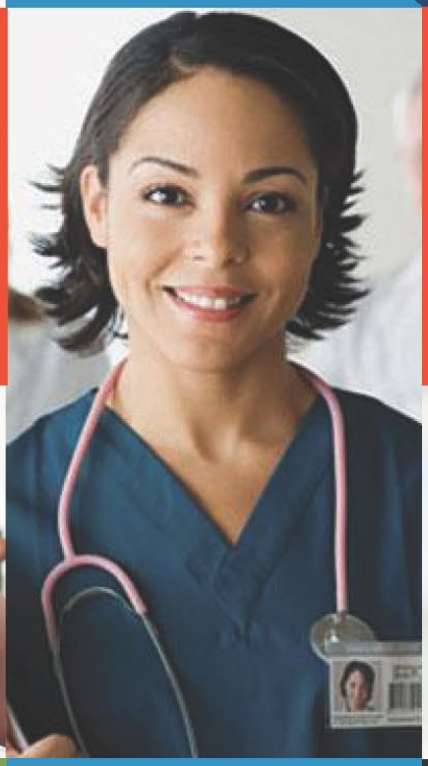
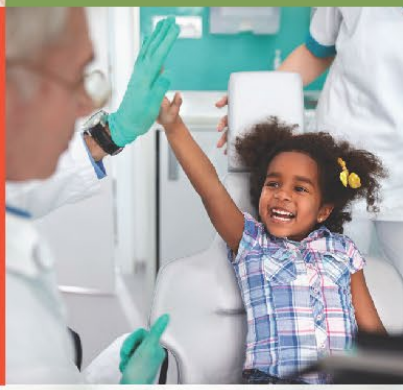
NC MEDICAID

ANNUAL TECHNICAL REPORT

April 2025

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES




HSAG
HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Report Purpose and Overview

Title 42 of the Code of Federal Regulations (42 CFR) at §438.364 requires that state Medicaid programs 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 E lists the required and recommended elements for the external quality review (EQR) technical report.

The North Carolina 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 the state's Medicaid managed care program. This EQR technical report was prepared for the Department by Health Services Advisory Group, Inc. (HSAG), the Department's EQRO.

Overview of North Carolina (NC) 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 the state 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.

Healthcare Programs Offered by NC Medicaid

Type	Population Served	Description
Standard Plans (SPs)	Most Medicaid beneficiaries, including those with low to moderate intensity behavioral health needs.	Prepaid health plans (PHPs) that provide integrated physical health, pharmacy, care coordination, and basic behavioral health services.[1] Launched on July 1, 2021.

[1] Behavioral health services = mental health disorder and substance use disorder services.

Type	Population Served	Description
Eastern Band of Cherokee Indians (EBCI) Tribal Option	Federally recognized tribal members and others who qualify for services through Indian Health Service (IHS) who live in the following counties: Buncombe, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, Swain, Transylvania.	A primary care case management entity created by the Cherokee Indian Hospital Authority (CIHA) that provides care coordination and management of medical, behavioral health, pharmacy, and support services. Launched on July 1, 2021.
Tailored Plans (TPs)	Beneficiaries with significant mental health needs, severe substance use disorders, intellectual/developmental disabilities (I/DDs) or traumatic brain injuries (TBIs).	Offers the same integrated health services as SPs but also provides enhanced I/DD, TBI, and behavioral health services. The TPs launched on July 1, 2024.
NC Medicaid Direct	Beneficiaries who are not enrolled in managed care Health Plans.	The new name for the traditional Medicaid FFS program. Provides care management for physical health services through Community Care of North Carolina (CCNC) and care coordination for behavioral health, I/DD, or TBI through six Local Management Entity-Managed Care Organizations (LME-MCOs), also described as prepaid inpatient health plans (PIHPs).
Children and Families Specialty Plan (CFSP)	The Department intends to launch a single statewide 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 behavioral health (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 beneficiaries.

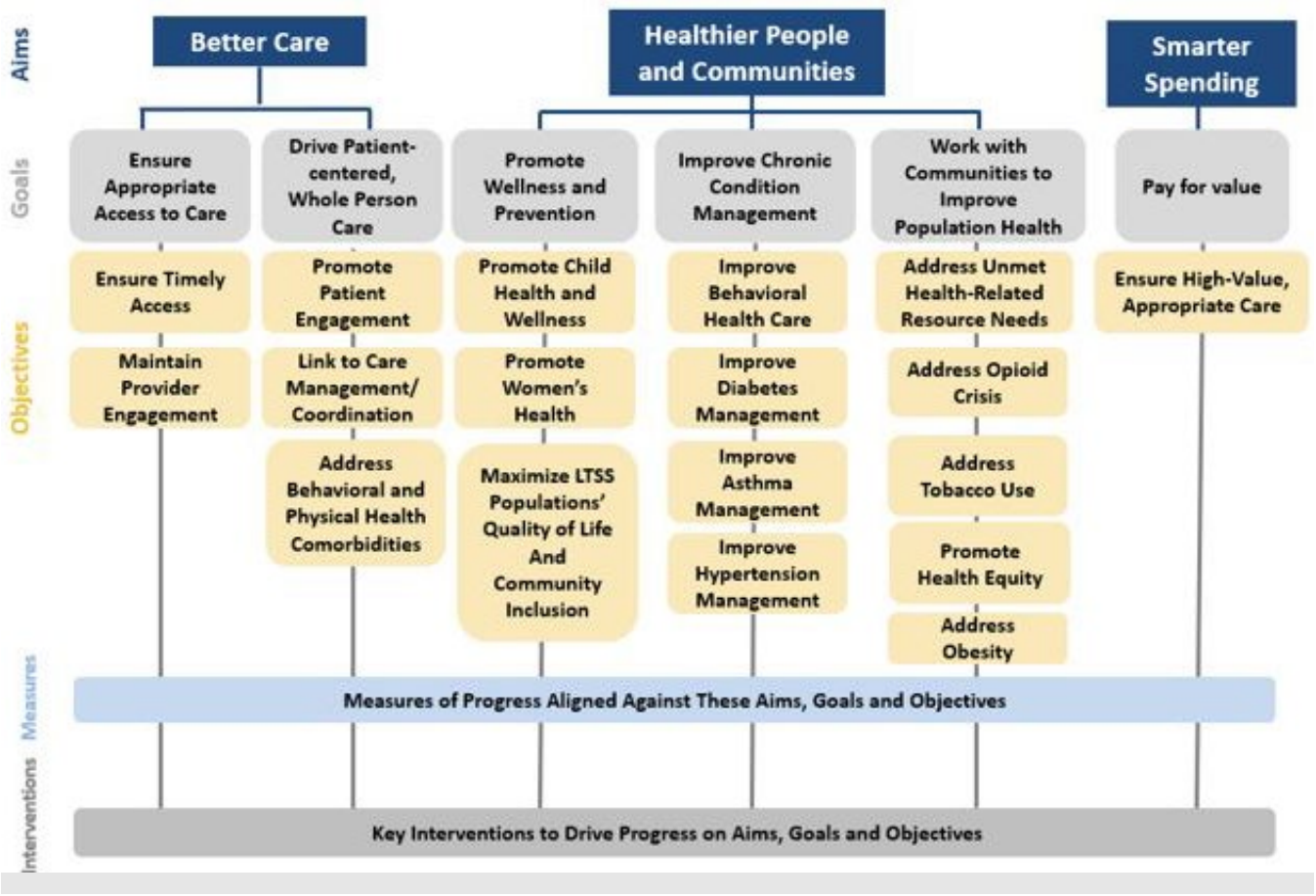
Quality Strategy

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), first published in 2018 and most recently updated in 2023, details NC Medicaid managed care's aims, goals, and objectives for

quality management and improvement and details specific quality improvement initiatives that are priorities for the Department. The Quality Strategy includes a framework reflecting the Department's commitment to three broad aims: Better Care Delivery, Healthier People and Healthier Communities, and Smarter Spending.[2] As depicted in Figure 1, a series of goals and objectives is included with each aim, highlighting key areas of expected progress and quality focus.

Figure 1—Overview of the Quality Strategy Framework



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

[2] DHB. *North Carolina's Medicaid Managed Care Quality Strategy*, April 11, 2023. Available at: https://medicaid.ncdhhs.gov/nc-medicaid-2023-quality-strategy/download?attachment Accessed on: Jan 8, 2024.

further refine the objectives to target specific improvement goals, including additional strategies that promote health equity.

Aggregating and Analyzing Statewide Data

42 CFR §438.364(a)(1) requires this technical report to include a description of the manner in which the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and accessibility of care furnished by the health plans. HSAG follows a four-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the quality, timeliness, and accessibility of care furnished by each health plan, as well as the program overall.

Step 1: HSAG analyzes 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 identifies common themes and the salient patterns that emerge across EQR activities for each domain and draws conclusions about overall quality, timeliness, and accessibility of care and services furnished by the health plans.

Step 3: From the information collected, HSAG identifies common themes and the salient patterns that emerge 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 identifies any patterns and commonalities that exist across the program to draw conclusions about the quality, timeliness, and accessibility of care for the program.

Detailed information about each activity's methodology is provided in the appendices of this report. For a comprehensive discussion of the strengths, opportunities for improvement, conclusions, and recommendations for each health plan, please refer to the results of each activity in Sections 2 and 3 of this report, as well as in Section 4 for health plan-specific analyses.

Please note, program-level and health plan-specific "strengths" are identified throughout this report in alignment with CMS guidance. However, rather than identifying "weaknesses," HSAG, in advisement from the Department, has designated "opportunities for improvement" throughout the report, which include areas where program or health plan performance was identified as needing improvement and recommendations were made to address performance.

Performance Domains

CMS identified the domains of quality, timeliness, and access as keys to evaluating health plan performance. HSAG used the following definitions to evaluate and draw conclusions about the performance of the health plans in each of these domains.

Quality

as it pertains to EQR, means the degree to which an MCO, 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]

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."[2] 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).

Access

as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by MCPs 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.[1]

[1] Department of Health and Human Services, CMS. 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] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs.*

Scope of External Quality Review (EQR)

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 EQR Protocols.[3] 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, timeliness, and accessibility of 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) beneficiaries. For this technical report, 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.

[3] U.S. Department of Health and Human Services, CMS EQR Protocols, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Jan 23, 2024.

Table 1—EQR Mandatory Activities

Activity	Description	CMS 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 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
Validation of Network Adequacy (NAV)	This activity includes validating data to determine whether the network standards, as defined by the state, were met.	**Protocol 4.** Validation of Network Adequacy

Health Plans

As noted in the overview, the PIHPs launched in April 2023; therefore, this is the first reporting cycle they were within scope of EQR activities. The TPs launched July 1, 2024; therefore, they were not within scope of EQR activities during this reporting cycle and will be included in the next technical report. Table 2, Table 3, and Table 4 display the Medicaid managed care health plans.

Table 2—NC Medicaid Managed Care SPs

SP Name	Short Name	Abbreviation	Health Plan Type
AmeriHealth Caritas North Carolina, Inc.	**AmeriHealth**	**ACNC**	PHP
Carolina Complete Health, Inc.	**Carolina Complete**	**CCH**	PHP
Healthy Blue of North Carolina	**Healthy Blue**	**HBNC**	PHP
UnitedHealthcare of North Carolina, Inc.	**UnitedHealthcare**	**UHC**	PHP
WellCare of North Carolina, Inc.	**WellCare**	**WCNC**	PHP

Table 3—EBCI Tribal Option Plans

EBCI Tribal Option*	Abbreviation	Health Plan Type
EBCI Tribal Option	**EBCI**	Indian Managed Care Entity (IMCE)

*Note that EQR activities are not conducted for the Tribal Option.

Table 4—PIHPs and TPs

PIHPs and TPs Name	Short Name	Health Plan Type
Alliance Health	Alliance	PIHP (LME/MCO) and TP
Eastpointe*	Eastpointe	PIHP (LME/MCO)
Partners Health Management	Partners	PIHP (LME/MCO) and TP
Sandhills Center*	Sandhills	PIHP (LME/MCO)
Trillium Health Resources	Trillium	PIHP (LME/MCO) and TP
Vaya Health	Vaya	PIHP (LME/MCO) and TP

*Due to health plan consolidation, **Eastpointe** and **Sandhills** ceased operations in February 2024.

NC Managed Care Program Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from the most current 12-month period to assess each health plan'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 SPs and PIHPs were analyzed to develop overarching conclusions and recommendations for the NC managed care program. Table 5 highlights substantive findings and Table 6 identifies actionable state-specific recommendations, when applicable, for the Department to further promote its Quality Strategy goals and objectives. Health plan-specific conclusions and recommendations are presented in Section 4.

Table 5—Overall NC Medicaid Program Conclusions: Quality, Access, and Timeliness

Program Strengths	Domain(s)[4]
All five SPs received an overall validation status of *Met* for the final validation in 2023 for all PIPs.	
All six PIHPs received a *High Confidence* level for the overall confidence of the PIP methodology in 2023 for all PIPs.	
HSAG determined that the data integration processes, data control processes, and documentation of performance measure generation were *Acceptable* for all SPs for measurement year (MY) 2022 and MY 2023, and that the data integration processes, data control processes, and information systems documentation were *Acceptable* for all PIHPs for MY 2023.	
Adult and child results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[5] survey, for both the NC Medicaid Program and SP aggregate, met or exceeded the national 50th percentile in 2023 for *Getting Needed Care* and *Getting Care Quickly*. Both adult and child survey measure results demonstrated improvements in 2023 compared to 2022.	

[4] = Quality, = Timeliness, = Access

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

Program Strengths	Domain(s)[4]
For adult and child CAHPS survey respondents for the NC Medicaid Program, results met or exceeded the national 50th percentile in 2023 for *Rating of All Health Care, Rating of Personal Doctor, Customer Service,* and *Coordination of Care*. All adult and child ratings remained the same or improved in 2023 compared to 2022.	
The NC Medicaid Program scored at or above the 90th percentile for the *How Well Doctors Communicate* child CAHPS measure.	
The NC Home- and Community-Based Services (HCBS) Program had significantly higher positive ratings in 2023 compared to the CAHPS database benchmark for the following measures: *Transportation to Medical Appointments*, *Personal Safety and Respect*, and *Planning Your Time and Activities*.	
Overall, encounter data record omission and surplus rates were low, with only a few instances where rates were greater than 5.0 percent.	
HSAG observed that, overall, the PIHPs and SPs had well-defined processes and procedures in place to ensure the efficient and accurate collection of beneficiary/member and provider data to support network adequacy monitoring and reporting.	
The PIHPs and SPs demonstrated dedicated efforts to identify gaps in provider networks throughout their service areas and identified ways to improve the accessibility and timeliness of care for enrollees.	
All SPs demonstrated substantial compliance with standards in the compliance review. The health plans' policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	

Program Weaknesses	Domain(s)
All five SPs' rates for the *Controlling High Blood Pressure* and *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes* measures were below the MY 2022 and MY 2023 NCQA 10th percentile.	
All five SPs' rates for the *Prenatal and Postpartum Care: Prenatal Care* measure were below the MY 2022 NCQA 10th percentile.	
All five SPs' rates for the *Screening for Depression and Follow-Up Plan* measure for adults and children were very low.	
The NC Medicaid Program scored at or between the 25th and 49th percentiles for the *Rating of Health Plan* measure for the adult and child populations.	
SP Behavioral Health and EBCI both scored below the 25th percentile for all CAHPS measures in the global rating measure domain.	
Three HCBS CAHPS individual item measures had significantly lower positive ratings in 2023 compared to the CAHPS database benchmark: *Staff work time supposed to*, *Treated the way you want by staff*, and *Contact case manager*.	

Program Weaknesses	Domain(s)
The HCBS CAHPS survey evaluation of positive ratings by race and ethnicity suggested that some disparities existed in beneficiary-reported experiences with HCBS across a few HCBS CAHPS survey measures, although few consistent patterns of disparities were evident.	
All instances of high record omission and record surplus rates in the encounter data were due to voided claims.	
Some encounter data element omission and element surplus rates were greater than 5.0 percent, and some accuracy rates were lower than 95.0 percent.	
HSAG observed that DHB excluded 7 percent of the PIHP beneficiary population from network adequacy monitoring and reporting because the enrollees did not live in the PIHPs' assigned catchment area.	

Recommendations for Targeting Goals and Objectives in the Quality Strategy

Table 6—Recommendations

Domain	Program Recommendations	Quality Strategy Pillar and Goal
	HSAG recommends that the SPs educate and consider incentive plans for providers on appropriate submission of Current Procedural Terminology (CPT) II codes for improving administrative capture of blood pressure control results and HbA1c results.	***Goal 1: Ensure appropriate access to care*** **Objective 1.2**: Maintain Medicaid provider engagement ***Goal 2: Drive equitable, patient-centered, whole person care*** **Objective 2.1**: Promote patient engagement in care ***Goal 4: Improve chronic condition management*** **Objective 4.2**: Improve diabetes management **Objective 4.4**: Improve hypertension management ***Goal 5: Work with communities to improve population health*** **Objective 5.4**: Promote health equity
	HSAG recommends that the SPs analyze for disparities/social determinants of health (SDOH) within the health plans' populations that contributed to lower access to timely prenatal care. Upon identification of a root cause, HSAG recommends that the health plans implement appropriate interventions to reduce barriers to care, such as expanding appointment access times to accommodate childcare needs or competing priorities.	***Goal 1: Ensure appropriate access to care*** **Objective 1.1**: Ensure equitable, timely access to care ***Goal 2: Drive equitable, patient-centered, whole person care*** **Objective 2.1**: Promote patient engagement in care ***Goal 3: Promote wellness and prevention***

Domain	Program Recommendations	Quality Strategy Pillar and Goal
		Objective 3.1: Promote child health, development, and wellness **Objective 3.2**: Promote women's health, including maternal morbidity and mortality
	DHB should evaluate additional interventions that will improve the frequency of depression screenings and follow-up plans. HSAG recommends that the SPs ensure providers receive reminders about screenings and consider creating educational materials for provider and clinic staff members to promote "buy in" for screening. HSAG recommends that health plans identify process improvements for members 18–44 years of age and identify provider-specific trends within the data and disseminate provider score cards as needed.	***Goal 1: Ensure appropriate access to care*** **Objective 1.1**: Ensure equitable, timely access to care **Objective 1.2**: Maintain Medicaid provider engagement ***Goal 2: Drive equitable, patient-centered, whole person care*** **Objective 2.1**: Promote patient engagement in care **Objective 2.2**: Link patients to appropriate care management and care coordination services **Objective 2.3**: Address behavioral and physical health comorbidities ***Goal 4: Improve chronic condition management*** **Objective 4.1**: Improve behavioral health care
	HSAG recommends that DHB explore what may be driving lower experience scores for *Rating of Health Plan* and develop initiatives designed to improve quality of care.	***Goal 2: Drive equitable, patient-centered, whole person care*** **Objective 2.1**: Promote patient engagement in care
	For the SP Behavioral Health population, HSAG recommends that health plans explore what may be impacting the drivers of lower experience scores of global CAHPS ratings, develop initiatives designed to improve quality of care, and focus on improving members' overall experiences with their healthcare. Health plans should determine if there is a shortage of specialists in the area or an unwillingness of the specialists to contract with the health plan that could be contributing to a lack of network adequacy and access issues.	***Goal 1: Ensure appropriate access to care*** **Objective 1.1**: Ensure equitable, timely access to care **Objective 1.2**: Maintain Medicaid provider engagement ***Goal 2: Drive equitable, patient-centered, whole person care*** **Objective 2.1**: Promote patient engagement in care ***Goal 4: Improve chronic condition management*** **Objective 4.1**: Improve behavioral health care ***Goal 5: Work with communities to improve population health*** **Objective 5.1**: Address unmet health-related resource needs

Domain	Program Recommendations	Quality Strategy Pillar and Goal
	DHB should consider efforts to determine possible barriers to care or opportunities for improvement that may result in increased satisfaction with HCBS experiences and implement improvement strategies to ensure beneficiaries have high-quality care and timely access to care. DHB should consider efforts to engage Black and Hispanic beneficiaries to determine possible barriers to care or opportunities for improvement that may result in increased satisfaction with their HCBS experiences.	***Goal 1: Ensure appropriate access to care*** **Objective 1.1**: Ensure equitable, timely access to care ***Goal 3: Promote wellness and prevention*** **Objective 3.3**: Maximize long-term services and supports (LTSS) populations' quality of life and community inclusion
	DHB should collaborate with the SPs to investigate root causes of encounter data record omission and record surplus rates greater than 5.0 percent and ensure voided claims are submitted correctly.	***Goal 6: Pay for value*** **Objective 6.1**: Ensure high-value, appropriate care
	DHB should collaborate with the SPs on submission guidelines for *Surgical Procedure Codes* since all Standard Plans submitted more values to HSAG than to DHB for records that had mismatching values.	***Goal 6: Pay for value*** **Objective 6.1**: Ensure high-value, appropriate care
	DHB should also ensure that the SPs submit the third digit (i.e., the frequency code) in the *Type of Bill Code* data element accurately.	***Goal 6: Pay for value*** **Objective 6.1**: Ensure high-value, appropriate care
	For pharmacy encounters, DHB should ensure that the SPs submit voided encounters correctly and accurately, specifically for values populated in the *Days Supply* and *Paid Amount* data elements.	***Goal 6: Pay for value*** **Objective 6.1**: Ensure high-value, appropriate care
	HSAG recommends that DHB explore potential revisions of the contract language, allowing analysis of network adequacy to include the beneficiaries outside of their assigned catchment area.	***Goal 1: Ensure appropriate access to care*** **Objective 1.1**: Ensure equitable, timely access to care

2. Comparative Statewide Results

Mandatory EQR Activities

Validation of Performance Improvement Projects

Overview

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. For CY 2023 and 2024, the Department required health plans to conduct PIPs in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i–iv). In accordance with §438.330(d)(2)(i–iv), each PIP must include:

- Measuring performance using objective quality indicators.
- Implementing system interventions to achieve improvement in quality.
- Evaluating effectiveness of the interventions.
- Planning and initiating of activities for increasing or sustaining improvement.

Objectives

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. 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. HSAG conducted validation, which verifies whether a PIP conducted by a health plan used sound methodology in its design, implementation, analysis, and reporting.

Validation Overview

HSAG's validation evaluates the technical methods of the PIP (i.e., the design, data analysis, implementation, and outcomes). Based on its review, HSAG determined the overall methodological validity of the PIP. For the 2023 validation year for the SPs, HSAG used CMS *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019 (CMS EQR Protocol 1).[1] Due to the timing of the release of the *Protocol 1. Validation of Performance Improvement*

Projects: A Mandatory EQR-Related Activity, February 2023[6], this protocol was used for the PIHPs in 2023 and for both health plan types in 2024.

For the 2023 validation, the SPs continued four PIP topics. Three clinical PIP topics corresponded to the following Healthcare Effectiveness Data and Information Set (HEDIS®)[7] measures: *Childhood Immunization Status (CIS)—Combination 10* (*CIS—Combo 10*),[8] *Timeliness of Prenatal Care and Postpartum Care (PPC)—Timeliness of Prenatal Care* and *Postpartum Care*, and *Hemoglobin A1c Control for Patients with Diabetes (HBD).* Additionally, each SP submitted a nonclinical PIP topic of its choice.

For the 2024 validation, the SPs submitted four new PIP topics. Three clinical PIP topics corresponded to the following HEDIS measures: *CIS—Combo 10*, *PPC*, and *Hemoglobin A1c Control Glycemic Status Assessment for Patients with Diabetes* (*GSD*). The health plans submitted a nonclinical PIP, *Health-Related Resource Needs (HRRN).*

For the 2023 validation, the PIHPs submitted two continuing clinical PIP topics: *Follow-Up After Hospitalization for Mental Health (FUH)—DHB Medicaid Direct* and *Follow-Up After Emergency Department (ED) Visit (FUM) for Mental Illness—DHB Medicaid-Direct*, and one nonclinical topic, *Transitions to Community Living* (*TCL*).

For the 2024 validation, the PIHPs submitted two continuing clinical PIP topics: *FUH* and *FUM*, and one nonclinical topic, *TCL*.

The topics addressed CMS' requirements related to quality outcomes—specifically, the quality, timeliness, and accessibility of care and services.

The TPs launched in July 2024; therefore, PIP-related activities for the TPs will occur in 2025.

Technical Methods of Data Collection and Analysis

To assess and validate PIPs, HSAG used a standardized scoring methodology to rate a health plan's compliance with each of the nine steps listed in CMS EQR Protocol 1. With the Department's input and approval, HSAG developed a PIP Validation Tool to ensure uniform assessment of the PIP. See Appendix A—Methodology for more information on validation scoring.

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[6] U.S. Department of Health and Human Services, CMS. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, February 2023. Available at: http://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Sep 8, 2024.

[7] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[8] *CIS—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 chickenpox/varicella zoster virus (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.

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from each health plan's PIP Submission Form. Each health plan completed the form for PIP activities conducted during the MY and submitted it to HSAG for validation. The PIP Submission Form and accompanying PIP Completion Instructions present instructions for documenting information related to each of the steps in CMS EQR Protocol 1. The health plans could also attach relevant supporting documentation with the PIP Submission Form. The following tables illustrate the data source for each health plan and PIP topic per validation year.

Table 7—SP and PIP-Specific Data Source

SP	Data Source	
	2023 Validation Year	2024 Validation Year
HEDIS CIS—Combo 10		
AmeriHealth	Administrative data through claims/ encounters	Hybrid data through certified HEDIS vendors.
Carolina Complete	Administrative data through claims/ encounters	Hybrid data through certified HEDIS vendors.
Healthy Blue	Administrative data through claims/ encounters	Hybrid data through certified HEDIS vendors.
UnitedHealthcare	Administrative data through claims/ encounters	Hybrid data through certified HEDIS vendors.
WellCare	Administrative data through claims/ encounters	Hybrid data through certified HEDIS vendors.
HEDIS PPC		
AmeriHealth	Administrative data through claims/ encounters	Hybrid data through certified HEDIS vendors.
Carolina Complete	Administrative data through claims/ encounters	Hybrid data through certified HEDIS vendors.
Healthy Blue	Administrative data through claims/ encounters	Hybrid data through certified HEDIS vendors.
UnitedHealthcare	Administrative data through claims/ encounters	Hybrid data through certified HEDIS vendors.
WellCare	Administrative data through claims/ encounters	Hybrid data through certified HEDIS vendors.
HEDIS HBD/GSD PIP		
AmeriHealth	Administrative data through claims/ encounters	Hybrid data through certified HEDIS vendors.
Carolina Complete	Administrative data through claims/ encounters	Hybrid data through certified HEDIS vendors.

SP	Data Source	
	2023 Validation Year	2024 Validation Year
Healthy Blue	Administrative data through claims/ encounters	Hybrid data through certified HEDIS vendors.
UnitedHealthcare	Administrative data through claims/ encounters	Hybrid data through certified HEDIS vendors.
WellCare	Administrative data through claims/ encounters	Hybrid data through certified HEDIS vendors.
Nonclinical PIP		
AmeriHealth	Care Needs Screening (CNS) Administrative data	Administrative data through BCM026 reports.
Carolina Complete	Improve Provider Satisfaction–Survey data	Administrative data through BCM026 reports.
Healthy Blue	Administrative data through claims/ Tobacco cessation data through Optum Quit for Life.	Administrative data through BCM026 reports.
UnitedHealthcare	CNS Survey Data	Administrative data through BCM026 reports.
WellCare	Administrative data through claims/ encounters	Administrative data through BCM026 reports.

Table 8—PIHP and PIP-Specific Data Source

PIHP	Data Source	
	2023 Validation Year	2024 Validation Year
FUH		
Alliance	Administrative data through claims/encounters	Administrative data through claims/encounters
Eastpointe*	Administrative data through claims/encounters	Not Applicable (NA)
Partners	Administrative data through claims/encounters	Administrative data through claims/encounters
Sandhills*	Administrative data through claims/encounters	NA
Trillium	Administrative data through claims/encounters	Administrative data through claims/encounters
Vaya Health	Administrative data through claims/encounters	Administrative data through claims/encounters

PIHP	Data Source	
	2023 Validation Year	2024 Validation Year
FUM		
Alliance	Administrative data through claims/encounters	Administrative data through claims/encounters
Eastpointe*	Administrative data through claims/encounters	NA
Partners	Administrative data through claims/encounters	Administrative data through claims/encounters
Sandhills*	Administrative data through claims/encounters	NA
Trillium	Administrative data through claims/encounters	Administrative data through claims/encounters
Vaya Health	Administrative data through claims/encounters	Administrative data through claims/encounters
TCL		
Alliance	Administrative data through NCTracks claims	Administrative data through Community Living Integration &Verification System (CLIVe) and Johns Hopkins All Claims Grouper (ACG) report.
Eastpointe*	Administrative data through CLIVe	NA
Partners	Administrative data through CLIVe	Administrative data through CLIVe
Sandhills*	Administrative data through CLIVe	NA
Trillium	Administrative data through CLIVe	Administrative data through CLIVe
Vaya Health	Administrative data through CLIVe	Administrative data through CLIVe

***Eastpointe** and **Sandhills** merged with **Trillium** in 2024.

PIP Validation Results and Outcomes for Validation Year 2023

SPs: *HEDIS CIS—Combo 10* PIP

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 9 displays the validation scores HSAG assigned to each SP's *HEDIS CIS—Combo 10* PIP.

Table 9—2023 *HEDIS CIS—Combo 10* PIP Validation Results

SP	Percentage Score of Evaluation Elements Met[1]	Percentage Score of Critical Elements Met[2]	Overall Validation Status[3]
AmeriHealth	100%	100%	*Met*

SP	Percentage Score of Evaluation Elements Met[1]	Percentage Score of Critical Elements Met[2]	Overall Validation Status[3]
Carolina Complete	100%	100%	*Met*
Healthy Blue	95%	100%	*Met*
UnitedHealthcare	95%	100%	*Met*
WellCare	95%	100%	*Met*

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.
[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[3] **Overall Validation Status**— Populated from the PIP Validation Tool and based on the percentage scores.

As shown in Table 9 above, for the *HEDIS CIS—Combo 10* PIP, all five SPs received *Met* for the overall validation status for the final validation.

The performance indicator is based on the HEDIS *CIS—Combo 10* measure, which assesses the percentage of members 2 years of age who completed the *CIS—Combo 10* vaccine series. Table 10 displays the baseline and remeasurement data as reported by the SPs.

Table 10—2023 Outcomes for the *HEDIS CIS—Combo 10* PIP

Performance Indicator Results		
SP	**Baseline (7/1/2021–12/31/2021)**	**Remeasurement 1 (1/1/2022–12/31/2022)**
AmeriHealth	7.3%	23.9%↑
Carolina Complete	32.6%	27.1%↓
Healthy Blue	39.6%	26.4%↓
UnitedHealthcare	29.5%	25.8%↓
WellCare	30.9%	28.0%↓

↑ Designates statistically significant improvement over the baseline measurement period (p value < 0.05).
↓ Designates statistically significant decline over the baseline measurement period (p value < 0.05).
HSAG rounded percentages to the first decimal place.

As shown in Table 10 above, results for Remeasurement 1 ranged from 23.9 percent to 28.0 percent. Only one health plan, **AmeriHealth**, achieved statistically significant improvement over the baseline, while the other health plans had statistically significant declines in performance when compared to the baseline.

SPs: *HEDIS PPC* PIP

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 11 displays the validation scores HSAG assigned to each SP's *HEDIS PPC* PIP.

Table 11—2023 *HEDIS PPC* PIP Validation Results

SP	Percentage Score of Evaluation Elements Met[1]	Percentage Score of Critical Elements Met[2]	Overall Validation Status[3]
AmeriHealth	100%	100%	*Met*
Carolina Complete	100%	100%	*Met*
Healthy Blue	96%	100%	*Met*
UnitedHealthcare	95%	100%	*Met*
WellCare	95%	100%	*Met*

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Overall Validation Status**— Populated from the PIP Validation Tool and based on the percentage scores.

As shown in Table 11 above, for the *HEDIS PPC* PIP, all five SPs received *Met* for the overall validation status for the final validation.

The performance indicators are based on the HEDIS *PPC* measure, which assesses the percentage of deliveries who received a prenatal visit during the first trimester, on or before the enrollment date, or within 42 days of enrollment in the health plan and the percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. Table 12 displays the baseline and remeasurement data that the health plans reported for each performance indicator. For Remeasurement 1, the prenatal indicator results ranged from 48.4 percent to 81.0 percent, and the postpartum indicator results ranged from 62.6 percent to 75.3 percent.

Table 12—2023 Outcomes for the *HEDIS PPC* PIP

Performance Indicator Results			
SP	**Performance Indicator**	**Baseline (7/1/2021–12/31/2021)**	**Remeasurement 1 (1/1/2022–12/31/2022)**
AmeriHealth	Prenatal	48.6%	69.1%↑
	Postpartum	60.7%	74.7%↑

Performance Indicator Results			
SP	**Performance Indicator**	**Baseline (7/1/2021–12/31/2021)**	**Remeasurement 1 (1/1/2022–12/31/2022)**
Carolina Complete	Prenatal	38.1%	51.9%↑
	Postpartum	64.7%	64.7%⇔
Healthy Blue	Prenatal	92.0%	81.0%↓
	Postpartum	79.6%	75.3%⇔
UnitedHealthcare	Prenatal	36.7%	48.4%↑
	Postpartum	60.4%	62.6%⇔
WellCare	Prenatal	73.0%	49.3%↓
	Postpartum	67.4%	62.7%↓

↑ Designates statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓Designates statistically significant decline over the baseline measurement period (p value < 0.05).
HSAG rounded percentages to the first decimal place.

As shown in Table 12 above, for the *Timeliness of Prenatal Care* indicator, three of the five health plans (**AmeriHealth**, **Carolina Complete**, and **UnitedHealthcare**) achieved statistically significant improvement over the baseline and two health plans (**Healthy Blue** and **WellCare**) demonstrated a statistically significant decline in performance when compared to the baseline.

For the *Timeliness of Postpartum Care* indicator, the results were mixed. One health plan (**AmeriHealth)** achieved statistically significant improvement over the baseline, while one health plan's performance remained the same (**Carolina Complete**), one health plan had non-statistically significant improvement (**UnitedHealthcare**), one health plan demonstrated a non-statistically significant decline (**Healthy Blue**), and one health plan (**WellCare**) demonstrated a statistically significant decline when compared to the baseline.

SPs: *HEDIS HBD* PIP

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 13 displays the validation scores HSAG assigned to each SP's *HEDIS HBD* PIP.

Table 13—2023 *HEDIS HBD* PIP Validation Results

SP	Percentage Score of Evaluation Elements Met[1]	Percentage Score of Critical Elements Met[2]	Overall Validation Status[3]
AmeriHealth	100%	100%	*Met*

SP	Percentage Score of Evaluation Elements Met[1]	Percentage Score of Critical Elements Met[2]	Overall Validation Status[3]
Carolina Complete	100%	100%	*Met*
Healthy Blue	95%	100%	*Met*
UnitedHealthcare	100%	100%	*Met*
WellCare	100%	100%	*Met*

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.
[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[3] **Overall Validation Status**— Populated from the PIP Validation Tool and based on the percentage scores.

As shown in Table 13 above, *for* the *HEDIS HBD* PIP, all five SPs received *Met* scores for the overall validation status for the final validation.

The performance indicator is the HEDIS *HBD: HbA1c Poor Control* measure, which assesses the percentage of members 18 to 75 years of age with a diagnosis of diabetes, type 1 or 2, with poor control (HbA1c > 9.0 percent). Table 14 displays the baseline and remeasurement data as reported by the SPs. For this inverse indicator, a lower percentage demonstrates improvement. The results for Remeasurement 1 ranged from 58.9 percent to 82.4 percent.

Table 14—2023 Outcomes for the *HEDIS HBD* PIP

Performance Indicator Results		
SP	**Baseline (7/1/2021–12/31/2021)**	**Remeasurement 1 (1/1/2022–12/31/2022)**
AmeriHealth	94.39%	58.9%↓↓
Carolina Complete	88.14%	72.7%↓↓
Healthy Blue	80.25%	82.4%⇔
UnitedHealthcare	77.32%	71.8%↓↓
WellCare	91.89%	71.0%↓↓

↓↓ Designates statistically significant improvement (inverse indicator) over the baseline measurement period (p value < 0.05).
⇔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
HSAG rounded percentages to the first decimal place.

As shown in Table 14 above, four of five health plans (**AmeriHealth**, **Carolina Complete**, **UnitedHealthcare**, and **WellCare**) achieved statistically significant improvement, and one health plan (**Healthy Blue**) demonstrated a non-statistically significant decline in performance.

SPs: Nonclinical PIP

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 15 displays the validation scores HSAG assigned to each SP's nonclinical PIP.

Table 15—2023 Nonclinical PIP Validation Results

SP	PIP Topic	Percentage Score of Evaluation Elements Met[1]	Percentage Score of Critical Elements Met[2]	Overall Validation Status[3]
AmeriHealth	*Improving the Number of CNSs Completed for Medicaid Members*	100%	100%	*Met*
Carolina Complete	*Improve Provider Satisfaction*	100%	100%	*Met*
Healthy Blue	*Method Counseling and Impact on Sustained Tobacco Cessation*	100%	100%	*Met*
UnitedHealthcare	*Maximizing CNS Completion Rates*	100%	100%	*Met*
WellCare	*HEDIS Access to Preventive/Ambulatory Care*	95%	100%	*Met*

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Overall Validation Status**— Populated from the PIP Validation Tool and based on the percentage scores.

As shown in Table 15 above, all five health plans received *Met* scores for the overall validation status with the final validation.

The performance indicator for the nonclinical PIPs varied by SP. Table 16 displays the baseline and remeasurement data as reported by each SP.

Table 16—2023 Outcomes for the Nonclinical PIPs

Performance Indicator Results			
SP	**Performance Indicator**	**Baseline (7/1/2021–12/31/2021)**	**Remeasurement 1 (1/1/2022–12/31/2022)**
AmeriHealth	The percentage of members completing an initial CNS.	1.7%	10.5%↑
Carolina Complete	The percentage of contracted primary care and obstetrician and gynecologist (OB/GYN) providers who responded with "Excellent" or "Good" to their satisfaction with the SP.	74.4%	65.8%⇔

Performance Indicator Results			
SP	**Performance Indicator**	**Baseline (7/1/2021–12/31/2021)**	**Remeasurement 1 (1/1/2022–12/31/2022)**
Healthy Blue	The percentage of members who self-report at least 30 days of tobacco cessation.	0.0%	0.4%↑
UnitedHealthcare	The percentage of members for whom the SP completed a CNS within 90 days of enrollment.	3.8%	7.4%↑
WellCare	The percentage of members 20 years and older who had an ambulatory or preventive care visit during the MY.	74.4%	71.2%↓

↑ Designates statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ Designates statistically significant decline in performance over the baseline measurement period (p value < 0.05).
HSAG rounded percentages to the first decimal place.

As shown in Table 16 above, for the nonclinical PIPs, three of the five health plans (**AmeriHealth**, **Healthy Blue**, and **UnitedHealthcare**) demonstrated statistically significant improvement in Remeasurement 1 over the baseline measurement period. One health plan, **Carolina Complete**, had a non-statistically significant decline in Remeasurement 1 and one health plan, **WellCare**, had a statistically significant decline in performance from baseline to Remeasurement 1.

PIHPs: *FUH* PIP

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 17 displays the validation scores and confidence levels HSAG assigned to each PIHP's *FUH* PIP.

Table 17—2023 *FUH* PIP Validation Results

PIHP	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Alliance	100%	100%	*High Confidence*	*Not Assessed*[4]		
Eastpointe	100%	100%	*High Confidence*	*Not Assessed*		

PIHP	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Partners	100%	100%	*High Confidence*	*Not Assessed*		
Sandhills	100%	100%	*High Confidence*	*Not Assessed*		
Trillium	100%	100%	*High Confidence*	*Not Assessed*		
Vaya Health	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[4] **Not Assessed**—HSAG did not assess Step 9 for those health plans that only reported baseline data.

