graham, Haywood, Jackson, and Swain (Opt in counties: Buncombe, Clay, Henderson, Macon, Madison, and Transylvania)