NC MEDICAID

ANNUAL TECHNICAL REPORT

April 2026

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.

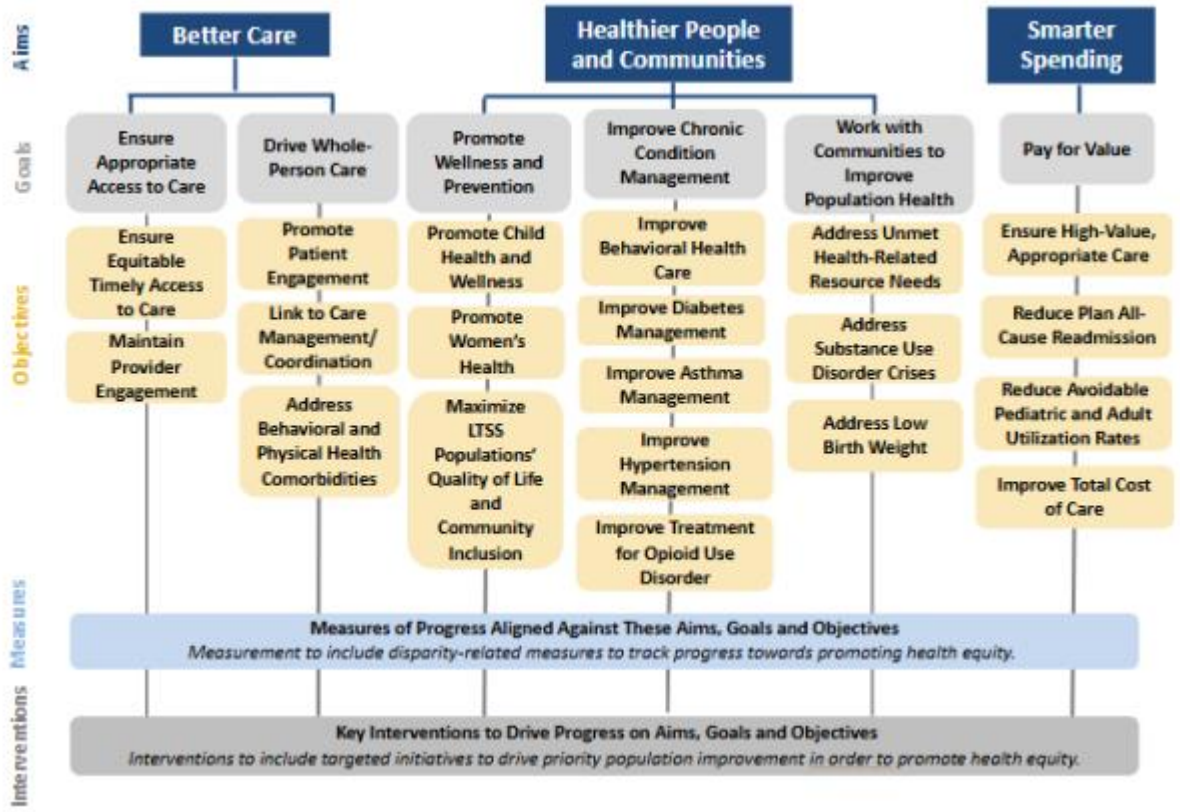
Type	Population Served	Description
Eastern Band of Cherokee Indians (EBCI) Tribal Option	Federally recognized tribal members and others who qualify for services through Indian Health Service (IHS) who live in the following counties: Buncombe, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, 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.
Behavioral Health and Intellectual/ Developmental Disabilities (I/DD) Tailored Plans (TPs)	Beneficiaries with significant mental health needs, severe substance use disorders, I/DD or traumatic brain injuries (TBIs).	Offers the same integrated health services as SPs but also provides enhanced behavioral health and I/DD state-funded services, TBI Waiver services, and Innovations Waiver services. 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 for NC Medicaid beneficiaries who are not enrolled in NC Medicaid Managed Care. Provides care management for physical health services through Community Care of North Carolina (CCNC) and care coordination and tailored care management for behavioral health, I/DD, or TBI through four Local Management Entity/Managed Care Organizations (LME/MCOs), also described as prepaid inpatient health plans (PIHPs).
Children and Families Specialty Plan (CFSP)	On December 1, 2025, the Department launched 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), published in 2025, details NC Medicaid managed care's aims, goals, and objectives for quality management and improvement and details specific quality improvement (QI) 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 21 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 and target specific improvement goals.

[2] DHB. *North Carolina's Medicaid Managed Care Quality Strategy*, June 18, 2025. Available at: https://medicaid.ncdhhs.gov/2025-nc-medicaid-managed-care-quality-strategy/download?attachment Accessed on: Jan 22, 2026.

Aggregating and Analyzing Statewide Data

CMS Medicaid managed care regulations, 42 CFR §438.364(a)(1), require 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. *2025 Standards and Guidelines for Accreditation of Health Plans.*

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/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 11, 2026.

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

Table 2, Table 3, and Table 4 display the Medicaid managed care health plans. As the CFSP program launched on December 1, 2025, the health plan will be included in future reports.

Table 2—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 and TP

PIHPs and TPs Name	Short Name	Health Plan Type
Partners Health Management	Partners	PIHP and TP
Trillium Health Resources	Trillium	PIHP and TP
Vaya Health	Vaya	PIHP and TP

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, PIHPs, and TPs were analyzed to develop overarching conclusions and recommendations for the NC managed care program. No health plans were exempt from mandatory EQR activities. 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]
For all PIPs, the SPs, PIHPs, and TPs demonstrated strengths and received a *High Confidence* rating for the first confidence level, indicating methodologically sound PIPs, except for one SP on the *Health-Related Resources Needs (HRRN)* PIP.	
For the Healthcare Effectiveness Data and Information Set (HEDIS®)[5] *Childhood Immunization Status (CIS)—Combination 10* (*CIS—Combo 10*) PIP, two SPs demonstrated non-statistically significant improvement in Remeasurement 1 compared to the baseline. For the *Timeliness of Prenatal Care and Postpartum Care (PPC)—Timeliness of Prenatal Care* and *Postpartum Care* PIP, two SPs had one performance indicator with statistically significant improvement and another performance indicator with non-statistically significant improvement in Remeasurement 1 compared to the baseline. One SP had non-statistically significant improvement for both performance indicators, and another SP had one performance indicator with non-statistically significant improvement. For the *Hemoglobin A1c Control for Patients With Diabetes* (*GSD*) PIP, one SP demonstrated statistically significant improvement in Remeasurement 1 compared to baseline for both indicators, and one SP had non-statistically significant improvement for both indicators. For the *HRRN* PIP, two SPs achieved a *High Confidence* rating for achieving statistically significant improvement in Remeasurement 1 compared to baseline.	

[4] = Quality, = Timeliness, = Access

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

Program Strengths	Domain(s)[4]
For the *Follow-Up After Hospitalization for Mental Illness (FUH)* PIP, two of the four PIHPs demonstrated statistically significant improvement in the first remeasurement compared to baseline, and one of the PIHPs demonstrated non-statistically significant improvement in the first remeasurement compared to baseline. For the *Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM)* PIP, two of the four PIHPs demonstrated statistically significant improvement compared to baseline, and two of the four PIHPs demonstrated non-statistically significant improvement compared to baseline.	
All five SPs' rates performed above the NCQA HEDIS measurement year (MY) 2024 50th percentile for the *Childhood Immunization Status (CIS)* Combination 7 indicator.	
All five SPs' rates increased compared to MY 2023 and performed above or just below the 50th percentile for the *Child and Adolescent Well-Care Visits (WCV)* measure total.	
All five SPs' rates increased compared to MY 2023 and performed above or just below the 50th percentile for both indicators of the *Well-Child Visits in the First 30 Months of Life (W30)* measure.	
Three of the five SPs' rates showed improvement between MY 2023 and MY 2024 for ages 18 to 64 years for the *Concurrent Use of Opioids and Benzodiazepines (COB)* measure.	
DHB completed statewide credentialing for all Medicaid providers and as such maintains greater recognition of existing provider resources within the State. Further, DHB performs an annual review of provider geographic access to assess the strength of its statewide Medicaid provider network and determine global adjustments and exceptions as needed.	
HSAG noted that SPs are nearly at full compliance for all BH provider time/distance access, with the exception for one provider type in two counties across the State, ensuring adequate access to BH services for Medicaid members.	
The NC Medicaid Program's 2024 top-box score was statistically significantly higher than the 2024 Home- and Community-Based Services (HCBS) Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[6] Database benchmark for all global and composite measures, eight of 15 composite individual survey items, and the recommendation measures and unmet need measures.	
The results from the medical record review (MRR) indicated that the encounters the SPs submitted and maintained in DHB's encounter processing system warehouse were relatively complete and accurate compared to the submitted medical records.	
All PIHPs and TPs reported using a wide variety of systems to collect, store, and check their encounter data and reported making multiple modifications to the data to align with DHB's encounter data submission guidelines. All PIHPs and TPs also reported robust methods to check for duplicate encounters, using a variety of fields across claim types to identify duplications.	

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

Program Weaknesses	Domain(s)
For the *HEDIS CIS—Combo 10* PIP, three SPs demonstrated a decline in performance in Remeasurement 1 compared to the baseline, resulting in a *No Confidence* rating. For the *HEDIS GSD* PIP, two SPs demonstrated a decline in Remeasurement 1 compared to the baseline, resulting in a *No Confidence* rating. For the *HEDIS PPC* PIP, one SP had one performance indicator with non-statistically significant improvement. For the *HRRN* PIP, one SP did not address feedback from the initial validation tool, resulting in a *Partially Met* validation score for the population and for the assessment of interventions, and two SPs demonstrated a decline in performance in Remeasurement 1 compared to the baseline.	
When compared to the prior MY, three SPs' rates decreased in MY 2024 for the *Screening for Depression and Follow-Up Plan, ages 65+* measure.	
All five SPs' rates were below the 50th percentile for the *Immunizations for Adolescents (IMA)* measure Combination 2 indicator.	
All five SPs' rates performed below the 50th percentile for the *Childhood Immunization Status (CIS)* measure Combination 10 indicator.	
All SPs' rates performed below the 25th percentile for the *Cervical Cancer Screening (CCS)* measure.	
All five SPs' rates were below the 25th percentile for both indicators of the *PPC* measure.	
All SPs reported low rates for both age groups for the *Controlling High Blood Pressure (CBP)* measure when compared to the 50th percentile for *CBP—Total*.	
All SPs performed poorly for both age groups of both indicators of the *GSD* measure when compared to the 50th percentile for *GSD—Total*.	
All four PIHPs' rates were below the 25th percentile for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)* measure.	
All four PIHPs' rates were below the 25th percentile for the *Follow-Up After Hospitalization for Mental Illness (FUH)* measure.	
All four PIHPs' rates were below the 50th percentile for the 30-day indicator of the *Follow-Up After Emergency Department Visit for Mental Illness (FUM)* measure.	
HSAG noted that the SPs and TPs demonstrated a shared lack of adequate child specialists available for Medicaid membership in two of the 23 specialties (Infectious Disease and Nephrology) statewide. Further, the SPs showed additional deficits among five child specialty types (Allergy/Immunology, Endocrinology, Hematology, Oncology, and Rheumatology) statewide.	
HSAG noted multiple instances of misalignment between the health plans and DHB related to global adjustments and exceptions during the state fiscal year (SFY) 2025 review period.	

Program Weaknesses	Domain(s)
For 2024 CAHPS, the NC SP Aggregate (**AmeriHealth**, **Carolina Complete**, **Healthy Blue**, **UnitedHealthcare**, and **WellCare**) and SP Behavioral Health for *Customer Service* (Adult CAHPS) scored below the 25th percentile. **AmeriHealth**, **Carolina Complete**, and TP Eligible scored below the 25th percentile for *Customer Service* (Child CAHPS).	
The NC Medicaid Program's 2024 top-box score was statistically significantly lower than the 2024 HCBS CAHPS Database benchmark for *Staff work time supposed to*, *Staff courteous and respectful*, *Treated the way you want by staff*, *Staff explain things in easy to understand way*, *Staff listen to you*, and *Help doing things in community*.	
Overall SP medical record omission rates for all key data elements were 10 percent or higher. Although the low procurement rates largely contributed to higher medical record omission rates, HSAG could not attribute all medical record omission rates to non-procured records.	
Although all PIHPs and TPs reported processes to reconcile transactions that were initially rejected due to either DHB's EDI translator or DHB-specific edits, all PIHPs and TPs reported a high percentage of encounters initially rejected that were not yet accepted.	
Although all PIHPs and TPs expressed satisfaction with the data quality checks their subcontractors perform, PIHPs and TPs reported not reviewing data submitted by at least one of their subcontractors prior to submission to DHB.	

Recommendations for Targeting Goals and Objectives in the Quality Strategy

Table 6—Recommendations

Domain	Program Recommendations	Quality Strategy Pillar and Goal
	SPs should develop active, innovative PIP interventions that have the potential for impacting the performance indicator outcomes and address the identified and prioritized barriers. The SPs should not initiate and test standard operating QI actions or processes already in place as interventions for the PIPs. SPs should use Plan-Do-Study-Act (PDSA) cycles as part of the improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful. The SPs must develop a methodologically sound approach or process to evaluate the effectiveness of each individual intervention; address the feedback that HSAG provides in the initial validation tool to receive a *High Confidence* rating; complete accurate statistical testing and report correct values in Step 7 of the PIP submission	***Goal 3: Promote wellness and prevention*** **Objective 3.1**: Promote child health, development, and wellness **Objective 3.2**: Promote women's health, including maternal morbidity and mortality ***Goal 4: Improve chronic condition management*** **Objective 4.2**: Improve diabetes management ***Goal 5: Work with communities to improve population health*** **Objective 5.1**: Address unmet HRRN

Domain	Program Recommendations	Quality Strategy Pillar and Goal
	form; and submit intervention worksheets for all interventions tested during the reported measurement period.	
	HSAG recommends that the SPs review patient health record data to target individuals ages 65 years and older who are in need of an initial depression screening and individuals who are overdue for an annual screening. The SPs can work with providers to incorporate depression screening questions as part of a pre-visit check-in or upon arrival for their appointment. The Geriatric Depression Scale (GDS) short form is especially useful for older adults due to its shorter length and yes/no style of questions.	***Goal 4: Improve chronic condition management*** **Objective 4.1:** Improve behavioral health care
	HSAG recommends that the PIHPs enhance existing provider resources to increase awareness of the services and referrals available for adolescent psychosocial care. HSAG also recommends that the PIHPs assist with coordination of care between first-line care centers and hospitals.	***Goal 4: Improve chronic condition management*** **Objective 4.1:** Improve behavioral health care ***Goal 2: Drive whole person care*** **Objective 2.2**: Link patients to effective care management and care coordination services
	HSAG recommends that the PIHPs evaluate current processes to ensure patients with a hospitalization for mental illness are discharged with a warm hand-off, including scheduling a follow-up appointment before the patient leaves the facility and clear instructions on how to navigate a telehealth visit.	***Goal 4: Improve chronic condition management*** **Objective 4.1:** Improve behavioral health care ***Goal 2: Drive whole person care*** **Objective 2.2**: Link patients to effective care management and care coordination services
	HSAG recommends that the PIHPs partner with providers to expand access to patients who have visited the ED due to mental illness. Expansion efforts could focus on extending available hours and telehealth options to assist patients with coordinating care needs.	***Goal 4: Improve chronic condition management*** **Objective 4.1:** Improve behavioral health care ***Goal 2: Drive whole person care*** **Objective 2.2**: Link patients to effective care management and care coordination services
	HSAG recommends that the SPs work with providers to incorporate missing vaccines into the child's regular vaccine schedule and discuss this approach with parents during office visits. HSAG also recommends that the SPs encourage providers to train office staff to identify needed immunizations when	***Goal 3: Promote wellness and prevention*** **Objective 3.1**: Promote child health, development, and wellness

Domain	Program Recommendations	Quality Strategy Pillar and Goal
	preparing for the office visit, which allows the provider to be prepared to discuss immunization needs with the parent during the visit.	
	HSAG recommends that the SPs work with providers to proactively schedule office visits and reminders that coincide with the recommended vaccination schedule from birth through 2 years of age. Establishing a visit schedule with the parents for needed vaccines helps to keep them educated on the status of their child's immunizations. Furthermore, offering reminder calls/text messages of upcoming visits may help with visit adherence.	***Goal 1: Ensure appropriate access to care*** **Objective 1.1:** Ensure equitable, timely access to care ***Goal 3: Promote wellness and prevention*** **Objective 3.1**: Promote child health, development, and wellness
	HSAG recommends avoiding missed opportunities by encouraging providers to complete cervical cancer screenings during both well visits and sick visits. HSAG also recommends using electronic health records (EHRs) to identify and outreach to patients to schedule screenings before they are overdue.	***Goal 3: Promote wellness and prevention*** **Objective 3.2**: Promote women's health, including maternal morbidity and mortality
	HSAG recommends that the SPs review successful improvement initiatives related to the *PPC* measure and continue to implement or expand them to continue increasing performance rates.	***Goal 3: Promote wellness and prevention*** **Objective 3.2**: Promote women's health, including maternal morbidity and mortality
	HSAG recommends that the SPs proactively outreach to patients with a hypertension diagnosis to coordinate follow up care and assist with medication management. HSAG further recommends that the SPs identify barriers patients have to adhering to their treatment plan, such as cost or transportation.	***Goal 4: Improve chronic condition management*** **Objective 4.4**: Improve hypertension management
	HSAG recommends that the SPs enhance existing processes to identify gaps in care and outreach to patients to assist with diabetes education and care coordination. HSAG recommends that the SPs work with provider partners who have the highest volume of patients with open GSD care gaps to conduct targeted interventions with date-based, measurable, and actionable objectives.	***Goal 2: Drive whole person care*** **Objective 2.2**: Link patients to effective care management and care coordination services ***Goal 4: Improve chronic condition management*** **Objective 4.2**: Improve diabetes management

Domain	Program Recommendations	Quality Strategy Pillar and Goal
	HSAG recommends that health plans work with DHB to address statewide gaps in specific specialist types in order to better support their recruiting and contracting efforts of eligible Medicaid providers for specialties that did not meet the time/distance threshold, with the goal of determining whether failure to meet the contract standard was the result of a lack of providers or an inability to contract providers in the geographic area.	***Goal 1: Ensure appropriate access to care*** **Objective 1.1:** Ensure equitable, timely access to care **Objective 1.2**: Maintain Medicaid provider engagement
	HSAG recommends that DHB clarify expectations of the health plans regarding global adjustments and exceptions within the instructions in the reporting templates to revert to contractual standards upon the expiration of previous guidance.	***Goal 1: Ensure appropriate access to care*** **Objective 1.1:** Ensure equitable, timely access to care **Objective 1.2**: Maintain Medicaid provider engagement
	For the CAHPS *Customer Service* measure, HSAG recommends that the Department and the SPs explore drivers of the lower experience scores of adults. **AmeriHealth**, **Carolina Complete**, and TP Eligible also should explore drivers of what may be impacting lower experience scores and develop initiatives designed to improve quality of care. In addition, obtaining direct patient feedback from members could be used to drill down into areas that need improvement.	***Goal 2: Drive whole person care*** **Objective 2.1**: Promote patient engagement in care
	HSAG recommends that the Department conduct root cause analyses or focus studies to further explore the perceptions of HCBS beneficiaries regarding the timeliness of and access to care and services they received; determine what could be driving lower scores compared to national averages; and implement appropriate interventions to improve performance related to the care members need.	***Goal 3: Promote wellness and prevention*** **Objective 3.3**: Maximize LTSS populations' quality of life and community inclusion
	SPs should investigate the root causes of EDV omissions and consider performing periodic record reviews of submitted claims to verify appropriate coding and data completeness, where appropriate. Findings from these reviews should be used to target education and training to providers regarding encounter data submissions, medical record documentation, and coding practices.	***Goal 6: Pay for value*** **Objective 6.5**: Improve total cost of care

Domain	Program Recommendations	Quality Strategy Pillar and Goal
	PIHPs and TPs should strengthen their EDV processes to ensure timely and complete resubmission of all rejected transactions.	***Goal 6: Pay for value*** **Objective 6.5**: Improve total cost of care
	PIHPs and TPs should explore the possibility of developing or enhancing monitoring reports to assess the accuracy, completeness, and/or timeliness of subcontractor-submitted claims and encounters.	***Goal 6: Pay for value*** **Objective 6.5**: Improve total cost of 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 Quality Assessment and Performance Improvement (QAPI) program for the services it furnishes to its enrollees. For CY 2025, 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 this year's validation, HSAG used CMS *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 1).[7]

[7] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 11, 2026.

For the 2025 validation, the SPs continued four PIP topics. Three clinical PIP topics corresponded to the following HEDIS measures: *CIS—Combo 10,*[8] *PPC*, and *GSD*. Additionally, each SP submitted a nonclinical PIP: *HRRN*.

The PIHPs submitted two continuing clinical PIP topics: *FUH* and *FUM*. Additionally, each PIHP submitted a new nonclinical *HRRN* PIP.

The TPs submitted three new PIP topics. The clinical PIP topics were *FUH* 7-day and 30-day indicators and *Initiation and Engagement of Substance Use Disorder Treatment (IET)—Engagement of Substance Use Disorder (SUD) Treatment*. For the nonclinical PIP, the topic was *HRRN*.

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

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.

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—2025 SP PIP-Specific Data Source

SP	Data Source
HEDIS CIS—Combo 10	
AmeriHealth	Administrative data using HEDIS Core Set methodology.
Carolina Complete	Administrative data using HEDIS Core Set methodology.
Healthy Blue	Administrative data using HEDIS Core Set methodology.

[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 influenzae 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.

SP	Data Source
UnitedHealthcare	Administrative data using HEDIS Core Set methodology.
WellCare	Administrative data using HEDIS Core Set methodology.
HEDIS PPC	
AmeriHealth	Hybrid data using HEDIS Core Set methodology.
Carolina Complete	Hybrid data using HEDIS Core Set methodology.
Healthy Blue	Hybrid data using HEDIS Core Set methodology.
UnitedHealthcare	Hybrid data using HEDIS Core Set methodology.
WellCare	Hybrid data using HEDIS Core Set methodology.
HEDIS GSD	
AmeriHealth	Hybrid data using HEDIS Core Set methodology.
Carolina Complete	Hybrid data using HEDIS Core Set methodology.
Healthy Blue	Hybrid data using HEDIS Core Set methodology.
UnitedHealthcare	Hybrid data using HEDIS Core Set methodology.
WellCare	Hybrid data using HEDIS Core Set methodology.
HRRN	
AmeriHealth	Administrative data through BCM026 reports.
Carolina Complete	Administrative data through a delegated vendor, EHR data, and survey data.
Healthy Blue	Administrative data through an internal care management system.
UnitedHealthcare	Administrative data through BCM026 reports and survey data.
WellCare	Administrative data through PowerBI dashboards for Health Risk Assessment completions.

Table 8—2025 PIHP PIP-Specific Data Source

PIHP	Data Source
FUH	
Alliance	Administrative data using HEDIS Core Set methodology.
Partners	Administrative data using HEDIS Core Set methodology.
Trillium	Administrative data using HEDIS Core Set methodology.
Vaya Health	Administrative data using HEDIS Core Set methodology.

PIHP	Data Source
FUM	
Alliance	Administrative data using HEDIS Core Set methodology.
Partners	Administrative data using HEDIS Core Set methodology.
Trillium	Administrative data using HEDIS Core Set methodology.
Vaya Health	Administrative data using HEDIS Core Set methodology.
HRRN	
Alliance	Administrative data through BCM026 reports.
Partners	Administrative data through EHR query.
Trillium	Administrative data through BCM026 reports.
Vaya Health	Administrative data through EHR query.

Table 9—2025 TP PIP-Specific Data Source

TP	Data Source
FUH	
Alliance	Administrative data using HEDIS Core Set methodology.
Partners	Administrative data using HEDIS Core Set methodology.
Trillium	Administrative data using HEDIS Core Set methodology.
Vaya Health	Administrative data using HEDIS Core Set methodology.
IET	
Alliance	Administrative data using HEDIS Core Set methodology.
Partners	Administrative data using HEDIS Core Set methodology.
Trillium	Administrative data using HEDIS Core Set methodology.
Vaya Health	Administrative data using HEDIS Core Set methodology.
HRRN	
Alliance	Administrative data through BCM026 reports.
Partners	Administrative data through EHR query.
Trillium	Administrative data through BCM026 reports.
Vaya Health	Administrative data through EHR query.

PIP Validation and Performance Indicator Results

SPs: *HEDIS CIS—Combo 10* PIP

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

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

SP	Type of Review[9]	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[10]	Percentage Score of Critical Elements Met[11]	Confidence Level[12]	Percentage Score of Evaluation Elements Met[4]	Percentage Score of Critical Elements Met[5]	Confidence Level[6]
AmeriHealth	Initial Submission	83%	100%	*Moderate Confidence*	67%	100%	*Moderate Confidence*
	Resubmission	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
Carolina Complete	Initial Submission	100%	100%	*High Confidence*	33%	100%	*No Confidence*
	Resubmission	*SP did not need to resubmit.*					
Healthy Blue	Initial Submission	82%	*75%*	*Low Confidence*	33%	100%	*No Confidence*
	Resubmission	100%	100%	*High Confidence*	33%	100%	*No Confidence*
United Healthcare	Initial Submission	94%	100%	*High Confidence*	33%	100%	*No Confidence*
	Resubmission	100%	100%	*High Confidence*	33%	100%	*No Confidence*

[9] **Type of Review—**Designates the PIP review as an initial submission, or resubmission. A resubmission means the PHP resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[10] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated 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)*.

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

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

SP	Type of Review[9]	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[10]	Percentage Score of Critical Elements Met[11]	Confidence Level[12]	Percentage Score of Evaluation Elements Met[4]	Percentage Score of Critical Elements Met[5]	Confidence Level[6]
WellCare	Initial Submission	63%	75%	*No Confidence*	0%	0%	*No Confidence*
	Resubmission	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*

As shown in Table 10 above, the *HEDIS CIS—Combo 10* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1 for all SPs, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned the following ratings: three health plans received a *No Confidence* level rating (**Healthy Blue**, **Carolina Complete** and **UnitedHealthcare**), and two health plans received a *Moderate Confidence* level rating (**AmeriHealth** and **WellCare**) for overall confidence that the PIP achieved significant improvement.

The performance indicator is the *HEDIS CIS—Combo 10* measure indicator, which assesses the percentage of eligible members who complete the *CIS—Combo 10* vaccine series. Table 11 displays the baseline and Remeasurement 1 data reported by the SPs for the *HEDIS CIS—Combo 10* PIP.

Table 11—2025 Performance Indicator Results for the *HEDIS CIS—Combo 10* PIP

Performance Indicator Results				
SP	Baseline (01/01/2023–12/31/2023)		Remeasurement 1 (01/01/2024–12/31/2024)	
AmeriHealth	N: 2,301	23.5%	N: 2,274	24.4%
	D: 9,811		D: 9,319	
Carolina Complete	N: 2,022	25.0%	N: 1,811	24.8%
	D: 8,076		D: 7,292	
Healthy Blue	N: 4,314	25.4%	N: 3,877	23.2%
	D: 16,977		D: 16,717	
UnitedHealthcare	N: 2,948	24.7%	N: 2,692	23.6%
	D: 11,948		D: 11,395	
WellCare	N: 3,682	26.4%	N: 3,817	26.9%
	D: 13,932		D: 14,176	

N–Numerator. D–Denominator.
HSAG rounded percentages to the first decimal place.

As shown in Table 11 above, for the baseline and Remeasurement 1 period, the SPs reported that varying percentages of children received the *CIS—Combo 10* vaccine series during the measurement year.

SPs: *HEDIS PPC* PIP

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 12 displays the validation scores and confidence levels HSAG assigned to each SP's *HEDIS PPC* PIP submission.

Table 12—2025 *HEDIS PPC* PIP Validation Results

SP	Type of Review[13]	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[14]	Percentage Score of Critical Elements Met[15]	Confidence Level[16]	Percentage Score of Evaluation Elements Met[12]	Percentage Score of Critical Elements Met[13]	Confidence Level[14]
AmeriHealth	Initial Submission	83%	91%	*Low Confidence*	67%	100%	*Moderate Confidence*
	Resubmission	96%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
Carolina Complete	Initial Submission	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
	Resubmission	*SP did not need to resubmit.*					
Healthy Blue	Initial Submission	79%	82%	*Low Confidence*	33%	100%	*Low Confidence*
	Resubmission	96%	100%	*High Confidence*	33%	100%	*Low Confidence*
United Healthcare	Initial Submission	91%	91%	*Low Confidence*	67%	100%	*Moderate Confidence*
	Resubmission	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*

[13] **Type of Review—**Designates the PIP review as an initial submission, or resubmission. A resubmission means the PHP resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.
[14] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated 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)*.
[15] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[16] **Confidence Level—**Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

SP	Type of Review[13]	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[14]	Percentage Score of Critical Elements Met[15]	Confidence Level[16]	Percentage Score of Evaluation Elements Met[12]	Percentage Score of Critical Elements Met[13]	Confidence Level[14]
WellCare	Initial Submission	88%	100%	*Moderate Confidence*	33%	100%	*Low Confidence*
	Resubmission	100%	100%	*High Confidence*	33%	100%	*Low Confidence*

As shown in Table 12 above, the *HEDIS PPC* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1 for all SPs, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology. For Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement), HSAG assigned the following ratings: two health plans received a *Low Confidence* level rating (**Healthy Blue** and **WellCare**) and three health plans received a *Moderate Confidence* level rating (**AmeriHealth**, **Carolina Complete** and **UnitedHealthcare**) for overall confidence that the PIP achieved significant improvement.

The performance indicator is the HEDIS *PPC* measure, which assesses:

- Prenatal: 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 during the measurement year.
- Postpartum: The percentage of deliveries that had a postpartum visit on or between seven days and 84 days after delivery.

Table 13 and Table 14 display the baseline and Remeasurement 1 data reported by the SPs for the *HEDIS PPC* PIP.

Table 13—2025 Baseline Performance Indicator Results for the *HEDIS PPC* PIP

Performance Indicator Results				
SP	Baseline (01/01/2023–12/31/2023)			
	Improving timeliness of care rate for prenatal care.		Improving timeliness of care rate for postpartum care.	
AmeriHealth	N: 299	72.7%	N: 307	74.7%
	D: 411		D: 411	
Carolina Complete	N: 311	75.7%	N: 274	66.7%
	D: 411		D: 411	

Performance Indicator Results				
SP	Baseline (01/01/2023–12/31/2023)			
	Improving timeliness of care rate for prenatal care.		Improving timeliness of care rate for postpartum care.	
Healthy Blue	N: 320 D: 411	77.9%	N: 321 D: 411	71.1%
UnitedHealthcare	N: 298 D: 411	72.5%	N: 312 D: 411	75.9%
WellCare	N: 316 D: 411	76.9%	N: 36 D: 411	81.8%

N–Numerator. D–Denominator.
HSAG rounded percentages to the first decimal place.

Table 14—2025 Remeasurement 1 Performance Indicator Results for the *PPC* PIP

Performance Indicator Results				
SP	Remeasurement 1 (01/01/2024–12/31/2024)			
	Improving timeliness of care rate for prenatal care.		Improving timeliness of care rate for postpartum care.	
AmeriHealth	N: 256 D: 335	76.4%	N: 273 D: 335	81.5%
Carolina Complete	N: 324 D: 411	78.8%	N: 314 D: 411	76.4%
Healthy Blue	N: 311 D: 411	75.7%	N: 330 D: 411	80.3%
UnitedHealthcare	N: 322 D: 411	78.4%	N: 320 D: 411	77.9%
WellCare	N: 333 D: 411	81.0%	N: 330 D: 411	80.3%

N–Numerator. D–Denominator.
HSAG rounded percentages to the first decimal place.

As shown in Table 13 and Table 14 above, for the baseline and Remeasurement 1 measurement period, SPs reported that varying percentages of members received a timely prenatal care visit and a timely postpartum care visit during the measurement year.

SPs: *HEDIS GSD* PIP

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 15 displays the validation scores and confidence levels HSAG assigned to each SP's *HEDIS GSD* PIP.

Table 15—2025 *HEDIS GSD* PIP Validation Results

Standard Plan	Type of Review[17]	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[18]	Percentage Score of Critical Elements Met[19]	Confidence Level[20]	Percentage Score of Evaluation Elements Met[8]	Percentage Score of Critical Elements Met[9]	Confidence Level[10]
AmeriHealth	Initial Submission	91%	100%	*Moderate Confidence*	100%	100%	*High Confidence*
	Resubmission	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Carolina Complete	Initial Submission	100%	100%	*High Confidence*	100%	100%	*High Confidence*
	Resubmission	*SP did not need to resubmit.*					
Healthy Blue	Initial Submission	88%	82%	*Low Confidence*	33%	100%	*No Confidence*
	Resubmission	100%	100%	*High Confidence*	33%	100%	*No Confidence*
UnitedHealthcare	Initial Submission	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
	Resubmission	*SP did not need to resubmit.*					
WellCare	Initial Submission	88%	100%	*Moderate Confidence*	33%	100%	*No Confidence*
	Resubmission	100%	100%	*High Confidence*	33%	100%	*No Confidence*

[17] **Type of Review—**Designates the PIP review as an initial submission, or resubmission. A resubmission means the PHP resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.
[18] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated 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)*.
[19] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[20] **Confidence Level—**Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

As shown in Table 15 above, the *GSD* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1 for all SPs, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned the following ratings: two health plans received a *No Confidence* level rating (**Healthy Blue** and **WellCare**), one health plan received a *Moderate Confidence* level rating (**UnitedHealthcare**), and two health plans received a *High Confidence* level rating (**AmeriHealth** and **Carolina Complete**) for overall confidence that the PIP achieved significant improvement.

The performance indicator is the HEDIS *GSD* measure, which assesses the number of members whose most recent glycemic status is less than 8.0 percent during the measurement year and whose most recent glycemic status is greater than 9.0 percent during the measurement year. Table 16 and Table 17 display the baseline and Remeasurement 1 data the SPs reported for the *HEDIS GSD* PIP.

Table 16—2025 Remeasurement 1 Performance Indicator Results for the *GSD* PIP

Performance Indicator Results				
Standard Plan	Baseline (01/01/2023–12/31/2023)			
	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent HbA1c was less than 8.0 percent during the measurement year.		The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent HbA1c was greater than 9.0 percent during the measurement year.	
AmeriHealth	N: 186 D: 411	45.3%	N: 196 D: 411	47.7%
Carolina Complete	N: 196 D: 411	47.4%	N: 180 D: 411	43.8%
Healthy Blue	N: 154 D: 411	37.5%	N: 216 D: 411	52.6%
UnitedHealthcare	N: 224 D: 411	54.5%	N: 147 D: 411	35.8%
WellCare	N: 238 D: 411	57.9%	N: 140 D: 411	34.1%

N–Numerator. D–Denominator.
HSAG rounded percentages to the first decimal place.

Table 17—2025 Remeasurement 1 Performance Indicator Results for the *GSD* PIP

Performance Indicator Results				
Standard Plan	Remeasurement 1 (01/01/2024–12/31/2024)			
	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent HbA1c was less than 8.0 percent during the measurement year.		The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent HbA1c was greater than 9.0 percent during the measurement year.	
AmeriHealth	N: 242 D: 411	58.9%	N: 135 D: 411	32.9%
Carolina Complete	N: 235 D: 411	51.2%	N: 138 D: 411	33.6%
Healthy Blue	N: 159 D: 411	38.7%	N: 209 D: 411	50.9%
UnitedHealthcare	N: 248 D: 411	60.3%	N: 140 D: 411	34.1%
WellCare	N: 215 D: 411	52.3%	N: 165 D: 411	40.2%

N–Numerator. D–Denominator.
HSAG rounded percentages to the first decimal place.

As shown in Table 16 and Table 17 above, for the baseline and Remeasurement 1 period, the SPs reported that varying percentages of members managed their HbA1c levels during the measurement year.

SPs: Nonclinical *HRRN* 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 SP's nonclinical *HRRN* PIP.

Table 18—2025 Nonclinical *HRRN* PIP Validation Results

Standard Plan	Type of Review[21]	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[22]	Percentage Score of Critical Elements Met[23]	Confidence Level[24]	Percentage Score of Evaluation Elements Met[16]	Percentage Score of Critical Elements Met[17]	Confidence Level[18]
AmeriHealth	Initial Submission	94%	100%	*High Confidence*	100%	100%	*High Confidence*
	Resubmission	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Carolina Complete	Initial Submission	88%	75%	*Low Confidence*	33%	100%	*No Confidence*
	Resubmission	88%	75%	*Low Confidence*	33%	100%	*No Confidence*
Healthy Blue	Initial Submission	82%	88%	*Low Confidence*	33%	100%	*No Confidence*
	Resubmission	100%	100%	*High Confidence*	33%	100%	*No Confidence*
UnitedHealthcare	Initial Submission	100%	100%	*High Confidence*	100%	100%	*High Confidence*
	Resubmission	*SP did not need to resubmit.*					
WellCare	Initial Submission	88%	88%	*Low Confidence*	100%	100%	*High Confidence*
	Resubmission	100%	100%	*High Confidence*	100%	100%	*High Confidence*

As shown in Table 18 above, the nonclinical *HRRN* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology for four SPs while one SP (**Carolina Complete**) was assigned a *Low*

[21] **Type of Review—**Designates the PIP review as an initial submission, or resubmission. A resubmission means the PHP resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.
[22] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated 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)*.
[23] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[24] **Confidence Level—**Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

Confidence level. For Validation Rating 2, HSAG assigned the following ratings: two health plans received a *No Confidence* level rating (**Carolina Complete** and **Healthy Blue**), and three health plans received a *High Confidence* level rating (**AmeriHealth**, **UnitedHealthcare**, and **WellCare**) for overall confidence that the PIP achieved significant improvement.

The performance indicator for the nonclinical *HRRN* PIP was increasing the number of unique members who completed a successful screening within the calendar year. Table 19 displays the baseline and Remeasurement 1 data reported by each SP.

Table 19—2025 Performance Indicator Results for the Nonclinical *HRRN* PIPs

Performance Indicator Results				
Standard Plan	**Baseline (01/01/2023–12/31/2023)**		**Remeasurement 1 (01/01/2024–12/31/2024)**	
AmeriHealth	N: 10,523 D: 418,908	2.5%	N: 44,557 D: 391,261	11.4%
Carolina Complete	N: 9,661 D: 256,183	3.8%	N: 11,769 D: 317,249	3.7%
Healthy Blue	N: 12,599 D: 553,374	2.3%	N: 13,194 D: 612,858	2.2%
UnitedHealthcare	N: 11,621 D: 474,307	2.5%	N: 17,556 D: 544,725	3.2%
WellCare	N: 72,177 D: 506,176	14.3%	N: 105,467 D: 562,974	18.7%

N–Numerator. D–Denominator.
HSAG rounded percentages to the first decimal place.

As shown in Table 19 above, for the baseline and Remeasurement 1 period, SPs reported that varying percentages of members completed a successful HRRN screening during the calendar year.

PIHPs: *FUH* 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 PIHP's *FUH* PIP.

Table 20—2025 *FUH* PIP Validation Results

Prepaid Inpatient Health Plan	Type of Review[25]	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[26]	Percentage Score of Critical Elements Met[27]	Confidence Level[28]	Percentage Score of Evaluation Elements Met[4]	Percentage Score of Critical Elements Met[5]	Confidence Level[22]
Alliance	Initial Submission	88%	100%	*Moderate Confidence*	100%	100%	*High Confidence*
	Resubmission	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Partners	Initial Submission	82%	88%	*Low Confidence*	100%	100%	*High Confidence*
	Resubmission	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Trillium	Initial Submission	94%	88%	*Low Confidence*	67%	100%	*Moderate Confidence*
	Resubmission	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
Vaya	Initial Submission	89%	88%	*Low Confidence*	33%	100%	*No Confidence*
	Resubmission	100%	100%	*High Confidence*	33%	100%	*No Confidence*

As shown in Table 20 above, the nonclinical *FUH* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1 for all PIHPs, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned the following ratings: one health plan received a *No Confidence* level rating (**Vaya**), one health plan received a *Moderate Confidence* level rating (**Trillium**), and two health plans received a *High Confidence* level rating (**Alliance** and **Partners**) for overall confidence that the PIP achieved significant improvement.

[25] **Type of Review—**Designates the PIP review as an initial submission, or resubmission. A resubmission means the PHP resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[26] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated 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)*.

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

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

The performance indicator for the *FUH* PIP was the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental disorders or intentional self-harm and who had a follow-up visit with a mental health provider within one to seven days of discharge from the hospital. Table 21 displays the baseline data reported by each PIHP.

Table 21—2025 Performance Indicator Results for the *FUH* PIPs

Performance Indicator Results				
PIHP	Baseline (01/01/2023–12/31/2023)		Remeasurement 1 (01/01/2024–12/31/2024)	
Alliance	N: 570 D: 2,567	22.2%	N: 1,581 D: 5,320	29.7%
Partners	N: 175 D: 660	26.5%	N: 225 D: 697	32.3%
Trillium	N: 11 D: 809	1.4%	N: 34 D: 1,448	2.3%
Vaya	N: 642 D: 2,502	25.7%	N: 794 D: 3,500	22.7%

N–Numerator. D–Denominator.
HSAG rounded percentages to the first decimal place.

