NC MEDICAID

ANNUAL TECHNICAL REPORT

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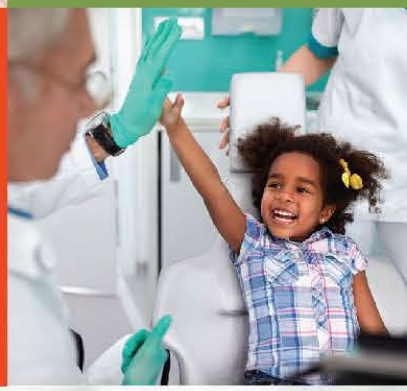
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES




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 (DHB or the Department) is the state agency responsible for the overall administration of NC's Medicaid managed care program. This state fiscal year (SFY) 2022 (July 1, 2021, to June 30, 2022) 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 and abbreviations 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.

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 (Tailored Plans) are integrated health plans providing the same services as Standard Plans, but they also provide additional services for individuals with significant BH and substance abuse disorders, I/DDs and traumatic brain injury (TBI) waiver enrollees, and enrollees using state-funded services. Tailored Plans will launch in October 2023.

In addition to Standard Plans and Tailored Plans, the Department intends to launch a single statewide Children and Families Specialty Plan (CFSP) to mitigate disruptions in care and coverage for children, youth, and families served by the child welfare system. The CFSP will 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 current and projected health plan types. A full list of health plans can be found in Appendix D.

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.

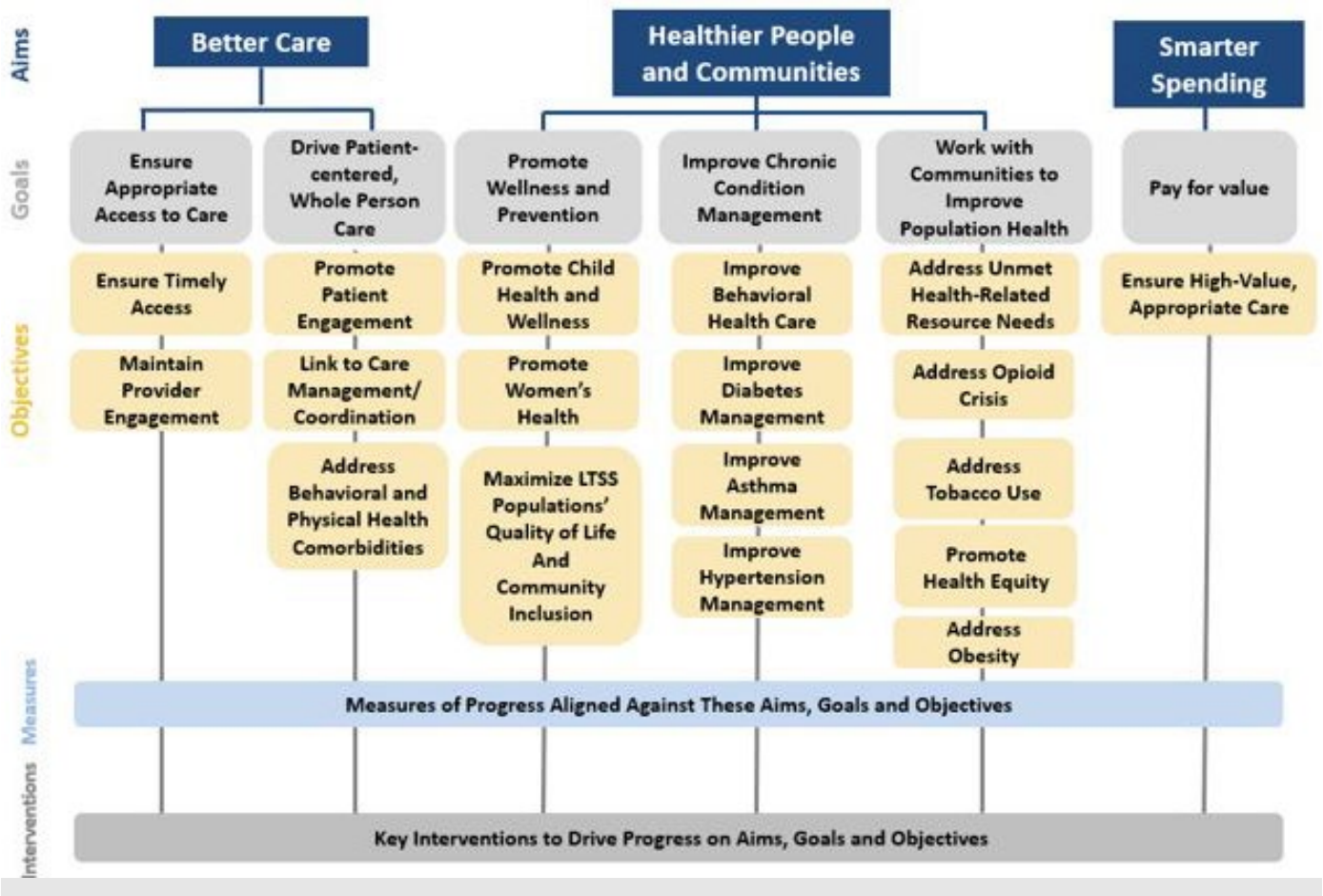
Opioid Strategy. To support broader state efforts to combat the opioid crisis, NC DHHS received federal authority to increase access to inpatient and residential substance use disorder treatment through reimbursement for services in institutions for mental diseases. This will provide beneficiaries access to all services within the American Society of Addiction Medicine (ASAM) Continuum of Care.

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: Feb 22, 2023.

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 strategies that promote health equity.

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 2022, HSAG conducted 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