As shown in Table 17 above, all six PIHPs received a *High Confidence* for Validation Rating 1 for the *FUH* PIP design in 2023. During 2023, the *FUH* PIP had not progressed to providing remeasurement data; therefore, Validating Rating 2 was *Not Assessed.*

Although the baseline measurement period was CY 2023 for all PIHP PIPs, the PIHPs submitted Steps 1 through 6 (Design stage) only for the 2023 annual validation.

PIHPs: *FUM* PIP

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 18 displays the validation scores and confidence levels HSAG assigned to each PIHP's *FUM* PIP.

Table 18—2023 *FUM* PIP Validation Results

PIHP	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Alliance	100%	100%	*High Confidence*	*Not Assessed*[4]		
Eastpointe	100%	100%	*High Confidence*	*Not Assessed*		
Partners	100%	100%	*High Confidence*	*Not Assessed*		
Sandhills	100%	100%	*High Confidence*	*Not Assessed*		
Trillium	100%	100%	*High Confidence*	*Not Assessed*		
Vaya Health	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[4] **Not Assessed**—HSAG did not assess Step 9 for those health plans that only reported baseline data.

As shown in Table 18 above, all six PIHPs received a *High Confidence* for Validation Rating 1 for the *FUM* PIP design in 2023. During 2023, the *FUM* PIP had not progressed to providing remeasurement data; therefore, Validating Rating 2 was *Not Assessed.*

Although the baseline measurement period was CY 2023 for all PIHP PIPs, the PIHPs submitted Steps 1 through 6 (Design stage) only for the 2023 annual validation.

PIHPs: *TCL* PIP

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 19 displays the validation scores and confidence levels HSAG assigned to each PIHP's *TCL* PIP.

Table 19—2023 *TCL* PIP Validation Results

PIHP	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Alliance	100%	100%	*High Confidence*	*Not Assessed*[4]		
Eastpointe	100%	100%	*High Confidence*	*Not Assessed*		
Partners	100%	100%	*High Confidence*	*Not Assessed*		
Sandhills	100%	100%	*High Confidence*	*Not Assessed*		
Trillium	100%	100%	*High Confidence*	*Not Assessed*		
Vaya Health	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[4] **Not Assessed**—HSAG did not assess Step 9 for those health plans that only reported baseline data.

As shown in Table 19 above, all six PIHPs received *High Confidence* for Validation Rating 1 for the *TCL* PIP design in 2023. During 2023, the *TCL* PIP had not progressed to providing remeasurement data, therefore; Validating Rating 2 was *Not Assessed.*

Although the baseline measurement period was CY 2023 for all PIHP PIPs, the PIHPs submitted Steps 1 through 6 (Design stage) only for the 2023 annual validation.

PIP Validation Results and Outcomes for Validation Year 2024

SPs: *HEDIS CIS—Combo 10* PIP

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 20 displays the validation scores and confidence levels HSAG assigned to each SP's *HEDIS CIS—Combo 10* PIP.

Table 20—2024 *HEDIS CIS—Combo 10* PIP Validation Results

SP	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
AmeriHealth	100%	100%	*High Confidence*	*Not Assessed*[4]		
Carolina Complete	100%	100%	*High Confidence*	*Not Assessed*[4]		
Healthy Blue	90%	100%	*High Confidence*	*Not Assessed*[4]		
UnitedHealthcare	100%	100%	*High Confidence*	*Not Assessed*[4]		
WellCare	100%	100%	*High Confidence*	*Not Assessed*[4]		

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[4] **Not Assessed**—HSAG did not assess Step 9 for those health plans that only reported baseline data.

As shown in Table 20 above, *for* the *HEDIS CIS—Combo 10* PIP, all five SPs received *High Confidence* for the overall validation status for the final validation.

The performance indicator is based on the *HEDIS CIS—Combo 10* measure, which assesses the percentage of members 2 years of age who completed the *CIS—Combo 10* vaccine series. Table 21 displays the baseline data as reported by the SPs.

Table 21—2024 Outcomes for the *HEDIS CIS—Combo 10* PIP

SP	Baseline (1/1/2023–12/31/2023)
AmeriHealth	22.14%
Carolina Complete	23.84%
Healthy Blue	22.87%
UnitedHealthcare	27.01%
WellCare	27.49%

As shown in Table 21 above, baseline results ranged from 22.14 percent to 27.49 percent.

SPs: *HEDIS PPC* PIP

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 22 displays the validation scores HSAG assigned to each SP's *HEDIS PPC* PIP.

Table 22—2024 *HEDIS PPC* PIP Validation Results

SP	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
AmeriHealth	100%	100%	*High Confidence*	*Not Assessed*[4]		
Carolina Complete	100%	100%	*High Confidence*	*Not Assessed*[4]		
Healthy Blue	100%	100%	*High Confidence*	*Not Assessed*[4]		
UnitedHealthcare	100%	100%	*High Confidence*	*Not Assessed*[4]		
WellCare	100%	100%	*High Confidence*	*Not Assessed*[4]		

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
[4] **Not Assessed**—HSAG did not assess Step 9 for those health plans that only reported baseline data.

As shown in Table 22 above, for the *HEDIS PPC* PIP, all five SPs received *High Confidence* for the overall validation status for the final validation.

The performance indicators are based on the HEDIS *PPC* measure, which assesses the percentage of deliveries who received a prenatal visit during the first trimester, on or before the enrollment date, or within 42 days of enrollment in the health plan and the percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. Table 23 displays the baseline data that the health plans reported for each performance indicator.

Table 23—2024 Outcomes for the *HEDIS PPC* PIP

SP	Performance Indicator	Baseline (1/1/2023–12/31/2023)
AmeriHealth	Prenatal	72.74%
	Postpartum	74.69%
Carolina Complete	Prenatal	66.67%
	Postpartum	75.67%
Healthy Blue	Prenatal	77.86%
	Postpartum	78.10%
UnitedHealthcare	Prenatal	72.51%
	Postpartum	75.91%
WellCare	Prenatal	76.89%
	Postpartum	81.75%

As shown in Table 23 above, for the *Timeliness of Prenatal Care* indicator, the baseline results ranged from 66.67 percent to 77.86 percent.

For the *Timeliness of Postpartum Care* indicator, the baseline results ranged from 74.69 percent to 81.75 percent.

SPs: *HEDIS GSD* PIP

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 24 displays the validation scores HSAG assigned to each SP's *HEDIS GSD* PIP.

Table 24—2024 *HEDIS GSD* PIP Validation Results

SP	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
AmeriHealth	100%	100%	*High Confidence*	*Not Assessed*[4]		
Carolina Complete	100%	100%	*High Confidence*	*Not Assessed*[4]		
Healthy Blue	100%	100%	*High Confidence*	*Not Assessed*[4]		
UnitedHealthcare	100%	100%	*High Confidence*	*Not Assessed*[4]		
WellCare	100%	100%	*High Confidence*	*Not Assessed*[4]		

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.
[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
[4] **Not Assessed**—HSAG did not assess Step 9 for those health plans that only reported baseline data.

As shown in Table 24 above, for the *HEDIS GSD* PIP, all five SPs received *High Confidence* for the overall validation status for the final validation.

The performance indicator is the *HEDIS GSD* measure, which assesses the percentage of members 18 to 75 years of age with a diagnosis of diabetes, type 1 or 2, with poor control (HbA1c > 9.0 percent) and in control (HbA1c <8.0 percent). Table 25 displays the baseline data as reported by each SP. For this inverse indicator, a lower percentage demonstrates improvement. The baseline results for HbA1c Control <8.0 percent ranged from 37.47 percent to 57.91 percent. For HbA1c >9.0 percent, results ranged from 34.06 percent to 52.55 percent.

Table 25—2024 Outcomes for the *HEDIS GSD* PIP

SP	Performance Indicator	Baseline (1/1/2023–12/31/2023)
AmeriHealth	HbA1c Control < 8.0%	45.25%
	HbA1c Poor Control >9.0%	47.68%
Carolina Complete	HbA1c Control < 8.0%	47.69%
	HbA1c Poor Control >9.0%	43.80%
Healthy Blue	HbA1c Control < 8.0%	37.47%
	HbA1c Poor Control >9.0%	52.55%
UnitedHealthcare	HbA1c Control < 8.0%	54.50%
	Hb1Ac Poor Control >9.0%	35.77%
WellCare	HbA1c Control < 8.0%	57.91%
	HbA1c Poor Control >9.0%	34.06%

SPs: *HRRN* Nonclinical PIP

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 26 displays the validation scores HSAG assigned to each SP's *HRRN* PIP.

Table 26—2024 *HRRN* PIP Validation Results

SP	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
AmeriHealth	100%	100%	*High Confidence*	*Not Assessed*[4]		
Carolina Complete	85%	78%	*Low Confidence*	*Not Assessed*[4]		
Healthy Blue	100%	100%	*High Confidence*	*Not Assessed*[4]		

SP	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
UnitedHealthcare	93%	89%	*Low Confidence*	*Not Assessed*[4]		
WellCare	100%	100%	*High Confidence*	*Not Assessed*[4]		

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.
[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
[4] **Not Assessed**—HSAG did not assess Step 9 for those health plans that only reported baseline data.

As shown in Table 26 above, three of the five health plans (**AmeriHealth**, **Healthy Blue**, and **WellCare**) received *High Confidence* for the overall validation status with the final validation. Two of the health plans (**Carolina Complete** and **UnitedHealthcare**) received a *Low Confidence* rating.

The performance indicator for the nonclinical PIPs varied by SP. Table 27 displays the baseline data as reported by each SP.

Table 27—2024 Outcomes for the *HRRN* PIPs

SP	Performance Indicator	Baseline (1/1/2023–12/31/2023)
AmeriHealth	The percentage of members with a successful screening within the calendar year.	2.51%
Carolina Complete	The percentage of members with a successful survey completed within the calendar year.	3.8%
Healthy Blue	The percentage of successful screenings completed from January 1st to December 1st of the MY.	2.28%
UnitedHealthcare	The rate of HRRN screenings completed within the calendar year.	6.81%
WellCare	HRRN successful screening within the calendar year.	14.26%

As shown in Table 27 above, for the *HRRN* PIPs, the baseline results ranged from 2.51 percent to 14.26 percent for successful screening completion.

PIHPs: *FUH* PIP

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 28 displays the validation scores and confidence levels HSAG assigned to each PIHP's *FUH* PIP.

Table 28—2024 *FUH* PIP Validation Results

PIHP	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Alliance	100%	100%	*High Confidence*	*Not Assessed*[4]		
Partners	92%	100%	*High Confidence*	*Not Assessed*[4]		
Trillium	100%	100%	*High Confidence*	*Not Assessed*[4]		
Vaya Health	100%	100%	*High Confidence*	*Not Assessed*[4]		

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.
[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
[4] **Not Assessed**—HSAG did not assess Step 9 for those health plans that only reported baseline data.

As shown in Table 28 above, all the PIHPs received a *High Confidence* for Validation Rating 1 for the *FUH* PIP design in 2024. During 2024, the *FUH* PIP had not progressed to providing remeasurement data, therefore, Validation Rating 2 was *Not Assessed.*

PIHPs: *FUM* PIP

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 29 displays the validation scores and confidence levels HSAG assigned to each PIHP's *FUM* PIP.

Table 29—2024 *FUM* PIP Validation Results

PIHP	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Alliance	100%	100%	*High Confidence*	*Not Assessed*[4]		
Partners	92%	100%	*High Confidence*	*Not Assessed*[4]		
Trillium	100%	100%	*High Confidence*	*Not Assessed*[4]		
Vaya Health	100%	100%	*High Confidence*	*Not Assessed*[4]		

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[4] **Not Assessed**—HSAG did not assess Step 9 for those health plans that only reported baseline data.

As shown in Table 29 above, all the PIHPs received a *High Confidence* for Validation Rating 1 for the *FUM* PIP design in 2024. During 2024, the *FUM* PIP had not progressed to providing remeasurement data; therefore, Validating Rating 2 was *Not Assessed.*

PIHPs: *TCL* PIP

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 30 displays the validation scores and confidence levels HSAG assigned to each PIHP's *TCL* PIP.

Table 30—2024 *TCL* PIP Validation Results

PIHP	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Alliance	100%	100%	*High Confidence*	*Not Assessed*[4]		
Partners	93%	100%	*High Confidence*	*Not Assessed*[4]		
Trillium	100%	100%	*High Confidence*	*Not Assessed*[4]		
Vaya Health	100%	100%	*High Confidence*	*Not Assessed*[4]		

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[4] **Not Assessed**—HSAG did not assess Step 9 for those health plans that only reported baseline data.

As shown in Table 30 above, all the PIHPs received a *High Confidence* for Validation Rating 1 for the *TCL* PIP design in 2024. During 2024, the *TCL* PIP had not progressed to providing remeasurement data; therefore, Validating Rating 2 was *Not Assessed*.

TP PIPs

As discussed in the introduction, the TPs launched in July 2024; therefore, the Department suspended PIP reporting for TPs. PIPs will be initiated in 2025.

Aim Statements and Interventions

An Aim statement is clear, concise, measurable, and answerable if the statement specifies measurable variables and analytics for a defined improvement strategy, population, and time period. The Aim

statement identifies the focus of the PIP and establishes the framework for data collection and analysis. HSAG assessed the appropriateness and adequacy of each plan's Aim statement.

A plan's success in achieving significant improvement in PIP outcomes is strongly influenced by the improvement strategies and interventions implemented during the PIP. As part of the PIP validation process, HSAG reviewed the interventions employed by the health plans for appropriateness to the barriers identified, and timeliness of the implementation of the interventions.

A description of each plan's Aim statement and interventions can be found in Appendix B.

PIP Statewide Strengths, Opportunities for Improvement, and Recommendations

Statewide strengths and opportunities for improvement related to PIPs are included in Table 5, and recommendations for improvement are included in Table 6. Strengths, opportunities for improvement, and recommendations are included in Section 3.

Performance Measure Validation

Federal regulations at 42 CFR §438.330(c) require states to specify standard performance measures for health plans to include in their comprehensive QAPI programs. Each year, the health plans must measure and report Department-specified performance measure data that enable the State to calculate the standard performance measures. In addition, an EQRO must perform an EQR that includes validation of contracted entity performance measures (42 CFR §438.358[b][1][ii]).

HSAG validated rates for a set of performance measures selected by DHB for validation. SPs were required to report only using the administrative methodology for DHB-selected measures in the scope of PMV, and they were required to apply measure specifications in accordance with the selected specification stewards.

HSAG also conducted an Information Systems Capabilities Assessment (ISCA) activity in accordance with 42 CFR §438.350(a) for four PIHPs in North Carolina in preparation for the PIHPs to report performance measures in MY 2025.

The TPs launched July 1, 2024; therefore, they were not included in PMV during this reporting cycle and will be reviewed in 2025.

Objectives

The purpose of PMV is to assess the accuracy of performance measures reported by the SPs and to determine the extent to which performance measures reported by the SPs follow State specifications and reporting requirements and validate the data collection and reporting processes the health plans used to calculate the performance measure rates. The purpose of the ISCA activity is to assess the capacity of the PIHPs' information systems to collect, process, and maintain data that will be used for reporting performance measures in future years.

Technical Methods of Data Collection and Analysis

HSAG conducted the PMV activities, which focused on assessing and evaluating the SPs' performance measure calculation and reporting. The scope of PMV activities evaluated the SPs' data integration, information systems, and measure calculation processes through the collection of information using the Information Systems Capabilities Assessment Tool (ISCAT). In addition, HSAG evaluated the SPs' information systems and processes specific to producing performance measure rates on a set of measures selected by DHB for MY 2022 and MY 2023. The ISCA activities evaluated the PIHPs' information systems used to collect, process, and maintain PIHP performance measure data in accordance with CMS EQR Protocol 2.

The Department selected 12 measures for the SPs to report using the HEDIS *Measurement Year 2022 Volume 2: Technical Specifications for Health Plans, HEDIS Measurement Year 2023 Volume 2: Technical Specifications for Health Plans,* Pharmacy Quality Alliance (PQA) measure specifications and guidelines, and DHB-specific measure specifications and guidelines. The Department selected eight measures for the PIHPs to report using the *HEDIS Measurement Year 2023 Volume 2: Technical Specifications for Health Plans*, PQA measure specifications and guidelines, University of Southern California (USC) measure specifications, and DHB-specific measure specifications and guidelines for MY 2023.

Results

SP PMV Results

There are several aspects crucial to the calculation of performance measure data. These include data integration, data control, and documentation of performance measure calculations. Overall, HSAG determined that the data integration processes, data control processes, and documentation of performance measure generation were **Acceptable** for all SPs for MY 2022 and MY 2023. Details of the validation process and findings for data integration, data control, and performance measure documentation were included in health plan-specific reports.

HSAG evaluated the SPs' data systems for processing the following data types used for reporting performance measure data: claims and encounters data processing, membership/eligibility data processing, case management data processing, data integration, and provider data processing. HSAG identified **no concerns** with the SPs' systems or processes for any of the data types.

Based on all validation activities, HSAG determined results for each of the validated performance measures. The CMS PMV protocol identifies four possible validation finding designations for performance measures, which are defined in Table 31 below.

Table 31—Designation Categories for Performance Measures

Designation	Definition
Reportable (R)	Measure was compliant with measure specifications.
Do Not Report (DNR)	SP rate was materially biased and should not be reported.

Designation	Definition
Not Applicable (NA)	The SP was not required to report the measure.
Not Reported (NR)	Measure was not reported because the SP did not offer the required benefit.

According to the protocol, the validation designation for the measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be not compliant based on the review findings. Consequently, an error for a single audit element may result in a designation of *DNR* because the impact of the error biased the reported performance measures by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, and the measure could be given a designation of *R*. Table 32 displays the measure-specific review finding and designation for MY 2022. Table 33 displays the measure-specific review finding and designation for MY 2023.

Table 32—MY 2022 Measure-Specific Review Findings and Designations for SPs

Performance Measure*	Specifications Steward	Validation Rating
Controlling High Blood Pressure (CBP)	NCQA	R
Cervical Cancer Screening (CCS)	NCQA	R
Chlamydia Screening in Women (CHL) —Total	NCQA	R
***Childhood Immunization Status (CIS) —Combo 10*	NCQA	R
Concurrent Use of Prescription Opioids and Benzodiazepines (COB)	PQA	R
Follow-Up After Hospitalization for Mental Illness (FUH)	NCQA	R
Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD)	NCQA	R
Rate of Screening for Health-Related Resource Needs (HRRN)	DHB	R
***Immunizations for Adolescents (IMA) —Combination 2*	NCQA	R
Prenatal and Postpartum Care (PPC)	NCQA	R
***Well-Child Visits in the First 30 Months of Life (W30)*	NCQA	R
Child and Adolescent Well-Care Visits (WCV)	NCQA	R

* DHB has approved reporting using the administrative methodology only.

**DHB has approved the application of continuous enrollment criteria for all measures in the scope of PMV. However, DHB acknowledges that rates may be low for *CIS—Combo 10*, *IMA—Combination 2*, and *W30* due to the mid-MY launch on July 1, 2021, into managed care, which may impact the SPs' ability to meet continuous enrollment criteria for these measures during MY 2022.

Table 33—MY 2023 Measure-Specific Review Findings and Designations for SPs

Performance Measure Name	Specifications Steward	Validation Rating
Controlling High Blood Pressure (CBP)	NCQA	R
Screening for Depression and Follow-Up Plan (CDF)	CMS	R
Childhood Immunization Status (CIS) — Combo 10	NCQA	R
Concurrent Use of Prescription Opioids and Benzodiazepines (COB)	PQA	R
Colorectal Cancer Screening (COL)	NCQA	R
**Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Screening Ratio*	DHHS	R
Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD)	NCQA	R
** Rate of Screening for Health-Related Resource Needs (HRRN)*	DHHS	R
Immunizations for Adolescents (IMA) — Combination 2	NCQA	R
Prenatal and Postpartum Care (PPC)	NCQA	R
Well-Child Visits in the First 30 Months of Life (W30)	NCQA	R
Child and Adolescent Well-Care Visits(WCV)	NCQA	R

*SPs and/or SP Vendors were responsible for conducting the SDOH screenings and submitting all SDOH screening data in the BCM026 file to DHHS. SPs were also responsible for reporting EPSDT screening encounter data to DHB. DHB then calculated *HRRN* and *EPSDT Screening Ratio* performance measure rates on behalf of each SP.

PIHP PMV Results

HSAG determined that the data integration processes, data control processes, and information systems documentation were **Acceptable** for all PIHPs for MY 2023 and deemed the PIHPs were ready to report these measures in MY 2024. Table 34 displays the measures that were the focus of the readiness review activity for the PIHPs. Since performance measure rates were not required for MY 2023, HSAG assessed the PIHPs' systems and processes for enrollment/eligibility data, claims/encounters, provider data, care management data, and supplemental data collection.

Table 34—MY 2023 PIHP Performance Measures

Performance Measure Name	Specifications Steward	Measurement Period
Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)	NCQA	MY 2023
Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	MY 2023

Performance Measure Name	Specifications Steward	Measurement Period
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	NCQA	MY 2023
Concurrent Use of Prescription Opioids and Benzodiazepines (COB)	PQA/CMS	MY 2023
Continuity of Pharmacotherapy for Opioid Use Disorder	USC	MY 2023
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	NCQA	MY 2023
Follow-Up After Hospitalization for Mental Illness (FUH)	NCQA	MY 2023
Rate of Screening for Health-Related Resource Needs (HRRN)	DHB	MY 2023

PMV Statewide Strengths, Opportunities for Improvement, and Recommendations

Statewide strengths and opportunities for improvement related to PMV are included in Table 5, and recommendations for improvement are included in Table 6. Strengths, opportunities for improvement, and recommendations are included in Section 3.

Performance Measure Results

Validated performance measure data results are reported in Appendix A—Methodology.

Compliance Monitoring Review

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 health plan'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 accordance with §438.358, HSAG conducted the Compliance Review on a full set of standards for each SP during calendar year (CY) 2023, thereby completing the required evaluation of the administrative and compliance process once in a three-year period. However, the full review was not completed before the end of the reporting period for the prior technical report; therefore, results are presented in this report.

The PIHPs launched in July 2023, and the TPs launched in July 2024; the first Compliance Review for both programs will be conducted in CY 2025.

Objectives

The primary objective of the Compliance Review is to provide meaningful information to DHB and the SPs regarding administrative processes to ensure compliance with federal and state requirements. HSAG used information and data derived from Compliance Reviews to reach conclusions and make recommendations about the quality, timeliness, and accessibility of care of Medicaid services provided to Medicaid enrollees.

Technical Methods of Data Collection and Analysis

The Compliance Review was conducted in two overall phases: initial review and remediation. In the initial review, HSAG completed a desk review of documents submitted by the health plan and conducted file reviews. A webinar review was then conducted with the health plan to clarify desk review and file review results. During the webinar, HSAG also assessed whether health plan staff were knowledgeable about the requirements, policies, and procedures. Following the initial review, HSAG produced a health plan-specific initial Compliance Review Report of Findings, which listed each element for which HSAG assigned a score of *Not Met*, as well as the associated findings and recommendations to bring the health plan's performance into full compliance with the requirement. DHB required the health plans to remediate each element for which HSAG assigned a score of *Not Met*. The health plans had a 30-day remediation period in which to submit additional documentation or implement policies and procedures that met the requirements. HSAG then assessed all remediation elements to determine if compliance with the requirements had been met and assigned a **final** score, which is included in this final Compliance Review report.

For any elements that remained out of compliance following remediation, HSAG will conduct a focused review[9] with the health plan. DHB and HSAG will monitor each health plan's progress toward correcting deficiencies.

Additional details about the methodology are in Appendix A—Methodology.

Standards

Table 35 displays the full set of standards for the Compliance Review, which also included a series of file reviews to assess compliance in various standards, as shown in Table 35.

Table 35—CY 2023 Full Set of Standards for the Three-Year Period: CY 2023–CY 2025

Standard #	Standard Name	File Reviews
I	Enrollment and Disenrollment	
II	Enrollee Rights and Confidentiality	Member Rights Checklist
III	Member Information	Member Handbook Checklist

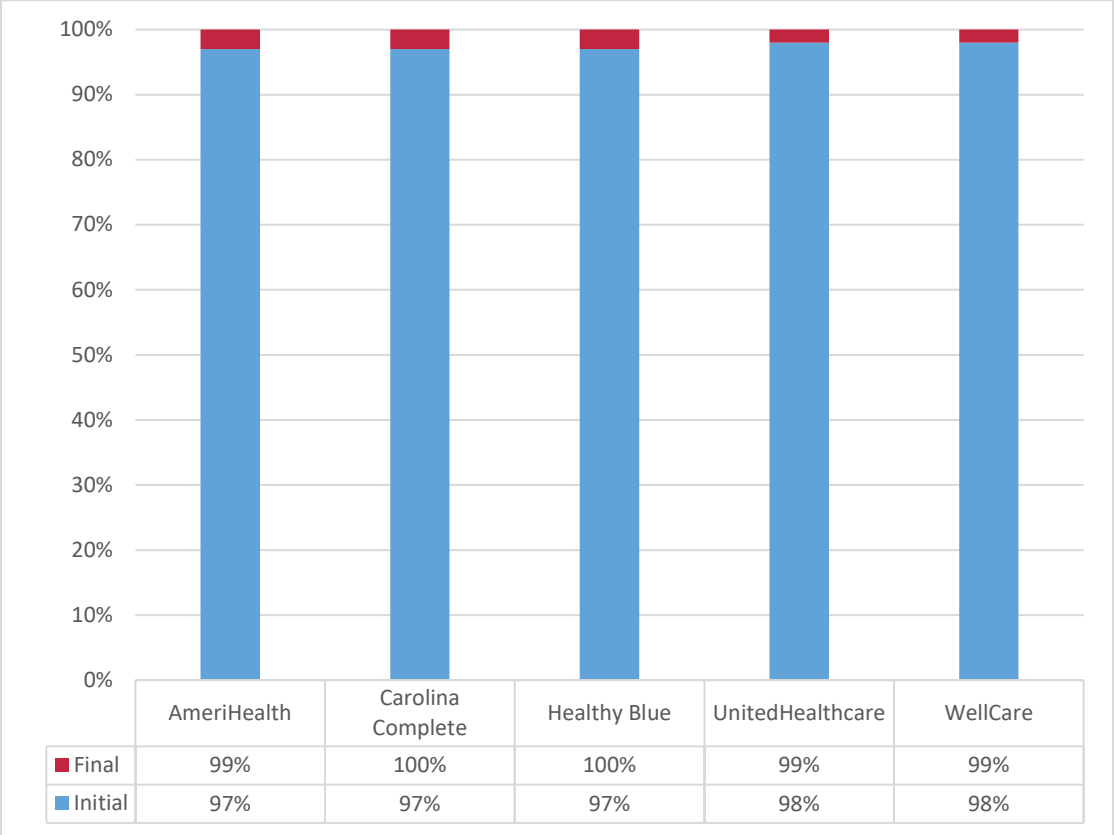
[9] Focused review is an EQRO activity to ensure oversight and monitoring of actions taken by the health plan to address noncompliance. DHB retains the right to impose any formal or informal action to improve performance as outlined in 42 CFR 438.66.

Standard #	Standard Name	File Reviews
IV	Emergency and Poststabilization Services	
V	Adequate Capacity and Availability of Services	
VI	Coordination and Continuity of Care	Care Management Record Review
VII	Coverage and Authorization of Services	Denial File Review
VIII	Provider Selection and Program Integrity	
IX	Subcontractual Relationships and Delegation	
X	Practice Guidelines	
XI	Health Information Systems	
XII	Quality Assessment and Performance Improvement Program	
XIII	Grievance and Appeal Systems	Grievance File Review Appeal File Review

Results for Compliance Review

Figure 2 displays the overall initial and final SP-specific compliance scores for all standards reviewed.

Figure 2—Overall Compliance Ratings by SP



As shown in Figure 2, all SPs achieved a final compliance score of 99 percent or 100 percent. The SPs were generally compliant with policies and procedures as well as file reviews. The health plans were provided an opportunity to remediate elements that did not achieve a score of 100 percent on initial review.

Compliance Review Statewide Strengths, Opportunities for Improvement, and Recommendations

Statewide strengths and opportunities for improvement related to compliance review are included in Table 5, and recommendations for improvement are included in Table 6. Strengths, opportunities for improvement, and recommendations are included in Section 3.

Validation of Network Adequacy

DHB contracted with HSAG to conduct network adequacy validation (NAV) for the SPs and PIHPs (as TPs launched in July 2024, they were not reviewed and will be included in 2025 activities). Title 42 of the Code of Federal Regulations (42 CFR) §438.350(a) requires States that contract with managed care organizations to have a qualified EQRO perform an annual EQR that includes NAV to ensure provider networks are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across the continuum of services. HSAG conducted NAV, validating the systems and processes, data sources,

methods, and results, according to the CMS EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity,* February 2023 (CMS EQR Protocol 4).[10]

HSAG worked with DHB to identify applicable quantitative network adequacy standards by provider and health plan type to be validated. Information such as description of network adequacy data and documentation, information flow from health plans to the State, prior year NAV reports, and additional supporting information relevant to network adequacy monitoring and validation were obtained from the State and incorporated into all phases of validation activities.

The purpose of NAV is to assess the accuracy of the state-defined network adequacy indicators reported by the health plans and to evaluate the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, systems and processes used, and determine the overall validation rating, which refers to the overall confidence that acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators, as established by the State. If States elect to calculate network adequacy results for each health plan, the EQRO will validate the indicator level results produced by the State, as if they were calculated by the health plan and validate the systems and processes, as well as source data provided to the State, to inform network adequacy analysis activities.

Objectives and Technical Methods of Data Collection and Analysis

HSAG was responsible for conducting the fiscal year 2024 NAV indicators, confirming DHB and the health plans' ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support the health plans' and DHB's network adequacy monitoring efforts.

HSAG completed the following CMS EQR Protocol 4 activities to conduct the NAV:

- **Defined the scope of the validation of quantitative network adequacy standards:** HSAG obtained information from the State (i.e., network adequacy standards, descriptions and samples of documentation the health plans submit to the State, a description of the network adequacy information flow, and any prior NAV reports), then worked with the State to identify and define network adequacy indicators and provider types, and to establish the NAV activities and timeline.
- **Identified data sources for validation:** HSAG worked with the State and health plans to identify NAV-related data sources and to answer clarifying questions regarding the data sources.
- **Reviewed information systems underlying network adequacy monitoring:** HSAG reviewed any previously completed health plan Information Systems Capabilities Assessments (ISCAs), then assessed processes for collecting network adequacy data that were not addressed in the ISCA, completed a comprehensive NAV ISCA by collecting an updated Information Systems Capabilities

[10] U.S. Department of Health and Human Services, CMS. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 4, 2024.

Assessment Tool (ISCAT) from DHB and each health plan, and interviewed DHB and health plan staff or other personnel involved in production of network adequacy results.

- **Validated network adequacy assessment data, methods, and results:** HSAG used the CMS EQR Protocol 4 Worksheet 4.6 to document each health plan's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its networks, and produce accurate results that support the health plans' and the State's network adequacy monitoring efforts. When evaluating DHB and the health plans for this validation step, HSAG assessed data reliability, accuracy, timeliness, and completeness; DHB's and the health plans' methods to assess network adequacy; and the validity of the network adequacy results that DHB and the health plans submitted. HSAG summarized its network adequacy indicator-level validation findings resulting in a *Low Confidence* or *No Confidence*, designation in the individual health plan-specific sections of this report.
- **Communicated preliminary findings to each health plan:** HSAG communicated preliminary NAV findings to DHB and each health plan that included findings, preliminary validation ratings, areas of potential concern, and recommendations for improvement. The DHB and each health plan were provided the opportunity to correct any preliminary report omissions and/or errors.
- **Submitted the NAV findings to the State in the form of the NAV aggregate report:** HSAG used the state-approved NAV aggregate report template to document the NAV findings and submitted the draft and final NAV aggregate report according to the state-approved timeline.

For additional details on the NAV methodology, please see Appendix A—Methodology.

Results for NAV

PIHP Analysis and Conclusions

HSAG assessed DHB's calculated results at the county level for the PIHP time/distance standards. DHB required that at least 95 percent of beneficiaries have access to each service type within the associated time/distance parameters for urban and rural county classifications. **Partners** was the only PIHP that was observed to be compliant for all service types and urbanicities. **Alliance**, **Trillium**, and **Vaya** PIHPs were observed to have county-level service type deficiencies. Adult and child partial hospitalizations were all observed to be noncompliant across all three health plans. Table 36 displays compliance by service type for the time/distance standard, and Table 37 displays the PIHPs with service type deficiencies.

Table 36—PIHP—Network Adequacy Time/Distance Standard Compliance

Service Type	Urbanicity	Compliance
Adult Outpatient BH Services	Rural	County-level *Not Met**
	Urban	*Met*
Child Outpatient BH Services	Rural	County-level *Not Met**
	Urban	*Met*
Location-Based Services—OTP	Rural	County-level *Not Met**
	Urban	*Met*

Service Type	Urbanicity	Compliance
Location-Based Services—Psychosocial Rehabilitation	Rural	County-level *Not Met**
	Urban	County-level *Not Met**
Location-Based Services—SACOT	Rural	County-level *Not Met**
	Urban	*Met*
Adult Location-Based Services—SAIOP	Rural	County-level *Not Met**
	Urban	County-level *Not Met**
Child Location-Based Services—SAIOP	Rural	County-level *Not Met**
	Urban	*Met*
Adult Partial Hospitalization	Rural	County-level *Not Met**
	Urban	County-level *Not Met**
Child Partial Hospitalization	Rural	County-level *Not Met**
	Urban	County-level *Not Met**

*Standard not met for a subset of counties.

Table 37—PIHP—Network Adequacy Time/Distance Standards Noncompliance by PIHP

PIHP	Service Type	Category/Specialty
Alliance	Partial Hospitalization	Adult Partial Hospitalization Child Partial Hospitalization
Trillium	Location-Based Services	OTP Psychosocial Rehabilitation SACOT
	Outpatient BH Services	Adult—Outpatient BH Services Child—Outpatient BH Services
	Partial Hospitalization	Adult Partial Hospitalization Child Partial Hospitalization
Vaya	Location-Based Services	OTP Psychosocial Rehabilitation SACOT SAIOP (Adult) SAIOP (Child)
	Partial Hospitalization	Adult Partial Hospitalization, Child Partial Hospitalization

HSAG assessed DHB's submitted results for the PIHP provider capacity service type standards. HSAG observed that all four PIHPs met the standards for the 1915(c) HCBS Waiver Services: NC Innovations service type. Table 38 displays the provider capacity service types and service type categories that were reported as deficient for each PIHP catchment area.

Table 38—PIHP—Network Adequacy Provider Capacity Standards Noncompliance

Service Type	Service Type Category	PIHP
1915(i) HCBS	Community Living and Support	**Alliance**, **Trillium**
	Individual and Transitional Support	
	Respite	
	Supported Employment	
Community/Mobile Services	Assertive Community Treatment (Adult)	**Trillium**
	Community Support Team (Adult)	**Vaya**
	Intensive In-Home Services (Child)	
Crisis Services	Ambulatory Withdrawal Management With Extended On-Site Monitoring (Adult)	**Alliance**, **Partners**, **Trillium**
	Facility-Based Crisis Services for Children and Adolescents (Child)	**Trillium**
	Ambulatory Detoxification (Adult)	**Alliance**, **Trillium**
Inpatient BH Services	Acute Care Hospitals With Adolescent Inpatient Substance Use Beds (Adolescent)	**Vaya**
Residential Treatment Services	Substance Abuse Non-Medical Community Residential Treatment (Adolescent)	**Partners**
	Substance Abuse Non-Medical Community Residential Treatment (Adult)	**Alliance**
	Substance Abuse Non-Medical Community Residential Treatment (Child)	**Partners**

SP Analysis and Conclusions

HSAG assessed DHB's calculated results across all SPs for the time/distance standard. HSAG observed that all SPs were compliant for the Adult and Child Partial Hospitalization (BH), Adult and Child Outpatient BH Services, and Adult and Child Primary Care service types, across all urbanicities. Table 39 displays compliance by service type for the time/distance standard. HSAG observed deficiencies across all six SPs in the Child Specialist service type, displayed in Table 40.

Table 39—SP—Network Adequacy Time/Distance Standard Compliance

Service Type	Urbanicity	Compliance
Hospitals	Rural	County-level *Not Met**
	Urban	*Met*
Adult Partial Hospitalization (BH)	Rural	*Met*

Service Type	Urbanicity	Compliance
	Urban	*Met*
Child Partial Hospitalization (BH)	Rural	*Met*
	Urban	*Met*
Location-Based Services	Rural	County-level *Not Met**
	Urban	*Met*
Obstetrics	Rural	County-level *Not Met**
	Urban	*Met*
Occupational, Physical, or Speech Therapists	Rural	County-level *Not Met**
	Urban	*Met*
Adult Outpatient BH Services	Rural	*Met*
	Urban	*Met*
Child Outpatient BH Services	Rural	County-level *Not Met**
	Urban	*Met*
Pharmacies	Rural	County-level *Not Met**
	Urban	*Met*
Primary Care (Adult)	Rural	*Met*
	Urban	*Met*
Primary Care (Child)	Rural	*Met*
	Urban	*Met*
Specialists (Adult)	Rural	County-level *Not Met**
	Urban	County-level *Not Met**
Specialists (Child)	Rural	County-level *Not Met**
	Urban	County-level *Not Met**

*Standard not met for the subset of counties.

Table 40—SP—Time/Distance Child Specialist Deficiencies: All SPs Under 95 Percent

Service Type	Deficient Specialist Type Under 95%		
Specialist (Child)	Allergy/Immunology Endocrinology Gastroenterology	Hematology Infectious Disease Nephrology	Neurology Oncology Rheumatology

HSAG assessed DHB's submitted results for the SPs' provider capacity service type standards. HSAG observed all six SPs were compliant for the Inpatient BH Services and Nursing Facilities service types for all applicable counties. Table 41 displays the provider capacity service types and service type categories that did not meet DHB's requirements.

Table 41—SP—Network Adequacy Provider Capacity Standards Noncompliance Without Exceptions

Service Type	Service Type Categories	SP
Crisis Services	Crisis Services	**AmeriHealth Carolina Complete UnitedHealthcare**
All State Health Plan LTSS	Home Care—Personal Care Services	**Carolina Complete Healthy Blue**
	Home Health—Home Health Services	**Carolina Complete Healthy Blue UnitedHealthcare**
	Home Health—Hospice Services	**Carolina Complete Healthy Blue WellCare**
	Home Health—Private Duty Nursing Services	**Carolina Complete Healthy Blue**

Network Adequacy Validation Statewide Strengths, Opportunities for Improvement, and Recommendations

Statewide strengths and opportunities for improvement related to network adequacy are included in Table 5, and recommendations for improvement are included in Table 6. Strengths, opportunities for improvement, and recommendations are included in Section 3 for SPs and PIHPs. The TPs launched July 1, 2024; therefore, they were not within scope of EQR activities during this reporting cycle.

Optional EQR Activities

Beneficiary Experience With Care

The Department contracted with HSAG to administer and report the results of the CAHPS Health Plan Surveys and HCBS CAHPS Survey for the adult Medicaid, child Medicaid, and adult HCBS populations.[11]

The standardized survey instruments selected for the 2023 CAHPS survey included:

- CAHPS 5.1 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set.

[11] The Adult and Child CAHPS questionnaires were developed under cooperative agreements among AHRQ, Harvard Medical School, RAND Corporation, and the Research Triangle Institute (RTI) and are used as a national standard for assessing members' healthcare experience. The HCBS CAHPS survey was developed by CMS for voluntary use by state Medicaid programs.

- CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and without the children with chronic conditions (CCC) measurement set.
- HCBS CAHPS survey without the Supplemental Employment module.[12]

The adult and child CAHPS surveys include a set of measures that can be classified as:

- Global ratings (ratings of beneficiary experience on a scale of 0 to 10).
- Composite measures (groups of related questions that are combined to form a composite).
- Individual measures (based on a single question).

The HCBS CAHPS survey includes a set of measures that can be classified as:

- Global ratings (ratings of beneficiary experience on a scale of 0 to 10).
- Composite measures (groups of related questions that are combined to form a composite).
- Recommendation measures (individual measures which ask how likely the beneficiary is to recommend a service).
- Unmet need measures (individual measures that identify if needs were not being met because of a lack of help).
- Physical safety measure (individual measure assessing the beneficiary's physical safety).

[12] Due to concerns identified by the CAHPS Consortium that the cognitive screening questions hindered data collection, these questions were asked but did not stop the survey if the member failed the cognitive screening questions.

Objectives

The goals of the adult and child CAHPS surveys are to provide performance feedback that is actionable and will aid in improving overall care. The CAHPS surveys ask adult beneficiaries or the parents/caretakers of child beneficiaries to report on and evaluate their experiences with their/their child's healthcare services in the last six months. These surveys cover topics that are important to beneficiaries, such as the communication skills of providers and the accessibility of services. The goal of the HCBS CAHPS survey is to gather direct feedback from Medicaid beneficiaries receiving HCBS about their experiences and the quality of the LTSS they receive.

Survey Populations

Adult and Child CAHPS

HSAG administered the 2023 adult and child CAHPS surveys to members in the five SPs. In addition, HSAG also administered the adult and child surveys to five specific NC Medicaid populations in 2023. These populations included:

- Individuals enrolled in a SP receiving behavioral health services (i.e., Standard Plan [SP] Behavioral Health population).
- Federally recognized tribal members and others eligible for services through Indian Health Service (IHS) associated only with the **Eastern Band of Cherokee Indians** (**EBCI**) who are enrolled in the **EBCI Tribal Option**.[13]
- Beneficiaries receiving healthcare through NC Medicaid Direct (formally known as fee-for-service).[14]
- Current NC Medicaid Direct enrollees who would qualify for TPs (TP Eligible) who have mental health needs, intellectual/developmental disabilities (I/DD), traumatic brain injuries (TBIs), or severe substance use disorders.[15]
- Child Medicaid Direct beneficiaries who are in foster care.

HSAG grouped adult and child respondents to create aggregate results for comparative purposes:

- NC Medicaid Program—Combined results of all five SPs, **EBCI Tribal Option**, and Medicaid Direct. For the child NC Medicaid Program, this aggregate also includes the Foster Care population.
- NC SP Aggregate—Combined results of all five SPs.

[13] The **EBCI Tribal Option** is a health plan managed by the Cherokee Indian Health Authority (CIHA). The tribal option manages beneficiaries primarily in Cherokee, Graham, Haywood, Jackson, and Swain counties.

[14] The Medicaid Direct population is composed of former foster youth, foster child or using adoption services, dual eligibles, waiver populations, and people that opted for Medicaid Direct.

[15] TPs, once implemented, will offer integrated physical health, pharmacy, care coordination, and behavioral health services for members who may have significant mental health needs, I/DD, TBIs, or severe substance use disorders.

Results were used to assess the experience of care for two populations:

- Adult beneficiaries—a general sample of adults (18 years of age or older) from the entire eligible population.
- Child beneficiaries—a general sample of children (17 years of age or younger) from the entire eligible population.

HCBS CAHPS

- HSAG administered the 2023 HCBS CAHPS survey to adult Medicaid beneficiaries who were currently receiving services through the 1915(c) waiver (specifically, the North Carolina Innovations Waiver Program, Community Alternatives Program for Disabled Adults Waiver Program, or Community Alternatives Program for Children Waiver Program) and received at least one qualifying HCBS service, including self-directed services (e.g., personal care service, behavioral health support, homemaker service, case management, community living and supports, or medical transportation). LME-MCOs have provider contracts for supports and services for beneficiaries in the Innovations Waiver. At the time of survey administration, there were six LME-MCOs in NC.[16]

[16] Following survey administration, Sandhills was dissolved, and Eastpointe and Trillium consolidated. The majority of Sandhills Center's counties were consolidated into Eastpointe/Trillium.

Results

Positive ratings were compared to the NCQA's Quality Compass® Benchmark and Compare Quality Data to determine which NCQA national percentile range the scores fell within.[17,18] Using the percentile distributions shown in Table 42, a star rating was assigned from one (★) to five (★★★★★) stars, where one star is below the national 25th percentile and five stars is greater than or equal to the national 90th percentile.

Table 42—NCQA National Percentile Distributions Used to Assign Star Ratings

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

Adult CAHPS Results

NC Medicaid Program, NC SP Aggregate, SP, and population-specific positive ratings were compared to NCQA's 2023 Quality Compass Benchmark and Compare Quality Data to determine which NCQA national percentile range the scores fell within.

Table 43 shows the positive ratings and star ratings based on a comparison to NCQA national percentiles for each of the global ratings.[19]

[17] Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[18] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023.* Washington, DC: NCQA, September 2023. Quality Compass® 2023 data are used with the permission of NCQA. Quality Compass 2023 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA.

[19] The positive rating score only looks at the percentage of positive results and does not use all the response options in calculating the results, which can lead to a less accurate measure of experience (e.g., does one health plan have a higher percentage of members that can never get the care they needed compared to other health plans). Robert Wood Foundation. *How to Report Results of the CAHPS Clinician & Group Survey*. Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/cg/cgkit/HowtoReportResultsofCGCAHPS080610FINAL.pdf. Accessed on: June 4, 2024.

Table 43—Adult Respondent Percentage of Positive Ratings and Star Ratings When Compared to NCQA National Percentiles, by Program-Specific Populations: Global Ratings (2023)

SP/Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
NC Medicaid Program	★★ **76.75%**	★★★★ **78.16%**	★★★★ **86.63%**	★★★★ **86.37%**
NC SP Aggregate	★ **73.96%**	★★★★ **78.57%**	★★★ **83.97%**	★★★ **84.26%**
AmeriHealth	★ 70.76%	★★★ 76.47%	★★★ 84.03%	★★ 80.45%
Carolina Complete	★★ 74.89%	★★ 73.68%	★★★ 83.00%	★★★ 83.64%
Healthy Blue	★★ 76.17%	★★★★ 79.61%	★★★★ 86.19%	★★★ 84.33%
UnitedHealthcare	★ 72.58%	★★★★ 78.13%	★★★ 83.72%	★★★★ 86.27%
WellCare	★ 74.63%	★★★★★ 82.31%	★★ 81.90%	★★★★ 85.71%
SP Behavioral Health	★ 69.26%	★ 68.98%	★ 79.95%	★★★ 83.27%
EBCI Tribal Option	★★ 74.77%	★★+ 72.37%	★★+ 80.90%	★★★+ 83.33%
NC Medicaid Direct	★★★ 78.74%	★★★★ 77.88%	★★★★★ 88.54%	★★★★★ 87.88%
TP Eligible	★ 72.88%	★★ 74.69%	★★★★ 86.39%	★★★ 83.25%

+ Indicates fewer than 100 respondents in the denominator. Caution should be exercised when evaluating these results. Positive rating is equivalent to the top-box score used by other states that contribute to national data.

Table 44 shows the positive ratings and star ratings based on a comparison to NCQA national percentiles for each of the composite measures.

Table 44—Adult Respondent Percentage of Positive Ratings and Star Ratings When Compared to NCQA National Percentiles, by Program-Specific Populations: Composite Measures (2023)

SP/Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
NC Medicaid Program	★★★★ **85.95%**	★★★★ **85.19%**	★★★ **93.83%**	★★★★ **91.90%**
NC SP Aggregate	★★★ **82.96%**	★★★ **83.72%**	★★★ **93.60%**	★★ **88.19%**
AmeriHealth	★★★ 81.79%	★★ 80.53%	★★★★ 94.22%	★ 84.82%
Carolina Complete	★★★ 82.78%	★★★★★ 87.71%	★★★ 93.23%	★★ 88.23%
Healthy Blue	★★★ 83.30%	★★★★ 86.93%	★★★ 93.93%	★ 85.77%
UnitedHealthcare	★★★ 83.03%	★★★ 83.65%	★★★★ 94.69%	★★★ 90.43%
WellCare	★★★ 83.55%	★★ 79.99%	★★ 91.76%	★★★★ 91.88%
SP Behavioral Health	★★ 79.11%	★★★ 82.07%	★ 90.48%	★ 83.62%
EBCI Tribal Option	★★★★★+ 87.47%	★★★+ 81.57%	★★★+ 92.83%	★★★★★+ 93.10%
NC Medicaid Direct	★★★★★ 88.07%	★★★★ 86.24%	★★★ 94.00%	★★★★★ 94.54%
TP Eligible	★★★ 84.20%	★★★ 83.51%	★★★★ 95.04%	★ 87.27%

+ Indicates fewer than 100 respondents in the denominator. Caution should be exercised when evaluating these results. Positive rating is equivalent to the top-box score used by other states that contribute to national data.

Table 45 shows the positive ratings and star ratings based on a comparison to NCQA national percentiles for the individual items and medical assistance with smoking and tobacco use items.

Table 45—Adult Respondent Percentage of Positive Ratings and Star Ratings When Compared to NCQA National Percentiles, by Program-Specific Populations: Individual Items and Medical Assistance With Smoking and Tobacco Use Cessation Items (2023)

SP/Population	Coordination of Care	Flu Vaccination Received	Advising Smokers and Tobacco Users to Quit	Discussing Cessation Medications	Discussing Cessation Strategies
NC Medicaid Program	★★★★ **87.66%**	★★★ **42.51%**	★★★★ **78.87%**	★★★ **54.14%**	★★★ **47.15%**
NC SP Aggregate	★★★ **86.02%**	★ **34.69%**	★★★ **76.16%**	★★ **49.11%**	★★ **43.15%**
AmeriHealth	★★★ 86.78%	★★ 35.57%	★★★★ 79.07%	★★ 47.65%	★★ 45.35%
Carolina Complete	★ 82.07%	★★★ 39.09%	★★★ 73.13%	★★ 47.01%	★★ 41.67%
Healthy Blue	★★★ 86.49%	★ 34.55%	★★★ 74.03%	★★ 47.06%	★ 38.56%
UnitedHealthcare	★★★★★ 90.00%	★★ 35.57%	★★★★ 79.05%	★★ 48.98%	★★ 45.95%
WellCare	★★ 83.10%	★ 30.65%	★★★ 75.33%	★★★ 54.36%	★★ 45.27%
SP Behavioral Health	★★ 84.94%	★★ 35.23%	★★★★ 79.82%	★★★★ 57.87%	★★★ 49.07%
EBCI Tribal Option	★+ 79.49%	★★★★★+ 54.55%	★★★★★+ 81.52%	★★★★+ 60.44%	★★★+ 48.89%
NC Medicaid Direct	★★★★ 88.84%	★★★★ 48.06%	★★★★★ 80.79%	★★★★ 57.71%	★★★ 50.00%
TP Eligible	★★★★ 87.56%	★★★ 43.72%	★★★★★ 84.32%	★★★★ 57.92%	★★★★★ 55.19%

+ Indicates fewer than 100 respondents in the denominator. Caution should be exercised when evaluating these results. Positive rating is equivalent to the top-box score used by other states that contribute to national data.

As shown in the tables above, when compared to NCQA national percentiles, NC Medicaid adult beneficiaries reported higher levels of experience across many of the measure domains, with eight of 13 measure rates assigned four or five stars for the NC Medicaid Program; however, SP Aggregate adult members reported lower levels of experience across several of the measure domains, with five of 13 measure rates assigned one or two stars. The *Rating of Health Plan* measure was the lowest-performing

measure across the NC Medicaid Program, NC SP Aggregate, SPs, and populations for the adult population.

Child CAHPS Results

NC Medicaid Program, NC SP Aggregate, SP, and population-specific positive ratings were compared to NCQA's 2023 Quality Compass Benchmark and Compare Quality Data to determine which NCQA national percentile range the scores fell within.

Table 46 shows the positive ratings and star ratings based on a comparison to NCQA national percentiles for each of the global ratings.

Table 46—Child Respondent Percentage of Positive Ratings and Star Ratings When Compared to NCQA National Percentiles, by Program-Specific Populations: Global Ratings (2023)

SP/Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
NC Medicaid Program	★★ **84.43%**	★★★ **88.04%**	★★★ **90.70%**	★★★ **87.03%**
NC SP Aggregate	★★ **85.94%**	★★★ **88.05%**	★★★ **90.63%**	★★★ **87.15%**
AmeriHealth	★ 83.19%	★★ 86.02%	★★ 88.63%	★★★ 86.61%
Carolina Complete	★★★ 87.62%	★★★★ 89.60%	★★★★★ 92.68%	★★★★ 89.57%
Healthy Blue	★★★ 86.88%	★★★★★ 91.41%	★★★ 91.09%	★★★ 87.60%
UnitedHealthcare	★★★ 87.50%	★★ 84.84%	★★★ 90.40%	★★★+ 88.17%
WellCare	★★ 84.59%	★★★ 87.64%	★★★ 90.72%	★★ 84.62%
SP Behavioral Health	★ 82.65%	★ 82.34%	★ 86.85%	★ 82.89%
EBCI Tribal Option	★+ 76.47%	★+ 79.49%	★+ 85.71%	★+ 81.25%
NC Medicaid Direct	★ 67.07%	★★★ 87.70%	★★★ 90.60%	★★+ 85.71%
TP Eligible	★ 78.66%	★★ 85.09%	★★★ 91.15%	★★★ 87.24%

SP/Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Foster Care	★ 83.25%	★★★★ 89.55%	★★★★★ 93.81%	★★★ 87.46%
+ Indicates fewer than 100 respondents in the denominator. Caution should be exercised when evaluating these results. Positive rating is equivalent to the top-box score used by other states that contribute to national data.				

Table 47 shows the positive ratings and star ratings based on a comparison to NCQA national percentiles for each of the composite and individual item measures.

Table 47—Child Respondent Percentage of Positive Ratings and Star Ratings When Compared to NCQA National Percentiles, by Program-Specific Populations: Composite and Individual Item Measures (2023)

SP/Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Coordination of Care
NC Medicaid Program	★★★ **85.96%**	★★★ **87.95%**	★★★★★ **96.14%**	★★★ **88.73%**	★★★ **84.71%**
NC SP Aggregate	★★★ **85.74%**	★★★ **87.72%**	★★★★ **95.91%**	★★★ **89.18%**	★★★ **84.64%**
AmeriHealth	★★★ 83.62%	★★ 84.13%	★★★ 95.05%	★★★★★ 92.57%	★★★ 84.78%
Carolina Complete	★★★ 85.83%	★★★★★ 91.36%	★★★★★ 97.38%	★★★★★ 92.66%	★★★★★ 92.54%
Healthy Blue	★★★★ 87.77%	★★★ 89.16%	★★★★★ 97.53%	★★★★ 91.10%	★★★ 84.42%
UnitedHealthcare	★★★ 85.29%	★★★ 87.03%	★★★ 93.98%	★+ 84.83%	★★+ 82.47%
WellCare	★★★ 85.35%	★★★ 87.38%	★★★★ 95.54%	★★ 86.01%	★★ 82.10%
SP Behavioral Health	★★★★ 88.54%	★★★★ 90.29%	★★★★★ 96.77%	★★★★ 90.27%	★★★★ 88.30%
EBCI Tribal Option	★★+ 82.23%	★★★+ 88.31%	★★★★★+ 97.62%	★★★★★+ 93.33%	★+ 73.08%
NC Medicaid Direct	★★★★ 88.03%	★★★+ 88.73%	★★★★★ 98.33%	★+ 83.60%	★★★+ 84.88%
TP Eligible	★★★ 85.96%	★★★★ 89.46%	★★★★ 95.51%	★ 85.66%	★★★ 84.24%

SP/Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Coordination of Care
Foster Care	★★★★ 87.99%	★★★★★ 93.93%	★★★★★ 97.82%	★★★ 87.78%	★★★★ 87.74%
+ Indicates fewer than 100 respondents in the denominator. Caution should be exercised when evaluating these results. Positive rating is equivalent to the top-box score used by other states that contribute to national data.					

As shown in Table 46 and Table 47, when compared to NCQA national percentiles, parents/caretakers of child beneficiaries reported better levels of experience across the measure domains, as only one measure rate fell below the 50th percentile for the NC Medicaid Program and NC SP Aggregate. The *Rating of Health Plan* measure was the lowest-performing measure across the NC Medicaid Program, NC SP Aggregate, SPs, and populations for the child population.

HCBS CAHPS Survey

HSAG evaluated the items (i.e., survey questions) that make up each composite measure to determine if there were any individual survey items that comprise the composite measure that had a lower positive rating (i.e., performed poorer) than the other composite items for the NC HCBS Program, as shown in Table 48.[20,21,22]

Table 48—Composite Item Positive Ratings: NC HCBS Program

Composite Measure/Individual Item	Positive Rating
Reliable and Helpful Staff Composite	**87.81%**
Staff on time to work	81.44%
Staff work time supposed to	83.38%
Informed if staff cannot come	87.71%
Staff Listen and Communicate Well Composite	**84.63%**
Staff easy to understand	75.07%
Treated the way you want by staff	84.12%
Staff listen to you	84.14%

[20] The positive rating score only looks at the percentage of positive results and does not use all the response options in calculating the results, which can lead to less accurate measure of experience. Robert Wood Foundation. *How to Report Results of the CAHPS Clinician & Group Survey*. Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/cg/cgkit/HowtoReportResultsofCGCAHPS080610FINAL.pdf. Accessed on June 3, 2024.

[21] The 2023 HCBS CAHPS survey administration yielded a low number of completed surveys. Known challenges with the survey instrument (e.g., length of the survey) and population surveyed may have contributed to a low number of responses. Please exercise caution when interpreting results due to the low number of completed surveys (n=494 completed surveys).

[22] For this report, only the composite positive ratings are displayed. Detailed results on the other response categories were reported in the 2023 North Carolina HCBS CAHPS Survey full report.

Composite Measure/Individual Item	Positive Rating
Helpful Case Manager Composite	**90.44%**
Contact case manager	89.21%
Helped getting other changes to services	88.24%*
Choosing the Services that Matter to You Composite	**81.31%**
Plan included important things	66.59%
Transportation to Medical Appointments Composite	**83.00%**
Timely pickup	70.94%
Personal Safety and Respect Composite	**95.86%**
Someone to talk to	90.42%
Planning Your Time and Activities Composite	**62.52%**
Together with family	50.84%
Together with friends	35.10%
Community	37.35%
* *Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.*	

Overall, respondents reported positive experiences with receiving transportation to medical appointments, their personal safety and respect, and planning their time and activities. Several measures performed at rates higher than the national average. Specifically, respondents felt that they had a way to get to appointments, which contributed to the higher rating for the *Transportation to Medical Appointments* composite measure. Additionally, respondents reported that they felt they had someone to talk to and that staff who help them do not take their money or things, which contributed to the higher rating for the *Personal Safety and Respect* composite measure. Lastly, respondents reported higher positive ratings for feeling like they could get together with their family and friends, had a sense of community, and knew what to do with their time, which contributed to the higher rating for the *Planning Your Time and Activities* composite measure when compared to the CAHPS database benchmark.

Additional Results

The 2023 Adult and Child Medicaid CAHPS Aggregate Report and 2023 HCBS Beneficiary Experience Report contained additional results beyond the results presented above.

CAHPS Statewide Strengths, Opportunities for Improvement, and Recommendations

Statewide strengths and opportunities for improvement related to CAHPS are included in Table 5, and recommendations for improvement are included in Table 6. Strengths, opportunities for improvement, and recommendations are included in Section 4 for SPs and PIHPs. The TPs launched July 1, 2024; therefore, they were not within scope of EQR activities during this reporting cycle.

Encounter Data Validation (EDV)

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, DHB required its SPs to submit high-quality encounter data. During the technical report period, DHB contracted HSAG to conduct an EDV study.

Objectives

- 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*, February 2023 (CMS EQR Protocol 5),[23] HSAG conducted a comparative analysis between DHB's electronic encounter data and the data extracted from the SPs' encounter data systems. The goal of this activity was to evaluate the extent to which the encounter data in DHB's Encounters Processing Solution (EPS) database were complete and accurate for encounters with dates of service between July 1, 2022, and June 30, 2023. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in the CMS EQR Protocol 5.

Results

Record Completeness

HSAG determined the percentage of records present in the health plan-submitted files that were not found in DHB's files (record omission) and the percentage of records present in DHB's files but not present in the health plan-submitted files (record surplus). Overall, record omission and surplus rates were low, with only a few instances where rates were greater than 5.0 percent.

Key findings included:

- **AmeriHealth** had high record omission rates for both professional and institutional encounters (7.6 percent and 17.4 percent, respectively). These high rates were due to **AmeriHealth** submitting records marked as paid to HSAG, while submitting the same records marked as denied to DHB. The EDV study restricted data to paid lines; however, if lines marked as denied that were part of a claim marked as paid at the header level were included in the analysis, both record omission rates for **AmeriHealth** would drop to 0.7 percent or less.
- Professional encounter record surplus rates were high for **UnitedHealthcare** at 13.0 percent, while institutional encounter record surplus rates were high for **Carolina Complete** at 10.9 percent and for **WellCare** at 10.6 percent. For all SPs, the high surplus rates were due to the health plans not submitting all voided records to HSAG. When restricting the surplus rate to final, paid claims, rates would drop to 5.1 percent or less for these instances.
- All record omission and surplus rates for pharmacy encounters were less than 5.0 percent.

[23] U.S. Department of Health and Human Services, CMS. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Aug 9, 2024.

Data Element Completeness and Accuracy

HSAG determined the key data elements for which one or more SPs had either a high element omission rate (the percentage of records with values present in the health plans' submitted data but not in DHB's submitted data), high element surplus rate (the percentage of records with values present in DHB's submitted data but not in the health plans' submitted data), or a low element-level accuracy rate (the percentage of records with the same non-missing values for a given data element in both the DHB's submitted data and the health plans' submitted data).

Key findings for professional encounters included:

- For **AmeriHealth** and **Carolina Complete**, the *Rendering Provider NPI* and *Rendering Provider Taxonomy Code* data elements had high element omission rates. For both plans, nearly all records had the same values populated for both the *Rendering Provider NPI* and *Billing Provider* in the health plan-submitted data when the *Rendering Provider NPI* was missing in the DHB-submitted data. Additionally, whenever *Rendering Provider NPI* was missing in the DHB-submitted data, *Rendering Provider Taxonomy Code* was also missing.
- **Carolina Complete** also had a high element omission rate for the *Referring Provider NPI* data element. In nearly all records in the **Carolina Complete**-submitted data that contained a *Referring Provider NPI* value when the DHB-submitted data did not contain this value, the *Referring Provider NPI* matched the *Rendering Provider NPI*.
- **AmeriHealth** was the only SP to have low element-level accuracy rates. In records with mismatching values for the *Header Paid Amount* and *Detail Paid Amount* data elements, the DHB-submitted data almost always contained a higher value than the health plan-submitted data. Interestingly, nearly all of these records were value-based payment claims.

Key findings for institutional encounters included:

- **UnitedHealthcare** had high element omission rates for the *Detail Service From Date* and *Detail Service To Date* data elements. In the records where the health plan-submitted data contained values when the DHB-submitted data did not contain values, **UnitedHealthcare**'s *Detail Service From Date* matched the *Header Service From Date*, and the *Detail Service To Date* matched the *Header Service To Date*.
- **WellCare** had a high element omission rate for the *Secondary Diagnosis Codes* data element. For the records where DHB's data did not contain *Secondary Diagnosis Codes*, **WellCare**'s *Secondary Diagnosis Codes* data element matched the *Primary Diagnosis Code*.
- **WellCare** had low accuracy rates for the *Header Service To Date* and *Secondary Diagnosis Codes* data elements. For records with mismatching values in the *Header Service To Date* data element, **WellCare** had the same values populated in the *Header Service From Date* and the *Header Service To Date*. For records with mismatching values in the *Secondary Diagnosis Codes* data element, **WellCare**'s data almost always had more *Secondary Diagnosis Codes* than the DHB-submitted data.

- **UnitedHealthcare** had a low accuracy rate for the *Service Units* data element, which was due to a zero value populated in the **UnitedHealthcare**-submitted data but a non-zero value populated in the DHB-submitted data for nearly all records with mismatching values.
- All SPs had low accuracy rates for the *Surgical Procedure Codes* data element. For the discrepant records, plans' data always had a greater number of surgical procedure codes compared to DHB-submitted data.
- **AmeriHealth**, **Carolina Complete**, and **UnitedHealthcare** each had low accuracy rates for the *Type of Bill Code* data element. For the records with mismatching values, the health plans' data almost always differed from the DHB-submitted data in the third digit, which specifies the billing frequency.

Key findings for pharmacy encounters included:

- All SPs had low accuracy rates for the *Days Supply* data element, while **AmeriHealth** and **UnitedHealthcare** also had low accuracy rates for the *Paid Amount* data element. In nearly all records for all SPs that contained a mismatch for both data elements, the DHB-submitted data contained a negative value, whereas the health plan-submitted data contained the same number as a positive value. Interestingly, nearly all of these records were marked as void.

Recommendations

To improve the quality of SPs' encounter data submissions, HSAG offers the following recommendations to assist DHB and the health plans in addressing opportunities for improvement.

- DHB should collaborate with the SPs to investigate root causes of record omission and record surplus rates greater than 5.0 percent.
  - Since all instances of high record omission and record surplus rates were due to voided claims, DHB should collaborate with the SPs to ensure voided claims are submitted correctly.
- DHB should collaborate with the SPs to investigate root causes of element omission and element surplus rates greater than 5.0 percent and accuracy rates lower than 95.0 percent. Doing so will allow DHB and the SPs to address any issues related to encounter data completeness and accuracy.
  - Specifically, DHB should collaborate with the SPs on submission guidelines for *Surgical Procedure Codes* since all SPs submitted more values to HSAG than to DHB for records that had mismatching values.
  - DHB should also ensure SPs submit the third digit (i.e., the frequency code) in the *Type of Bill Code* data element accurately.
  - For pharmacy encounters, DHB should ensure SPs submit voided encounters correctly and accurately, specifically for values populated in the *Days Supply* and *Paid Amount* data elements.

Calculation of Performance Measures

Federal 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 health plans' QAPI programs. HSAG met with the Department and finalized 13 measures for calculation for CY 2023. HSAG calculated the PMs in alignment with the applicable administrative technical specifications and in accordance with CMS EQR *Protocol 7. Calculation of Additional Performance Measures: An Optional EQR-Related Activity,* February 2023 (EQR Protocol 7).[24] For the statewide calculations inclusive of NC Medicaid, HSAG included all NC Medicaid beneficiaries (SP, **EBCI Tribal Option**, NC Medicaid Direct [including TP-eligible and PIHPs). In addition to an overall NC Medicaid statewide rate, HSAG calculated aggregates for each program.

[24] U.S. Department of Health and Human Services, CMS. *Protocol 7. Calculation of Additional Performance Measures: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: June 1, 2024.

3. Additional EQR Activities

This section presents a description of activities HSAG conducted as optional EQR activities, as allowed for by federal regulations and as requested by HFS.

Annual Care Management Performance Evaluation (CMPE)

Introduction

DHB contracted with HSAG to conduct validation of beneficiary assignment when SPs and DHHS assign beneficiaries to Advanced Medical Homes (AMHs)/PCPs in accordance with DHHS' published data specifications and time frames. Further, DHB contracted with HSAG to solicit qualitative SP feedback on the implementation of the modified enrollment files used to support monthly care gap reporting.

The purpose of the validation was to assess NC FAST, DHHS' portal for NC Medicaid Direct beneficiary assignment, and the SPs' application of the DHHS-defined auto-assignment algorithm or a DHHS-approved alternative algorithm, denoting any variations of use within each stage of the algorithm. Further, the validation assessed DHHS' and the SPs' application of provider panel size and restrictions[25] within the beneficiary assignment logic as well as claims data used for beneficiary assignment, detecting the root cause for identified discrepancies or outliers to the algorithm and providing recommendations to ensure appropriate algorithmic alignment with the available beneficiary and provider data. Additionally, the validation was designed to obtain and assess qualitative feedback from the SPs regarding the interim quality performance measure gap reports, specifically identifying any changes noted since the implementation of the enrollment span workaround.

HSAG approached validation activities by gathering information by conducting a short questionnaire with the SPs and DHHS; reviewing all supporting files and documentation from the Standard Plans and DHHS; and interviewing SP and DHHS staff. HSAG assessed the full beneficiary auto-assignment process and logic using the beneficiary assignment files, provider panel files, and primary source verification (PSV) as an adjunct in the analysis of beneficiary assignment processes.

Strengths, Opportunities for Improvement, and Recommendations

By assessing DHHS' and the SPs' systems and processes and comparing the auto-assignment algorithm to the source data files provided by DHHS and each SP, HSAG identified the areas of strength and opportunities for improvement. HSAG also derived strengths and opportunities from the qualitative

[25] Provider panel size and restrictions are unavailable through NC FAST and NCTracks. PHPs are responsible for tracking their contracted provider panel limits and restrictions, offering a process for provider-requested panel modifications. More information is available at: https://medicaid.ncdhhs.gov/fact-sheet-panel-management-primary-care-practices/open. Accessed on: Aug 14, 2024.

feedback on gap reporting, as provided by each SP. The strengths and opportunities for DHHS are included below and for each SP in Section 4.

DHHS

Strength #1: DHHS and GDIT deployed a multifaceted approach in its beneficiary assignment process, using mailed letters to members to encourage self-selection of PCPs prior to auto-assignment, revalidating all members' suggested PCP auto-assignments in alignment with provider specifications prior to GDIT's NC FAST file submission, and comparing NC FAST's validation of the PCP auto-assignment suggestion against each member's NC FAST PCP assignment field for potential data mismatches.

Opportunity #1: DHHS did not incorporate historical PCP assignments, historical SP encounters, family SP assignments, family claims or encounter data, or the members' medical needs, language, or cultural preferences into its auto-assignment algorithm, citing a lack of system integration for these data and an absence of unique case numbers for family identification.

Recommendation: For a more comprehensive approach to its beneficiary assignment algorithm, HSAG recommends that DHHS identify opportunities for future system integration of historical SP encounter data and identify additional data fields that can be provided to GDIT to supplement the encounter data; family linkages; and medical, cultural, or language data elements.

Provider Access Surveys

During the technical report period, HSAG and its subcontractor collaborated with DHB to conduct access and availability "revealed" and "secret shopper" surveys to evaluate the accuracy of provider information and appointment availability for specialists, primary care providers (PCPs), and OB/GYNs. Results of the surveys will be provided to DHB upon completion of the activity.

Collaborative Quality Symposiums

HSAG is tasked to organize and conduct at least one quality symposium each calendar year to promote the statewide goals of delivering high-quality, accessible care to members/beneficiaries. Quality symposiums are interactive conferences that include the health plans and stakeholders. HSAG subcontracted with Constellation Quality Health (CQH) to conduct the annual quality symposiums.

The following three quality symposiums were conducted in May and June 2024.

- Promoting High Quality Pediatric Care Management: Lessons From the NC Integrated Care for Kids Care Model
- Balancing the Scales to Weight Inclusive, Whole Child Approaches Supporting Nutrition and Physical Activity
- Collaboration During Pregnancy and Postpartum: Health Plans, Providers, and Care Managers Combine to Improve Care

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 conducted SP program integrity reviews to determine compliance with program integrity requirements. The purpose of the review is to assess the degree to which the SPs ensure the effective use and management of public resources in the delivery of services to Medicaid managed care members and how the SPs increase awareness within their organization and across their provider network of methods to prevent, detect, and report potential fraud, waste, and abuse.

During CY 2024, HSAG's subcontractor, CQH, conducted desk, file, and webinar reviews with all five SPs. Findings and recommendations were provided in final health plan-specific reports.

Semiannual Audits

Section 122C-124.2(a) of the North Carolina General Statutes (G.S.) requires the Secretary of Health and Human Services to certify whether each LME/MCO approved to operate the 1915(b)/(c) Medicaid Waiver is in compliance with the requirements of G.S. §122C-1242(b). DHB contracted with HSAG to conduct a review of each LME/MCO to determine compliance with claims accuracy and timeliness, solvency, and Health Insurance Portability and Accountability Act of 1996 (HIPAA) transactions.

HSAG and its subcontractor worked with DHB throughout the technical report period to develop the scope and timeline for the activity. The initial round of final audit reports was delivered in May 2024, and the second round was delivered in December 2024.

Quarterly PIP Review

HSAG conducted quarterly PIP reviews to assess the SPs' and PIHPs' progress on each of their required PIPs. HSAG completed the quarterly reviews and provided feedback to DHB and the health plans according to the established timelines.

Annual Quality Assessment and Performance Improvement (QAPI) Plan Review

HSAG conducted an annual review to assess the SPs' and PIHPs' QAPI plans. HSAG completed the reviews and provided feedback to DHB according to the established timelines.

Total Cost of Care (TCOC)

DHB contracted with HSAG to develop and maintain a Medicaid-focused TCOC toolkit and reporting suite. HSAG was tasked with providing data analytics on an array of resource use and total cost indices and developing reporting dashboards, as well as building, maintaining, and hosting a web-based portal that providers, health plans, and DHB can access. During the reporting period, HSAG developed and executed the launch of the web-based portal and reporting dashboard.

Evaluation of Quality Strategy

North Carolina published its first Quality Strategy for Medicaid managed care on June 16, 2021. In July 2021, the Department completed the first phase of managed care implementation with the launch of SPs and the EBCI Tribal Option. On April 11, 2023, the Department released a revised Quality Strategy to incorporate program changes and additional populations.

Regulations at 42 CFR §438.340(c)(2), (c)(2)(i), and (c)(2)(ii) require states to review and update their quality strategy as needed, but no less than every three years. A state's review of the quality strategy must include an evaluation of the effectiveness of the quality strategy conducted within the previous three years. In CY 2024, HSAG assisted DHB with its Quality Strategy evaluation in accordance with CMS' *Quality Strategy Toolkit for States*.[26]

[26] CMS. *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit for States*. Available at: https://www.medicaid.gov/medicaid/downloads/managed-care-quality-strategy-toolkit.pdf. Accessed on: Feb 22, 2023.

SPs

HSAG assessed the strengths and weaknesses of each health plan with respect to the quality, timeliness, and accessibility of healthcare services. Please note that abbreviations for various HEDIS performance measures are used in this section. Please refer to Appendix C for tables which include the corresponding full measure names.

AmeriHealth Caritas North Carolina, Inc.

Detailed results from the EQR's substantive findings of **AmeriHealth** are summarized in Table 49 for each activity. This table highlights the extent to which **AmeriHealth** furnishes high quality, timely, and appropriate access to healthcare services, and recommendations for how **AmeriHealth** can best address issues identified for each activity.

Table 49—AmeriHealth Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)
PIPs		
+	**Strength: AmeriHealth** received an overall validation status of *Met* for the final validation in 2023 for all PIPs.	
+	**Strength: AmeriHealth** achieved statistically significant improvement for the performance indicators of all PIPs.	
PMV		
+	**Strength: AmeriHealth** passed the *HRRN* measure source code review for MY 2022 and produced appropriate data files for the State to calculate the *HRRN* measure. **AmeriHealth** overcame issues in MY 2022 related to provider record capture delaying provider data entry into Facets. Provider enrollment now runs daily without significant issues.	
+	**Strength:** For MY 2023, **AmeriHealth** demonstrated adequate processes in place to receive and process claims and encounters, membership/enrollment, data integration, provider data, and supplemental data. **AmeriHealth** also continued to improve its claims auto-adjudication rates and its supplemental data capture, which had a significant positive impact on several rates.	
−	**Weakness:** Challenges remain for North Carolina's health information exchange (HIE) and North Carolina Immunization Registry (NCIR) data to be processed in **AmeriHealth**'s system.	

Strength/ Weakness	Description	Domain(s)
	Recommendations: AmeriHealth should work with NCIR and the NC HIE to enhance data capture of immunizations to include in the rate reporting for the HEDIS *CIS* measure.	
−	**Weakness: AmeriHealth**'s MY 2023 rates for *Well-Child Visits in the First 30 Months of Life (W30)* dropped 3.55 percentage points year-over-year. Although within the bias of 5 percentage points, another drop in this rate could be significant when comparing it over a multi-year period. **Recommendations: AmeriHealth** should evaluate additional interventions that will improve the frequency of *W30* visits.	
−	**Weakness: AmeriHealth**'s rates for the *CBP* and *HBD* measures were below the MY 2023 NCQA 10th percentile. **Recommendations: AmeriHealth** should educate and consider incentive plans for providers on appropriate submission of CPT II codes for improving administrative capture of *CBP* and *HBD* results.	
−	**Weakness: AmeriHealth**'s MY 2023 *CDF* rates continued to be a challenge. **Recommendations: AmeriHealth** should evaluate additional interventions that will improve the frequency of *CDF* rates. **AmeriHealth** should ensure providers receive reminders about screenings and consider creating educational materials for provider and clinic staff members to promote "buy in" for screening. In addition, **AmeriHealth** should identify process improvements for members 18–44 years of age to identify provider-specific trends within the data and disseminate provider score cards as needed.	
Compliance With Standards		
+	**Strength: AmeriHealth** demonstrated overall compliance with standards, as evidenced by a final total compliance review score of 99 percent. The health plan's policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff members were generally knowledgeable about the requirements, policies, and procedures.	
−	**Weakness: AmeriHealth**'s care management record review demonstrated inconsistent compliance with attempts to reach members within 90 days of enrollment to complete the CNS and inconsistent compliance with sharing the member's comprehensive assessment with the member's provider. **Recommendations: AmeriHealth** should continue oversight and monitoring procedures to ensure timely completion of the CNS and ensure procedures include sharing the comprehensive assessment with the member's provider.	

Strength/ Weakness	Description	Domain(s)
−	**Weakness: AmeriHealth** failed to ensure that its member handbook met the requirements outlined in the NC Medicaid handbook template. **Recommendations: AmeriHealth** should continue to pursue DHB approval of the member handbook and upon approval, immediately implement the approved version of the member handbook.	
−	**Weakness: AmeriHealth** was unable to demonstrate a procedure to use telemedicine, e-visits, and or other technology solutions to assess availability. **Recommendations: AmeriHealth** should consider incorporating additional technology solutions in its assessment of availability and include provider accessibility information to improve the provider directory display details.	
NAV		
+	**Strength: AmeriHealth** trained multiple programmers and staff members on the network adequacy program requirements, which helped maintain program integrity.	
+	**Strength: AmeriHealth** continuously monitored data quality and validated inbound data exchanges from DHHS.	
−	**Weakness:** No specific opportunities were identified related to the data collection and management processes **AmeriHealth** had in place to inform network adequacy standard and indicator calculations. **Recommendations:** NA.	
Optional/Additional EQR Activities		
+	**Strength: AmeriHealth**'s CAHPS scores were at or between the 75th and 89th percentiles for *How Well Doctors Communicate* and *Advising Smokers and Tobacco Users to Quit* for the adult population, and at or above the 90th percentile for *Customer Service* for the child population.	
+	**Strength:** The EDV activity identified that record surplus rates for all encounter types, along with pharmacy encounter record omission rates, were below 5.0 percent. This indicates that encounters in both the DHB-submitted and health plan-submitted data could largely be identified in both data sources.	
+	**Strength:** The EDV activity identified that most element omission and element surplus rates were less than 5.0 percent, indicating that records which could be matched between the DHB-submitted and health plan-submitted data were largely complete.	
+	**Strength:** The EDV activity identified that all but two elements in each encounter type had an accuracy rate greater than 95 percent, indicating that records which could be matched between the DHB-submitted and health plan-submitted data largely contained the same values.	