As shown in Table 21 above, for the baseline and Remeasurement 1 period, PIHPs reported that varying percentages of inpatient hospital discharges had a follow-up appointment with a behavioral health provider within one to seven days of discharge during the measurement period.

PIHPs: *FUM* PIP

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 22 displays the validation scores and confidence levels HSAG assigned to each PIHP's *FUM* PIP.

Table 22—2025 *FUM* PIP Validation Results

Prepaid Inpatient Health Plan	Type of Review[29]	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[30]	Percentage Score of Critical Elements Met[31]	Confidence Level[32]	Percentage Score of Evaluation Elements Met[24]	Percentage Score of Critical Elements Met[25]	Confidence Level[26]
Alliance	Initial Submission	100%	100%	*High Confidence*	100%	100%	*High Confidence*
	Resubmission	*PIHP did not need to resubmit.*					
Partners	Initial Submission	82%	88%	*Low Confidence*	67%	100%	*Moderate Confidence*
	Resubmission	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
Trillium	Initial Submission	94%	86%	*Low Confidence*	67%	100%	*Moderate Confidence*
	Resubmission	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Vaya	Initial Submission	100%	100%	*High Confidence*	33%	100%	*No Confidence*
	Resubmission	100%	100%	*High Confidence*	33%	100%	*No Confidence*

As shown in Table 22 above, the nonclinical *FUM* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1 for all PIHPs, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned the following ratings: one health plan received a *No Confidence* level rating (**Vaya**), one health plan received a *Moderate Confidence* level rating (**Partners**), and two health plans received a *High Confidence* level rating (**Alliance** and **Trillium**) for overall confidence that the PIP achieved significant improvement.

[29] **Type of Review—**Designates the PIP review as an initial submission, or resubmission. A resubmission means the PHP resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[30] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated 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)*.

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

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

The performance indicator for the *FUM* PIP was the total number of ED visits by members aged 6 years of age and older with a principal diagnosis of mental illness, or intentional self-harm, and had a follow-up visit for mental illness within seven days after discharge. Table 23 displays the baseline and remeasurement data reported by each PIHP.

Table 23—2025 Performance Indicator Results for the *FUM* PIPs

Performance Indicator Results				
PIHP	Baseline (01/01/2023–12/31/2023)		Remeasurement 1 (01/01/2024–12/31/2024)	
Alliance	N: 1,123 D: 5,179	21.7%	N: 2,316 D: 6,500	35.6%
Partners	N: 154 D: 453	34.0%	N: 189 D: 499	37.9%
Trillium	N: 387 D: 1,373	28.2%	N: 560 D: 1,761	31.8%
Vaya	N: 632 D: 1,280	49.4%	N: 1,158 D: 3,065	37.8%

N–Numerator. D–Denominator.
HSAG rounded percentages to the first decimal place.

As shown in Table 23 above, for the baseline and Remeasurement 1 period, PIHPs reported that varying percentages of ED visits by members aged 6 years of age and older, who had an ED visit, with a principal diagnosis of mental illness or intentional self-harm, had a follow-up visit for mental illness within seven days from time of discharge during the measurement year.

PIHPs: Nonclinical *HRRN* PIP

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 24 displays the validation scores and confidence levels HSAG assigned to each PIHP's nonclinical *HRRN* PIP.

Table 24—2025 *HRRN* PIP Validation Results

Prepaid Inpatient Health Plan	Type of Review[33]	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[34]	Percentage Score of Critical Elements Met[35]	Confidence Level[36]	Percentage Score of Evaluation Elements Met[28]	Percentage Score of Critical Elements Met[29]	Confidence Level[30]
Alliance	Initial Submission	83%	100%	*Moderate Confidence*	*Not Assessed*[31]		
	Resubmission	100%	100%	*High Confidence*			
Partners	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[31]		
	Resubmission	*PIHP did not need to resubmit.*					
Trillium	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[31]		
	Resubmission	*PIHP did not need to resubmit.*					
Vaya	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[31]		
	Resubmission	*PIHP did not need to resubmit.*					

As shown in Table 24 above, the nonclinical *HRRN* PIP was validated through the first six steps in the PIP Validation Tool. For Validation Rating 1 for all PIHPs, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology. The PIHPs had not progressed to reporting remeasurement data and, therefore, were not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

The performance indicator for the nonclinical *HRRN* PIP was the percentage of enrollees who received and completed HRRN screening using the NC DHHS Standardized Social Determinants of Health

[33] **Type of Review—**Designates the PIP review as an initial submission, or resubmission. A resubmission means the PHP resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.
[34] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated 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)*.
[35] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[36] **Confidence Level—**Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
[31] **Not Assessed**—HSAG did not assess Validation Rating 2 as the PIHP reported the Design phase for each PIP.

(SDOH) Screening Questions. Once the PIHPs progress to reporting data, the baseline and remeasurement data will be included in subsequent years' technical reports.

TPs: *FUH* PIP

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 25 displays the validation scores and confidence levels HSAG assigned to each TP's *FUH* PIP.

Table 25—2025 *FUH* PIP Validation Results

Tailored Plan	Type of Review[37]	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[38]	Percentage Score of Critical Elements Met[39]	Confidence Level[40]	Percentage Score of Evaluation Elements Met[32]	Percentage Score of Critical Elements Met[33]	Confidence Level[34]
Alliance	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[35]		
	Resubmission	*TP did not need to resubmit.*					
Partners	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[35]		
	Resubmission	*TP did not need to resubmit.*					
Trillium	Initial Submission	83%	80%	*Low Confidence*	*Not Assessed*[35]		
	Resubmission	100%	100%	*High Confidence*			
Vaya	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[35]		
	Resubmission	*TP did not need to resubmit.*					

As shown in Table 25 above, the clinical *FUH* PIP was validated through the first six steps in the PIP Validation Tool. For Validation Rating 1 for all TPs, HSAG assigned a *High Confidence* level for

[37] **Type of Review—**Designates the PIP review as an initial submission, or resubmission. A resubmission means the PHP resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.
[38] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated 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)*.
[39] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[40] **Confidence Level—**Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
[35] **Not Assessed**—HSAG did not assess Validation Rating 2 as the TP reported the Design phase for each PIP.

adhering to acceptable PIP methodology. The TPs had not progressed to reporting remeasurement data and, therefore, were not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

The first performance indicator for the *FUH* PIP was the percentage of discharge for individuals ages 6 through 64 years 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. Two rates are reported:

1. The percentage of discharges for which the member received follow-up within seven days after discharge.
2. The percentage of discharges for which the member received follow-up within 30 days after discharge.

Once the TPs progress to reporting data, the baseline and remeasurement data will be included in subsequent years' technical reports.

TPs: *IET* PIP

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 26 displays the validation scores and confidence levels HSAG assigned to each TP's *IET* PIP.

Table 26—2025 *IET* PIP Validation Results

Prepaid Inpatient Health Plan	Type of Review[41]	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[42]	Percentage Score of Critical Elements Met[43]	Confidence Level[44]	Percentage Score of Evaluation Elements Met[36]	Percentage Score of Critical Elements Met[37]	Confidence Level[38]
Alliance	Initial Submission	50%	40%	*No Confidence*	*Not Assessed*[39]		
	Resubmission	100%	100%	*High Confidence*			

[41] **Type of Review—**Designates the PIP review as an initial submission, or resubmission. A resubmission means the PHP resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.
[42] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated 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)*.
[43] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[44] **Confidence Level—**Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
[39] **Not Assessed**—HSAG did not assess Validation Rating 2 as the TP reported the Design phase for each PIP.

Prepaid Inpatient Health Plan	Type of Review[41]	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[42]	Percentage Score of Critical Elements Met[43]	Confidence Level[44]	Percentage Score of Evaluation Elements Met[36]	Percentage Score of Critical Elements Met[37]	Confidence Level[38]
Partners	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[39]		
	Resubmission	*TP did not need to resubmit.*					
Trillium	Initial Submission	83%	80%	*Low Confidence*	*Not Assessed*[39]		
	Resubmission	100%	100%	*High Confidence*			
Vaya	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[39]		
	Resubmission	*TP did not need to resubmit.*					

As shown in Table 26 above, the clinical *IET* PIP was validated through the first six steps in the PIP Validation Tool. For Validation Rating 1 for all TPs, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology. The TPs had not progressed to reporting remeasurement data and, therefore, were not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

The performance indicator for the *IET* PIP was the percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation. Once the TPs progress to reporting data, the baseline and remeasurement data will be included in subsequent years' technical reports.

TPs: Nonclinical *HRRN* PIP

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 27 displays the validation scores and confidence levels HSAG assigned to each TP's nonclinical *HRRN* PIP.

Table 27—2025 *HRRN* PIP Validation Results

Prepaid Inpatient Health Plan	Type of Review[45]	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[46]	Percentage Score of Critical Elements Met[47]	Confidence Level[48]	Percentage Score of Evaluation Elements Met[28]	Percentage Score of Critical Elements Met[29]	Confidence Level[30]
Alliance	Initial Submission	83%	100%	*Moderate Confidence*	*Not Assessed*[31]		
	Resubmission	100%	100%	*High Confidence*			
Partners	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[31]		
	Resubmission	*PIHP did not need to resubmit.*					
Trillium	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[31]		
	Resubmission	*PIHP did not need to resubmit.*					
Vaya	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[31]		
	Resubmission	*PIHP did not need to resubmit.*					

As shown in Table 27 above, the nonclinical *HRRN* PIP was validated through the first six steps in the PIP Validation Tool. For Validation Rating 1 for all PIHPs, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology. The PIHPs had not progressed to reporting remeasurement data and, therefore, were not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

The performance indicator for the nonclinical *HRRN* PIP was the percentage of enrollees who received and completed a HRRN screening using the NC DHHS Standardized SDOH Screening Questions. Once

[45] **Type of Review—**Designates the PIP review as an initial submission, or resubmission. A resubmission means the PHP resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.
[46] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated 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)*.
[47] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[48] **Confidence Level—**Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
[31] **Not Assessed**—HSAG did not assess Validation Rating 2 as the PIHP reported the Design phase for each PIP.

the TPs progress to reporting data, the baseline and remeasurement data will be included in subsequent years' technical reports.

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 health 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 health 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 4.

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. The SPs and PIHPs were required to report only using the administrative methodology for DHB-selected measures, and were required to apply measure specifications in accordance with measure stewards.

HSAG also conducted an Information Systems Capabilities Assessment (ISCA) activity in accordance with 42 CFR §438.350(a) for four TPs in North Carolina in preparation for the TPs to report performance measures in MY 2026.

Objectives

The purpose of PMV is to assess the accuracy of the performance measure data reported by the SPs and PIHPs. This assessment includes determining the extent to which the reported performance measures follow State specifications and reporting requirements, and to 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 TPs' 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

The scope of PMV activities included evaluating the SPs' and PIHPs' 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' and PIHPs' information systems and processes specific to producing performance measure rates on a set of measures selected by DHB for MY 2024. The ISCA activities evaluated the TPs' information systems used to collect, process, and maintain TP performance measure data in accordance with CMS EQR Protocol 2.[49]

For MY 2024, the Department selected 12 measures for the SPs to report using the methodologies outlined in the *HEDIS Measurement Year 2024 Volume 2: Technical Specifications for Health Plans,* Pharmacy Quality Alliance (PQA) measure specifications and guidelines, and DHB-specific measure specifications and guidelines. The Department also selected eight measures for the PIHPs to report using the methodologies outlined in the *HEDIS Measurement Year 2024 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.

Based on all validation activities, HSAG determined results for each of the validated performance measures. The CMS PMV protocol outlines four possible validation finding designations for performance measures, which are defined in Table 28 below.

Table 28—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.
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 noncompliant 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*.

[49] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 12, 2026.

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 2024. 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.

Table 29 displays the measure-specific review finding and designation for MY 2024 for all SPs.

Table 29—MY 2024 Measure-Specific Review Findings and Designations for SPs

Performance Measure Name	Specifications Steward	Validation Rating
Cervical Cancer Screening (CCS)	NCQA	Reportable
Child and Adolescent Well-Care Visits (WCV)	NCQA	Reportable
Childhood Immunization Status (CIS)	NCQA	Reportable
Concurrent Use of Opioids and Benzodiazepines (COB)	PQA/CMS	Reportable
Controlling High Blood Pressure (CBP)	NCQA	Reportable
*Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Screening Ratio**	DHHS	Reportable
Glycemic Status Assessment for Patients With Diabetes (GSD)	NCQA	Reportable
Immunizations for Adolescents (IMA)	NCQA	Reportable
Prenatal and Postpartum Care (PPC)	NCQA	Reportable
*Rate of Screening for Health-Related Resource Needs (HRRN)**	DHHS	Reportable
Screening for Depression and Follow-Up Plan	CMS	Reportable
Well-Child Visits in the First 30 Months of Life (W30)	NCQA	Reportable

*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 evaluated the PIHPs' 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 PIHPs' systems or processes for any of the data types.

HSAG determined that the data integration processes, data control processes, and information systems documentation were **Acceptable** for all PIHPs for MY 2024. Table 30 displays the measure-specific review findings and designations for all PIHPs for MY 2024.

Table 30—MY 2024 Measure-Specific Review Findings and Designations for PIHPs

Performance Measure Name	Specifications Steward	Validation Rating
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	NCQA	Reportable
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	NCQA	Reportable
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	NCQA	Reportable
Concurrent Use of Opioids and Benzodiazepines (COB)	PQA/CMS	Reportable
Follow-Up After Hospitalization for Mental Illness (FUH)	NCQA	Reportable
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	NCQA	Reportable
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	NCQA	Reportable

TP PMV Results

Since performance measure rates were not required for MY 2024, HSAG completed an ISCA to evaluate the TPs' 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 2025 data. HSAG determined that the data integration processes, data control processes, and information systems documentation were **Acceptable** for all TPs.

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 4.

Performance Measure Results

Validated performance measure data results are reported in Appendix C—Performance Measure Results.

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 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 and results were presented in the prior technical report. The next review of the full set of standards will be conducted in CY 2026.

Results of the 2025 Compliance Reviews for the PIHPs and the TPs are presented below.

Objectives

The primary objective of the Compliance Review is to provide meaningful information to DHB and the health plans 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.

For any elements that remained out of compliance following remediation, HSAG will conduct a focused review[50] 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 31 displays the full set of standards for the Compliance Review, which also included a series of file reviews to assess compliance in various standards.

Table 31—CY 2025 Full Set of Standards for the PIHP and TP Three-Year Period: CY 2023–CY 2025

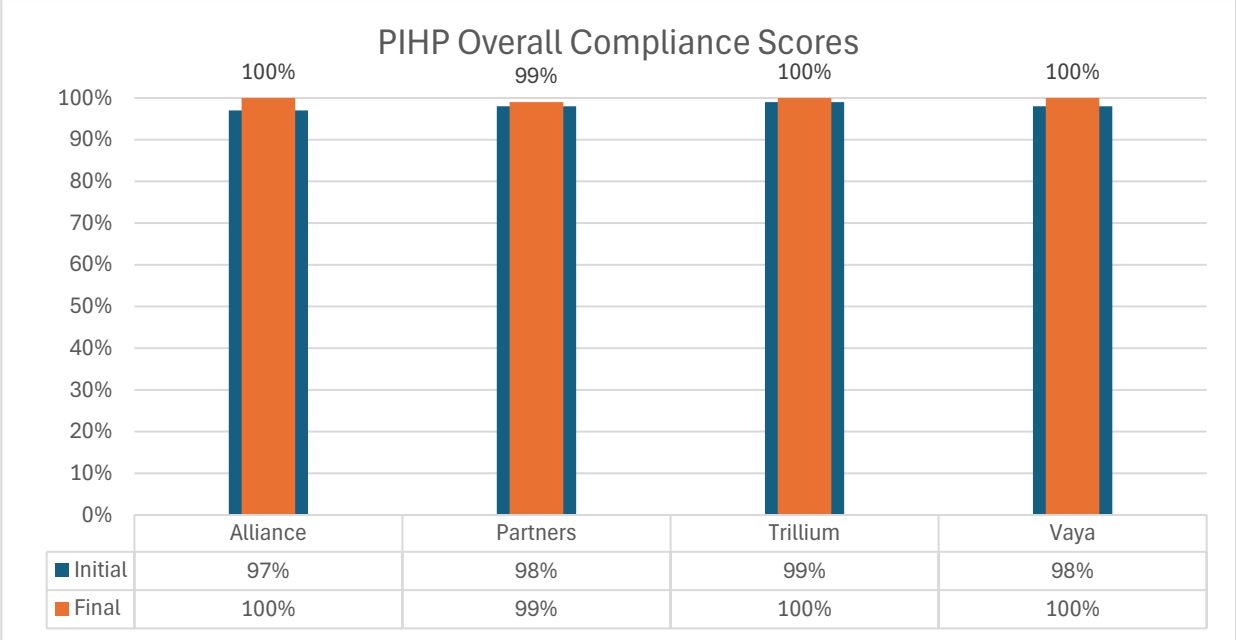
Standard #	Standard Name	File Reviews
I	Enrollment and Disenrollment	
II	Enrollee Rights and Confidentiality	Member Rights Checklist
III	Member Information	Member Handbook Checklist
IV	Emergency and Poststabilization Services	
V	Adequate Capacity and Availability of Services	
VI	Coordination and Continuity 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

Compliance Review Results

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

[50] 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.

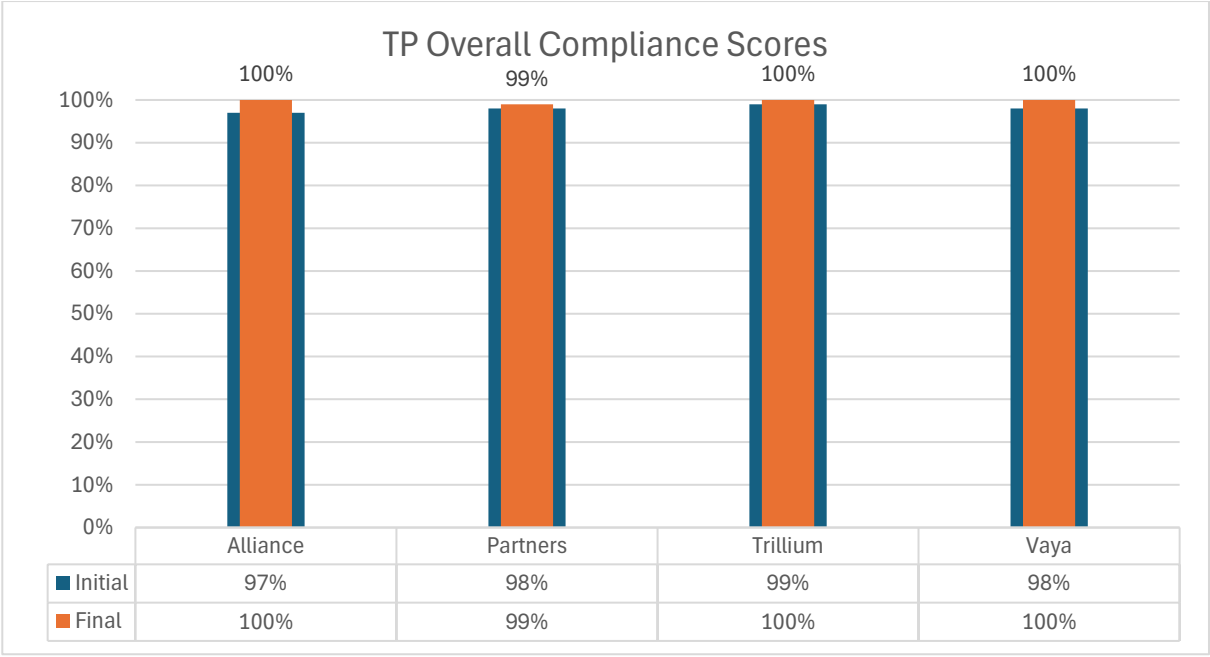
Figure 2—Overall Compliance Ratings by PIHP



As shown in Figure 2, all PIHPs achieved a final compliance score of 99 percent or 100 percent. The PIHPs 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.

Figure 3 displays the overall initial and final TP-specific compliance scores for all standards reviewed.

Figure 3—Overall Compliance Ratings by TP



The TPs achieved a final compliance score of 99 percent or 100 percent. The TPs 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 4.

Validation of Network Adequacy

DHB contracted with HSAG to conduct network adequacy validation (NAV) for the SPs, PIHPs and TPs. Title 42 of the Code of Federal Regulations (42 CFR) §438.350(a) requires states that contract with MCOs 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).[51]

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's 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 2025 NAV indicators, confirming DHB and the health plans' ability to collect reliable and valid network adequacy monitoring data, use sound methods

[51] 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, 2026.

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), worked with the State to identify and define network adequacy indicators and provider types, and established 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 ISCAs, assessed processes for collecting network adequacy data that were not addressed in the ISCA, completed a comprehensive NAV ISCA by collecting an updated ISCAT from DHB and each health plan, and interviewed DHB and health plan staff or other personnel involved in the 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. HSAG did not assess compliance with State or federal requirements through the NAV activity; however, HSAG's compliance subject-matter experts and DHB evaluated any potential MCO-specific deviations from State and federal requirements for determination of non-compliance and appropriate follow-up and remediations with the MCOs.
- **Progress made from prior year:** HSAG used the CMS EQR Protocol 4 Worksheet 4.8 to document each health plan's summary of activities in progress or completed, to address the prior year's NAV recommendations. HSAG provided an assessment of the health plans' progress made on implementing these recommendations over the past year based on information gathered during the validation process from the SFY 2025 audit period.
- **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

Standard Plan Analysis and Conclusions

HSAG assessed DHB's calculated results for SP Specialty Time/Distance statewide compliance. Table 32 represents each specialty non-time/distance provider type and the percentage of counties within the regions serviced that met the 95 percent compliance threshold statewide for all five SPs. HSAG found that all five SPs fell below the 95 percent compliance threshold for seven of the 23 specialty provider types but achieved statewide compliance for 12 of the 23 specialty provider types.

Table 32—Standard Plan Comparison Specialty Care Provider Type Time/Distance Statewide Compliance Results

Provider Type	Percentage of Counties Meeting 95 Percent Compliance Threshold Statewide				
	AmeriHealth	Carolina Complete	Healthy Blue	UnitedHealthcare	WellCare
Allergy/Immunology (Child)	50%	61%	79%	66%	84%
Anesthesiology (Child)	100%	100%	100%	100%	100%
Cardiology (Child)	98%	100%	98%	99%	99%
Dermatology (Child)	97%	100%	98%	100%	98%
ENT/Otolaryngology (Child)	99%	100%	99%	100%	100%
Endocrinology (Child)	84%	90%	85%	88%	87%
Gastroenterology (Child)	89%	95%	88%	89%	90%
General Surgery (Child)	100%	100%	100%	100%	100%
Hematology (Child)	81%	88%	85%	86%	86%
Infectious Disease (Child)*	46%	59%	48%	56%	57%
Nephrology (Child)	67%	71%	64%	68%	71%
Neurology (Child)	90%	95%	96%	94%	97%
Oncology (Child)	81%	88%	85%	86%	86%
Ophthalmology (Adult)	95%	100%	99%	100%	100%
Ophthalmology (Child)	95%	100%	99%	100%	99%
Optometry (Child)	99%	100%	100%	100%	100%
Orthopedic Surgery (Child)	100%	100%	100%	100%	100%

Provider Type	Percentage of Counties Meeting 95 Percent Compliance Threshold Statewide				
	AmeriHealth	Carolina Complete	Healthy Blue	UnitedHealthcare	WellCare
Pain Management (Child)	99%	100%	100%	100%	100%
Psychiatry (Child)	99%	100%	100%	99%	100%
Pulmonology (Child)*	84%	93%	89%	90%	95%
Radiology (Child)	92%	98%	100%	93%	100%
Rheumatology (Child)	58%	76%	57%	59%	69%
Urology (Child)	100%	100%	100%	100%	100%

*Not met with submitted exception request.

HSAG assessed DHB's calculated results for SP BH time/distance provider compliance and compared results across all four health plans. HSAG identified that all SPs met the compliance requirements for BH provider type time/distance compliance except for Location-Based Services in Region 6 (Dare and Hyde counties).

Based on the results submitted by DHB, HSAG found that **Carolina Complete** and **UnitedHealthcare** were fully compliant with the requirement to maintain at least two long-term services and supports (LTSS) providers per county for all four LTSS service types: Home Health Services, Hospice Services, Personal Care Services, and Private Duty Nursing Services. Table 33 provides a comparison of each health plan's compliance results for State Health Plan LTSS Services.

Table 33—Standard Plan Comparison All State Health Plan LTSS Service Types Compliance Results

Standard Category	Service Type	Compliance Results	AmeriHealth	Carolina Complete	Healthy Blue	United-Healthcare	WellCare
All State Health Plan LTSS Services	Home Health Services	*Met*	50	41	76	100	100
		Not Met	50	0	—	0	0
		*Not Met**	—	—	24	—	—
	Private Duty Nursing	*Met*	64	41	83	100	100
		Not Met	36	0	—	0	0
		*Not Met**	—	—	17	—	—
	Personal Care Services	*Met*	81	41	98	100	100
		Not Met	19	0	—	0	0
		*Not Met**	—	—	2	—	—
	Hospice Services	*Met*	33	41	34	100	98
		Not Met	67	0	—	0	—
		*Not Met**	—	—	66	—	2

—Designates that the result category was not applicable to the health plan.

*Not met with submitted exception request.

TP/PIHP Analysis and Conclusions

HSAG reviewed DHB's calculated results for specialty time/distance requirements across all TPs. Table 34 outlines each specialty provider type in scope of review and shows the percentage of counties that achieved the 95 percent compliance threshold for each of the four TPs. HSAG found that all four plans fell below the 95 percent threshold for two of the 23 specialty provider types, while eight of the 23 provider types met the threshold across all plans.

Table 34—Tailored Plan Comparison Specialty Provider Type Time/Distance Compliance Results

Provider Type	Percentage of Counties Meeting 95 Percent Compliance Threshold			
	Alliance	Partners	Trillium	Vaya
Allergy/Immunology (Child)	100%	92%	95%	100%
Anesthesiology (Child)	100%	100%	100%	100%
Cardiology (Child)	86%	100%	100%	100%
Dermatology (Child)	86%	100%	89%	97%
ENT/Otolaryngology (Child)	100%	93%	100%	100%
Endocrinology (Child)	86%	100%	87%	97%
Gastroenterology (Child)	86%	100%	98%	94%
General Surgery (Child)	100%	100%	100%	100%
Hematology (Child)	86%	80%	96%	97%
Infectious Disease (Child)*	50%	67%	91%	42%
Nephrology (Child)	86%	80%	93%	68%
Neurology (Child)	86%	100%	95%	100%
Oncology (Child)	86%	80%	93%	97%
Ophthalmology (Adult)	100%	100%	100%	100%
Ophthalmology (Child)	100%	100%	100%	100%
Optometry (Child)	100%	100%	100%	100%
Orthopedic Surgery (Child)	100%	100%	100%	100%
Pain Management (Child)	86%	100%	100%	97%
Psychiatry (Child)	100%	100%	100%	100%
Pulmonology (Child)*	83%	100%	98%	100%
Radiology (Child)	86%	100%	98%	100%
Rheumatology (Child)	86%	46%	98%	64%
Urology (Child)	100%	100%	100%	100%

*All counties within catchment area were not reported.

HSAG assessed DHB's calculated results for PIHP/TP BH time/distance provider types compliance and compared results across all four health plans. Table 35 represents each BH provider type and the percentage of counties within each health plan's catchment area that met the 95 percent compliance threshold. HSAG observed that all four health plans met the 95 percent compliance threshold for three of the seven provider types reviewed.

Table 35—Health Plan Comparison Behavioral Health Provider Type Time/Distance Compliance Results

Provider Type	Percentage of Counties Meeting 95 Percent Compliance Threshold			
	Alliance	Partners	Trillium	Vaya
Outpatient Behavioral Health Services (Adult)	100%	100%	100%	100%
Outpatient Behavioral Health Services (Child)	100%	100%	100%	100%
Partial Hospitalization (Adult)	100%	100%	87%	84%
Partial Hospitalization (Child)	100%	100%	87%	56%
Psychosocial Rehabilitation Services (Adult)	100%	100%	98%	88%
Substance Abuse Comprehensive Outpatient Treatment (SACOT)	100%	100%	96%	63%
Substance Abuse Intensive Outpatient Program (SAIOP)	100%	100%	100%	97%

Based on the results submitted by DHB, HSAG found that **Alliance** was the only health plan that met the requirement to maintain at least two LTSS providers per county for all four LTSS service types, including Home Health Services, Hospice Services, Personal Care Services, and Private Duty Nursing Services. In addition, all four health plans were compliant for Personal Care Services. Table 36 provides a comparison of each health plan's compliance results for State Health Plan LTSS Services.

Table 36—Health Plan Comparison All State Health Plan LTSS Service Types Compliance Results

Service Type	Alliance	Partners	Trillium	Vaya
Home Health Services	*Met*	*Met*	*Not Met*	*Met*
Hospice Services	*Met*	*Not Met*	*Met*	*Not Met*
Personal Care Services	*Met*	*Met*	*Met*	*Met*
Private Duty Nursing Services	*Met*	*Met*	*Not Met*	*Not Met*

Based on DHB's submitted results, HSAG determined that all PIHP/TPs met five of the 17 BH service types. Additionally, a commonality was identified across all plans, specifically that Crisis Services—Ambulatory Withdrawal Management with Extended On-Site Monitoring was unmet statewide. Table 37 below shows non-compliance service types by plan.

Table 37—Health Plan Comparison Behavioral Health Provider Type Time/Distance Compliance Results

Standard Category	Service Type	TP/PIHP Not Meeting Requirement
Crisis Services	Ambulatory Detoxification	**Alliance**
	Ambulatory Withdrawal Management with Extended On-Site Monitoring	**Alliance**, **Partners** (TP only), **Trillium**, **Vaya**
	Facility-Based Crisis Services for Children and Adolescents	**Partners** (PIHP only)
	Professional Treatment Services in Facility-Based Crisis Program	**Alliance**, **Vaya**
Community Mobile Services	Assertive Community Treatment (Adult)	**Vaya**
	Community Support Team (Adult)	**Vaya**
	Diagnostic Assessment (Adult)	**Vaya**
	Diagnostic Assessment (Child)	**Vaya**
	Intensive In-Home Service (Child)	**Vaya**
Residential Treatment Services	Substance Abuse Non-Medical Community Residential Treatment (Adolescent)	**Alliance**, **Partners**, **Vaya** (PIHP only)
	Substance Abuse Non-Medical Community Residential Treatment (Adult)	**Alliance**, **Vaya**
	Substance Abuse Non-Medical Community Residential Treatment (Women/Child)	**Alliance**, **Partners**, **Vaya** (PIHP only)

DHB Analysis and Conclusions

HSAG completed an ISCA for DHB, which included an assessment of any concerns related to data sources used in the NAV during the preceding 12 months. HSAG evaluated DHB's information systems

and data processing procedures to support network adequacy indicator reporting; DHB's personnel to support network adequacy indicator reporting; DHB's information systems and processes to capture enrollment data for members to confirm the system was capable of collecting data on member characteristics as specified by the State; and DHB's information systems and processes to capture provider data.

HSAG's assessment also included delegated entity data and oversight, network adequacy indicator reporting processes, and evaluation and assessment of the data methods that DHB used to calculate results generated for each network adequacy indicator in the scope of NAV.

HSAG did not identify any opportunities for improvement. By assessing DHB's performance and NAV reporting processes, HSAG identified the following areas of strength:

- DHB maintained detailed reporting user guides to support health plans in preparing their quarterly and annual network adequacy reports. These comprehensive guides provided step-by-step instructions for completing all required submissions, promoting accuracy, consistency, and compliance across reporting periods.
- DHB employed a highly comprehensive network adequacy global adjustment process designed to evaluate the overall strength of the State's network. This process took a proactive stance by anticipating and addressing network adequacy needs through a holistic assessment of provider availability statewide.
- DHB implemented uniformed reporting templates across all health plans, promoting consistency and accuracy in the submission of required contractual reports.

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 4.

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.[52]

The standardized survey instruments selected for the 2024 CAHPS survey included:

- CAHPS 5.1 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set.
- 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.[53]

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).
- Medical assistance with smoking measures (individual measures that assess different facets of providing medical assistance with smoking and tobacco use cessation).

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).

[52] 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 and to be administered by an interviewer in person or by telephone; however, HSAG only administered the HCBS CAHPS survey by telephone.

[53] 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 2024 adult and child CAHPS surveys to members in the five SPs. In addition, HSAG also administered the adult and child CAHPS surveys to six specific NC Medicaid populations. These populations included:

- Individuals enrolled in an SP and receiving behavioral health services (i.e., 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**.[54]
- Beneficiaries receiving healthcare through NC Medicaid Direct (formally known as fee-for-service).[55]
- Current NC Medicaid Direct enrollees who would qualify for TPs (TP Eligible) who have mental health needs, I/DD, TBI, or severe substance use disorders.[56]
- Child Medicaid Direct beneficiaries who are in foster care.
- Adult Medicaid Direct beneficiaries formerly in foster care (i.e., former 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.

[54] The tribal option manages beneficiaries primarily in Cherokee, Graham, Haywood, Jackson, and Swain counties. The **EBCI Tribal Option** is a Primary Care Case Management program managed by the Cherokee Indian Health Authority (CIHA).

[55] 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.

[56] TPs, not yet implemented at the time of the survey, will offer integrated physical health, pharmacy, care coordination, and behavioral health services for members who may have significant mental health needs, I/DD, TBI, 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 and older) from the entire eligible population.
- Child beneficiaries—a general sample of children (17 years of age and younger) from the entire eligible population.

HCBS CAHPS

- HSAG administered the 2024 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). These services were provided by LME/MCOs and Community Living and Supports. At the time of survey administration, there were four LME/MCOs in NC.[57]

CAHPS Results

NC Medicaid Program, NC SP Aggregate, each SP/population 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.[58,59,60] Using the percentile distributions shown in Table 38, 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.

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

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

[59] 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.

[60] 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 plan have a higher percentage of members that can never get the care they needed compared to other 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: Mar 10, 2026.

Table 38—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

In the national percentile comparison tables, reading down the table provides all plan/program performance on a given measure, while reading across the table provides a chosen plan's/program's performance across all measures.

Additionally, the 2024 scores for the NC Medicaid Program, NC SP Aggregate, and each SP/population were compared to the 2023 scores to determine whether there were statistically significant differences. Statistically significant results are noted with triangles (▲ or ▼)[61]. Measures that did not meet the minimum number of 100 respondents required by NCQA are denoted with a cross (+). Caution should be used when evaluating scores derived from fewer than 100 respondents.

[61] The 2024 results presented in this report represent a baseline assessment of beneficiaries' experiences specific to Former Foster Care; therefore, a year-over-year analysis could not be performed, and caution should be exercised when interpreting the results for the Former Foster Care population.

Adult CAHPS Results

Table 39 shows the positive ratings and star ratings based on a comparison to NCQA national percentiles as well as year-over-year results for each of the global ratings.

Table 39—Adult Respondent Percentage of Positive Ratings and Star Ratings When Compared to NCQA National Percentiles, With Year-Over-Year Analysis, by Program-Specific Populations: Global Ratings (2024)

SP/Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
NC Medicaid Program	★★★ **79.36%**	★★★ **76.54%**	★★★★★ **87.39%**	★★★★ **84.76%**
NC SP Aggregate	★★ **74.94%**	★★★ **75.86%**	★★★ **84.75%**	★★ **80.83%**
AmeriHealth	★ 72.29%	★★★ 77.64%	★★★ 84.17%	★★★★★ 88.07%▲
Carolina Complete	★★ 74.72%	★★ 74.30%	★★★ 84.75%	★★ 81.54%
Healthy Blue	★★ 77.38%	★★★★ 77.74%	★★★★ 85.44%	★ 77.67%
UnitedHealthcare	★★ 75.65%	★★ 74.36%	★★★ 84.79%	★★ 78.81%
WellCare	★ 72.71%	★★ 73.73% ▼	★★★ 84.08%	★★ 81.40%
SP Behavioral Health	★ 72.11%	★ 70.45%	★ 79.19%	★★ 79.66%
EBCI Tribal Option	★★ 75.68%	★ 65.52%+	★★★★ 86.75%+	★ 66.67%+
NC Medicaid Direct	★★★★ 83.03%	★★★ 77.16%	★★★★★ 89.58%	★★★★★ 88.07%
TP Eligible	★★★ 78.68% ▲	★★★★ 79.71%	★★★★★ 87.69%	★★★★ 86.58%
Former Foster Care	★ 61.90%+	S	★ 75.00%+	S

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.
▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.
+ Indicates fewer than 100 respondents in the denominator. Caution should be exercised when evaluating these results.
S Indicates results have been suppressed in accordance with CMS cell size suppression policy.
Positive rating is equivalent to the top-box score used by other states that contribute to national data.

Table 40 shows the positive ratings and star ratings based on a comparison to NCQA national percentiles as well as year-over-year results for each of the composite measures.

Table 40—Adult Respondent Percentage of Positive Ratings and Star Ratings When Compared to NCQA National Percentiles, With Year-Over-Year Analysis, by Program-Specific Populations: Composite Measures (2024)

SP/Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
NC Medicaid Program	★★★★ **86.13%**	★★★ **84.64%**	★★★★ **94.38%**	★★★★ **91.35%**
NC SP Aggregate	★★★ **81.89%**	★★★ **82.04%**	★★★★ **94.10%**	★ **87.30%**
AmeriHealth	★★★ 83.23%	★★★ 83.59%	★★★ 93.64%	★ 87.39%
Carolina Complete	★★★ 82.17%	★★★ 81.74% ▼	★★★ 93.95%	★ 86.47%
Healthy Blue	★★ 80.47%	★★ 79.96% ▼	★★★★ 94.35%	★ 86.60%
UnitedHealthcare	★★★★ 84.96%	★★★ 84.00%	★★★ 93.48%	★★ 89.35%
WellCare	★★ 80.29%	★★★ 82.58%	★★★★ 94.69%	★ 87.11%
SP Behavioral Health	★★★★ 84.69% ▲	★★★★ 85.61%	★★ 91.99%	★ 87.41%
EBCI Tribal Option	★★★★★ 87.80%+	★★★★★ 88.12%+	★★★★★ 96.55%+	★★★★★ 96.00%+
NC Medicaid Direct	★★★★★ 89.64%	★★★★ 86.80%	★★★★ 94.60%	★★★★★ 94.64%
TP Eligible	★★★★★ 89.68% ▲	★★★★ 85.62%	★★★★ 94.40%	★★ 88.84%
Former Foster Care	S	S	S	S

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.
▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.
+ Indicates fewer than 100 respondents in the denominator. Caution should be exercised when evaluating these results.
S Indicates results have been suppressed in accordance with CMS cell size suppression policy.
Positive rating is equivalent to the top-box score used by other states that contribute to national data.

Table 41 shows the positive ratings and star ratings based on a comparison to NCQA national percentiles as well as year-over-year results for the individual items and medical assistance with smoking and tobacco use items.

Table 41—Adult Respondent Percentage of Positive Ratings and Star Ratings When Compared to NCQA National Percentiles, With Year-Over-Year Analysis by Program-Specific Populations: Individual Items and Medical Assistance With Smoking and Tobacco Use Cessation Items (2024)

SP/Population	Coordination of Care	Advising Smokers and Tobacco Users to Quit	Discussing Cessation Medications	Discussing Cessation Strategies
NC Medicaid Program	★★★★ **87.56%**	★★★★ **79.96%**	★★★★ **57.53%**	★★★ **48.00%**
NC SP Aggregate	★★ **84.38%**	★★★ **76.21%**	★★★ **51.50%**	★★ **43.79%**
AmeriHealth	★ 81.68%	★★★ 76.69%	★★★ 50.51%	★★ 44.59%
Carolina Complete	★★★ 85.37%	★★★★ 77.02%	★★★ 50.60%	★★ 46.18%
Healthy Blue	★★ 84.41%	★★★ 75.11%	★★★ 50.84%	★ 39.83%
UnitedHealthcare	★★★ 85.71%	★★★ 75.50%	★★★ 51.52%	★★★ 46.98%
WellCare	★★ 84.74%	★★★★ 77.69%	★★★ 53.85%	★★ 45.17%
SP Behavioral Health	★★ 84.98%	★★★★★ 81.47%	★★★★ 58.06%	★★★★ 51.03%
EBCI Tribal Option	★★ 82.76%+	★★★★ 74.44%+	★★★★ 60.00%+	★★★★ 51.11%+
NC Medicaid Direct	★★★★★ 90.15%	★★★★★ 83.09%	★★★★★ 62.55%	★★★★ 51.45%
TP Eligible	★★ 84.26%	★★★★★ 85.14%	★★★★ 59.11%	★★★★★ 54.80%
Former Foster Care	S	S	S	S

S Indicates results have been suppressed in accordance with CMS cell size suppression policy.
+ 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, adult members

reported lower levels of experience across several of the measure domains, with four of 13 measure rates, *Rating of Health Plan*, *Customer Service*, *Coordination of Care*, and *Discussing Cessation Strategies* assigned one or two stars by a majority of the SP/NC Medicaid populations. The *Rating of Health Plan* measure was the lowest-performing measure across the NC Medicaid Program, NC SP Aggregate, SPs, and NC Medicaid populations for the adult population.