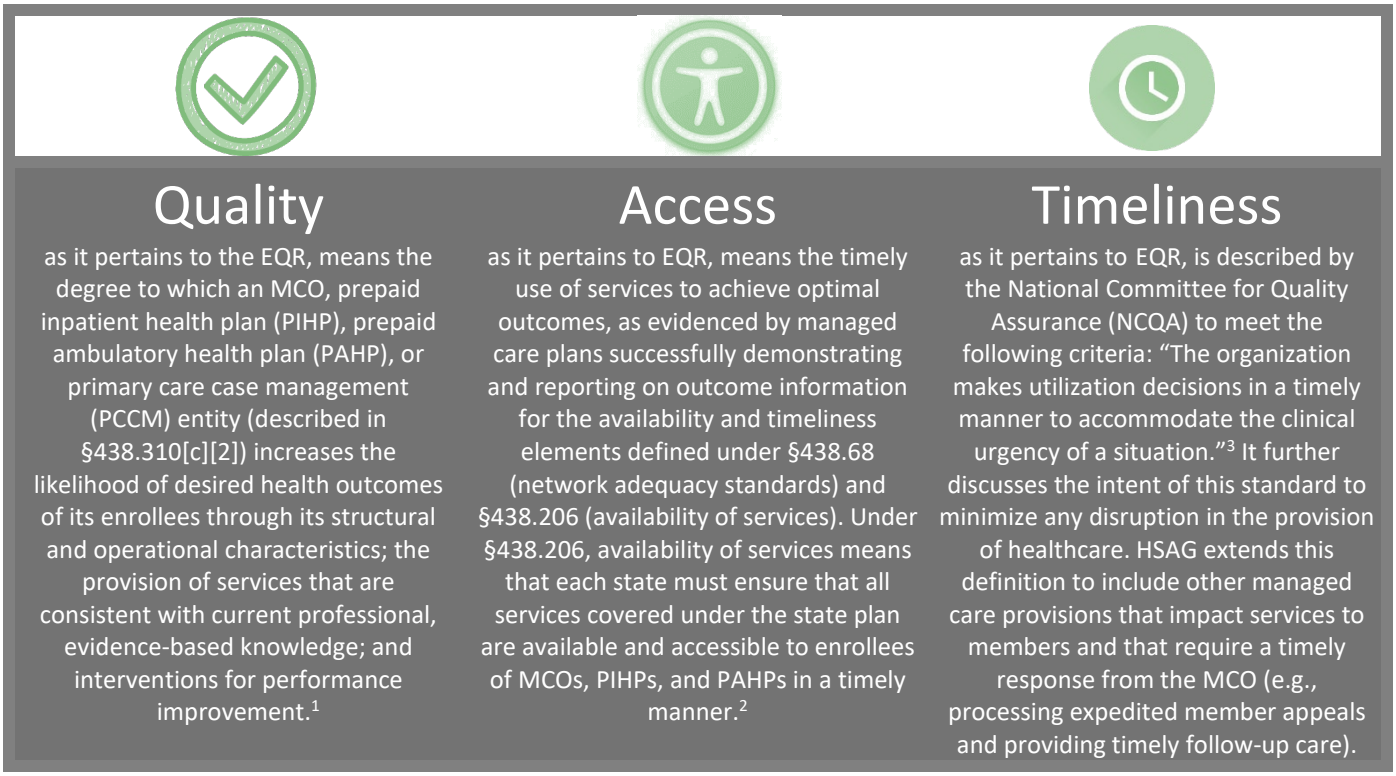
Activity	Description	CMS EQR Protocol
Mandatory Activities*		
Compliance With Standards	This activity determines the extent to which a Medicaid and CHIP health plan is in compliance with federal standards and associated state-specific requirements, when applicable.	**Protocol 3.** Review of Compliance With Medicaid and CHIP Managed Care Regulations
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
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

* As the CMS network adequacy validation protocol was not issued in SFY 2022, states were only 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: Feb 22, 2023.

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.



[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

HSAG used its analyses and evaluations of EQR activity findings from SFY 2022 to assess each PHP's performance in providing quality, timely, and accessible healthcare services to beneficiaries as required in 42 CFR §438.364. The overall findings and conclusions regarding quality, timeliness, and access for all PHPs were analyzed to develop overarching conclusions and recommendations for the NC managed care program. In accordance with 42 CFR §438.364(a)(1), HSAG provides a description of how 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 care furnished by the health plans.

Step 1: HSAG analyzed the quantitative results obtained from each EQR activity for each health plan to identify strengths and weaknesses in each domain of quality, timeliness, and access to services furnished by the health plan for the EQR activity.

Step 2: From the information collected, HSAG identified common themes and the salient patterns that emerged across EQR activities **for each domain** and drew conclusions about the overall quality of, timeliness of, and access to care and services furnished by the health plans.

Step 3: From the information collected, HSAG identified common themes and the salient patterns that **emerged across ALL EQR activities related to strengths and opportunities for improvement in one or more of the domains** of quality, timeliness, and access to care and services furnished by the health plans.

Step 4: HSAG identified any patterns and commonalities across the program to draw conclusions about the quality of, timeliness of, and access to care for the program.

Table 2 provides the overall strengths and opportunities for improvement of the NC managed care program that were identified as a result of the EQR activities. PHP-specific conclusions and recommendations are located in the Health Plan-Specific Conclusions and Recommendations section.

Table 2—Overall NC Medicaid Program Conclusions: Quality, Access, and Timeliness

EQRO Results	
Domain	**Conclusion**
Quality	**Strength:** The PHPs demonstrated a member-centric, quality-driven approach to serving the Medicaid population. **Strength:** The encounter data validation (EDV) information systems (IS) review assessed self-reported qualitative information from all five PHPs. Based on the PHP contract and DHB's requirements, PHPs demonstrated their capability to collect, process, and transmit encounter data to DHB, as well as develop data review and correction processes that can promptly respond to quality issues identified by DHB. **Strength:** The PMV activity identified that all five PHPs demonstrated extensive knowledge and experience in claims and encounter, membership/enrollment, data integration, rate production, and medical record procurement and abstraction processes. **Strength:** All five PHPs achieved a PIP validation status of *Met* and 100 percent of the validation criteria for the first six steps submitted for validation. All PIPs were found to be methodologically sound. **Opportunity for Improvement:** To improve the quality of encounter data submissions from the PHPs, DHB may want to assess whether there are common root cause(s) for PHP encounter rejections. **Opportunity for Improvement**: The PHPs did not consistently ensure that policies, procedures, processes, or committee materials satisfied program integrity (PI) requirements. These findings suggest that the PHPs may not have implemented processes to ensure all federal and DHB requirements were met. **Opportunity for Improvement:** Results of the PMV activity indicated that two health plans had an opportunity to establish consistent data feeds with the State immunization registry. This finding may impact the PHPs' ability to accurately assess enrollees for gaps in care.

EQRO Results	
Domain	**Conclusion**
Access	**Strength:** Provider participation in quality forums revealed interest in continuing discussions to address access to care and best practices to improve Healthcare Effectiveness Data and Information Set (HEDIS®),[3] access measures.
Timeliness	**Strength:** There was strong participation in EQRO activities, with consistent and timely submission of information that provided evidence of progress toward goals and continued improvement. **Opportunity for Improvement:** Results of the PMV activity indicated that two health plans had an opportunity to establish consistent data feeds with the State immunization registry. This finding may impact the PHPs' ability to ensure that timely reporting of services is captured in quality measure reporting.

Recommendations for Targeting Goals and Objectives in the Quality Strategy

The NC Quality Strategy is designed to build an innovative, whole-person, well-coordinated system of care that addresses both medical and non-medical drivers of health and an enhanced focus on promoting health equity. In consideration of the goals of the Quality Strategy and the comparative review of findings for all activities, HSAG's recommendations for quality improvement (QI) that target the identified goals within the NC Quality Strategy are included in Table 3.

Table 3–Quality Strategy Recommendations for the NC Medicaid Managed Care Program

Program Recommendations	
Recommendation	**Associated Quality Strategy Goal and/or Objective**
To improve program wide performance in support of Goals 1 and 3, HSAG recommends the following: • Evaluate State immunization registry data feeds to ensure capture of information needed to accurately assess enrollee gaps in care and support accurate PHP PM reporting. • Require the PHPs to continue PIP efforts to address childhood immunization and prenatal/postpartum care rates. • Consider continued efforts to provide education, resources, and discussion of best practices to encourage improvements to measures that capture access to care and promotion of wellness and prevention.	**Goal 1: Ensure appropriate access to care** Objective 1.1: Ensure timely access to care **Goal 3: Promote wellness and prevention** Objective 3.1: Promote child health, development, and wellness Objective 3.2: Promote women's health

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

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 a PHP'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.