Strength/ Weakness	Description	Domain(s)
+	**Strength:** For the CMPE, **AmeriHealth** maintained a dashboard that tracked beneficiary auto-assignments that were reported to and accepted by NC FAST to monitor the effectiveness of its auto-assignment algorithm and produced a weekly report of member counts from the incremental and full beneficiary assignment files and compared this report to the information in Facets to ensure that it captured all members in the beneficiary assignment files.	
+	**Strength:** The program integrity review activity identified that **AmeriHealth** has an active process for investigating allegations of member fraud, waste, and abuse (FWA).	
+	**Strength:** For the program integrity review, reconciliation of **AmeriHealth**'s quarterly reports (i.e., the quarterly FWA reports of providers and members) with the Special Investigation Unit (SIU) Case File List submitted for this review confirmed, for the information available on these lists, 100% accuracy of data on the quarterly reports.	
+	**Strength:** For the program integrity review, the health plan successfully remediated all initial findings.	
−	**Weakness: AmeriHealth**'s CAHPS scores were below the 25th percentile for *Customer Service* for the adult population and *Rating of Health Plan* for the adult and child populations. **Recommendations: AmeriHealth** should explore what may be driving lower experience scores and develop initiatives designed to improve quality of care.	
−	**Weakness:** The EDV activity identified that the record omission rates for professional and institutional encounters were high at 7.6 percent and 17.4 percent, respectively. This was due to the claim lines submitted as paid in the **AmeriHealth**-submitted data that were marked as denied in the DHB-submitted data. **Recommendations: AmeriHealth** should ensure that the claim status of each record is accurate.	
−	**Weakness:** The EDV activity identified that the encounter element omission rates were low for most, but not all, data elements between the DHB-submitted and health plan-submitted data. **Recommendations: AmeriHealth** should ensure that the Professional encounters: *Rendering Provider NPI* and *Rendering Provider Taxonomy Code* data elements are submitted completely.	
−	**Weakness:** The EDV activity identified that matched records largely contained similar values between the DHB-submitted and health plan-submitted data, except for some data elements. **Recommendations: AmeriHealth** should ensure the following data elements have accurate values:	

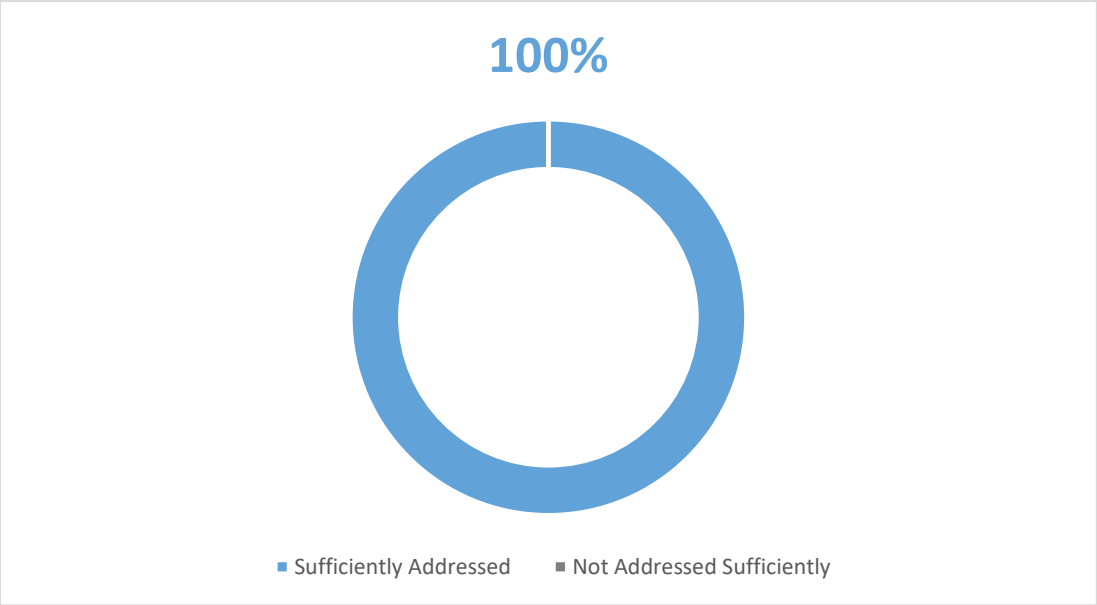
Strength/ Weakness	Description	Domain(s)
	• Professional encounters: *Header Paid Amount* and *Detail Paid Amount* • Institutional encounters: *Surgical Procedure Codes* and *Type of Bill Code* • Pharmacy encounters: *Days Supply* and *Paid Amount*	
–	**Weakness:** For the CMPE, **AmeriHealth** could not provide the phase of algorithmic assignment for members included in the first full beneficiary assignment file of each month of the lookback period, as requested by HSAG. **AmeriHealth** noted that frequent changes to member eligibility and gaps in member eligibility meant that the phase of assignment could change when the member is reassigned or treated as a new member for assignment. **Recommendations: AmeriHealth** should establish a process to produce beneficiary assignment files for audit purposes that show the historical phase of algorithmic assignment for multiple periods.	
–	**Weakness:** For the CMPE, **AmeriHealth** used a lookback period of 12 months for claims-based assignments, but the SP PCP auto-assignment requirements require a lookback period of 18 months. **Recommendations: AmeriHealth** should update its auto-assignment algorithm to align with the SP PCP auto-assignment requirements for an 18-month lookback period for claims-based assignments and work with DHB on any questions related to the requirements.	

Follow-Up on Prior Year Recommendations

HSAG evaluated **AmeriHealth**'s approach to addressing the recommendations and/or findings issued in the prior technical report while conducting the CY 2024 EQR activities.

Figure 3 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report EQR.

Figure 3—Percentage of Prior EQR Recommendations Addressed by AmeriHealth



AmeriHealth-specific recommendations and follow-up assessments are summarized in Table 50.

Table 50—Assessment of AmeriHealth's Approach to Addressing Previous Annual Recommendations

Prior Recommendation	Assessment
PIPs	
HSAG recommended **AmeriHealth** consider short testing and evaluation periods for its current interventions. The testing and evaluation of interventions should allow **AmeriHealth** to quickly gather data and make data driven decisions on the status of an intervention. If the intervention is not having the desired impact, mid-course revisions can be made or a new intervention can be initiated.	**AmeriHealth sufficiently addressed the recommendation. AmeriHealth** received technical assistance to address evaluation metrics impacted by claims logs and noted it will identify rapid cycle evaluation measures for interventions.
HSAG recommended **AmeriHealth** revisit its causal/barrier analysis process at least annually to ensure that identified barriers are still relevant and determine if new barriers exist that can impede progress. HSAG also recommended **AmeriHealth** apply lessons learned and knowledge gained during the PIP process to make changes and revisions to current QI processes and activities and seek technical assistance from HSAG throughout the PIP process to address any questions or concerns.	**AmeriHealth sufficiently addressed the recommendation. AmeriHealth** described conducting in-depth system failure mode and effects analysis as well as causal mapping for metrics of priority at least annually.

Prior Recommendation	Assessment
HSAG recommended **AmeriHealth** reference the PIP Completion Instructions as it updates its PIP submission forms to ensure that all requirements for each completed step have been addressed.	**AmeriHealth sufficiently addressed the recommendation. AmeriHealth** received completion feedback and addressed feedback in resubmissions.
PMV	
HSAG recommended **AmeriHealth** continue to work with NCIR and the North Carolina HIE to help develop defined parameters and expectations of quality data and size of data transfer to help **AmeriHealth** capture the necessary data to support quality rate reporting. Established workgroups between **AmeriHealth** staff and external organization staff should work to define timelines and expectations of data to ensure that **AmeriHealth** can gain timely access to these data in order to incorporate the data for future measure reporting.	**AmeriHealth sufficiently addressed the recommendation. AmeriHealth** established a direct data feed connection with NCIR and initiated a monthly data exchange for use in rate calculation and reporting. **AmeriHealth** also worked with other health plans to advocate for improvement of the HIE data. **AmeriHealth** noted improvements for the *CIS* and *Immunizations for Adolescents* (*IMA)* performance measures.
HSAG identified the following opportunity: **AmeriHealth**'s rates were slightly lower than the rates for some other SPs for the *CIS-10, IMA-2, W30, CCS, CDC,* and *WCV* measures. HSAG recommended that **AmeriHealth** continue to monitor its performance on all measures and evaluate rates in comparison to national benchmarks (where available) to determine if future MY rates improve once **AmeriHealth** has more experience serving its North Carolina members. If future MY rates do not improve, **AmeriHealth** should evaluate additional interventions that will improve access to care across impacted measures.	**AmeriHealth sufficiently addressed the recommendation. AmeriHealth** implemented provider and member incentive programs and member education and outreach initiatives across measures. **AmeriHealth** noted improvements in four of the identified performance measures.
NAV	
HSAG recommended that to improve access to care, the health plans should conduct an in-depth review of provider types for which time and distance standards were not met and use analysis results to guide contracting efforts or implement additional strategies to address network gaps.	**AmeriHealth sufficiently addressed the recommendation. AmeriHealth** described monthly review of the network adequacy data to work on closing gaps and researching resources to automate reporting to identify newly added providers on the State's provider enrollment file to decrease the time it takes to manually create target lists. **AmeriHealth** also improved Contracting Governance Committee Review meetings to track and monitor the redline process, worked on financial strategies to close contract negotiations, and identified strategies for overcoming barriers.

Prior Recommendation	Assessment
Optional/Additional EQR Activities	
Although **AmeriHealth** largely submitted data in a timely manner during the EDV study, the contractual obligation of submitting professional and institutional encounters within 30 days and pharmacy encounters within seven days was not met. HSAG recommended **AmeriHealth** should work with DHB to ensure timely submission of encounters.	**AmeriHealth sufficiently addressed the recommendation. AmeriHealth** noted that DHB's process requires health plans to manually enter data into the encounters processing system (EPS) and does not include the submission date and paid date, which leads to mismatched numbers and an inaccurate representation of the missing metric. **AmeriHealth** reported compliance with the metric when calculated with the submission date and paid date of those encounters. **AmeriHealth** identified strategies for overcoming barriers, including working with DHB to advocate for revisions to DHB's calculation method and removal of manual entry.
AmeriHealth submitted CPT/HCPCS codes about 83 percent of the time in the institutional encounters. **AmeriHealth** should work with DHB to monitor the completeness of CPT/HCPCS codes in submitted encounter data.	**AmeriHealth sufficiently addressed the recommendation. AmeriHealth** identified that providers were submitting claims without the required data for certain bill types. **AmeriHealth** updated claims business rules, educated providers, and noted a decrease in encounter rejections.
AmeriHealth contracted with AMH providers. AMHs, at the time of contracting, designated or identified their clinically integrated networks (CINs) for **AmeriHealth** to establish connectivity for data exchanges. To ensure CINs and PHPs have the same provider data between the entities, HSAG recommends that PHPs establish data exchange agreements to share AMH provider information with the CINs to ensure accuracy of data between parties.	**AmeriHealth sufficiently addressed the recommendation. AmeriHealth** identified the cause of the breakdown and implemented a new strategy with CINs to ensure AMH3/CIN affiliation integrity. **AmeriHealth** began a monthly verification process, noted improvement with most CINs, and identified strategies for overcoming barriers.
AmeriHealth found instances wherein the termination of eligibility and then subsequent reinstatement and extension of eligibility via the 834 file created issues for the auto-assignment algorithm. HSAG recommended that **AmeriHealth** determine if the algorithm needs updating to ensure beneficiaries can be reassigned to the same provider if parameters for reassignment are met.	**AmeriHealth sufficiently addressed the recommendation. AmeriHealth** identified the cause of the issue and implemented a code change that greatly reduced errors. **AmeriHealth** used Tableau dashboards for weekly monitoring of PCP assignment reporting, noted a reduction in NCFAST submission errors, and identified strategies for overcoming barriers.

Carolina Complete Health, Inc.

Detailed results from the EQR's substantive findings are summarized in Table 51 for each activity. This table highlights the extent to which **Carolina Complete** furnishes high quality, timely, and appropriate access to healthcare services, and recommendations for how **Carolina Complete** can best address the issues identified for each activity.

Table 51—Carolina Complete Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)
PIPs		
+	**Strength: Carolina Complete** received an overall validation status of *Met* for the final validation in 2023 for all PIPs.	
+	**Strength: Carolina Complete** achieved statistically significant improvement for the performance indicator of the *HEDIS HBD* PIP.	
−	**Weakness: Carolina Complete** had a statistically significant decline in performance when compared to the baseline for the *HEDIS CIS—Combo 10* PIP performance indicator. **Recommendations:** The health plan should conduct a root cause analysis to identify opportunities to address barriers to enrollee completion of recommended immunization schedules.	
PMV		
+	**Strength:** In MY 2022, **Carolina Complete**'s leadership staff met regularly to review claim performance and communicated results to the claims team to raise awareness for quality improvement opportunities, and its provider data management department reconciled provider data with DHHS' PEF through weekly audits and notified DHHS of any discrepancies identified in reconciliation to ensure accuracy of provider data.	
+	**Strength:** In MY 2023, **Carolina Complete** demonstrated adequate processes in place to receive and process claims and encounters, membership/enrollment, data integration, provider data, and supplemental data. **Carolina Complete** also continued to improve its claims auto-adjudication rates and supplemental data capture, which had a significant positive impact on several rates.	
−	**Weakness: Carolina Complete** was auto-adjudicating claims at 84.3 percent in 2022, which was slightly lower than its peers for the same time frame. **Recommendations: Carolina Complete** should continue to look for opportunities to increase auto-adjudication rates through minimizing manual processing.	

Strength/ Weakness	Description	Domain(s)
−	**Weakness: Carolina Complete**'s rates for the *CBP* and *HBD* measures were below the MY 2023 NCQA 10th percentile. **Recommendations: Carolina Complete** should educate and consider incentive plans for providers on appropriate submission of CPT II codes for improving administrative capture of *CBP* and *HBD* results.	
−	**Weakness: Carolina Complete**'s MY 2023 *CDF* rates continued to be a challenge. **Recommendations: Carolina Complete** should evaluate additional interventions that will improve the frequency of *CDF* rates. **Carolina Complete** should ensure providers receive reminders about screenings and consider creating educational materials for provider and clinic staff members to promote "buy in" for screening. In addition, **Carolina Complete** should identify process improvements for members 18–44 years of age to identify provider-specific trends within the data and disseminate provider score cards as needed.	
Compliance With Standards		
+	**Strength: Carolina Complete** demonstrated overall compliance with standards as evidenced by a final total compliance review score of 100 percent. The health plan's policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff members were generally knowledgeable about the requirements, policies, and procedures.	
−	**Weakness: Carolina Complete**'s care management record review demonstrated inconsistent compliance with attempts to complete the annual comprehensive assessment and sharing the member's comprehensive assessment with the member's provider. **Recommendations: Carolina Complete** should continue to monitor completion of the annual comprehensive assessment, continue system updates to ensure it is shared with the member's provider, and train staff members on system upgrades.	
−	**Weakness: Carolina Complete** failed to ensure that its member handbook met the requirements outlined in the NC Medicaid handbook template. **Recommendations: Carolina Complete** should continue to pursue DHB approval of the member handbook and upon approval, immediately implement the approved version of the member handbook.	
−	**Weakness: Carolina Complete**'s appeals file review demonstrated inconsistent compliance with having a procedure to obtain member consent when a third party submits an expedited appeal. **Recommendations: Carolina Complete** must revise the expedited appeal procedure to ensure compliance with obtaining the member's consent when a provider fails to provide that information to the health plan.	

Strength/ Weakness	Description	Domain(s)
NAV		
+	**Strength: Carolina Complete** compared monthly and annual reporting to identify gaps in adequacy through its network, ensuring data completeness.	
+	**Strength: Carolina Complete** fully integrated the PEF into its Portico, Amisys, and Quest systems and continually assessed data integrity through independent audits.	
−	**Weakness:** No specific opportunities were identified related to the data collection and management process **Carolina Complete** had in place to inform network adequacy standard and indicator calculations.	
Optional/Additional EQR Activities		
+	**Strength: Carolina Complete**'s CAHPS scores were at or above the 90th percentile for *Getting Care Quickly* for the adult population and for *Rating of Personal Doctor* for the child population. Also, for the child population, **Carolina Complete** scored at or between the 75th and 89th percentiles for *Rating of All Health Care* and *Rating of Specialist Seen Most Often.*	
+	**Strength:** The EDV activity identified that record surplus rates for professional and pharmacy encounter types, along with record omission rates for all encounter types, were below 5.0 percent. This indicates that encounters in both the DHB-submitted and health plan-submitted data could largely be identified in both data sources.	
+	**Strength:** The EDV activity identified that most element omission and element surplus rates were less than 5.0 percent, indicating that records which could be matched between the DHB-submitted and health plan-submitted data were largely complete.	
+	**Strength:** The EDV activity identified that all but three data elements (in two encounter types) had an accuracy rate greater than 95 percent, indicating that records which could be matched between the DHB-submitted and health plan-submitted data largely contained the same values.	
+	**Strength:** For CMPE, **Carolina Complete** demonstrated robust reconciliation and audit processes between its enrollment, claims, and provider systems to reduce errors and ensure data completeness.	
+	**Strength:** The program integrity review activity identified that **Carolina Complete** provides comprehensive annual FWA training to directors, officers, employees, delegated entities, and subcontractors. This training includes an annual Board of Directors Compliance Training.	
+	**Strength:** For the program integrity review, the health plan successfully remediated all initial findings.	

Strength/ Weakness	Description	Domain(s)
–	**Weakness: Carolina Complete**'s CAHPS scores were below the 25th percentile for *Coordination of Care* for the adult population. **Recommendations: Carolina Complete** should explore what may be driving lower experience scores and develop initiatives designed to improve quality of care.	
–	**Weakness:** The EDV activity identified that the record surplus rate for institutional encounters was high at 10.9 percent. This was due to voided claims in the DHB-submitted data that were not identified in the health plan-submitted data. **Recommendations: Carolina Complete** should ensure records are submitted completely.	
–	**Weakness:** The EDV activity identified that the encounter element omission rates were low for most, but not all, data elements between the DHB-submitted and health plan-submitted data. **Recommendations: Carolina Complete** should ensure the Professional encounters: *Rendering Provider NPI, Referring Provider NPI,* and *Rendering Provider Taxonomy Code* data elements are submitted completely.	
–	**Weakness:** The EDV activity identified that matched records largely contained similar values between the DHB-submitted and health plan-submitted data, except for some data elements. **Recommendations: Carolina Complete** should ensure the following data elements have accurate values: • Professional encounters: *Surgical Procedure Code* and *Type of Bill Code* • Pharmacy encounters: *Days Supply*	
–	**Weakness:** For CMPE, HSAG identified an AMH Tier 3 practice beneficiary assignment file during the lookback period submitted for review that was not transmitted to the respective CIN, Aledade. **Carolina Complete** investigated and confirmed a limitation in its enterprise data warehouse (EDW) resulting in incorrect file generation of the attested and contracted Tier 3 practice. **Carolina Complete** confirmed that Aledade is the only AMH/CIN impacted by this issue and began a process to ensure the EDW captures the attested and contracted tiers appropriately. **Recommendations: Carolina Complete** should increase its oversight of the Centene IT team when it generates and transmits the weekly and full beneficiary assignment files. Additionally, HSAG recommends adding contracted AMH data to the audits conducted for the attested AMH data driven by the PEF.	

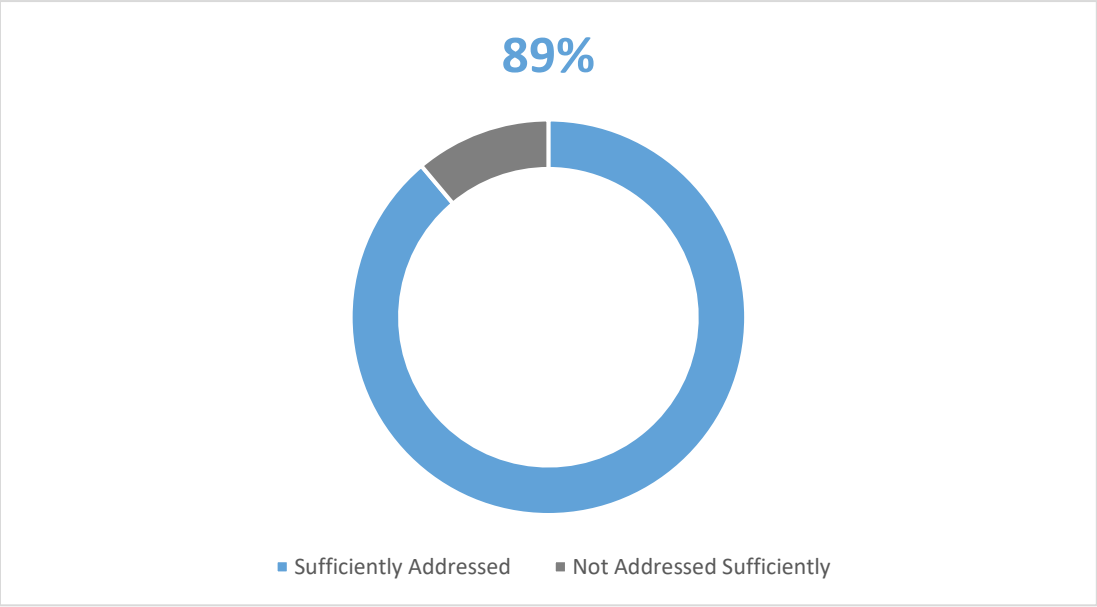
Strength/ Weakness	Description	Domain(s)
−	**Weakness:** For CMPE, **Carolina Complete** conducted a larger percentage (6.7 percent) of manual review frequency compared to its peers. **Recommendations: Carolina Complete** should continue to look for opportunities to increase automation and leverage IT controls where possible.	
−	**Weakness:** For CMPE, **Carolina Complete** did not follow the SP PCP auto-assignment requirements for scenarios in which multiple PCPs are identified at each step. **Carolina Complete** indicated that when multiple associations were identified in a given step, each provider was evaluated based on the distance from the member, and the first provider that passed validation was assigned. **Recommendations: Carolina Complete** should update its auto-assignment logic so that, "the outcome is matched with AMHs/PCPs identified in the previous step, and the ones that are common should be used to move forward in the algorithm" per the SP PCP Auto-Assignment requirements and work with DHB on any questions related to the requirements.	
−	**Weakness:** For CMPE, **Carolina Complete** did not follow the SP PCP Auto-Assignment requirements for determining the prior PCP. **Carolina Complete** indicated that it used claims history to determine the prior PCP. **Recommendations: Carolina Complete** should update its auto-assignment logic so that it is aligned with the SP PCP auto-assignment requirements for determining the prior PCP, and should work with DHB on any questions related to the requirements.	

Follow-Up on Prior Year Recommendations

HSAG evaluated **Carolina Complete**'s approach to addressing the recommendations and/or findings issued during in the prior technical report while conducting the CY 2024 EQR activities.

Figure 4 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

Figure 4—Percentage of Prior EQR Recommendations Addressed by Carolina Complete



Carolina Complete-specific recommendations and follow-up assessments are summarized in Table 52.

Table 52—Assessment of Carolina Complete's Approach to Addressing Previous Annual Recommendations

Prior Recommendation	Assessment
PIPs	
HSAG recommended **Carolina Complete** consider short testing and evaluation periods for its current interventions. The testing and evaluation of interventions should allow **Carolina Complete** to quickly gather data and make data driven decisions on the status of an intervention. If the intervention is not having the desired impact, mid-course revisions can be made or a new intervention can be initiated.	**Carolina Complete sufficiently addressed the recommendation. Carolina Complete** adopted several interventions that align with this recommendation to incorporate rapid-cycle intervention testing and evaluation, and provided examples of those efforts. **Carolina Complete** noted improvement in several performance measures and identified strategies for overcoming barriers.
HSAG recommended **Carolina Complete** revisit its causal/barrier analysis process at least annually to ensure that identified barriers are still relevant and determine if new barriers exist that can impede progress. HSAG also recommended **Carolina Complete** apply lessons learned and knowledge gained during the PIP process to make changes and revisions to current QI processes and activities and seek technical assistance from HSAG throughout the PIP process to address any questions or concerns.	**Carolina Complete sufficiently addressed the recommendation. Carolina Complete** described several continuous improvement methodologies that it incorporates into its PIP processes based on lessons learned, best practices, and feedback. **Carolina Complete** noted improvement of three administrative rates and identified strategies for overcoming barriers.

Prior Recommendation	Assessment
HSAG recommended **Carolina Complete** reference the PIP Completion Instructions as it updates its PIP submission forms to ensure that all requirements for each completed step have been addressed.	**Carolina Complete sufficiently addressed the recommendation. Carolina Complete** implemented a decision log to track and document all future instructions from the State and HSAG to ensure a clear reference point for compliance. **Carolina Complete** also uses multiple readers and a standardized rubric for internal scoring. **Carolina Complete** identified barriers and strategies for overcoming barriers.
HSAG recommended **Carolina Complete** ensures to address each of the "Validation Feedback" comments that are associated with Met validations scores in the 2023 annual submission.	**Carolina Complete sufficiently addressed the recommendation. Carolina Complete** established an internal review team to ensure that all "Validation Feedback" is incorporated and uses a structured review process to verify that recommendations or comments provided by HSAG are implemented effectively. **Carolina Complete** identified barriers and strategies for overcoming barriers.
PMV	
HSAG identified the following opportunity: **Carolina Complete**'s rate was slightly lower than the rate for some other SPs for the PPC measure indicators. HSAG recommended that **Carolina Complete** continue to monitor its performance on this measure indicator and evaluate the rate in comparison to national benchmarks (where available) to determine if the future MY rate improves once **Carolina Complete** has more experience serving its North Carolina members. If the future MY rate does not improve, **Carolina Complete** should evaluate additional interventions that will improve access to care for these measure indicators.	**Carolina Complete sufficiently addressed the recommendation. Carolina Complete** adopted several interventions targeting prenatal and postpartum rates; fortified existing care gap reports to providers with actionable lists; and enhanced the existing care management program, Start Smart for Babies. **Carolina Complete** noted improvement in performance measure rates and identified strategies for overcoming barriers.
NAV	
HSAG recommended that to improve access to care, the health plans should conduct an in-depth review of provider types for which time and distance standards were not met and use analysis results to guide contracting efforts or implement additional strategies to address network gaps.	**Carolina Complete did not sufficiently address the recommendation. Carolina Complete** noted that some network gaps do not have providers within the time/distance standard and described its process for running geo access reports and outreaching providers for contracting. However, **Carolina Complete** did not identify specific barriers, strategies to address those barriers, or present any innovative approaches.

Prior Recommendation	Assessment
Optional/Additional EQR Activities	
Although **Carolina Complete** largely submitted professional and institutional data in a timely manner, the contractual obligation of submitting these encounters within 30 days of payment was not met. Additionally, **Carolina Complete** submitted 52 percent of pharmacy encounters within seven days of payment, which is below the contractual obligation of submitting pharmacy encounters within seven days of payment. HSAG recommended that **Carolina Complete** work with DHB to ensure timely submission of encounters.	**Carolina Complete sufficiently addressed the recommendation. Carolina Complete** identified multiple issues with its pharmacy benefits manager (PBM) and a timeliness miss during an entire service month. **Carolina Complete** worked with its PBM to resolve issues and achieved a consistent timeliness service level authorization (SLA) rate of 99% or higher.
Carolina Complete submitted greater than 40 percent of pharmacy encounters prior to the payment date. HSAG recommended that **Carolina Complete** work with DHB to ensure pharmacy encounters are submitted after the payment date.	**Carolina Complete sufficiently addressed the recommendation. Carolina Complete** reviewed the rejections and worked with its PBM to identify and correct the issue, and started meeting timeliness requirements after the fixes were implemented.
Carolina Complete submitted CPT/HCPCS codes about 83 percent of the time in institutional encounters. HSAG recommended that **Carolina Complete** work with DHB to monitor the completeness of CPT/HCPCS codes in submitted encounter data.	**Carolina Complete sufficiently addressed the recommendation. Carolina Complete** reported submission of all the CPT/HCPCS codes that were received on the claims as encounters and that the encounters for which CPT/HCPCS codes were not reported were institutional encounters (which only have revenue codes).

Healthy Blue of North Carolina

Detailed results from the EQR's substantive findings are summarized in Table 53 for each activity. This table highlights the extent to which **Healthy Blue** furnishes high quality, timely, and appropriate access to healthcare services, and recommendations for how **Healthy Blue** can best address issues identified for each activity.

Table 53—Healthy Blue Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)
PIPs		
+	**Strength: Healthy Blue** received an overall validation status of *Met* for the final validation in 2023 for all PIPs.	
+	**Strength: Healthy Blue** achieved statistically significant improvement for the performance indicator of the *HEDIS HBD* PIP and the nonclinical PIP.	
−	**Weakness: Healthy Blue** had statistically significant declines in performance when compared to the baseline for the *HEDIS CIS—Combo 10* PIP performance indicator and the prenatal performance indicator of the *HEDIS PPC* PIP. **Recommendations:** The health plan should conduct a root cause analysis to identify opportunities to address barriers to enrollee completion of recommended immunization schedules and timely prenatal provider visits.	
PMV		
+	**Strength:** In MY 2022, **Healthy Blue** utilized quality improvement processes to continually enhance the delivery of care by leveraging data-driven analyses and best practices with its partners. **Healthy Blue** also showed proficiency in monitoring delegated entities and ensuring compliance and performance optimization through diligent oversight and strategic relationship management.	
+	**Strength:** In MY 2023, **Healthy Blue** demonstrated adequate processes in place to receive and process claims and encounters, membership/enrollment, data integration, provider data, and supplemental data. **Healthy Blue** also continued to improve its claims auto-adjudication rates and its supplemental data capture, which had a significant positive impact on several rates.	
−	**Weakness: Healthy Blue**'s rates for the *CBP* and *HBD* measures were below the MY 2023 NCQA 10th percentile. **Recommendations: Healthy Blue** should educate and consider incentive plans for providers on appropriate submission of CPT II codes for improving administrative capture of *CBP* and *HBD* results.	

Strength/ Weakness	Description	Domain(s)
−	**Weakness: Healthy Blue**'s MY 2023 *CDF* rates continued to be a challenge. **Recommendations: Healthy Blue** should evaluate additional interventions that will improve the frequency of *CDF* rates. **Healthy Blue** should also ensure providers receive reminders about screenings and consider creating educational materials for provider and clinic staff members to promote "buy in" for screening. In addition, **Healthy Blue** should identify process improvements for members 18–44 years of age to identify provider-specific trends within the data and disseminate provider score cards as needed.	
Compliance With Standards		
+	**Strength: Healthy Blue** demonstrated overall compliance with standards, as evidenced by a final total compliance review score of 100 percent. The health plan's policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff members were generally knowledgeable about the requirements, policies, and procedures.	
−	**Weakness: Healthy Blue**'s care management record review demonstrated inconsistent compliance with ensuring timely completion of the initial comprehensive assessment, documenting all member needs in the care plan, and sharing the member's comprehensive assessment with the member's provider. **Recommendations: Healthy Blue** should continue procedures for oversight and monitoring of timely completion of the initial comprehensive assessment, documentation of any identified needs in the member's care plan, and sharing the member's comprehensive assessment with the member's provider. In addition, **Healthy Blue** should continue oversight and monitoring of the internal corrective action plan for CM requirements.	
−	**Weakness: Healthy Blue** failed to ensure that its member handbook met the requirements outlined in the NC Medicaid handbook template. **Recommendations: Healthy Blue** should continue to pursue DHB approval of the member handbook and upon approval, immediately implement the approved version of the member handbook.	
−	**Weakness: Healthy Blue**'s grievance file review demonstrated inconsistent compliance with timely grievance resolution. **Recommendations: Healthy Blue** should continue to monitor timely grievance resolutions.	

Strength/ Weakness	Description	Domain(s)
NAV		
+	**Strength: Healthy Blue** applied sound methodologies for validation of provider data, including review and deduplication of identified duplicate records, prior to calculating network adequacy reports.	
+	**Strength: Healthy Blue** used record counts and trending reports to monitor and validate data completeness and accuracy of network adequacy files.	
−	**Weakness:** No specific opportunities were identified related to the data collection and management process that **Healthy Blue** had in place to inform network adequacy standard and indicator calculations.	
Optional/Additional EQR Activities		
+	**Strength: Healthy Blue**'s CAHPS scores were at or above the 90th percentile for *Rating of All Health Care* and *How Well Doctors Communicate* for the child population. **Healthy Blue** also scored at or between the 75th and 89th percentiles for *Getting Needed Care* and *Customer Service* for the child population. For the adult population, **Healthy Blue** also scored at or between the 75th and 89th percentiles for *Getting Care Quickly*.	
+	**Strength:** The EDV activity identified that record omission rates and record surplus rates for all encounter types were below 5.0 percent. This indicates that encounters in both the DHB-submitted and health plan-submitted data could be identified in both data sources.	
+	**Strength:** The EDV activity identified that element surplus rates and element omission rates for all encounter types were less than 5.0 percent, indicating that records which could be matched between the DHB-submitted and health plan-submitted data were largely complete.	
+	**Strength:** The EDV activity identified that all but two data elements (in two encounter types) had an accuracy rate greater than 95 percent, indicating that records which could be matched between the DHB-submitted and health plan-submitted data largely contained the same values.	
+	**Strength:** For CMPE, **Healthy Blue**'s beneficiary assignment algorithm aligned with DHHS' defined algorithm and used additional business rules to check for availability of historical claims data prior to running the algorithm. **Healthy Blue** also incorporated additional validations to integrate claims data into the prior AMH/PCP assignment and family member's AMH/PCP assignment phases of the algorithm, only assigning to a prior AMH/PCP or family member's AMH/PCP if it identified associated claims.	

Strength/ Weakness	Description	Domain(s)
+	**Strength:** The program integrity review activity identified that in 2023, **Healthy Blue** completed 10 reviews that were focused on specific NC provider billing practices, and driven by data analysis, to identify potential FWA.	
+	**Strength:** For the program integrity review, the health plan successfully remediated all initial findings.	
−	**Weakness: Healthy Blue**'s CAHPS scores were below the 25th percentile for *Customer Service*, *Flu Vaccination Received*, and *Discussing Cessation Strategies* for the adult population. **Recommendations: Healthy Blue** should explore what may be driving lower experience scores and develop initiatives designed to improve quality of care.	
−	**Weakness:** The EDV activity identified that matched records largely contained similar values between the DHB-submitted and health plan-submitted data, except for some data elements. **Recommendations: Healthy Blue** should ensure the following data elements have accurate values: • Institutional encounters: *Surgical Procedure Codes* • Pharmacy encounters: *Days Supply*	
−	**Weakness:** For CMPE, HSAG identified invalid enrollment spans within the beneficiary assignment files. Upon further research, **Healthy Blue** identified that it transforms the 834 file enrollment date spans into custom **Healthy Blue** enrollment spans, using the age of the member to apply future dates of enrollment for eligible members. **Recommendations:** Since the enrollment date spans listed within the beneficiary assignment files were used by AMH providers and CINs to identify active Medicaid enrollment for the provision of services, HSAG recommends that **Healthy Blue** maintain the 834 file enrollment date spans within the beneficiary assignment files to demonstrate the members' current enrollment in Medicaid.	
−	**Weakness:** For CMPE, HSAG identified multiple members within the beneficiary assignment files who did not meet the age and/or gender requirements as specified within the PEFs. **Healthy Blue** investigated a sample of 147 members 21 years of age and older who were assigned to KidzCare during the lookback period and noted 122 of those members were assigned based on self-selection, for which validation checks against age and gender panel specifications are not required. **Recommendations: Healthy Blue** should work with DHHS to identify whether the application of age and gender panel specifications should be reevaluated as a required validation element for the self-selected AMH beneficiary assignment phase.	

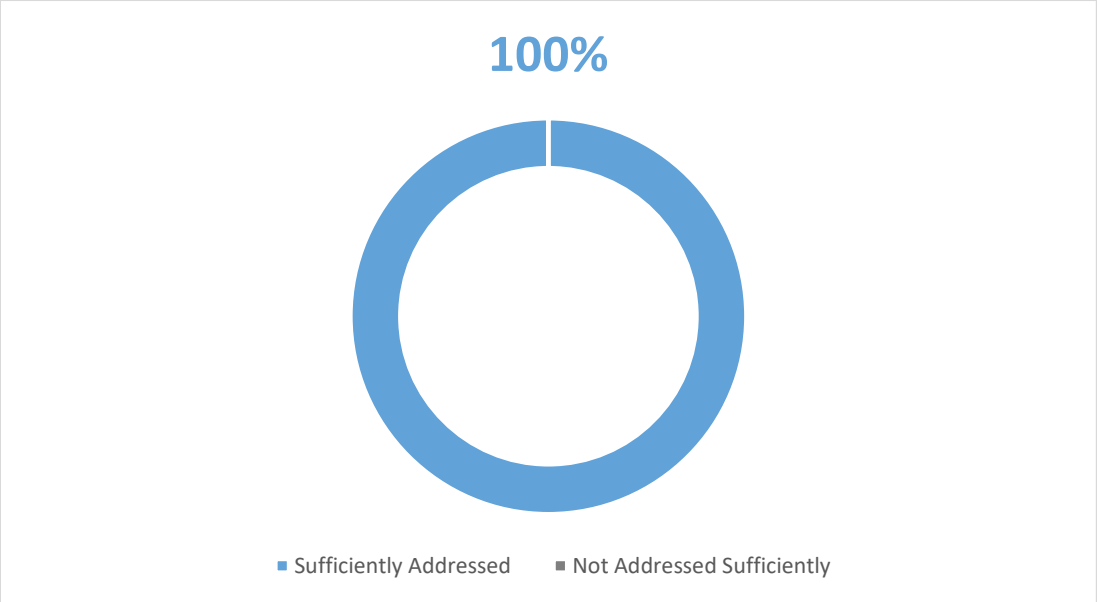
Strength/ Weakness	Description	Domain(s)
−	**Weakness:** For CMPE, **Healthy Blue** did not follow the SP PCP auto-assignment requirements for determining prior PCP. **Healthy Blue** indicated that it used claims history to determine the prior PCP. **Recommendations: Healthy Blue** should update its auto-assignment logic so that it is aligned with the SP PCP auto-assignment requirements for determining prior PCP and work with DHB on any questions related to the requirements.	

Follow-Up on Prior Year Recommendations

HSAG evaluated **Healthy Blue**'s approach to addressing the recommendations and/or findings issued during in the prior technical report while conducting the CY 2024 EQR activities.

Figure 5 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

Figure 5—Percentage of Prior EQR Recommendations Addressed by Healthy Blue



Healthy Blue-specific recommendations and follow-up assessments are summarized in Table 54.