Additionally, the following significant differences for the year-over-year analysis were identified for the adult population:

- TP Eligible's 2024 top-box scores were statistically significantly *higher* than the 2023 top-box scores for two measures, *Rating of Health Plan* and *Getting Needed Care*.
- **AmeriHealth**'s 2024 top-box score was statistically significantly *higher* than the 2023 top-box score for one measure, *Rating of Specialist Seen Most Often*.
- SP Behavioral Health's and TP Eligible's 2024 top-box score were statistically significantly *higher* than the 2023 top-box score for one measure, *Getting Needed Care*.
- **WellCare**'s 2024 top-box score was statistically significantly *lower* than the 2023 top-box score for one measure, *Rating of All Health Care*.
- **Carolina Complete**'s and **Healthy Blue**'s 2024 top-box scores were statistically significantly *lower* than the 2023 top-box scores for one measure, *Getting Care Quickly*.

Child CAHPS Results

Table 42 shows the positive ratings and star ratings based on a comparison to NCQA national percentiles as well as year-over-year results for each of the global ratings.

Table 42—Child Respondent Percentage of Positive Ratings and Star Ratings When Compared to NCQA National Percentiles, With Year-Over-Year Analysis, by Program-Specific Populations: Global Ratings (2024)

SP/Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
NC Medicaid Program	**★★ 86.16%**	**★★★ 86.57%**	**★★★ 90.40%**	**★★★ 87.64%**
NC SP Aggregate	**★★ 86.54%**	**★★★ 86.54%**	**★★★ 90.26%**	**★★★ 87.63%**
AmeriHealth	★★ 86.68%	★★ 85.39%	★★ 88.18%	★★★ 86.92%
Carolina Complete	★★★ 88.91%	★★★ 87.63%	★★★★ 92.11%	★★★★★ 92.00%
Healthy Blue	★★ 85.84%	★★ 84.38% ▼	★★★ 90.26%	★★★ 87.02%
UnitedHealthcare	★★ 85.27%	★★★★ 88.86%	★★★★ 92.04%	★★ 85.37%

SP/Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
WellCare	★★★ 87.04%	★★★ 87.70%	★★ 89.25%	★★★ 88.33%
SP Behavioral Health	★ 80.36%	★ 83.22%	★★★★★ 92.45% ▲	★★ 85.00%
EBCI Tribal Option	★ 68.33%+	★ 80.00%+	★ 78.26%+	★★★★★ 90.48%+
NC Medicaid Direct	★ 82.88% ▲	★★★ 87.35%	★★★★★ 92.46%	★★ 88.29%
TP Eligible	★ 82.68%	★ 80.98%	★ 86.97%	★★ 85.24%
Foster Care	★ 80.96%	★ 83.73% ▼	★★ 88.81% ▼	★ 82.49%

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.
▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.
+ 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 43 shows the positive ratings and star ratings based on a comparison to NCQA national percentiles as well as year-over-year results for each of the composite and individual item measures.

Table 43—Child Respondent Percentage of Positive Ratings and Star Ratings When Compared to NCQA National Percentiles, With Year-Over-Year Analysis, 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	**★★★★ 86.74%**	**★★★ 89.18%**	**★★★★ 96.08%**	**★★ 87.64%**	**★★★★ 87.98%**
NC SP Aggregate	**★★★★ 86.58%**	**★★★ 88.77%**	**★★★★ 95.88%**	**★★ 87.51%**	**★★★★ 88.22%**
AmeriHealth	★★★ 86.31%	★★★ 86.67%	★★★ 94.27%	★ 85.74% ▼	★★★ 86.71%
Carolina Complete	★★★ 85.67%	★★★ 86.49% ▼	★★★ 94.82% ▼	★ 85.61% ▼	★★★ 86.05%
Healthy Blue	★★★ 84.22%	★★★ 88.16%	★★★★★ 96.86%	★★★ 88.27%	★★★★ 87.50%

SP/Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Coordination of Care
UnitedHealthcare	★★★★ 87.38%	★★★ 89.35%	★★★★★ 96.87% ▲	★★★ 89.53%	★★★★★ 90.60%
WellCare	★★★★★ 89.83%	★★★★★ 92.15% ▲	★★★★ 95.60%	★★ 87.28%	★★★★★ 89.61%
SP Behavioral Health	★★★★★ 91.57%	★★★★★ 92.89%	★★★★★ 96.87%	★★ 87.33%+	★★★★ 89.51%
EBCI Tribal Option	★★★★★ 91.49%+	★★ 85.61%+	★★★★★ 100.00%+	★★★★★ 92.50%+	★★ 80.95%+
NC Medicaid Direct	★★★★ 88.45%	★★★★★ 93.57%	★★★★★ 98.21%	★★★ 88.76%	★★★ 85.82%
TP Eligible	★★★ 86.91%	★★★★ 90.79%	★★★ 95.25%	★ 85.45%	★★★ 84.62%
Foster Care	★★★★ 87.25%	★★★★★ 91.83%	★★★★★ 97.30%	★★★ 88.95%+	★★★ 84.65%

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.
▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.
+ 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 42 and Table 43, when compared to NCQA national percentiles, parents/caretakers of child members reported better levels of experience across the measure domains, as only two measure rates 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 NC Medicaid populations for the child population.

Additionally, the following significant differences for the year-over-year analysis were identified for the child population:

- Medicaid Direct's 2024 top-box score was statistically significantly *higher* than the 2023 top-box scores for one measure, *Rating of Health Plan*.
- SP Behavioral Health's 2024 top-box score was statistically significantly *higher* than the 2023 top-box scores for one measure, *Rating of Personal Doctor*.
- **WellCare**'s 2024 top-box score was statistically significantly *higher* than the 2023 top-box scores for one measure, *Getting Care Quickly*.
- **UnitedHealthcare**'s 2024 top-box score was statistically significantly *higher* than the 2023 top-box scores for one measure, *How Well Doctors Communicate*.
- **Healthy Blue**'s 2024 top-box score was statistically significantly *lower* than the 2023 top-box scores for one measure, *Rating of All Health Care*.

- Foster Care's 2024 top-box scores were statistically significantly *lower* than the 2023 top-box scores for two measures, *Rating of All Health Care* and *Rating of Personal Doctor*.
- **AmeriHealth**'s 2024 top-box score was statistically significantly *lower* than the 2023 top-box scores for one measure, *Customer Service*.
- **Carolina Complete**'s 2024 top-box scores were statistically significantly *lower* than the 2023 top-box scores for three measures, *Getting Care Quickly*, *How Well Doctors Communicate,* and *Customer Service*.

HCBS CAHPS Survey

HSAG compared NC HCBS Program's positive ratings to AHRQ's HCBS CAHPS Database benchmarks to determine whether positive ratings were statistically significantly higher or lower.[62,63] Additionally, NC HCBS Program's positive ratings for 2024 were compared to 2023 to determine if there were significant differences, as shown in Table 44. [64,65,66]

Table 44—National Comparisons and Year-Over-Year Analysis: NC HCBS Program—Significant Differences

Measures	Positive Rating	2024 HCBS CAHPS Database Benchmark
Global Rating		
Rating of Case Manager	85.86% H	76.00%
Composite Measures		
Helpful Case Manager	94.51% H ▲	91.00%
Transportation to Medical Appointments	84.47% H	76.00%
Personal Safety and Respect	95.62% H	93.00%
Planning Your Time and Activities	64.53% H	59.00%

62 Agency for Healthcare Research and Quality. *The CAHPS® Home and Community-Based Services (HCBS) Survey Database 2024 Chartbook*. January 2024. Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/cahps-database/2024-hcbs-chartbook.pdf. Accessed on: Feb 18, 2026.

63 The 2024 HCBS CAHPS Database benchmarks represent survey data collected from January 1 to December 31, 2022. Caution should be exercised when comparing the 2024 HCBS CAHPS Database benchmarks to the NC HCBS Program 2024 results, which represent survey data collected from July 23, 2024, to September 18, 2024.

64 Positive ratings combine responses from the standard population and legal guardian population.

65 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 Feb 18, 2026.

66 The 2024 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=645 completed surveys).

Measures	Positive Rating	2024 HCBS CAHPS Database Benchmark
Composite Individual Survey Items		
Staff work time supposed to	82.80% L	88.00%
Staff courteous and respectful	90.20% L	93.00%
Treated the way you want by staff	85.66% L	89.00%
Staff explain things in easy to understand way	82.47% L	86.00%
Staff listen to you	82.85% L	87.00%
Contact Case Manager	93.89% ▲	94.00%
Helped getting or fixing equipment	97.18% H	89.00%
Way to get to appointments	90.67% H	81.00%
Timely pickup	72.09% H	61.00%
Someone to talk to	89.87% H	82.00%
Together with family	56.20% H	45.00%
Together with friends	42.24% H	31.00%
Community	36.40% H	23.00%
Help doing things in community	70.58% L	77.00%
What to do with time	89.82% H	86.00%
Recommendation Measures		
Recommend Case Manager	80.67% H	77.00%
Unmet Need Measures		
No Unmet Need in Medication Administration	81.82%$^{+}$ H	63.00%

▲Indicates the 2024 score is statistically significantly higher than the 2023 score.
^{H} Indicates the score is significantly higher than the 2024 HCBS CAHPS Database benchmark.
^{L} Indicates the score is significantly lower than the 2024 HCBS CAHPS Database benchmark.
$^{+}$ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

As shown in Table 44 above, overall, respondents reported positive experiences with their case manager, receiving transportation to medical appointments, their personal safety and respect, planning their time and activities, and taking their medicines when they were supposed to.

The following significant differences for the year-over-year analysis were identified for the NC HCBS Program:

- The NC Medicaid Program's 2024 top-box score was statistically significantly higher than the 2023 top-box scores for two measures, *Helpful Case Manager* and *Contact Case Manager*.

The following significant differences compared to the national benchmarks were identified for the NC HCBS Program:

- The NC Medicaid Program's 2024 top-box score was statistically significantly *higher* than the 2024 HCBS CAHPS Database benchmark for one global rating measure, *Rating of Case Manager*.
- The NC Medicaid Program's 2024 top-box score was statistically significantly *higher* than the 2024 HCBS CAHPS Database benchmark for four composite measures: *Helpful Case Manager*, *Transportation to Medical Appointments*, *Personal Safety and Respect*, *Planning Your Time and Activities*.
- The NC Medicaid Program's 2024 top-box score was statistically significantly *higher* than the 2024 HCBS CAHPS Database benchmark for eight individual survey items: *Helped getting or fixing equipment*, *Way to get to appointments*, *Timely pickup*, *Someone to talk to*, *Together with family*, *Together with friend*s, *Community*, and *What to do with time*.
- The NC Medicaid Program's 2024 top-box score was statistically significantly *higher* than the 2024 HCBS CAHPS Database benchmark for one Recommendation measure, *Recommend Case Manager.*
- The NC Medicaid Program's 2024 top-box score was statistically significantly *higher* than the 2024 HCBS CAHPS Database benchmark for one No Unmet Need measure, *No Unmet Need in Medication Administration*.

The NC Medicaid Program's 2024 top-box score was statistically significantly *lower* than the 2024 HCBS CAHPS Database benchmark for six individual survey items: *Staff work time supposed to*, *Staff courteous and respectful*, *Treated the way you want by staff*, *Staff explain things in easy to understand way*, *Staff listen to you*, and *Help doing things in community*.

Additional Results

The 2024 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.

Encounter Data Validation (EDV)

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, DHB required health plans 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),[67] HSAG conducted the following core evaluation activities for the EDV study:

- Information Systems (IS) review—Assessment of DHB's, the PIHPs', and the TPs' information systems and processes. The goal of this activity is to examine the extent to which DHB's, the PIHPs', and the TPs' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's Capability in the CMS EQR Protocol 5.
- Medical Record Review (MRR)—Analysis of DHB's electronic encounter data completeness and accuracy by comparing DHB's electronic encounter data to the information documented in the corresponding beneficiaries' medical records. This activity corresponds to Activity 4: Review Medical Records in the CMS EQR Protocol 5.

PIHPs and TPs—IS Review Results

Based on the questionnaire responses received from the PIHPs and TPs, all PIHPs and TPs had the capability to collect, process, and transmit encounter data to DHB, as well as respond to quality issues DHB identified, and then resubmit the corrections. PIHPs and TPs generally set up their policies and procedures based on DHB's expectations listed in the companion guides, encounter data submission guidelines (EDSG),[68] and service-level agreements (SLAs). While the PIHPs and TPs made an effort to meet all expectations, there were areas for the PIHPs and TPs to improve.

Encounter Data Sources and Systems

All PIHPs and TPs reported using a wide variety of systems to collect, store, and check their encounter data. Additionally, all PIHPs and TPs demonstrated an ability to modify and enhance fields to align with DHB's EDSG; identify duplicate records; and submit paid, denied, and adjusted claims to DHB.

Payment Structure of Encounter Data

All PIHPs and TPs reported varied payment structures that differed between the PIHPs and TPs and claim type. For inpatient services, payment methodologies were consistent across the PIHPs and TPs (e.g., the PIHPs largely used a per diem payment structure), while for outpatient services, payment methodologies were generally consistent within the PIHPs and TPs (e.g., **Trillium** paid both PIHP and TP services with a percent of billed payment methodology). The PIHPs and TPs also reported following the NC Medicaid Fee Schedule for bundled services. For TPL data, the PIHPs and TPs used the DHB

[67] 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: Feb 12, 2026.

[68] NCDHHS NC Medicaid Division of Health Benefits. Medicaid Enterprise System's Module Encounter Processing System: Encounter Data Submission Guide. EPS-EDI-DSG-001, May 7, 2025, Document Version, 1.16.

834 eligibility file and other methods to collect and verify information, while zero paid claims and capitated encounters were submitted in accordance with the EDSG.

Encounter Data Quality Monitoring

DHB had the following SLAs to monitor encounter data accuracy, completeness, and timeliness:

- Accuracy: The number of paid encounters that passed all validation edits (Workgroup for Electronic Data Interchange Strategic National Implementation Process [WEDI SNIP] levels 1–7 and state-specific validations) and were accepted by DHB compared to the total number of paid encounters submitted.
- Completeness: The paid amounts on submitted individual encounter records compared to the paid amounts reported on financial reports the PIHPs and TPs submitted to DHB.
- Timeliness:
  - Medical: The number of accepted encounters the PIHPs and TPs submitted within 30 calendar days from the adjudication/payment date.
  - Pharmacy: The number of accepted encounters the PIHPs and TPs submitted within seven calendar days from the adjudication/payment date.

The quality checks either the PIHPs and TPs or their subcontractors perform range in scope and depth; however, the quality checks aligned with DHB's SLAs. The PIHPs, TPs, and their subcontractors used a wide array of quality checks, including checking claim volume by submission month, electronic data interchange (EDI) compliance edits, field-level completeness and validity, reconciliation with financial reports, and timeliness checks. Across all data types, no PIHPs, TPs, or their subcontractors reported performing an MRR to evaluate the completeness and accuracy of their data. This was likely due to the resource-intensive nature of MRR.

All PIHPs and TPs reported processes to reconcile transactions that were initially rejected due to either DHB's EDI translator or DHB-specific edits. Although the overall percentage of rejected encounters that had not yet been submitted was small compared to all submitted encounters, the percentage of rejected encounters that had not yet been accepted remained high across all PIHPs, TPs, and encounter types. Across the PIHPs, TPs, and encounter types, the most common reason for rejections were related to the beneficiary not being enrolled in the benefit plan or managed care on the date of service.

IS Review Recommendations

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

- Although all PIHPs and TPs reported processes to reconcile transactions that were initially rejected due to either DHB's EDI translator or DHB-specific edits, all PIHPs and TPs reported a high percentage of encounters initially rejected that were not yet accepted. HSAG recommends that the PIHPs and TPs strengthen their processes to ensure timely and complete resubmission of all rejected transactions.

- Although all PIHPs and TPs expressed satisfaction with the data quality checks their subcontractors perform, the PIHPs and TPs reported not reviewing data submitted by at least one of their subcontractors prior to submission to DHB. The PIHPs and TPs should explore the possibility of developing or enhancing monitoring reports to assess the accuracy, completeness, and/or timeliness of subcontractor-submitted claims and encounters.

SPs—MRR Results

Medical Record Procurement

Overall, the SPs submitted 78.7 percent of the 411 requested medical records, with procurement rates ranging from 62.5 percent (**Healthy Blue**) to 94.9 percent (**Carolina Complete**). Among the SPs, the most common reason medical records were not submitted was due to a non-responsive provider or the provider not responding in a timely manner (76.2 percent).

For each requested professional service, providers selected a second date of service, if available, to evaluate if all services were in DHB's encounter data. While it is not expected for all beneficiaries to have more than one encounter with the same provider during the measurement period, providers identified and submitted a record for a second date of service for 28.3 percent of all requested professional services. The second date of service submission rates ranged from 5.3 percent (**Carolina Complete**) to 37.9 percent (**UnitedHealthcare**).

HSAG reviewed a total of 1,597 sampled records (98.7 percent of submitted sampled records) and 236 second date of service records (80.8 percent of submitted second date of service records).

Encounter Data Completeness

Table 45 displays the medical record and encounter data omission rates for each key data element. Omissions identified in the medical records (where service information in the encounter data is not supported by the medical records) and omissions identified in the encounter data (where services documented in the medical records are absent from the encounter data) highlight discrepancies in the completeness of DHB's encounter data. Rates 10 percent or lower are preferable for both measures, as they indicate consistent and comprehensive documentation across both data sources.

Table 45—Encounter Data Completeness Summary

Key Data Elements	Medical Record Omission*		Encounter Data Omission*	
	All SP Rates	SP Range	All SP Rates	SP Range
Date of Service	20.1%^	5.3%–33.6%	0.9%	0.0%–1.3%
Diagnosis Code	23.0%^	7.9%–38.2%	0.6%	0.3%–0.8%
Procedure Code	24.2%^	8.5%–38.3%	1.3%	0.8%–1.7%
Procedure Code Modifier	25.7%^	12.5%–38.5%	0.7%	0.4%–1.0%
Revenue Code	26.7%^	6.9%–52.9%	0.0%	0.0%–0.0%

* Lower rates indicate better performance.
^Red text indicates rates greater than 10.0 percent.

Based on the results shown in Table 45, HSAG identified the following key findings:

- The medical record omission rates (i.e., percent of records found in the encounter data that were not supported by the beneficiaries' records) exceeded 20.0 percent for all key data elements, indicating that the encounter data were inadequately supported by the medical records. Notably, the majority of omissions for all data elements were due to either missing medical records or insufficient documentation to support the sampled dates of service.
  - Other common reasons for elevated medical record omissions rates included providers not documenting the services performed in the medical records despite submitting claims and encounters, or providers not providing the service(s) reflected in the encounter data.
- The encounter data omission rates (i.e., percent of records found in the submitted beneficiaries' records that were not supported by the encounter data) were below 2.0 percent for all five key data elements, indicating the beneficiaries' medical records were well supported by the encounter data.
  - Potential reasons for encounter data omissions included providers' billing offices making coding errors or failing to submit codes despite performing the specific services, differences related to North Carolina-specific billing and reimbursement guidelines, and lags between the provider's performance of the service and the submission of the encounter to the SP and/or DHB.

Encounter Data Accuracy

Table 46 displays the element accuracy rates for each key data element and the all-element accuracy rates. HSAG evaluated the accuracy of encounter data for dates of service that were present in both DHB's encounter data and the corresponding beneficiaries' medical records. HSAG evaluated the key data elements (*Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Revenue Code* [institutional encounters only]) for accuracy if the individual data element was present in both DHB's encounter data and the medical records. Rates 90 percent or higher for each data element reflect better performance and stronger alignment between the two data sources.

Additionally, HSAG calculated the all-element accuracy rate, which represents the percentage of dates of service where all evaluated data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* for professional services and *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Revenue Code* for institutional services) were accurate and fully supported by the corresponding medical records.

Table 46—Encounter Data Accuracy

Key Data Elements	All SP Rates	SP Range	Error Type
Diagnosis Code	99.2%	98.8%–99.6%	Inaccurate Code: 75.6% Specificity Error: 24.4%
Procedure Code	98.8%	98.1%–99.1%	Inaccurate Code: 90.7% Higher Level of Service in Medical Record: 1.3% Lower Level of Service in Medical Record: 8.0%

Key Data Elements	All SP Rates	SP Range	Error Type
Procedure Code Modifier	>99.9%	99.8%–100%	—
Revenue Code	100%	100%–100%	—
All-Element Accuracy*	76.3%^	73.1%–78.5%	—

* The denominator for the element accuracy rate for each data element was defined differently from the denominator for the all-element accuracy rate. Therefore, the all-element accuracy rate cannot be derived from the accuracy rate from each data element.
"—" denotes that the error type analysis was not applicable to a given data element.
^Red text indicates rates lower than 90.0 percent.

Based on the results shown in Table 46, HSAG identified the following key findings:

- In general, when key data elements were present in both DHB's encounter data and the medical records and were evaluated independently, the data elements were found to be accurate, with all key data elements having an overall SP encounter data accuracy rate of 98.8 percent or higher. This indicates a strong alignment between the data recorded in the encounter data and the medical records.
- The most common error type affecting the *Diagnosis Code* and *Procedure Code* data elements were due to inaccurate coding, affecting 75.6 percent of inaccurate diagnosis codes and 90.7 percent of inaccurate procedure codes.
- Overall, 76.3 percent of the dates of service present in both data sources accurately represented all four data elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Revenue Code*) when compared to the beneficiaries' medical records. At the SP level, the all-element accuracy rate ranged from 73.1 percent (**Healthy Blue**) to 78.5 percent (**Carolina Complete**).
  - The overall all-element inaccuracies were mainly caused by high medical record omission rates across all data elements and low procurement rates.

MRR Recommendations

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

- The results from the MRR indicated that the encounters the SPs submitted and maintained in DHB's encounter processing system (EPS) warehouse were relatively complete and accurate when compared to the submitted medical records. As such, HSAG recommends that DHB continue its current efforts in monitoring encounter data submissions and addressing any identified data issues with the SPs' encounter data submissions.
- Although HSAG allowed additional time for the SPs to procure records, some SPs' medical record submission rates remained low, which negatively affected the medical record omission study indicators for all key data elements evaluated. As such, to ensure accountability for record procurement requirements, the SPs may consider strengthening and/or enforcing their contract requirements and oversight via the following:
  - Enhance contract requirements: Establish and reinforce accountability measures to ensure the timely submission of complete and accurate records.

  - Enforce contract language: Implement contractual provisions that mandate the submission of records by contracted providers, with an emphasis on timely and responsive communication.
  - Address non-responsive providers: Develop and enforce strategies to mitigate delays caused by non-responsive providers, ensuring timely submission of service records for auditing and other evaluations.
- Since the results of the record review are dependent on the SPs' submission of complete and accurate supporting documentation, HSAG recommends that DHB establish record submission standards. These standards may ensure the SPs are more responsive to procuring requested records, leading to more representative results of the actual documentation available.
- The overall medical record omission rates for all key data elements were 10 percent or higher. Although the low procurement rates largely contributed to higher medical record omission rates, HSAG could not attribute all medical record omission rates to non-procured records. Therefore, the SPs should investigate the root causes of these omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Findings from these reviews should be used to target education and training to providers regarding encounter data submissions, medical record documentation, and coding practices.

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 MY 2024. 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).[69] For the statewide calculations inclusive of NC Medicaid, HSAG included all NC Medicaid beneficiaries (SP, TPs, **EBCI Tribal Option**, and NC Medicaid Direct [including PIHPs]). In addition to an overall NC Medicaid statewide rate, HSAG calculated aggregate rates for each line of business (SP, TPs, **EBCI Tribal Option**, and NC Medicaid Direct [including PIHPs]).

[69] 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: Feb 12, 2026.

3. Additional EQR Activities

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

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 obstetrics and gynecology (OB/GYN) providers. Results of the surveys are provided to DHB upon completion of the activity.

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

During CY 2025, HSAG's subcontractor, CQH, conducted desk, file, and webinar reviews with all five SPs and all four PIHPs. 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 2025, and the second round was delivered in December 2025.

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.

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 47 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 47—AmeriHealth Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)
PIPs		
+	**Strength:** For all PIPs, **AmeriHealth** received a *High Confidence* level for adhering to acceptable PIP methodology and *High Confidence* for overall confidence that the PIP achieved significant improvement (for two of four PIPs).	
PMV		
+	**Strength: AmeriHealth** demonstrated substantial improvement in the *Prenatal and Postpartum Care (PPC)* measure for both numerators, with an 8.07 percent year-over-year increase in *Postpartum Care* and a 9.98 percent year-over-year increase in *Timeliness of Prenatal Care*.	
+	**Strength:** For MY 2023, **AmeriHealth** achieved a 98 percent approval acceptance rate for medical and pharmacy claims and maintains a 91 percent auto-adjudication rate, meaning most claims were processed automatically without manual intervention.	
−	**Weakness:** While **AmeriHealth** used multiple outreach channels (mail, phone, text, online portal), there is still an opportunity to further improve member engagement and *HRRN* screening completion rates. **Recommendations: AmeriHealth** should implement additional strategies, such as personalized follow-ups, incentives, or community partnerships that could help reach harder-to-engage populations and increase overall completion.	

Strength/ Weakness	Description	Domain(s)
−	**Weakness: AmeriHealth**'s *Screening for Depression and Follow-Up Plan (CDF)* rates continued to be low year-over-year. **Recommendations: AmeriHealth** should continue to evaluate additional interventions that will improve a follow-up plan for members who receive a positive depression screening.	
Compliance With Standards (Not Conducted During Reporting Cycle)		
NAV		
+	**Strength: AmeriHealth** demonstrated robust processes for provider data maintenance via its Provider Data Lifecycle approach to data management. This process allowed for up-to-date data configuration and error detection to support timeliness and accuracy.	
−	**Weakness:** The review of Quest parameters submitted for network adequacy calculations revealed that **AmeriHealth** applied adjusted standards that did not align with contractual requirements. DHB confirmed that for the audit period, no global exceptions or adjustments were approved; therefore, the calculations should have adhered strictly to contractual standards. **Recommendations: AmeriHealth** should work closely with DHB to verify the accuracy of parameters used in network adequacy calculations. Additionally, **AmeriHealth** should implement a process to ensure Quest templates are promptly updated upon the date of expiration indicated in DHB's notification to reflect contractual standards whenever global exceptions/adjustments are not issued by DHB.	
−	**Weakness: AmeriHealth** did not achieve full compliance with county-level time/distance or other required access standards across multiple service areas, including 19 out of 23 child specialty provider types, and did not meet any of the State Health Plan LTSS service type contractual requirements during the period in review. **Recommendations: AmeriHealth** should continue strengthening its recruiting and contracting efforts to add eligible Medicaid providers in all specialty areas that did not meet the required access standards. **AmeriHealth** should also collaborate with DHB to request exceptions, when appropriate, to help determine whether noncompliance stems from an insufficient provider supply or challenges in contracting with providers within the geographic region.	
Optional/Additional EQR Activities		
+	**Strength: AmeriHealth**'s CAHPS 2024 top-box score was statistically significantly *higher* than the 2023 top-box score for one adult measure, *Rating of Specialist Seen Most Often*.	

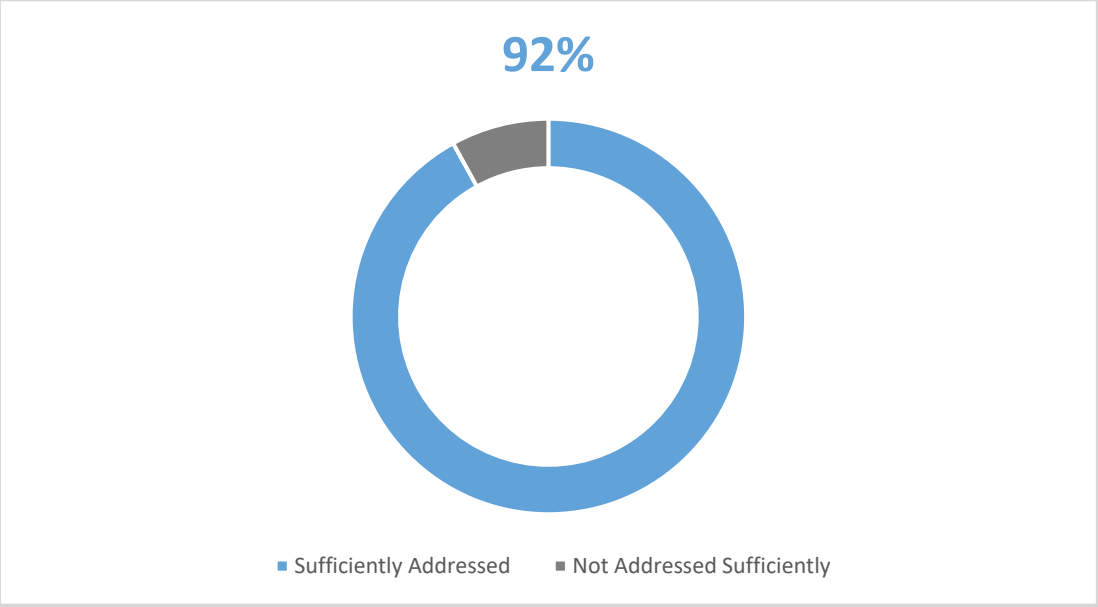
Strength/ Weakness	Description	Domain(s)
+	**Strength: AmeriHealth**'s institutional services medical record omission rate for one data element (*Date of Service*) was below 10.0 percent. The professional services encounter data omission rates for all data elements (*Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were below 10.0 percent, and the institutional services encounter data omission rates for all data elements (*Date of Service*, *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Revenue Code*) were below 10.0 percent. This indicates that the submitted records contained information that could be largely identified in the encounter data.	
+	**Strength: AmeriHealth**'s professional services accuracy rates for all data elements (*Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were above 90.0 percent, and the institutional services accuracy rates for all data elements (*Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Revenue Code*) were above 90.0 percent.	
−	**Weakness: AmeriHealth**'s CAHPS scores were below the 25th percentile for the adult measures of *Rating of Health Plan*, *Customer Service*, and *Coordination of Care* and for the child measure of *Customer Service*. **AmeriHealth**'s 2024 top-box score was statistically significantly lower than the 2023 top-box scores for one child measure, *Customer Service*. **Recommendations: AmeriHealth** should explore drivers of what may be impacting lower experience scores and develop initiatives designed to improve quality of care. In addition, obtaining direct patient feedback from members could be used to drill down into areas that need improvement.	
−	**Weakness: AmeriHealth**'s professional services medical record omission rates for all data elements (*Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were greater than 10.0 percent, and the institutional services medical record omission rates for four data elements (*Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Revenue Code*) were greater than 10.0 percent. **Recommendations: AmeriHealth** should investigate the root cause of these findings and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness. Findings from these reviews should be shared with providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	

Follow-Up on Prior Year's Recommendations

HSAG evaluated **AmeriHealth**'s approach to addressing the recommendations and/or findings issued in the prior technical report while conducting the CY 2025 EQR activities.

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

Figure 4—Percentage of Prior EQR Recommendations Addressed by AmeriHealth



AmeriHealth-specific recommendations and follow-up assessments are summarized in Table 48.

Table 48—Assessment of AmeriHealth's Approach to Addressing Previous Annual Recommendations

Prior Recommendation	Assessment
PMV	
HSAG recommended that **AmeriHealth** continue to work with the North Carolina Immunization Registry (NCIR) and the North Carolina Health Information Exchange (HIE) to enhance data capture of immunizations to include in the rate reporting for the HEDIS CIS measure.	**AmeriHealth sufficiently addressed the recommendation. AmeriHealth** established a direct data feed connection with NCIR and noted improvements in *CIS* rates.
HSAG identified the following opportunity: **AmeriHealth**'s 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	**AmeriHealth sufficiently addressed the recommendation. AmeriHealth** confirmed that year-over-year finalized rates showed continuous improvement.

Prior Recommendation	Assessment
multi-year period. HSAG recommended **AmeriHealth** evaluate additional interventions that will improve the frequency of *W30* visits.	
AmeriHealth's rates for the *CBP* and *Hemoglobin A1c Control for Patients with Diabetes* (*HBD)* measures were below the MY 2023 NCQA 10th percentile. HSAG recommended that **AmeriHealth** educate and consider incentive plans for providers on appropriate submission of Current Procedural Terminology Category II (CPT II) codes for improving administrative capture of *CBP* and *HBD* results.	**AmeriHealth sufficiently addressed the recommendation. AmeriHealth** offered a CPT II code incentive to providers and increased the dollar amount of the incentive in the second half of 2025. **AmeriHealth** was successful in engaging key providers in clinical supplemental data exchange and noted significant year-over-year improvement in administrative rates for these measures.
AmeriHealth's MY 2023 *CDF* rates continued to be a challenge. HSAG recommended that **AmeriHealth** 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 scorecards as needed.	**AmeriHealth sufficiently addressed the recommendation. AmeriHealth** included *CDF* rates on provider scorecards and provided education on the importance of screening for depression and follow up via multiple provider channels. In 2025, **AmeriHealth** targeted education to providers on the use and billing of appropriate G codes to capture screening and follow-up completion, and included the *CDF* measure in its PCP Total Cost of Care Provider Incentive program. Additionally, NC DHHS has prioritized the *CDF* measure for early work happening with the HIE, given the known challenges of collecting clinical data to support rate calculations for this measure. **AmeriHealth** reported a favorable trend in monthly rates for same point in time year-over-year.
Compliance With Standards	
AmeriHealth's care management record review demonstrated inconsistent compliance with attempts to reach members within 90 days of enrollment to complete the care needs screening (CNS) and inconsistent compliance with sharing the member's comprehensive assessment with the member's provider. HSAG recommended that **AmeriHealth** continue its oversight and monitoring procedures to ensure timely completion of the CNS and ensure procedures include sharing the comprehensive assessment with the member's provider.	**AmeriHealth sufficiently addressed the recommendation. AmeriHealth** created a CNS dashboard in January 2024 that gives line of sight at a member level on CNS attempts in the first 90 days of enrollment and when a member has had three attempts. For assessment sharing with providers, beginning in January 2023, all care managers were trained in the process of sharing documents with providers. These elements were added to the new hire training curriculum and added as part of chart audits. **AmeriHealth** reported a chart audit rate of success of 96 percent for documentation sharing with providers.

Prior Recommendation	Assessment
AmeriHealth failed to ensure that its member handbook met the requirements outlined in the NC Medicaid handbook template. HSAG recommended that **AmeriHealth** continue to pursue DHB approval of the member handbook and upon approval, immediately implement the approved version of the member handbook.	**AmeriHealth sufficiently addressed the recommendation. AmeriHealth** included the missing terms in the key words section of its handbook and conducted an additional internal review for subsequent editions of the handbook.
AmeriHealth was unable to demonstrate a procedure to use telemedicine, e-visits, and/or other technology solutions to assess availability. HSAG recommended that **AmeriHealth** consider incorporating additional technology solutions in its assessment of availability and include provider accessibility information to improve the provider directory display details.	**AmeriHealth sufficiently addressed the recommendation. AmeriHealth** updated its policy with the quarterly procedure to verify use of telemedicine, e-visits, and/or other technology solutions to access availability and conducts an annual review of all policies and procedures.
For the care management performance evaluation (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. HSAG recommended that **AmeriHealth** establish a process to produce beneficiary assignment files for audit purposes that show the historical phase of algorithmic assignment for multiple periods.	**AmeriHealth sufficiently addressed the recommendation. AmeriHealth** described difficulties with providing data for the CMPE as specified. The CMPE was conducted in accordance with DHB's specifications; however, this activity has been discontinued so no further action is required for **AmeriHealth**.
As identified by 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. HSAG recommended that **AmeriHealth** 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.	**AmeriHealth sufficiently addressed the recommendation. AmeriHealth** worked closely with NC DHHS to completely modify the auto-assignment algorithm, including migrating code from a 12-month to an 18-month lookback period for historic claims. **AmeriHealth** reported other changes it is simulating in testing with NC DHHS and expects to have a greater impact on auto-assignment, such as a previous provider being weighted as a Level 1 selection. This activity has been discontinued so no further action is required for **AmeriHealth**.
Optional/Additional EQR Activities	
AmeriHealth's CAHPS scores were below the 25th percentile for *Customer Service* for the adult population and *Rating of Health Plan* for the adult	**AmeriHealth did not sufficiently address the recommendation. AmeriHealth** described the use of problem solving and improvement tools to

Prior Recommendation	Assessment
and child populations. HSAG recommended that **AmeriHealth** explore what may be driving lower experience scores and develop initiatives designed to improve quality of care.	dive deeper and understand root causes, key drivers, and potential initiatives to improve customer service experience, and subsequently CAHPS scores. **AmeriHealth** discussed CAHPS measures/performance, queried members during member advisory council meetings to better understand their experiences and needs, and noted slight improvements across several measures. However, **AmeriHealth**'s scores remained below the 25th percentile.
AmeriHealth's 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. HSAG recommended that **AmeriHealth** ensure the claim status of each record is accurate.	**AmeriHealth sufficiently addressed the recommendation. AmeriHealth** identified that denied lines on paid claims were incorrectly included in the report, updated the report to remove denied lines on paid claims, and will continue to review the report for accuracy.
AmeriHealth's encounter element omission rates were low for most, but not all data elements between the DHB-submitted and health plan-submitted data. HSAG recommended that **AmeriHealth** ensure the Professional encounters (*Rendering Provider NPI* and *Rendering Provider Taxonomy Code*) data elements are submitted completely.	**AmeriHealth sufficiently addressed the recommendation. AmeriHealth** identified that the EDV report defaulted to the rendering provider National Provider Identifier (NPI) and taxonomy defaulted to the billing provider information. **AmeriHealth** updated the report code to alleviate this issue and noted that omission rates subsequently dropped. The report will continue to be reviewed for accuracy.
The EDV activity identified that matched records largely contained similar values between the DHB-submitted and **AmeriHealth**-submitted data, except for some data elements. HSAG recommended that **AmeriHealth** ensure the following data elements have accurate value: • 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*	**AmeriHealth sufficiently addressed the recommendation. AmeriHealth** identified that all lines for value-based payments were not included in the report and updated the report code to alleviate this issue. **AmeriHealth** noted that accuracy rates subsequently increased and the report will continue to be reviewed for accuracy.

Carolina Complete Health, Inc.

Detailed results from the EQR's substantive findings are summarized in Table 49 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 49—Carolina Complete Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)
PIPs		
+	**Strength:** For three of four PIPs, **Carolina Complete** received a *High Confidence* level for adhering to acceptable PIP methodology and *High Confidence* for overall confidence that the PIP achieved significant improvement for the *HEDIS GSD* PIP.	
−	**Weakness: Carolina Complete** received a *No Confidence* level rating for overall confidence that the *HEDIS CIS—Combo 10* PIP and *HRRN* PIP achieved significant improvement and demonstrated a decline in performance in Remeasurement 1 compared to the baseline resulting in a *No Confidence* rating. **Recommendations: Carolina Complete** should continually revisit its QI processes to make mid-course corrections, as needed; develop a sound method or process to evaluate the effectiveness of each individual intervention; and address the feedback that HSAG provides in the initial validation tool to receive a *High Confidence* rating. **Carolina Complete** should develop active, innovative interventions that have the potential for impacting the performance indicator outcomes and address the identified and prioritized barriers. **Carolina Complete** should not initiate and test standard operating QI actions or processes already in place as interventions for the PIP and should use PDSA cycles as part of the improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful. **Carolina Complete** must complete accurate statistical testing and report correct values in Step 7 of the PIP submission form and submit intervention worksheets for all interventions tested during the reported measurement period.	
PMV		
+	**Strength: Carolina Complete** maintains rigorous internal audit and quality assurance measures. Claims are regularly audited using statistically valid random samples. **Carolina Complete** achieves high accuracy rates of 97 percent for processing and 99 percent for financial accuracy. These practices help ensure compliance, data integrity, and continuous improvement in claims management.	