In SFY 2022, HSAG conducted preparatory activities and collaborated with the Department to initiate the compliance review process in subsequent contract 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. The purpose of PMV is to assess the accuracy of PMs reported by PHPs and to determine the extent to which those PMs follow state specifications and reporting requirements.

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 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.

Quality Strategy Measures

The Department requires the Standard Plans to monitor and evaluate the quality of care through the use of HEDIS and Department-defined PMs. Table 4 lists PMs that are outlined in the Quality Strategy for priority focus for Standard Plan accountability and that were in place during HEDIS measurement year (MY) 2021. 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 4—Assignment of PMs to the Quality, Timeliness, and Access Domains[4]

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	✓	✓	✓
Immunizations 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	✓		✓

[4] Table 4 lists measures in place during HEDIS MY 2021.

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	✓	✓	✓

PMV Results

The HEDIS reporting year (RY) is one year following the year reflected in the data; for example, HEDIS MY 2021 refers to the analyses of data collected from January 1, 2021, through December 31, 2021, which is reported in RY 2022. 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-MY 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;[5] 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.

In SFY 2022, HSAG conducted a revised scope of PMV activities which focused on assessing and evaluating the PHPs' readiness and preparedness for PM calculation and reporting. The scope of PMV activities evaluated the PHPs' data integration, IS, and measure calculation processes through the collection of information using the Information Systems Capabilities Assessment Tool (ISCAT) and interviews with key PHP staff members through virtual reviews which included live systems demonstrations.

Final PMV reports were delivered to DHB and the Standard Plans in February 2022. These health plan-specific reports, inclusive of PHP-specific strengths, opportunities for improvement, and recommendations, are available in Appendix E.

[5] 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: Feb 22, 2023.

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. 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.
- Planning and initiation of activities for increasing or sustaining improvement.

PIPs are conducted to achieve, significant improvements in clinical and nonclinical areas of care that can have a favorable effect on health outcomes and member satisfaction.

Objectives

PIPs provide a structured method through ongoing measurement and intervention to assess and improve processes, and thereby outcomes, of care for the population that a health plan serves. Health plans conduct PIPs to assess and improve the quality of clinical and nonclinical healthcare and services received.

Preparatory Activities

HSAG provided training for the Standard Plans to review the PIP submission requirements and validation process. Additionally, HSAG provided ongoing technical assistance, if requested by the Standard Plans, throughout the process to ensure PIPs were methodologically sound and met CMS requirements. HSAG and DHB also prepared for PIPs to be implemented by the Standard Plans in contract year 2 and confirmed the addition of Tailored Plan PIPs for contract year 2.

The Department required the Standard Plans to conduct PIPs for the following topics: *Childhood Immunization Status Combo 10*, *Timeliness of Prenatal Care*, and *HbA1c Poor Control (>9%)*. Additionally, each Standard Plan conducted a nonclinical PIP topic for validation. HSAG conducted validation of the Standard Plan PIPs, which verifies whether a PIP conducted by a health plan used sound methodology in its design, implementation, analysis, and reporting. In its PIP evaluation and validation, HSAG used CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019 (EQR Protocol 1).[6] Final validation tools were delivered to DHB and the Standard Plans in December 2021.

Technical Assistance

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.

[6] 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: Feb 22, 2023.

Data Collection

Methods and Tools

HSAG obtains the data needed to conduct the PIP validation from the Standard Plans' PIP Submission Form. This form provides detailed information about the Standard Plans' completed PIP activities. In SFY 2021, the Standard Plans completed 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 PIP 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 is 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 reports 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.

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.

Standard Plan-Specific Validation Results

Table 5 summarizes the Standard Plans' performance for each PIP topic. The Standard Plans' primary PIP activities this year were initiating new PIPs and completing the first six steps of the submission form. For this year's validation, the PIPs had not progressed to including baseline data or initiating QI activities or interventions. These will be reported in the next annual EQR technical report. For the annual validation, HSAG validated the first six steps that were completed (PIP design) for each new PIP submitted. The following table includes the Standard Plan name, PIP topic and Aim statement, and the validation scores and status for each Standard Plan's PIP topic.

Table 5—Standard Plans' Performance for Each PIP Topic

Standard Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met[1]	Percentage Score of Critical Elements Met[2]	Overall Validation Status[3]
AmeriHealth Caritas North Carolina	*Improving Childhood Immunizations With Combo 10** Do targeted interventions increase the percentage of members in the eligible population who complete the *Childhood Immunization Status—Combination 10 (CIS)* immunization requirements?	The percentage of children 2 years of age who are compliant with the HEDIS MY 2021 *CIS—Combination 10* requirements by their second birthday.	100%	100%	*Met*
	Comprehensive Diabetes Care for Members With Hemoglobin A1c Control Over 9.0 Do targeted interventions decrease the percentage of members with an HbA1c result greater than 9 percent?	The percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had an HbA1c greater than 9 percent.	100%	100%	*Met*

Standard Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met[1]	Percentage Score of Critical Elements Met[2]	Overall Validation Status[3]
AmeriHealth Caritas North Carolina (cont.)	*Social Determinants of Health (SDOH) Referrals to NCCARE360* Do targeted interventions increase the percentage of members who have a positive screening for SDOH and referred to NCCARE360 on or before the enrollment start date?	The percentage of members who screened positive for one or more SDOH on the care needs assessment and were referred to NCCARE360.	100%	100%	*Met*
	Timeliness of Prenatal Care Do targeted interventions increase the percentage of women in the eligible population who receive a prenatal visit either within the first trimester, on or before the enrollment start date, or within 42 days of enrollment with AmeriHealth Caritas North Carolina?	The percentage of deliveries that received a prenatal visit within the first trimester, on or before the enrollment start date, or within 42 days of enrollment with AmeriHealth Caritas North Carolina.	100%	100%	*Met*

Standard Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met[1]	Percentage Score of Critical Elements Met[2]	Overall Validation Status[3]
Carolina Complete Health, Inc.	*CIS Combo 10* Targeted interventions will result in an increase of 5 percent from baseline in the Combo 10 immunization rate for Carolina Complete Health's (CCH's) eligible 2-year old members.	Measurement of *CIS—Combination 10*	100%	100%	*Met*
	Comprehensive Diabetes Care (CDC): HbA1c Poor Control (> 9.0%) Targeted interventions will result in a 5 percent decrease from baseline in CCH's members ages 18 to 75 years with diabetes (type 1 and type 2) who have hemoglobin A1c (HbA1c) poor control (>9.0%).	The percentage of CCH members ages 18 to 75 years with a diagnosis of diabetes (type 1 or type 2) with poor control (>9.0%).	100%	100%	*Met*
	Timeliness of Prenatal Care Targeted interventions will result in an increase of 5 percent from baseline in the timeliness of prenatal care rate for CCH's eligible deliveries of live births.	The percentage of deliveries of live births that received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment with CCH.	100%	100%	*Met*