Table 54—Assessment of Healthy Blue's Approach to Addressing Previous Annual Recommendations

Prior Recommendation	Assessment
PIPs	
HSAG recommended **Healthy Blue** revisit its causal/barrier analysis process at least annually to ensure that identified barriers are still relevant and determine if new barriers exist that can impede progress. HSAG also recommended **Healthy Blue** apply lessons learned and knowledge gained during the PIP process to make changes and revisions to current QI processes and activities and seek technical assistance from HSAG throughout the PIP process to address any questions or concerns.	**Healthy Blue sufficiently addressed the recommendation. Healthy Blue** completed a new root cause analysis, identified new interventions, and reported on plans to remove previous long-term interventions from the PIPs.
HSAG recommended **Healthy Blue** reference the PIP Completion Instructions as it updates its PIP submission forms to ensure that all requirements for each completed step have been addressed.	**Healthy Blue sufficiently addressed the recommendation. Healthy Blue** received training and technical assistance from the EQRO, and its annual submission was approved.
HSAG recommended the PHP ensures to address each of the "Validation Feedback" comments that are associated with Met validations scores in the 2023 annual submission.	**Healthy Blue sufficiently addressed the recommendation. Healthy Blue** received training and technical assistance from the EQRO and addressed feedback in its subsequent submissions.
Revisit and revise the performance indicator goals that were exceeded by the baseline performance.	**Healthy Blue sufficiently addressed the recommendation. Healthy Blue** updated its goals, which were deemed appropriate in subsequent submissions.
PMV	
HSAG identified the following opportunity: **Healthy Blue**'s Enterprise Data Warehouse team was still working to address the receipt of duplicate claims from multiple lab data sources, and the Inovalon QSI-XL HEDIS engine continued to reject duplicate lab records. HSAG recommended that **Healthy Blue** continue to investigate the root cause and source of the duplicate claims to resolve prior to integrating into the Inovalon QSI-XL HEDIS engine. This will reduce the processing time of duplicate data and eliminate any risk of duplicates being counted within a performance measure impacted by lab services.	**Healthy Blue sufficiently addressed the recommendation. Healthy Blue** modified its logic, which allows the health plan to track if an update was received for the specimen and ensure that only the latest version of the update is maintained. This modification resolved the issue.

Prior Recommendation	Assessment
HSAG recommended that **Healthy Blue** reviews the reporting and measurement specifications with operations staff members to ensure the correct measurement period is defined in the HEDIS engine parameters.	**Healthy Blue sufficiently addressed the recommendation. Healthy Blue** updated the reporting period and re-ran the reporting; however, no results were changed. **Healthy Blue** will continue to follow HEDIS specifications.
NAV	
HSAG recommended that to improve access to care, the health plans should conduct an in-depth review of provider types for which time and distance standards were not met and use analysis results to guide contracting efforts or implement additional strategies to address network gaps.	**Healthy Blue sufficiently addressed the recommendation. Healthy Blue** described a thorough analysis process, its robust methodology, and its strategies for addressing barriers.
Optional/Additional EQR Activities	
Although **Healthy Blue** largely submitted professional and institutional data in a timely manner, the contractual obligation of submitting these encounters within 30 days of payment was not met. Additionally, **Healthy Blue** submitted 54 percent of pharmacy encounters within seven days of payment, which is below the contractual obligation of submitting pharmacy encounters within seven days of payment. HSAG recommended that **Healthy Blue** work with DHB to ensure timely submission of encounters.	**Healthy Blue sufficiently addressed the recommendation. Healthy Blue** automated all processes related to encounters, thus minimizing delays, and implemented internal reports and dashboards to monitor submissions and timeliness. As a result, **Healthy Blue** consistently met timeliness submission requirements.
Healthy Blue submitted greater than 40 percent of pharmacy encounters prior to the payment date. HSAG recommended that **Healthy Blue** work with DHB to ensure pharmacy encounters are submitted after the payment date.	**Healthy Blue sufficiently addressed the recommendation. Healthy Blue** automated its processes to ensure that pharmacy encounters are submitted within seven calendar days following payment. Additionally, **Healthy Blue** required internal notifications and attestations for the submission file to consistently monitor timely submissions. As a result, **Healthy Blue** consistently met timeliness submission requirements.
Healthy Blue submitted CPT/HCPCS codes about 83 percent of the time in institutional encounters. HSAG recommended **Healthy Blue** work with DHB to monitor the completeness of CPT/HCPCS codes in submitted encounter data.	**Healthy Blue sufficiently addressed the recommendation. Healthy Blue** implemented additional front-end claim edits to better align to the requirements and, as a result, reported fewer State rejections related to missing CPT/HCPCS codes.

Prior Recommendation	Assessment
Healthy Blue contracted with AMH providers. AMHs, at the time of contracting, designated or identified their CINs for **Healthy Blue** to establish connectivity for data exchanges. To ensure CINs and PHPs have the same provider data between the entities, HSAG recommended that **Healthy Blue** establish data exchange agreements to share AMH provider information with the CINs to ensure accuracy of data between parties.	**Healthy Blue sufficiently addressed the recommendation. Healthy Blue** continued the development and evolution of the data exchange, and embedded the listing and timing expectations of data exchanges in its agreements with the CIN/AMH providers as well as in the BAAs and data use agreements with its CINs.

UnitedHealthcare of North Carolina, Inc.

Detailed results from the EQR's substantive findings are summarized in Table 55 for each activity. This table highlights the extent to which **UnitedHealthcare** furnishes high quality, timely, and appropriate access to healthcare services, and recommendations for how **UnitedHealthcare** can best address issues identified for each activity.

Table 55—UnitedHealthcare Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)
PIPs		
+	**Strength: UnitedHealthcare** received an overall validation status of *Met* for the final validation in 2023 for all PIPs.	
+	**Strength: UnitedHealthcare** achieved statistically significant improvement for all performance indicators of all PIPs, except for the postpartum indicator of the *HEDIS PPC* PIP.	
PMV		
+	**Strength:** In MY 2022 and MY 2023, **UnitedHealthcare** demonstrated adequate processes in place to receive and process claims and encounters, membership/enrollment, data integration, provider data, and supplemental data.	
+	**Strength:** In MY 2022 and MY 2023, **UnitedHealthcare** had extensive experience using supplemental data sources and leveraged supplemental data sources to support performance measure rate reporting.	
−	**Weakness: UnitedHealthcare**'s MY 2022 rates were slightly lower than the rates for other PHPs for the *WCV*, *IMA-2*, *W30*, and *PPC* measures. **Recommendations: UnitedHealthcare** should evaluate additional interventions that will improve access to care across impacted measures.	
−	**Weakness: UnitedHealthcare**'s MY 2023 rates for *CDF-AD* and *CHF-CH* continued to be very low. **Recommendations: UnitedHealthcare** should evaluate additional interventions that will improve the frequency of depression screenings and follow-up plans. **UnitedHealthcare** should also ensure providers receive reminders about screenings and consider creating educational materials for provider and clinic staff members to promote "buy in" for screening and identify process improvements for members 18–44 years of age. **UnitedHealthcare** should identify provider-specific trends within the data and disseminate provider score cards as needed.	

Strength/ Weakness	Description	Domain(s)
−	**Weakness: UnitedHealthcare**'s rates for the *CBP* and *HBD* measures were below the MY 2023 NCQA 10th percentile. **Recommendations: UnitedHealthcare** should educate and consider incentive plans for providers on appropriate submission of CPT II codes for improving administrative capture of *CBP* and *HBD* results.	
Compliance With Standards		
+	**Strength: UnitedHealthcare** demonstrated overall compliance with standards, as evidenced by a final total compliance review score of 99 percent. The health plan's policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff members were generally knowledgeable about the requirements, policies, and procedures.	
−	**Weakness: UnitedHealthcare**'s care management record review demonstrated inconsistent compliance with documenting all member needs in the care plan. **Recommendations: UnitedHealthcare** should continue oversight and monitoring to ensure that all identified member needs are included in the member care plan.	
−	**Weakness: UnitedHealthcare** failed to ensure that its member handbook met the requirements outlined in the NC Medicaid handbook template. **Recommendations: UnitedHealthcare** should continue to pursue DHB approval of the member handbook and upon approval, immediately implement the approved version of the member handbook.	
−	**Weakness: UnitedHealthcare** was unable to demonstrate compliance with advance directive requirements. The health plan's remediation included implementation of an advance directive policy and procedure for care management staff members; however, the health plan failed to demonstrate that all member-facing departments were included in the process and trained on advance directive requirements. **Recommendations: UnitedHealthcare** should ensure all member-facing operational areas of the health plan use and are trained on the advance directive policy and procedure.	
NAV		
+	**Strength: UnitedHealthcare** established robust processes to maintain updated and accurate provider data through its provider data audits, credentialing process, and provider office outreach campaigns.	
+	**Strength: UnitedHealthcare** offered providers a variety of options to update and attest to provider data, including My Practice Profile (MPP), inbound demographic change line, roster processing, and	

Strength/ Weakness	Description	Domain(s)
	CAQH ProView, increasing the likelihood of the accuracy of the provider data used in network adequacy reporting.	
−	**Weakness:** No specific opportunities were identified related to the data collection and management process **UnitedHealthcare** had in place to inform network adequacy standard and indicator calculations.	
Optional/Additional EQR Activities		
+	**Strength: UnitedHealthcare**'s CAHPS scores were at or above the 90th percentile for *Coordination of Care* for the adult and child populations. For the adult population, **UnitedHealthcare** also scored at or between the 75th and 89th percentiles for *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *How Well Doctors Communicate.* For the child population, **UnitedHealthcare** also scored at or between the 75th and 89th percentiles for *Advising Smokers and Tobacco Users to Quit.*	
+	**Strength:** The EDV activity identified that record surplus rates for institutional and pharmacy encounter types, along with record omission rates for all encounter types, were below 5.0 percent. This indicates that encounters in both the DHB-submitted and health plan-submitted data could largely be identified in both data sources.	
+	**Strength:** The EDV activity identified that most element omission and element surplus rates were less than 5.0 percent, indicating that records which could be matched between the DHB-submitted and health plan-submitted data were largely complete.	
+	**Strength:** The EDV activity identified that all but five data elements (in two encounter types) had an accuracy rate greater than 95 percent, indicating that records which could be matched between the DHB-submitted and health plan-submitted data largely contained the same values.	
+	**Strength:** For CMPE, **UnitedHealthcare** confirmed provider assignments that were specified in the daily 834 files with DHHS before loading the assignments into Facets. The health plan also maintained historical panel information for contracted providers and was able to provide HSAG complete provider panels for each month of the lookback period of the review.	
+	**Strength:** The program integrity review activity identified that **UnitedHealthcare**'s staff described several initiatives being implemented that are specific to NC Medicaid providers. These initiatives will identify provider billing aberrations, which could result in recoupments.	
+	**Strength:** For the program integrity review, the health plan successfully remediated all initial findings.	

Strength/ Weakness	Description	Domain(s)
–	**Weakness: UnitedHealthcare**'s CAHPS scores were below the 25th percentile for *Customer Service*, *Flu Vaccination Received*, and *Discussing Cessation Strategies* for the adult population. **Recommendations: UnitedHealthcare** should explore what may be driving lower experience scores and develop initiatives designed to improve quality of care.	
–	**Weakness: UnitedHealthcare**'s CAHPS scores were below the 25th percentile for *Rating of Health Plan* for the adult population and *Customer Service* for the child population. **Recommendations: UnitedHealthcare** should explore what may be driving lower experience scores and develop initiatives designed to improve quality of care.	
–	**Weakness:** The EDV activity identified that the professional encounter record surplus rate was high at 13.0 percent. This was due to voided claims in the DHB-submitted data that were not identified in the health plan-submitted data. **Recommendations: UnitedHealthcare** should ensure records are submitted completely.	
–	**Weakness:** The EDV activity identified that the encounter element omission rates were low for most, but not all, data elements between the DHB-submitted and health plan-submitted data. **Recommendations: UnitedHealthcare** should ensure that data elements for the *Detail Service From Date* and *Detail Service To Date* institutional encounters are submitted completely.	
–	**Weakness:** The EDV activity identified that matched records largely contained similar values between the DHB-submitted and health plan-submitted data, except for some data elements. **Recommendations: UnitedHealthcare** should ensure the following data elements have accurate values: • Institutional encounters: *Service Units*, *Surgical Procedure Codes*, and *Type of Bill Code* • Pharmacy encounters: *Days Supply* and *Paid Amount*	
–	**Weakness: UnitedHealthcare**'s daily incremental beneficiary assignment file included maintenance codes to denote active, terminating, and newly assigned members. **UnitedHealthcare**'s weekly full beneficiary assignment file indicated the final assignment of members for the given week, but did not denote active, terminating, and newly assigned members. **Recommendations: UnitedHealthcare** should update its weekly full beneficiary assignment file to include the appropriate maintenance codes to communicate the assignment status of members.	

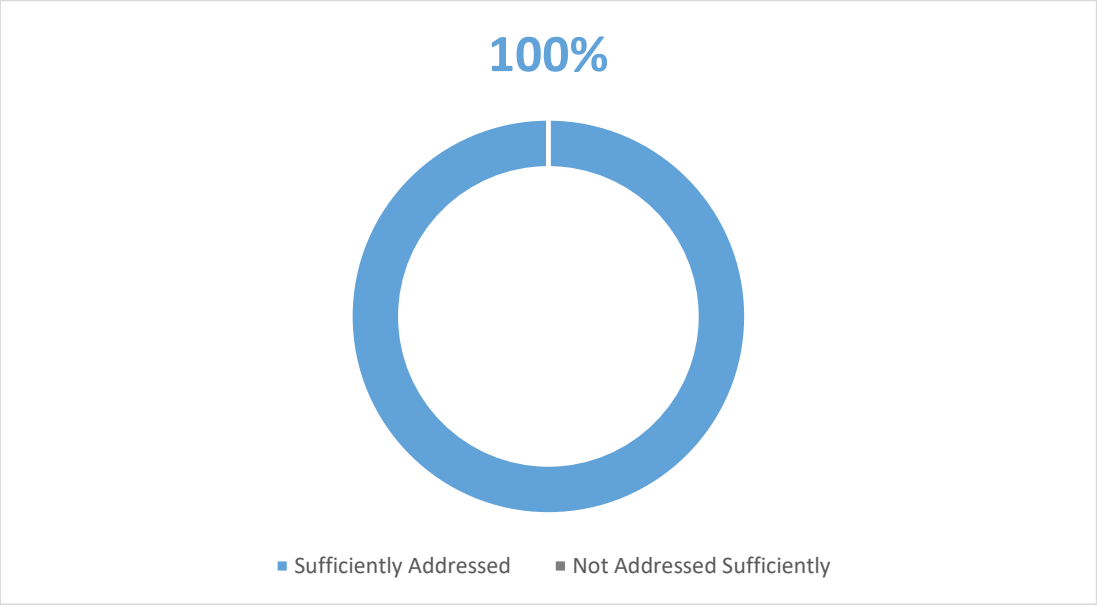
Strength/ Weakness	Description	Domain(s)
−	**Weakness: UnitedHealthcare** used a lookback period of 24 months for claims-based assignments, but the SP PCP auto-assignment requirements require a lookback period of 18 months. Additionally, **UnitedHealthcare** identified only 10 providers when applying the claims-based logic step in its algorithm. **Recommendations: UnitedHealthcare** should update its auto-assignment algorithm to align with the SP PCP auto-assignment requirements for identifying all providers seeing members within an 18-month lookback period for claims-based assignments and work with DHB on any questions related to the requirements.	

Follow-Up on Prior Year Recommendations

HSAG evaluated **UnitedHealthcare**'s approach to addressing the recommendations and/or findings issued during in the prior technical report while conducting the CY 2024 EQR activities.

Figure 6 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

Figure 6—Percentage of Prior EQR Recommendations Addressed by UnitedHealthcare



UnitedHealthcare-specific recommendations and follow-up assessments are summarized in Table 56.

Table 56—Assessment of UnitedHealthcare's Approach to Addressing Previous Annual Recommendations

Prior Recommendation	Assessment
PIPs	
HSAG recommended **UnitedHealthcare** revisit its causal/barrier analysis process at least annually to ensure that identified barriers are still relevant and determine if new barriers exist that can impede progress. HSAG also recommended **UnitedHealthcare** apply lessons learned and knowledge gained during the PIP process to make changes and revisions to current QI processes and activities and seek technical assistance from HSAG throughout the PIP process to address any questions or concerns.	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** has implemented several initiatives, including enhanced data tracking of interventions, which have been incorporated into various committees and workgroups to ensure continuous quality improvement and effective barrier analysis. **UnitedHealthcare** noted improvement within workgroups and identified strategies for addressing barriers.
HSAG recommended the **UnitedHealthcare** reference the PIP Completion Instructions as it updates its PIP submission forms to ensure that all requirements for each completed step have been addressed.	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** assigned multiple staff members to review PIP submission forms against completion instructions and EQRO feedback on prior submissions.
HSAG recommended the **UnitedHealthcare** ensures to address each of the "Validation Feedback" comments that are associated with Met validations scores in the 2023 annual submission.	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** described its process for addressing validation feedback and identified strategies for addressing barriers.
PMV	
HSAG identified the following opportunity: HSAG identified that **UnitedHealthcare**'s rates were slightly lower than the rates for other SPs for the *WCV*, *IMA-2*, *W30*, *PPC*, and *CDC* measures. HSAG recommended that **UnitedHealthcare** continue to monitor its performance on all measures, and evaluate rates in comparison to national benchmarks (where available), to determine if future MY rates improve once **UnitedHealthcare** has more experience serving its North Carolina members. If future MY rates do not improve, **UnitedHealthcare** should evaluate additional interventions that will improve access to care across impacted measures.	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** conducted a root cause analysis to collect additional data on the various causes contributing to lower rates in these measures and utilized the data in various workgroups to design interventions. **UnitedHealthcare** reported year-over-year rate improvement in many of the identified measures and identified strategies for addressing barriers.
NAV	
HSAG recommended that to improve access to care, the health plans should conduct an in-depth review of provider types for which time and distance standards were not met and use analysis	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** described various barriers, noted performance improvements realized by implementing initiatives, and identified strategies for addressing barriers.

Prior Recommendation	Assessment
results to guide contracting efforts or implement additional strategies to address network gaps.	
Optional/Additional EQR Activities	
Although **UnitedHealthcare** largely submitted professional and institutional data in a timely manner, the contractual obligation of submitting these encounters within 30 days of payment was not met. Additionally, **UnitedHealthcare** submitted 12 percent of pharmacy encounters within seven days of payment, which is below the contractual obligation of submitting pharmacy encounters within seven days of payment. HSAG recommended that **UnitedHealthcare** work with DHB to ensure timely submission of encounters.	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** initiated an IT project to hold pharmacy encounters until the claim paid date is greater than or equal to the current date, and then it releases the encounter for submission. As a result, **UnitedHealthcare** achieved a consistent timeliness SLA rate of 99% or higher.
UnitedHealthcare submitted greater than 80 percent of pharmacy encounters prior to the payment date. HSAG recommended that **UnitedHealthcare** work with DHB to ensure pharmacy encounters are submitted after the payment date.	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** initiated an IT project to hold pharmacy encounters until the claim paid date is greater than or equal to the current date, and then it releases the encounter for submission. As a result, **UnitedHealthcare** achieved a consistent timeliness SLA rate of 99% or higher.
UnitedHealthcare submitted CPT/HCPCS codes about 83 percent of the time in institutional encounters. HSAG recommended **UnitedHealthcare** work with DHB to monitor the completeness of CPT/HCPCS codes in submitted encounter data.	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** explained that paid encounters that did not have a procedure code were billed that way and identified types of services where this occurs (e.g., anesthesia, medical supplies, recovery room). **UnitedHealthcare** noted that these were claims paid without a CPT code and the encounter was accepted by the State, which is not a weakness within encounters since it is submitting the information as billed.
UnitedHealthcare reported a system limitation in assigning beneficiaries to mid-level practitioners (e.g., nurse practitioners and physician assistants) which resulted in incorrect beneficiary assignments at the AMH level. Although **UnitedHealthcare** has indicated it will implement a new process using its Living Data tool to track all provider panel limitations and changes, HSAG recommended **UnitedHealthcare** should prioritize implementing this solution considering the risk of ongoing incorrect beneficiary	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** identified a system limitation and implemented a code change that resolved the issue. **UnitedHealthcare** implemented an extensive overhaul of the AMH assignment process and reported a decrease in provider complaints regarding panel assignments and an increase in the reporting of correct demographics to AMH partners.

Prior Recommendation	Assessment
assignments will continue to increase until this system issue is corrected.	
UnitedHealthcare indicated confidence that its current beneficiary-to-PCP auto-assignment algorithm is working correctly; however, it did not provide any additional information regarding analyses it has conducted to confirm. To determine whether its auto-assignment algorithm requires updates, HSAG recommended that **UnitedHealthcare** conducts ongoing analyses of its frequency of reassigning beneficiaries from their auto-assigned PCP to another provider.	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** reported a sharp decrease in member move requests since a code change was implemented July 2023. **UnitedHealthcare** identified barriers and strategies for addressing those barriers.

WellCare of North Carolina, Inc

Detailed results from the EQR's substantive findings are summarized in Table 57 for each activity. This table highlights the extent to which **WellCare** furnishes high quality, timely, and appropriate access to healthcare services, and recommendations for how **WellCare** can best address issues identified for each activity.

Table 57—WellCare Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)
PIPs		
+	**Strength: WellCare** received an overall validation status of *Met* for the final validation in 2023 for all PIPs.	
+	**Strength: WellCare** achieved statistically significant improvement for the performance indicator of the *HEDIS HBD* PIP.	
−	**Weakness: WellCare** had statistically significant declines in performance when compared to the baseline for the *HEDIS CIS—Combo 10* PIP performance indicator, both performance indicators of the *HEDIS PPC* PIP, and the performance indicator of the nonclinical PIP. **Recommendations:** The health plan should conduct a root cause analysis to identify opportunities to address barriers to enrollee completion of recommended immunization schedules, timely prenatal provider visits, and health-related resource needs screenings.	
PMV		
+	**Strength:** In MY 2022, **WellCare**'s claims department continuously audited random samples of all paid, denied, appealed, and adjusted claims in order to assess claims data completeness, payment and financial accuracy, and compliance with contractual obligations. **WellCare** held meetings with a quality management team to address findings that are used by leadership to raise awareness for quality improvement opportunities.	
+	**Strength: WellCare** successfully passed the source code review for the *HRRN* measure in MY 2022 without issue.	
+	**Strength:** In MY 2023, **WellCare** consistently demonstrated quality achievements through meeting accuracy goals for claims payment and coding, and used supplemental data sources to the maximum to improve its performance measure rate reporting.	
−	**Weakness:** Claims processors are required to consistently achieve a quality target of 99.5 percent financial accuracy and 98 percent payment accuracy, and a production target of 100 percent. **WellCare**'s results for these targets were not consistently met during MY 2022.	

Strength/ Weakness	Description	Domain(s)
	Recommendations: WellCare should continue to monitor and address opportunities to improve and find efficiencies in the claims audit process to consistently meet departmental goals.	
−	**Weakness:** In MY 2022, **WellCare**'s data completeness for claims was 83.8 percent after a 90-day runout period. **Recommendations: WellCare** should find areas of improvement to increase the completeness in the range of 90 percent by 90 days, as administrative claims are integral in determining denominators and numerators for reporting.	
−	**Weakness: WellCare**'s MY 2023 rates for *CDF-AD* and *CHF-CH* were very low, although in line with its cohorts. **Recommendations: WellCare** should evaluate additional interventions that will improve the frequency of depression screenings and follow-up plans. **WellCare** should ensure providers receive reminders about screenings and consider creating educational materials for provider and clinic staff members to promote "buy in" for screening. In addition, **WellCare** should identify process improvements for members 18–44 years of age and identify provider-specific trends within the data and disseminate provider score cards as needed.	
−	**Weakness: WellCare**'s rates for the *CBP* and *HBD* measures were below the MY 2023 NCQA 10th percentile. **Recommendations: WellCare** should educate and consider incentive plans for providers on appropriate submission of CPT II codes for improving administrative capture of *CBP* and *HBD* results.	
Compliance With Standards		
+	**Strength: WellCare** demonstrated overall compliance with standards, as evidenced by a final total compliance review score of 99 percent. The health plan's policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff members were generally knowledgeable about the requirements, policies, and procedures.	
−	**Weakness: WellCare**'s care management record review demonstrated inconsistent compliance with documenting all member needs in the care plan. **Recommendations: WellCare** should continue oversight and monitoring to ensure that all identified member needs are included in the member care plan. This procedure must be inclusive for all members, regardless of whether or not the member is experiencing a transition of care.	

Strength/ Weakness	Description	Domain(s)
−	**Weakness: WellCare** failed to ensure that its member handbook met the requirements outlined in the NC Medicaid handbook template. **Recommendations: WellCare** should continue to pursue DHB approval of the member handbook and upon approval, immediately implement the approved version of the member handbook.	
NAV		
+	**Strength: WellCare** maintained strong data validation processes for Quest data integration, including record count reconciliation from source to target systems and trended reports to identify any potential data gaps.	
+	**Strength: WellCare** performed frequent audits of the Xcelys provider subsystem data to ensure provider data accuracy for network adequacy reporting.	
+	**Strength: WellCare**'s process for ensuring that duplicate member records were merged prior to reporting was sufficient for accurate reporting.	
−	**Weakness:** No specific opportunities were identified related to the data collection and management process **WellCare** had in place to inform network adequacy standard and indicator calculations.	
Optional/Additional EQR Activities		
+	**Strength: WellCare**'s CAHPS scores were at or above the 90th percentile for *Rating of All Health Care* for the adult population. Also for the adult population, **WellCare** scored at or between the 75th and 89th percentiles for *Rating of Specialist Seen Most Often* and *Customer Service.* For the child population, **WellCare** scored at or between the 75th and 89th percentiles for *How Well Doctors Communicate.*	
+	**Strength:** The EDV activity identified that record surplus rates for professional and pharmacy encounter types, along with record omission rates for all encounter types, were below 5.0 percent. This indicates that encounters in both the DHB-submitted and health plan-submitted data could largely be identified in both data sources.	
+	**Strength:** The EDV activity identified that most element omission and element surplus rates were less than 5.0 percent, indicating that records which could be matched between the DHB-submitted and health plan-submitted data were largely complete.	
+	**Strength:** The EDV activity identified that all but four data elements (in two encounter types) had an accuracy rate greater than 95 percent, indicating that records which could be matched between the DHB-submitted and health plan-submitted data largely contained the same values.	

Strength/ Weakness	Description	Domain(s)
+	**Strength:** For CMPE, **WellCare** demonstrated continued process improvement by providing more accurate, timely, and consistent documentation to AMHs/PCPs with active participation in State workgroups and meetings, and implementing various improvements that ultimately led to more member support and improved health outcomes.	
+	**Strength:** The program integrity review activity identified that, as required by **WellCare**'s policy, the preliminary review reports in the files reviewed were completed in a timely manner.	
+	**Strength:** For the program integrity review, the health plan successfully remediated all initial findings.	
−	**Weakness: WellCare**'s CAHPS scores were below the 25th percentile for *Rating of Health Plan* for the adult population and *Flu Vaccination Received* for the child population. **Recommendations: WellCare** should explore what may be driving lower experience scores and develop initiatives designed to improve quality of care.	
−	**Weakness:** The EDV activity identified that the institutional encounter record surplus rate was high at 10.6 percent. This was due to voided claims in the DHB-submitted data that were not identified in the health plan-submitted data. **Recommendations: WellCare** should ensure records are submitted completely.	
−	**Weakness:** The EDV activity identified that the encounter element omission rates were low for most, but not all, data elements between the DHB-submitted and health plan-submitted data. **Recommendations: WellCare** should ensure that the *Secondary Diagnosis Codes* data element for institutional encounters is submitted completely.	
−	**Weakness:** The EDV activity identified that matched records largely contained similar values between the DHB-submitted and health plan-submitted data, except for some data elements. **Recommendations: WellCare** should ensure the following data elements have accurate values: • Institutional encounters: *Header Service To Date*, *Secondary Diagnosis Codes*, and *Surgical Procedure Codes* • Pharmacy encounters: *Days Supply*	
−	**Weakness:** For CMPE, **WellCare** did not set a provider panel size limit and relied on the providers to ensure that their ability to accept new patients was updated in a timely manner in NCTracks. As a result, **WellCare** received member complaints regarding provider	

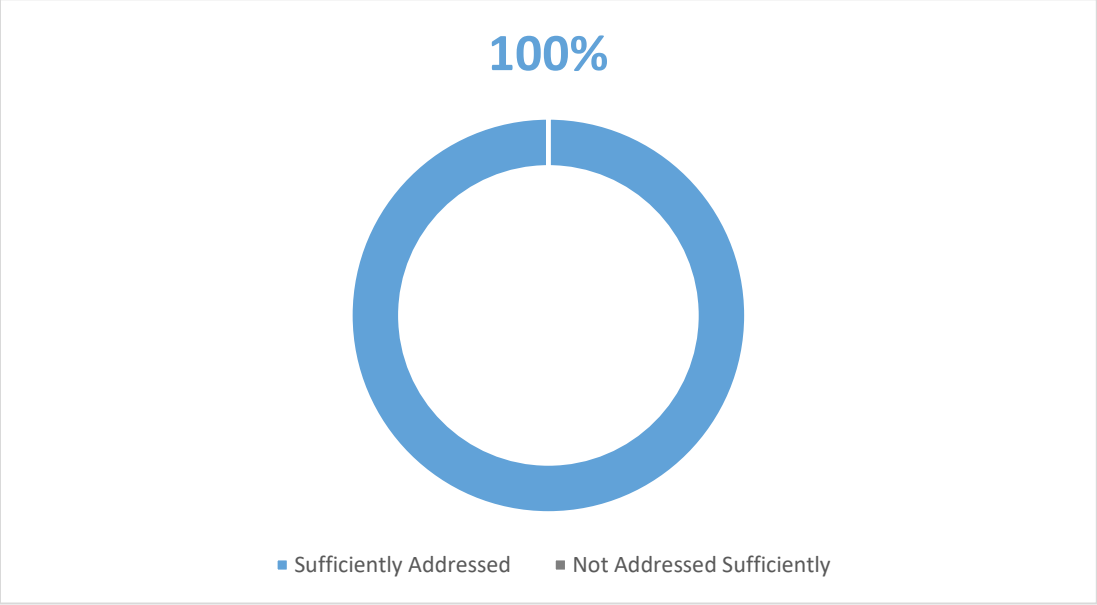
Strength/ Weakness	Description	Domain(s)
	reassignment if members were assigned to providers who did not update their preference to stop accepting new patients. **Recommendations: WellCare** should set an internal default limit to trigger a review and notification to providers to ensure they are updating their accepting new patient indicator.	

Follow-Up on Prior Year Recommendations

HSAG evaluated **WellCare**'s approach to addressing the recommendations and/or findings issued during in the prior technical report while conducting the CY 2024 EQR activities.

Figure 7 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

Figure 7—Percentage of Prior EQR Recommendations Addressed by WellCare



WellCare-specific recommendations and follow-up assessments are summarized in Table 58.

Table 58—Assessment of WellCare's Approach to Addressing Previous Annual Recommendations

Prior Recommendation	Assessment
PIPs	
HSAG recommended **WellCare** revisit its causal/barrier analysis process at least annually to ensure that identified barriers are still relevant and determine if new barriers exist that can impede progress. HSAG also recommended **WellCare** apply lessons learned and knowledge gained during the PIP process to make changes and revisions to current QI processes and activities and seek technical assistance from HSAG throughout the PIP process to address any questions or concerns.	**WellCare sufficiently addressed the recommendation. WellCare** implemented a workflow to review identified barriers and determine if they are still relevant, and whether new barriers exist. The health plan also conducts a biweekly PIP workgroup. **WellCare** received a score of 100% for all evaluation elements for all PIP topics upon resubmission for 2024.
HSAG recommended **WellCare** reference the PIP Completion Instructions as it updates its PIP submission forms to ensure that all requirements for each completed step have been addressed.	**WellCare sufficiently addressed the recommendation. WellCare** added the PIP Completion Instructions to a resources folder accessible to all PIP owners and implemented a review process by the PIP workgroup and QI leadership. **WellCare** received a score of 100% for all evaluation elements for all PIP topics upon resubmission for 2024.
Address any *Partially Met*, *Not Met*, or Validation Feedback comments associated with *Met* validation scores in the next annual submission.	**WellCare sufficiently addressed the recommendation. WellCare** incorporated feedback and received a score of 100% for all evaluation elements for all PIP topics upon resubmission for 2024.
PMV	
HSAG identified the following opportunity: **WellCare** indicated that the North Carolina immunization registry had issues returning records to the SP; therefore, **WellCare** was in the process of studying the problem with the State's analysts. HSAG recommended that **WellCare** continue its efforts working with the State to resolve the ongoing data challenges occurring with the State's immunization registry, as these data are critical to support quality reporting across immunization measures within the scope of PMV: *CIS—Combo 10 and Immunizations for Adolescents—Combination 2*.	**WellCare sufficiently addressed the recommendation. WellCare** noted the missing vaccine information in the NCIR output file. **WellCare**'s loading process pulls the missing vaccine information when it comes in the NCIR file. **WellCare** monitors results and cross-references the information between the data and the NCIR file.

Prior Recommendation	Assessment
HSAG recommended that **WellCare** conduct ongoing monitoring of member-level details at the measure-level, to ensure that members are not inappropriately reported in measure denominators and numerators.	**WellCare sufficiently addressed the recommendation. WellCare** identified a misunderstanding of custom data fields in the member data repository that was used as part of the member matching process. The new system yielded improved methods of merging member data, and no similar deficiencies occurred after the previous errors were mitigated.
NAV	
HSAG recommended that to improve access to care, the health plans should conduct an in-depth review of provider types for which time and distance standards were not met and use analysis results to guide contracting efforts or implement additional strategies to address network gaps.	**WellCare sufficiently addressed the recommendation. WellCare** added Quest reporting that allows for identification of contracting prospects based on available providers. **WellCare** improved performance through weekly meetings to review deficiencies and identify prospective providers using internally generated reports and Quest reports.
Additional EQR Activities	
Although **WellCare** largely submitted professional and institutional data in a timely manner, the contractual obligation of submitting these encounters within 30 days of payment was not met. Additionally, **WellCare** submitted 52% of pharmacy encounters within seven (7) days of payment, which is below the contractual obligation of submitting pharmacy encounters within seven (7) days of payment. HSAG recommended that **WellCare** work with the DHB to ensure timely submission of encounters.	**WellCare sufficiently addressed the recommendation. WellCare** provided its PBM with instructions on submitting encounters, reviewed rejections from the PBM, and assisted the PBM with submitting encounters. After these interventions, **WellCare** began to meet SLA requirements.
WellCare submitted greater than 40% of pharmacy encounters prior to the payment date. HSAG recommended that **WellCare** work with DHB to ensure pharmacy encounters are submitted after the payment date.	**WellCare sufficiently addressed the recommendation. WellCare** reviewed the rejections and instructed its PBM to not send future paid dates and hold the encounters until correct paid dates were available. The PBM worked with IT teams to identify and correct the claim adjudication system issue, resulting in correct check dates being populated. As a result, **WellCare** began to meet SLA requirements.

Prior Recommendation	Assessment
WellCare submitted CPT/healthcare common procedure coding system (HCPCS) codes about 83% of the time in institutional encounters. HSAG recommended **WellCare** work with DHB to monitor the completeness of CPT/HCPCS codes in submitted encounter data.	**WellCare sufficiently addressed the recommendation. WellCare** described that it submitted all CPT/HCPCS codes received on claims as encounters and that claims that did not report CPT/HCPCS codes are the inpatient institutional encounters which only have revenue codes.
WellCare should assess its provider data in comparison to the provider enrollment file, identifying provider data mismatches from which to assess for root cause.	**WellCare sufficiently addressed the recommendation. WellCare** described a series of interventions and reported improved efficiency and reconciliation of provider data management.
A **WellCare** staff member told the CIN that all provider enrollment file data is manually entered into the **WellCare** system, without any automation. HSAG recommended that it is critical for **WellCare** to ensure that all staff members who are working with the CINs are correctly trained in the PEF data flow and automation steps that **WellCare** uses to load and validate the data. Inconsistent **WellCare** messaging to the CINs can contribute to continued provider abrasion and loss of trust.	**WellCare sufficiently addressed the recommendation. WellCare** identified some staff members who were not trained/re-trained on workflow and conducted staff training. The new training was incorporated into new hire and reeducation protocols. **WellCare** identified no additional barriers.

PIHPs

HSAG assessed the strengths and weaknesses of each PIHP with respect to the quality, timeliness, and accessibility of healthcare services.

Alliance Health

Detailed results from the EQR's substantive findings of **Alliance** are summarized in Table 59 for each activity. This table highlights the extent to which **Alliance** furnishes high quality, timely, and appropriate access to healthcare services, and recommendations for how **Alliance** can best address issues identified for each activity.

Table 59—Alliance Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)
PIPs		
+	**Strength: Alliance** received a *High Confidence* level for the overall confidence of the PIP methodology in 2023 for all PIPs.	
PMV		
+	**Strength: Alliance** demonstrated a robust disaster recovery capabilities plan in MY 2023 that ensured exceptional data availability and protection in the event of a system failure. This plan included key elements of security using comprehensive off-site backup and recovery, regular failover, and recovery testing.	
+	**Strength:** In MY 2023, **Alliance** was committed to performance and process improvement by actively monitoring performance measures and developing a real-time dashboard to provide performance rates, trends, and forecasts. This monitoring will ensure data-driven decision making and continuous improvements.	
Compliance With Standards (Not Conducted During Reporting Cycle)		
NAV		
+	**Strength: Alliance** had robust policies and procedures demonstrating its capability to ensure the accuracy of network adequacy indicator calculation and monitoring as well as reporting metrics by maintaining several multi-staffed quality assurance methods to verify the accuracy of data.	
+	**Strength: Alliance**'s Network Performance Committee conducted biweekly meetings with DHHS to discuss the progress and resolution of identified network gaps.	

Strength/ Weakness	Description	Domain(s)
−	**Weakness:** No specific opportunities were identified related to the data collection and management processes **Alliance** had in place to inform network adequacy standard and indicator calculations.	
Optional/Additional EQR Activities		
	There were no health plan-specific strengths or weaknesses identified from optional or additional EQR activities.	

Follow-Up on Prior Year Recommendations

Due to their mid-year managed care launch, the PIHPs were not included in EQR activities during the previous reporting cycle; therefore, no follow up was required.

Partners Health Management

Detailed results from the EQR's substantive findings of **Partners** are summarized in Table 60 for each activity. This table highlights the extent to which **Partners** furnishes high quality, timely, and appropriate access to healthcare services, and recommendations for how **Partners** can best address issues identified for each activity.

Table 60—Partners Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)
PIPs		
+	**Strength: Partners** received a *High Confidence* level for the overall confidence of the PIP methodology in 2023 for all PIPs.	
PMV		
+	**Strength: Partners** deployed the Alpha+ system for its managed care operations that supported strong data quality and a well-structured database for calculating performance indicators, reporting, and data validation, ensuring quick access to correct data for prompt error identification.	
+	**Strength: Partners** demonstrated multiple levels of validation to ensure the accuracy and completeness of all data ingested and processed within its systems.	
−	**Weakness:** During the virtual review, **Partners** described its care management process for completing the SDOH screening. **Partners** indicated that the assessment was deemed as complete even if all questions were not answered, and the assessment was placed in a finalized status. If a paper SDOH screening was completed and then	

Strength/ Weakness	Description	Domain(s)
	entered into TruCare, the date on the screening would be the date the screening was entered into TruCare. **Recommendations:** HSAG recommends that **Partners**' implement a system response requirement before assessments are considered finalized. This quality process can be implemented by using pre-defined response options (e.g., yes, no, not applicable, and declined to respond) for most questions within the assessment and add an option to save unfinalized assessments for completion at a later date and time, if requested by the beneficiary. Also, HSAG recommends for **Partners** to implement a system to match paper assessments to case managers by appointment to detect what is not entered in TruCare by the case managers.	
Compliance With Standards (Not Conducted During Reporting Cycle)		
NAV		
+	**Strength: Partners** demonstrated robust policies and procedures demonstrating its capability of ensuring the accuracy of network adequacy indicator calculation and monitoring and reporting metrics by maintaining several multi-staffed quality assurance methods to verify the accuracy of data.	
+	**Strength: Partners** had a CFT that worked to ensure network access and adequacy standards were met or put into the process of being met through a variety of methods, including targeted provider recruitment efforts, RFP/RFI, and marketing the service needs to providers. Exemptions were monitored through CFT each month as goals and objectives were set to meet network adequacy standards.	
−	**Weakness:** No specific opportunities were identified related to the systems, management processes, or data integration **Partners** had in place to inform network adequacy standard and indicator calculation and reporting.	
Optional/Additional EQR Activities		
	There were no health plan-specific strengths or weaknesses identified from optional or additional EQR activities.	