Strength/ Weakness	Description	Domain(s)
+	**Strength: Carolina Complete** has a robust and efficient claims processing system, with an auto-adjudication rate of over 95 percent. Most claims are processed automatically, which reduce manual intervention, speed up payment cycles, and minimize errors.	
−	**Weakness:** While **Carolina Complete** is compliant with DHB's HRRN outreach, its completion rate is low. **Recommendations: Carolina Complete** could explore additional strategies, such as personalized follow-up, incentives for completion, multilingual outreach, or leveraging of community partnerships to reach hard-to-engage populations.	
−	**Weakness:** Although **Carolina Complete** has implemented comprehensive outreach efforts, areas for improvement remain in the *Early and Periodic Screening, Diagnostic, and Treatment* (*EPSDT*) *Screening Ratio* measure. **Recommendations: Carolina Complete** should consider evaluating the effectiveness of its outreach efforts and further evaluate whether providing assistance for scheduling and transportation could increase pediatric member adherence to recommended preventive care visit time frames.	
−	**Weakness: Carolina Complete**'s *Screening for Depression and Follow-Up Plan* (*CDF*) rates continued to be lower than other SPs' *CDF* rates, year-over-year. **Recommendations: Carolina Complete** should continue to evaluate additional interventions that will improve the timeliness of documenting a follow-up plan for members who receive a positive depression screening.	
Compliance With Standards (Not Conducted During Reporting Cycle)		
NAV		
+	**Strength: Carolina Complete** moved to an automated process during the review period that enhanced provider data integrity by matching contracting data to the Provider Enrollment File (PEF) and Portico. This automation eliminated manual processes and human error.	
−	**Weakness: Carolina Complete** did not meet full county-level compliance for time/distance standards for 11 of the 23 child provider specialty types. **Recommendations: Carolina Complete** should continue its recruiting and contracting efforts of eligible Medicaid providers for specialties that did not meet the time/distance threshold, with the goal of determining whether failure to meet the contract standard was the result of a lack of providers or an inability to contract providers in the geographic area.	

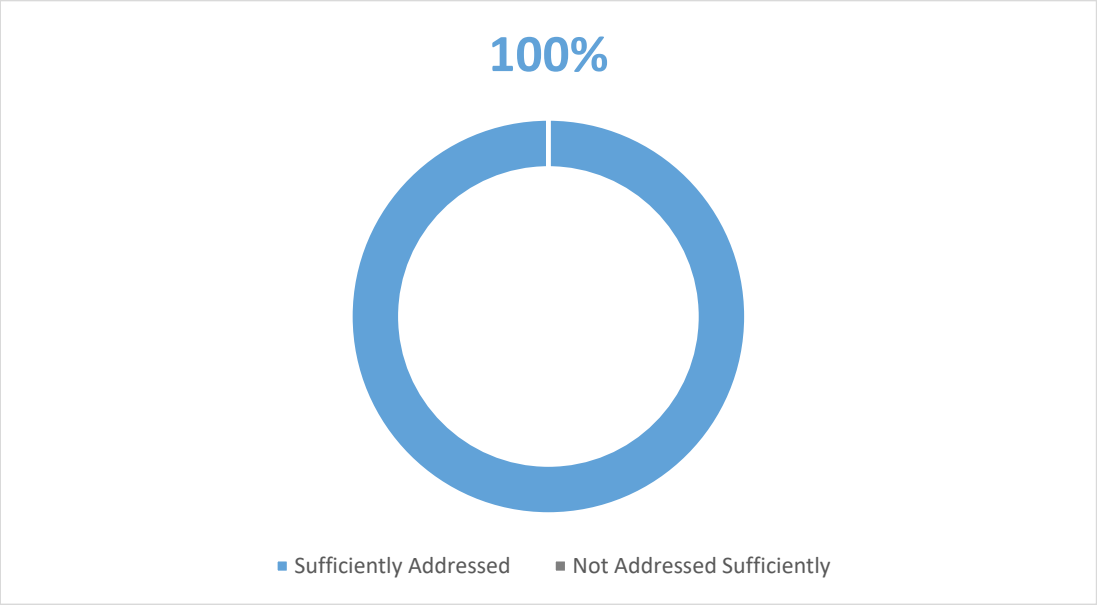
Strength/ Weakness	Description	Domain(s)
Optional/Additional EQR Activities		
+	**Strength: Carolina Complete**'s professional services medical record omission rates for two data elements (*Date of Service* and *Diagnosis Code*) were below 10.0 percent, and the institutional services medical record omission rates for four data elements (*Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Revenue Code*) were below 10.0 percent. The professional services encounter data omission rates for all data elements (*Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were below 10.0 percent, and the institutional services encounter data omission rates for all data elements (*Date of Service*, *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Revenue Code*) were below 10.0 percent. This indicates that submitted records and the encounter data contained information that could largely be identified in both data sources.	
+	**Strength: Carolina Complete**'s professional services accuracy rates for all data elements (*Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were above 90.0 percent, and the institutional services accuracy rates for all data elements (*Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Revenue Code*) were above 90.0 percent.	
−	**Weakness: Carolina Complete**'s CAHPS scores were below the 25th percentile for the adult and child *Customer Service* measure. **Carolina Complete**'s 2024 top-box scores were statistically significantly lower than the 2023 top-box scores for one adult measure, *Getting Care Quickly* and three child measures, *Getting Care Quickly*, *How Well Doctors Communicate,* and *Customer Service.* **Recommendations: Carolina Complete** should explore drivers of what may be impacting lower experience scores and develop initiatives designed to improve quality of care. In addition, obtaining direct patient feedback from members could be used to drill down into areas that need improvement.	
−	**Weakness: Carolina Complete**'s professional services medical record omission rates for two data elements (*Procedure Code* and *Procedure Code Modifier*) were greater than 10.0 percent, and the institutional services medical record omission rate for one data element (*Procedure Code Modifier*) was greater than 10.0 percent. **Recommendations: Carolina Complete** should investigate the root cause of these findings and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness. Findings from these reviews should be shared with providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	

Follow-Up on Prior Year's Recommendations

HSAG evaluated **Carolina Complete**'s approach to addressing the recommendations and/or findings issued during the prior technical report while conducting the CY 2025 EQR activities.

Figure 5 illustrates the degree to 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 Carolina Complete



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

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

Prior Recommendation	Assessment
PIPs	
Carolina Complete had a statistically significant decline in performance when compared to the baseline for the *HEDIS CIS—Combo 10* PIP performance indicator. HSAG recommended that **Carolina Complete** conduct a root cause analysis to identify opportunities to address barriers to enrollee completion of recommended immunization schedules.	**Carolina Complete sufficiently addressed the recommendation and noted small improvements. Carolina Complete** partnered with all five PHPs to host statewide, on-site vaccination events at provider offices, equipped providers with targeted member lists to identify children at risk of falling behind on immunizations, and conducted a robust member outreach campaign targeting members who missed vaccines.
PMV	
Carolina Complete was auto-adjudicating claims at 84.3 percent in 2022, which was slightly lower than its peers for the same time frame. HSAG recommended that **Carolina Complete** continue to look for opportunities to increase auto-adjudication rates through minimizing manual processing.	**Carolina Complete sufficiently addressed the recommendation. Carolina Complete** implemented automation tools and reported a nearly 10 percent rate increase in auto-adjudication.
Carolina Complete's rates for the *CBP* and *HBD* measures were below the MY 2023 NCQA 10th percentile. HSAG recommended that **Carolina Complete** educate and consider incentive plans for providers on appropriate submission of CPT II codes for improving administrative capture of *CBP* and *HBD* results.	**Carolina Complete sufficiently addressed the recommendation. Carolina Complete** began engaging with providers on the use of CPT II codes and the importance of collecting the data through supplemental means and updated measure resource tools for providers.
Carolina Complete's MY 2023 *CDF* rates continued to be a challenge. HSAG recommended that **Carolina Complete** 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 providers 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 scorecards as needed.	**Carolina Complete sufficiently addressed the recommendation and reported improvements. Carolina Complete** created a *CDF* measure reference guide, including screening guidance to educate providers, and initiated discussions with providers.

Prior Recommendation	Assessment
Compliance	
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. HSAG recommended that **Carolina Complete** 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.	**Carolina Complete sufficiently addressed the recommendation and observed improvement. Carolina Complete** established ongoing monitoring of the system and reporting of annual comprehensive assessment completion to identify gaps in real time, enhanced system functionality to support consistent and automated sharing of completed assessments with providers, and implemented validation checks to ensure documentation was complete. Additionally, **Carolina Complete** targeted training and refresher education to care management staff on updated system workflows, assessment requirements, and provider communication processes.
Carolina Complete failed to ensure that its member handbook met the requirements outlined in the NC Medicaid handbook template. HSAG recommended that **Carolina Complete** continue to pursue DHB approval of the member handbook and upon approval, immediately implement the approved version of the member handbook.	**Carolina Complete sufficiently addressed the recommendation. Carolina Complete** continued to collaborate with DHB by utilizing the currently available template, submitting updates in accordance with the inbound deliverable process, and escalating deliverables that are pending review/approval for an extended period.
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. HSAG recommended that **Carolina Complete** 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.	**Carolina Complete sufficiently addressed the recommendation. Carolina Complete** updated its desk-level procedures and now requires written consent from the member or legal guardian for appeals processing. **Carolina Complete** included written consent as an audit element so that it will be closely monitored.
Optional/Additional EQR Activities	
Carolina Complete's CAHPS scores were below the 25th percentile for *Coordination of Care* for the adult population. HSAG recommended that **Carolina Complete** explore what may be driving lower experience scores and develop initiatives designed to improve quality of care.	**Carolina Complete sufficiently addressed the recommendation and noted performance improvements. Carolina Complete** implemented a more strategic onboarding approach by combining new member orientation with tailored text messaging journeys to optimize member health plan benefit utilization and engagement. **Carolina Complete** established a workgroup to focus on improving member engagement and educating providers on the importance of enhancing member experiences.

Prior Recommendation	Assessment
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. HSAG recommended that **Carolina Complete** ensure records are submitted completely.	**Carolina Complete sufficiently addressed the recommendation. Carolina Complete i**dentified the issue that led to this finding, which was not a system issue. **Carolina Complete** noted that it will obtain clarification on the data being submitted prior to the submission of HSAG data.
Encounter element omission rates were low for most, but not all; data elements between the DHB-submitted and health plan-submitted data. HSAG recommended that **Carolina Complete** ensure the professional encounters: *Rendering Provider NPI*, *Referring Provider NPI*, and *Rendering Provider Taxonomy Code* data elements are submitted completely.	**Carolina Complete sufficiently addressed the recommendation. Carolina Complete** followed HSAG's request and copied the rendering provider information from the billing information for the report. **Carolina Complete** will include required data in future HSAG audits.
Matched records largely contained similar values between the DHB-submitted and health plan-submitted data, except for some data elements. HSAG recommended that **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*	**Carolina Complete sufficiently addressed the recommendation and noted performance improvement. Carolina Complete** identified the mismatch that resulted in HSAG's finding and described its plans to treat DHB and PHP values equally.
For the CMPE, HSAG identified an Advanced Medical Home (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. HSAG recommended **Carolina Complete** 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.	**Carolina Complete sufficiently addressed the recommendation. Carolina Complete** updated its generation logic to exclude the generation of the Aledade BA file and audited provider data against the provider enrollment file daily to ensure that source data are aligned with the State. This activity has been discontinued so no further action is required for **Carolina Complete**.

Prior Recommendation	Assessment
Carolina Complete conducted a larger percentage (6.7 percent) of manual review frequency compared to its peers. HSAG recommended that **Carolina Complete** continue to look for opportunities to increase automation and leverage IT controls where possible.	**Carolina Complete sufficiently addressed the recommendation. Carolina Complete** reviewed and updated its business system requirements to more closely align with the 834 companion guide. **Carolina Complete** reported that enrollment fallout from 834 processing has largely decreased.
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. HSAG recommended that **Carolina Complete** 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.	**Carolina Complete sufficiently addressed the recommendation. Carolina Complete** partnered with the State's PCP auto-assignment team to participate in a modeling exercise of the State's upcoming logic changes and developed a timeline to implement changes.
Carolina Complete did not follow the PCP auto-assignment requirements for determining the prior PCP. **Carolina Complete** indicated that it used claims history to determine the prior PCP. HSAG recommended that **Carolina Complete** update its auto-assignment logic so that it is aligned with the PCP auto-assignment requirements for determining the prior PCP, and should work with DHB on any questions related to the requirements.	**Carolina Complete sufficiently addressed the recommendation. Carolina Complete** partnered with the State to model proposed logic changes to the State's PCP assignment algorithm and developed a timeline to implement changes.

Healthy Blue of North Carolina

Detailed results from the EQR's substantive findings are summarized in Table 51 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 51—Healthy Blue Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)
PIPs		
+	**Strength:** For all PIPs, **Healthy Blue** received a *High Confidence* level for adhering to acceptable PIP methodology.	
−	**Weakness: Healthy Blue** received a *No Confidence* level rating for overall confidence that the *HEDIS PPC* PIP, *HEDIS CIS—Combo 10* PIP, and *HRRN* PIP achieved significant improvement and demonstrated a decline in performance in Remeasurement 1 (for at least one indicator) compared to the baseline resulting in a *No Confidence* rating. **Recommendations: Healthy Blue** should continually revisit its QI processes to make mid-course corrections, as needed; develop a sound method or process to evaluate the effectiveness of each individual intervention; and address the feedback that HSAG provides in the initial validation tool to receive a *High Confidence* rating. **Healthy Blue** should develop active, innovative interventions that have the potential for impacting the performance indicator outcomes and address the identified and prioritized barriers. **Healthy Blue** should not initiate and test standard operating QI actions or processes already in place as interventions for the PIP and should use PDSA cycles as part of the improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful. **Healthy Blue** must complete accurate statistical testing and report correct values in Step 7 of the PIP submission form and submit intervention worksheets for all interventions tested during the reported measurement period.	
PMV		
+	**Strength: Healthy Blue**'s efficient and reliable claims processing system supported prompt and accurate payment while maintaining high standards for quality assurance. **Healthy Blue** enforced timeliness and accuracy standards, processed claims within 30 days, and demonstrated a financial accuracy goal of 99 percent.	

Strength/ Weakness	Description	Domain(s)
+	**Strength: Healthy Blue** demonstrated strong data protection and business continuity practices that minimized risks related to data loss, corruption, and unauthorized access. Physical and electronic security measures were in place, including strict access controls for computer rooms and compliance with HIPAA safeguards. Privileged account management policies ensured that only authorized personnel had access to sensitive data.	
−	**Weakness:** While **Healthy Blue** was compliant with DHB's *HRRN* outreach performance measure specifications, its completion rate was low compared to all SPs. **Recommendations: Healthy Blue** could explore additional strategies, such as personalized follow-up, incentives for completion, multilingual outreach, or leveraging of community partnerships to reach hard-to-engage populations.	
−	**Weakness: Healthy Blue** used multiple supplemental data sources (e.g., lab vendors and the State immunization registry) to support performance measure reporting. While **Healthy Blue** performed validation activities, such as User Acceptance Testing (UAT) and automated data quality checks, the ISCAT noted that some minimal data checks/edits were performed on delegated entity data. **Healthy Blue** acknowledged occasional discrepancies due to data complexity, volume, and market dynamics. **Recommendations:** Implementing more rigorous and standardized data quality checks, reconciliation procedures, and root cause analysis for discrepancies can further improve data completeness, accuracy, and reliability for performance measure reporting.	
−	**Weakness:** Although **Healthy Blue** implemented comprehensive outreach efforts, areas for improvement remain in the *EPSDT Screening Ratio* measure. **Recommendations: Healthy Blue** should consider evaluating the effectiveness of its outreach efforts and also determine whether providing assistance for scheduling and transportation could increase pediatric member adherence to recommended preventive care visit time frames.	
Compliance With Standards (Not Conducted During Reporting Cycle)		
NAV		
+	**Strength: Healthy Blue** demonstrated a strong process for ensuring accuracy within its member data by maintaining quality reviews, auditing manually edited data weekly, and utilizing a standardized checklist to ensure completeness and tracking.	

Strength/ Weakness	Description	Domain(s)
−	**Weakness:** In review of **Healthy Blue**'s business requirement document related to child and adult definitions, HSAG identified misalignment with DHB's definition of a child/adult. **Healthy Blue** defined Adult PH members as 18 years and older and Child PH members were defined as less than 18 years old. In review of the DHB-provided guidance, DHB defines Adult as 21 years and older and Child as less than 21 years, specifically for PH. **Recommendations: Healthy Blue** should conduct a comprehensive review and standardization of business rules governing child and adult definitions, to ensure alignment with DHB's guidance.	
−	**Weakness: Healthy Blue**'s did not achieve full compliance with county-level time/distance or other required access standards across multiple service areas, including 15 out of 23 child specialty provider types, and did not meet any of the All State LTSS service type contractual requirements during the period in review. **Recommendations: Healthy Blue** should continue strengthening its recruiting and contracting efforts to add eligible Medicaid providers in all areas that did not meet the required access standards, with the goal of determining whether failure to meet the contract standard was the result of the lack of providers or an inability to contract providers in the geographic area.	
Optional/Additional EQR Activities		
+	**Strength: Healthy Blue**'s professional services encounter data omission rates for all data elements (*Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were below 10.0 percent, and the institutional services encounter data omission rates for all data elements (*Date of Service*, *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Revenue Code*) were below 10.0 percent. This indicates that the submitted records contained information that could be largely identified in the encounter data.	
+	**Strength: Healthy Blue**'s professional services accuracy rates for all data elements (*Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were above 90.0 percent, and the institutional services accuracy rates for all data elements (*Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Revenue Code*) were above 90.0 percent.	
−	**Weakness: Healthy Blue**'s CAHPS scores were below the 25th percentile for the adult measures of *Rating of Specialist Seen Most Often, Customer Service,* and *Discussing Cessation Strategies*. **Healthy Blue**'s 2024 top-box scores were statistically significantly lower than the 2023 top-box scores for one adult measure, *Getting Care Quickly* and one child measure, *Rating of All Health Care*. **Recommendations: Healthy Blue** should explore drivers of what may be impacting lower experience scores and develop initiatives designed	

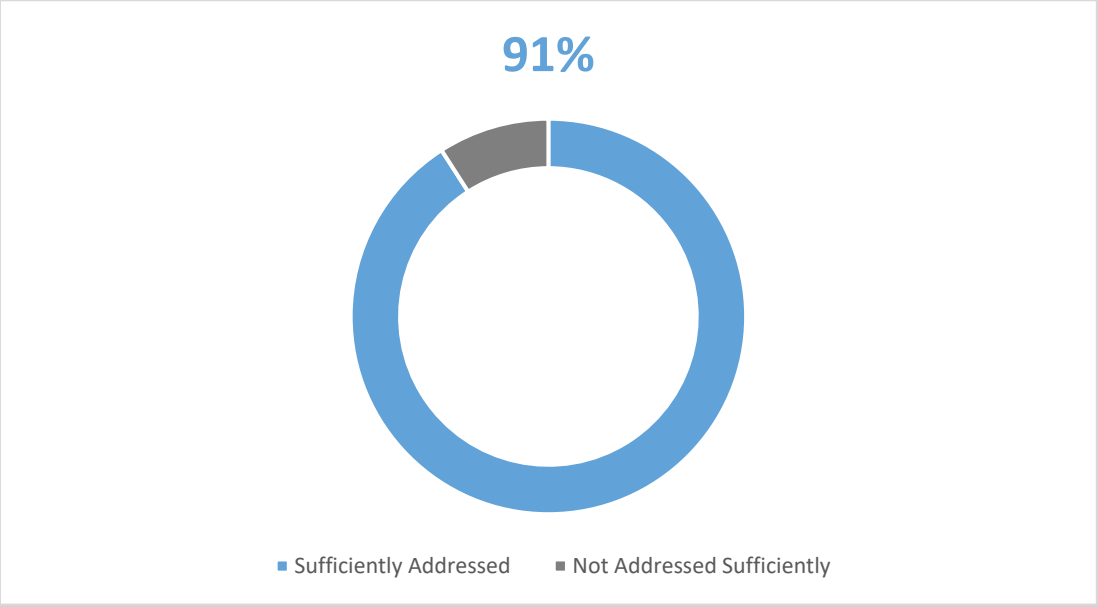
Strength/ Weakness	Description	Domain(s)
	to improve quality of care. In addition, obtaining direct patient feedback from members could be used to drill down into areas that need improvement.	
−	**Weakness: Healthy Blue**'s professional services medical record omission rates for all data elements (*Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were greater than 10.0 percent, and the institutional services medical record omission rates for all data elements (*Date of Service*, *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Revenue Code*) were greater than 10.0 percent. **Recommendations: Healthy Blue** should investigate the root cause of these findings and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness. Findings from these reviews should be shared with providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	

Follow-Up on Prior Year's Recommendations

HSAG evaluated **Healthy Blue**'s approach to addressing the recommendations and/or findings issued during the prior technical report while conducting the CY 2025 EQR activities.

Figure 6 illustrates the degree to 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 Healthy Blue



Healthy Blue-specific recommendations and follow-up assessments are summarized in Table 52.

Table 52—Assessment of Healthy Blue's Approach to Addressing Previous Annual Recommendations

Prior Recommendation	Assessment
PIPs	
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. HSAG recommended that **Healthy Blue** conduct a root cause analysis to identify opportunities to address barriers to completion of recommended immunization schedules and timely prenatal provider visits.	**Healthy Blue sufficiently addressed the recommendation. Healthy Blue** implemented a change to the Clinical Coverage Policy, which now requires CPT II codes for prenatal visits prior to payment for delivery claims. **Healthy Blue** expanded CPT II provider education to include all AMH Tiers and offered a supplemental data/electronic medical record (EMR) connectivity incentive to providers in Value-Based Programs. **Healthy Blue** described additional interventions that were implemented, such as engaging providers to secure medical records, sharing gap reports with providers, and targeting outreach to members. **Healthy Blue** did not report improvement, but identified steps it will take next year to improve hybrid medical record collection and rates.
PMV	
Healthy Blue's rates for the *CBP* and *HBD* measures were below the MY 2023 NCQA 10th percentile. HSAG recommended that **Healthy Blue** educate and consider incentive plans for providers on appropriate submission of CPT II codes for improving administrative capture of *CBP* and *HBD* results.	**Healthy Blue sufficiently addressed the recommendation. Healthy Blue** identified that a low submission rate of CPT II codes by providers is a key weakness and increases the difficulty of tracking performance accurately. **Healthy Blue** conducted provider education on code submission and reviewed scorecards during provider office hours. **Healthy Blue** implemented a supplemental data/EMR connectivity incentive.
Healthy Blue's MY 2023 *CDF* rates continued to be a challenge. HSAG recommended that **Healthy Blue** 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-	**Healthy Blue did not sufficiently address the recommendation. Healthy Blue** provided scorecards to providers, conducted office hours to review scorecard results, and included this measure in its value-based incentive program. However, these were interventions previously in place that did not result in improvements and **Healthy Blue** did not report implantation of new interventions. **Healthy Blue** noted that it identified the need to develop and

Prior Recommendation	Assessment
specific trends within the data and disseminate provider scorecards as needed.	disseminate provider educational materials and plans to do so in future years.
Compliance With Standards	
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. HSAG recommended that **Healthy Blue** 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.	**Healthy Blue sufficiently addressed the recommendation and noted improved performance. Healthy Blue** implemented an internal corrective action plan, including conducting an enhanced record review of 10 percent of the LTSS membership to identify trends and offering comprehensive refresher training. Finally, **Healthy Blue** enhanced its record review tool and increased the frequency of ongoing record reviews.
Healthy Blue failed to ensure that its member handbook met the requirements outlined in the NC Medicaid handbook template. HSAG recommended that **Healthy Blue** continue to pursue DHB approval of the member handbook and upon approval, immediately implement the approved version of the member handbook.	**Healthy Blue sufficiently addressed the recommendation. Healthy Blue** updated the member handbook and created a tracking system to ensure the most recent State templates are used.
Healthy Blue's grievance file review demonstrated inconsistent compliance with timely grievance resolution. HSAG recommended that **Healthy Blue** continue to monitor timely grievance resolutions.	**Healthy Blue sufficiently addressed the recommendation and noted improvement. Healthy Blue** conducted a root cause analysis, provided education, and held monthly meetings with grievance staff.
Optional/Additional EQR Activities	
Healthy Blue's CAHPS scores were below the 25th percentile for *Customer Service*, *Flu Vaccination Received*, and *Discussing Cessation Strategies* for the adult population. HSAG recommended that **Healthy Blue** explore what may be driving lower experience scores and develop initiatives designed to improve quality of care.	**Healthy Blue sufficiently addressed the recommendation and noted improvements. Healthy Blue** developed a tobacco cessation presentation, added it to the provider website, and continued prior interventions, such as care gap reports, scorecards, and value-based incentive programs. **Healthy Blue** also implemented live call listening to enable managers to provide timely coaching to associates.

Prior Recommendation	Assessment
Healthy Blue matched records largely contained similar values between the DHB-submitted and health plan-submitted data, except for some data elements. HSAG recommended that **Healthy Blue** should ensure the following data elements have accurate values: • Institutional encounters: *Surgical Procedure Codes* • Pharmacy encounters: *Days Supply*	**Healthy Blue sufficiently addressed the recommendation. Healthy Blue** described causes of the pharmacy encounter data elements and corrected the EDV file for a mapping issue for *Surgical Procedure Codes*. **Healthy Blue** confirmed that these codes will be reported accurately in future audits.
For the 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. HSAG recommended that **Healthy Blue** maintain the 834 file enrollment date spans within the beneficiary assignment files to demonstrate the members' current enrollment in Medicaid.	**Healthy Blue sufficiently addressed the recommendation. Healthy Blue** described its participation in workgroups with DHHS to discuss beneficiary assignment file changes. This activity has been discontinued so no further action is required for **Healthy Blue**.
For the 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. HSAG recommended that **Healthy Blue** 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.	**Healthy Blue sufficiently addressed the recommendation. Healthy Blue** described continual monitoring of provider member panels to ensure accurate assignment and engagement of assigned members. This activity has been discontinued so no further action is required for **Healthy Blue.**
For the CMPE, **Healthy Blue** did not follow the SP PCP Auto-Assignment requirements for determining the prior PCP. **Healthy Blue** indicated that it used claims history to determine the prior PCP. HSAG recommended that **Healthy Blue** update its auto-assignment logic so that it is aligned with the SP PCP auto-assignment requirements for determining the prior PCP, and work with DHB on any questions related to the requirements.	**Healthy Blue sufficiently addressed the recommendation. Healthy Blue** described its discussions with DHHS regarding improvement to the auto-assignment process as well as its plans to implement any approved changes. This activity has been discontinued so no further action is required for **Healthy Blue.**

UnitedHealthcare of North Carolina, Inc.

Detailed results from the EQR's substantive findings are summarized in Table 53 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 53—UnitedHealthcare Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)
PIPs		
+	**Strength:** For all PIPs, **UnitedHealthcare** received a *High Confidence* level for adhering to acceptable PIP methodology and *High Confidence* for overall confidence that the PIP achieved significant improvement for the *HRRN* PIP.	
−	**Weakness: UnitedHealthcare** received a *No Confidence* level rating for overall confidence that the *HEDIS CIS—Combo 10* PIP achieved significant improvement and demonstrated a decline in performance in Remeasurement 1 compared to the baseline resulting in a *No Confidence* rating. **Recommendations: UnitedHealthcare** should continually revisit its QI processes to make mid-course corrections, as needed; develop a sound method or process to evaluate the effectiveness of each individual intervention; and address the feedback that HSAG provides in the initial validation tool to receive a *High Confidence* rating. **UnitedHealthcare** should develop active, innovative interventions that have the potential for impacting the performance indicator outcomes and address the identified and prioritized barriers. **UnitedHealthcare** should not initiate and test standard operating QI actions or processes already in place as interventions for the PIP and should use PDSA cycles as part of the improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful. **UnitedHealthcare** must complete accurate statistical testing and report correct values in Step 7 of the PIP submission form and submit intervention worksheets for all interventions tested during the reported measurement period.	
PMV		
+	**Strength: UnitedHealthcare** demonstrated adequate processes in place to receive and process claims and encounters, membership enrollment, data integration, provider data, and supplemental data.	
+	**Strength: UnitedHealthcare** has extensive experience using supplemental data sources. **UnitedHealthcare** leveraged supplemental data sources to support performance measure rate reporting.	

Strength/ Weakness	Description	Domain(s)
+	**Strength: UnitedHealthcare** successfully migrated its care management system from Virtual Health Helios to Community Care without performance measure data loss or disruption.	
+	**Strength: UnitedHealthcare** increased its *Prenatal and Postpartum Care (PPC)* by 6.96 percent and 6.45 percent, respectively, from the prior year.	
−	**Weakness: UnitedHealthcare**'s rate for *Screening for Depression and Follow-Up Plan for Adults (CDF-AD)* continued to be low. **Recommendations: UnitedHealthcare** should evaluate additional data sources to capture depression screenings and interventions that will improve the frequency of depression screenings and follow-up plans.	
Compliance With Standards (Not Conducted During Reporting Cycle)		
NAV		
+	**Strength: UnitedHealthcare** established robust internal processes for inputting and maintaining provider data. These processes included thorough quality checks to validate data accuracy.	
−	**Weakness: UnitedHealthcare** did not meet full county-level compliance with time/distance standards for 13 of the 23 child provider specialty types. **Recommendations: UnitedHealthcare** should continue its recruiting and contracting efforts of eligible Medicaid providers for provider specialties that did not meet the time and distance threshold, with the goal of determining whether failure to meet the contract standard was the result of a lack of providers or an inability to contract providers in the geographic area.	
Optional/Additional EQR Activities		
+	**Strength: UnitedHealthcare**'s 2024 top-box score was statistically significantly higher than the 2023 top-box scores for one child measure, *How Well Doctors Communicate,* and none of **UnitedHealthcare**'s CAHPS scores were below the 25th percentile.	
+	**Strength: UnitedHealthcare**'s professional services encounter data omission rates for all data elements (*Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were below 10.0 percent, and the institutional services encounter data omission rates for all data elements (*Date of Service*, *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Revenue Code*) were below 10.0 percent. This indicates that the submitted records contained information that could be largely identified in the encounter data.	
+	**Strength: UnitedHealthcare**'s professional services accuracy rates for all data elements (*Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were above 90.0 percent, and the	

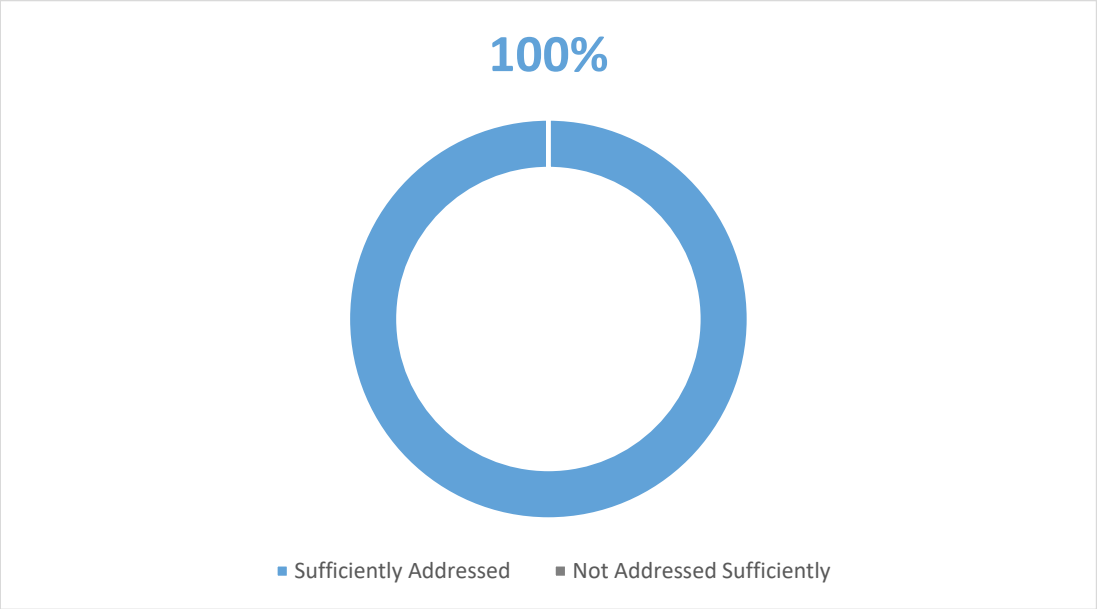
Strength/ Weakness	Description	Domain(s)
	institutional services accuracy rates for all data elements (*Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Revenue Code*) were above 90.0 percent.	
–	**Weakness: UnitedHealthcare**'s professional services medical record omission rates for all data elements (*Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were greater than 10.0 percent, and the institutional services medical record omission rates for all data elements (*Date of Service*, *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Revenue Code*) were greater than 10.0 percent. **Recommendations: UnitedHealthcare** should investigate the root cause of these findings and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness. Findings from these reviews should be shared with providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	

Follow-Up on Prior Year's Recommendations

HSAG evaluated **UnitedHealthcare**'s approach to addressing the recommendations and/or findings issued during the prior technical report while conducting the CY 2025 EQR activities.

Figure 7 illustrates the degree to 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 UnitedHealthcare



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

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

Prior Recommendation	Assessment
PMV	
UnitedHealthcare's MY 2022 rates were slightly lower than the rates for other PHPs for the *WCV*, *IMA-2*, *W30*, and *PPC* measures. HSAG recommended that **UnitedHealthcare** evaluate additional interventions that will improve access to care across impacted measures.	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** described its continuous QI process, deployed strategies to aid in overcoming identifying barriers, and noted that data reflecting claims processed through 11/22/2025 showed **UHC** had already achieved year-over-year rate improvement in *PPC*, *W30*, *WCV*, and *IMA-2*.
UnitedHealthcare's MY 2023 rates for *CDF-AD* and *CHF-CH* continued to be very low. HSAG recommended that **UnitedHealthcare** 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 scorecards as needed.	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** described conducting provider outreach and education on the use of Healthcare Common Procedure Coding System (HCPCS) codes to improve rates, collecting structured data to support numerator compliance, and developing an internal data dashboard to monitor utilization of HCPCS codes. **UnitedHealthcare** also noted that data reflecting claims processed through 11/22/2025 showed **UHC** had already achieved year-over-year rate improvement and exceeded standard plan targets in the *CDF-AD* and *CDF-CH* measures.
UnitedHealthcare's rates for the *CBP* and *HBD* measures were below the MY 2023 NCQA 10th percentile. HSAG recommended that **UnitedHealthcare** educate and consider incentive plans for providers on appropriate submission of CPT II codes for improving administrative capture of *CBP* and *HBD* results.	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** described targeting member outreach to those without recommended diabetic testing; developing provider and member incentives; and partnering with community- and faith-based organizations to promote member education and activities to support healthy lifestyle behaviors, such as cooking and nutrition classes and wellness events. **UnitedHealthcare** also noted that data reflecting claims processed through 11/22/2025 showed **UHC** had already achieved year-over-year rate improvement and exceeded standard plan targets in the *CBP* and *HBD* measures.

Prior Recommendation	Assessment
Compliance With Standards	
UnitedHealthcare's care management record review demonstrated inconsistent compliance with documenting all member needs in the care plan. HSAG recommended that **UnitedHealthcare** continue oversight and monitoring to ensure all identified member needs are included in the member care plan.	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** implemented extensive training sessions, offered additional office hours, and conducted thorough audits to strengthen and improve the documentation process. **UnitedHealthcare** reported improved documentation practices and generated more positive feedback for its clinical team.
UnitedHealthcare failed to ensure that its member handbook met the requirements outlined in the NC Medicaid handbook template. HSAG recommended that **UnitedHealthcare** continue to pursue DHB's approval of the member handbook and upon approval, immediately implement the approved version of the member handbook.	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** updated its member handbook and implemented a process for reviewing all new and updated regulatory requirements.
UnitedHealthcare was unable to demonstrate compliance with advance directive requirements. The health plan's remediation included implementation of an advance directive policy and a 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. HSAG recommended that **UnitedHealthcare** ensure all member-facing operational areas of the health plan use and are trained on the advance directive policy and procedure.	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** revised its policy, trained all staff on the new procedure, and assured all staff will receive ongoing training.
Optional/Additional EQR Activities	
UnitedHealthcare's CAHPS scores were below the 25th percentile for *Customer Service*, *Flu Vaccination Received*, and *Discussing Cessation Strategies* for the adult population. HSAG recommended that **UnitedHealthcare** explore what may be driving lower experience scores and develop initiatives designed to improve quality of care.	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** noted that only a small percentage of its overall population completed the CAHPS survey, identified other causes of low rates, noted that more responses are being received, and reported improvement in CAHPS scores. **UnitedHealthcare** reviewed respondent-level details to identify themes in responses; used quarterly Advisory Committee meetings to gather additional feedback from members; and reviewed results from plan-fielded through Net Promoter Score surveys to continually monitor and enhance member experiences across all interactions with a **UHC** representative.

Prior Recommendation	Assessment
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. HSAG recommended that **UnitedHealthcare** explore what may be driving lower experience scores and develop initiatives designed to improve quality of care.	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** noted that only a small percentage of its overall population completed the CAHPS survey, reported improvement in CAHPS scores, and noted that more responses are being received. **UnitedHealthcare** reviewed respondent-level details to identify themes in responses; used quarterly Advisory Committee meetings to gather additional feedback from members; and reviewed results from plan-fielded through Net Promoter Score surveys to continually monitor and enhance member experiences across all interactions with a **UHC** representative.
UnitedHealthcare's 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. HSAG recommended that **UnitedHealthcare** ensure records are submitted completely.	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** identified an extract issue that accounted for the finding and corrected its extract criteria.
UnitedHealthcare's encounter element omission rates were low for most, but not all, data elements between the DHB-submitted and health plan-submitted data. HSAG recommended that **UnitedHealthcare** ensure data elements for the *Detail Service From Date* and *Detail Service To Date* institutional encounters are submitted completely.	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** adjusted its extract process to HSAG and will include both detail line from date and detail line to date for future EDV audits.
Matched records largely contained similar values between the DHB-submitted and health plan-submitted data, except for some data elements. HSAG recommended that **UnitedHealthcare** 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*	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** corrected its mapping process for extracting records from a BASIS data warehouse.
For the CMPE, **UnitedHealthcare**'s daily incremental beneficiary assignment file included maintenance codes to denote active, terminating, and newly assigned members. **UnitedHealthcare**'s weekly full beneficiary	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** completed a project to incorporate several codes into the full weekly beneficiary file. This activity has been

Prior Recommendation	Assessment
assignment file indicated the final assignment of members for the given week, but did not denote active, terminating, and newly assigned members. HSAG recommended that **UnitedHealthcare** update its weekly full beneficiary assignment file to include the appropriate maintenance codes to communicate the assignment status of members.	discontinued so no further action is required for **UnitedHealthcare**.
For the CMPE, **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. HSAG recommended that **UnitedHealthcare** 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.	**UnitedHealthcare sufficiently addressed the recommendation. UnitedHealthcare** launched a project to update logic to only review 18 months of data. This update will reduce the amount of history used to assign members. This activity has been discontinued so no further action is required for **UnitedHealthcare**.

WellCare 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 **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 55—WellCare Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)
PIPs		
	**Strength:** For all PIPs, **WellCare** received a *High Confidence* level for adhering to acceptable PIP methodology and *High Confidence* for overall confidence that the PIP achieved significant improvement for the *HRRN* PIP.	
	**Weakness: WellCare** received a *No Confidence* level rating for overall confidence that the *HEDIS PPC* PIP and *HEDIS GSD* PIP achieved significant improvement and demonstrated a decline in performance in Remeasurement 1 (for at least one indicator) compared to the baseline resulting in a *No Confidence* rating.	

Strength/ Weakness	Description	Domain(s)
	Recommendations: WellCare should continually revisit its QI processes to make mid-course corrections, as needed; develop a sound method or process to evaluate the effectiveness of each individual intervention; and address the feedback that HSAG provides in the initial validation tool to receive a *High Confidence* rating. **WellCare** should develop active, innovative interventions that have the potential for impacting the performance indicator outcomes and address the identified and prioritized barriers. **WellCare** should not initiate and test standard operating QI actions or processes already in place as interventions for the PIP and should use PDSA cycles as part of the improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful. **WellCare** must complete accurate statistical testing and report correct values in Step 7 of the PIP submission form and submit intervention worksheets for all interventions tested during the reported measurement period.	
PMV		
+	**Strength: WellCare**'s claims adjudication and encounter processing are highly automated, with a reported auto-adjudication rate of 92.60 percent, supporting efficiency and accuracy in claims management.	
+	**Strength: WellCare** maintained thorough documentation for all programs and reports related to performance measure reporting, following a structured software development life cycle (SDLC).	
+	**Strength: WellCare** demonstrated improvement in compliance with the PPC measure, achieving a 12.70 percent increase for *Prenatal Care* and a 5.85 percent increase for *Postpartum Care*.	
−	**Weakness: WellCare**'s unsuccessful outreach attempts for HRRN SDOH screenings were not visible within individual member records in front-end systems, limiting care team awareness of SDOH screening status. **Recommendations: WellCare** should integrate backend outreach data into member profiles to provide care managers with a complete view of engagement efforts, improving follow-up and member support.	
−	**Weakness: WellCare** received monthly extracts from the NC Health Information Exchange Authority (HIEA), but data quality issues prevent the use of extracts for performance measure submission and comprehensive quality audits. **Recommendations: WellCare** should collaborate with NC HIEA and participating providers to improve data validation processes and expand usable data streams, enhancing the value of supplemental data for performance measurement.	

