North Carolina's Medicaid Managed Care Quality Strategy

North Carolina Department of Health and Human Services

6/18/2025

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

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I. Introduction and Overview

North Carolina's Medicaid[1] program is multifaceted and far-reaching, serving more than three million beneficiaries with a diverse set of needs. Medicaid provides coverage for more than 50% of North Carolina births and insures just over 40% of North Carolina's children. Medicaid also funds necessary services for beneficiaries with severe behavioral health needs, covers Long Term Services and Supports (LTSS) for adults with disabilities, and supports children and adults with developmental disabilities through innovative community-based services.[2]

In September 2015, the North Carolina General Assembly enacted Session Law 2015-245, directing the transition of the state's Medicaid program from a predominantly fee-for-service structure, called NC Medicaid Direct, to a capitated managed care structure. The North Carolina Department of Health and Human Services (NCDHHS) remains committed to transitioning to NC Medicaid Managed Care to advance high-value care, improve population health, engage and support members and providers, and establish a sustainable program with predictable costs. On July 1, 2021, the Department completed the first phase of managed care implementation with the launch of Standard Plans and the Eastern Band of Cherokee Indians (EBCI) Tribal Option. On July 1, 2024, the Department launched Behavioral Health and Intellectual/Developmental Disability Tailored Plans (BH I/DD Tailored Plans). The Children and Families Specialty Plan (CFSP) is scheduled to launch on Dec. 1, 2025. Blue Cross Blue Shield of North Carolina has been awarded the CFSP contract.[3]

In implementing managed care, North Carolina is building on its foundation to improve the health of North Carolinians. This Quality Strategy is built with the desire to shape an innovative, whole-person, well-coordinated system of care that addresses both medical and nonmedical drivers of health. In order to achieve its goals of improving health outcomes for all North Carolinians, the Quality Strategy also focuses on reducing health disparities across North Carolina, which the Department defines as improving access to care and closing gaps where known disparities in access or outcomes exist.

A. Overview of North Carolina's Program-Level Transition To Managed Care

Prior to the launch of managed care in 2021, North Carolina had separate payment and delivery systems: one for physical health services and one for behavioral health and I/DD services. Physical health services were historically delivered by NC Medicaid Direct and managed through a Primary Care Case Management (PCCM) program named Community Care of North Carolina (CCNC) Behavioral health and I/DD services were historically delivered by local, limited-benefit managed care plans. In 2005, the Department implemented a concurrent 1915(b)/(c) Medicaid waiver to establish managed behavioral health and I/DD care through Local Management Entities-Managed Care Organizations (LME/MCOs or

[1] North Carolina's separate Children's Health Insurance Program (CHIP) for children aged 6-18, NC Health Choice, was combined with Medicaid on April 1, 2023.
[2] Kaiser Family Foundation. Medicaid State Fact Sheets. North Carolina. Available at http://files.kff.org/attachment/fact-sheet-medicaid-state-NC.
[3] Updates on CFSP can be found at the NC Medicaid CFSP webpage..

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PIHPs). The LME/MCO concept was initially designed as a pilot project to serve Medicaid beneficiaries with mental health, developmental disability and substance use needs in a limited geographical catchment area across the state. Four LME/MCOs remain in place in 2025.

On July 1, 2021, NC Medicaid transitioned most Medicaid beneficiaries to Standard Plans, which are integrated managed care plans. For remaining managed care eligible populations, which generally included people with more complex or specific needs, enrollment into managed care occurred in phases (see Table 1). On Dec. 1, 2023, approximately 600,000 state residents became eligible for NC Medicaid through Medicaid expansion. Under expansion, NC Medicaid covers people ages 19 through 64 years with incomes up to 138% of the federal poverty level (FPL).[4] Expansion increased and diversified the population of NC Medicaid, allowing for more adults into the program who may otherwise not have access to health benefits. This has allowed the Department to focus on new areas for quality measurement. More information on the approach to quality measure calculations for Expansion members is included in the When Tailored Plans launched in July 2024, populations eligible for BH I/DD Tailored Plans were enrolled, including Managed Care-eligible Medicaid members with I/DD, traumatic brain injury (TBI) and/or serious behavioral health disorders who met the criteria specified by North Carolina Session Law 2018-48