Follow-Up on Prior Year Recommendations

Due to their mid-year managed care launch, the PIHPs were not included in EQR activities during the previous reporting cycle; therefore, no follow up was required.

Trillium Health Resources

Detailed results from the EQR's substantive findings of **Trillium** are summarized in Table 61 for each activity. This table highlights the extent to which **Trillium** furnishes high quality, timely, and appropriate access to healthcare services, and recommendations for how **Trillium** can best address issues identified for each activity.

Table 61—Trillium Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)
PIPs		
+	**Strength: Trillium** received a *High Confidence* level for the overall confidence of the PIP methodology in 2023 for all PIPs.	
PMV		
+	**Strength: Trillium** demonstrated multiple levels of validation to ensure the accuracy and completeness of all data ingested and processed within its systems.	
−	**Weakness:** During the virtual review, **Trillium** described its provider portal functionality, including a feature that allows providers to enter third-party insurance information for **Trillium**'s coordination of beneficiary benefits. **Trillium** then approved the data entry and ingested this third-party insurance into TBS and submitted the insurance information to DHHS. **Trillium** noted that it relied upon providers to enter accurate third-party insurance information, and did not validate the information prior to ingestion into TBS. **Recommendations:** As a best practice recommendation, HSAG suggests that **Trillium** implement additional quality assurance or validation protocols to ensure the accuracy and completeness of manual third-party insurance data entry prior to ingestion into TBS.	
−	**Weakness:** During the virtual review, **Trillium** described its care management process for completing the CMCA and CNS. **Trillium** indicated that the assessment was deemed as complete when all questions were answered, and the assessment was placed in a finalized status. **Trillium** used pre-defined response options (e.g., yes, no, not applicable, and declined to respond) for most questions within the assessment, and it maintained an option to save unfinalized assessments for completion at a later date and time, if requested by the beneficiary. **Trillium** also relied on standard operating procedures and care management reports to ensure the Care Management Team was adequately completing and finalizing the assessments. However, the system did not require responses for any of the questions before it could be finalized.	

Strength/ Weakness	Description	Domain(s)
	Recommendations: As an additional method of quality assurance in assessment completeness, and given **Trillium**'s use of standard disposition response options and the ability to save assessments in an unfinalized status for future completion per a beneficiary's request, HSAG recommends that **Trillium** implement system response requirements before assessments can be finalized.	
Compliance With Standards (Not Conducted During Reporting Cycle)		
NAV		
+	**Strength: Trillium** maintained desktop policies and procedures governing technical aspects of network adequacy reporting, including data collection, storage, and transformations.	
+	**Strength: Trillium** used a ticketing system to manage provider network data changes, helping streamline the process and ensuring provider data accuracy.	
+	**Strength: Trillium** maintained staff dedicated specifically to network adequacy reporting who demonstrated subject matter expertise in network adequacy data governance and dataset maintenance.	
+	**Strength: Trillium** identified robust and ongoing processes for network adequacy performance review, including executive and committee report reviews.	
−	**Weakness:** No specific opportunities were identified related to the data collection and management process **Trillium** had in place to inform network adequacy standard and indicator calculations.	
Optional/Additional EQR Activities		
	There were no health plan-specific strengths or weaknesses identified from optional or additional EQR activities.	

Follow-Up on Prior Year Recommendations

Due to their mid-year managed care launch, the PIHPs were not included in EQR activities during the previous reporting cycle; therefore, no follow up was required.

Vaya Health

Detailed results from the EQR's substantive findings of **Vaya Health** are summarized in Table 62 for each activity. This table highlights the extent to which **Vaya Health** furnishes high quality, timely, and appropriate access to healthcare services, and recommendations for how **Vaya Health** can best address issues identified for each activity.

Table 62—Vaya Health Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)
PIPs		
+	**Strength: Vaya** received a *High Confidence* level for the overall confidence of the PIP methodology in 2023 for all PIPs.	
PMV		
+	**Strength: Vaya** demonstrated adequate systems and processes to receive and process enrollment/eligibility data as well as claims and encounters, and to accurately integrate the data within its data warehouse.	
+	**Strength: Vaya** demonstrated multiple levels of validation to ensure the accuracy and completeness of all data ingested and processed within its systems.	
Compliance With Standards (Not Conducted During Reporting Cycle)		
NAV		
+	**Strength: Vaya** identified robust processes, including automated procedures, and oversight to ensure the accuracy of beneficiary and provider data flows into HSP and the EDW.	
−	**Weakness:** Provider specialty codes were applied to the Quest provider file using a manual process. **Recommendations:** HSAG recommends that **Vaya** consider options to reduce manual data processing used for Quest file production to eliminate the introduction of possible errors.	
Optional/Additional EQR Activities		
	There were no health plan-specific strengths or weaknesses identified from optional or additional EQR activities.	

Follow-Up on Prior Year Recommendations

Due to their mid-year managed care launch, the PIHPs were not included in EQR activities during the previous reporting cycle; therefore, no follow up was required.

TPs

The TPs launched July 1, 2024; therefore, they were not within scope of EQR activities during this reporting cycle, and HSAG was unable to make any conclusions or recommendations.

Follow-Up on Prior Year Recommendations

In the prior reporting year, although the TPs were not yet in operation, DHB directed these health plans to proceed with the PIP design. Therefore, in the previous technical report, HSAG included conclusions and recommendations pertaining to the PIP activities of the TPs. However, when the TP launch was delayed until July 2024, the Department suspended PIP reporting for TPs. As a result, the Department did not require the TPs to address the previous year's EQRO recommendations, since they were specific to the PIP process that was suspended.

Appendix A. Methodology

PIP

For calendar year (CY) 2023, the Department required the PIHPs to conduct PIPs in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i–iv). In accordance with §438.330(d)(2)(i–iv), each PIP must include:

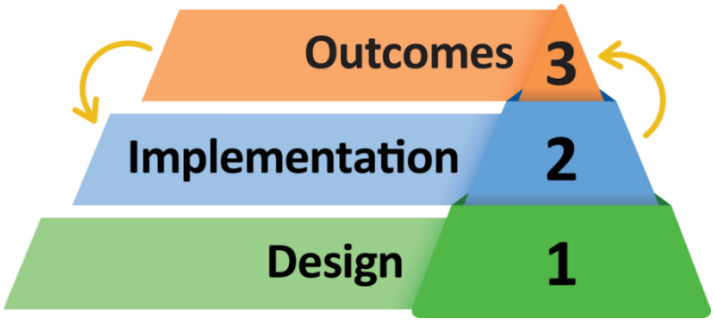
- Measuring performance using objective quality indicators
- Implementing system interventions to achieve improvement in quality
- Evaluating effectiveness of the interventions
- Planning and initiating of activities for increasing or sustaining improvement

To monitor, assess, and validate PIPs, HSAG uses a standardized scoring methodology to rate a PIHP's compliance with each of the nine steps listed in the CMS Protocol 1. With the Department's input and approval, HSAG 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 CMS Protocol 1 steps:

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

Below, Figure 8 illustrates the three stages of the PIP process—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 steps in this stage include development of the PIP topic, Aim statement, population, sampling methods, performance indicators, and data collection. To implement successful improvement strategies, a methodologically sound PIP design is necessary.

Figure 8—Stages of the PIP Process



Once a health plan establishes its PIP design, the PIP progresses into the Implementation stage (Steps 7 and 8). During this stage, a health plan evaluates and analyzes its data, identifies barriers to performance, and develops interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve outcomes. The Outcomes stage (Step 9) is the final stage, which involves the evaluation of statistically significant improvement, and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when performance indicators demonstrate statistically significant improvement over baseline performance through repeated measurements over comparable time periods. This stage is the culmination of the previous two stages. If the outcomes do not improve, a health plan should revise its causal/barrier analysis processes and adapt QI strategies and interventions accordingly.

HSAG obtains the information and data needed to conduct the PIP validation from a health plan's PIP Submission Form. This form provides detailed information about a health plan's PIP related to the steps completed and evaluated by HSAG for the CY 2023 validation cycle.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as Met, Partially Met, Not Met, Not Applicable, or Not Assessed. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be Met.

In alignment with CMS Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. One validation rating reflects HSAG's confidence that the PIHP adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. This validation rating is based on the scores for applicable evaluation elements in Steps 1 through 8 of the PIP Validation Tool. The second validation rating is only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP Validation Tool. For each applicable validation rating, HSAG reports the percentage of applicable evaluation elements that received a Met validation score and the corresponding confidence level: High Confidence, Moderate Confidence, Low Confidence, or No Confidence. The confidence level definitions for each validation rating are as follows:

1. **Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)**

   High Confidence: High confidence in reported PIP results. All critical evaluation elements were Met, and 90 percent to 100 percent of all evaluation elements were Met across all steps.

   Moderate Confidence: Moderate confidence in reported PIP results. All critical evaluation elements were Met, and 80 percent to 89 percent of all evaluation elements were Met across all steps.\

   Low Confidence: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were Met; or one or more critical evaluation elements were Partially Met.

   No Confidence: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were Met; or one or more critical evaluation elements were Not Met.

2. **Overall Confidence That the PIP Achieved Significant Improvement (Step 9)**

   High Confidence: All performance indicators demonstrated statistically significant improvement over the baseline.

   Moderate Confidence: One of the three scenarios below occurred:

   - All performance indicators demonstrated improvement over the baseline, and some but not all performance indicators demonstrated statistically significant improvement over the baseline.
   - All performance indicators demonstrated improvement over the baseline, and none of the performance indicators demonstrated statistically significant improvement over the baseline.
   - Some but not all performance indicators demonstrated improvement over baseline, and some but not all performance indicators demonstrated statistically significant improvement over baseline.

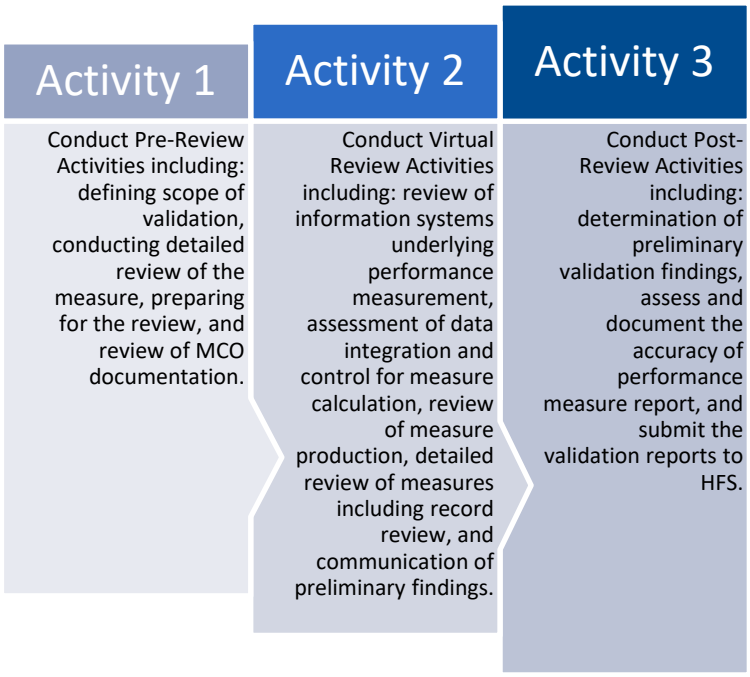
   Low Confidence: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator or some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated statistically significant improvement over the baseline.

   No Confidence: The remeasurement methodology was not the same as the baseline methodology for all performance indicators or none of the performance indicators demonstrated improvement over the baseline.

PMV Audits

HSAG validated the data collection and reporting processes of the North Carolina SPs, to report the performance measure data for MY 2022 (January 1, 2022, through December 31, 2022) and MY 2023 (January 1, 2023, through December 31, 2023) in accordance with CMS' Protocol 2 cited earlier in this report. HSAG also assessed the readiness of NC PIHPs to report performance measures in MY 2024 in accordance with CMS' Protocol 2 cited earlier in this report. Figure 9 presents the protocol activities conducted.

Figure 9—Protocol 2 Activities



NCQA,[27] CMS, and DHB provided the specifications and supplemental guidance that the North Carolina SPs and PIHPs were required to use for assessing information system capabilities and reporting the performance measures, and which HSAG utilized to define the scope of the validation.

The following list describes the types of documentation and data collected and how HSAG conducted analysis of data:

- **Information systems review—**HSAG utilized each plan's completed ISCAT and relevant supplemental documentation to assess the integrity of information systems and data processes used for collecting and processing data, and processes used for performance measure calculation. HSAG thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed

[27] National Committee for Quality Assurance. HEDIS Measures and Technical Resources. Available at: https://www.ncqa.org/hedis/measures/. Accessed on: October 31, 2024.

additional clarification. Where applicable, HSAG used the information provided in each ISCAT to begin completing the review tools.

- **Source code (programming language) for performance indicators—**HSAG required each plan that calculated the performance indicators using computer programming language to submit source code for each performance indicator being validated. HSAG completed a line-by-line review of the supplied source code to ensure compliance with the state-defined performance indicator specifications. HSAG identified areas of deviation from the specifications, evaluating the impact to the indicator and assessing the degree of bias (if any). HSAG required plans that did not use computer programming language to calculate the performance indicators to submit documentation describing the steps the health plan took for indicator calculation.
- **Performance indicator reports—**HSAG reviewed SP's prior rate reports along with the current reports to assess trending patterns and rate reasonability.
- **Primary source verification (PSV)—**HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirmed entry; and detected errors. HSAG selected cases across evaluated measures to verify that each plan had appropriately applied measure specifications for accurate rate reporting. Each plan provided HSAG with a listing of the data it had reported to DHB, from which HSAG randomly selected a sample of cases. Prior to and during the virtual site visit, screenshots of the data and each plan's live systems were reviewed for verification. This approach enabled each plan to explain its processes regarding any exception processing or unique, case-specific nuances that may or may not impact final measure reporting.
- **Supporting documentation—**HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

The PMV review of each plan's reported data consisted of remote validation and post-validation activities focusing on enrollment and eligibility processes, claims and encounter processes, and performance measure production. HSAG conducted a virtual site review with each plan during 2024. The virtual site review included:

- A review of key information systems and the data systems and processes critical to the calculation of measures. HSAG conducted interviews with key staff familiar with the collection, processing, and monitoring of the health plan's data used in producing performance measures.
- A review of the database management systems and processes used to integrate key source data and the health plan's calculation and reporting of performance measures, including accurate numerator and denominator identification and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).
- A demonstration of key information systems, database management systems, and analytic systems to support documented evidence and interview responses.

Compliance Review

In accordance with 42 CFR §438.358, the DHB or an EQRO, must perform the mandatory EQR activity for each managed care plan, within a three-year period, to determine compliance with federal regulations. Since July 1, 2021, HSAG has served as the EQRO for SPs and at the request of DHB, HSAG will conduct a Compliance Review for each SPs in CY 2023.

This section describes the methodology HSAG utilizes to complete the Compliance Review. HSAG followed the guidelines outlined in the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019 (CMS Protocol 3).[28]

Requirements of Compliance Review

In accordance with CMS Protocol 3, the standards that are subject to this protocol include the following:

- §438.56 Disenrollment: Requirements and Limitations
- §438.100 Enrollee Rights
- §438.114 Emergency and Poststabilization Services
- §438.206 Availability of Services
- §438.207 Assurances of Adequate Capacity and Services
- §438.208 Coordination and Continuity of Care
- §438.210 Coverage and Authorization of Services
- §438.214 Provider Selection
- §438.224 Confidentiality
- §438.228 Grievance and Appeal Systems
- §438.230 Subcontractual Relationships and Delegation
- §438.236 Practice Guidelines
- §438.242 Health Information Systems
- §438.330 Quality Assessment and Performance Improvement Program

Objectives for Conducting the Compliance Review

The primary objective of the Compliance Review is to provide meaningful information to DHB and the SPs regarding administrative processes to ensure compliance with federal requirements. In preparation

[28] U.S. Department of Health and Human Services, CMS. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 10, 2024.

for the Compliance Review, HSAG worked closely with DHB and the SPs to ensure a coordinated and supportive approach to completing the required activities.

Compliance Review Activities

Activity One: Establish Compliance Thresholds

HSAG performs a series of pre-planning steps to define levels of compliance for use throughout the Compliance Review, as shown in Table 63.

Table 63—Activity One: Establish Compliance Thresholds

For this step,	HSAG will…
Step 1:	**Collect information from DHB.**
	Work with DHB to define the scope of the review and applicable federal regulations.
Step 2:	**Prepare the data collection tools for the review standards.**
	In collaboration with DHB, HSAG develops compliance review tools, as well as specific file review tools. The review standards include: • Standard I—Enrollment and Disenrollment • Standard II—Enrollee Rights and Confidentiality[29] • Standard III—Member Information • Standard IV—Emergency and Poststabilization Services • Standard V—Adequate Capacity and Availability of Services • Standard VI—Coordination and Continuity of Care • Standard VII—Coverage and Authorization of Services • Standard VIII—Provider Selection and Program Integrity • Standard IX—Subcontractual Relationships and Delegation • Standard X—Practice Guidelines • Standard XI—Health Information Systems • Standard XII—Quality Assessment and Performance Improvement Program • Standard XIII—Grievance and Appeal Systems

[29] Enrollee and Member are used interchangeably throughout this document.

For this step,	HSAG will…
Step 3:	**Define levels of compliance.**
	HSAG assigns each element within the standards in the compliance review tools a score of *Met*, *Not Met*, or *Not Applicable (NA)*. HSAG uses scores of *Met* and *Not Met* to indicate the degree of compliance with the requirements. HSAG uses a designation of *NA* when a requirement was not applicable during the review period. *Met* indicates full compliance defined as both of the following: • All documentation listed under a regulatory provision or component thereof is present. • Staff are able to provide responses to reviewers that are consistent with each other and with the documentation. *Not Met* indicates noncompliance defined as the following: • Not all documentation is present and staff have little or no knowledge of processes or issues addressed by the regulatory provisions.
Step 4:	**Develop a timeline for the review process.**
	HSAG works with DHB to construct a detailed timeline to ensure completion of all review activities and provides advance notice to each SP.

Activity Two: Perform Preliminary Review

HSAG performs a series of preliminary steps, including a desk review, as shown in Table 64.

Table 64—Activity Two: Perform Preliminary Review

For this step,	HSAG will…
Step 1:	**Establish early contact with the SPs.**
	In collaboration with DHB, HSAG sets the schedule and establishes expectations for the Compliance Review.
Step 1a:	**Prepare and submit the pre-assessment form.**
	The pre-assessment form is used to identify gaps in information necessary to ensure a comprehensive EQR process and productive interactions with the SPs during the review. The form requires each SP to describe its organization, key operational areas, and its functions.

<table>
<tr><th>For this step,</th><th>HSAG will…</th></tr>
<tr><td>Step 1b:</td><td>Forward the standard review tools and file review tools to the SPs.</td></tr>
<tr><td></td><td>SP-specific standard review tools are provided to assist each SP in preparing for the review. The standard review tools include documents required for submission. In addition, the SPs are provided specifications for timelines and instructions for submitting the data required for sampling for the file reviews. Listed below are the standards and associated file reviews.
<table>
<tr><th>#</th><th>Standard Name</th><th>File Reviews</th></tr>
<tr><td>I</td><td>Enrollment and Disenrollment</td><td>None</td></tr>
<tr><td>II</td><td>Enrollee Rights and Confidentiality</td><td>None</td></tr>
<tr><td>III</td><td>Member Information</td><td>None</td></tr>
<tr><td>IV</td><td>Emergency and Poststabilization Services</td><td>None</td></tr>
<tr><td>V</td><td>Adequate Capacity and Availability of Services</td><td>None</td></tr>
<tr><td>VI</td><td>Coordination and Continuity of Care</td><td>Care Management</td></tr>
<tr><td>VII</td><td>Coverage and Authorization of Services</td><td>Denials</td></tr>
<tr><td>VIII</td><td>Provider Selection and Program Integrity</td><td>None</td></tr>
<tr><td>IX</td><td>Subcontractual Relationships and Delegation</td><td>None</td></tr>
<tr><td>X</td><td>Practice Guidelines</td><td>None</td></tr>
<tr><td>XI</td><td>Health Information Systems</td><td>None</td></tr>
<tr><td>XII</td><td>Quality Assessment and Performance Improvement Program</td><td>None</td></tr>
<tr><td>XIII</td><td>Grievance and Appeal Systems</td><td>Grievances
Appeals</td></tr>
</table></td></tr>
<tr><td>Step 1c:</td><td>Respond to the SPs’ questions related to the review and provide additional information needed before the review.</td></tr>
<tr><td></td><td>Prior to conducting the reviews, HSAG conducts kick-off meetings with DHB and the SPs. HSAG maintains contact with the SPs as needed to answer questions and to provide information to key management staff. HSAG communicates regularly with DHB about HSAG’s discussions with the SPs and their responses to questions.</td></tr>
<tr><td>Step 1d:</td><td>Receive data files from the SPs, select and post samples to HSAG’s Secure Access File Exchange (SAFE) site for each SP.</td></tr>
<tr><td></td><td>HSAG generates unique record review samples based on data files supplied by each SP for each file review.</td></tr>
</table>

For this step,	HSAG will…
Step 2:	**Perform a preliminary document review (desk review).**
	Receive documents for desk review from each SP. HSAG reviewers use the documentation to gain insight into each SP's processes for providing access to care for its members, its structure and operations, and its quality assessment and performance improvement program. HSAG begins compiling preliminary findings before the virtual review. During the desk review process, reviewers: • Document findings from the review of the materials submitted by each SP as evidence of their compliance with the requirements. • Identify areas and issues requiring further clarification or follow-up during the virtual review. • Identify information not found in the desk review documentation that HSAG will request during the virtual review.

Activity Three: Conduct Virtual Reviews

Due to the coronavirus disease 2019 (COVID-19), DHB and HSAG work with each SP to schedule a virtual webinar review. HSAG conducts staff interviews with each SP and collects the information necessary to assess the SPs' compliance with federal regulations. The steps of the virtual webinar review process are shown in Table 65.

Table 65—Activity Three: Conduct Virtual Reviews

For this step,	HSAG will…
Step 1:	**Determine the length of the virtual webinar review and the dates.**
	HSAG determines the virtual webinar review to be scheduled for three consecutive business days with each SP. SPs are given available date options and notified in advance of selected dates.
Step 2:	**Identify the number and types of reviewers needed.**
	The review team that HSAG assigned are content area experts who have in-depth knowledge of DHB's Medicaid systems and requirements, and who also have extensive experience and proven competency conducting the compliance reviews. To ensure inter-rater reliability, HSAG reviewers are trained on the review methodology to ensure that the determinations for each element of the review are made in the same manner. The reviewers are assigned specific standards and ongoing communication and coordination among the team ensures uniformity of the review. The team leader reviews the findings and scores for all standards to ensure accuracy and consistency of approach among reviewers.
Step 3:	**Establish an agenda.**
	An agenda is developed to assist each SP in planning for participation in the virtual webinar review. The agenda sets the tone, expectations, the objectives, and time frames for the virtual webinar review. If additional information is needed, each SP is offered a pre-virtual webinar call with HSAG.

For this step,	HSAG will…
Step 4:	**Conduct virtual webinar review.**
	During the virtual webinar review, HSAG: • Conducts interviews with SP staff to obtain a complete picture of compliance with contract requirements to explore any issues not fully addressed in the documents, and to increase overall understanding of the SP's performance. • Reviews information, documentation, and systems demonstrations. • Receives assistance from SP staff in answering specific questions or locating specific documents or other sources of information. • Receives and reviews files designated for the file reviews. • Summarizes findings for each standard under review.
Step 5:	**Conduct exit interviews.**
	As a final step, HSAG meets with SP staff and DHB to provide a high-level summary of the preliminary findings from the virtual webinar review. The purpose of the exit interview allows HSAG to clarify its understanding of the information collected throughout the compliance review process and provide the SP the opportunity to respond to initial compliance issues to ensure the findings are true noncompliance and not due to misunderstanding or misinterpretation.

Activity Four: Compile and Analyze Findings

HSAG documents components of the review and the final compliance determinations for each regulatory provision via the steps outlined in Table 66. The documented findings serve as evidence of the comprehensiveness of the EQR process and validity of the findings.

Table 66—Activity Four: Compile and Analyze Findings

For this step,	HSAG will…
Step 1:	**Collect supplemental information.**
	DHB and HSAG establish a post-review period in which each SP submits additional documentation to determine compliance with requirements.
Step 2:	**Compile data and information.**
	HSAG documents additional information it reviewed, including sources of the information and its findings.
Step 3:	**Analyze findings.**
	HSAG reviews all standards in the review tool for each SP. HSAG analyzes the information to determine the performance for each of the elements in the standards. HSAG assigns each element within the standards in the compliance review tool a score of *Met*, *Not Met*, or *NA*.

Activity Five: Report Results and Assess SP Remediation Actions

HSAG drafts reports with the results of the review for each SP's compliance with federal requirements and monitors remediation using the steps shown in Table 67.

Table 67—Activity Five: Report Results

For this step,	HSAG will…
Step 1:	**Submit a report outline to DHB.**
	HSAG develops a report outline and submits it to DHB for approval. The outline is then used by HSAG to draft a report with the results of each SP.
Step 2:	**Submit an initial Compliance Review Report of Findings.**
	After completing the documentation of findings and scoring for each of the standards, HSAG prepares a draft report for each SP that describes findings, the scores it assigned for each requirement within the standards, and HSAG's assessment of compliance and any areas requiring remediation. The reports are forwarded to DHB for review and approval.
Step 3:	**Receive and assess the SPs' remediation.**
	DHB requires the SPs to remediate each element for which HSAG assigned a score of *Not Met*. The SPs have a 30 calendar day remediation period in which to submit additional documentation or implement policies and procedures that meet requirements. HSAG then assesses all remediated elements to determine if compliance with requirements have been met and assigns a final score, which is included in this final Compliance Review report.
Step 4:	**Submit a final Compliance Review report to DHB.**
	Following closure of the remediation period and DHB's approval of each report, HSAG issues final reports to DHB and the applicable SP.
Step 5:	**Focused Review**
	For any elements that remain out of compliance following remediation, HSAG will conduct a focused review with the SP. DHB and HSAG will monitor each SP's progress toward correcting deficiencies with the following criteria: • The completeness of addressing each required action and assigning a responsible individual, a timeline/completion date, and specific plans of action/interventions that the SP will implement to bring the element into compliance. • The degree to which the planned activities/interventions meet the intent of the requirement. • The degree to which the planned interventions are anticipated to bring the SP into compliance with the requirement. • The appropriateness of the timeline for correcting the deficiency. Any SP that does not meet the preceding criteria will require resubmission until approved by DHB and HSAG.

File Review Methodologies

Care Management File Review Methodology

Purpose of Review

The purpose of the CM record review is to assess health plan compliance with general CM elements, as directed by State and federal requirements.

File Review Process

In collaboration with DHB, HSAG will identify an evaluation time frame for retrospective review of the health plans' CM files. Prior to the webinar review, the following process will be utilized to identify sample cases that will be assessed for element compliance during the webinar review.

Step 1: Request enrollee universe from health plans, utilizing evaluation time frame for retrospective review.

Step 2: Upon receipt of the enrollee file, identify number of enrollees in care coordination.

Step 3: Select random sample cases of enrollees.

Step 4: Provide health plan with sample cases.

File Review Assessment: Webinar Review

During the webinar review, HSAG will conduct a file review, utilizing the sample files provided to the health plan. The file review will consist of the elements included within the Care Management File Review tool. The health plan's appropriate CM representative will navigate the health plan's CM system and respond to questions. The review team will determine evidence of compliance with each of the scored elements. A *Yes, No,* or *NA* score will be assigned to each element under review.

Scoring Methodology for File Review

HSAG will use a two-point scoring methodology. Each requirement will be scored as *Yes* or *No* according to the criteria identified below. HSAG will also use a designation of *NA* if the requirement is not applicable to the beneficiary's case; *NA* findings will not be included in the two-point scoring methodology.

Yes indicates full compliance defined as all of the following:

- All documentation listed under contract requirements was present in the case file.
- Cases reviewed met the scoring criteria assigned to each requirement.

No indicates noncompliance defined as either of the following:

- Not all documentation was present.

NA indicates a requirement that will not be scored for compliance.

HSAG will calculate an overall percentage-of-compliance score for each of the CM requirements. HSAG will calculate the score for each requirement by adding the score from each case, indicating either a score of *Yes* (value: 1 point) or *No* (value: 0 points), and dividing the summed scores by the total number of applicable cases.

Standard Performance

DHB has established a performance benchmark of 80 percent compliance for each scored element.

Appeals File Review Methodology

Purpose of Review

The purpose of the appeals file review is to assess health plan compliance with timelines and reporting for appeals as required by federal statutes and regulations.

HSAG will complete a file review and webinar review to evaluate the health plans' compliance with appeals requirements.

File Review Process

In collaboration with DHB, HSAG will identify an evaluation time frame for retrospective review of the health plans' appeal processing. Prior to the webinar review, the following file review methodology will be utilized to identify compliance and findings requiring additional assessment during the webinar review.

Step 1: Request appeals universe from health plans, utilizing evaluation time frame for retrospective review.

Step 2: Upon receipt of the appeals file, filter by date of receipt of appeal.

Step 3: Select random sample cases, accounting for responsible party and appeal type (standard, expedited) to ensure appropriate representation.

Step 4: Provide health plan with sample cases and request case documentation (including original denial) and appeal letters sent to enrollees.

Step 5: Upon receipt of submissions, complete file review tool.

File Review Assessment

HSAG will assess the health plans' appeals documentation for, at a minimum, the following elements.

- Timely resolution of appeal.
- Compliance with requirements for decision letter(s).

Scoring Methodology for File Review

HSAG will use a two-point scoring methodology. Each requirement will be scored as *Yes* or *No* according to the criteria identified below.

Yes indicates full compliance defined as all of the following:

- All documentation listed under federal requirements was present in the case file.
- Cases reviewed met the scoring criteria assigned to each requirement.

No indicates noncompliance defined as the following:

- Not all documentation was present.

HSAG will calculate an overall percentage-of-compliance score for each requirement. HSAG will calculate the score for each requirement by adding the score from each case, indicating either a score of *Yes* (value: 1 point) or *No* (value: 0 points), and dividing the summed scores by the total number of applicable cases.

Standard Performance

DHB has established a performance benchmark of 80 percent compliance for each scored element.

Webinar Review

During the webinar review, HSAG will address any concerns or findings identified as a result of the desk review. HSAG will evaluate the files with health plan staff present so that the HSAG reviewer may ask the staff questions and clarify processes or areas of concern. The HSAG reviewer may identify missing documentation and allow the health plan staff the opportunity to locate the missing information. File review findings may be revised if documentation reviewed during the webinar review supports revision.

Denials File Review Methodology

Purpose of Review

The purpose of the denials file review is to assess health plan compliance with timeliness and reporting for denials as required by federal statutes and regulations.

HSAG will complete a file review and webinar review to evaluate the health plans' compliance with denials requirements.

File Review Process

In collaboration with DHB, HSAG will identify an evaluation time frame for retrospective review of the health plans' authorizations and denials processing. Prior to the webinar review, the following file

review methodology will be utilized to identify compliance and findings requiring additional assessment during the webinar review.

Step 1: Request denials universe from health plans, utilizing evaluation time frame for retrospective review.

Step 2: Upon receipt of the denials file, filter by date of receipt of request.

Step 3: Select random sample cases, accounting for responsible party and case type to ensure appropriate representation.

Step 4: Provide health plan with sample cases and request case documentation and denial notices sent to enrollees.

Step 5: Upon receipt of submissions, complete file review tool.

File Review Assessment

HSAG will assess the health plans' denials documentation for, at a minimum, the following elements.

- Timely resolution of denial.
- Compliance with reading level requirements for decision letter(s).

Scoring Methodology for File Review

HSAG will use a two-point scoring methodology. Each requirement will be scored as *Yes* or *No* according to the criteria identified below.

Yes indicates full compliance defined as all of the following:

- All documentation listed under federal requirements was present in the case file.
- Cases reviewed met the scoring criteria assigned to each requirement.

No indicates noncompliance defined as the following:

- Not all documentation was present.

HSAG will calculate an overall percentage-of-compliance score for each requirement. HSAG will calculate the score for each requirement by adding the score from each case, indicating either a score of *Yes* (value: 1 point) or *No* (value: 0 points), and dividing the summed scores by the total number of applicable cases.

Standard Performance

DHB has established a performance benchmark of 80 percent compliance for each scored element.

Webinar Review

During the webinar review, HSAG will address any concerns or findings identified as a result of the desk review. HSAG will evaluate the files with health plan staff present so that the HSAG reviewer may

ask the staff questions and clarify processes or areas of concern. The HSAG reviewer may identify missing documentation and allow the health plan staff the opportunity to locate the missing information. HSAG will mark an element as deficient only if the staff cannot locate the information needed to satisfy the element. File review findings may be revised if documentation reviewed during the webinar review supports revision.

Grievances File Review Methodology

Purpose of Review

The purpose of the grievances file review is to assess health plan compliance with timelines, monitoring, and reporting for grievances as required by federal statutes and regulations.

HSAG will complete a file review and webinar review to evaluate the health plans' compliance with grievance requirements.

File Review Process

In collaboration with DHB, HSAG will identify an evaluation time frame for retrospective review of the health plans' grievances processing. Prior to the webinar review, the following file review methodology will be utilized to identify compliance and findings requiring additional assessment during the webinar review.

Step 1: Request grievances universe from health plans, utilizing evaluation time frame for retrospective review.

Step 2: Upon receipt of the grievances file, filter by date of receipt of grievance.

Step 3: Select random sample cases.

Step 4: Provide health plan with sample cases and request grievance documentation including letters sent to enrollees.

Step 5: Upon receipt of submissions, complete file review tool.

File Review Assessment

HSAG will assess the health plans' grievances documentation for, at a minimum, the following elements.

- Timely acknowledgment of grievance.
- Timely resolution of grievance.
- Compliance with requirements for acknowledgment and resolution letter(s).

Scoring Methodology for File Review

HSAG will use a two-point scoring methodology. Each requirement will be scored as *Yes* or *No* according to the criteria identified below.

Yes indicates full compliance defined as all of the following:

- All documentation listed under federal requirements was present in the case file.
- Cases reviewed met the scoring criteria assigned to each requirement.

No indicates noncompliance defined as the following:

- Not all documentation was present.

HSAG will calculate an overall percentage-of-compliance score for each requirement. HSAG will calculate the score for each requirement by adding the score from each case, indicating either a score of *Yes* (value: 1 point) or *No* (value: 0 points), and dividing the summed scores by the total number of applicable cases.

Standard Performance

DHB has established a performance benchmark of 80 percent compliance for each scored element.

Webinar Review

During the webinar review, HSAG will address any concerns or findings identified as a result of the desk review. HSAG will evaluate the files with health plan staff present so that the HSAG reviewer may ask the staff questions and clarify processes or areas of concern. The HSAG reviewer may identify missing documentation and allow the health plan staff the opportunity to locate the missing information. File review findings may be revised if documentation reviewed during the webinar review supports revision.

Network Adequacy Validation

Standards and Indicators Validated

States that contract with MCEs to provide Medicaid or CHIP services are required to develop quantitative network adequacy standards across a subset of provider types to set expectations for each contracted MCE's provider networks. States may elect to use a variety of quantitative standards including, but not limited to, minimum provider-to-member ratios, time and distance, percentage of providers accepting new patients, and/or combinations of these quantitative measures. Based on DHB-defined network adequacy standards, DHB and the EQRO defined the network adequacy indicators, which the EQRO then validated. The indicators are metrics used to assess adherence to the quantitative network adequacy standards required and set forth by the State. DHB identified network adequacy indicators to be validated for the reporting period(s) of July 1, 2023–June 30, 2024.[30] The following tables list the network adequacy standards and indicators HSAG validated.

Table 68—PIHP Time/Distance Network Adequacy Standards Validated

Service Type	Urban Standard	Rural Standard
Outpatient Behavioral Health (BH) Services	Two or more providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of beneficiaries	Two or more providers within 45 minutes or 45 miles of residence for at least 95% of beneficiaries
Location-Based Services*	Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient Treatment (SACOT), Substance Abuse Intensive Outpatient Program (SAIOP), and Outpatient Opioid Treatment Program (OTP): Two or more providers of each service within 30 minutes or 30 miles of residence for at least 95% of beneficiaries	Psychosocial Rehabilitation, SACOT, SAIOP, and OTP: Two or more providers of each service within 45 minutes or 45 miles of residence for at least 95% of beneficiaries
Partial Hospitalization	One or more provider of partial hospitalization within 30 minutes or 30 miles of residence for at least 95% of beneficiaries	One or more provider of partial hospitalization within 60 minutes or 60 miles of residence for at least 95% of beneficiaries

- * Child and Adolescent Day Treatment Services: Not subject to standard.

[30] PIHP Annual Network Adequacy review based on data reported as of March 31, 2023, due to first year contracting with the PIHPs.

Table 69—PIHP Provider Capacity Standards Validated

Service Type	Standard
Crisis Services	• Professional Treatment Services in Facility-Based Crisis Program: the greater of: – Two or more facilities within each PIHP region, OR – One facility within each region per 450,000 total regional population (total regional population as estimated by combining North Carolina Office of State Budget and Management (NC OSBM) county estimates). • Facility-Based Crisis Services for Children and Adolescents: one or more provider within each PIHP region – Non-Hospital Medical Detoxification: two or more providers within each PIHP region – Ambulatory Detoxification, Ambulatory Withdrawal Management With Extended On-Site Monitoring, Clinically Managed Residential Withdrawal: one or more provider of each crisis service within each PIHP region
Inpatient BH Services	• One or more provider of each inpatient BH service within each PIHP region
Community/Mobile Services	• Two or more providers of community/mobile services within each PIHP region • Each county in PIHP region must have access to one or more provider that is accepting new patients
1915(i) Home- and Community-Based Services (HCBS)	• Community Living and Support, Individual and Transitional Support, Respite, and Supported Employment (for intellectual and developmental disabilities [IDD] and mental health/substance use disorder [MH/SUD]): two or more providers of each 1915(i) HCBS option service within each PIHP region
Residential Treatment Services	• Residential Treatment Facility Services: access to one or more licensed provider per PIHP region • Substance Abuse Medically Monitored Residential Treatment: access to one or more licensed provider per PIHP region (refer to 10A NCAC 27G.3400) • Substance Abuse Non-Medical Community Residential Treatment: – Adult: access to one or more licensed provider per PIHP region (refer to licensure requirements determined by the Department) – Adolescent: contract with all designated Cross Area Service Programs (CASPs) within the PIHP region – Women and Children: contract with all designated CASPs within the PIHP region • Substance Abuse Halfway House: – Adult: access to one or more male and one or more female program per PIHP region (Refer to 10A NCAC 27G.5600) – Adolescent: access to one or more program per PIHP region (refer to 10A NCAC 27G.5600)

Service Type	Standard
1915(c) HCBS Waiver Services: NC Innovations	• Community Living and Support, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living: two or more providers of each Innovations waiver service within each PIHP region • Crisis Intervention and Stabilization Supports, Day Supports, Financial Support Services: one or more provider of each Innovations waiver service within each PIHP region
1915(c) HCBS Waiver Services: NC Traumatic Brain Injury (TBI) Waiver (applicable to TBI Waiver participating counties only)	• Community Networking, Life Skills Training, Residential Supports, Resource Facilitation, In-Home Respite, Supported Employment: two or more providers of each TBI waiver service within each PIHP region • Day Supports, Cognitive Rehabilitation, Crisis Intervention and Stabilization Supports: one or more provider of each TBI waiver service within each PIHP region

Table 70—SP Time/Distance Standards Validated

Service Type	Urban Standard	Rural Standard
Primary Care	Two or more providers within 30 minutes or 10 miles for at least 95% of beneficiaries	Two or more providers within 30 minutes or 30 miles for at least 95% of beneficiaries
Specialty Care	Two or more providers (per specialty type) within 30 minutes or 15 miles for at least 95% of beneficiaries	Two or more providers (per specialty type) within 60 minutes or 60 miles for at least 95% of beneficiaries
Hospitals*	One or more hospitals within 30 minutes or 15 miles for at least 95% of beneficiaries	One or more hospitals within 30 minutes or 30 miles for at least 95% of beneficiaries
Pharmacies*	Two or more pharmacies within 30 minutes or 10 miles for at least 95% of beneficiaries	Two or more pharmacies within 30 minutes or 30 miles for at least 95% of beneficiaries
Obstetrics[1]	Two or more providers within 30 minutes or 10 miles for at least 95% of beneficiaries	Two or more providers within 30 minutes or 30 miles for at least 95% of beneficiaries
Occupational, Physical, or Speech Therapists*	Two or more providers (of each provider type) within 30 minutes or 10 miles for at least 95% of beneficiaries	Two or more providers (of each provider type) within 30 minutes or 30 miles for at least 95% of beneficiaries

Service Type	Urban Standard	Rural Standard
Outpatient BH Services	Two or more providers of each outpatient BH service within 30 minutes or 30 miles for at least 95% of beneficiaries	Two or more providers of each outpatient BH service within 45 minutes or 45 miles for at least 95% of beneficiaries
Location-Based Services (BH)	Two or more providers of each service within 30 minutes or 30 miles for at least 95% of beneficiaries	Two or more providers of each service within 45 minutes or 45 miles for at least 95% of beneficiaries
Partial Hospitalization (BH)	One or more provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of beneficiaries	One or more provider of specialized services partial hospitalization within 60 minutes or 60 miles for at least 95% of beneficiaries

[1] Measured on beneficiaries who are female and ages 14 through 44 years. Certified nurse midwives may be included to satisfy Obstetrics access requirements.