Standard Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met[1]	Percentage Score of Critical Elements Met[2]	Overall Validation Status[3]
Carolina Complete Health, Inc. (cont.)	*Improve Provider Satisfaction* Targeted provider interventions will result in an increase of 5 percent from baseline for primary care or obstetrics/gynecology (OB/GYN) providers for CCH who answer "excellent" or "good" to Question #19—How would you describe your overall experience interacting with Carolina Complete Health on the DHB North Carolina Provider Experience Survey?	The percentage of CCH's contracted primary care and OB/GYN providers who responded with "Excellent" or "Good" to their satisfaction with the PHP.	100%	100%	*Met*

Standard Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met[1]	Percentage Score of Critical Elements Met[2]	Overall Validation Status[3]
Healthy Blue of North Carolina, Inc.	*Impact of Member Incentives on Adherence to Timely Childhood Immunizations* Do targeted interventions result in an increase in the Combo 10 immunization rate for Healthy Blue's eligible 2-year-old members?	The percentage of children 2 years of age who had timely childhood immunizations by their second birthday.	100%	100%	*Met*
	Impact of Care Coordination Delivered by Network Tier 3 Advance Medical Homes on Diabetes Management Do targeted interventions result in a decrease in Healthy Blue's members ages 18 to 75 years with diabetes (type 1 and type 2) who have HbA1c poor control (>9.0%)?	The percentage of members 18 to 75 years of age with diabetes (types 1 and 2) whose HbA1c was at the following levels during the MY: HbA1c poor control (>9.0%).	100%	100%	*Met*
	Method of Member Outreach and Impact on Timely Prenatal Visits Do targeted interventions result in an increase in Healthy Blue's *Timeliness of Prenatal Care* measure indicator rate?	The percentage of deliveries that received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment.	100%	100%	*Met*

Standard Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met[1]	Percentage Score of Critical Elements Met[2]	Overall Validation Status[3]
Healthy Blue of North Carolina, Inc. (cont.)	*Method of Counseling and Impact on Sustained Tobacco Cessation* Do targeted interventions result in an increase in members 13 years of age and older identified as tobacco users who self-report at least 30 days of tobacco cessation?	The percentage of members who self-report tobacco cessation.	100%	100%	*Met*

Standard Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met[1]	Percentage Score of Critical Elements Met[2]	Overall Validation Status[3]
UnitedHealthcare of North Carolina, Inc.	*Increasing Childhood Immunization Combo 10 Rates* Do targeted interventions increase the percentage of eligible children that receive the required Combo 10 series of immunizations during the measurement period?	The percentage of children 2 years of age who have received *CIS Combination 10* by their second birthday.	100%	100%	*Met*
	Comprehensive Diabetes Care (CDC)—HbA1c Poor Control Do targeted interventions decrease the percentage of eligible members who have a HbA1c of greater than 9% during the MY?	The percentage of members with *Comprehensive Diabetes Care—HbA1c Poor Control >9%.*	100%	100%	*Met*
	Improving the Timeliness of Prenatal Care Rate Do targeted interventions increase the percentage of deliveries that received a prenatal care visit within the required time frame?	The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment.	100%	100%	*Met*
	Maximizing Care Needs Screening Completion Rates Do targeted interventions increase the percentage of care needs screenings that are completed within 90 days of enrollment during the measurement period?	The percentage of enrollees for whom the PHP completed a care needs screening within 90 days of enrollment.	100%	100%	*Met*

Standard Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met[1]	Percentage Score of Critical Elements Met[2]	Overall Validation Status[3]
WellCare of North Carolina, Inc.	*Childhood Immunizations—Combo 10* Do interventions increase the rate of compliance with childhood Combo 10 immunizations for eligible members as measured by the HEDIS *CIS* measure?	The percentage of enrolled children 2 years of age who had childhood Combo 10 immunizations by their second birthday.	100%	100%	*Met*
	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) Do targeted interventions result in a reduced number of members with a HbA1c greater than 9?	The percentage of members ages 18–75 years by December 31 of MY 2021 with diabetes (type 1 and type 2) who had HbA1c poor control (>9.0%).	100%	100%	*Met*
	Timeliness of Prenatal Care Do targeted interventions increase the percentage of women who receive timely prenatal care as defined by the percentage of women who received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment?	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the start date, or within 42 days of enrollment in the organization.	100%	100%	*Met*

Standard Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met[1]	Percentage Score of Critical Elements Met[2]	Overall Validation Status[3]
WellCare of North Carolina, Inc. (cont.)	*Access to Preventive/Ambulatory Care* Does the implementation of targeted interventions increase the number of preventive care visits for eligible members (20 years of age and older as of the MY) as measured by the HEDIS *Adults' Access to Preventive/Ambulatory Health Services (AAP)* measure?	The percentage of members 20 years and older who had an ambulatory or preventive care visit during the MY.	100%	100%	*Met*

* *Childhood Immunization Status—Combination 10* (Combo 10) measure indicator includes the following vaccinations: four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR), documented history of the illness or seropositive test result for each antigen; three haemophilus influenza type B (HiB); three hepatitis B (HepB), or documented history of the illness or seropositive test result for antigen; one chicken pox (VZV), or documented history of the illness or seropositive test result for antigen; four pneumococcal conjugate (PCV); one hepatitis A (HepA), or documented history of the illness or seropositive test result for antigen; two or three rotavirus (RV); and two influenza (flu) vaccines.

Conclusions

Strengths, Weaknesses, and Recommendations

As described in Table 5, the validation results across all Standard Plans show a validation status of *Met* and achievement of 100 percent of the validation criteria for the first six steps submitted for validation. All PIPs were found to be methodologically sound. A sound design creates the foundation for the Standard Plans to progress to subsequent PIP stages—collecting data and implementing interventions that have the potential to impact performance indicator results and the desired outcomes for the project.

Based on the validation of the Standard Plans' submitted PIPs, there were no identified weaknesses. HSAG has the following recommendations as the Standard Plans progress to conducting QI activities and reporting remeasurement outcomes. The Standard Plans should:

- Use QI tools such as a causal/barrier analysis, key driver diagram, process mapping, and/or failure modes and effects analysis to determine and prioritize barriers, drivers, and/or weaknesses within processes. The use of these tools will help the Standard Plans determine what interventions to test and implement.
- Develop active, innovative interventions that have the potential for impacting the performance indicator outcomes.
- Develop a process or plan to evaluate the effectiveness of each individual intervention.
- Use Plan-Do-Study-Act (PDSA) cycles as part of the improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful.
- Revisit the causal/barrier analysis tools used at least annually to ensure the Standard Plan remains on track and the identified barriers and opportunities for improvement are still relevant and applicable.
- Use the PIP Completion Instructions as additional steps of the PIP process are completed. This will ensure all documentation requirements have been addressed.
- Seek technical assistance from HSAG as needed.

NETWORK ADEQUACY

Introduction

Validation of network adequacy is a mandatory EQR activity, and states must begin conducting this activity, described in §438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. While a federal protocol has yet to be released, HSAG collaborated with DHB to develop a methodology to validate each PHP's provider network to ensure compliance with 42 CFR §§438.68 and 438.358 and assess members' access to care.

During SFY 2022, HSAG met with the Department to confirm study goals, data sources, and the overall project plan. HSAG's subcontractor then developed a detailed methodology defining the eligible population of providers (i.e., the sample frame), sampling protocol, data collection process, study indicators, and survey scripts for secret shopper and revealed caller surveys.