The Children and Families Specialty Plan (CFSP) is scheduled to launch statewide on Dec. 1, 2025 .[5] Medicaid-enrolled children and youth currently or formerly in foster care or receiving adoption assistance, as well as their family members, will be eligible for the CFSP; Medicaid-enrolled children and families receiving Child Protective Services In-Home Services or EBCI Family Safety Program will also be eligible. A subset of CFSP-eligible children and youth served by the child welfare system will be auto-enrolled at CFSP launch. Please refer to the Update on North Carolina's CFSP Policy Paper for more information on eligibility.[6]

1. Populations Served Outside of Managed Care

There are limited exceptions to mandatory enrollment in Medicaid managed care for certain populations that may be better served outside managed care. These populations are either *exempt* (meaning they may choose, but are not required, to enroll in NC Medicaid Managed Care) or are *excluded* (meaning they must remain enrolled in NC Medicaid Direct and may not enroll in NC Medicaid Managed Care).

North Carolina continues to operate NC Medicaid Direct for exempt, excluded and delayed populations. NC Medicaid Direct continues to operate the Community Alternatives Program for Children (CAP/C) and Community Alternatives Program for Disabled Adults (CAP/DA) waivers, whose quality requirements are available online at CAP/C Waiver and CAP/DA Waiver.[7] The CCNC PCCM program continues to manage the physical health care needs of NC Medicaid Direct beneficiaries, except for those enrolled in the EBCI Tribal Option or eligible for Tailored Care Management. The Department contracts with regional LME/MCOs, which act as capitated Prepaid Inpatient Health Plans (PIHPs), to offer Behavioral Health

[4] More information available on the NC Medicaid Questions and Answers about Medicaid Expansion webpage.
[5] Updates can be found on the NC Medicaid Children and Families Specialty Plan webpage.
[6] More information can be found in the Update on North Carolina's CFSP Policy Paper.
[7] More information available on the CAP/C webpage and CAP/DA webpage.

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and I/DD services to NC Medicaid Direct beneficiaries. During this time of transition, the quality measures and requirements for each of these special programs have remained in place, and all state Medicaid programs have focused on the unifying Aims outlined in the section that follows. Table 1 lists the entities that deliver services to Medicaid enrollees as part of the managed care transition and are involved in quality measurement and improvement efforts. These entities are described further below.

Table 1. Summary of Managed Care Entities in North Carolina

Health Plan Name	Entity Type	Managed Care Authority	Populations Served	Launch Date
Standard Plans	MCO	1115	Majority of Medicaid and NC Health Choice population	July 1, 2021
Medicaid Direct Prepaid Inpatient Health Plans (PIHPs)	LME/MCO	1915(b) Waiver	Beneficiaries delayed, excluded or exempt from integrated managed care (behavioral health, I/DD services)	April 1, 2005
Behavioral Health Intellectual/ Developmental Disability Tailored Plans	MCO	1115	Beneficiaries with significant behavioral health conditions (serious mental illness (SMI), serious emotional disturbance, or severe substance use disorder (SUD)), I/DD or TBI. Please refer to NC Medicaid Managed Care, Tailored Plan Eligibility and Enrollment, Appendix B–Tailored Plan Eligibility Criteria for full eligibility information.[8]	July 1, 2024
CFSP	MCO	1115	Children served by the child welfare system. Please refer to the Update on North Carolina's CFSP Policy Paper for more information.[9]	Dec. 1, 2025
Varies based on member characteristics	N/A	1115	Adults ages 19 through 64 years with higher incomes are covered under North Carolina's Medicaid expansion. Adults ages 19 through 64 earning up to 138% of the FPL may be eligible[10]	Dec. 1, 2023

[8] Available in the Tailored Plan Eligibility Criteria.
[9] Available in the Update on North Carolina's CFSP Policy Paper.
[10] More information available on the NC Medicaid Questions and Answers about Medicaid Expansion webpage.

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Health Plan Name	Entity Type	Managed Care Authority	Populations Served	Launch Date
	N/A	N/A	Medicaid-only Beneficiaries receiving long-stay nursing home services	No later than July 1, 2026 (five years after Standard Plan launch)[11]
	N/A	N/A	Individuals who are dual eligible for Medicare and Medicaid	No later than July 1, 2026 (five years after Standard Plan launch)[12]
	N/A	N/A	Individuals who are 55 years or older and are certified to need nursing facility care to live independently	Feb. 1, 2008