Strength/ Weakness	Description	Domain(s)
Compliance With Standards (Not Conducted During Reporting Cycle)		
NAV		
+	**Strength: WellCare** demonstrated robust processes in place to ensure oversight of the provider network and compliance with the standards. Through weekly feedback sessions between the NAV Reporting team and Provider Contracting team as well as weekly monitoring of the provider network and constant contracting outreach efforts, **WellCare** was able to proactively target gaps. All efforts to address gaps were monitored via a tracker and reported to all relevant departments and the plan CEO.	
−	**Weakness: WellCare** did not meet full county-level compliance with time/distance standards for 13 of the 23 child provider specialty types. **Recommendations: WellCare** should continue its recruiting and contracting efforts of eligible Medicaid providers for provider specialties that did not meet the time and distance threshold, with the goal of determining whether failure to meet the contract standard was the result of a lack of providers or an inability to contract providers in the geographic area.	
Optional/Additional EQR Activities		
+	**Strength: WellCare**'s 2024 top-box score was statistically significantly higher than the 2023 top-box scores for one child measure, *Getting Care Quickly*.	
+	**Strength: WellCare**'s professional services encounter data omission rates for all data elements (*Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were below 10.0 percent, and the institutional services encounter data omission rates for all data elements (*Date of Service*, *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Revenue Code*) were below 10.0 percent. This indicates that the submitted records contained information that could be largely identified in the encounter data.	
+	**Strength: WellCare**'s professional services accuracy rates for all data elements (*Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were above 90.0 percent, and the institutional services accuracy rates for all data elements (*Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Revenue Code*) were above 90.0 percent.	
−	**Weakness: WellCare**'s CAHPS scores were below the 25th percentile for the adult measures of *Rating of Health Plan.* **WellCare**'s CAHPS 2024 top-box score was statistically significantly lower than the 2023 top-box score for one adult measure, *Rating of All Health Care*. **Recommendations: WellCare** should explore drivers of what may be impacting lower experience scores and develop initiatives designed to	

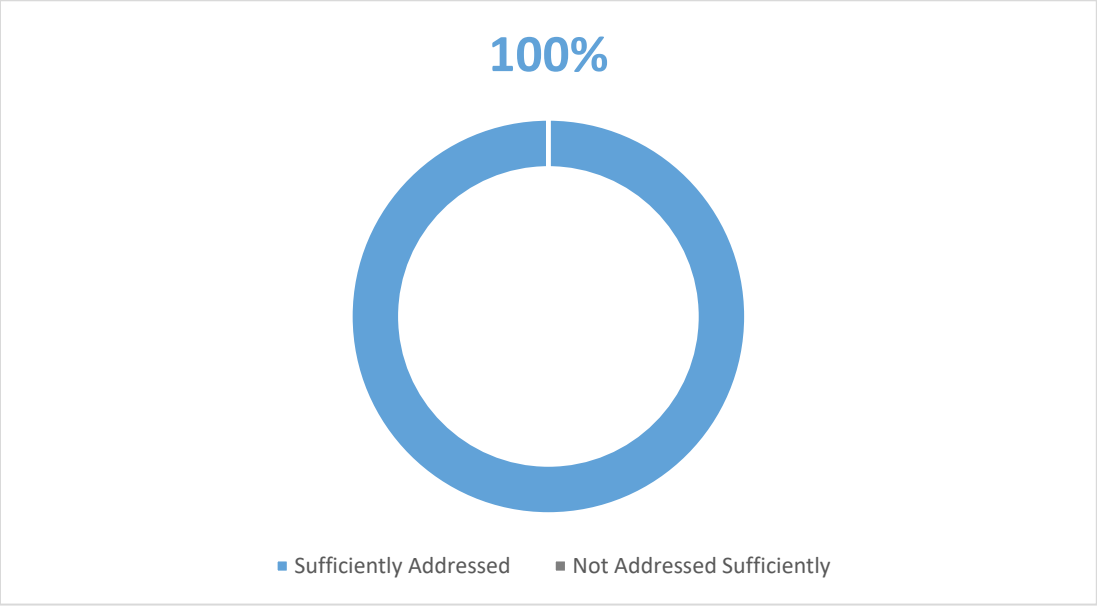
Strength/ Weakness	Description	Domain(s)
	improve quality of care. In addition, obtaining direct patient feedback from members could be used to drill down into areas that need improvement.	
–	**Weakness: WellCare**'s professional services medical record omission rates for all data elements (*Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were greater than 10.0 percent, and the institutional services medical record omission rates for all data elements (*Date of Service*, *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Revenue Code*) were greater than 10.0 percent. **Recommendations: WellCare** should investigate the root cause of these findings and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness. Findings from these reviews should be shared with providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	

Follow-Up on Prior Year's Recommendations

HSAG evaluated **WellCare**'s approach to addressing the recommendations and/or findings issued during the prior technical report while conducting the CY 2025 EQR activities.

Figure 8 illustrates the degree to which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

Figure 8—Percentage of Prior EQR Recommendations Addressed by WellCare



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

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

Prior Recommendation	Assessment
PIPs	
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. HSAG recommended that **WellCare** 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.	**WellCare sufficiently addressed the recommendation. WellCare** conducted root cause analyses, partnered with providers to host community vaccine events, and launched phone outreach to close gaps. For the PPC *HEDIS PIP*, **WellCare** conducted focused engagement and chart reviews with low-performing practices to improve rates, published a QR code for self-screening, offered screenings at community events, sent outreach letters, and embedded care engagement specialists in workflows to complete screenings and referrals during care gap calls. **WellCare** noted slight improvements for both PIPs.
PMV	
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. HSAG recommended that **WellCare** continue to monitor and address opportunities to improve and find efficiencies in the claims audit process to consistently meet departmental goals.	**WellCare sufficiently addressed the recommendation. WellCare** implemented enhanced internal controls to ensure contract deviations are configured correctly, increased user acceptance testing, added post-production validation, introduced system trackers to identify configuration issues early, and established continuous monitoring of denials and rejections to detect potential issues before provider escalation.
In MY 2022, **WellCare**'s data completeness for claims was 83.8 percent after a 90-day runout period. HSAG recommended that **WellCare** 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.	**WellCare sufficiently addressed the recommendation. WellCare** implemented targeted provider education on proper billing protocols through virtual claims clinics and regional on-site events, and developed toolkits and real-time support to assist providers in reducing errors and improving data submission accuracy. **WellCare** reported that denial and rejection rates have decreased from approximately 25 percent in 2022 to around 10 percent in 2024–2025.
WellCare's MY 2023 rates for *CDF-AD* and *CHF-CH* were very low, although in line with its cohorts. HSAG recommended that **WellCare** evaluate additional interventions that will improve the	**WellCare sufficiently addressed the recommendation. WellCare** implemented multiple initiatives, including developing provider education materials, conducting

Prior Recommendation	Assessment
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 scorecards as needed.	provider education during weekly webinars, and initiating data analysis to identify provider-specific trends and opportunities for improvement. **WellCare** reported that an initial review of post-intervention data showed early improvement in documented depression screenings and follow-up plans among Medicaid providers who received targeted education and reminders.
WellCare's rates for the *CBP* and *HBD* measures were below the MY 2023 NCQA 10th percentile. HSAG recommended that **WellCare** educate and consider incentive plans for providers on appropriate submission of CPT II codes for improving administrative capture of *CBP* and *HBD* results.	**WellCare sufficiently addressed the recommendation. WellCare** implemented provider education initiatives focused on the importance of CPT II code submission for *CBP* and *HBD* measures. **WellCare** observed improvements in CPT II code submission rates for *CBP* by 8 percent and *HBD* by 6 percent.
Compliance With Standards	
WellCare's care management record review demonstrated inconsistent compliance with documenting all member needs in the care plan. HSAG recommended that **WellCare** 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 the member is experiencing a transition of care.	**WellCare sufficiently addressed the recommendation. WellCare** provided its care team with enhanced training related to care planning and partnered with technology to enhance care plan development by linking care plans directly to member assessments. **WellCare** also enhanced its internal audit tool to ensure all staff are held accountable to performance metrics and noted improved audit scores.
WellCare failed to ensure that its member handbook met the requirements outlined in the NC Medicaid handbook template. HSAG recommended that **WellCare** continue to pursue DHB approval of the member handbook and upon approval, immediately implement the approved version of the member handbook.	**WellCare sufficiently addressed the recommendation. WellCare** aligned processes to fully adhere to contractual requirements and State guidelines, and noted that its member handbook process is now clearly documented with defined roles and review checkpoints involving both health plan and corporate teams to ensure compliance.
Additional EQR Activities	
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. HSAG recommended that **WellCare** explore what may be driving lower experience scores and develop initiatives designed to improve quality of care.	**WellCare sufficiently addressed the recommendation. WellCare** enhanced customer service training, shifted toward a more member experience-driven approach to create more personable and supportive conversations, established a feedback loop with members during Advisory Committee meetings, and surveyed members to identify

Prior Recommendation	Assessment
	what matters most in their care experiences. **WellCare** plans to use these insights to inform targeted communications and outreach efforts. **WellCare** also implemented several initiatives to improve child flu vaccination rates.
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. HSAG recommended that **WellCare** ensure records are submitted completely.	**WellCare sufficiently addressed the recommendation. WellCare** attended kick-off sessions hosted by DHB and HSAG prior to an audit to clarify intent and instructions. **WellCare** executed subsequent data validation requests more easily by outreaching to the contacts made available by DHB and HSAG for clarifying questions related to data collection.
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. HSAG recommended that **WellCare** ensure the *Secondary Diagnosis Codes* data element for institutional encounters is submitted completely.	**WellCare sufficiently addressed the recommendation. WellCare** worked closely with the State during the implementation of new encounter data indicators in which both the health plan and the State reviewed and provided feedback to each other if data anomalies were identified. **WellCare** reported fewer tickets around issues involving encounter data.
Matched records largely contained similar values between the DHB-submitted and health plan-submitted data, except for some data elements. HSAG recommended that **WellCare** 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*	**WellCare sufficiently addressed the recommendation. WellCare** reviewed data mapping for encounter submissions to confirm appropriate data fields were aligned with the requirements. **WellCare** worked with its new pharmacy vendor to ensure all data mappings were aligned with National Council for Prescription Drug Programs (NCPDP) requirements. **WellCare** reported there have been no further issues.
For the 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 reassignment if members were assigned to providers who did not update their preference to stop accepting new patients. HSAG recommended that **WellCare** set an internal default limit to trigger a review and notification to providers to ensure they are updating their accepting new patient indicator.	**WellCare sufficiently addressed the recommendation. WellCare** added new attribute fields and completed logic updates that were needed. **WellCare** set the provider panel size limit, which is reflected in the PCP auto-assignment limits, and updated the provider panel questions on the provider enrollment form. This activity has been discontinued so no further action is required for **WellCare**.

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

Strength/ Weakness	Description	Domain(s)
PIPs		
+	**Strength:** For both clinical PIPs, **Alliance** received a *High Confidence* level for adhering to acceptable PIP methodology and for overall confidence that the PIP achieved significant improvement.	
PMV		
+	**Strength: Alliance** established robust auditing and monitoring practices related to claims, encounters, and impact reporting. Detailed workflows related to auditing and monitoring were found within operational procedures shared with HSAG.	
+	**Strength: Alliance** demonstrated its commitment to ensuring completion of the HRRN assessment within the allotted time frames for the measure. **Alliance** demonstrated accurate documentation of contact attempts and assessment responses within its Jiva platform. Appropriate internal auditing and monitoring practices were in place.	
−	**Weakness: Alliance** used manual processes within some of its workflows, including merging two Medicaid IDs assigned to the same person and populating data within State reports. **Recommendations: Alliance** should review current manual processes throughout workflows and work toward automating those processes. Manual processes allow for human error and the potential to inadvertently manipulate data components.	
−	**Weakness:** During HSAG's review of the member-level file detail, **Alliance** reported for the *FUM* measure the date of the ED discharge as the date the member was discharged from a hospital subunit. **Alliance** explained that when a member is stabilized in the ED and an attempt to transfer to an inpatient mental health facility is unsuccessful, the member is moved from the ED to a subunit for an extended time period. According to the ED Value Set, the *FUM* measure specifications require an ED visit to identify member eligibility for *FUM* measure reporting. Although **Alliance** appropriately coded the ED visit, the member's stay in the subunit reflected an unspecified visit setting code that did not align with the ED Value Set required in the measure specifications to satisfy the ED event.	

Strength/ Weakness	Description	Domain(s)
	Recommendations: Alliance should continue to work with Inovalon to identify ED events and ensure the logic used to determine the discharge date aligns with the HEDIS *FUM* measure specifications.	
−	**Weakness: Alliance**'s reported rate was the lowest performing for *Follow-Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder (ADHD) Medication (ADD)—Initiation Phase*. **Recommendations:** HSAG recommends that **Alliance** evaluate opportunities to enhance its outreach provided to parents to educate and assist with scheduling follow-up appointments to monitor the effectiveness and side effects of ADHD medication.	
Compliance With Standards		
+	**Strength: Alliance**'s policies and procedures were generally compliant with contract requirements. Interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
−	**Weakness: Alliance** demonstrated an opportunity for improvement related to care management requirements assessed in the file review. **Recommendations: Alliance** should ensure compliance with the care management requirements outlined in the PIHP contract, including timely completion of screenings, assessments and care plans for members, and more robust care planning.	
−	**Weakness: Alliance** maintained a peer-to-peer and reconsideration process that was inconsistent with the Medicaid managed care rule. **Recommendations: Alliance** should ensure that its peer-to-peer procedures meet federal requirements.	
NAV		
+	**Strength: Alliance** demonstrated robust policies and procedures to ensure the accuracy of network adequacy indicator calculations, monitoring, and reporting metrics. These processes included thorough quality checks to validate data accuracy.	
−	**Weakness: Alliance** manually populated PRV reports using a single staff member, which introduced a risk of human error. **Recommendations: Alliance** should implement automated population and/or add verification and validation steps by multiple staff members or departments to ensure data accuracy.	
−	**Weakness:** The review of Quest parameters submitted for network adequacy calculations revealed **Alliance** applied adjusted standards that did not align with contractual requirements. DHB confirmed that for the audit period, no global exceptions or adjustments were approved; therefore, the calculations should have adhered strictly to contractual standards.	

Strength/ Weakness	Description	Domain(s)
	Recommendations: Alliance should work closely with DHB to verify the accuracy of parameters used in network adequacy calculations. Additionally, **Alliance** should implement a process to ensure Quest templates are promptly updated upon the date of expiration indicated in DHB's notification to reflect contractual standards whenever global exceptions/adjustments are not issued by DHB.	
−	**Weakness: Alliance** did not achieve full compliance with county-level time/distance or other required access standards across multiple service types, including 13 of the 23 child specialty provider types and six of the 17 BH non-time/distance service types. **Recommendations: Alliance** should continue strengthening its recruiting and contracting efforts to add eligible Medicaid providers in all service type areas that did not meet the required access standards. **Alliance** should also collaborate with DHB to request exceptions, when appropriate, to help determine whether noncompliance stems from an insufficient provider supply or challenges in contracting with providers within the geographic region.	
Optional/Additional EQR Activities		
+	**Alliance** demonstrated its capability to collect, process, and transmit encounter data to DHB, as well as develop data review and correction processes that can promptly respond to quality issues DHB identified.	
−	**Weakness: Alliance** reported that it was satisfied with the data quality checks its subcontractors performed and did not conduct additional reviews prior to submission to DHB for its pharmacy, vision, and durable medical equipment (DME) subcontractors. **Recommendations: Alliance** should explore the possibility of constructing or improving monitoring reports to assess the accuracy, completeness, and/or timeliness of encounter data submitted by these subcontractors.	
−	**Weakness:** Although **Alliance** had processes in place to reconcile transactions that were initially rejected due to either DHB's EDI translator or DHB-specific edits, **Alliance** reported that a high percentage of encounters remained unaccepted after initial rejection. **Recommendations: Alliance** should strengthen its efforts to ensure that all rejected transactions are accurately corrected and resubmitted in a timely manner.	
−	**Weakness: Alliance** did not demonstrate the use of claim type-specific processes to detect duplicated encounters prior to submitting data to DHB. **Recommendations: Alliance** should consider enhancing its duplicate detection approach by incorporating data fields tailored to each encounter type.	

Follow-Up on Prior Year's Recommendations

There were no health plan-specific weaknesses identified from the prior year's EQR activities; therefore, no recommendations were suggested. HSAG will evaluate **Alliance**'s approach to addressing the recommendations and/or findings issued during this reporting cycle in the next technical report.

Partners Health Management

Detailed results from the EQR's substantive findings of **Partners** are summarized in Table 58 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 58—Partners Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)
PIPs		
+	**Strength:** For both clinical PIPs, **Partners** received a *High Confidence* level for adhering to acceptable PIP methodology. For the *FUH* PIP, **Partners** received *High Confidence* for overall confidence that the PIP achieved significant improvement	
PMV		
+	**Strength: Partners**' collaboration with Pyx Health allowed members to access the required care needs screenings digitally and reported high engagement from membership. Providing access to digital tools allowed members to complete assessments and engage with supports at times that are convenient, improving capture rate and ensuring compliance with the *HRRN* measure required by the State.	
−	**Weakness: Partners** had limited capability to visualize data metrics in real time. Access to search for specific data from large data sets within the data warehouse was limited to ad hoc reports built by the IT team. **Recommendations:** HSAG recommends that **Partners**' programming staff prioritize building data visualization tools, such as Power BI, to monitor performance and serve as an additional validation check for performance measure rates produced by CareSeed. For data that are deposited directly into the data warehouse, additional reporting and visualization tools would allow for real-time access and readability of specific data related to performance measure reporting, such as retrieval of pharmacy data from large data sets for specific populations or time periods.	
−	**Weakness: Partners** reported that it does not currently use supplemental data sources, as its systems are not equipped to ingest non-standard file formats. Supplemental data could improve performance measure reporting and reflect more accurate performance. **Recommendations:** HSAG recommends that **Partners**' programming staff prioritize finding methods to convert non-standard file types so that supplemental data can be used for performance measure reporting.	

Strength/ Weakness	Description	Domain(s)
−	**Weakness: Partners**' rate for the 65+ age stratification for the *FUH* measure was lower than the 6–17 and 18–64 age stratifications. A low rate for the 65+ age stratification for the *FUH* measure is a trend among all North Carolina PIHPs and is indicative of a statewide gap in care for the 65+ population. **Recommendations:** HSAG recommends that **Partners** explore implementation of additional protocols to ensure members are reached for follow-up care. Some examples might include leveraging additional staff members to conduct member outreach by phone or e-mail to schedule appointments, providing information about resources to assist members with transportation to their appointments, or providing counseling to members to communicate the importance of follow-up.	
Compliance With Standards		
+	**Strength: Partners**' policies and procedures were generally compliant with contract requirements. Interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
−	**Weakness: Partners** demonstrated an opportunity for improvement related to care management requirements assessed in the file review. **Recommendations: Partners** should ensure compliance with the care management requirements outlined in the PIHP contract, including timely completion of screenings, assessments and care plans for members, and more robust care planning.	
−	**Weakness: Partners** maintained a peer-to-peer and reconsideration process that was inconsistent with the Medicaid managed care rule. **Recommendations: Partners** should ensure that its peer-to-peer procedures meet federal requirements.	
−	**Weakness: Partners** was unable to demonstrate compliance with all requirements for the availability of member materials. **Recommendations: Partners** should develop a procedure to ensure that paper materials are sent within five business days upon a member's request.	
NAV		
+	**Strength: Partners** demonstrated robust policies and procedures to ensure accurate calculation, monitoring, and reporting of network adequacy indicators. These processes included comprehensive quality checks performed by both **Partners** staff and IBH Analytics to validate data accuracy.	
−	**Weakness:** The review of IBH Analytics parameters submitted for network adequacy calculations revealed that **Partners** applied adjusted standards that did not align with contractual requirements. DHB	

Strength/ Weakness	Description	Domain(s)
	confirmed that for the audit period, no global exceptions or adjustments were approved; therefore, the calculations should have adhered strictly to contractual standards. **Recommendations:** HSAG recommends that **Partners** work closely with DHB to verify the accuracy of parameters used in network adequacy calculations. Additionally, **Partners** should implement a process to ensure IBH Analytics templates are promptly updated upon the date of expiration indicated in DHB's notification to reflect contractual standards whenever global exceptions/adjustments are not issued by DHB.	
−	**Weakness: Partners** did not achieve full compliance with county-level time/distance or other required access standards across multiple service types, including seven of the 23 child specialty provider types, one of the four LTSS service types, and six of the 17 BH non-time/distance service types. **Recommendations:** HSAG recommends that **Partners** continue strengthening its recruiting and contracting efforts to add eligible Medicaid providers in all service type areas that did not meet the required access standards. **Partners** should also collaborate with DHB to request exceptions, when appropriate, to help determine whether noncompliance stems from an insufficient provider supply or challenges in contracting with providers within the geographic region.	
Optional/Additional EQR Activities		
+	**Strength: Partners** demonstrated its capability to collect, process, and transmit encounter data to DHB, as well as develop data review and correction processes that can promptly respond to quality issues DHB identified.	
−	**Weakness: Partners** indicated that it did not store any of its subcontractor data. **Recommendations: Partners** should consider storing subcontractor data to support data quality assurance by ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare oversight and accountability.	
−	**Weakness: Partners** reported that it was satisfied with the data quality checks its subcontractors performed and did not conduct additional reviews prior to submission to DHB for its pharmacy, vision, and non-emergency medical transportation (NEMT) subcontractors. **Recommendations: Partners** should explore the possibility of constructing or improving monitoring reports to assess the accuracy, completeness, and/or timeliness of encounter data submitted by these subcontractors.	

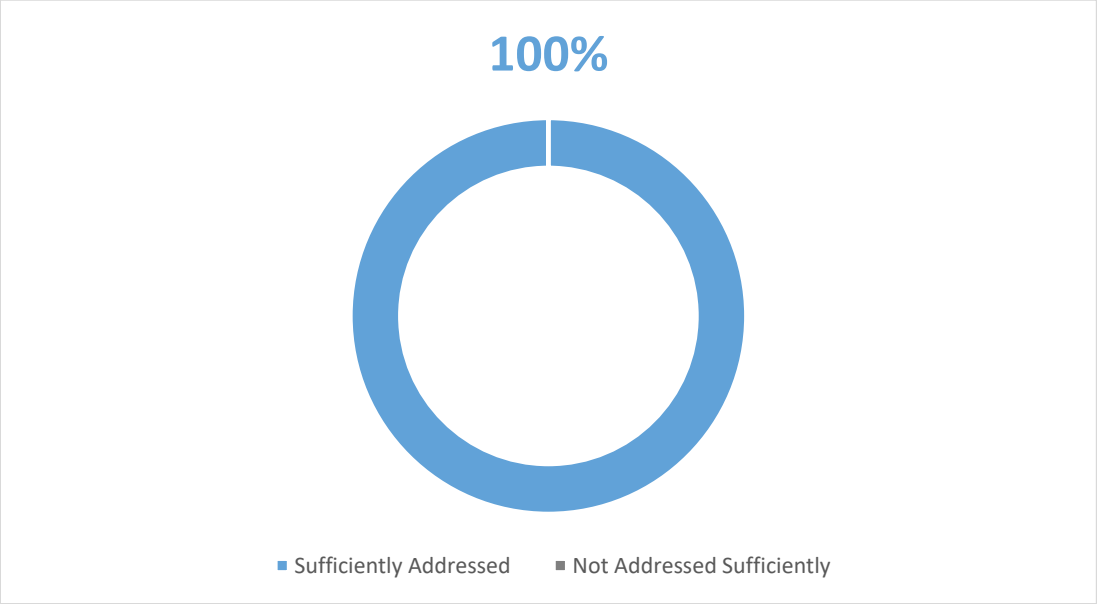
Strength/ Weakness	Description	Domain(s)
−	**Weakness:** Although **Partners** had processes in place to reconcile transactions that were initially rejected due to either DHB's EDI translator or DHB-specific edits, **Partners** reported that a high percentage of encounters remained unaccepted after initial rejection. **Recommendations: Partners** should strengthen its efforts to ensure that all rejected transactions are accurately corrected and resubmitted in a timely manner.	
−	**Weakness: Partners** did not demonstrate the use of claim type-specific processes to detect duplicated encounters prior to submitting data to DHB. **Recommendations: Partners** should consider enhancing its duplicate detection approach by incorporating data fields tailored to each encounter type.	

Follow-Up on Prior Year's Recommendations

HSAG evaluated **Partners**' approach to addressing the recommendations and/or findings issued during the prior technical report while conducting the CY 2025 EQR activities.

Figure 9 illustrates the degree to which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

Figure 9—Percentage of Prior EQR Recommendations Addressed by Partners



Partners-specific recommendations and follow-up assessments are summarized in Table 59.

Table 59—Assessment of Partners' Approach to Addressing Previous Annual Recommendations

Prior Recommendation	Assessment
PMV	
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 that **Partners** implement a system to match paper assessments to case managers by appointment to detect what is not entered in TruCare by the case managers.	**Partners sufficiently addressed the recommendation. Partners** revised its assessment, including enhancing options of responses. The health plan also confirmed that all assessments are completed in its care management platform.

Trillium Health Resources

Detailed results from the EQR's substantive findings of **Trillium** are summarized in Table 60 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 60—Trillium Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)
PIPs		
+	**Strength:** For both clinical PIPs, **Trillium** received a *High Confidence* level for adhering to acceptable PIP methodology. For the *FUM* PIP, **Partners** received *High Confidence* for overall confidence that the PIP achieved significant improvement.	
PMV		
+	**Strength: Trillium**'s claim auto-adjudication rate was greater than 99 percent. **Trillium** performed quality audits on 100 percent of all manual claims to ensure accuracy.	
+	**Strength: Trillium** enhanced its Care Management platform and transitioned to using 834 files as the source of truth, corroborating its strength regarding planned enhancements.	
−	**Weakness: Trillium r**eported that it does not use supplemental data sources. Supplemental data would improve performance measure reporting and reflect more accurate performance. **Recommendations:** HSAG suggests that **Trillium** work with the State to obtain and use supplemental data that can be used for performance measure reporting.	
−	**Weakness: Trillium** had multiple versions of the Rate Review Template due to its use of only administrative data for all measures and formatting concerns. The collection method for *ADD* and *APM* was defined in the template as "electronic clinical data systems." This caused some confusion about which required fields were to be populated. The formatting concerns were due to the calculation of the rates not rounding to two decimal places. **Recommendations:** In order to more effectively meet the state-provided deadlines, HSAG recommends additional internal review prior to submission.	
−	**Weakness: Trillium**'s reported rates for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* and *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up* measures were outliers compared to the other PIHPs.	

Strength/ Weakness	Description	Domain(s)
	Recommendations: HSAG recommends that **Trillium** track members' self-reported barriers to receiving follow-up care to ensure member-centric interventions, such as enhancing member awareness of available resources (e.g., transportation or follow-up appointment reminders), are implemented accordingly.	
−	**Weakness: Trillium**'s reported rates were the lowest performing among the PIHPs for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure. **Recommendations:** HSAG recommends that **Trillium** enhance its ability to promptly identify members who are prescribed antipsychotic medications and assist with scheduling diabetes screening with their provider. This may include identification of additional data sources to allow prompt identification of members' prescriptions.	
−	**Weakness: Trillium**'s reported rates for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure were outliers compared to the other PIHPs. **Recommendations:** HSAG recommends that **Trillium** evaluate its ability to improve outreach to parents to provide education on the importance of metabolic testing and assist in coordinating with providers to complete needed testing.	
Compliance With Standards		
+	**Strength: Trillium**'s policies and procedures were generally compliant with contract requirements. Interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
−	**Weakness: Trillium** demonstrated an opportunity for improvement related to care management requirements assessed in the file review. **Recommendations: Trillium** should ensure compliance with the care management requirements outlined in the Medicaid Direct contract, including more robust care planning.	
−	**Weakness: Trillium** maintained a peer-to-peer and reconsideration process that was inconsistent with the Medicaid managed care rule. **Recommendations: Trillium** should ensure that its peer-to-peer procedures meet federal requirements.	
NAV		
+	**Strength: Trillium** demonstrated robust policies and procedures to ensure the accuracy of network adequacy indicator calculations, monitoring, and reporting metrics. These processes included thorough quality checks to validate data accuracy.	

Strength/ Weakness	Description	Domain(s)
+	**Strength: Trillium** demonstrated a strong commitment to provider data accuracy by incorporating a validation tool within its TBS system, enabling staff to efficiently verify provider information against the data submitted in the PEF by DHHS.	
−	**Weakness: Trillium** reported using the 2023 global adjustments provided by DHB due to a delay in receipt of global adjustments, which were not in alignment with the standard contractual requirements. DHB confirmed that for the audit period, no global exceptions or adjustments were approved; therefore, the calculations should have adhered strictly to contractual standards. **Recommendations: Trillium** should work closely with DHB to verify the accuracy of parameters used in network adequacy calculations. Additionally, **Trillium** should implement a process to ensure Quest templates are promptly updated upon the date of expiration indicated in DHB's notification to reflect contractual standards whenever global exceptions/adjustments are not issued by DHB.	
−	**Weakness: Trillium** did not achieve full compliance with county-level time/distance or other required access standards across multiple service types, including 12 of the 23 child specialty provider types, four of the seven BH provider types, two of the four LTSS service types, and one of the BH non-time/distance service types. **Recommendations: Trillium** should continue strengthening its recruiting and contracting efforts to add eligible Medicaid providers in all service type areas that did not meet the required access standards. **Trillium** should also collaborate with DHB to request exceptions, when appropriate, to help determine whether noncompliance stems from an insufficient provider supply or challenges in contracting with providers within the geographic region.	
Optional/Additional EQR Activities		
+	**Trillium** demonstrated its capability to collect, process, and transmit encounter data to DHB, as well as develop data review and correction processes that can promptly respond to quality issues DHB identified.	
−	**Weakness: Trillium** reported that it was satisfied with the data quality checks its subcontractors performed and did not conduct additional reviews prior to submission to DHB for its pharmacy, vision, and NEMT subcontractors. **Recommendations: Trillium** should explore the possibility of constructing or improving monitoring reports to assess the accuracy, completeness, and/or timeliness of encounter data submitted by these subcontractors.	

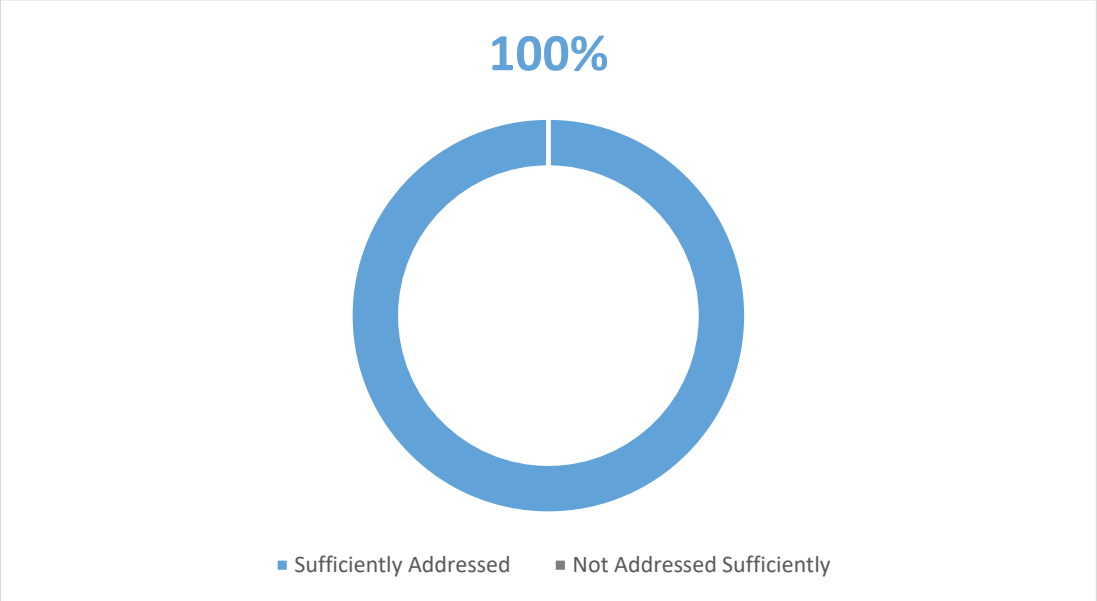
Strength/ Weakness	Description	Domain(s)
−	**Weakness:** Although **Trillium** had processes in place to reconcile transactions that were initially rejected due to either DHB's EDI translator or DHB-specific edits, **Trillium** reported that a high percentage of encounters remained unaccepted after initial rejection. **Recommendations: Trillium** should strengthen its efforts to ensure that all rejected transactions are accurately corrected and resubmitted in a timely manner.	
−	**Weakness: Trillium** reported conducting only two quality checks for claims and encounters stored in its data warehouses. **Recommendations: Trillium** should consider expanding its quality monitoring efforts through the development of additional reports assessing data accuracy, completeness, and/or timeliness of these claims/encounters.	

Follow-Up on Prior Year's Recommendations

HSAG evaluated **Trillium**'s approach to addressing the recommendations and/or findings issued during the prior technical report while conducting the CY 2025 EQR activities.

Figure 10 illustrates the degree to which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

Figure 10—Percentage of Prior EQR Recommendations Addressed by Trillium



Trillium-specific recommendations and follow-up assessments are summarized in Table 61.

Table 61—Assessment of Trillium' Approach to Addressing Previous Annual Recommendations

Prior Recommendation	Assessment
PMV	
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. HSAG recommended **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.	**Trillium sufficiently addressed the recommendation. Trillium** implemented HSAG's recommendations so that when third-party insurance is submitted in **Trillium**'s provider portal, specialists validate the information submitted in the third-party vendor portal before approving the submission. **Trillium** reported that its third-party liability checks ensure data ingested into its business system are accurate and complete.
During the virtual review, **Trillium** described its care management process for completing the care management comprehensive assessment 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 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. HSAG recommended that **Trillium** implement system response requirements before assessments can be finalized.	**Trillium sufficiently addressed the recommendation. Trillium** described the development of a report to monitor and manage assessment completion, development of an automated supervisor notification process, and additional strategies it plans to implement.

Vaya Health

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

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

Strength/ Weakness	Description	Domain(s)
PIPs		
+	**Strength:** For the *HRRN* PIP, **Vaya** received a *High Confidence* level for adhering to acceptable PIP methodology.	
−	**Weakness: Vaya** received a *No Confidence* level rating for overall confidence that the *FUH* PIP and *FUM* PIP achieved significant improvement and demonstrated a decline in performance in Remeasurement 1 (for at least one indicator) compared to the baseline resulting in a *No Confidence* rating. **Vaya** utilized the same interventions for both *FUH* and *FUM* PIPs. **Recommendations: Vaya** should implement measure specific interventions for each PIP topic based on the unique barriers identified for each measure. **Vaya** should continually revisit its QI processes to make mid-course corrections, as needed, and develop active, innovative interventions that have the potential for impacting the performance indicator outcomes and address the identified and prioritized barriers. **Vaya** should not initiate and test standard operating QI actions or processes already in place as interventions for the PIP. **Vaya** should use PDSA cycles as part of the improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful. In addition, **Vaya** should implement measure specific interventions for each PIP topic based on the unique barriers identified for each measure and develop a sound method or process to evaluate the effectiveness of each individual intervention.	
PMV		
+	**Strength: Vaya** has a strong weekly claims audit process with regular meetings to assess needed follow-up or corrective action. Routine, focused audits that are based on identified risk areas from the weekly claim audits ensure errors are minimized and claims are processed efficiently. Claims staff are regularly coached when errors or inefficiencies are identified, strengthening **Vaya**'s reporting accuracy and completeness.	

Strength/ Weakness	Description	Domain(s)
+	**Strength: Vaya**'s rates for the *Concurrent Use of Opioids and Benzodiazepines* (*COB*) measure were exceptionally low: 4.22 percent for members 18–64 years of age and 0.00 percent for members 65 years of age and older. This low rate reflects a commitment to member treatment plans that prioritize medication safety.	
−	**Weakness: Vaya**'s initial Member-Level Detail (MLD) file contained invalid and illogical data to support performance measure compliance. The screenshots provided to validate the data in the MLD file were insufficient to support the data provided. **Vaya** reported that this weakness existed due to ongoing integration with Cotiviti. A corrected MLD file was provided to HSAG with updated data to reflect accurate member counts and compliance. **Recommendations: Vaya** should continue to work regularly with Cotiviti to ensure that full system integration is achieved. **Va**ya's regular and ongoing review of programming logic will ensure that performance measure reporting continues to be complete and accurate, even as new data sources are integrated into **Vaya**'s processes.	
−	**Weakness: Vaya** contracted external TCM providers to complete SDOH screenings; however, because the screenings conducted by contracted TCM providers were supplied in a portable document format (PDF) that could not be converted to a Microsoft Excel or comma separated value (CSV) format for reporting, **Vaya**'s care coordination staff conducted additional screenings that were entered into the Guiding Care platform. **Recommendations:** To reduce the administrative burden on staff and the member populations, HSAG recommends that **Vaya** explore methods to convert the screenings conducted by contracted TCM providers to an alternative file format or encourage external TCM providers to enter the screenings directly into Guiding Care to ensure the screenings are captured in a reportable format. This would eliminate the need to expend additional resources to meet the State standard for reporting.	
−	**Weakness:** While **Vaya**'s rates for the 6–17 age stratification for the *FUH* and *FUM* measures are strong, the rates for the 18–64 and 65+ age stratifications for the *FUH* and *FUM* measures demonstrate significant opportunities for improvement. **Recommendations:** HSAG recommends implementing additional protocols to ensure that members are reached for follow-up care. Some examples include leveraging additional staff members to conduct member outreach by phone or email to schedule appointments, providing information about resources to assist members with transportation to their appointments, or providing counseling to members to communicate the importance of follow-up care.	

Strength/ Weakness	Description	Domain(s)
Compliance With Standards		
+	**Strength: Vaya**'s policies and procedures were generally compliant with contract requirements. Interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
−	**Weakness: Vaya** demonstrated an opportunity for improvement related to care management requirements assessed in the file review. **Recommendations: Vaya** should ensure completion of the training of care management staff in January 2026 and compliance with the care management requirements outlined in the Medicaid Direct contract, including more robust care planning.	
−	**Weakness: Vaya** maintained a peer-to-peer and reconsideration process that was inconsistent with the Medicaid managed care rule. **Recommendations: Vaya** should ensure that its peer-to-peer procedures meet federal requirements.	
NAV		
+	**Strength: Vaya** demonstrated robust policies and procedures to ensure the accuracy of network adequacy indicator calculations, monitoring, and reporting metrics. These processes included thorough quality checks to validate data accuracy.	
−	**Weakness: Vaya** reported using the previously applied global adjustments provided by DHHS because DHB was delayed in its notification of global adjustments. DHB confirmed that for the audit period, no global exception or adjustments were approved; therefore, the calculations should have adhered strictly to contractual standards. **Recommendations: Vaya** should work closely with DHB to verify the accuracy of parameters used in network adequacy calculations. Additionally, **Vaya** should implement a process to ensure Quest templates are promptly updated upon the date of expiration indicated in DHB's notification to reflect contractual standards whenever global exceptions/adjustments are not issued by DHB.	
−	**Weakness: Vaya** did not achieve full compliance with county-level time/distance or other required access standards across multiple service types, including nine of the 23 child specialty provider types, five of the seven BH provider types, two of the four LTSS service types, and six of the BH non-time/distance service types. **Recommendations: Vaya** should continue strengthening its recruiting and contracting efforts to add eligible Medicaid providers in all service type areas that did not meet the required access standards. **Vaya** should also collaborate with DHB to request exceptions, when appropriate, to help determine whether noncompliance stems from an insufficient	

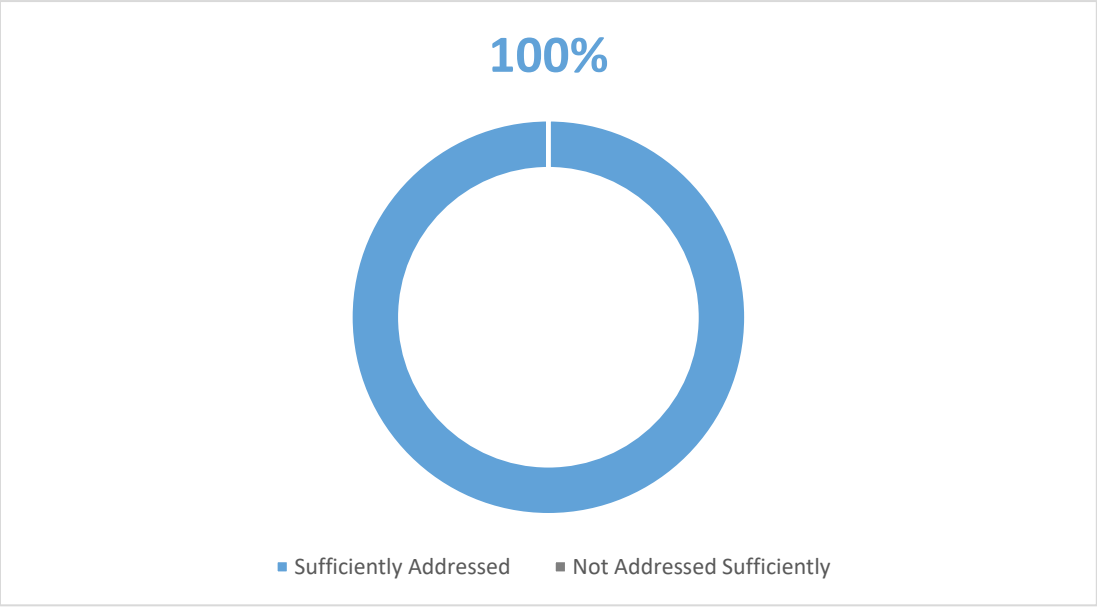
Strength/ Weakness	Description	Domain(s)
	provider supply or challenges in contracting with providers within the geographic region.	
Optional/Additional EQR Activities		
+	**Vaya** demonstrated its capability to collect, process, and transmit encounter data to DHB, as well as develop data review and correction processes that can promptly respond to quality issues DHB identified.	
−	**Weakness: Vaya** modified NEMT encounters received from its subcontractor before submitting them to DHB. **Recommendations: Vaya** should collaborate with DHB to confirm whether these modifications require communication back to the subcontractor to ensure alignment with contractual and data integrity expectations.	
−	**Weakness: Vaya** reported that it was satisfied with the data quality checks its subcontractors performed and did not conduct additional reviews prior to submission to DHB for its pharmacy and vision subcontractors. **Recommendations: Vaya** should explore the possibility of constructing or improving monitoring reports to assess the accuracy, completeness, and/or timeliness of encounter data submitted by these subcontractors.	
−	**Weakness:** Although **Vaya** had processes in place to reconcile transactions that were initially rejected due to either DHB's EDI translator or DHB-specific edits, **Vaya** reported that a high percentage of encounters remained unaccepted after initial rejection. **Recommendations: Vaya** should strengthen its efforts to ensure that all rejected transactions are accurately corrected and resubmitted in a timely manner.	
−	**Weakness: Vaya** reported not performing quality checks on data stored in the data warehouse once the initial development and testing are complete. **Recommendations: Vaya** should consider performing additional routine quality assurance checks on data collected to confirm that the data are processed as expected and that data processing systems continue to function as intended.	