DHB approved the final methodology in May 2022, which also includes activities for SFY 2023. Results will be provided in future technical reports.

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 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:

- 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 care management performance evaluation
- Collaborative QI forums
- PI reviews
- Quarterly PIP reviews
- Quarterly QAPI reviews
- Various evaluations and reports

During SFY 2022, 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.

The EDV study proposed in the EQRO's scope of work is scheduled to be completed in SFY 2023.

In SFY 2022, HSAG developed a methodology to conduct an IS review for the EDV study 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.[7] The goal of this activity is to examine the extent to which DHB's and the PHPs' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's Capability in the CMS EQR Protocol 5. The IS questionnaires were delivered to DHB and the PHPs in March 2022.

The IS review seeks to define how each participant in the encounter data process collects and processes encounter data such that the data flow from the PHPs to DHB is understood. The IS review is key to understanding whether the IS infrastructures are likely to produce complete and accurate encounter data. The methodology for the IS review process contained the following three stages.

Stage 1—Document Review

HSAG initiated the IS review with a thorough desk review of documents related to encounter data initiatives/validation activities currently put forth by DHB. Documents for review included data dictionaries and DHB's current encounter data submission requirements. The information obtained from this review was important for developing a targeted questionnaire that addressed important topics of interest to DHB.

Stage 2—Development and Fielding of Customized Encounter Data Assessment

HSAG developed and distributed two questionnaires: one for the PHPs and one for the DHB. To conduct a customized encounter data assessment, HSAG first aligned the EDV activity to incorporate information collected through PMV (CMS EQR Protocol 2). This process allowed this activity to be coordinated across projects, preventing duplication and minimizing the impact on the PHPs. HSAG then

[7] 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: Feb 22, 2023.

developed a questionnaire customized in collaboration with DHB to gather information and specific procedures for data processing, personnel, and data acquisition capabilities. This assessment also included a review of supplemental documentation regarding other data systems, including member demographic, member enrollment, and provider data. Lastly, this review included specific topics of interest to DHB. The questionnaire for DHB had similar domains; however, it focused on DHB's data exchange with the PHPs.

Stage 3—Key Informant Interviews

After reviewing responses to the questionnaire, HSAG followed up with key DHB and PHP information technology personnel to clarify any questions from the questionnaire responses. Overall, the IS reviews allowed HSAG to document current processes and develop a thematic process map identifying critical points that impact the submission of quality encounter data. From this analysis, HSAG was able to provide actionable recommendations to the existing encounter data systems on areas for improvement or enhancement.

HSAG will produce an aggregate report that includes PHP-specific findings in SFY 2023.

Consumer Surveys

The Department contracted with HSAG to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[8] 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 the PHPs and four specific populations (i.e., EBCI Tribal Option, FFS, BH I/DD Tailored Plan-eligible, and Standard Plan 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 2022, HSAG conducted several survey preparation activities with the Department, including finalization of supplemental questions and survey document text, and receipt and validation of DHB sample frame files. DHB submitted final sample frame files in April 2022; HSAG confirmed deliverables with DHB in May 2022. HSAG will administer the survey in SFY 2023 and include the results in the SFY 2023 EQR technical report.

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

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.

In January 2022, HSAG and the Department selected 10 measures for HSAG to calculate on behalf of the five PHPs. In SFY 2023, HSAG will calculate the PMs using DHB-provided claims/encounter data in alignment with the applicable administrative technical specifications for MY 2021 and in accordance with CMS EQR *Protocol 7. Calculation of Additional Performance Measures: An Optional EQR-Related Activity*, October 2019.[9]

Focus 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.[10]

Quality Rating of Health Plans

Regulations at 42 CFR §438.334 require the development of a Medicaid managed care quality rating system. HSAG stays abreast of CMS' development of an EQRO 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.

The Department contracted with HSAG to develop an annual PHP Report Card that compares the PHPs to each other in key performance areas to help Medicaid beneficiaries select a PHP. The following key performance areas, which will comprise quality PMs and CAHPS survey results, will be included in the PHP Report Card: Overall Rating, Doctors' Communication, Getting Care, Keeping Kids Healthy, Living With Illness, and Women's Health.

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[9] 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: Feb 22, 2023.

[10] 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: Feb 22, 2023.

During SFY 2022, HSAG worked with the Department to determine the PHP report card methodology, data sources, format, and timing. DHB approved the methodology and format for an informational only report card in May and June 2022, respectively. The report card will be produced in SFY 2023.

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.

DHB contracted HSAG to facilitate the annual collection and validation of data submitted by the PHPs regarding their AMH, at-risk child, high-risk pregnancy, and long-term services and supports (LTSS) care management programs.

HSAG worked with DHB throughout SFY 2022 to develop a revised scope and methodology to evaluate the accuracy of PHPs' member attribution to AMHs and contracted Clinically Integrated Networks (CINs). DHB approved the revised scope of the activity in March 2022; however, DHB requested HSAG to delay initiation of the evaluation until SFY 2023. HSAG and DHB therefore continued planning discussions throughout SFY 2022 to incorporate additional care management performance evaluation activities to include HSAG's validation of data submitted by the PHPs and accuracy of member attribution to AMHs and CINs, with a target implementation in SFY 2023.

Quality Improvement Forums

HSAG is tasked 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. Quality forums are interactive conferences that include the Standard Plans, providers, and other stakeholders. In SFY 2022, HSAG's subcontractor conducted the following three quality forums, all of which were held in May 2022.

- Prenatal and Postpartum Outcomes: Early, Consistent, Intensive Interventions With High-Risk Members
- Increasing Childhood and Adolescent Immunization Rates
- Controlling NC's Sugar Problem One Practice at a Time, Performance Improvement Project NQF [National Quality Forum] 0059 Diabetes: Poor Control

Program Integrity Reviews

To meet federal requirements outlined in Section 1902 (a)(68) of the Social Security Act and the requirements outlined in the CMS Medicaid managed care regulations, HSAG's subcontractor conducted PHP PI reviews to determine compliance with PI requirements. The purpose of the review was to assess the degree to which the PHP ensured the effective use and management of public resources in the delivery of services to Medicaid managed care members and how the PHP increased

awareness within its organization and across its provider network of methods to prevent, detect, and report potential fraud, waste, or abuse (FWA).

During SFY 2022, HSAG and its subcontractor met with the Department to finalize the scope, methodology, and timeline for the PI reviews. Desk, file, and webinar reviews were conducted with all five PHPs by the end of May 2022.

Findings and recommendations for the PHPs were provided in final reports that are available on request.

Quarterly PIP Review

DHB requested that HSAG conduct quarterly PIP reviews to assess the Standard Plans' progress on each of the four PIPs. DHB approved HSAG's quarterly PIP review proposal and template in January 2022. HSAG completed quarterly reviews, providing feedback to DHB and the PHPs, in February and May 2022.

Quarterly QAPI Review

DHB requested that HSAG conduct quarterly QAPI reviews, to assess the Standard Plans' progress on their QAPI workplans and programs. DHB approved HSAG's quarterly QAPI review proposal in April 2022. HSAG completed a quarterly review, providing feedback to DHB and the PHPs, in May 2022.