* Service types are not subject to separate adult and pediatric provider standards. These service types include hospitals; pharmacies; occupational, physical, or speech therapists; LTSS; and nursing facilities.

Table 71—SP Provider Capacity Standards Validated

Service Type	Standard	
Crisis Services (BH)	One or more provider of each crisis service within each PHP* Region	
Inpatient BH Services	One or more provider of each inpatient BH service within each PHP Region	
Nursing Facilities**	PHP must have at least one nursing facility accepting new patients in every county	
Service Type	**Rural**	**Urban**
All State Health Plan LTSS (except nursing facilities)**	PHP must have at least two LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services, and hospice services), identified by distinct National Provider Identifier (NPI), accepting new patients available to deliver each State Health Plan LTSS in every county.	PHP must have at least two providers accepting new patients available to deliver each State Health Plan LTSS in every county

* SPs in North Carolina are formally known and identified contractually for provider capacity standards and indicators as PHPs.

** Service types are not subject to separate adult and pediatric provider standards. These service types include hospitals, pharmacies, occupational, physical, or speech therapists, LTSS, and nursing facilities.

Description of Validation Activities

Pre-Validation Strategy

NAV consists of several activities that fall into three phases of activities: (1) planning, (2) analysis, and (3) reporting, as outlined in the CMS EQR Protocol 4. To complete validation activities for the MCEs and for DHB, HSAG obtained all state-defined network adequacy standards and indicators.

HSAG prepared a document request packet that was submitted to each MCE outlining the activities conducted during the validation process. The document request packet included a request for documentation to support HSAG's ability to assess the MCEs' information systems and processes, network adequacy indicator methodology, and accuracy in network adequacy reporting at the indicator level. Documents requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with the MCEs to identify all data sources informing calculation and reporting at the network adequacy indicator level. Data and documentation from the MCE such as, but not limited to, network data files or directories and member/beneficiary enrollment files, were obtained through a single documentation request packet provided to each MCE.

HSAG hosted an MCE-wide webinar focused on providing technical assistance to the MCE to develop a greater understanding of all activities associated with NAV, standards/indicators in the scope of validation, helpful tips on how to complete the ISCAT, and a detailed review of expected deliverables with associated timelines.

Validation activities were conducted via interactive virtual review and are referred to as a "virtual review," as the activities are the same in a virtual format as in an on-site format.

Validation Team

The HSAG validation team was composed of the lead reviewer(s) and several validation staff. HSAG assembled the team based on the skills required for NAV and requirements set forth by the State. Some staff, including the lead reviewer, participated in the virtual review meetings; other validation staff participated in the desk review of submitted documentation only. A full list of the validation team, their roles, and their skills and expertise are provided in Appendix A.

Technical Methods of Data Collection and Analysis

CMS EQR Protocol 4 identifies key activities and data sources needed for NAV. The following list describes the types of data collected and how HSAG conducted an analysis of these data:

- **Information systems underlying network adequacy monitoring:** HSAG conducted an ISCA using DHB's and the MCE's completed ISCAT and relevant supplemental documentation to understand the processes for maintaining and updating provider data, including how DHB and the MCE tracks providers over time, across multiple office locations, and through changes in participation in the health plan's network. The ISCAT was used to assess the ability of DHB and the MCE's information systems to collect and report accurate data related to each network adequacy indicator. To do so, HSAG sought

to understand DHB's and the health plan's information technology (IT) system architecture, file structure, information flow, data processing procedures, and completeness and accuracy of data related to current provider networks. HSAG thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.

- **Validate network adequacy logic for calculation of network adequacy indicators:** HSAG required DHB and each MCE that calculated the state-defined network adequacy indicators to submit documented code, logic, or manual workflows for each indicator in the scope of the validation. HSAG completed a line-by-line review of the logic provided to ensure compliance with the state-defined indicator specifications. HSAG identified whether the required variables were in alignment with the state-defined indicators used to produce DHB and the MCE's indicator calculations. HSAG required DHB and each MCE that did not use computer programming language to calculate the performance indicators to submit documentation describing the steps DHB and the MCE took for indicator calculation.
- **Validate network adequacy data and methods:** HSAG assessed data and documentation from DHB and the MCEs that included, but was not limited to, network data files or directories, member enrollment data files, claims and encounter data files (if applicable), member experience survey results, and/or provider and member handbooks. HSAG assessed all data files used for network adequacy calculation at the indicator level for validity and completeness.
- **Validate network adequacy results:** HSAG assessed DHB and each MCE's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support MCE and State network adequacy monitoring efforts. HSAG validated network adequacy reporting against state-defined indicators and against the most recent network adequacy reports to assess trending patterns and reasonability of reported indicator-level results, if available. HSAG assessed whether the results were valid, accurate, and reliable, and if DHB and the MCE's interpretation of the data was accurate.
- **Supporting documentation:** HSAG requested documentation that would provide auditors with additional information to complete the validation process, including policies and procedures, file layouts, data dictionaries, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

Virtual Review Validation Activities

HSAG conducted a virtual review with DHB and the MCEs. HSAG collected information using several methods, including interviews, system demonstrations, review of source data output files, primary source verification (PSV), observation of data processing, and review of final network adequacy indicator-level reports. The virtual review activities performed for DHB and each MCE are described below:

- Opening meeting
- Review of ISCAT and supporting documentation
- Evaluation of underlying systems and processes
- Overview of data collection, integration, methods, and control procedures

- Network adequacy source data PSV and results
- Closing conference

HSAG conducted interviews with key DHB and MCE staff who were involved with the calculation and reporting of network adequacy indicators. Appendix A lists the DHB and MCE interviewees.

Opening meeting: The opening meeting included an introduction of the validation team and key DHB and MCE staff involved in the NAV activities, the review purpose, the required documentation, basic meeting logistics, and organization overview.

Review of the ISCAT and supporting documentation: This session was designed to be interactive with key DHB and MCE staff so that the validation team could obtain a complete picture of all steps taken to generate responses to the ISCAT, and understand systems and processes for maintaining and updating provider data and assessing DHB's and the health plan's information systems required for NAV. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and verified source data and processes used to inform data reliability and validity of network adequacy reporting.

Evaluation of underlying systems and processes: HSAG evaluated DHB's and the MCE's information systems, focusing on DHB's and the MCE's processes for maintaining and updating provider data; integrity of the systems used to collect, store, and process data; DHB and MCE oversight of external information systems, processes, and data; and knowledge of the staff involved in collecting, storing, and analyzing data. Throughout the evaluation, HSAG conducted interviews with key DHB and MCE staff familiar with the processing, monitoring, reporting, and calculation of network adequacy indicators. Key staff included executive leadership, enrollment specialists, provider relations, business analysts, data analytics staff, claims processors, and other front-line staff familiar with network adequacy monitoring and reporting activities.

Overview of data collection, integration, methods, and control procedures: The overview included discussion and observation of methods and logic used to calculate each network adequacy indicator. HSAG evaluated the integration and validation process across all source data and how the analytics files were produced to inform network adequacy monitoring and calculation at the indicator level. HSAG also addressed control and security procedures during this session.

Network adequacy source data PSV and results: HSAG performed additional validation using PSV to further validate the accuracy and integrity of the source data files used to inform network adequacy monitoring and reporting at the indicator level. PSV is a review technique used to confirm that the information from the primary source information systems matches the analytic output files used for reporting. Using this technique, HSAG assessed the methods, logic, and processes used to confirm accuracy of the data and detect errors. HSAG selected key data elements within each source data output file to confirm that the primary source system maintained by DHB and the MCE or obtained through external entities matched. For example, the PSV review may detect programming logic errors resulting in further root cause analysis and corrections. HSAG reviewed indicator-level results and assessed alignment with state-defined requirements.

Closing conference: The closing conference included a summation of preliminary findings based on the review of the underlying systems and processes, data collection, integration, and methods used. In addition, findings from the virtual review and documentation requirements for any post-virtual review activities were shared with DHB and the MCEs.

Network Adequacy Indicator Validation Rating Determinations

HSAG evaluated DHB's and the MCE's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support DHB's and the MCEs' network adequacy monitoring efforts.

HSAG used the CMS EQR Protocol 4 indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that DHB and the MCEs used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated each network adequacy indicator's validation score by identifying the number of *Met* and *Not Met* elements recorded in HSAG's CMS EQR Protocol 4 Worksheet 4.6, noted in Table 72.

Table 72—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of *Met* elements
B. Total number of *Not Met* elements
Validation Score = A / (A + B) x 100%
Number of *Not Met* elements determined to have significant bias on the results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if **DHB**'s and the MCE's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, which are defined in, and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table 73—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

Table 74 and Table 75 present example validation rating determinations. Table 74 presents an example of a validation rating determination that is based solely on the validation score, as there were no *Not Met* elements that were determined to have significant bias on the results, whereas Table 75, presents an example of a validation rating determination that includes a *Not Met* element that had significant bias on the results.

Table 74—Example Validation Rating Determination

Worksheet 4.6 Summary	Worksheet 4.6 Result	Validation Rating Determination
A. Total number of *Met* elements	16	*Moderate Confidence (Example)*
B. Total number of *Not Met* elements	3	
Validation Score = A / (A + B) x 100%	84.2%	
Number of *Not Met* elements determined to have significant bias on the results	0	

Table 75—Example Validation Rating Determination

Worksheet 4.6 Summary	Worksheet 4.6 Result	Validation Rating Determination
A. Total number of *Met* elements	15	*No Confidence (Example)*
B. Total number of *Not Met* elements	4	
Validation Score = A / (A + B) x 100%	78.9%	
Number of *Not Met* elements determined to have significant bias on the results	1	

Significant bias was determined based on the magnitude of errors detected and not solely based on the number of elements *Met* or *Not Met*. HSAG determined that a *Not Met* element had significant bias on the results by:

- Requesting that DHB and the MCE provide a root cause analysis of the finding.
- Working with DHB and the MCE to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- Reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact, within HSAG's NAV Oversight Review Committee, to determine the degree of bias.
- Finalizing a bias determination within HSAG's NAV Oversight Review Committee based on the following threshold:
  - The impact biased the reported network adequacy indicator result by more than 5 percentage points, the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from compliant to noncompliant or changed from noncompliant to compliant), or the impact was unable to be quantified and therefore was determined to have the potential for significant bias.

Appendix B. PIP Aim Statements and Interventions

Aim Statements

Table 76—2023 SP PIP Aim Statements

SP	PIP Aim Statement
HEDIS CIS—Combo 10	
AmeriHealth	Do targeted interventions increase the percentage of eligible members who complete the *CIS—Combo 10* immunization requirements?
Carolina Complete	Targeted interventions will result in an increase of 5 percent from baseline in the *CIS—Combo 10* immunization rate for **Carolina Complete**'s eligible two-year-old members.
Healthy Blue	Do targeted interventions result in an increase in the *CIS—Combo 10* immunization rate for **Healthy Blue**'s eligible two-year-old members?
UnitedHealthcare	Do targeted interventions increase the percentage of children that receive the required Combo 10 series of immunizations during the measurement period?
WellCare	**WellCare** will increase the rate of childhood immunizations *CIS—Combo 10* for eligible members through a system of interventions as evidenced by 5 percent relative improvement over the baseline calendar year 2021 for the *CIS—Combo 10* measure, by end of calendar year/PIP performance period.
HEDIS PPC	
AmeriHealth	1. Do targeted interventions increase 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 with **AmeriHealth**? 2. Do targeted interventions increase the percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery?
Carolina Complete	Targeted interventions will result in an increase of 5 percent from baseline in the Timeliness of Prenatal and Postpartum Care rate for **Carolina Complete**'s eligible deliveries of live births.
Healthy Blue	1. Do targeted interventions result in an increase in **Healthy Blue**'s *Timeliness of Prenatal Care* rate? 2. Do targeted interventions result in an increase in **Healthy Blue**'s *Timeliness of Postpartum Care* rate?
UnitedHealthcare	Do targeted interventions increase the percentage of deliveries that received a prenatal and/or postpartum care visit within the required timeframe during the measurement period?

SP	PIP Aim Statement
WellCare	1. Do targeted interventions increase the percentage of deliveries who received a prenatal care visit in the first trimester, on or before the enrollment date or within 42 days of enrollment? 2. Do targeted interventions increase the percentage of deliveries who received a postpartum care visit on or between seven and 84 days after delivery?
HEDIS HDB	
AmeriHealth	Do targeted interventions decrease the percentage of members with a HbA1c result equal to or greater than 9.0%?
Carolina Complete	Targeted interventions will result in a 5 percent decrease from baseline in **Carolina Complete**'s members ages 18 to 75 with diabetes (type 1 and type 2) who have HbA1c poor control (>9.0%).
Healthy Blue	Do targeted interventions results in a decrease in **Healthy Blue**'s members ages 18 to 75 with diabetes (type 1 and type 2) who have HbA1c poor control (>9.0%)?
UnitedHealthcare	Do targeted interventions decrease the percentage of eligible members who have a HbA1c of greater than 9% during the MY?
WellCare	**WellCare** of NC will reduce the percentage of members with a HbA1c greater than 9% indicating poor control, through a system of interventions, as evidenced by a 5% relative improvement over the baseline calendar year 2021 for the HEDIS *Comprehensive Diabetes Care—HbA1c Control Poor Control* measure, by end of calendar year/PIP performance period.
Nonclinical	
AmeriHealth	Do targeted interventions increase the number of completed initial Care Needs Screenings within 90 days of enrollment in the health plan?
Carolina Complete	Targeted provider interventions will result in an increase of 5 percent from baseline for Primary Care or OB/GYN providers for **Carolina Complete** who answer "Excellent" or "Good" to Question #19 in the DHB North Carolina Provider Experience Survey: "How would you describe your overall experience interacting with **Carolina Complete Health**?"
Healthy Blue	Do targeted interventions result in an increase in **Healthy Blue**'s members ages 13 years and older identified as tobacco users who self-report at least 30 days tobacco cessation?
UnitedHealthcare	Do targeted interventions increase the percentage of care needs screenings that are completed within 90 days of enrollment during the measurement period?
WellCare	**WellCare** of NC will increase the number of preventive care visits for eligible members through a system of interventions, as evidenced by 5 percent relative improvement over the baseline calendar year 2021 for the HEDIS *Adults' Access to Preventive/Ambulatory Health Services* measure, by end of calendar year/PIP performance period.

Table 77—2023 PIHP PIP Aim Statements

PIHP	PIP Aim Statement
	FUH
Alliance	Do targeted interventions increase the percentage of beneficiaries 6 years old and older who were hospitalized for treatment of selected mental disorders or intentional self-harm and who had a follow up visit by a mental health provider within 1–7 days after their discharge from the hospital?
Eastpointe	Do targeted interventions increase the percentage of follow-up appointments with a mental health provider within 7 days for beneficiaries ages 6 years and older who were hospitalized with a mental illness or intentional self-harm?
Partners	Do targeted interventions increase the percentage of discharges for which the Medicaid Direct beneficiaries diagnosed with mental illness or intentional self-harm, 6 years of age and older having a follow-up visit with a mental health provider within 7 days?
Sandhills	The percentage of follow-up visits after hospitalization for mental illness or intentional self-harm diagnoses with a mental health provider for beneficiaries 6 years of age and older will increase by 28 percent within 7 days after discharge.
Trillium	Will targeted interventions (inpatient/discharge planning team) increase the percentage of discharges for Medicaid Direct beneficiaries 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 7 days after discharge from the baseline to a 5 percent relative improvement?
Vaya Health	Do targeted interventions increase the percentage of discharges for which the beneficiary diagnosed with a mental illness or intentional self-harm, 6 years of age and older had a follow-up visit with a mental health provider within 7 days?
	FUM
Alliance	Do targeted interventions increase the number of beneficiaries 6 years of age and older who had an emergency department visit for treatment of mental disorders or intentional self-harm and who had a follow-up visit by a provider within 1–7 days after their discharge?
Eastpointe	Do targeted interventions increase the percentage of follow-up within 7 days of an ED visit for beneficiaries ages 6 years and older with a mental health disorder or with a principal diagnosis of intentional self-harm?
Partners	Do targeted interventions increase the percentage of emergency department visits for which the Medicaid Direct beneficiaries with mental illness, or intentional harm diagnosis, 6 years and older having a follow-up with any practitioner within 7 days?
Sandhills	Do targeted interventions result in significant improvement for the entire eligible population after emergency room visits within 7 days for mental illness with a mental health provider for beneficiaries 6 years of age and older?
Trillium	Will targeted interventions increase the percentage of follow-ups within 7 days of an emergency department (ED) visit for Medicaid Direct beneficiaries who are 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm from the baseline to a 5% relative improvement?

PIHP	PIP Aim Statement
Vaya Health	Do targeted interventions increase the percentage of emergency department visits for adults and children 6 years of age and older with a diagnosis of mental illness or intentional self-harm and who received a follow-up visit for mental illness within 7 days?
TCL	
Alliance	Do targeted interventions increase the percentage of individuals diagnosed with serious mental illness (SMI), 18 years of age and older in the In-Reach and transitioned phase of TCL that complete an appointment with a primary care provider between the time frames of 90 days housing slot approved and 90 days post housing residency?
Eastpointe	Do targeted interventions decrease the percentage of housed beneficiaries diagnosed with SMI/severe persistent mental illness (SPMI) from separating from TCL?
Partners	Do targeting interventions decrease the percentage of beneficiaries diagnosed with SMI and SPMI in TCL 18 years of age and older of housing separation?
Sandhills	Do target interventions for beneficiaries 18 years and older with a diagnosis of SMI in transitions in community Improve targeted interventions for beneficiaries 18 years and older with a diagnosis of SMI in TCL decrease the percentage of individuals who separated from housing during the measurement period?
Trillium	Will targeted interventions (i.e., re-educating beneficiaries on their tenancy rights and lease agreement) decrease the housing separation rate of Medicaid Direct SMI and SPMI TCL beneficiaries 18 years of age and older in permanent supportive housing in the community?
Vaya Health	Do targeted interventions decrease the annual housing separation rate for TCL beneficiaries 18 year or older with SMI/SPMI?

Table 78—2024 SP PIP Aim Statements

SP	PIP Aim Statement
HEDIS CIS—Combo 10	
AmeriHealth	Do targeted interventions increase the percentage of eligible members who complete the *CIS—Combo 10* immunization requirements?
Carolina Complete	Will the targeted interventions that **Carolina Complete** implements result in a relative improvement of at least 5 percent from baseline in the *CIS—Combo 10* HEDIS measure rate among all eligible members during each measurement period?
Healthy Blue	Will targeted interventions result in an increase in the *CIS—Combo 10* immunization rate for **Healthy Blue**'s eligible two-year old members during the MY?
UnitedHealthcare	Do targeted interventions increase the percentage of children that receive the required *CIS—Combo 10* series of immunizations during the measurement period?
WellCare	**WellCare** of NC will increase the rate of childhood immunizations for eligible members through a system of targeted interventions as evidenced by 5 percent relative improvement over the baseline calendar year 2023 for the *CIS—Combo 10* by end of PIP performance period.

SP	PIP Aim Statement
HEDIS PPC	
AmeriHealth	**Prenatal:** Do targeted interventions increase 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 with **AmeriHealth**? **Postpartum**: Do targeted interventions increase the percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery?
Carolina Complete	Will the targeted interventions that **Carolina Complete** implements result in a relative improvement of at least 5 percent from baseline in the *HEDIS PPC* measure rates among all eligible pregnant members during each measurement period?
Healthy Blue	Do targeted interventions result in an increase in **Healthy Blue**'s *Timeliness of Prenatal Care* rate by 5% during the measurement period? Do targeted interventions result in an increase in **Healthy Blue**'s *Timeliness of Postpartum Care* rate by 5 percent during the measurement period?
UnitedHealthcare	Do targeted interventions increase the percentage of deliveries that received a prenatal and/or postpartum care visit within the required timeframe during the measurement period?
WellCare	Through a system of targeted interventions, **WellCare** of NC will increase the rate of Prenatal and Postpartum Care for eligible members through a system of interventions as evidenced by 5 percent relative improvement over the baseline calendar year 2023 for the HEDIS for each sub-measure: timeliness to prenatal care and postpartum care, respectively by end of calendar year/PIP performance period.
***HEDIS GSD* PIP**	
AmeriHealth	**HbA1c Control <8.0%** Do targeted interventions increase the percentage of members with a HbA1c result less than 8.0%? **HbA1c Poor Control >9.0%** Do targeted interventions decrease the percentage of members with a Hemoglobin A1c result greater than 9.0%?
Carolina Complete	Will the targeted interventions that **Carolina Complete** implements result in relative improvement of at least a 5 percent from baseline for the in the glycemic status for the less than 8.0% and greater than 9.0 percent HEDIS measure rates among eligible members with diabetes during each measurement period?
Healthy Blue	Do targeted interventions result in a decrease in **Healthy Blue**'s members ages 18 to 75 with diabetes (Type 1 and Type 2) who have HbA1c poor control (>9.0%) or an increase HbA1c (<8%) during each reported remeasurement period?
UnitedHealthcare	Do targeted interventions improve the percentage of eligible members who are in adequate control of their diabetes as evidenced by HbA1c of less than 8.0 percent during the MY? Do targeted interventions reduce the percentage of eligible members who are in poor control of their diabetes as evidenced by HbA1c of greater than 9.0 percent during the MY?

SP	PIP Aim Statement
WellCare	Will the use of targeted interventions increase the percentage of members with diabetes with an HbA1c less than 8.0 percent and decrease the percentage with HbA1c poor control (9.0%), as evidenced by a 5 percent relative improvement over the baseline calendar year 2023 for the HEDIS GSD measure/sub-measure, by end of the PIP performance period.
Health Related Resources Needs (HRRN) Screening	
AmeriHealth	Do targeted interventions increase the rate of screening of HRRNs completed within the calendar year?
Carolina Complete	Will the targeted interventions that **Carolina Complete** implements result in a relative improvement of at least a 5 percent from baseline for the Health-Related Resource Needs (HRRN) completion rate from 60 percent to 80 percent among eligible members with diabetes during each measurement period?
Healthy Blue	Will targeted interventions increase the rate of Care Needs Screener completion upon enrollment or re-enrollment into the Plan during each reported period?
UnitedHealthcare	Do targeted interventions increase the percentage of health-related resource need screenings that are completed within the calendar year?
WellCare	**WellCare** will increase the percentage of enrollees who complete a successful screening within the calendar year (January 1st- December 31st). The increase will occur through a system of targeted interventions, as evidenced by 5 percent relative improvement over the baseline calendar year 2023, by end of calendar year/PIP performance period.

Table 79—2024 PIHP PIP Aim Statements

PIHP	PIP Aim Statement
FUH	
Alliance	Do targeted interventions increase the percentage of beneficiaries 6 years old and older who were hospitalized for treatment of selected mental disorders or intentional self-harm and who had a follow up visit by a mental health provider within 1–7 days after their discharge from the hospital? The improvement of this measure, as specified by the stratified targets set by the state, will increase the number of beneficiaries who receive follow-up visit by a mental health provider within 1-7 days after their discharge from a community-based hospital, state psychiatric hospital, state ADATC, or detox/ facility-based crisis service.
Partners	Do targeted interventions increase the percentage of discharges for which the Medicaid Direct beneficiaries diagnosed with mental illness or intentional self-harm, 6 years of age and older having a follow-up visit with a mental health provider within 7-days?

PIHP	PIP Aim Statement
Trillium	Will targeted interventions (implementing an inpatient/discharge planning team) increase the percentage of discharges for Medicaid Direct beneficiaries 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 7-days after discharge from the baseline to a 5 percent relative improvement?
Vaya Health	Do targeted interventions increase the percentage of discharges for which the member diagnosed with a mental illness or intentional self-harm, 6 years of age and older had a follow-up visit with a mental health provider within 7-days?
FUM	
Alliance	Do targeted interventions increase the number of beneficiaries aged 6 years of age and older with an ED visit, with a principal diagnosis of mental illness or intentional self-harm, and who had a follow-up visit for mental illness within 7-days from time of discharge? The improvement of this measure will increase the number of beneficiaries who receive a follow-up visit, with any practitioner, within 1-7 days of discharge.
Partners	Do targeted interventions increase the percentage of emergency department visits for which the Medicaid Direct beneficiaries with mental illness, or intentional harm diagnosis, 6 years and older having a follow-up with any practitioner within 7 days?
Trillium	Will targeted interventions (requesting the latest member phone number from the ED before member discharge) increase the percentage of follow-ups within 7 days of an emergency department (ED) visit for Medicaid Direct beneficiaries who are 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm from the baseline to a 5 percent relative improvement?
Vaya Health	Do targeted interventions increase the percentage of emergency department visits for adults and children 6 years of age and older with a diagnosis of mental illness or intentional self-harm and who received a follow-up visit for mental illness within 7-days?
TCL	
Alliance	Do targeted member, provider, and system level interventions increase the percentage of individuals in the in-reach and transitioned phase of the TCL program transitioning to community living (between the time frames of 90 days housing slot approved and 90 days post housing residency) who complete an appointment with a primary care provider for physical health assessments and/or monitoring?
Partners	Do targeting interventions decrease the percentage of beneficiaries diagnosed with SMI and SPMI in TCL 18 years of age and older of housing separation?
Trillium	Will targeted interventions (i.e., re-educating beneficiaries on their tenancy rights and lease agreement) decrease the housing separation rate of Medicaid Direct SMI and SPMI TCL beneficiaries 18 years of age and older in permanent supportive housing in the community?
Vaya Health	Do targeted interventions decrease the annual housing separation rate for TCL beneficiaries 18 years or older with SMI/SPMI?

Barriers and Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. The SPs' choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the SPs' overall success in achieving the desired outcomes for the PIP.

SPs: HEDIS CIS—Combo 10 PIP

Table 82 through Table 84 illustrate the barriers and interventions for the *HEDIS CIS—Combo 10* PIP.

Table 80—2023 Barriers and Interventions for AmeriHealth

Barriers	Interventions
Lack of member engagement, education, and awareness.	Telephonic outreach to provide parents and guardians education regarding the importance of childhood immunizations.
	Text message campaign providing child vaccine information, including common myths associated with vaccinations. Messaging also includes appointment and transportation information.
Stakeholders not involved in the PIP process.	Established and launched a PIP workgroup to ensure collaboration and contributions across cross-functional teams with the plan.
Lack of provider education and awareness of the Quality Enhancement Program (QEP) program.	Provider incentive program that offers PCPs an incentive for gap closure supporting *CIS—Combo 10* performance.
Lack of provider education and knowledge of performance.	Quarterly scorecard given to providers with incentive program results, which will allow practices to see their performance within the HEDIS measures and care gaps.

Table 81—Barriers and Interventions for Carolina Complete

Barriers	Interventions
Vaccination hesitancy.	Member Telephonic Outreach: Outreach members who missed screening and preventive services; engage members; provide education, support, and care coordination until the member reaches 2 years of age or becomes ineligible; and offer assistance to members with barriers.

Barriers	Interventions
Parental/guardian lack of awareness regarding wellness checks and vaccination recommendations.	Proactive Outreach Management: Inform the member of the early and periodic screening, diagnostic, and treatment (EPSDT) benefits within the first 60 days of enrollment into the PHP, educate active members on the need for timely well-care visits, and provide support and education on the importance of obtaining the recommended vaccines.
Members lack information on incentives for their preventive screenings or immunizations.	Member Healthy Rewards Program: Members receive a $25.00 gift card when all six infant well-child visits are completed.

Table 82—2023 Barriers and Interventions for Healthy Blue

Barriers	Interventions
Lack of member incentives to complete the *CIS—Combo 10* vaccine series, particularly the influenza and rotavirus vaccines.	Provide incentives to members for completing the vaccine series. Proposing a $75.00 incentive for completing the series and a $50.00 incentive for completing the rotavirus vaccine.
Members' lack of awareness related to the Healthy Rewards program and ability to earn rewards for completing *CIS—Combo 10* vaccinations.	Member engagement via live outbound calls and text messages.
Low enrollment rates in the gift card program.	Members have 12 gift cards to choose from upon successful completion of all required immunizations.
Member confusion about how to enroll into the Healthy Rewards program and access the Benefits Reward Hub.	Members were educated regarding the Healthy Rewards program at the H2U community events and at Member Advisory Committee meetings.
Inability to reach large number of members at one time regarding Healthy Rewards program notification.	

Table 83—2023 Barriers and Interventions for UnitedHealthcare

Barriers	Interventions
Lack of provider awareness around member open care gaps	The AMH Provider Support Team provides population health and quality improvement education to all AMH tiered providers. • Quarterly newsletter to providers Immunization Rates-highlighting National Immunization Month. • Provider practices are given care gap report showing childhood immunization rates.

Barriers	Interventions
	• Provider bonus program for helping members become more engaged in preventive health—bonus provided when care gap is closed.
Lack of education on importance of vaccination completion and available immunization information.	The care management team provides member engagement and education to members/parents/caregivers. • Transportation arrangements • Healthy First Steps Rewards Program • Vaccine hesitancy education document for members and providers
Lack of evening and weekend appointment times.	Provider support and education: Intervention not yet documented.
No methodology to support race and ethnicity to identify and improve disparities.	PHP will analyze data and determine how to address disparities with targeted interventions.
Vaccine hesitancy and lack of education regarding the importance of immunizations; particularly, the flu vaccine.	Member engagement and education.
Presence of disparity indicated for Black/African American members in receipt of vaccinations by 2 years of age.	

Table 84—2023 Barriers and Interventions for WellCare

Barriers	Interventions
Provider lacks awareness of well-child checks needed (exact dates to meet the *CIS—Combo 10* timeline).	The Quality Practice Advisors (QPA) team explains member-specific care gap reports to the providers, offers consulting services for clinical and office workflow, offers training for staff on best practices for preventive health, and conducts joint operating committees with practice management.
Not as many members are notified of immunizations as expected through care management.	Care managers remind parents of members who are on their caseloads about *CIS—Combo 10* vaccine series/immunizations needed.
Members are not aware of the last well-child visit to the doctor and need reminders.	Targeted outreach conducted with members monthly via postcard mailings reminding members that immunizations are due.

SPs: *HEDIS PPC* PIP

Table 87 through Table 89 illustrate the barriers and interventions for the *HEDIS PPC* PIP.

Table 85—2023 Barriers and Interventions for AmeriHealth

Barriers	Interventions
Prenatal Care: Early identification and engagement of pregnant members.	Enhancement of the Early Pregnancy Identification Report to ensure appropriate and timely outreach to pregnant members is conducted.
Prenatal Care: Lack of member engagement, education, and awareness of prenatal care visits and follow-up.	Welcome packets sent to pregnant women to encourage and engage them about timely prenatal care. "Keys to Your Care" maternity texting program. Pregnant members receive a text with helpful notifications, reminders to schedule appointments, and education pertaining to what to expect during pregnancy. Provide an incentive via CareCard for completing prenatal care visits. Initiate a community baby shower to educate and encourage members to receive prenatal and postpartum care.
Prenatal Care: Stakeholders not involved in the PIP process.	Established and launched a PIP workgroup to ensure collaboration and contributions across cross-functional teams with the PHP.
Prenatal Care and Postpartum Care: Global obstetrics billing obscures individual visits.	Provide the Provider HEDIS Quick Reference Guide for 0500F CPT code use.
Prenatal Care and Postpartum Care: Global obstetrics/Midwives lack of familiarity of PPC measures.	Offer provider incentive supporting PPC performance within the perinatal QEP program.
Postpartum Care: Lack of member education and awareness of needed postpartum care.	Provide an incentive for timely completion of a postpartum exam. The Bright Start Team completes telephonic outreach after the member gives birth to educate and encourage the member about timely postpartum care. "Keys to Your Care" maternity texting program. Pregnant members receive a text with helpful notifications, reminders to schedule appointments, and education pertaining to what to expect during pregnancy and postnatal period. Initiate a community baby shower to educate and encourage members to receive prenatal and postpartum care.

Barriers	Interventions
Postpartum Care: Stakeholders not involved in the PIP process.	Established and launched a PIP workgroup to ensure collaboration and contributions across cross-functional teams with the plan.

Table 86—2023 Barriers and Interventions for Carolina Complete

Barriers	Interventions
Members are not reporting pregnancies to providers.	The Notification of Pregnancy (NOP) is a Centene assessment that identifies pregnant member and collects risk information. Members are stratified into low, medium, and high-risk groups according to a proprietary risk stratification model, with the goal of enrolling members into a care management program to improve maternal health outcomes and maternal health care visits.
Members lack information or incentive about the importance of timely prenatal care.	**Carolina Complete** will load reward dollars up to 75 dollars, earned by engaging in healthy behaviors, such as a health screening for NOP or preventative visits like postpartum care, to the member's rewards account when one or more targeted actions have been completed.

Table 87—2023 Barriers and Interventions for Healthy Blue

Barriers	Interventions
Lack of member awareness of the importance of prenatal and postpartum visits and the available services during the first trimester.	Educate members on the importance of prenatal visits and services during the first trimester and within the first 12 weeks after delivery. This program (My Advocate) is part of the New Baby, New Life program; pregnant members are automatically enrolled in the My Advocate Obstetrics Screener Call Program. This program assists with the identification of high-risk pregnant women for referral to the local health department's Case Management High Risk Pregnancy Program.
Members are not scheduling and/or attending prenatal appointments.	Initiated the Enterprise Quality Live Telephonic Call Campaign. Members are engaged via live telephonic calls. Members receive assistance with making required appointments.
High-risk members are not scheduling and/or attending appointments.	**Healthy Blue** projects began to discuss and collaborate with the Obstetrics Care Management team about educating high-risk pregnancy members on the importance of prenatal and postpartum visits.
Low penetration rates in contacting eligible prenatal members.	**Healthy Blue** continues conversations with the National Quality call team and is prioritizing this campaign. **Healthy Blue** will continue to monitor results using the

Barriers	Interventions
	"Enterprise Quality Call Report" and will report the results to the Department.
Providers use global billing and are not submitting a 500F code for prenatal visits.	**Healthy Blue** identifies providers who use global billing and do not submit 500F codes and provide the needed education.

Table 88—2023 Barriers and Interventions for UnitedHealthcare

Barriers	Interventions
Family planning and preconception/contraception health awareness.	Member engagement and education: Care management team provides members with education about the importance of prenatal and postpartum care.
Lack of education and information.	Member engagement and education: "After Delivery" campaign which focuses on postpartum care. Value-added service engagement with member to address SDOH by providing transportation, care management needs, needed resources, etc.
Correct coding and billing.	Provider support and education: The AMH team provides a one-page document with coding and billing guidance to providers.
Limited and low provider engagement with PPC measure.	AMH provider team support and education.

Table 89—2023 Barriers and Interventions for WellCare

Barriers	Interventions
Members' lack of awareness on how receiving timely and adequate prenatal and postpartum care can directly impact the overall health and well-being of themselves and their babies.	Member and provider support via the **WellCare** Maternity Care Management model: Outreach is conducted, and care management services offered to all plan managed members who are pregnant via collaboration with local health departments. Members receive education on pregnancy self-care, the importance of routine provider visits, diagnosis and condition-specific education, program benefits, assessment for SDOH needs, referrals made as needed, and assistance with finding providers.
COVID-19 has caused a decrease of events planned and attended, but it is anticipated that these will increase in volume, frequency, and anticipated attendance going forward.	Member-focused community outreach and incentives: Care managers, care coordinators, and the Community Engagement Team perform targeted member outreach within the community and provide incentives to all new and expectant mothers.

Barriers	Interventions
Provider lacks reporting needed by **WellCare** to reach out to members for timely follow-up.	Provider outreach and education: Maternal Health Clinical Nurse Liaisons collaborate with local health departments to offer training and support for staff and providers. Training includes provider education and follow-up on quality measure scores for timeliness of prenatal and postpartum care.

SPs: *HEDIS HBD* PIP

Table 90 through Table 94 illustrate the barriers and interventions for the *HEDIS HBD* PIP.

Table 90—2023 Barriers and Interventions for AmeriHealth

Barriers	Interventions
Lack of provider knowledge and utilization of CPT-II codes.	Provider support and education via the HEDIS toolkit was finalized and approved to be shared with the providers. This toolkit will provide education and increase utilization of the CPT-II codes.
	Offer provider incentive supporting diabetes HbA1c poor control (>9.0) performance in the PCP TCOC/QEP program.
	Provide a quick reference guide (Provider HEDIS Quick Reference Guide) for providers on using codes to meet HEDIS guidelines.
Stakeholders not involved in the PIP process.	Established and launched a PIP workgroup to ensure collaboration and contributions across cross-functional teams with the plan.
Lack of member engagement and/or education about the importance of HbA1c testing.	Telephonic outreach to members with diabetes to educate and encourage them about HbA1c testing and care gap closure.
	Institute a diabetes text message campaign.
Plan is not receiving HbA1c values from lab providers.	Acquisition and validation of supplemental data receipt by lab providers.

Table 91—2023 Barriers and Interventions for Carolina Complete

Barriers	Interventions
Members are not receiving their annual HbA1c test, and many go undiagnosed.	HbA1c Provider Tip Sheet: This sheet provides CPT codes for diabetes care and best practices for using codes.

Barriers	Interventions
	Provider engagement team provides education to providers on how to use the provider portal and how to identify members with care gaps. Care alerts notify member services to address when a diabetic member screening gap is present. Submitted request to the Department to begin implementing the proactive outreach member calls to diabetic members with diabetic care gaps.
Members receive inadequate treatment plans or follow-up for diabetes control.	Diabetes Prevention and Care Management Program: The diabetes management program team partners with care management staff to engage members in supportive care management, enhanced education with in-depth, web-based, clinical resources, and provides care managers access to specialized endocrinologists via clinical rounds.
Members lack information or incentive about the importance of the timing of preventative screenings or diabetes management.	Member Healthy Rewards Program: Members are eligible for a $20.00 gift card for completing a comprehensive diabetes care screening that consists of a HbA1c test, kidney screening, and retinopathy screening or a $20.00 gift card for completing a care needs screening assessment.