Follow-Up on Prior Year's Recommendations

HSAG evaluated **Vaya**'s approach to addressing the recommendations and/or findings issued during the prior technical report while conducting the CY 2025 EQR activities.

Figure 11 illustrates the degree to which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

Figure 11—Percentage of Prior EQR Recommendations Addressed by Vaya



Vaya-specific recommendations and follow-up assessments are summarized in Table 63.

Table 63—Assessment of Vaya's Approach to Addressing Previous Annual Recommendations

Prior Recommendation	Assessment
Compliance With Standards	
Provider specialty codes were applied to the Quest provider file using a manual process. HSAG recommended that **Vaya** consider options to reduce manual data processing used for Quest file production to eliminate the introduction of possible errors.	**Vaya sufficiently addressed the recommendation. Vaya** reduced its manual processing time by 50 percent by modifying structured query language (SQL) queries that limit the size of the file outputs (for physical health providers) and utilizing SQL queries to pull information which creates an initial Quest Analytics behavioral health provider file (for behavioral health providers). **Vaya** noted it will take time to build out fully automated specialty code application solutions but that it will continue its efforts.

TPs

HSAG assessed the strengths and weaknesses of each TP 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 64 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 64—Alliance Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)
PIPs		
+	**Strength:** For all PIPs, **Alliance** received a *High Confidence* level for adhering to acceptable PIP methodology.	
PMV		
+	**Strength:** HSAG determined that the data integration processes, data control processes, and information systems documentation were *Acceptable.*	
Compliance With Standards		
+	**Strength: Alliance**'s policies and procedures were generally compliant with contract requirements. Interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
−	**Weakness: Alliance** demonstrated an opportunity for improvement related to care management requirements assessed in the file review. **Recommendations: Alliance** should ensure compliance with the care management requirements outlined in the TP contract.	
−	**Weakness: Alliance** maintained a peer-to-peer and reconsideration process that was inconsistent with the Medicaid managed care rule. **Recommendations: Alliance** should ensure that its peer-to-peer procedures meet federal requirements.	
NAV		
+	**Strength: Alliance** demonstrated robust policies and procedures to ensure the accuracy of network adequacy indicator calculations, monitoring, and reporting metrics. These processes included thorough quality checks to validate data accuracy.	

Strength/ Weakness	Description	Domain(s)
−	**Weakness: Alliance** manually populated PRV reports using a single staff member, which introduced a risk of human error. **Recommendations: Alliance** should implement automated population and/or add verification and validation steps by multiple staff members or departments to ensure data accuracy.	
−	**Weakness:** The review of Quest parameters submitted for network adequacy calculations revealed **Alliance** applied adjusted standards that did not align with contractual requirements. DHB confirmed that for the audit period, no global exceptions or adjustments were approved; therefore, the calculations should have adhered strictly to contractual standards. **Recommendations: Alliance** should work closely with DHB to verify the accuracy of parameters used in network adequacy calculations. Additionally, **Alliance** should implement a process to ensure Quest templates are promptly updated upon the date of expiration indicated in DHB's notification to reflect contractual standards whenever global exceptions/adjustments are not issued by DHB.	
−	**Weakness: Alliance** did not achieve full compliance with county-level time/distance or other required access standards across multiple service types, including 13 of the 23 child specialty provider types and six of the 17 BH non-time/distance service types. **Recommendations: Alliance** should continue strengthening its recruiting and contracting efforts to add eligible Medicaid providers in all service type areas that did not meet the required access standards. **Alliance** should also collaborate with DHB to request exceptions, when appropriate, to help determine whether noncompliance stems from an insufficient provider supply or challenges in contracting with providers within the geographic region.	
Optional/Additional EQR Activities		
+	**Alliance** demonstrated its capability to collect, process, and transmit encounter data to DHB, as well as develop data review and correction processes that can promptly respond to quality issues DHB identified.	
−	**Weakness: Alliance** reported that it was satisfied with the data quality checks its subcontractors performed and did not conduct additional reviews prior to submission to DHB for its pharmacy, vision, and DME subcontractors. **Recommendations: Alliance** should explore the possibility of constructing or improving monitoring reports to assess the accuracy, completeness, and/or timeliness of encounter data submitted by these subcontractors.	

Strength/ Weakness	Description	Domain(s)
−	**Weakness:** Although **Alliance** had processes in place to reconcile transactions that were initially rejected due to either DHB's EDI translator or DHB-specific edits, **Alliance** reported that a high percentage of encounters remained unaccepted after initial rejection. **Recommendations: Alliance** should strengthen its efforts to ensure that all rejected transactions are accurately corrected and resubmitted in a timely manner.	
−	**Weakness: Alliance** did not demonstrate the use of claim type-specific processes to detect duplicated encounters prior to submitting data to DHB. **Recommendations: Alliance** should consider enhancing its duplicate detection approach by incorporating data fields tailored to each encounter type.	

Follow-Up on Prior Year's Recommendations

Due to their mid-year managed care launch, the TPs 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 65 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 65—Partners Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)
PIPs		
+	**Strength:** For all PIPs, **Partners** received a *High Confidence* level for adhering to acceptable PIP methodology.	
PMV		
+	**Strength:** HSAG determined that the data integration processes, data control processes, and information systems documentation were *Acceptable.*	
Compliance With Standards		
+	**Strength: Partners**' policies and procedures were generally compliant with contract requirements. Interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
−	**Weakness: Partners** demonstrated an opportunity for improvement related to care management requirements assessed in the file review. **Recommendations: Partners** should ensure compliance with the care management requirements outlined in the TP contract, including timely completion of screening and assessments and more robust care planning.	
−	**Weakness: Partners** maintained a peer-to-peer and reconsideration process that was inconsistent with the Medicaid managed care rule. **Recommendations: Partners** should ensure that its peer-to-peer procedures meet federal requirements.	
−	**Weakness: Partners** was unable to demonstrate compliance with all requirements for the availability of member materials. **Recommendations: Partners** should develop a procedure to ensure that paper materials are sent within five business days upon a member's request.	

Strength/ Weakness	Description	Domain(s)
NAV		
+	**Strength: Partners** demonstrated robust policies and procedures to ensure accurate calculation, monitoring, and reporting of network adequacy indicators. These processes included comprehensive quality checks performed by both **Partners** staff and IBH Analytics to validate data accuracy.	
−	**Weakness:** The review of IBH Analytics parameters submitted for network adequacy calculations revealed that **Partners** applied adjusted standards that did not align with contractual requirements. DHB confirmed that for the audit period, no global exceptions or adjustments were approved; therefore, the calculations should have adhered strictly to contractual standards. **Recommendations: Partners** should work closely with DHB to verify the accuracy of parameters used in network adequacy calculations. Additionally, **Partners** should implement a process to ensure Quest templates are promptly updated upon the date of expiration indicated in DHB's notification to reflect contractual standards whenever global exceptions/adjustments are not issued by DHB.	
−	**Weakness: Partners** did not achieve full compliance with county-level time/distance or other required access standards across multiple service types, including seven of the 23 child specialty provider types, one of the four LTSS service types, and six of the 17 BH non-time/distance service types. **Recommendations: Partners** should continue strengthening its recruiting and contracting efforts to add eligible Medicaid providers in all service type areas that did not meet the required access standards. **Partners** should also collaborate with DHB to request exceptions, when appropriate, to help determine whether noncompliance stems from an insufficient provider supply or challenges in contracting with providers within the geographic region.	
Optional/Additional EQR Activities		
+	**Strength: Partners** demonstrated its capability to collect, process, and transmit encounter data to DHB, as well as develop data review and correction processes that can promptly respond to quality issues DHB identified.	
−	**Weakness: Partners** indicated that it did not store any of its subcontractor data. To enhance oversight and ensure accessibility for quality review and operational purposes. **Recommendations: Partners** should consider storing subcontractor data to support data quality assurance by ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare oversight and accountability.	

Strength/ Weakness	Description	Domain(s)
−	**Weakness: Partners** reported that it was satisfied with the data quality checks its subcontractors performed and did not conduct additional reviews prior to submission to DHB for its pharmacy, vision, and NEMT subcontractors. **Recommendations: Partners** should explore the possibility of constructing or improving monitoring reports to assess the accuracy, completeness, and/or timeliness of encounter data submitted by these subcontractors.	
−	**Weakness:** Although **Partners** had processes in place to reconcile transactions that were initially rejected due to either DHB's EDI translator or DHB-specific edits, **Partners** reported that a high percentage of encounters remained unaccepted after initial rejection. **Recommendations: Partners** should strengthen its efforts to ensure that all rejected transactions are accurately corrected and resubmitted in a timely manner.	
−	**Weakness: Partners** did not demonstrate the use of claim type-specific processes to detect duplicated encounters prior to submitting data to DHB. **Recommendations: Partners** should consider enhancing its duplicate detection approach by incorporating data fields tailored to each encounter type.	

Follow-Up on Prior Year's Recommendations

Due to their mid-year managed care launch, the TPs 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 66 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 66—Trillium Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)
PIPs		
+	**Strength:** For all PIPs, **Trillium** received a *High Confidence* level for adhering to acceptable PIP methodology.	
PMV		
+	**Strength:** HSAG determined that the data integration processes, data control processes, and information systems documentation were *Acceptable.*	
Compliance With Standards		
+	**Strength: Trillium**'s policies and procedures were generally compliant with contract requirements. Interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
−	**Weakness: Trillium** demonstrated an opportunity for improvement related to care management requirements assessed in the file review. **Recommendations: Trillium** should ensure compliance with the care management requirements outlined in the TP contract, including more robust care planning.	
−	**Weakness: Trillium** maintained a peer-to-peer and reconsideration process that was inconsistent with the Medicaid managed care rule. **Recommendations: Trillium** should ensure that its peer-to-peer procedures meet federal requirements.	
NAV		
+	**Strength: Trillium** demonstrated robust policies and procedures to ensure the accuracy of network adequacy indicator calculations, monitoring, and reporting metrics. These processes included thorough quality checks to validate data accuracy.	
+	**Strength: Trillium** demonstrated a strong commitment to provider data accuracy by incorporating a validation tool within its TBS system, enabling staff to efficiently verify provider information against the data submitted in the PEF by DHHS.	

Strength/ Weakness	Description	Domain(s)
−	**Weakness: Trillium** reported using the 2023 global adjustments provided by DHB due to a delay in receipt of global adjustments, which were not in alignment with the standard contractual requirements. DHB confirmed that for the audit period, no global exceptions or adjustments were approved; therefore, the calculations should have adhered strictly to contractual standards. **Recommendations: Trillium** should work closely with DHB to verify the accuracy of parameters used in network adequacy calculations. Additionally, **Trillium** should implement a process to ensure Quest templates are promptly updated upon the date of expiration indicated in DHB's notification to reflect contractual standards whenever global exceptions/adjustments are not issued by DHB.	
−	**Weakness: Trillium** did not achieve full compliance with county-level time/distance or other required access standards across multiple service types, including 12 of the 23 child specialty provider types, four of the seven BH provider types, two of the four LTSS service types, and one of the BH non-time/distance service types. **Recommendations: Trillium** should continue strengthening its recruiting and contracting efforts to add eligible Medicaid providers in all service type areas that did not meet the required access standards. **Trillium** should also collaborate with DHB to request exceptions, when appropriate, to help determine whether noncompliance stems from an insufficient provider supply or challenges in contracting with providers within the geographic region.	
Optional/Additional EQR Activities		
+	**Strength: Trillium** demonstrated its capability to collect, process, and transmit encounter data to DHB, as well as develop data review and correction processes that can promptly respond to quality issues DHB identified.	
−	**Weakness: Trillium** reported that it was satisfied with the data quality checks its subcontractors performed and did not conduct additional reviews prior to submission to DHB for its pharmacy, vision, and NEMT subcontractors. **Recommendations: Trillium** should explore the possibility of constructing or improving monitoring reports to assess the accuracy, completeness, and/or timeliness of encounter data submitted by these subcontractors.	
−	**Weakness:** Although **Trillium** had processes in place to reconcile transactions that were initially rejected due to either DHB's EDI translator or DHB-specific edits, **Trillium** reported that a high percentage of encounters remained unaccepted after initial rejection.	

Strength/ Weakness	Description	Domain(s)
	Recommendations: Trillium should strengthen its efforts to ensure that all rejected transactions are accurately corrected and resubmitted in a timely manner.	
−	**Weakness: Trillium** reported conducting only two quality checks for claims and encounters stored in its data warehouses. **Recommendations: Trillium** should consider expanding its quality monitoring efforts through the development of additional reports assessing data accuracy, completeness, and/or timeliness of these claims/encounters.	

Follow-Up on Prior Year's Recommendations

Due to their mid-year managed care launch, the TPs 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** are summarized in Table 67 for each activity. This table highlights the extent to which **Vaya** furnishes high quality, timely, and appropriate access to healthcare services, and recommendations for how **Vaya** can best address issues identified for each activity.

Table 67—Vaya Health Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)
PIPs		
+	**Strength:** For all PIPs, **Vaya** received a *High Confidence* level for adhering to acceptable PIP methodology.	
−	**Weakness:** For the *FUH* PIP, **Vaya** utilized the same interventions for both *FUH* and *FUM* PIPs and demonstrated a decline in the Remeasurement 1 data compared to baseline. **Recommendations: Vaya** should implement measure specific interventions for each PIP topic based on the unique barriers identified for each measure and continually revisit its QI processes to make mid-course corrections, as needed. **Vaya** should develop active, innovative interventions that have the potential for impacting the performance indicator outcomes and address the identified and prioritized barriers. **Vaya** should not initiate and test standard operating QI actions or processes already in place as interventions for the PIP. **Vaya** should use PDSA cycles as part of the improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful. **Vaya** should implement measure specific interventions for each PIP topic based on the unique barriers identified for each measure and develop a methodologically sound method or process to evaluate the effectiveness of each individual intervention.	
PMV		
+	**Strength:** HSAG determined that the data integration processes, data control processes, and information systems documentation were *Acceptable.*	
Compliance With Standards		
+	**Strength: Vaya**'s policies and procedures were generally compliant with contract requirements. Interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
−	**Weakness: Vaya** demonstrated an opportunity for improvement related to care management requirements assessed in the file review.	

Strength/ Weakness	Description	Domain(s)
	Recommendations: Vaya should ensure completion of the training of care management staff in January 2026 and ongoing compliance with the care management requirements outlined in the TP contract, including more robust care planning.	
−	**Weakness: Vaya** maintained a peer-to-peer and reconsideration process that was inconsistent with the Medicaid managed care rule. **Recommendations: Vaya** should ensure that its peer-to-peer procedures meet federal requirements.	
NAV		
+	**Strength: Vaya** demonstrated robust policies and procedures to ensure the accuracy of network adequacy indicator calculations, monitoring, and reporting metrics. These processes included thorough quality checks to validate data accuracy.	
−	**Weakness: Vaya** reported using the previously applied global adjustments provided by DHHS because DHB was delayed in its notification of global adjustments. DHB confirmed that for the audit period, no global exception or adjustments were approved; therefore, the calculations should have adhered strictly to contractual standards. **Recommendations: Vaya** should work closely with DHB to verify the accuracy of parameters used in network adequacy calculations. Additionally, **Vaya** should implement a process to ensure Quest templates are promptly updated upon the date of expiration indicated in DHB's notification to reflect contractual standards whenever global exceptions/adjustments are not issued by DHB.	
−	**Weakness: Vaya** did not achieve full compliance with county-level time/distance or other required access standards across multiple service types, including nine of the 23 child specialty provider types, five of the seven BH provider types, two of the four LTSS service types, and six of the BH non-time/distance service types. **Recommendations: Vaya** should continue strengthening its recruiting and contracting efforts to add eligible Medicaid providers in all service type areas that did not meet the required access standards. **Vaya** should also collaborate with DHB to request exceptions, when appropriate, to help determine whether noncompliance stems from an insufficient provider supply or challenges in contracting with providers within the geographic region.	
Optional/Additional EQR Activities		
+	**Vaya** demonstrated its capability to collect, process, and transmit encounter data to DHB, as well as develop data review and correction processes that can promptly respond to quality issues DHB identified.	

Strength/ Weakness	Description	Domain(s)
−	**Weakness: Vaya** modified NEMT encounters received from its subcontractor before submitting them to DHB. **Recommendations: Vaya** should collaborate with DHB to confirm whether these modifications require communication back to the subcontractor to ensure alignment with contractual and data integrity expectations.	
−	**Weakness: Vaya** reported that it was satisfied with the data quality checks its subcontractors performed and did not conduct additional reviews prior to submission to DHB for its pharmacy and vision subcontractors. **Recommendations: Vaya** should explore the possibility of constructing or improving monitoring reports to assess the accuracy, completeness, and/or timeliness of encounter data submitted by these subcontractors.	
−	**Weakness:** Although **Vaya** had processes in place to reconcile transactions that were initially rejected due to either DHB's EDI translator or DHB-specific edits, **Vaya** reported that a high percentage of encounters remained unaccepted after initial rejection. **Recommendations: Vaya** should strengthen its efforts to ensure that all rejected transactions are accurately corrected and resubmitted in a timely manner.	
−	**Weakness: Vaya** reported not performing quality checks on data stored in the data warehouse once the initial development and testing are complete. **Recommendations: Vaya** should consider performing additional routine quality assurance checks on data collected to confirm that the data are processed as expected and that data processing systems continue to function as intended.	

Follow-Up on Prior Year's Recommendations

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

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:

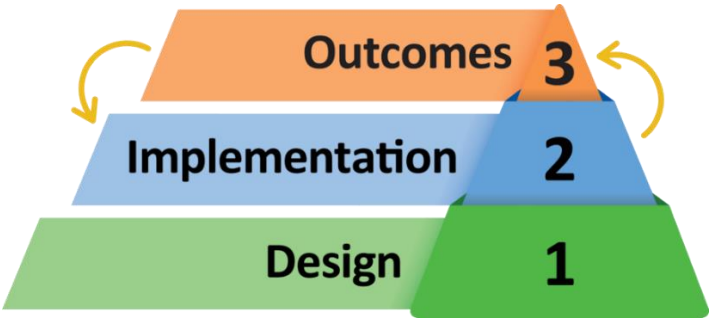
- Measuring performance using objective quality indicators
- Implementing system interventions to achieve improvement in quality
- Evaluating effectiveness of the interventions
- Planning and initiating of activities for increasing or sustaining improvement

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

Figure 12 below 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 (Steps 1–6) 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 12—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 2025 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

Activity Objectives

As set forth in 42 CFR §438.350(a), the validation of performance measures calculated by the SPs, PIHPs, and/or DHB during the preceding 12 months was one of the mandatory EQR activities. The primary objectives of the performance measure validation activities were to:

- Evaluate the accuracy of the performance measure data calculated and/or reported by the SPs, PIHPs, and DHB.
- Determine the extent to which the specific performance measures calculated and/or reported by the SPs, PIHPs, and DHB followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure reporting and calculation process.

Table 68 shows the data sources used in the validation of performance measures and the periods to which the data applied.

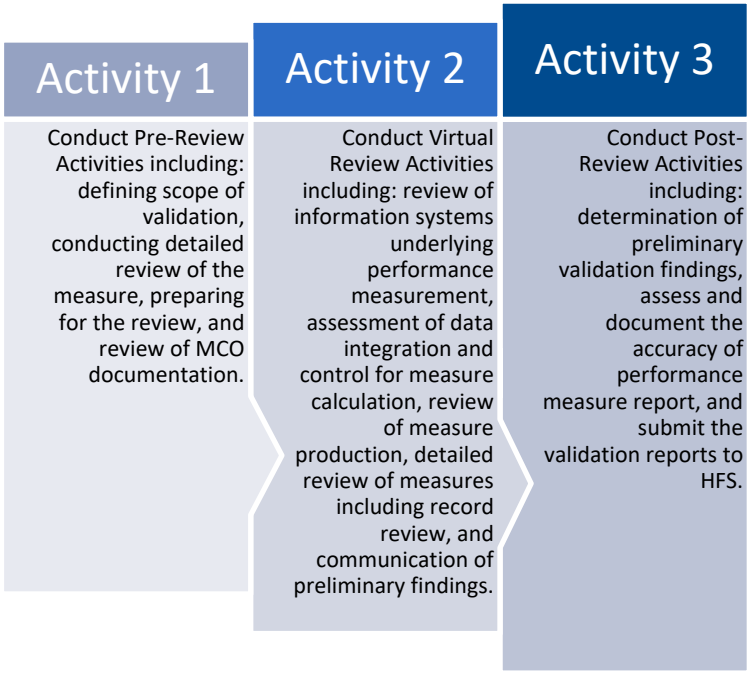
Table 68—Data Sources and Time Frames

Data Sources	Period to Which Data Applied
ISCAT (from SPs/PIHPs)	SFY 2025
Source code/programming language for performance measures (from SPs/PIHPs and DHB) or description of the performance measure calculation process (from SPs/PIHPs)	SFY 2025
Performance measure results (from SPs/PIHPs and DHB)	SFY 2025
Supporting documentation (from SPs/PIHPs and DHB)	SFY 2025
Virtual interviews and systems demonstrations (from SPs/PIHPs)	SFY 2025

PMV Audits

HSAG validated the data collection and reporting processes of the North Carolina SPs to report the performance measure data for MY 2024 (January 1, 2024, through December 31, 2024) in accordance with CMS' Protocol 2 cited earlier in this report. HSAG also assessed the readiness of NC TPs to report performance measures in MY 2025 in accordance with CMS' Protocol 2 cited earlier in this report. Figure 13 presents the protocol activities conducted.

Figure 13—Protocol 2 Activities



NCQA,[70] 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 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.

[70] National Committee for Quality Assurance. HEDIS Measures and Technical Resources. Available at: https://www.ncqa.org/hedis/measures/. Accessed on: Feb 12, 2026.

- **Performance indicator reports—**HSAG reviewed the SPs' 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 2025. 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.

HSAG validated a set of performance indicators that were developed and selected by DHB for validation for the measurement year of 2024: January 1, 2024, through December 31, 2024. The reporting cycle and measurement period were specified for each indicator by DHB.

Table 69 lists the performance measures calculated by the SPs for MY 2024 that began on January 1, 2024, and ended on December 31, 2024.

Table 70 lists the performance measures calculated by the PIHPs for MY 2024 that began on January 1, 2024, and ended on December 31, 2024.

Table 71 lists the performance measures calculated by DHB for MY 2024 that began on January 1, 2024, and ended on December 31, 2024.

Table 69—Performance Measures Calculated by the SPs

Measure	Measurement Period
Controlling High Blood Pressure (CBP)	MY 2024
Screening for Depression and Follow-Up Plan (CDF)	MY 2024
Childhood Immunization Status (CIS)—Combo 10	MY 2024
Concurrent Use of Prescription Opioids and Benzodiazepines (COB)	MY 2024
Cervical Cancer Screening (CCS)	MY 2024
Glycemic Status Assessment for Patients With Diabetes (GSD)	MY 2024
Immunizations for Adolescents (IMA)—Combination 2	MY 2024
Prenatal and Postpartum Care (PPC)	MY 2024
Well-Child Visits in the First 30 Months of Life (W30)	MY 2024
Child and Adolescent Well-Care Visits(WCV)	MY 2024

Table 70—Performance Measures Calculated by the PIHPs

Measure	Measurement Period
Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)	MY 2024
Metabolic Monitoring for Children and Adolescents on Antipsychotics	MY 2024
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	MY 2024
Concurrent Use of Prescription Opioids and Benzodiazepines (COB)	MY 2024
Follow-up After ED Visit for Mental Illness	MY 2024
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	MY 2024
Follow-Up After Hospitalization for Mental Illness (FUH)	MY 2024

Table 71—Performance Measures Calculated by DHB

Measure	Measurement Period
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Screening Ratio	MY 2024
Rate of Screening for Health-Related Resource Needs (HRRN)	MY 2024

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that the SPs and PIHPs provided to members, HSAG determined results for each performance measure and assigned each a measure designation of *Reportable*, *Do Not Report*, or *Not Applicable*. HSAG further analyzed the quantitative results (e.g., performance measure results compared to the MPSs) and qualitative results (e.g., data collection and reporting processes) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the SPs' and PIHPs' Medicaid members.

Report (R)	Measure was compliant with State specifications.
Do Not Report (DNR)	PIHP/SP rate was materially biased and should not be reported.
No Applicable (NA)	The PIHP/SP was not required to report the measure.
Not Reported (NR)	Measure was not reported because the PIHP/SP did not offer the required benefit.

Technical Methods of Data Collection and Analysis

During the performance measure review, HSAG performed a variety of review activities.

For each of the SPs and PIHPs, HSAG's review consisted of the following activities:

Pre-Site Review Activities:

- Collaborated with DHB to develop the scope of work, methodology, and performance measure validation tools.
- Prepared and forwarded to the SPs and PIHPs a detailed timeline, description of the performance measure review, pre-site review information packet, a submission requirements checklist, and a post-site review document tracker.
- Scheduled the site review with the SPs and PIHPs.
- Hosted a pre-site review preparation session with all SPs and PIHPs.
- Conducted a desk review of supporting documentation the SPs and PIHPs submitted to HSAG.
- Followed up with the SPs and PIHPs, as needed, based on the results of HSAG's preliminary desk review.
- Developed an agenda for the virtual review interview sessions and provided the agenda to the SPs and PIHPs to facilitate preparation for HSAG's review.

Virtual Review Activities:

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed SP and PIHP key program staff members.
- Conducted an IS review of the data systems that the SPs and PIHPs used in their operations, applicable to the standards under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

Post-Site Review Activities:

- Conducted a review of additional documentation submitted by the SPs and PIHPs.
- Prepared SP- and PIHP-specific reports detailing the findings of HSAG's review.

Compliance Review

In accordance with 42 CFR §438.358, 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.

This section describes the methodology HSAG utilizes to complete the Compliance Review. HSAG followed the guidelines outlined in CMS' *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity* (CMS Protocol 3), February 2023.[71]

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

[71] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 12, 2026.

- §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 health plans regarding administrative processes to ensure compliance with federal requirements. In preparation for the Compliance Review, HSAG worked closely with DHB and the health plans 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 72 below.

Table 72—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 developed 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 • Standard III—Member Information • Standard IV—Emergency and Poststablization Services • Standard V—Adequate Capacity and Availability of Services • Standard VI—Coordination and Continuity of Care, including Transitions to Community Living (TCL) • 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

For this step,	HSAG will…
	• Standard XII—Quality Assessment and Performance Improvement (QAPI) Program • Standard XIII—Grievance and Appeal Systems
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 members 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 members 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 health plan.

Activity Two: Perform Preliminary Review

HSAG performs a series of preliminary steps, including a desk review, as shown in Table 73.

Table 73—Activity Two: Perform Preliminary Review

For this step,	HSAG will…
Step 1:	**Establish early contact with the health plans.**
	In collaboration with DHB, HSAG set the schedule and established 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 health plans during the review. The form requires the health plans to describe their organizations, key operational areas, and 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 health plans.</td></tr>
<tr><td></td><td>Health plan-specific standard review tools are provided to assist each health plan in preparing for the review. The standard review tools include documents required for submission. In addition, the health plans are provided specifications for timelines and instructions for submitting the data required for sampling of 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>Member 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 Poststablization 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, including TCL requirements</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>QAPI 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 health plans questions related to the review and provided 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 health plans. HSAG maintains contact with the health plans as needed to answer questions and provide information to key members of the management staff. HSAG communicates regularly with DHB about HSAG’s discussions with the health plans and their responses to questions.</td></tr>
<tr><td>Step 1d:</td><td>Receive data files from the health plans, select and post samples to HSAG’s SAFE site for each health plan.</td></tr>
<tr><td></td><td>HSAG generates unique record review samples based on data files supplied by each health plan 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 health plan. HSAG reviewers use the documentation to gain insight into each health plan'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 health plan as evidence of its 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

HSAG works with each health plan to schedule a virtual webinar review. HSAG conducts staff interviews with each health plan and collects the information necessary to assess the health plans' compliance with federal regulations. The steps of the virtual webinar review process are shown in Table 74 below.

Table 74—Activity Three: Conduct Virtual Reviews

For this step,	HSAG will…
Step 1:	**Determine the length of virtual webinar review and the dates.**
	HSAG determines the virtual webinar review to be scheduled for three consecutive business days with each health plan. Health plans 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 members 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 interrater 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, while ongoing communication and coordination among the team members ensure 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 health plan in planning for participation in the virtual webinar review. The agenda sets the tone, expectations, objectives, and time frames for the virtual webinar review. If additional information is needed, each health plan 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 health plan 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 health plan's performance. • Reviews information, documentation, and systems demonstrations. • Receives assistance from health plan staff members 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 health plan 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 provides the health plan with the opportunity to respond to initial compliance issues to ensure the findings are truly non-compliant and not due to a 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 75. The documented findings serve as evidence of the comprehensiveness of the EQR process and validity of the findings.

Table 75—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 health plan 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 health plan. 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 health plan's compliance with federal requirements and monitors remediation using the steps shown in Table 76.

Table 76—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 health plan.
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 health plan that described 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 health plans' remediation.**
	DHB requires health plans to remediate each element for which HSAG assigned a score of *Not Met*. The health plans have a 30-day remediation period in which to submit additional documentation or implement policies and procedures that met 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 health plan.
Step 5:	**Monitor corrective action plans (CAPs).**
	For any elements that remain out of compliance following remediation, the health plan is required to submit a CAP to HSAG. DHB and HSAG will monitor each health plan's progress toward correcting deficiencies. The following criteria will be used to evaluate the sufficiency of the CAP: • The completeness of the CAP document in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific plans of action/interventions that the health plan 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 health plan into compliance with the requirement. • The appropriateness of the timeline for correcting the deficiency. Any CAPs that do not meet the preceding criteria will require resubmission by the health plan until approved by DHB and HSAG. Implementation of the CAP will begin once approval is received.

Network Adequacy Validation

Standards and Indicators Validated

States that contract with MCOs 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 MCO'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) during July 1, 2024–June 30, 2025. The results represent a snapshot in time, summarizing cumulative network adequacy data collected over the preceding 12 months. The following tables list the network adequacy standards and indicators HSAG validated.

Table 77—PIHP/TP Time/Distance Network Adequacy Standards Validated

Service Type	Urban Standard	Rural Standard
Specialty Care (multiple specialty types)* (TPs only)	Two or more providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members	Two or more providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members
Outpatient Behavioral Health Services	Two or more providers of each outpatient BH service within 30 minutes or 30 miles for at least 95% of members	Two or more providers of each outpatient BH service within 45 minutes or 45 miles for at least 95% of members
Location-Based Services (multiple service types)**	Two or more providers of each service within 30 minutes or 30 miles of residence for at least 95% of members	Two or more providers of each service within 45 minutes or 45 miles of residence for at least 95% of members
Partial Hospitalization	One or more providers of partial hospitalization within 30 minutes or 30 miles for at least 95% of members	One or more providers of partial hospitalization within 60 minutes or 60 miles for at least 95% of members

* All pediatric specialties and ophthalmology (adult/child).

** Psychosocial Rehabilitation Services, Substance Abuse Comprehensive Outpatient Treatment (SACOT), and Substance Abuse Intensive Outpatient Program (SAIOP).

Table 78—PIHP/TP Provider Capacity Standards Validated

Service Type	Standard
All State Health Plan Long-Term Services and Supports (LTSS) (except nursing facilities) (TPs only)	Two or more 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 NPI, accepting new patients available to deliver each State Health Plan LTSS in every county.
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 Management County estimates).
Crisis Services (Facility-Based Crisis Services for Children and Adolescents)	One or more providers within each PIHP Region
Crisis Services (Non-Hospital Medical Detoxification)	Two or more providers within each PIHP Region
Crisis Services (Ambulatory Detoxification)	One or more providers of each crisis service within each PIHP Region
Crisis Services (Ambulatory Withdrawal Management with Extended On-Site Monitoring)	One or more providers of each crisis service within each PIHP Region
Community/Mobile Services	• Two or more providers of community/mobile services within each PIHP Region. • Each county in the PIHP Region must have access to one or more providers who are accepting new patients.
Residential Treatment Services (Residential Treatment Facility Services)	Access to one or more licensed provider per PIHP Region
Residential Treatment Services (Substance Abuse Medically Monitored Residential Treatment)	Access to one or more licensed provider per PIHP Region
Residential Treatment Services (Substance Abuse Non-Medical Community Residential Treatment)	• **Adult:** Access to one or more licensed provider per PIHP Region • **Adolescent:** Contract with all designated Cross Area Service Programs (CASPs) within the PIHP Region • **Women & Children:** Contract with all designated CASPs within the PIHP Region

Table 79—SP Time/Distance Standards Validated

Service Type	Urban Standard	Rural Standard
Specialty Care (multiple specialties) *	Two or more providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members	Two or more providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members
Outpatient Behavioral Health Services	Two or more providers of each outpatient BH service within 30 minutes or 30 miles for at least 95% of members	Two or more providers of each outpatient behavioral health service within 45 minutes or 45 miles for at least 95% of members
Location-Based Services (Behavioral Health)	Two or more providers of each service within 30 minutes or 30 miles for at least 95% of members	Two or more providers of each service within 45 minutes or 45 miles for at least 95% of members
Partial Hospitalization (Behavioral Health)	One or more providers of partial hospitalization within 30 minutes or 30 miles for at least 95% of members	One or more providers of partial hospitalization within 60 minutes or 60 miles for at least 95% of members

*All the pediatric specialties and ophthalmology (adult/child).

Table 80—SP Provider Capacity Standards Validated

Service Type	Urban Standard	Rural Standard
All State Health Plan LTSS (except nursing facilities)	Two or more providers accepting new patients available to deliver each State Health Plan LTSS in every county	Two or more 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 NPI, accepting new patients available to deliver each State Health Plan LTSS in every county.

Description of Validation Activities

Pre-Validation Strategy

NAV consists of several activities that fall into three phases—(1) planning, (2) analysis, and (3) reporting—as outlined in the CMS EQR Protocol 4. To complete validation activities for the managed care entities (MCEs) and 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 MCEs 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 MCEs 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 each MCE's completed ISCAT and relevant supplemental documentation to understand the processes for maintaining and updating provider data, including how DHB and the MCE track 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 MCE'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's 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 MCE'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 discussions and observations 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 MCE.

Network Adequacy Indicator Validation Rating Determinations

HSAG evaluated DHB's and the MCEs' 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 81.

Table 81—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 MCEs' 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 82—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 83 and Table 84 present example validation rating determinations. Table 83 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 84, presents an example of a validation rating determination that includes a *Not Met* element that had significant bias on the results.

Table 83—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 84—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 MCEs provide a root cause analysis of the finding.
- Working with DHB and the MCEs 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 85—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 all eligible members during each measurement period.
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 during the measurement year?
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 2023 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 HEDIS *PPC* measure rates among all eligible pregnant members during each measurement period.
Healthy Blue	1. Do targeted interventions result in an increase in **Healthy Blue**'s *Timeliness of Prenatal Care* rate by 5 percent during the measurement period? 2. 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	**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.

SP	PIP Aim Statement
	HEDIS GSD
AmeriHealth	• Do targeted interventions increase the percentage of members with a Hemoglobin A1c result less than 8.0 percent? • Do targeted interventions decrease the percentage of members with a Hemoglobin A1c result greater than 9.0 percent?
Carolina Complete	Will the targeted interventions result in relative improvement of at least a 5 percent from baseline in the glycemic status for the less than 8.0 percent and greater than 9.0 percent HEDIS measure rates among eligible members with diabetes during each measurement period?
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 percent) or an increase HbA1c (<8 percent) 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 measurement year? • 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 measurement year?
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 percent), 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?
	Nonclinical *HRRN*
AmeriHealth	Do targeted interventions increase the rate of screening of HRRNs completed within the calendar year?
Carolina Complete	Will the targeted interventions result in a relative improvement of at least a 5 percent from baseline for the 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 screening completion upon enrollment or re-enrollment into the plan during each reported period?
UnitedHealthcare	Do targeted interventions increase the percentage of HRRN 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. 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 86—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?
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?
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 a principal diagnosis of mental illness or any diagnosis of intentional self-harm and who had a follow-up service within 7?
Vaya	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 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?
Partners	Do targeted interventions increase the percentage of ED 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 ED visit for Medicaid Direct members who are 6 years of age and older with a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service within 7 days of the ED visit (8 total days)?
Vaya	Do targeted interventions increase the percentage of ED 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?
	HRRN
Alliance	Do targeted member, provider, and system interventions increase the percentage of enrollees who receive and complete a HRRN screening using the NC DHHS Standardized SDOH Screening Questions?
Partners	Do targeted interventions increase the percentage of completed HRRN screening of Medicaid Direct enrollees during the reporting remeasurement period?
Trillium	Will targeted interventions increase the percentage of Medicaid Direct enrollees who receive and complete a HRRN screening using the NC DHHS Standardized SDOH screening questions, demonstrating either a 5 percent relative improvement or a statistically significant improvement over the baseline?

PIHP	PIP Aim Statement
Vaya	Do targeted interventions increase the percentage of Medicaid Direct enrollees who receive and complete a health-related resource needs screening using the NC DHHS Standardized SDOH Screening Questions?

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 87 through Table 91 illustrate the barriers and interventions for the *HEDIS CIS—Combo 10* PIP.

Table 87—Barriers and Interventions for AmeriHealth

Barriers	Interventions
• Member vaccination hesitancy and adherence to well-child visits. • Incorrect provider coding and documentation. • Lack of documentation in NCIR. • Providers not using Modifier code 25 for Evaluation/Management services during sick visits.	TeleECHO Project: A six-month educational, coaching, and QI series on childhood and adolescent immunizations and well-child visits for identified providers starting March 28, 2024, through September 25, 2024. Providers will pull data from their own practices monthly to show performance within their practice for meeting immunization and well visits. Providers will obtain Continuing Medical Education and Maintenance of Certification Improvement in Medical Practice credits for participating fully in the education and QI series.