Total Cost of Care (TCOC)

DHB requested that HSAG provide a proposal for the Medicaid TCOC project, using the Health Partners TCOC Toolkit[11] as the foundation for developing the project. HSAG proposed a multi-phase project, which was approved by DHB in March 2022. During SFY 2022, HSAG continued to develop the program and architecture, and met with DHB to discuss decision points and a timeline for the project.

Hospital at Home (HaH) Evaluation

DHB requested that HSAG provide a proposal to conduct a short-term rapid-cycle impact evaluation of the DHHS' HaH program. The Acute HAH program is an expansion of the CMS Hospital Without Walls initiative as part of a comprehensive effort to increase hospital capacity, maximize resources, and combat coronavirus disease 2019 (COVID-19), and creates flexibility that allows for certain healthcare services to be provided outside of a traditional hospital setting and within a patient's home. DHB approved HSAG's evaluation proposal in November 2021. DHB submitted data to HSAG throughout 2022 for analysis.

[11] HealthPartners' Total Cost of Care and Resource Use (TCOC) framework. Available at: https://www.healthpartners.com/about/improving-healthcare/tcoc/. Accessed on: Mar 3, 2023.

Access to Care Report

The Annual Access to Care Report provides a profile of access to care using measures as detailed in the Department's Quality Strategy. The purpose of the Annual Access to Care Report is to document the accessibility of the provider networks and perception of access. During SFY 2022, HSAG and its subcontractor collaborated with DHB on the scope, measures, and data sources to be included in the report.

Health Equity Report

The goal of the 2021 Annual Health Equity Report is to measure and monitor a state's progress toward eliminating the health status gaps experienced by racial and ethnic minorities; provide current data that may aid community-based organizations, tribal governments, local health departments, state agencies, legislators, local businesses, and communities in devising services and outreach plans; and inform key decision makers about eliminating health disparities through policy reform and system change.

During SFY 2022, DHB and HSAG worked to identify data sources and draft narrative related to State initiatives for eliminating health disparities. HSAG also delivered the methodology to DHB in May 2022 and continued discussions with DHB regarding data.

Annual Quality Report

DHB requested that HSAG provide a proposal to complete an Annual Quality Report to assess performance on quality measures related to the three aims and associated goals in the Department's Medicaid Managed Care Quality Strategy. DHB approved HSAG's evaluation proposal in December 2021. DHB submitted data to HSAG in 2022 for analysis.

HEALTH PLAN-SPECIFIC CONCLUSIONS AND RECOMMENDATIONS

Introduction

This section summarizes an assessment of each health plan's strengths and opportunities for improvement for the quality, timeliness, and accessibility of healthcare services furnished to Medicaid beneficiaries and recommendations for improving the quality of healthcare services furnished by each health plan, as required by 42 CFR §438.364.

Methodology

42 CFR §438.364 requires a description of how the data from all activities conducted were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and accessibility of the care furnished by each health plan. EQR activities typically measure program performance through quantitative data (i.e., data are numeric and consist of frequency counts, percentages, or other statistics) that provide evidence of outcomes and help assess a health plan's or a program's progress toward its stated goals. While data demonstrate what is occurring, these data do not necessarily indicate what caused the occurrence.

The EQRO is tasked with drawing conclusions from the data for an overall assessment that distinguishes successful efforts from ineffective activities and services and providing recommendations for improving results. HSAG analyzes the quantitative results obtained from each EQR activity for each health plan to identify strengths and opportunities for improvement for providing healthcare timeliness, access, and quality across activities. HSAG then identifies whether common themes or patterns exist across the data and conducts a qualitative analysis to draw conclusions about overall quality of, access to, and timeliness of care and services to be drawn for each health plan independently and the overall statewide Medicaid managed care program.

Due to the timing of implementation of the Standard Plans, EQRO activities were in various stages of completion during SFY 2022; therefore, health plan-specific conclusions and recommendations are limited. HSAG identified the following strengths and opportunities for improvement based on the activities completed during SFY 2022 and will continue to evaluate the health plans and provide recommendations in the SFY 2023 report.

PHP-Specific Conclusions and Recommendations

AmeriHealth Caritas North Carolina, Inc.

Strengths

Related to PMV

- Quality: AmeriHealth demonstrated extensive knowledge and experience in claims and encounter, membership/enrollment, data integration, rate production, and medical record procurement and abstraction processes.
- Quality: AmeriHealth demonstrated a member-centric, quality-driven approach to serving the Medicaid population.

Related to PIPs

- Quality: AmeriHealth achieved a validation status of *Met* and 100 percent of the validation criteria for the first six steps submitted for validation.
- Quality: All PIPs were found to be methodologically sound.

Related to Program Integrity (PI)

- Quality: AmeriHealth had comprehensive policies and procedures that clearly outlined PI processes, requirements, and overall operations.
- Quality: The training materials provided by AmeriHealth demonstrated an expansive training program for AmeriHealth's compliance officer, the PHP's senior management, the provider network, and the PHP's employees on the federal and State standards and requirements under the Contract.

Opportunities for Improvement

Opportunity: Quality: AmeriHealth indicated it had not yet obtained an established data feed for State immunization registry data.

Recommendation: HSAG recommends working directly with the NC DHHS/DHB in establishing a direct data feed to support AmeriHealth's quality measure reporting across all immunization measures within the scope of PMV elected measures: *Childhood Immunization Status—Combination 10* and *Immunizations for Adolescents—Combination 2*.

Opportunity: Quality: The PI review identified some inconsistencies in the health plan's policies, procedures, and committee documents.

Recommendation: The health plan should correct its documentation to accurately reflect staff person responsibility for compliance activities.

Carolina Complete Health, Inc.

Strengths

Related to PMV

- Quality: Carolina Complete demonstrated extensive knowledge and experience in its claims and encounters, membership/enrollment, data integration, rate production, and medical record procurement and abstraction processes.
- Quality: Carolina Complete demonstrated a member-centric, quality-driven approach to serving the Medicaid population.
- Quality: The health plan demonstrated exceptional responsiveness, engagement, and preparedness over the course of the CY 2021 PMV activities.

Related to PIPs

- Quality: Carolina Complete achieved a validation status of *Met* and 100 percent of the validation criteria for the first six steps.
- Quality: All PIPs were found to be methodologically sound.

Related to PI

- Quality: The review of these investigative cases showed that Carolina Complete was compliant with its PI policies and procedures while conducting Special Investigations Unit (SIU) investigations.
- Quality: The Compliance Review found that Carolina Complete had comprehensive policies and procedures which clearly outlined PI processes, requirements, and overall operations.
- Access: Carolina Complete had a pharmacy network audit program that included staff dedicated to performing audits and investigating pharmacy claims data. The health plan contracted with CVS Caremark as the pharmacy benefits manager to ensure compliance of the pharmacy network.

Opportunities for Improvement

Opportunity: Quality: During the PMV virtual review, Carolina Complete provided a system demonstration of Unified Member View (UMV), which was used to process and store membership and enrollment data received from the State. Key demographic and contact information that came directly through the State daily 834 file was integrated into UMV. If a member or provider notified Carolina Complete of a change in address and/or phone number, UMV did not have the capability to store the updated contact information in fields within UMV that are not overridden by the daily integration of the 834 files. The contact information will only update if the State was informed of the changes and they are updated through the 834 process.