Table 92—2023 Barriers and Interventions for Healthy Blue

Barriers	Interventions
Providers cannot easily extract a list of members who are due for HbA1c testing and did not have a follow-up outreach process for these members.	Provider visits were done to offer education to the providers and support for diabetes metrics.
Limited resources/education materials to offer to providers related to HBD HbA1c poor control.	The provider relations team requested additional guidance/education from the Quality Department to offer educational tools and resources to providers. Quality management assessed the provider relations team's knowledge on the HBD HbA1c Poor Control (>9%) clinical measure and will develop resources to assist the provider relations team with provider education and training. The provider relations team hosts ongoing "Office Hour Calls," and in-person visits with network providers to assess overall performance and to offer support.
Members lack knowledge on the importance of maintaining a healthy lifestyle/proper nutritional habits.	The plan implemented the Health Advancement Workgroup in 2023. This group will facilitate development of member educational materials.

Table 93—2023 Barriers and Interventions for UnitedHealthcare

Barriers	Interventions
Lack of provider awareness around member open care gaps.	The AMH team provides population health and quality improvement education to all AMH tiered providers. • Monthly update focused on comprehensive diabetes care. • Clinical leadership meetings with a focus on diabetes care, incorporating provider feedback, data overview, and interventions to improve performance. • Provider care gap reports for diabetes care measures. • Provider bonus program for helping members become more engaged in preventive health—bonus provided when care gap is closed.
Workflow, resources, and staffing constraints related to the COVID-19 pandemic.	Intervention(s) not deployed yet for this barrier.
Lack of self-management to improve diet and lifestyle.	
Incorrect or missing coding/billing by providers.	AMH provider team support and education.
Low provider participation/engagement around incentives.	

Table 94—2023 Barriers and Interventions for WellCare

Barriers	Interventions
Lack of member recall: Member does not remember when last HbA1c was drawn or last visit for medication monitoring.	The care engagement specialist performs targeted outreach to members with open care gaps via telephone to educate about gaps and **WellCare**'s benefits.
Members are not receiving one-to-one counseling to work with them for as long as necessary to reduce the HbA1c results.	Good Measures Program: **WellCare** has engaged a vendor that will assess the member for individual needs. Available resources include nutritionists to educate and assist with incorporating better food choices, and when necessary, to provide referrals to address food insecurity and better nutritional options. The program also offers a one-to-one counselor to work with the member for as long as necessary to reduce the HbA1c results. These services are available to those members who have been referred by a physician, care manager, or self-referred.
Members are not choosing health improvement behaviors such as physical activity and healthy eating that support wellness and diabetes management.	Qualified members receive a three-month membership to Curves (gym), including one-to-one counseling with a health coach that will educate members on the importance of exercise and proper nutrition and their direct effect on glucose control.

Barriers	Interventions
Members have trouble managing their diabetes without support.	Telemedicine for diabetic management and the Weight Watchers program is offered.

SPs: Nonclinical PIP

Table 95 through Table 99 illustrate the barriers and interventions for the nonclinical PIP.

Table 95—2023 Barriers and Interventions for AmeriHealth

Barriers	Interventions
Inconsistent data regarding enrollment and the various member assessments that can be included and considered as a care needs screening.	Care needs screening and health risk assessment dashboard development. The population health team is working with the enterprise analytics team to develop a dashboard that includes data to measure performance for the completion of assessments.
Stakeholders not involved in the PIP process.	Established and launched a PIP workgroup to ensure collaboration and contributions across cross-functional teams with the plan.
Lack of member awareness of the importance of completing the care needs screening.	Welcome text campaign to encourage members to complete the care needs screening.
	Outreach calls are made to newly enrolled members. The intervention focuses on multi-member households and begins outreach efforts 30 days post enrollment.
Low CNS completions with paper forms in the new member welcome packets.	Member can utilize a quick response (QR) code to complete the CNS. The QR code is located in the new member welcome packets.

Table 96—2023 Barriers and Interventions for Carolina Complete

Barriers	Interventions
Lack of consistent communication—not everyone is given updates on changes to the plan's policies and procedures.	Joint Operating Committee meeting to discuss high priority risk/issues to improve provider satisfaction and provide up-to-date information. Topics include improvement strategies, current issues, and support needs. Monthly provider newsletters and bulletins are emailed to providers and posted on the plan's provider website.
Providers need additional resources related to provider education and training.	Monthly provider education via on-demand and/or live trainings are offered.
Lack of provider awareness on updates or changes to contractual policies, procedures, and relational issues.	Surveys are available to providers regarding every interaction that a provider has with **Carolina Complete** network. The three surveys are:

Barriers	Interventions
	• Provider training survey • Provider feedback survey (i.e., email survey) • Website feedback survey
Insufficient resolution delivery/communication style.	Help Stat: A provider communication function available on each page of the provider-facing website that allows providers to reach directly to the network via email and is triaged during business hours to allow fast response without the hassle of searching for the right person to reach. The Provider Engagement Team monitors, reviews, and routes provider inquiries to the appropriate department for timely resolution.

Table 97—2023 Barriers and Interventions for Healthy Blue

Barriers	Interventions
Lack of member participation and knowledge about tobacco cessation counseling opportunities.	Health program representatives attempt to reach members through a text message campaign. The message provides information on the Optum Quit for Life program. Member education materials are also distributed at marketing events.
Lack of social support from health and other service providers.	**Healthy Blue** created an educational presentation for providers. The intent of the presentation is to educate providers on **Healthy Blue**'s tobacco cessation benefits, including nicotine replacement therapy options, reimbursement information, and vendor program scope and resources.

Table 98—2023 Barriers and Interventions for UnitedHealthcare

Barriers	Interventions
Incorrect phone numbers.	The interdisciplinary team is working on ways to reconcile or supplement member contact information.
Dedicated time to complete screening/potential duplication of questions within SDOH and other care management assessment questions. Lack of member incentive and participation of care needs screening completion.	Script was enhanced to engage members during phone interactions to discuss potential services available and to complete the care needs screening questions. Postcards mailed to new members who have not completed the care needs screening within 60-days of enrollment, which included an incentive for completing the screening.

Barriers	Interventions
Unable to reach missing and/or incorrect member contact information.	Member engagement and education.
Low member response to incentive offerings.	

Table 99—2023 Barriers and Interventions for WellCare

Barriers	Interventions
Provider lacks awareness that member has not received annual visit.	The QPA team explains member-specific care gap reports to the providers, offers consulting services for clinical and office workflow, offers training for staff on best practices for preventive health, and conducts joint operating committees with practice management.
Lack of member recall: Member does not remember the last office visit or forgets to see doctor year to year.	The care engagement specialist performs targeted outreach to members with open care gaps via telephone to educate them about their gaps in care and **WellCare**'s benefits.
Provider lacks awareness that member has not received an annual visit. Lack of knowledge of member benefits.	Provider Relations Team visits providers and offers training for **WellCare** onboarding and education regarding benefits and care gaps.

SPs: *HEDIS CIS—Combo 10* PIP

Table 100 through Table 104 illustrate the barriers and interventions for the *HEDIS CIS—Combo 10* PIP.

Table 100—2024 Barriers and Interventions for AmeriHealth

Barriers	Interventions
Member vaccination hesitancy and adherence well child visits	TeleECHO Project: A 6-month educational, coaching, and quality improvement series on childhood and adolescent immunizations and well child visits for identified providers.
Incorrect provider coding and documentation	
Lack of documentation in North Carolina Immunization Registry (NCIR)	
Providers not using Modifier 25 for Evaluation/Management services during sick visits	

Table 101—2024 Barriers and Interventions for Carolina Complete

Barriers	Interventions
Member Education about childhood Immunizations	Growth Chart and Magnet
Access to care, ease of appointment scheduling	Targeted Member Outreach (Duke University Affiliated Physicians)

Table 102—2024 Barriers and Interventions for Healthy Blue

Barriers	Interventions
Lack of member incentives to complete the *CIS—Combo 10* vaccine series, particularly the influenza and rotavirus vaccines.	Increase Receipt of Provider Supplemental Data/ electronic health record (EHR) Integration.
Missed Reporting database. Claim Verification may not be received for all vaccines administered.	Educate AMH Tier 1 and 2 Providers Regarding Utilization of Gap-in-Care Reports.
Missed opportunities to collaborate with AMH Tier 1 and 2 providers.	Immunization Events Based on Geographic Distribution by Race.
Access to Care.	Member Incentive Flyer Mailing
Vaccine Hesitancy.	Pay for Quality (P4Q) Provider Incentive
• Lost opportunity at sick visits. • Vaccine requires refrigeration (added cost). • Local Health Departments serve as vaccine repositories (coordination of care) • Personnel needed at pediatric offices.	Increase Receipt of Provider Supplemental Data/EHR Integration.

Table 103—2024 Barriers and Interventions for UnitedHealthcare

Barriers	Interventions
Appointment adherence, knowledge deficit, access & availability, transportation	Member Outreach

Table 104—2024 Barriers and Interventions for WellCare

Barriers	Interventions
1. To address the barrier of prioritize member outreach, a new data report that captures age and immunizations needed is used by the care engagement specialist team. Additionally, calls are prioritized by regions with the greatest opportunity for improvement. 2. To address data capture barriers, data regarding results of the calls, reached members, immunization refusals, reasons for refusal, as well as parent/caregiver intent to obtain the immunizations needed are captured via QOT, a software application that aides in tracking member outreaches. Data is captured of members contacted/reached and those that attended and received immunizations on the day of the event. Claims are reviewed to	*CIS—Combo 10* Member Outreach: CIS Member Outreach prioritizing members aged 21-23 months who are able to receive needed vaccines in the appropriate timeframe.

Barriers	Interventions
determine if immunizations are compliant for intervention effectiveness tracking.	
1. To address the barrier of prioritization of at-risk members, providers/Community Partners are determined from regional compliance data to focus on areas with the greatest need for improvement. 2. To address provider staffing barriers and lack of engagement, providers/community partners are contacted by QPAs to determine willingness to have a Vaccine Party. If agreed, meetings are set up to collaborate and coordinate the event. Once event date and time is established, member parents are contact by care engagement specialist team/other QI staff to inform them of the event.	Vaccine parties offered to providers and community partners: addressing low compliance rates with the *CIS—Combo 10* immunizations.

SPs: *HEDIS PPC* PIP

Table 105 through Table 109 illustrate the barriers and interventions for the *HEDIS PPC* PIP.

Table 105—2024 Barriers and Interventions for AmeriHealth

Barriers	Interventions
AmeriHealth engagement with prenatal care providers	AMH and CIN – New Collaboration Strategy

Table 106—2024 Barriers and Interventions for Carolina Complete

Barriers	Interventions
• Lack of member knowledge regarding prenatal and postpartum care • Lack of sustained, recurring community educational resources • Lack of support systems within community • Lack of culturally appropriate practices	Monthly Moms Collaborative
Lack of engagement with staff due to extensive time commitment to current Start Smart for your Baby program.	Watching Over Mothers & Babies: Wellframe application
• Lack of social support, psychosocial challenges of pregnancy, scheduling conflicts • Limited appointment availability.	Group Prenatal Campaign

Table 107—2024 Barriers and Interventions for Healthy Blue

Barriers	Interventions
Provider knowledge deficit r/t to CPT II codes when global billing	OB/GYN Providers targeted education and communication on the clinical coverage changes for Global and CPT II code billing (0500F and 0503F)
• Provider knowledge deficit r/t to CPT II code billing • Providers global billing without the CPT II code	Practice consultants provide education to the OB/GYN QIP Providers on CPT II code billing
Member knowledge deficit	Targeted education in Region 5 African-American members

Table 108—2024 Barriers and Interventions for UnitedHealthcare

Barriers	Interventions
Knowledge deficit CPT II utilization	OB/GYN Provider Support Model

Table 109—2024 Barriers and Interventions for WellCare

Barriers	Interventions
1. Data barriers; the **WellCare** Dashboard data to review performance rates for prenatal and postpartum care by region and identify provider practices with the greatest opportunity for rate improvement. Provider Engagement barriers, QPAs perform outreach to engaged providers within identified region to share data findings, provide PPC measure education, best practices, coding tips, and assess potential barriers to closing PPC gaps. Providers are encouraged to embrace oversight of care for the maternity population within their attributed membership. 2. PCP accountability and buy in for OB/GYN specialist visit reporting QPAs have disseminated information to providers on PPC quality incentives and discussed their potential earnings for closing gaps. 3. Staffing barriers and data concerns, select providers with the greatest opportunity for improvement have agreed to allow QPAs to perform a targeted chart retrieval sprint utilizing the practice's EHR system. 4. Medical record exchange and access, QI staff work with practices to determine next steps on	Provider Partnership: AMH/PCPs are held accountable for servicing OB/GYN coding practices.

Barriers	Interventions
chart retrieval process via EHR granted access or in-person retrieval. 5. Data collection barriers, a tracking system that allows for ongoing review and continuous monitoring for the overall effectiveness of the intervention has been implemented. Key metrics for data collected include: a. Provider Performance – to track and evaluate provider performance for compliance both pre- and post-intervention. b. Chart Review – to evaluate the accessibility of charts within the EHR. c. Compliant Chart Retrieval – to track and evaluate the number of compliant prenatal and postpartum records retrieved for pseudo-claim gap closure.	

SPs: *HEDIS Comprehensive Diabetes Care—HbA1c Control Poor Control* PIP

Table 110 through Table 114 illustrate the barriers and interventions for the *HEDIS HBD* PIP.

Table 110—2024 Barriers and Interventions for AmeriHealth

Barriers	Interventions
Lack of transportation to Diabetes Self-Management Education and Support Program (DSMES) classes	Create a Care Management job aid to address barriers to attending the DSMES classes, such as transportation.
Lack of access to DSMES programs (i.e., rural areas, class times)	
Unwillingness to participate in DSMES program	

Table 111—2024 Barriers and Interventions for Carolina Complete

Barriers	Interventions
Access to care issues for members unable to complete an HbA1c in their provider's office.	At-home HbA1c Test Kits for diabetic members.
Lack of resources and understanding to self-manage diabetes.	Health Coaching for diabetic members.

Table 112—2024 Barriers and Interventions for Healthy Blue

Barriers	Interventions
Members are unaware of DSME classes available to them.	Case Manager Outreach - DSME
• Providers order HbA1c test; however, some testing labs bill the claim but do not report results. • EHR integration not in place for PCP to share results.	Collaborate with labs and providers to close care gaps

Table 113—2024 Barriers and Interventions for UnitedHealthcare

Barriers	Interventions
Appointment adherence, medication adherence, knowledge deficit, SDOH, goal setting	Member Outreach

Table 114—2024 Barriers and Interventions for WellCare

Barriers	Interventions
1. Socioeconomic constraints and SDOH impact available transportation options at the time of registration to facilitate attendance. 2. Language barriers on educational materials, surveys, and communication are available in languages of the participants. 3. Family barriers impacting member's ability to attend and participate in classes such as the time of the classes and child-care during the classes.	Healthy Choices: Managing Your HbA1C This intervention was selected to address members' limited knowledge and understanding of diabetes management.
Care gaps in the absence of implementing CPT II coding.	Diabetes dashboard deep dive This intervention was selected to address process, procedural, and provider challenges related to the PHP's receipt of member HbA1c results.

SPs: *Health-Related Resource Needs (HRRN)* PIP

Table 115 through Table 119 illustrate the barriers and interventions for the *HRRN* PIP.

Table 115—2024 Barriers and Interventions for AmeriHealth

Barriers	Interventions
Missed opportunities to complete CNSs/HRNs during interactions with members in the community.	The "Make Every Encounter Count" initiative is a systematic intervention created to ensure all member-facing associates are assisting members in completing

Barriers	Interventions
Completion of CNSs/HRRNs is not included in all workflows of member facing teams.	their initial and/or annual care needs screening (CNS) at every encounter regardless of reason.

Table 116—2024 Barriers and Interventions for Carolina Complete

Barriers	Interventions
Members are not aware of the need for HRRN survey within 90 days of enrollment and avenues to complete the surveys.	Increase Member Outreach avenues
Inconsistent follow-up by providers to encourage completion of surveys.	Increase Provider engagement

Table 117—2024 Barriers and Interventions for Healthy Blue

Barriers	Interventions
The Healthy Reward dollar amount was too low to incentivize members to complete the CNS.	Increase of Healthy Reward Dollar Amount (After Completion of CNS).

Table 118—2024 Barriers and Interventions for UnitedHealthcare

Barriers	Interventions
Lack of resources	Member Outreach- UHCCP NC conducts member outreach through HARC and Care Management to complete a health-related resource needs screening within the first 90 days of enrollment or re-enrollment.

Table 119—2024 Barriers and Interventions for WellCare

Barriers	Interventions
Health plan staff outside of Care Management, who have contact with members are not completing care needs screenings that are due/overdue. Care engagement specialists contact members for care gap closure purposes but did not previously check for status of care needs screening/complete if due.	Care Engagement Specialist Completion of Care Needs Screening
Members would like to, and can complete the screenings themselves, but are unaware of how to access the vendor portal.	Icario/Revel QR Code Development

Barriers	Interventions
Members are willing to complete the screening, but it is an inopportune time and request to complete at a later time and/or date. Members would prefer to complete independently/privately vs with assistance of in person health plan staff.	
WellCare of NC frequently hosts and participates in community events, but it is not built into the current workflow to review the care needs screening status when outreaching members to invite to the events. Currently Care Needs Screenings are not completed with members at events.	Integrating Care Needs Screening into Wellness and Resource Event
Not all members are receiving the required three outreach attempts by Icario for the screening completion within 90 days or enrollment or re-enrollment.	Icario/Revel Additional Unable to Reach Letter

PIHP PIPs

For the 2023 annual validation, the PIHPs submitted the Design stage (Steps 1–6); therefore, causal/barrier analysis processes and interventions were reported in the 2024 annual validation. The tables below reflect the barriers and interventions submitted.

PIHP Plans: *Follow-Up After Hospitalization for DHB Medicaid Direct—Mental Health (FUH)* PIP

Table 120 through Table 123 illustrate the barriers and interventions for the *FUH* PIP.

Table 120—2024 Barriers and Interventions for Alliance

Barriers	Interventions
It was observed that educational efforts were needed to enhance the learning experience and to better equip Providers with their roles to enhance their processes, clarify industry standards and adjustments, streamline approaches and to better service beneficiaries overall.	Provider Education Series Topic (value-based care & HEDIS, quality measures & gaps in care)
Beneficiary supportive services after mental health hospitalization discharge, and need for beneficiary medication reconciliation review, communications with the beneficiary and support.	Beneficiary Outreach (48 hour) after discharge. Develop a clinical team of nurses to perform outreach to beneficiaries with the inclusion of medication reconciliations to assist the beneficiary with medication accuracy, support, transition of care, beneficiary health safeguards, and 7-day FUH appointment confirmations.

Table 121—2024 Barriers and Interventions for Partners

Barriers	Interventions
Clinical staff not becoming aware of beneficiaries in the hospital or being discharged, timely.	Improve Communication of Inpatient Hospitalization/Discharge information with clinical teams.
There are several ways that clinical staff become aware of beneficiary inpatient or discharged from the hospital.	
Network providers and hospitals have different methods of communicating beneficiary inpatient or discharge information, if communicated at all in some instances.	

Table 122—2024 Barriers and Interventions for Trillium

Barriers	Interventions
Lack of a targeted team to manage inpatient beneficiaries and discharge planning.	**Trillium** will develop and implement an inpatient/discharge planning team that will create processes and workflows to ensure beneficiaries are contacted effectively.

Table 123—2024 Barriers and Interventions for Vaya Health

Barriers	Interventions
1. Timely awareness of when a beneficiary has been admitted to the hospital for a mental health related visit. 2. Need for quick, appropriate linkage to care following a qualifying hospital admission. 3. Difficulty obtaining data of qualifying discharges and appropriate follow-up prior to submission of a claim.	Peer Bridger Program: a provider-based peer support services to engage with beneficiaries who have been discharged from the hospital for a mental health reason (as defined in the measure parameters) to assist in connecting beneficiaries with follow-up care.

PIHP Plans: *Follow-Up After Emergency Department Visit for DHB Medicaid Direct—Mental Illness (FUM)* PIP

Table 124 through Table 127 illustrate the barriers and interventions for the *FUM* PIP.

Table 124—2024 Barriers and Interventions for Alliance

Barriers	Interventions
• Internal coordination and collaboration challenges fueled by limited knowledge of the measure and follow-up services. • Providers limited knowledge of the measure and follow-up services.	FUM Informational Sheet. The FUM Informational Sheet is a document used to enhance the understanding of the measure, billing codes, and the role in meeting the measure among staff.
Lack of communication about follow-up and accountability for the measure among providers.	Training Session on Value-Based Contracting – Quality Measures – HEDIS
Work silos, inconsistent understanding of warm hand-offs.	FUM Pathway to follow-up infographic to increase awareness about the pathway and handoffs for beneficiaries who has been discharged from the ED to their follow-up visit.

Table 125—2024 Barriers and Interventions for Partners

Barriers	Interventions
Clinical staff are not becoming aware of beneficiary ED visits, timely.	Improve the communication of beneficiary ED visits with clinical teams.
There are several ways that clinical staff become aware of beneficiaries in the ED.	
Network providers and hospitals have different methods of communicating beneficiary ED visit information with clinical teams.	

Table 126—2024 Barriers and Interventions for Trillium

Barriers	Interventions
Beneficiaries are unreachable because their phone numbers change, or they don't answer.	The designated **Trillium** staff will promptly request the latest beneficiary phone number from the ED, either verbally or electronically, before beneficiary discharge.

Table 127—2024 Barriers and Interventions for Vaya Health

Barriers	Interventions
• Timely awareness of when a beneficiary is seen in the ED setting. • Need for quick, appropriate linkage to care following a qualifying ED visit.	ED Care Transitions Workflow: Development of a **Vaya** process to support beneficiaries who are transitioning from hospitals after an ED visit so that they receive care from an outpatient provider within seven (7) days following a mental health-related visit.
• Improved provider awareness of the need for follow-up care after an ED visit for mental illness and the FUM measure. • Improved provider awareness of data needs in the Admission, Discharge, Transfer feed.	FUM Provider Education will focus on providing education to providers regarding the HEDIS FUM measure

PIHP Plans: *TCL Primary Care Provider Visits* PIP

Table 128 through Table 131 illustrate the barriers and interventions for the *TCL* PIP.

Table 128—2024 Barriers and Interventions for Alliance

Barriers	Interventions
The need for timely comprehensive assessments/summaries which identify health concerns and outstanding coordination activities to inform the various handoffs that occur between **Alliance** transition coordinators, care managers,	The integration of medical data reviews conducted by Diversion clinicians at the onset of housing eligibility consideration for pop 4-5 beneficiaries

Barriers	Interventions
housing support staff and post-transition community support providers.	
Timely information exchange & collaborative decision making among coordinating staff to proactively inform and guide the beneficiaries' transitioning process is needed to support medically safe housing placements.	Weekly housing slot staffing meetings to case conference housing placements.
Beneficiaries with complex health needs face challenges and are at high risk for/ or not consistently receiving annual health exams and follow- up monitoring of physical health conditions by a primary care provider.	Team approach to beneficiary education using motivational interviewing techniques; client centered, trauma informed counseling; the assessments; and primary health care needs identified during Medical Data Review. Educate beneficiaries on medical provider and transportation service availability, behavioral health urgent cares, and crisis assessment centers accessible to them.
Coordinating provider staff need timely, relevant, and useful housing information to support quicker beneficiary placements. Need provider engagement & communications to address TCL beneficiaries primary health care needs during transitioning phase.	Provide targeted education on beneficiary medical considerations to assertive community treatment, transportation management providers, community support teams, advanced medical homes plus, care management agencies, property managers, and internal and external stakeholders who help the people we serve navigate complex housing systems.

Table 129—2024 Barriers and Interventions for Partners

Barriers	Interventions
Adult care homes provide 24 hour supervised care settings including all activities of daily living such as dressing, bathing, medication administration, and coordination of care.	Implementation of registered nurse, occupational therapy team.
Beneficiaries are not used to caring for themselves when coming from adult care homes where everything is provided for daily.	
Beneficiaries may have complex medical conditions and, or significant functional deficit conditions that significantly impede the transition of the beneficiary into the community.	

Table 130—2024 Barriers and Interventions for Trillium

Barriers	Interventions
Beneficiaries violate their lease and are evicted.	**Trillium** will re-educate beneficiaries on their tenancy rights and lease agreement when they are identified as Post Transition.

Table 131—2024 Barriers and Interventions for Vaya Health

Barriers	Interventions
• Resolving barriers that put TCL beneficiaries at risk of separation before they become urgent. • Accurate data and tracking of TCL separations, including death and incarceration. • Improving the relationship between the PIHP, beneficiaries, and providers to work in unison to prevent housing separations.	Pre-separation Huddle: Transition and Housing transition coordinators and in-reach staff conduct a weekly Pre-Separation Huddle where they present cases for recommendations and support for TCL beneficiaries at risk of losing housing.
• TCL beneficiaries separate due to having medically complex cases. • TCL beneficiaries unable to be supported by a registered nurse or occupational therapist under the Pilot Program due to travel distance.	Registered nurse, occupational therapy consult program to support TCL participants who have medical conditions through consultation referrals.

Appendix C. Performance Measure Results

To ensure that all NC Medicaid managed care beneficiaries receive high-quality care, the Department requires the health plans to report on, and ultimately be held accountable for, performance on a select set of measures. These measures are 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. In its Quality Strategy, the Department selected standard performance measures, as required by 42 CFR §438.330(c), some of which SPs and TPs are required to measure and report to the Department. Others will be directly measured by the Department, or by external partners (e.g., The Cecil G. Sheps Center for Health Services Research). 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. Note that the results presented in Appendix C may show variation from the results presented in the DHHS-published *NC Medicaid Quality Measure Performance and Targets for the AMH Measure Set*[1] due to potential differences in source data (e.g., supplemental data sources, etc.) and rate reporting time frames (i.e., rates are finalized earlier for the *NC Medicaid Quality Measure Performance Results and Targets for the AMH Measure Set* compared to the final HSAG-validated rates).

Standard Plan Results

Table 132 and Table 133 present the MY 2022 and MY 2023 performance measure results for the Standard Plans.

Table 132—MY 2022 Performance Measure Results for Standard Plans

MY 2022 Performance Measures	Acronym	AmeriHealth	Carolina Complete Health	Healthy Blue	United HealthCare	WellCare
Controlling High Blood Pressure	*CBP*	18.34%	23.11%	22.02%	20.74%	24.72%
Cervical Cancer Screening	*CCS*	45.88%	50.93%	50.04%	45.73%	50.90%
Chlamydia Screening in Women—Total	*CHL*	58.34%	61.07%	56.56%	57.65%	56.51%
Childhood Immunization Status—Combo 10	*CIS*	23.90%	27.06%	26.48%	25.77%	28.60%

[1] North Carolina Department of Health and Human Services, Medicaid. *NC Medicaid Quality Measure Performance and Targets for the AMH Measure Set*. Available at:https://medicaid.ncdhhs.gov/nc-medicaid-quality-measure-performance-and-targets-amh-measure-set/download?attachment. Accessed on: Apr 23, 2025.

MY 2022 Performance Measures	Acronym	AmeriHealth	Carolina Complete Health	Healthy Blue	United HealthCare	WellCare
Concurrent Use of Opioids and Benzodiazepines—18–64 Years	*COB*	10.42%	9.08%	13.35%	12.57%	12.31%
Concurrent Use of Opioids and Benzodiazepines—65+ Years		*NA*	*NA*	6.25%	*NA*	*NA*
Follow-Up After Hospitalization for Mental Illness—7-Day Total	*FUH*	32.71%	29.83%	35.27%	33.56%	28.67%
Follow-Up After Hospitalization for Mental Illness—30-Day Total		53.35%	53.96%	58.67%	53.92%	48.22%
Hemoglobin A1c Control for Patients with Diabetes—HbA1c Control (<8.0%)	*HBD*	23.66%	23.13%	15.80%%	24.19%	25.76%
Hemoglobin A1c Control for Patients with Diabetes—HbA1c Poor Control (>9.0%)		72.93%	72.65%	82.41%	71.76%	69.82%
Immunizations for Adolescents—Combination 2	*IMA*	27.27%	31.60%	30.91%	26.36%	30.78%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	*PPC*	55.66%	51.88%	51.64%	48.42%	53.48%
Prenatal and Postpartum Care—Postpartum Care		64.97%	63.33%	64.44%	62.63%	67.70%
Well-Child Visits in the First 30 Months of Life—First 15 Months	*W30*	62.01%	64.62%	65.34%	58.37%	64.53%

MY 2022 Performance Measures	Acronym	AmeriHealth	Carolina Complete Health	Healthy Blue	United HealthCare	WellCare
Well-Child Visits in the First 30 Months of Life—15–30 Months		66.76%	68.64%	71.21%	66.34%	71.18%
Child and Adolescent Well-Care Visits—3–11 Years	*WCV*	57.88%	58.12%	61.53%	54.72%	59.88%
Child and Adolescent Well-Care Visits—12–17 Years		50.32%	50.46%	54.50%	47.05%	51.92%
Child and Adolescent Well-Care Visits—18–21 Years		24.13%	24.53%	26.53%	21.58%	25.29%
Child and Adolescent Well-Care Visits—Total		50.15%	50.33%	53.69%	46.70%	52.11%

NA-Measure rates that results in an NA are considered reportable; however, the denominator is too small to report (e.g., less than 30).
* DHB has approved the application of Continuous Enrollment criteria for all measures in scope of PMV. However, DHB acknowledges that rates may be low for CIS-10, IMA-2, and W30 due to the mid-MY launch on July 1, 2021, into Managed Care, which may have additional impact on PHPs ability to meet continuous enrollment for these measures during MY 2022.

Table 133—MY 2023 Performance Measure Results for Standard Plans

MY 2023 Performance Measures	Acronym	AmeriHealth	Carolina Complete Health	Healthy Blue	United HealthCare	WellCare
Controlling High Blood Pressure	*CBP*	38.77%	28.75%	32.80%	29.89%	38.67%
Screening for Depression and Follow-Up Plan—12–17 Years	*CDF*	2.66%	1.90%	4.00%	5.55%	3.22%
Screening for Depression and Follow-Up Plan—18–64 Years		0.86%	0.36%	2.11%	2.97%	3.55%
Screening for Depression and Follow-Up Plan—65+ Years		0.00%	0.00%	2.96%	3.22%	4.46%

MY 2023 Performance Measures	Acronym	AmeriHealth	Carolina Complete Health	Healthy Blue	United HealthCare	WellCare
Childhood Immunization Status—Combo 10	*CIS*	23.45%	25.04%	25.41%	24.67%	26.44%
Concurrent Use of Opioids and Benzodiazepines—18–64 Years	*COB*	10.75%	8.86%	13.54%	12.70%	12.83%
Concurrent Use of Opioids and Benzodiazepines—65+ Years		NA	NA	NA	NA	NA
Colorectal Cancer Screening—46-50 Years	*COL*	22.63%	23.16%	25.75%	23.80%	24.55%
Colorectal Cancer Screening—51-75 Years		32.26%	34.24%	35.18%	34.74%	35.21%
Colorectal Cancer Screening—Total		29.49%	30.65%	32.15%	31.82%	32.20%
Hemoglobin A1c Control for Patients with Diabetes —HbA1c Control (<8.0%)	*HBD*	31.53%	25.89%	29.85%	30.01%	33.59%
Hemoglobin A1c Control for Patients with Diabetes —HbA1c Poor Control (>9.0%)		63.91%	70.23%	65.96%	65.63%	61.80%
Immunizations for Adolescents—Combination 2	*IMA*	28.13%	32.28%	30.43%	28.01%	31.55%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	*PPC*	58.21%	55.13%	53.43%	49.82%	50.62%
Prenatal and Postpartum Care—Postpartum Care		67.37%	65.58%	64.80%	66.13%	67.99%

MY 2023 Performance Measures	Acronym	AmeriHealth	Carolina Complete Health	Healthy Blue	United HealthCare	WellCare
Well-Child Visits in the First 30 Months of Life—First 15 Months	*W30*	66.32%	67.11%	67.68%	63.91%	66.79%
Well-Child Visits in the First 30 Months of Life—15–30 Months		70.30%	69.92%	72.45%	68.42%	71.59%
Child and Adolescent Well-Care Visits—3–11 Years	*WCV*	61.50%	61.34%	63.07%	59.95%	61.16%
Child and Adolescent Well-Care Visits—12–17 Years		53.28%	54.19%	55.75%	51.80%	53.49%
Child and Adolescent Well-Care Visits—18–21 Years		27.24%	28.31%	29.85%	25.93%	27.68%
Child and Adolescent Well-Care Visits—Total		53.61%	54.03%	55.43%	52.15%	53.76%

NA-Measure rates that results in an NA are considered reportable; however, the denominator is too small to report (e.g., less than 30).

PIHP Results

Since performance measure rates were not required for MY 2023, HSAG assessed the PIHPs' systems and processes for enrollment/eligibility data, claims/encounters, provider data, care management data, and supplemental data collection to determine their readiness to report MY 2024 data. Results of the performance measure validation are reported in Section 2 of this report.

TP Results

The TPs launched July 1, 2024; therefore, they were not within scope of EQR activities during this reporting cycle.

Appendix D. Activity Timeline

Mandatory Activities[32]

Plans Types Included in Activity	Activity Cadence	Measurement Year/ Activity Year/Data Span Included in Report	Activity Commenced	Activity Concluded
Validation of PIPs				
SPs	Annual	CY 2021, CY 2022, CY 2023	Health plan submission of PIP Submission Form: September 2024 Initial validation findings and health plan responses: October–November 2024	Final validation findings provided to DHB and health plans: November 2024
PIHPs	Annual	Not applicable; not yet in data reporting phase	Health plan submission of PIP Submission Form: November 2024 Initial validation findings and health plan responses: January 2025	Final validation findings provided to DHB and health plans: January 2025
PMV				
SPs	Annual	MY 2022 and MY 2023	Pre-Virtual Review Phase: September and October 2024 Virtual Review Phase: October and November 2024	Follow-Up and Reporting Phase: October 2024–February 2025
PIHPs	Annual	Not applicable; readiness to report only	Pre-Virtual Review Phase: September and October 2024 Virtual Review Phase: October and November 2024	Follow-Up and Reporting Phase: October 2024–February 2025

[32] TPs launched in July 2024 and were not included in mandatory activities during this technical report cycle.

Plans Types Included in Activity	Activity Cadence	Measurement Year/ Activity Year/Data Span Included in Report	Activity Commenced	Activity Concluded
Compliance Monitoring				
SPs	Once every three years	CY 2023	Desk review: February–May 2023 File and webinar review: June–August 2023 Reporting and remediation: November–December 2023	Final reports delivered March 2024
PIHPs	Once every three years	Scheduled for review in CY 2025	Scheduled for review in CY 2025	Scheduled for review in CY 2025
NAV				
SPs, PIHPs, DHB	Annual	SFY 2024	Pre-Virtual Review Phase: September and October 2024 Virtual Review Phase: October and November 2024	Follow-Up and Reporting Phase: October 2024–February 2025

Optional/Additional Activities[33]

Activity	Activity Cadence	Measurement Year/ Activity Year/Data Span Included in Report	Activity Commenced	Activity Concluded
Optional Activities				
Beneficiary Experience With Care/Quality of Care Surveys (CAHPS)	Annual	2023 survey	Beneficiary letters mailed June 2023 Survey field closed August 2023 Data reconciliation, analysis and reporting conducted September 2023–January 2024	Final reports delivered November 2024
HCBS CAHPS	Annual	2023 survey	Telephonic survey administration conducted September–October 2023 Data reconciliation, analysis and reporting conducted October 2023–January 2024	Final report delivered June 2024
Calculation of Performance Measures	Annual	MY 2023	Data receipt: April–July 2024 Rate Calculation: June–October 2024	Final rates provided November 2024
Encounter Data Validation: SPs	Every three years	Encounters with dates of service between July 1, 2022, and June 30, 2023		
Additional Activities				
Provider Access Surveys: SPs	Annual	Provider network data submitted by the health plans in September 2024	Submission of health plan provider network data in September 2024 Conduct secret shopper calls October-December 2024	Final report projected May 2025

[33] TPs launched in July 2024 and were not included in optional or additional activities during this technical report cycle.

Activity	Activity Cadence	Measurement Year/ Activity Year/Data Span Included in Report	Activity Commenced	Activity Concluded
Care Management Performance Evaluation: SPs	Annual	September–December 2023	Pre-audit activities conducted February–March 2024 Desk review conducted June–September 2024 Virtual site review activities conducted July–September 2024	Final report delivered December 2024
Program Integrity Reviews: SPs	Annual	CY 2023	Pre-on-site activities conducted January–May 2024 Virtual on-site activities conducted May–August 2024 Follow-up completed June–December 2024	Final reports delivered October 2024–January 2025
PIP Review: SPs, PIHPs	Quarterly	CY 2024	Submissions in October 2024, January 2025 and April 2025	Reviews completed in November 2024, February 2025, and May 2025
Annual QAPI Review: SPs, PIHPs	Annual	CY 2024	Submissions in October 2024	Reports delivered to DHB December 2024 and February 2025
Semiannual Audits: PIHPs	Semiannual	September 2023–August 2024	First review Desk review April 2024 Data analysis and follow up May 2024 Second review Desk review October 2024 Data analysis and follow-up November 2024	Report submissions June 2024 and December 2024/January 2025

Activity	Activity Cadence	Measurement Year/ Activity Year/Data Span Included in Report	Activity Commenced	Activity Concluded
Evaluation of Quality Strategy	Once every three years per the quality strategy revision cycle	CY 2021, CY 2022	August 2024	November 2024
Quality Symposiums	Annual	2024	May 2024	June 2024

Appendix E. EQR Technical Report Requirements

Table 134 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 134 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, NA represents "not applicable" to indicate that this information will be included in subsequent reports and page numbers will be able to be determined.

Table 134—EQR Technical Report Requirements

Item #	Required Elements	Page Number
1.	The state submitted its EQR technical report by April 30th.	NA
2.	Include a clickable or hyperlinked table of contents for easy navigation throughout the report.	I–ii
3.	All eligible Medicaid and CHIP plans are included in the report.	1–2, 6–7
4.	Describe the manner in which the data from all activities conducted in accordance with § 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, or PAHP, or PCCM entity.	4–5, Appendix A
5.	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.	12–35, Appendix A, Appendix B
6.	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.	35–39, Appendix A, Appendix C
7.	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.	39–42, Appendix A
8.	Network Adequacy Validation: A description of objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.	42–47, Appendix A
9.	Include an assessment of each MCE's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries. Include recommendations for improving the quality of health care services furnished by each MCO, PIHP, or PAHP.	Section 4 (67–112)

Item #	Required Elements	Page Number
10.	The technical report must include recommendations for how the state can target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid or CHIP beneficiaries.	9–11
11.	Ensure methodologically appropriate, comparative information about all *MCE*s, consistent with guidance included in the EQR protocols issued in accordance with § 438.352(e).	Throughout report
12.	Include an assessment of the degree to which each MCE has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.	Section 4 (67–112)
13.	Include the names of the MCOs exempt from EQR by the State, including the beginning date of the current exemption period, or that no MCOs are exempt, as appropriate.	6, 7
14.	EQR technical reports should share the EQRO's timeline for conducting EQR activities.	Appendix D
15.	The information included in the technical report must not disclose the identity or other protected health information of any patient. 42 CFR 438.364(d).	NA