Table 88—Barriers and Interventions for Carolina Complete

Barriers	Interventions
Limited Record Collection: This intervention addresses limited record collection for immunization outside of NCIR.	**Administrative Intervention:** This intervention is designed to improve administrative reporting of childhood immunizations by ensuring robust data collection and targeted provider outreach. To maximize provider reporting, **Carolina Complete** is evaluating all existing data streams it uses to process immunization compliance data. During this continuous data collection, **Carolina Complete**

Barriers	Interventions
	analyzes results to identify trends and patterns in care, allowing for more targeted and efficient gap-closing efforts from providers.
• **Access to Care:** Caregivers may face challenges with access to care (e.g., lack of transportation, limited appointment availability) or may have difficulty navigating the healthcare system. • **Knowledge/Understanding:** Caregivers may lack awareness that their child is overdue for immunizations or may not understand the urgency of completing the full vaccine series on time. • **Continuity of Care:** The fragmented nature of care delivery across multiple health plans can lead to missed opportunities for gap closure.	**All-PHP Vaccine Events:** This intervention is a QI initiative designed to improve CIS-10 measure performance across North Carolina and was developed in collaboration with all five North Carolina Medicaid PHPs. Recognizing the need for a unified strategy to improve childhood immunization rates the PHPs began coordinating on-site vaccination events in partnership with local pediatric and family medicine providers across the State. The structure of the initiative reduces the burden on providers. The PHPs jointly plan and coordinate all of the logistics; the providers only need to host the event. The PHPs collectively enhance engagement by organizing extracurricular activities (e.g., face painting, giveaways, interactive games) and schedule events during school breaks and closures to foster a sense of community. This creates a high-impact opportunity for providers to support quality performance and improve access to care for their patients. Each participating PHP identifies members to the provider under the age of two years old who are due for any required CIS-10 immunizations. PHPs then directly outreach to those members' caregivers to encourage attendance at a designated vaccine event. The PHPs strategically schedule the events to reduce access barriers while simultaneously leveraging the existing provider-patient relationship, which enhances trust. This initiative reflects a coordinated, statewide strategy among all five North Carolina Medicaid PHPs, demonstrating collaboration and a unified effort to improve childhood immunization rates. This model increases provider participation and ensures more equitable access to immunizations for Medicaid members regardless of plan attribution due to the unified approach among all five Medicaid PHPs that allows for consistent outreach, expanded community engagement, and shared resources, all of which

Barriers	Interventions
	contribute to more equitable vaccine access for Medicaid-enrolled children across North Carolina.
• **Inaccurate Member Contact Information:** Outdated or incorrect phone numbers, addresses, or emails reduce the success of outreach efforts and limit member engagement. • **Insufficient Health Plan Cohesion:** Misalignment across departments can lead to fragmented outreach strategies and reduced impact. Lack of regular cross team planning can result in outreach that is reactive instead of proactive. • **Inconsistent Messaging Across Channels:** Caregivers may receive conflicting or unclear messages from different departments, weakening trust and creating confusion amongst outreach efforts.	**Member Outreach and Engagement Workgroup:** Internal work groups and committees play a pivotal role in the work of the QI department at **Carolina Complete**. These work groups and committees aid in prioritizing initiatives, focusing on members with the greatest need or an initiative's expected impact on health outcomes and member experience. **Carolina Complete** established the Member Outreach and Engagement Workgroup as a system-level intervention designed to improve outreach effectiveness and member engagement. This internal workgroup brings together staff from Quality, Marketing, Case Management, and the Call Center to analyze outreach efforts and identify opportunities for improvement. The Member Outreach and Engagement Workgroup reports directly to the Performance Improvement Team (PIT). Discussions during these meetings include trends in barriers, opportunities for improvement, best practices, and identified interventions surrounding outreach and engagement practices amongst the different functional areas. The workgroup meets monthly to review performance metrics, evaluate outreach strategies, and address known and emerging barriers to member engagement. By combining diverse perspectives and departmental insights, the workgroup develops actionable recommendations to refine messaging, adjust outreach timing, enhance communication channels, and align internal workflows. The Member Outreach and Engagement Workgroup directly supports **Carolina Complete**'s broader QI goals by ensuring that outreach strategies remain data-informed, member-centered, and operationally feasible. It plays a critical role in translating outreach performance data into practice changes that strengthen the effectiveness of both individual and population-level interventions. It plays a critical role in translating outreach performance data into practice changes that strengthen the effectiveness of both individual and population-level interventions.

Barriers	Interventions
• **Knowledge and Awareness:** Parents may not know which vaccines are required or when they are due. • **Access to Care:** Caregivers may struggle with scheduling, transportation, clinic hours, or finding a provider. • **Misinformation:** Some families may have concerns or misinformation about vaccine safety, especially in rural or underserved communities.	**Multi-Channel Outreach: Carolina Complete** developed and implemented this targeted, multi-channel member outreach intervention aimed at improving timely childhood immunization compliance. The outreach methods include a combination of direct calls, text messages, proactive outreach member (POM) automated calls, postcards, and letters to parents and caregivers.

Table 89—Barriers and Interventions for Healthy Blue

Barriers	Interventions
Missed reporting/database.	Increase receipt of provider supplemental data/EHR integration. During contract renewals, an incentive will be implemented for supplemental data submission and EHR connectivity for those providers with value-based agreements.
Missed opportunities to collaborate with AMH Tier 1 and 2 providers.	Educate AMH Tier 1 and 2 providers regarding utilization of gap-in-care reports. The **Healthy Blue** Healthcare Network team plans to connect with targeted (AMH) Tier 1 and 2 providers to solicit their participation. The objective is to instruct these PCPs on how to retrieve their individualized Gaps-In-Care (GIC) reports and employ this information for closing member care gaps.
• Access to care. • Vaccine hesitancy. • Vaccine availability in pediatric offices. • Children are unable to get vaccinations at pharmacies.	Immunization events based on geographic distribution by race: Using the member GIC reports, specific ZIP Codes for non-compliance will be targeted to partner with provider groups and local health departments in those locales and hold immunization events. Consideration will also be given to the influenza vaccination, as it typically represents a missing sub-measure of CIS Combo 10, when planning the education and events.
Vaccine hesitancy.	Member incentive flyer mailing. **Healthy Blue** aims to increase member awareness of monetary rewards for flu vaccinations and other healthy activities, such as well visits, to encourage timely completion of CIS Combo-10 vaccinations.
• Lost opportunity at sick visits. • Vaccine requires refrigeration (added cost).	Pay for Quality (P4Q) provider incentive. This incentive program targets providers not in a value-based program and rewards them for helping **Healthy**

Barriers	Interventions
• Local health departments serve as vaccine repositories (coordination of care). • Personnel needed at pediatric offices.	**Blue** members meet HEDIS quality standards. Incentives are based on CIS combo 10 performance and claims received, and providers receive a monthly gap in care report.

Table 90—Barriers and Interventions for UnitedHealthcare

Barriers	Interventions
Lack of provider knowledge (timing/age restrictions) vaccine hesitancy and accessibility.	**Rotavirus Vaccine Provider:** This intervention focuses on educating providers about rotavirus vaccination, a required antigen of the *Childhood Immunization Status—Combination 10* (*CIS-10*) measure, while also promoting the adoption of the 2-dose rotavirus vaccine schedule as a strategy to reduce member barriers and enhance compliance.
Data sharing through EMR interfaces, accurate claims, and billing	**Utilizing structured data to enhance CIS Combo-10 rates:** This is a provider and system intervention with the aim of improving administrative rates. The intervention includes collaboration between UnitedHealthcare Community Plan of North Carolina (UHCCP NC) and Kidzcare Pediatrics with the aim to increase CIS-10 compliance rates.
Appointment adherence, knowledge deficit, access and availability, transportation.	**Community Health Worker Member Outreach to address CIS-10 care opportunities:** This is a member-focused intervention Live calling telephonic outreach aiding with appointment scheduling, reminder, and follow up phone calls.

Table 91—Barriers and Interventions for WellCare

Barriers	Interventions
• Vaccine hesitancy and resistance • Ineffective member outreach • Prioritization of highest risk members	**CIS Combo 10 Member Outreach:** CIS Member Outreach prioritizing members aged 21–23 months who are able to receive needed vaccines in the appropriate time frame.
• Need prioritization of at-risk members • Provider staffing barriers and lack of engagement	**Vaccine parties offered to providers and community partners:** Providers/community partners are determined from regional compliance data to focus on areas with the greatest need for improvement, addressing low compliance rates with the CIS Combo 10 immunizations. If agreed, meetings are set up to collaborate and coordinate the

Barriers	Interventions
	event. Once event date and time is established, member parents are contacted by Care Engagement Specialists Team/other QI staff to inform them of the event.
• Administrative burden of NCIR • Rates delayed due to claims • Inaccuracy of claims • Low rate of gap closure for CIS Combo 10	**CIS Combo 10 Epic Payer Platform (EPP) Pilot:** This provider/administrative intervention is to conduct a pilot program involving at least two healthcare providers implementing the EPP.

SPs: HEDIS CIS—Combo 10 PIP

Table 92 through Table 96 illustrate the barriers and interventions for the *HEDIS CIS—Combo 10* PIP.

Table 92—Barriers and Interventions for AmeriHealth

Barriers	Interventions
Member vaccination hesitancy and adherence well child visits	TeleECHO Project: A 6-month educational, coaching, and QI series on childhood and adolescent immunizations and well-child visits for identified providers starting March 28, 2024, through September 25, 2024. Providers will pull data from their own practices monthly to show performance within their practice for meeting immunization and well visits. Providers will obtain Continuing Medical Education and Maintenance of Certification Improvement in Medical Practice credits for participating fully in the education and QI series.
Incorrect provider coding and documentation	
Lack of documentation in NCIR	
Providers not using Modifier 25 for Evaluation/ Management services during sick visits	

Table 93—Barriers and Interventions for Carolina Complete

Barriers	Interventions
Limited Record Collection: This intervention addresses limited record collection for immunization outside of NCIR.	**Administrative Intervention:** This intervention is designed to improve administrative reporting of childhood immunizations by ensuring robust data collection and targeted provider outreach. To maximize provider reporting, **Carolina Complete** is evaluating all existing data streams it uses to process immunization compliance data. During this continuous data collection, **Carolina Complete** analyzes results to identify trends and patterns in care,

Barriers	Interventions
	allowing for more targeted and efficient gap-closing efforts from providers.
• **Access to Care:** Caregivers may face challenges with access to care (e.g., lack of transportation, limited appointment availability) or may have difficulty navigating the healthcare system. • **Knowledge/Understanding:** Caregivers may lack awareness that their child is overdue for immunizations or may not understand the urgency of completing the full vaccine series on time. • **Continuity of Care:** The fragmented nature of care delivery across multiple health plans can lead to missed opportunities for gap closure.	**All-PHP Vaccine Events:** This intervention is a QI initiative designed to improve CIS-10 measure performance across North Carolina and was developed in collaboration with all five North Carolina Medicaid PHPs. Recognizing the need for a unified strategy to improve childhood immunization rates the PHPs began coordinating on-site vaccination events in partnership with local pediatric and family medicine providers across the State. The structure of the initiative reduces the burden on providers. The PHPs jointly plan and coordinate all of the logistics; the providers only need to host the event. The PHPs collectively enhance engagement by organizing extracurricular activities (e.g., face painting, giveaways, interactive games) and schedule events during school breaks and closures to foster a sense of community. This creates a high-impact opportunity for providers to support quality performance and improve access to care for their patients. Each participating PHP identifies members to the provider under the age of two years old who are due for any required CIS-10 immunizations. PHPs then directly outreach to those members' caregivers to encourage attendance at a designated vaccine event. The PHPs strategically schedule the events to reduce access barriers while simultaneously leveraging the existing provider-patient relationship, which enhances trust. This initiative reflects a coordinated, statewide strategy among all five North Carolina Medicaid PHPs, demonstrating collaboration and a unified effort to improve childhood immunization rates. This model increases provider participation and ensures more equitable access to immunizations for Medicaid members regardless of plan attribution due to the unified approach among all five Medicaid PHPs that allows for consistent outreach, expanded community engagement, and shared resources, all of which

Barriers	Interventions
	contribute to more equitable vaccine access for Medicaid-enrolled children across North Carolina.
• **Inaccurate Member Contact Information:** Outdated or incorrect phone numbers, addresses, or emails reduce the success of outreach efforts and limit member engagement. • **Insufficient Health Plan Cohesion:** Misalignment across departments can lead to fragmented outreach strategies and reduced impact. Lack of regular cross team planning can result in outreach that is reactive instead of proactive. • **Inconsistent Messaging Across Channels:** Caregivers may receive conflicting or unclear messages from different departments, weakening trust and creating confusion amongst outreach efforts.	**Member Outreach and Engagement Workgroup:** Internal work groups and committees play a pivotal role in the work of the QI department at **Carolina Complete**. These work groups and committees aid in prioritizing initiatives, focusing on members with the greatest need or an initiative's expected impact on health outcomes and member experience. **Carolina Complete** established the Member Outreach and Engagement Workgroup as a system-level intervention designed to improve outreach effectiveness and member engagement. This internal workgroup brings together staff from Quality, Marketing, Case Management, and the Call Center to analyze outreach efforts and identify opportunities for improvement. The Member Outreach and Engagement Workgroup reports directly to the Performance Improvement Team (PIT). Discussions during these meetings include trends in barriers, opportunities for improvement, best practices, and identified interventions surrounding outreach and engagement practices amongst the different functional areas. The workgroup meets monthly to review performance metrics, evaluate outreach strategies, and address known and emerging barriers to member engagement. By combining diverse perspectives and departmental insights, the workgroup develops actionable recommendations to refine messaging, adjust outreach timing, enhance communication channels, and align internal workflows. The Member Outreach and Engagement Workgroup directly supports **Carolina Complete**'s broader QI goals by ensuring that outreach strategies remain data-informed, member-centered, and operationally feasible. It plays a critical role in translating outreach performance data into practice changes that strengthen the effectiveness of both individual and population-level interventions. It plays a critical role in translating outreach performance data into practice changes that strengthen the effectiveness of both individual and population-level interventions.

Barriers	Interventions
• **Knowledge and Awareness:** Parents may not know which vaccines are required or when they are due. • **Access to Care:** Caregivers may struggle with scheduling, transportation, clinic hours, or finding a provider. • **Misinformation:** Some families may have concerns or misinformation about vaccine safety, especially in rural or underserved communities.	**Multi-Channel Outreach: Carolina Complete** developed and implemented this targeted, multi-channel member outreach intervention aimed at improving timely childhood immunization compliance. The outreach methods include a combination of direct calls, text messages, POM automated calls, postcards, and letters to parents and caregivers.

Table 94—Barriers and Interventions for Healthy Blue

Barriers	Interventions
Missed reporting/database.	Increase receipt of provider supplemental data/ EHR integration: During contract renewals, an incentive will be implemented for supplemental data submission and EHR connectivity for those providers with value-based agreements.
Missed opportunities to collaborate with AMH Tier 1 and 2 providers.	Educate AMH Tier 1 and 2 providers regarding utilization of gap-in-care reports. The **Healthy Blue** Healthcare Network team plans to connect with targeted (AMH) Tier 1 and 2 providers to solicit their participation. The objective is to instruct these PCPs on how to retrieve their individualized GIC reports and employ this information for closing member care gaps.
• Access to care. • Vaccine hesitancy. • Vaccine availability in pediatric offices. • Children are unable to get vaccinations at pharmacies.	Immunization events based on geographic distribution by race: Using the member GIC reports, specific ZIP Codes for non-compliance will be targeted to partner with provider groups and local health departments in those locales and hold immunization events. Consideration will also be given to the influenza vaccination, as it typically represents a missing sub-measure of CIS Combo 10, when planning the education and events.
Vaccine hesitancy.	Member incentive flyer mailing: **Healthy Blue** aims to increase member awareness of monetary rewards for flu vaccinations and other healthy activities, such as well visits, to encourage timely completion of CIS Combo-10 vaccinations.
• Lost opportunity at sick visits. • Vaccine requires refrigeration (added cost).	Pay for Quality (P4Q) provider incentive. This incentive program targets providers not in a value-

Barriers	Interventions
• Local health departments serve as vaccine repositories (coordination of care). • Personnel needed at pediatric offices.	based program and rewards them for helping **Healthy Blue** members meet HEDIS quality standards. Incentives are based on CIS combo 10 performance and claims received, and providers receive a monthly GIC report.

Table 95—Barriers and Interventions for UnitedHealthcare

Barriers	Interventions
Lack of provider knowledge (timing/age restrictions) vaccine hesitancy and accessibility.	**Rotavirus Vaccine Provider:** This intervention focuses on educating providers about rotavirus vaccination, a required antigen of the *Childhood Immunization Status—Combination 10* (*CIS-10*) measure, while also promoting the adoption of the 2-dose rotavirus vaccine schedule as a strategy to reduce member barriers and enhance compliance.
Data sharing through EMR interfaces, accurate claims, and billing	**Utilizing structured data to enhance CIS Combo-10 rates:** This is a provider and system intervention with the aim of improving administrative rates. The intervention includes collaboration between **UnitedHealthcare** Community Plan of North Carolina (UHCCP NC) and Kidzcare Pediatrics with the aim to increase CIS-10 compliance rates.
Appointment adherence, knowledge deficit, access and availability, transportation.	**Community Health Worker Member Outreach to address CIS-10 care opportunities:** This is a member-focused intervention: Live calling telephonic outreach aiding with appointment scheduling, reminder, and follow up phone calls.

Table 96—Barriers and Interventions for WellCare

Barriers	Interventions
• Vaccine hesitancy and resistance • Ineffective member outreach • Prioritization of highest risk members	**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.
• Need prioritization of at-risk members • Provider staffing barriers and lack of engagement	**Vaccine parties offered to providers and community partners:** Providers/community partners are determined from regional compliance data to focus on areas with the greatest need for improvement, addressing low compliance rates with the CIS Combo 10 immunizations. If agreed,

Barriers	Interventions
	meetings are set up to collaborate and coordinate the event. Once event date and time is established, member parents are contacted by Care Engagement Specialists Team/other QI staff to inform them of the event.
• Administrative burden of NCIR • Rates delayed due to claims • Inaccuracy of claims • Low rate of gap closure for CIS Combo 10	**CIS Combo 10 EPP Pilot:** This provider/administrative intervention is to conduct a pilot program involving at least two healthcare providers implementing the EPP.

SPs: HEDIS PPC PIP

Table 97 and Table 101 through illustrate the barriers and interventions for the *HEDIS PPC* PIP.

Table 97—Barriers and Interventions for AmeriHealth

Barriers	Interventions
Lack of PHP engagement with prenatal care providers.	**AmeriHealth** developed a new strategic initiative with large Advanced Medical Home Tier 3 (AMH3) and Clinically Integrated Network (CIN) partners. This initiative will allow **AmeriHealth** the opportunity to share information on the new **AmeriHealth** Maternity Care Incentive Program, where providers are eligible to receive a $20 payment for each member attributed to their practice for whom and appropriate CPT II code has been submitted. Providers are eligible for a $20 payment for submitting an 0500F code at the first prenatal visit, as well as a $20 payment for submitting an 0503F code at the postpartum visit.
Historical claims data indicated that many OB/GYN providers were not utilizing CPT Category II codes to capture the date of first prenatal visit and/or the postpartum visit, limiting **AmeriHealth**'s ability to understand current PPC performance and care.	Improve Administrative Rate Capture through Increased utilization of Current Procedural Terminology (CPT) Category II Codes among OB/GYN providers by utilizing targeted outreach and providing education to providers for which **AmeriHealth** did not receive CPT Category II 0500F claims during the baseline period.
Members do not complete postpartum visits within 7-84 days of delivery.	**AmeriHealth** Doula Expansion Project: Expansion of **AmeriHealth** Doula Pilot Project to have community-based doula services available to an additional 140

Barriers	Interventions
	members (approximate) in an increased number of the 6 North Carolina Medicaid Regions.

Table 98—Barriers and Interventions for Carolina Complete

Barriers	Interventions
• **Members:** – Pregnant members often report a lack of personalized and culturally appropriate care. – Members experience a lack of trust in the healthcare system because of limited involvement in prenatal care. – Members have a perception of low support of culturally similar providers, support systems, and fellow pregnant members throughout care. • **Providers:** – Time constraints, burnout, cultural competency, member engagement and continuity of care are all barriers for providers.	**Group Prenatal Care (GPC) Campaign: Carolina Complete** is creating a pilot program to engage with targeted members and providers to participate in group prenatal care, following the Centering Pregnancy (CP) model from the Centering Healthcare Institute (CHI). CHI is a nonprofit organization that works directly with providers to implement group health care programs, including a program specifically for pregnancy.
• **Knowledge and Awareness:** Members are unaware of the resources available to them from **Carolina Complete** and other community partners. • **Support Systems:** There is a lack of consistency and presence of healthcare educators in this geographic area. • **Culturally Responsive Care:** American Indian (AI) members often have a distinct cultural approach to pregnancy and childbirth and therefore are not aware of the current recommendations for timeliness of care. • **Community Education Resources:** Members often cannot attend optional appointments and support groups offered outside their community due to a lack of transportation.	**Monthly Moms Collaborative: Carolina Complete** is developing a monthly community engagement collaborative dedicated to AI pregnant and postpartum members who live in the Pembroke, NC area. The direct interaction between **Carolina Complete** and members will allow for facilitated discussion and education regarding a variety of pregnancy- and child-related topics specific to this population.
• **Member Engagement:** Difficulty reaching members telephonically for Start Smart for Your Baby (SSFB) program enrollment. • **Time Constraints:** Members are unable to commit the amount of time required for **Carolina Complete** staff to complete telephonic assessments necessary for enrollment.	**Wellframe for Moms and Babies (WoMB):** WoMB participants will be digitally linked to a quality improvement coordinator (QIC). The QIC who is leading the WoMB intervention is a Licensed Practical Nurse (LPN) and lactation consultant and therefore equipped to deliver the support that may be necessary to answer members' questions, as well as

Barriers	Interventions
• **Perceived Lack of Benefit:** Members who are multiparous failing to see the benefits of the program. • **Evolving Needs during Pregnancy:** SSFB cases being closed prior to delivery, limiting the SSFB case managers from being able to conduct thorough postpartum assessments and provide adequate support during the postpartum time period. Members only being offered enrollment in SSFB during their first trimester due to limited staff capability.	refer them to the SSFB program, should case management be appropriate.
• **Time Constraints:** Parents spend long hours at the hospital, making it difficult to schedule or attend their own postpartum or follow-up appointments. • **Transportation:** Families may be traveling back and forth to specialized neonatal intensive care units (NICUs), often far from home, which limits their capacity to attend other visits. • **Care Coordination:** Multiple specialist appointments can take precedence over maternal care needs, reducing the mother's ability to attend postpartum care. • **Psychosocial and Emotional Complexities:** High stress, anxiety, or postpartum depression are more common after preterm birth or NICU admission, which can reduce capacity for self-care. • **Caregiver Priorities:** Mothers often prioritize the infant's survival and follow-up appointments over their own postpartum care.	**NICU and Preterm Engagement:** The NICU and Preterm Engagement initiative expands the scope of the SSFB care management (CM) program. While SSFB focuses on prenatal and postpartum care for all pregnant members, the QI team at **Carolina Complete** developed this intervention to identify **Carolina Complete** members whose newborns were admitted to the NICU or were preterm at birth to offer enrollment in SSFB for the remainder of the postpartum period. Recognizing that NICU stays often occur without prior pregnancy complications, many birthing parents may be unprepared for the emotional, physical, and social challenges that follow, such as breastfeeding, postpartum depression, and disrupted postpartum recovery. These unique needs underscore the importance of proactive outreach after delivery.
• **Multiple Methods:** Providers use multiple methods to report prenatal and postpartum care visits. • **Not Receiving all Data in Claims:** Providers do not send all applicable data in the member claim such as with bundled billing. • **Billing Guidelines:** Current billing guidelines can create insufficient data required to close the care gap.	**Administrative Intervention:** This intervention is designed to improve administrative reporting of prenatal and postpartum visits by ensuring robust data collection and targeted provider outreach. To maximize provider reporting, **Carolina Complete** is evaluating all existing data streams it uses to process prenatal and postpartum visit data. During this continuous data collection, **Carolina Complete** analyzes results to identify trends and patterns in care, allowing for more targeted and efficient gap-closing efforts from providers.

Barriers	Interventions
• **Provider Assignment:** Members may not always obtain their prenatal and postpartum visit from their assigned provider.	**Carolina Complete** is dedicated to shifting from a focus on retrospective HEDIS data collection toward a more structured year-round data collection strategy with the utilization of Current Procedural Terminology (CPT) Category II codes. To further this goal, this intervention focuses on identifying members for whom are pregnant or that **Carolina Complete** has received a claim or the medical chart indicating there was a prenatal or postpartum visit, but the documentation is missing key details to close the care gap. The overarching goals of this effort are to decrease medical record requests, enhance the identification of opportunities to improve patient care, and decrease provider abrasion from unnecessary outreach.

Table 99—Barriers and Interventions for Healthy Blue

Barriers	Interventions
Provider knowledge deficit related to CPT II codes when global billing	Educate providers on CAT II codes billing (0500F and 0503F) when global billing will impact Timeliness of Prenatal Care and Postpartum Care.
• Provider knowledge deficit related to CPT II code billing • Providers global billing without the CPT II code	Practice consultants (PC) educated Obstetric Quality Incentive Program (OBQIP) providers that are not performing at target for Timeliness of Prenatal & Postpartum care on their CY 2023 performance scorecards. OB consultants shared the scorecards with 3 providers that are enrolled in OBQIP Performance program. The scorecards are discussed during regular provider meetings. Sharing this report with providers will afford them the opportunity to improve or meet their target rates. PC will educate and encourage providers to submit on CAT II code 0500F & 0503F when global billing.

Table 100—Barriers and Interventions for UnitedHealthcare

Barriers	Interventions
Knowledge deficit CPT II utilization.	**Obstetrics (OB) Provider Support Model:** This is a provider focused intervention, aimed at improving administrative rates. Focused OB provider in person, electronic, and virtual outreach to provide education related to CPT II codes, also referred to as F-codes,

Barriers	Interventions
	requirements, and sharing of best practices in utilization of CPT II codes.
Motivational, Financial	**OB Provider Incentives:** This is a provider intervention. Through the Community Plan Primary Care Professional Incentive (CP-PCPi) program, providers can earn bonuses for helping UHCCP NC members become more engaged in their preventive health care. UHCCP NC introduced a new incentive program in 2024 for select OB providers to receive financial incentive for closing Prenatal and Postpartum Care (PPC) care opportunities during the current measurement year. The Maternal Child Health (MCH) team serves as the primary quality liaison for participating OB provider offices in this program.
Appointment adherence, knowledge deficit, access and availability, transportation, racial disparity.	**Community Health Worker (CHW) Member Outreach to address PPC opportunities for Black, Indigenous, and People of Color (BIPOC) population:** This is a member focused intervention. Live calling telephonic outreach aiding with appointment scheduling, reminder, and follow up phone calls.

Table 101—Barriers and Interventions for WellCare

Barriers	Interventions
• Data barriers. • Provider engagement barriers • PCP accountability and buy in for OB/GYN specialist visit reporting • Staffing barriers and data concerns • Medical record exchange and access • Data collection barriers	Provider Partnership: AMH/PCPs are held accountable for servicing OB/GYN coding practices. • The **WellCare** Dashboard data to review performance rates for PPC by region and identify provider practices with the greatest opportunity for rate improvement. • Quality Practice Advisors perform outreach to engaged providers within identified region to share data findings; provide PPC measure education, best practices, and 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. • Quality Practice Advisors have disseminated information to providers on PPC quality incentives and discussed their potential earnings for closing gaps.

Barriers	Interventions
	• Selected providers with the greatest opportunity for improvement have agreed to allow Quality Practice Advisors to perform a targeted chart retrieval sprint utilizing the practice's EMR system. • QI staff worked with practices to determine next steps on chart retrieval process via EMR-granted access or in-person retrieval. • 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: – Provider Performance—to track and evaluate provider performance for compliance both pre- and post-intervention. – Chart Review—to evaluate the accessibility of charts within the EMR. – Compliant Chart Retrieval—to track and evaluate the number of compliant prenatal and postpartum records retrieved for pseudo-claim gap closure.

SPs: HEDIS GSD PIP

Table 102 through Table 106 illustrate the barriers and interventions for the *HEDIS GSD* PIP.

Table 102—Barriers and Interventions for AmeriHealth

Barriers	Interventions
Lack of transportation to Diabetes Self-Management Education and Support (DSMES) program classes	The DSMES program focuses on self-care behaviors, such as healthy eating, being active, and monitoring blood sugar and is a key step in improving health outcomes and quality of life for people with diabetes.
Lack of access to DSMES programs (i.e., rural areas, class times)	
Unwillingness to participate in DSMES program	
• Inconsistent data and lack of standardization from practices and health care organizations. • Inefficient data exchange.	Increasing Administrative Data Exchange via Data Aggregator—Identify and implement data exchange aggregator vendors between health plan and PCPs to increase Hemoglobin A1C value compliance rates of members in the GSD measure.

Barriers	Interventions
	The data aggregator will be implemented for providers who do not currently utilize the Epic platform as their electronic medical record.
Insufficient GSD CPT Category II codes included in claims.	Implementation of Current Procedural Terminology (CPT) Category II code provider monetary incentive to increase administrative data capture of A1c values. **AmeriHealth** will implement monetary incentives to Providers to increase the utilization of CPT Category II codes to increase administrative data capture for the GSD measure. Data will be evaluated to identify Providers with opportunities to increase CPT Category II code utilization, and the opportunity for monetary compensation will be shared in collaboration with the Provider Network Management (PNM) team via Joint Operating Committees (JOCs) and Provider meetings.
Care coordination barriers for members living with diabetes, including transportation, food, and access to care.	Collaboration with Wider Circle for Health Education and Care Navigation Support - Collaboration with Wider Circle to support health education needs and care navigation support for members in Region 3, specially in Mecklenburg County.

Table 103—Barriers and Interventions for Carolina Complete

Barriers	Interventions
• **Access to Care:** Members with diabetes who do not have well controlled diabetes and need assistance to reduce their A1c levels. • **Lack of Personalized Support:** Need to be able to identify members with an A1c level between 8.0 percent and 9.0 percent who may need additional support and resources that will help them to have improve diabetes management by helping to decrease their A1c levels.	**Health Coaching Referral for Members Glycemic Status:** Members will be contacted to offer **Carolina Complete** Diabetes Health Coaching services to help them improve their A1c level and management of their diabetes. This includes, but is not limited to, telephonic coaching that does not require the member to leave their home, medication education, nutrition coaching, and access to disease self-management tools and education.
• **Continuity/Access to Care:** Members diagnosed with diabetes are not receiving an annual A1c test. • **Time Constraints/Transportation:** Members are currently experiencing external barriers that may	**Hemoglobin A1c (HbA1c) At-Home Test Kits:** **Carolina Complete** partnered with a national vendor to send at-home A1c kits to all eligible members who met the following criteria: • Diagnosis of Type 1 or Type 2 diabetes, and

Barriers	Interventions
be preventing them from physically going into the providers' office.	• Members had a valid mailing address, and • Members' PCP consented to the A1c at-home test kit, and • Members whose most recent A1c result in 2023 was greater than 9 percent, or • Members who did not take an A1c test in 2023.
• **Multiple Methods:** Providers use multiple methods to report A1C results. • **Administrative Burden:** Providers cite administrative burden and/or inability to use CPT II codes. • **Access to Test:** Members may not always obtain their A1C test from their assigned provider.	**Administrative Intervention:** This intervention is designed to improve administrative reporting of A1C results for members living with diabetes by ensuring robust data collection and targeted provider outreach. To maximize provider reporting, **Carolina Complete** is evaluating all existing data streams it uses to process A1C data. During continuous data collection, **Carolina Complete** analyzes results to identify trends and patterns in care, allowing for more targeted and efficient gap-closing efforts from providers. **Carolina Complete** chose this intervention to close care gaps that would not close through claim submission alone. The analysis identifies providers/practices that may not be coding these claims appropriately so that **Carolina Complete** can deliver education on the benefits and importance of using CPT II codes and establish supplemental data extraction to help ease the administrative burden that providers experience. This enables accurate and timely results, allowing for increased opportunities to engage patients in healthy behavior change. **Carolina Complete** is dedicated to shifting from its focus on retrospective HEDIS collection to a more structured year-round data collection strategy with the utilization of CPT II codes. To further this goal, this intervention focuses on identifying members for whom **Carolina Complete** has received a claim for an A1C test but are missing an A1C result. The overarching goals of this effort are to decrease medical record requests, enhance the identification of opportunities to improve patient care, and decrease provider abrasion from unnecessary outreach.

Table 104—Barriers and Interventions for Healthy Blue

Barriers	Interventions
Members are unaware of DSME classes available to them.	Case Manager Outreach—DSMEs. Case Manager will outreach members that are enrolled in Condition Care with diabetes with education on the value of DSME, identifying and accessing DSME programs available locally or online, and assisting members with navigating the DSME enrollment process.
• Providers order HbA1c test; however, some testing labs bill the claim but do not report results. • EHR integration is not in place for PCP to share results.	Collaborate with labs and providers to close care gaps. To close the HEDIS HBD/GSD measure, an HbA1c result is necessary. Claims lacking this result will be identified, and efforts will be made to pursue supplemental data submission with the appropriate entity.

Table 105—Barriers and Interventions for UnitedHealthcare

Barriers	Interventions
Lack of knowledge of CPT II code utilization.	**Diabetes Coding Educations for Providers:** This is a provider-focused intervention with the aim of improving administrative rates for the *Glycemic Status Assessment for Patients With Diabetes (GSD)* measure.
Appointment adherence, medication adherence, knowledge deficit, SDOH, and goal setting.	**Member Educational Outreach:** This is a member-focused intervention. Based on claims analysis, members in the GSD measure who have poor glycemic control (hemoglobin A1c >9%) or who have not completed hemoglobin A1c (A1c) test within the current calendar year are targeted for telephonic care management outreach for diabetes management.

Table 106—Barriers and Interventions for WellCare

Barriers	Interventions
Process, procedural, and provider challenges related to the PHP's receipt of member A1c results.	Diabetes Dashboard Deep Dive • Utilize the Diabetes Deep Dive Dashboard to identify members flagged as "no result." This status occurs when claims indicate that an A1C test was ordered but lacks a CPT II code to document the result. • Quality Practice Advisors (QPAs) will utilize their provider relationships and EHR access to retrieve charts for members identified as "no result" on the Diabetes Dashboard.

Barriers	Interventions
• Socioeconomic constraints and SDOH. • Language barriers. • Family barriers such as schedule conflicts and childcare.	Healthy Choices: Managing Your A1c This intervention was selected to address members' limited knowledge and understanding of diabetes management. • The PHP provides clear details on available transportation options at the time of registration to facilitate attendance. • The PHP ensures that all educational materials, surveys, and communication are available in languages of the participants. • The PHP made a class available on the weekend to accommodate family schedules and allow family participation. The PHP also arranged on-site childcare during classes to ensure parents can attend without worrying about their children.

SPs: Nonclinical HRRN PIP

Table 107 through Table 111 illustrate the barriers and interventions for the *HRRN* PIP.

Table 107—Barriers and Interventions for AmeriHealth

Barriers	Interventions
Missed opportunities to complete CNS during interactions with members in the community.	The "Make Every Encounter Count" intervention was created to ensure all member-facing associates are assisting members in collecting their initial and/or annual CNS at every encounter regardless of reason.
Lack of member outreach for HRRN completion between day 91 and 365.	**POM Campaign:** The POM Campaign is an initiative that will provide HRRN outreach specifically targeting members who are newly enrolled between day 91 and day 365. The POM campaign has an auto-dialer function that will contact members via telephone, inform them of the HRRN screening, and provide an option to connect them with an **AmeriHealth** associate to complete the HRRN during the call.

Table 108—Barriers and Interventions for Carolina Complete

Barriers	Interventions
• **Member Awareness:** Members are not aware of the need for HRRN survey within 90 days of enrollment and avenues to complete the surveys. • **Member Engagement:** Members may not engage with a single form of outreach (e.g., phone or email). • **Member Inaccessibility:** For members who are not comfortable using digital platforms, providing traditional communication methods such as physical mail ensures that these members are not excluded from receiving important information about HRRN screenings.	**Increase Member Outreach Avenues:** Increase ways members are outreached to include live phone calls and texting to educate member on the importance of HRRN screenings and guide them through the process.
• **Lack of Awareness/ Understanding:** Providers may not fully understand the importance of HRRN assessments or how they impact patient care and compliance. The education and training component addresses this by offering detailed information and emphasizing the value of these assessments. • **Time Limitations:** Providers often have limited time during the visits due to competing clinical responsibilities. By providing dedicated support and constant education, the intervention acknowledges their workload and offers motivation and assistance to prioritize HRRN completion.	**Increase Provider Engagement:** **Carolina Complete** will partner with Advance Medical Home (AMH) providers to prioritize HRRN screenings by discussing with members during their visits on the importance of completing the screenings. **Carolina Complete** will provide training sessions to providers about the importance of completing HRRN assessments. Emphasis on the positive impact the screening has on patient outcomes, care coordination, and state compliance requirements. Discuss with providers how they can access the completed assessments as well.

Table 109—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. The Plan uses outreach/education and monetary incentives to encourage members to complete their CNS. In April 2024, the Plan increased the dollar reward amount from $10 to $25. Beginning July 2024, the Plan used short message service (SMS) text message outreach to inform members of this opportunity with the increased dollar reward amount.

Table 110—Barriers and Interventions for UnitedHealthcare

Barriers	Interventions
Time to complete screening, duplication of questions within the HRRN screening and other CM assessments, incorrect phone numbers.	**CHW Member Outreach for HRRN completion:** This is a system intervention. UHCCP NC current standard operating procedure conducts member outreach through the Hospitality Access and Retention Center (HARC) vendor and Care Management teams to complete a HRRN screening.
Members struggling to find time to complete HRRN screenings. Unable to reach members who did not complete the screening.	**Leveraging internal teams to maximize HRRN completion:** This is a system intervention. UHCCP NC current standard operating procedure conducts member outreach through the HARC vendor and Care Management teams to complete a HRRN screening.

Table 111—Barriers and Interventions for WellCare

Barriers	Interventions
• Health plan staff outside of care management who have contact with members who are not completing CNS' that are overdue. • Care engagement specialists (CES) workers contact members for care gap closure purposes but did not previously check for status of CNS completion if due.	**CES Completion of CNS:** CES workers will now review the member's case to determine if a CNS is due, determine if this is an initial or annual screening, and offer to complete the screening over the phone with the member and/or guardian.
WellCare frequently hosts and participates in community events, but it is not built into the current workflow to review the CNS status when outreaching members to invite them to the events. Currently CNS are not completed with members at events.	**Integrating CNS into Wellness and Resource Event:** An event was hosted for members due or overdue for a CNS. Care management volunteered staff to attend the event and complete CNS is needed. A private space was set aside at the event location for the screenings to be completed.
Not all members are receiving the required three outreach attempts by Icario for the screening completion within 90 days or enrollment or reenrollment.	**Icario/Revel Additional Unable to Reach Letter:** WellCare requested that Icario add 1–2 additional letters to those members with no number or an invalid number to ensure all three attempts are completed to meet contractual requirements.
Members would like to, and can complete the screenings themselves, but are unaware of how to access the vendor portal.	**Icario/Revel Quick Response Code Development:** WellCare requested that Icario develop a QR code that can be used to direct members to the Icario portal to complete the CNS. The Icario contract was updated to reflect this request.

PIHPs: FUH PIP

Table 112 through Table 115 illustrate the barriers and interventions for the *FUH* PIP.

Table 112—Barriers and Interventions for Alliance

Barriers	Interventions
Member supportive services after mental health hospitalization discharge, and need for member medication reconciliation review, communications with the member, and support.	48-Hour Outreach to Member After Hospitalization for DHB Medicaid Direct Mental Illness (FUH). Care management clinical nursing staff performs outreach calls to members at a maximum of 48 hours after a member discharges from a mental health provider facility.
• Weak Interoperability and Data Sharing—Low participation in NC HealthConnex and limited infrastructure restrict timely exchange of patient information. • Unreliable admission, discharge, transfer (ADT) Feeds—Inconsistent or missing alerts from NC Notify delay real-time care coordination and outreach.	Enhancing Health Information Technology (HIT) Equity to Improvement FUH 7-Day Performance. This intervention aims to evaluate the impact of HIT capacity on FUH 7-Day performance for Medicaid members. Persistent challenges during prior interventions highlighted the need to strengthen HIT-driven processes within behavioral health discharge workflows, as these directly influence timely member engagement.
Communication, educational gaps, value-based contracting process and outcomes alignment geared toward 7-Day FUH outcomes and HEDIS measures performance.	Provider Education Training Session on VBC—Quality Measures—HEDIS. The purpose of this intervention is providing a framework with targeted education and resources that aim to improve the understanding and application of quality measures.
• Limited or Fragmented electronic health record (EHR) Systems—Many providers lack a functional EHR or use disconnected systems that limit discharge visibility and coordination. • Weak Interoperability and Data Sharing—Low participation in NC HealthConnex and limited infrastructure restrict timely exchange of patient information. • Unreliable ADT Feeds—Inconsistent or missing alerts from NC Notify delay real-time care coordination and outreach.	Enhancing HIT equity to improve FUH 7-day performance. This intervention aims to measure the impact of robust HIT capacity on FUH 7-day performance.