Recommendation: HSAG recommends that Carolina Complete explore the feasibility within or outside UMV where most current contact information about the member can be stored. Hosting accurate contact information about the member helps support ensuring that successful member outreach for QI initiatives focused on key PMs and on member satisfaction and experience surveys.

Opportunity: Quality: During the PMV virtual review, Carolina Complete confirmed there were no capitated arrangements for facility and professional claims. However, Carolina Complete expressed the potential for establishing capitated agreements over the next two years. **Recommendation:** Should Carolina Complete consider entering capitated arrangements, HSAG recommends ensuring that strong processes are in place to oversee the timeliness of billing by capitated entity and to ensure that rejected and/or denied claims are corrected and resubmitted. These activities will support ensuring that services rendered which are not tied to an FFS payment arrangement are reported in a timely manner and captured in Carolina Complete's PM calculations.
Opportunity: Quality: Source code review of the *Concurrent Use of Opioids and Benzodiazepines (COB)* and *Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)* measures was conducted with Interpreta, CCH's HEDIS certified software engine vendor, and resulted in corrective action. The *COB* measure defaulted to a 45-day allowable gap, which did not align with specifications. The *OMP* measure did not allow for any gap in continuous enrollment which does not align with measure specifications. **Recommendation:** HSAG recommends that Carolina Complete provide screen shots from Interpreta to demonstrate that Interpreta has resolved these issues prior to source code review activities performed in CY 2022. HSAG will also conduct source code review directly with Interpreta to confirm changes were made.
Opportunity: Quality: The PI review identified some omissions in the health plan's policies and committee documents. **Recommendation:** The health plan should correct its documentation to ensure compliance with PHP contract requirements.
Opportunity: Quality: Carolina Complete's Compliance Plan requires the health plan to "perform oversight activities to prevent the sharing of confidential, proprietary or competitive in nature information with WellCare NC" but does not describe the processes behind this oversight and prevention. **Recommendation:** The health plan should revise its Compliance Plan to describe the process by which Carolina Complete safeguards against the sharing of protected health information and proprietary information.
Opportunity: Quality: The Carolina Complete Comprehensive Compliance Program does not include a provider self-audit process and procedure. **Recommendation:** The health plan should develop a provider self-audit process that will support network providers in self-disclosing billing system errors or issues that result in overpayments.
Opportunity: Timeliness: The PI review identified that the CCH Fraud Prevention Plan had not been updated since 2020. **Recommendation:** The health plan should ensure that the Fraud Prevention Plan is annually reviewed, updated, and submitted to the State.

Healthy Blue of North Carolina

Strengths	**Related to PMV** • Quality: Healthy Blue demonstrated extensive knowledge and experience in its claims and encounters, membership/enrollment, data integration, rate production, and medical record procurement and abstraction processes. • Quality: Healthy Blue had extensive experience in the market and community through its partnership with both Anthem Blue Cross Blue Shield and Amerigroup. **Related to PIPs** • Quality: Healthy Blue achieved a validation status of *Met* and 100 percent of the validation criteria for the first six steps submitted for validation. • Quality: All PIPs were found to be methodologically sound. **Related to PI** • Quality: During the on-site review, Healthy Blue staff reported an increase in the number of referrals from members and other external stakeholders. • Timeliness: Healthy Blue provided a computer-based system for training and educating the PHP's compliance officer, senior management, Board of Directors, subcontractors, providers, and employees.
Opportunities for Improvement	**Opportunity:** Quality: During the PMV virtual review, Healthy Blue confirmed a small percentage of capitation for professional claims. Strong oversight of capitated arrangement is critical to ensure the timely reporting of services is captured in Healthy Blue's quality measure reporting, including the monitoring of rejected and denied claims for resolution and resubmission. **Recommendation:** HSAG recommends ensuring that strong processes are in place to oversee the timeliness of billing by capitated entity, as well as ensuring that rejected and/or denied claims are corrected and resubmitted. These activities will support ensuring that services rendered which are not tied to an FFS payment arrangement are reported in a timely manner and captured in Healthy Blue's PM calculations. **Opportunity:** Quality: Healthy Blue indicated that a large volume of lab data from multiple lab sources appeared to include a high volume of duplicate claims that are being rejected through the Inovalon software. **Recommendation:** HSAG recommends that Healthy Blue further investigate the root cause and source of the duplicate claims to resolve prior to integrating into the Inovalon HEDIS engine. This will reduce the processing time of duplicate data and eliminate any risk of duplicates being counted within a PM impacted by lab services. **Opportunity:** Quality: The PI review identified some omissions of references to supporting documents in the health plan's Compliance Plan and Program Integrity Plan, as well as contextual information in its SIU Antifraud Plan.

Recommendation: The health plan should revise its documents to ensure references to all supporting documents have been included and provide additional context to describe alignment and required activities and processes completed to support the PI program.

UnitedHealthcare of North Carolina, Inc.

Strengths

Related to PMV

- Quality: UnitedHealthcare demonstrated extensive knowledge and experience in claims and encounter, membership/enrollment, data integration, rate production, and medical record procurement and abstraction processes.
- Quality: UnitedHealthcare has extensive experience in the NC market and familiarity with the community through its other health insurance lines of business in the State (Medicare, Health Insurance Marketplace, etc.).

Related to PIPs

- Quality: UnitedHealthcare achieved a validation status of *Met* and 100 percent of the validation criteria for the first six steps submitted for validation.
- Quality: All PIPs were found to be methodologically sound.

Related to PI

- Quality: During the on-site review, UHC staff demonstrated familiarity with the Recipient Explanation of Medicaid Benefits process.

Opportunities for Improvement

Opportunity: Quality: UnitedHealthcare reported initial challenges related to obtaining clinical data from providers in support of PM reporting.

Recommendation: While UnitedHealthcare reported these initial challenges, the PHP had outlined appropriate mitigation strategies to obtain additional clinical data. HSAG recommends that UnitedHealthcare continue using its described process for onboarding providers to receive select clinical data in support of PM reporting. For MY 2021, UnitedHealthcare may maximize its efforts by initiating the clinical data exchange with providers attributed to serving the highest proportion of the PHP's members, based on utilization reports. Demonstrating its progress as of December 2021, the PHP indicated it had established 17 bidirectional data connections with 1,296 providers through its AMH delegation arrangements.

Opportunity: Quality: The PI review identified some omissions in the health plan's policies and committee documents.

Recommendation: The health plan should correct its documentation to ensure compliance with PHP contract requirements.

Opportunity: Timeliness: The PI review identified workplan omissions in the health plan's documents. **Recommendation:** The health plan should update its Annual Comprehensive Compliance Plan to include the workplan and develop and implement workplans for announced and unannounced site visits and field audits of high-risk providers.
Opportunity: Access: The PI review found that there were a limited number of UHC investigations drawn via tips from NC beneficiaries, employees of network providers, and/or other community stakeholders. **Recommendation:** The health plan should increase its local data mining efforts to identify potential FWA.

WellCare of North Carolina, Inc.