Table 113—Barriers and Interventions for Partners

Barriers	Interventions
• Clinical staff or not becoming aware of members in the hospital or being discharged, timely. • There are several ways that clinical staff become aware of members being inpatient or discharged from the hospital. • Network providers and hospitals have different methods of communicating inpatient member or discharge information, if communicated at all in some instances.	**Improve Communication of Inpatient Hospitalization/discharge information with clinical teams:** Use survey data collected weekly from Care Transitions Team to identify barriers of timely notification and response of Medicaid Direct members' inpatient hospital and discharge status to be addressed.
Systemic issue of clinical staff including providers associated with members not receiving timely notification of members inpatient/discharge status. Patient-related issues like transportation and understanding instructions.	**Understanding the Perspectives on Barriers and Facilitators to Attend Appointments After Discharge:** Identify specific challenges and potential solutions to ensure Medicaid Direct members engage in a follow-up appointment after discharge from the hospital to lead to more effective interventions.
Member can forget appointments amidst the demands of daily life, especially after a disruptive hospital stay.	**Promoting Post-Hospitalization Appointment Adherence:** Provide automated reminders to members about their appointments after hospitalization sent via text messages, emails, or phone calls.
Members may be struggling to follow treatment plans due to the nature of their illness or complex medication schedules. A lack of understanding about their illness and the services available can cause members to delay seeking help or not recognize the need for care at all. Also, these high utilizer members may lack reliable contact information or stable housing, which hinders follow-up care and makes connection to services difficult.	**Extended Supports for High Utilizer Group (HUG):** Care Managers provide additional assessments and supports for life planning activities, including decisions about how care, treatment or services are to be delivered during times when the high utilizer members are unable to make decisions. Care manager documents whether the member has a Psychiatric Advance Directive or other life-planning documents in place and provides written information on life planning and serves as a resource for additional education.

Table 114—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.

Barriers	Interventions
The State Quality Measure Performance Data shows American Indian/Alaska Native (AIAN) populations have lower post-discharge follow-up care rates than non-AIAN populations.	**Trillium** will develop and implement an interactive session for internal team members and community partners serving Tribal members and communities.

Table 115—Barriers and Interventions for Vaya

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:** 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.

PIHPs: FUM PIP

Table 116 through Table 119 illustrate the barriers and interventions for the *FUM* PIP.

Table 116—Barriers and Interventions for Alliance

Barriers	Interventions
Work silos, inconsistent understanding of warm hand-offs.	**FUM Pathway to follow-up infographic:** The purpose of this intervention is to increase awareness across the agency of the pathway and hand-offs for a member who has been discharged from the ED to their follow-up visit.
Providers limited knowledge of the measure and follow-up services.	**FUM Informational Sheet (Providers):** The informational sheet is a document used to enhance the understanding of the measure, billing codes, and the role in meeting the measure among providers.
Internal coordination and collaboration challenges fueled by limited knowledge of the measure and follow-up services.	**FUM Informational Sheet (Internal Alliance Health staff):** 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:** The purpose of this intervention is to provide workshop participants with a comprehensive knowledge of value-based contracting

Barriers	Interventions
	and enhance their understanding of quality measures, such as HEDIS and their application in value-based contracting. The 1½ hour workshop will be videorecorded with participants having access to the recording and any training materials after the session.
Lack of access to communication among members who may not have a reliable phone or a current phone number. Financial constraints in that a member may not be able to afford consistent phone service could also be a barrier.	**Mobile Connectivity:** Leveraging technical to enhance member care. This intervention aims to improve follow-up care for members discharged from the ED with a mental illness diagnosis or intentional self-harm by providing them with a free mobile phone with allotted minutes and data. Members can experience barriers to communication, which can lead to missed follow-up appointments as well as gaps in care and services. By supplying mobile phones with minutes and data, this intervention is geared at improving the opportunity to reach members (with an updated contact phone number) to schedule follow-up appointments as well as other activities related to medication adherence, crisis intervention, and social support services.

Table 117—Barriers and Interventions for Partners

Barriers	Interventions
• Clinical staff are not becoming aware of member ED visits, timely. • There are several ways that clinical staff become aware of members in the ED. • Network providers and hospitals have different methods of communicating member ED visit information with clinical teams.	**Improve the Communication of Member ED visits with clinical teams:** Use survey data collected weekly from CTT to identify barriers of timely notification and response of Medicaid Direct members' inpatient hospital and discharge status to be addressed.
Systemic issue of clinical staff including providers associated with members not receiving timely notification of members being in the ED. Member-related issues like transportation and understanding instructions.	**Understanding the Perspectives on Barriers and Facilitators to Attend Appointments after ED visit:** Identify specific challenges and potential solutions to ensure Medicaid Direct members engage in a follow-up appointment after ED visit to lead more effective interventions.
Members can forget appointments amidst the demands of daily life, especially after a disruptive ED visit.	**Promoting Post-ED Visit Appointment Adherence:** Provide automated reminders to members about their appointments after ED visit sent via text messages, emails, or phone calls.

Barriers	Interventions
Members may be struggling to follow treatment plans due to the nature of their illness or complex medication schedules. A lack of understanding about their illness and the services available can cause members to delay seeking help or not recognize the need for care at all. Also, these high utilizer members may lack reliable contact information or stable housing, which hinders follow-up care and makes connection to services difficult.	**Extended Supports for High Utilizer Group (HUG):** Care Managers provide additional assessments and supports for life planning activities, including decisions about how care, treatment or services are to be delivered during times when the high utilizer members are unable to make decisions. Care manager documents whether the member has a Psychiatric Advance Directive or other life-planning documents in place and provides written information on life planning and serves as a resource for additional education.

Table 118—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.
The CY2023 State Quality Measure Performance Data shows AIAN populations have lower post-discharge follow-up care rates than non-AIAN populations.	**Trillium** will develop and implement an interactive session for internal team members and community partners serving Tribal members and communities.

Table 119—Barriers and Interventions for Vaya

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 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:** This intervention will focus on providing education to providers regarding HEDIS *FUM* measure, why this is important for patient care, and tips EDs and follow-up providers can implement to improve performance.

PIHPs: Nonclinical HRRN PIP

Once the PIHPs progress to reporting barriers and interventions, the barriers and interventions will be included in subsequent years' technical reports.

TPs: PIPs

Once the TPs progress to reporting barriers and interventions, the barriers and interventions will be included in subsequent years' technical reports.

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 the health plans are required to measure and report to the Department. Others will be directly measured by the Department or its 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*[72], and other public-facing SP stratified data, due to potential differences in source data (e.g., supplemental data sources) 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 120 presents the MY 2022 through MY 2024 performance measure results for the SPs (trending provided as available).

Table 120—MY 2022–MY 2024 Performance Measure Results for SPs

Performance Measures	MY	AmeriHealth	Carolina Complete	Healthy Blue	United-HealthCare	WellCare
Cervical Cancer Screening	MY 2022	45.88%	50.93%	50.04%	45.73%	50.90%
	MY 2023*					
	MY 2024	49.60%	50.15%	46.77%	48.18%	48.23%
Child and Adolescent Well-Care Visits—3–11 Years	MY 2022	57.88%	58.12%	61.53%	54.72%	59.88%
	MY 2023	61.50%	61.34%	63.07%	59.95%	61.16%
	MY 2024	62.69%	64.16%	64.96%	62.95%	63.76%
Child and Adolescent Well-Care Visits—12–17 Years	MY 2022	50.32%	50.46%	54.50%	47.05%	51.92%
	MY 2023	53.28%	54.19%	55.75%	51.80%	53.49%
	MY 2024	54.95%	56.29%	57.82%	54.72%	56.47%

[72] 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: Mar 2, 2026.

Performance Measures	MY	AmeriHealth	Carolina Complete	Healthy Blue	United-HealthCare	WellCare
Child and Adolescent Well-Care Visits—18–21 Years	MY 2022	24.13%	24.53%	26.53%	21.58%	25.29%
	MY 2023	27.24%	28.31%	29.85%	25.93%	27.68%
	MY 2024	29.61%	31.69%	31.56%	29.03%	31.41%
Child and Adolescent Well-Care Visits—Total	MY 2022	50.15%	50.33%	53.69%	46.70%	52.11%
	MY 2023	53.61%	54.03%	55.43%	52.15%	53.76%
	MY 2024	55.10%	56.62%	57.28%	55.10%	56.61%
Childhood Immunization Status—Combo 10	MY 2022	23.90%	27.06%	26.48%	25.77%	28.60%
	MY 2023	23.45%	25.04%	25.41%	24.67%	26.44%
	MY 2024	24.68%	24.84%	23.19%	23.47%	26.93%
Concurrent Use of Opioids and Benzodiazepines—18–64 Years	MY 2022	10.42%	9.08%	13.35%	12.57%	12.31%
	MY 2023	10.75%	8.86%	13.54%	12.70%	12.83%
	MY 2024	11.11%	9.49%	12.76%	11.88%	11.67%
Concurrent Use of Opioids and Benzodiazepines—65+ Years	MY 2022	NA	NA	6.25%	NA	NA
	MY 2023	NA	NA	NA	NA	NA
	MY 2024	NA	NA	NA	NA	NA
Controlling High Blood Pressure—18–64 Years	MY 2024	52.04%	46.87%	43.73%	48.75%	50.93%
Controlling High Blood Pressure—65+ Years	MY 2024	53.96%	44.83%	39.15%	48.55%	48.04%
Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—18–64 Years	MY 2024	41.03%	36.53%	32.08%	36.11%	39.59%
Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—65–75 Years	MY 2024	48.48%	32.61%	35.07%	40.34%	46.39%
Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0%—18–64 Years	MY 2024	53.10%	58.23%	63.24%	58.37%	54.60%

Performance Measures	MY	AmeriHealth	Carolina Complete	Healthy Blue	United-HealthCare	WellCare
Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0%—65–75 Years	MY 2024	46.21%	61.96%	58.77%	57.39%	47.59%
Immunizations for Adolescents—Combination 2	MY 2022	27.27%	31.60%	30.91%	26.36%	30.78%
	MY 2023	28.13%	32.28%	30.43%	28.01%	31.55%
	MY 2024	29.92%	33.62%	32.54%	30.11%	32.34%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	MY 2022	55.66%	51.88%	51.64%	48.42%	53.48%
	MY 2023	58.21%	55.13%	53.43%	49.82%	50.62%
	MY 2024	68.19%	58.43%	57.49%	56.78%	63.32%
Prenatal and Postpartum Care—Postpartum Care	MY 2022	64.97%	63.33%	64.44%	62.63%	67.70%
	MY 2023	67.37%	65.58%	64.80%	66.13%	67.99%
	MY 2024	75.44%	70.25%	69.71%	72.58%	73.84%
Screening for Depression and Follow-Up Plan—12–17 Years	MY 2023	2.66%	1.90%	4.00%	5.55%	3.22%
	MY 2024	4.12%	1.85%	4.14%	4.25%	3.93%
Screening for Depression and Follow-Up Plan—18–64 Years	MY 2023	0.86%	0.36%	2.11%	2.97%	3.55%
	MY 2024	1.91%	0.72%	1.87%	2.30%	2.00%
Screening for Depression and Follow-Up Plan—65+ Years	MY 2023	0.00%	0.00%	2.96%	3.22%	4.46%
	MY 2024	1.34%	0.92%	1.95%	2.25%	1.36%
Screening for Depression and Follow-Up Plan—Total	MY 2023	1.59%	1.04%	2.84%	4.05%	3.42%
	MY 2024	2.67%	1.13%	2.59%	2.90%	2.64%
Well-Child Visits in the First 30 Months of Life—First 15 Months	MY 2022	62.01%	64.62%	65.34%	58.37%	64.53%
	MY 2023	66.32%	67.11%	67.68%	63.91%	66.79%
	MY 2024	68.28%	69.21%	68.84%	66.35%	68.58%
Well-Child Visits in the First 30 Months of Life—15–30 Months	MY 2022	66.76%	68.64%	71.21%	66.34%	71.18%
	MY 2023	70.30%	69.92%	72.45%	68.42%	71.59%
	MY 2024	72.75%	72.24%	74.08%	71.75%	74.40%

NA—Measure rates that results in an NA are considered reportable; however, the denominator is too small to report (e.g., less than 30).
* Performance measure not reported in denoted year.

PIHP Results

Table 121 presents the MY 2024 performance measure results for the PIHPs.

Table 121—MY 2024 Performance Measure Results for PIHPs

Performance Measures	MY	Alliance	Partners	Trillium	Vaya
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	2024	4.41%	48.05%	24.48%	14.96%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	2024	4.49%	55.88%	8.11%	21.67%
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—1–11 Years	2024	32.07%	53.72%	14.17%	24.39%
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—12–17 Years	2024	51.47%	62.37%	27.92%	40.38%
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	2024	45.17%	59.46%	23.93%	35.86%
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—1–11 Years	2024	21.73%	43.62%	6.15%	12.20%
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—12–17 Years	2024	34.04%	47.85%	7.85%	24.68%
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	2024	30.05%	46.43%	7.36%	21.15%
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—1–11 Years	2024	17.93%	42.55%	5.61%	10.57%
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—12–17 Years	2024	31.51%	44.89%	6.54%	23.40%
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	2024	27.10%	44.11%	6.27%	19.77%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—1–11 Years	2024	35.48%	61.05%	39.52%	42.41%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—12–17 Years	2024	44.44%	51.05%	42.69%	42.86%

Performance Measures	MY	Alliance	Partners	Trillium	Vaya
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	2024	41.96%	53.92%	41.85%	42.73%
Concurrent Use of Opioids and Benzodiazepines—18–64 Years	2024	9.62%	17.67%	12.83%	4.22%
Concurrent Use of Opioids and Benzodiazepines—65+ Years	2024	NA	NA	11.11%	NA
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—6–17 Years	2024	36.53%	36.48%	13.99%	39.32%
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—18–64 Years	2024	29.03%	18.07%	2.65%	19.29%
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—65+ Years	2024	11.15%	4.76%	NA	9.57%
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	2024	29.07%	20.32%	4.74%	22.15%
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—6–17 Years	2024	61.05%	59.71%	10.49%	60.68%
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—18–64 Years	2024	48.47%	32.45%	1.06%	31.41%
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—65+ Years	2024	24.20%	11.56%	NA	19.15%
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	2024	48.89%	35.65%	2.85%	35.74%
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—6–17 Years	2024	40.68%	51.27%	67.63%	57.56%
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—18–64 Years	2024	31.82%	30.05%	44.94%	35.15%
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—65+ Years	2024	23.23%	25.73%	16.67%	23.42%
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	2024	33.84%	35.75%	49.69%	40.61%
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—6–17 Years	2024	59.20%	67.66%	45.32%	78.22%

Performance Measures	MY	Alliance	Partners	Trillium	Vaya
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—18–64 Years	2024	47.25%	43.92%	30.70%	46.90%
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—65+ Years	2024	37.74%	38.76%	10.00%	34.23%
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	2024	50.07%	50.27%	33.61%	54.79%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	2024	71.36%	77.64%	39.20%	60.94%

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

TP Results

Since performance measure rates were not required for MY 2024, HSAG completed an ISCA to evaluate the TPs' 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 2025 data. Results of the performance measure validation are reported in Section 2 of this report.

DHB Results

Table 122 presents the MY 2024 performance measure results for the SPs, as calculated by DHB.

Table 122—MY 2024 SP Performance Measure Results

Performance Measures	MY	AmeriHealth	Carolina Complete	Healthy Blue	United-HealthCare	WellCare
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Screening Ratio	2024	0.58	0.61	0.60	0.60	0.61
Rate of Screening for Health-Related Resource Needs (HRRN)	2023	2.8%	2.8%	1.9%	2.5%	14.85%
	2024	6.67%	2.87%	1.74%	3.22%	18.73%

Table 123 presents the MY 2024 performance measure results for the PIHPs, as calculated by DHB.

Table 123—MY 2024 PIHP Performance Measure Results

Performance Measure	MY	Alliance	Partners	Trillium	Vaya
Rate of Screening for Health-Related Resource Needs (HRRN)	2024	3.2%	2.1%	3.9%	2.1%

Appendix D. NAV Indicator Ratings

MCO Name	Standard Type	Indicator Name	Validation Rating
Alliance			
Alliance	PIHP/TP—Capacity Standards—Remeasurement Year (RY) 2025	Ambulatory Detoxification: One or more providers of each crisis service within each PIHP Region.	*High Confidence*
Alliance	PIHP/TP—Capacity Standards—RY 2025	Ambulatory Withdrawal Management With Extended On-Site Monitoring: One or more providers of each crisis service within each PIHP Region.	*High Confidence*
Alliance	PIHP/TP—Capacity Standards—RY 2025	Facility-Based Crisis Services for Children and Adolescents: One or more providers within each PIHP Region.	*High Confidence*
Alliance	PIHP/TP—Capacity Standards—RY 2025	Non-Hospital Medical Detoxification: Two or more providers within each PIHP Region.	*High Confidence*
Alliance	PIHP/TP—Capacity Standards—RY 2025	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.	*High Confidence*
Alliance	PIHP/TP—Capacity Standards—RY 2025	Residential Treatment Facility Services: Access to one or more licensed provider per PIHP Region.	*High Confidence*
Alliance	PIHP/TP—Capacity Standards—RY 2025	Substance Abuse Medically Monitored Residential Treatment: Access to one or more licensed provider per PIHP region.	*High Confidence*
Alliance	PIHP/TP—Capacity Standards—RY 2025	Substance Abuse Non-Medical Community Residential Treatment: Adolescent: Contract with all designated CASPs within the PIHP Region.	*High Confidence*
Alliance	PIHP/TP—Capacity Standards—RY 2025	Substance Abuse Non-Medical Community Residential Treatment: Adult: Access to one or more licensed provider per PIHP Region.	*High Confidence*
Alliance	PIHP/TP—Capacity Standards—RY 2025	Substance Abuse Non-Medical Community Residential Treatment: Women & Children: Contract with all designated CASPs within the PIHP Region.	*High Confidence*

MCO Name	Standard Type	Indicator Name	Validation Rating
Alliance	PIHP/TP—Capacity Standards—RY 2025	Two or more providers of Community/Mobile Services within each PIHP Region; Each county in PIHP Region must have access to one or more Community/Mobile Service providers who are accepting new patients.	*High Confidence*
Alliance	PIHP/TP—Time and Distance—RY 2025	One or more providers of Partial Hospitalization within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
Alliance	PIHP/TP—Time and Distance—RY 2025	One or more providers of Partial Hospitalization within 60 minutes or 60 miles for at least 95% of members—Rural	*High Confidence*
Alliance	PIHP/TP—Time and Distance—RY 2025	Two or more providers of each Location-Based service within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
Alliance	PIHP/TP—Time and Distance—RY 2025	Two or more providers of each Location-Based service within 45 minutes or 45 miles for at least 95% of members—Rural	*High Confidence*
Alliance	PIHP/TP—Time and Distance—RY 2025	Two or more providers of each Outpatient Behavioral Health service within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
Alliance	PIHP/TP—Time and Distance—RY 2025	Two or more providers of each Outpatient Behavioral Health service within 45 minutes or 45 miles for at least 95% of members—Rural	*High Confidence*
Alliance	PIHP/TP—Time and Distance—RY 2025	Two or more Specialty Care providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members—Rural	*High Confidence*
Alliance	TP—Capacity Standards—RY 2025	Two or more 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 NPI, accepting new patients available to deliver each State Health Plan LTSS in every county.	*High Confidence*
Alliance	TP—Time and Distance—RY 2025	Two or more Specialty Care providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members—Urban	*High Confidence*

MCO Name	Standard Type	Indicator Name	Validation Rating
AmeriHealth			
AmeriHealth	SP—Capacity Standards—RY 2025	Two or more 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 NPI, accepting new patients available to deliver each State Health Plan LTSS in every county. —Rural	*High Confidence*
AmeriHealth	SP—Capacity Standards—RY 2025	Two or more providers accepting new patients available to deliver each State Health Plan LTSS in every county—Urban	*High Confidence*
AmeriHealth	SP—Time and Distance—RY 2025	One or more providers of Partial Hospitalization within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
AmeriHealth	SP—Time and Distance—RY 2025	One or more providers of Partial Hospitalization within 60 minutes or 60 miles for at least 95% of members—Rural	*High Confidence*
AmeriHealth	SP—Time and Distance—RY 2025	Two or more providers of each Location-Based service within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
AmeriHealth	SP—Time and Distance—RY 2025	Two or more providers of each Location-Based service within 45 minutes or 45 miles for at least 95% of members—Rural	*High Confidence*
AmeriHealth	SP—Time and Distance—RY 2025	Two or more providers of each Outpatient Behavioral Health service within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
AmeriHealth	SP—Time and Distance—RY 2025	Two or more providers of each Outpatient Behavioral Health service within 45 minutes or 45 miles for at least 95% of members—Rural	*High Confidence*
AmeriHealth	SP—Time and Distance—RY 2025	Two or more Specialty Care providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members—Urban	*High Confidence*
AmeriHealth	SP—Time and Distance—RY 2025	Two or more Specialty Care providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members—Rural	*High Confidence*

MCO Name	Standard Type	Indicator Name	Validation Rating
Carolina Complete			
Carolina Complete	SP—Capacity Standards—RY 2025	Two or more 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 NPI, accepting new patients available to deliver each State Health Plan LTSS in every county—Rural	*High Confidence*
Carolina Complete	SP—Capacity Standards—RY 2025	Two or more providers accepting new patients available to deliver each State Health Plan LTSS in every county—Urban	*High Confidence*
Carolina Complete	SP—Time and Distance—RY 2025	One or more providers of Partial Hospitalization within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
Carolina Complete	SP—Time and Distance—RY 2025	One or more providers of Partial Hospitalization within 60 minutes or 60 miles for at least 95% of members—Rural	*High Confidence*
Carolina Complete	SP—Time and Distance—RY 2025	Two or more providers of each Location-Based service within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
Carolina Complete	SP—Time and Distance—RY 2025	Two or more providers of each Location-Based service within 45 minutes or 45 miles for at least 95% of members—Rural	*High Confidence*
Carolina Complete	SP—Time and Distance—RY 2025	Two or more providers of each Outpatient Behavioral Health service within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
Carolina Complete	SP—Time and Distance—RY 2025	Two or more providers of each Outpatient Behavioral Health service within 45 minutes or 45 miles for at least 95% of members—Rural	*High Confidence*
Carolina Complete	SP—Time and Distance—RY 2025	Two or more Specialty Care providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members—Urban	*High Confidence*
Carolina Complete	SP—Time and Distance—RY 2025	Two or more Specialty Care providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members—Rural	*High Confidence*

MCO Name	Standard Type	Indicator Name	Validation Rating
Healthy Blue			
Healthy Blue	SP—Capacity Standards—RY 2025	Two or more 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 NPI, accepting new patients available to deliver each State Health Plan LTSS in every county. —Rural	*High Confidence*
Healthy Blue	SP—Capacity Standards—RY 2025	Two or more providers accepting new patients available to deliver each State Health Plan LTSS in every county—Urban	*High Confidence*
Healthy Blue	SP—Time and Distance—RY 2025	One or more providers of Partial Hospitalization within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
Healthy Blue	SP—Time and Distance—RY 2025	One or more providers of Partial Hospitalization within 60 minutes or 60 miles for at least 95% of members—Rural	*High Confidence*
Healthy Blue	SP—Time and Distance—RY 2025	Two or more providers of each Location-Based service within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
Healthy Blue	SP—Time and Distance—RY 2025	Two or more providers of each Location-Based service within 45 minutes or 45 miles for at least 95% of members—Rural	*High Confidence*
Healthy Blue	SP—Time and Distance—RY 2025	Two or more providers of each Outpatient Behavioral Health service within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
Healthy Blue	SP—Time and Distance—RY 2025	Two or more providers of each Outpatient Behavioral Health service within 45 minutes or 45 miles for at least 95% of members—Rural	*High Confidence*
Healthy Blue	SP—Time and Distance—RY 2025	Two or more Specialty Care providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members—Urban	*High Confidence*
Healthy Blue	SP—Time and Distance—RY 2025	Two or more Specialty Care providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members—Rural	*High Confidence*

MCO Name	Standard Type	Indicator Name	Validation Rating
Partners			
Partners	PIHP/TP—Capacity Standards—RY 2025	Ambulatory Detoxification: One or more providers of each crisis service within each PIHP Region.	*High Confidence*
Partners	PIHP/TP—Capacity Standards—RY 2025	Ambulatory Withdrawal Management With Extended On-Site Monitoring: One or more providers of each crisis service within each PIHP Region.	*High Confidence*
Partners	PIHP/TP—Capacity Standards—RY 2025	Facility-Based Crisis Services for Children and Adolescents: One or more providers within each PIHP Region.	*High Confidence*
Partners	PIHP/TP—Capacity Standards—RY 20255	Non-Hospital Medical Detoxification: Two or more providers within each PIHP Region.	*High Confidence*
Partners	PIHP/TP—Capacity Standards—RY 2025	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.	*High Confidence*
Partners	PIHP/TP—Capacity Standards—RY 2025	Residential Treatment Facility Services: Access to one or more licensed provider per PIHP Region.	*High Confidence*
Partners	PIHP/TP—Capacity Standards—RY 2025	Substance Abuse Medically Monitored Residential Treatment: Access to one or more licensed provider per PIHP region.	*High Confidence*
Partners	PIHP/TP—Capacity Standards—RY 2025	Substance Abuse Non-Medical Community Residential Treatment: Adolescent: Contract with all designated CASPs within the PIHP Region.	*High Confidence*
Partners	PIHP/TP—Capacity Standards—RY 2025	Substance Abuse Non-Medical Community Residential Treatment: Adult: Access to one or more licensed provider per PIHP Region.	*High Confidence*
Partners	PIHP/TP—Capacity Standards—RY 2025	Substance Abuse Non-Medical Community Residential Treatment: Women & Children: Contract with all designated CASPs within the PIHP Region.	*High Confidence*

MCO Name	Standard Type	Indicator Name	Validation Rating
Partners	PIHP/TP—Capacity Standards—RY 2025	Two or more providers of Community/Mobile Services within each PIHP Region. Each county in PIHP Region must have access to one or more Community/Mobile Service providers who are accepting new patients.	*High Confidence*
Partners	PIHP/TP—Time and Distance—RY 2025	One or more providers of Partial Hospitalization within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
Partners	PIHP/TP—Time and Distance—RY 2025	One or more providers of Partial Hospitalization within 60 minutes or 60 miles for at least 95% of members—Rural	*High Confidence*
Partners	PIHP/TP—Time and Distance—RY 2025	Two or more providers of each Location-Based service within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
Partners	PIHP/TP—Time and Distance—RY 2025	Two or more providers of each Location-Based service within 45 minutes or 45 miles for at least 95% of members—Rural	*High Confidence*
Partners	PIHP/TP—Time and Distance—RY 2025	Two or more providers of each Outpatient Behavioral Health service within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
Partners	PIHP/TP—Time and Distance—RY 2025	Two or more providers of each Outpatient Behavioral Health service within 45 minutes or 45 miles for at least 95% of members—Rural	*High Confidence*
Partners	PIHP/TP—Time and Distance—RY 2025	Two or more Specialty Care providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members—Rural	*High Confidence*
Partners	TP—Capacity Standards—RY 2025	Two or more 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 NPI, accepting new patients available to deliver each State Health Plan LTSS in every county.	*High Confidence*
Partners	TP—Time and Distance—RY 2025	Two or more Specialty Care providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members—Urban	*High Confidence*

MCO Name	Standard Type	Indicator Name	Validation Rating
Trillium			
Trillium	PIHP/TP—Capacity Standards—RY 2025	Ambulatory Detoxification: One or more providers of each crisis service within each PIHP Region.	*High Confidence*
Trillium	PIHP/TP—Capacity Standards—RY 2025	Ambulatory Withdrawal Management With Extended On-Site Monitoring: One or more providers of each crisis service within each PIHP Region.	*High Confidence*
Trillium	PIHP/TP—Capacity Standards—RY 2025	Facility-Based Crisis Services for Children and Adolescents: One or more providers within each PIHP Region.	*High Confidence*
Trillium	PIHP/TP—Capacity Standards—RY 2025	Non-Hospital Medical Detoxification: Two or more providers within each PIHP Region.	*High Confidence*
Trillium	PIHP/TP—Capacity Standards—RY 2025	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.	*High Confidence*
Trillium	PIHP/TP—Capacity Standards—RY 2025	Residential Treatment Facility Services: Access to one or more licensed provider per PIHP Region.	*High Confidence*
Trillium	PIHP/TP—Capacity Standards—RY 2025	Substance Abuse Medically Monitored Residential Treatment: Access to one or more licensed provider per PIHP region.	*High Confidence*
Trillium	PIHP/TP—Capacity Standards—RY 2025	Substance Abuse Non-Medical Community Residential Treatment: Adolescent: Contract with all designated CASPs within the PIHP Region.	*High Confidence*
Trillium	PIHP/TP—Capacity Standards—RY 2025	Substance Abuse Non-Medical Community Residential Treatment: Adult: Access to one or more licensed provider per PIHP Region.	*High Confidence*
Trillium	PIHP/TP—Capacity Standards—RY 2025	Substance Abuse Non-Medical Community Residential Treatment: Women & Children: Contract with all designated CASPs within the PIHP Region.	*High Confidence*

MCO Name	Standard Type	Indicator Name	Validation Rating
Trillium	PIHP/TP—Capacity Standards—RY 2025	Two or more providers of Community/Mobile Services within each PIHP Region; Each county in PIHP Region must have access to one or more Community/Mobile Service providers who are accepting new patients.	*High Confidence*
Trillium	PIHP/TP—Time and Distance—RY 2025	One or more providers of Partial Hospitalization within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
Trillium	PIHP/TP—Time and Distance—RY 2025	One or more providers of Partial Hospitalization within 60 minutes or 60 miles for at least 95% of members—Rural	*High Confidence*
Trillium	PIHP/TP—Time and Distance—RY 2025	Two or more providers of each Location-Based service within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
Trillium	PIHP/TP—Time and Distance—RY 2025	Two or more providers of each Location-Based service within 45 minutes or 45 miles for at least 95% of members—Rural	*High Confidence*
Trillium	PIHP/TP—Time and Distance—RY 2025	Two or more providers of each Outpatient Behavioral Health service within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
Trillium	PIHP/TP—Time and Distance—RY 2025	Two or more providers of each Outpatient Behavioral Health service within 45 minutes or 45 miles for at least 95% of members—Rural	*High Confidence*
Trillium	PIHP/TP—Time and Distance—RY 2025	Two or more Specialty Care providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members—Rural	*High Confidence*
Trillium	TP—Capacity Standards—RY 2025	Two or more 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 NPI, accepting new patients available to deliver each State Health Plan LTSS in every county.	*High Confidence*
Trillium	TP—Time and Distance—RY 2025	Two or more Specialty Care providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members—Urban	*High Confidence*

MCO Name	Standard Type	Indicator Name	Validation Rating
UnitedHealthcare			
UnitedHealthcare	SP—Capacity Standards—RY 2025	Two or more 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 NPI, accepting new patients available to deliver each State Health Plan LTSS in every county. —Rural	*High Confidence*
UnitedHealthcare	SP—Capacity Standards—RY 2025	Two or more providers accepting new patients available to deliver each State Health Plan LTSS in every county—Urban	*High Confidence*
UnitedHealthcare	SP—Time and Distance—RY 2025	One or more providers of Partial Hospitalization within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
UnitedHealthcare	SP—Time and Distance—RY 2025	One or more providers of Partial Hospitalization within 60 minutes or 60 miles for at least 95% of members—Rural	*High Confidence*
UnitedHealthcare	SP—Time and Distance—RY 2025	Two or more providers of each Location-Based service within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
UnitedHealthcare	SP—Time and Distance—RY 2025	Two or more providers of each Location-Based service within 45 minutes or 45 miles for at least 95% of members—Rural	*High Confidence*
UnitedHealthcare	SP—Time and Distance—RY 2025	Two or more providers of each Outpatient Behavioral Health service within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
UnitedHealthcare	SP—Time and Distance—RY 2025	Two or more providers of each Outpatient Behavioral Health service within 45 minutes or 45 miles for at least 95% of members—Rural	*High Confidence*
UnitedHealthcare	SP—Time and Distance—RY 2025	Two or more Specialty Care providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members—Urban	*High Confidence*
UnitedHealthcare	SP—Time and Distance—RY 2025	Two or more Specialty Care providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members—Rural	*High Confidence*

MCO Name	Standard Type	Indicator Name	Validation Rating
Vaya			
Vaya	PIHP/TP—Capacity Standards—RY 2025	Ambulatory Detoxification: One or more providers of each crisis service within each PIHP Region.	*High Confidence*
Vaya	PIHP/TP—Capacity Standards—RY 2025	Ambulatory Withdrawal Management With Extended On-Site Monitoring: One or more providers of each crisis service within each PIHP Region.	*High Confidence*
Vaya	PIHP/TP—Capacity Standards—RY 2025	Facility-Based Crisis Services for Children and Adolescents: One or more providers within each PIHP Region.	*High Confidence*
Vaya	PIHP/TP—Capacity Standards—RY 2025	Non-Hospital Medical Detoxification: Two or more providers within each PIHP Region.	*High Confidence*
Vaya	PIHP/TP—Capacity Standards—RY 2025	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.	*High Confidence*
Vaya	PIHP/TP—Capacity Standards—RY 2025	Residential Treatment Facility Services: Access to one or more licensed provider per PIHP Region.	*High Confidence*
Vaya	PIHP/TP—Capacity Standards—RY 2025	Substance Abuse Medically Monitored Residential Treatment: Access to one or more licensed provider per PIHP region.	*High Confidence*
Vaya	PIHP/TP—Capacity Standards—RY 2025	Substance Abuse Non-Medical Community Residential Treatment: Adolescent: Contract with all designated CASPs within the PIHP Region.	*High Confidence*
Vaya	PIHP/TP—Capacity Standards—RY 2025	Substance Abuse Non-Medical Community Residential Treatment: Adult: Access to one or more licensed provider per PIHP Region.	*High Confidence*
Vaya	PIHP/TP—Capacity Standards—RY 2025	Substance Abuse Non-Medical Community Residential Treatment: Women & Children: Contract with all designated CASPs within the PIHP Region.	*High Confidence*

MCO Name	Standard Type	Indicator Name	Validation Rating
Vaya	PIHP/TP—Capacity Standards—RY 2025	Two or more providers of Community/Mobile Services within each PIHP Region; Each county in PIHP Region must have access to one or more Community/Mobile Service providers who are accepting new patients.	*High Confidence*
Vaya	PIHP/TP—Time and Distance—RY 2025	One or more providers of Partial Hospitalization within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
Vaya	PIHP/TP—Time and Distance—RY 2025	One or more providers of Partial Hospitalization within 60 minutes or 60 miles for at least 95% of members—Rural	*High Confidence*
Vaya	PIHP/TP—Time and Distance—RY 2025	Two or more providers of each Location-Based service within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
Vaya	PIHP/TP—Time and Distance—RY 2025	Two or more providers of each Location-Based service within 45 minutes or 45 miles for at least 95% of members—Rural	*High Confidence*
Vaya	PIHP/TP—Time and Distance—RY 2025	Two or more providers of each Outpatient Behavioral Health service within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
Vaya	PIHP/TP—Time and Distance—RY 2025	Two or more providers of each Outpatient Behavioral Health service within 45 minutes or 45 miles for at least 95% of members—Rural	*High Confidence*
Vaya	PIHP/TP—Time and Distance—RY 2025	Two or more Specialty Care providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members—Rural	*High Confidence*
Vaya	TP—Capacity Standards—RY 2025	Two or more 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 NPI, accepting new patients available to deliver each State Health Plan LTSS in every county.	*High Confidence*
Vaya	TP—Time and Distance—RY 2025	Two or more Specialty Care providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members—Urban	*High Confidence*

MCO Name	Standard Type	Indicator Name	Validation Rating
WellCare			
WellCare	SP—Capacity Standards—RY 2025	Two or more 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 NPI, accepting new patients available to deliver each State Health Plan LTSS in every county—Rural	*High Confidence*
WellCare	SP—Capacity Standards—RY 2025	Two or more providers accepting new patients available to deliver each State Health Plan LTSS in every county—Urban	*High Confidence*
WellCare	SP—Time and Distance—RY 2025	One or more providers of Partial Hospitalization within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
WellCare	SP—Time and Distance—RY 2025	One or more providers of Partial Hospitalization within 60 minutes or 60 miles for at least 95% of members—Rural	*High Confidence*
WellCare	SP—Time and Distance—RY 2025	Two or more providers of each Location-Based service within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
WellCare	SP—Time and Distance—RY 2025	Two or more providers of each Location-Based service within 45 minutes or 45 miles for at least 95% of members—Rural	*High Confidence*
WellCare	SP—Time and Distance—RY 2025	Two or more providers of each Outpatient Behavioral Health service within 30 minutes or 30 miles for at least 95% of members—Urban	*High Confidence*
WellCare	SP—Time and Distance—RY 2025	Two or more providers of each Outpatient Behavioral Health service within 45 minutes or 45 miles for at least 95% of members—Rural	*High Confidence*
WellCare	SP—Time and Distance—RY 2025	Two or more Specialty Care providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members—Urban	*High Confidence*
WellCare	SP—Time and Distance—RY 2025	Two or more Specialty Care providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members—Rural	*High Confidence*

Appendix E. Activity Timeline

Mandatory Activities

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 2024	Health plan submission of PIP Submission Form: September 2025 Initial validation findings and health plan responses: October–November 2025	Final validation findings provided to DHB and health plans: November 2025
PIHPs	Annual	CY 2024	Health plan submission of PIP Submission Form: October 2025 Initial validation findings and health plan responses: November–December 2025	Final validation findings provided to DHB and health plans: December 2025
TPs	Annual	Not applicable; not yet in data reporting phase	Health plan submission of PIP Submission Form: October 2025 Initial validation findings and health plan responses: November–December 2025	Final validation findings provided to DHB and health plans: December 2025
PMV				
SPs	Annual	MY 2024	Pre-Virtual Review Phase: September and October 2025 Virtual Review Phase: October and November 2025	Follow-Up and Reporting Phase: October 2025–February 2026
PIHPs	Annual	MY 2024	Pre-Virtual Review Phase: September and October 2025 Virtual Review Phase: October and November 2025	Follow-Up and Reporting Phase: October 2025–February 2026

Plans Types Included in Activity	Activity Cadence	Measurement Year/ Activity Year/Data Span Included in Report	Activity Commenced	Activity Concluded
TPs	Annual	Not applicable; readiness to report only	Pre-Virtual Review Phase: September and October 2025 Virtual Review Phase: October and November 2025	Follow-Up and Reporting Phase: October 2025–February 2026
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	CY 2025	Desk review: April–July 2025 File and webinar review: May–July 2025 Reporting and remediation: November 2025–January 2026	Final reports delivered March 2026
TPs	Once every three years	CY 2025	Desk review: April–July 2025 File and webinar review: May–July 2025 Reporting and remediation: November 2025–January 2026	Final reports delivered March 2026
NAV				
SPs, PIHPs, TPs, DHB	Annual	SFY 2024	Pre-Virtual Review Phase: September and October 2025 Virtual Review Phase: October and November 2025	Follow-Up and Reporting Phase: October 2025–February 2026

Optional/Additional Activities

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	2024 survey	Beneficiary letters mailed February 2024 Survey field closed May 2024 Data reconciliation, analysis, and reporting conducted May 2024–February 2025	Final reports delivered May 2025
HCBS CAHPS	Annual	2024 survey	Telephonic survey administration conducted July–September 2024 Survey field closed September 2024 Data reconciliation, analysis, and reporting conducted September 2024–January 2025	Final report delivered May 2025
Calculation of Performance Measures	Annual	MY 2024	Data receipt: Monthly 2025 Rate Calculation: August–October 2025	Final rates provided November 2025
Encounter Data Validation: SPs, PIHPs	Every three years	Encounters with dates of service between July 1, 2023, and June 30, 2024	SP MRR Procurement, Review and Analysis: March–October 2025 TP and PIHP Information Systems Review Questionnaire/Universal Survey Tool completion: April–May 2025 Compile Findings: May–July 2025	Final reports delivered September 2025 and January 2026

Activity	Activity Cadence	Measurement Year/ Activity Year/Data Span Included in Report	Activity Commenced	Activity Concluded
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 February 2026
Program Integrity Reviews: SPs, PIHPs	Annual	CY 2024	SPs: Pre-on-site activities conducted January–May 2025 Virtual on-site activities conducted May–August 2025 Follow-up completed June 2025–January 2026 PIHPs: Pre-on-site activities conducted March–June 2025 Virtual on-site activities conducted July–October 2025 Follow-up completed September 2025–January 2026	Final reports delivered October 2025–January 2026
PIP Review: SPs, PIHPs	Quarterly	CY 2024, CY 2025	Submissions in February 2025, May 2025, August 2025, and November 2025	Reviews completed in February 2025, May 2025, August 2025, and November 2025

Activity	Activity Cadence	Measurement Year/ Activity Year/Data Span Included in Report	Activity Commenced	Activity Concluded
Semiannual Audits: PIHPs	Semiannual	September 2024–August 2025	First review: Desk review April 2025 Data analysis and follow up May 2025 Second review: Desk review October 2025 Data analysis and follow-up November 2025	Report submissions June 2025 and December 2025

Appendix F. EQR Technical Report Requirements

Table 124 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 124 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 124—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.	15–38, 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.	38–41, 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.	42–45, 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.	45–52, Appendix A, Appendix D
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 (74–140)

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.	10–14
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 (74–140)
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 E
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