Strengths

Related to PMV

- Quality: WellCare demonstrated extensive knowledge and experience in claims and encounters, membership/enrollment, data integration, rate production, and medical record procurement and abstraction processes. Individuals responsible for PM data integration and reporting have about 15 years of experience working at the PHP.
- Quality: WellCare had numerous member- and provider-facing initiatives and incentives that were intended to improve quality measure performance. HSAG encourages WellCare to track the measure-specific impact of any of these interventions and incentives so that best practices can be identified to share with DHB and to spread to other WellCare preventive services, as applicable.

Related to PIPs

- Quality: WellCare achieved a validation status of *Met* and 100 percent of the validation criteria for the first six steps submitted for validation.
- Quality: All PIPs were found to be methodologically sound.

Related to PI

- Quality: During the on-site review, WellCare provided a detailed description of the WellCare of NC Compliance Work Plan.
- Timeliness: WellCare procedures aligned with the NC Medicaid PHP Contract requirements for processing provider payment suspensions or withholdings.
- Access: WellCare's NC Fraud Prevention Plan Line of Business: WellCare of NC document describes its web-based training and education program for internal and external stakeholders.

Opportunities for Improvement

Opportunity: Quality: WellCare indicated that the NC immunization registry had issues returning records to the PHP; therefore, WellCare was in the process of studying the problem with the State's analysts.

Recommendation: WellCare should continue working with the State to resolve the ongoing data challenges occurring with the State immunization registry, as these data are critical to support quality reporting across immunization measures within the scope of PMV: *Childhood Immunization Status—Combination 10* and *Immunizations for Adolescents—Combination 2*.

Opportunity: Quality: The PI review identified some omissions in the health plan's policies. **Recommendation:** The health plan should correct its documentation to ensure compliance with PHP contract requirements.
Opportunity: Timeliness: The PI review identified that the health plan's Fraud Prevention Plan was not submitted or implemented in a timely manner and did not demonstrate final language. **Recommendation:** The health plan should ensure that all dates in the NC Fraud Prevention Plan Line of Business: WellCare of NC document correspond with the current Plan year, and that draft language is finalized.
Opportunity: Access: The PI review identified some omissions in the health plan's Fraud Prevention Plan. **Recommendation:** The health plan should correct its documentation to ensure compliance with PHP contract requirements.

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 effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR. As SFY 2022 was NC's first year of operation for statewide managed care and, therefore, no prior EQR recommendations were established, 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 health plans are included in the report.	49
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.	6–7
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.	34–43
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.	8
3d	Recommends improvements to the quality of healthcare services furnished by each MCO.	8, 34–43
3e	Provides state-level recommendations for performance improvement.	Various
3f	Ensures methodologically appropriate, comparative information about all MCOs.	Various
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.	34
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.**	13–15
4a	**Interventions.**	15

	Required Elements	Page Number
4b	**Objectives.**	14
4c	**Technical methods of data collection and analysis.**	15
4d	**Description of data obtained.**	15
4e	**Conclusions drawn from the data.**	25
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.**	10–12
5a	**Objectives.**	10–12, Appendix D
5b	**Technical methods of data collection and analysis.**	
5c	**Description of data obtained.**	
5d	**Conclusions drawn from the data.**	
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:	9
6a	**Objectives.**	NA
6b	**Technical methods of data collection and analysis.**	NA
6c	**Description of data obtained.**	NA
6d	**Conclusions drawn from the data.**	NA
7	**Each remaining activity** included in the technical report must include a **description of the activity** and the following information:	27–33
7a	**Objectives.**	27–33
7b	**Technical methods of data collection and analysis.**	27–33
7c	**Description of data obtained.**	27–33
7d	**Conclusions drawn from the data.**	27–33

APPENDIX B. GLOSSARY OF ACRONYMS

42 CFR ..... Title 42 of the Code of Federal Regulations
AAP ..... *Adults' Access to Preventive/Ambulatory Health Services*
AHRQ ..... Agency for Healthcare Research and Quality
AMH ..... Advanced Medical Home
ASAM ..... American Society of Addiction Medicine
BH ..... Behavioral Health
CAHPS ..... Consumer Assessment of Healthcare Providers and Systems
CCC ..... Children With Chronic Conditions
CCH ..... Carolina Complete Health, Inc.
CDC ..... *Comprehensive Diabetes Care*
CFSP ..... Children and Families Specialty Plan
CHIP ..... Children's Health Insurance Program
CIHA ..... Cherokee Indian Hospital Authority
CIN ..... Clinically Integrated Network
CIS ..... *Childhood Immunization Status—Combination 10*
CMS ..... Centers for Medicare & Medicaid Services
COB ..... *Concurrent Use of Opioids and Benzodiazepines*
COVID-19 ..... Coronavirus Disease 2019
CY ..... Calendar Year
DHB ..... North Carolina Division of Health Benefits
DHHS ..... Department of Health and Human Services
DTaP ..... Diphtheria, Tetanus, and Acellular Pertussis
EBCI ..... Eastern Band of Cherokee Indians
EDV ..... Encounter Data Validation
EQR ..... External Quality Review
EQRO ..... External Quality Review Organization
FFS ..... Fee-for-Service
FWA ..... Fraud, Waste, or Abuse
HbA1c ..... Hemoglobin A1c
HEDIS ..... Healthcare Effectiveness Data and Information Set
HepA ..... Hepatitis A
HepB ..... Hepatitis B
HiB ..... Haemophilus Influenza Type B
HSAG ..... Health Services Advisory Group, Inc.

I/DD ..... Intellectual/Developmental Disability
IHS ..... Indian Health Service
IMCE ..... Indian Managed Care Entity
IPV ..... Polio Vaccine
IS ..... Information Systems
ISCAT ..... Information Systems Capabilities Assessment Tool
LME ..... Local Management Entity
LTSS ..... Long-Term Services and Supports
MCO ..... Managed Care Organization
MCP ..... Managed Care Plan
MMR ..... Measles, Mumps, Rubella
MY ..... Measurement Year
NAV ..... Network Adequacy Validation
NC ..... North Carolina
NCQA ..... National Committee for Quality Assurance
NQF ..... National Quality Forum
OB/GYN ..... Obstetrics/Gynecology
OMP ..... *Use of Opioids from Multiple Providers in Persons Without Cancer*
PAHP ..... Prepaid Ambulatory Health Plan
PCCM ..... Primary Care Case Management
PCV ..... Pneumococcal Conjugate Vaccine
PDSA ..... Plan-Do-Study-Act
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
RV ..... Rotavirus Vaccine
RY ..... Reporting Year
SDOH ..... Social Determinants of Health
SFY ..... State Fiscal Year
SIU ..... Special Investigations Unit
TBD ..... To Be Determined
TBI ..... Traumatic Brain Injury
UHC ..... UnitedHealthcare
VZV ..... Chicken Pox Vaccine

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
Carolina Complete Health, Inc.	Carolina Complete	PHP	Regions 3, 4, and 5
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

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)

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

APPENDIX D. PMV REPORTS

NC Medicaid Managed Care Health Plans

HSAG conducted a revised scope of PMV activities focused on reviewing data integration, IS, and measure calculation processes to assess the PHPs' readiness and preparedness for future formal PM reporting in accordance with CMS EQR Protocol 2 cited earlier in this report. HSAG produced PHP-specific reports, which are presented in this appendix.