Table 2. Summary of PCCM Entities in North Carolina

Health Plan Name	Entity Type	Authority	Populations Served	Launch Date
EBCI Tribal Option	PCCM	State Plan Amendment	Federally recognized tribal members and other individuals eligible to receive services from the Indian Health Service (IHS) in the 11 identified counties in western North Carolina Excluded from PCCM Enrollment • Care Management and Tailored Care Management are duplicative services and a member cannot receive both services. The Department shall disenroll the member from the PCCM Entity if a member opts into Tailored Care Management.	July 1, 2021
CCNC	PCCM	State Plan Amendment	PCCM Mandatory • Individuals being served through the CAP/C or CAP/DA • Medically needy individuals • Individuals who participate in the North Carolina Health Insurance Premium Payment program Exempt PCCM Enrollment with	Has existed since prior to managed care launch

[11] Section 4.(5) of Session Law 2015-245, as amended by Section 5.(b) of Session Law 2018-49.
[12] Section 4.(5) of Session Law 2015-245, as amended by Section 5.(b) of Session Law 2018-49.

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Health Plan Name	Entity Type	Authority	Populations Served	Launch Date
			opportunity to opt-in • Individuals eligible for the EBCI Tribal Option Individuals eligible for the CFSP until such time that it comes into effect Exempt PCCM Enrollment with opportunity to opt out • Individuals who are enrolled in both Medicare and Medicaid for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing Excluded from PCCM Enrollment • Care Management and Tailored Care Management are duplicative services and a member cannot receive both services. The Department shall disenroll the member from the PCCM Entity if a member opts into Tailored Care Management Please refer to the PCCM Entity Contract for more information.[13]	

2. Integrated Managed Care Plans

a. Standard Plans

On July 1, 2021, North Carolina transitioned most Medicaid members to fully capitated and integrated Standard Plans.[14] The majority of enrollees, including adults and children with low- to moderate-intensity behavioral health needs, receive integrated physical health, behavioral health, LTSS and pharmacy services through Standard Plans.

b. Behavioral Health I/DD Tailored Plans

Managed care-eligible Medicaid members with I/DD, TBI and/or serious behavioral health disorders who meet the criteria are enrolled in Tailored Plans, which launched on July 1, 2024, as regional, specialized

[13] Available on the NC Medicaid Community Care of North Carolina (CCNC) webpage.
[14] Full text of Session Law 2015-245.
Full text of Session Law 2018-48.
Full text of Session Law 2020-88.

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managed care products focused on the needs of these populations. BH I/DD Tailored Plans offer the same services as Standard Plans, in addition to 1915(c) Innovations and TBI waiver services as well as an array of specialized behavioral health and I/DD services. The BH I/DD Tailored Plans also offer Tailored Care Management as a Health Home entitlement. In July 2023, the Department transitioned select critical Home and Community-Based Services (HCBS) for enrollees with significant behavioral health needs, I/DD and TBI previously covered under 1915(b)(3) authority to 1915(i).[15] These are currently offered by PIHP and BH I/DD Tailored Plans and in the future will be offered by the CFSP. In addition to managing Medicaid services, Tailored Plans are also responsible for managing state-funded behavioral health, I/DD and TBI services as LME/MCOs previously did for uninsured and underinsured individuals.[16,17]

c. CFSP

When launched, the CFSP[18] will be a single, statewide NC Medicaid Managed Care plan that will support Medicaid-enrolled children, youth and families served by the child welfare system through the provision of seamless, integrated and coordinated health. As a statewide entity, the CFSP—regardless of where a member lives—will provide members with access to a broad range of physical health, behavioral health and pharmacy services, LTSS and I/DD services, as well as services to address unmet health-related resource needs (HRRN). The CFSP is intended to launch on Dec. 1, 2025 as determined by the Department and the North Carolina General Assembly.

3. PCCM Programs

a. EBCI Tribal Option

The Department supports the self-determination goals of the Eastern Band of Cherokee Indians (EBCI) and has partnered with the Cherokee Indian Hospital Authority (CIHA) to address the health needs of the state's EBCI members through the EBCI Tribal Option.[19] The EBCI Tribal Option is the first Indian managed care entity in the nation and establishes a new delivery system for enrolled populations.

The EBCI Tribal Option is a non-risk-bearing managed care option for federally recognized tribal members and other individuals eligible to receive services from the Indian Health Service. The EBCI Tribal Option launched on July 1, 2021. The EBCI Tribal Option is primarily offered in five counties: Cherokee, Graham, Haywood, Jackson and Swain. Eligible members in the following counties may opt in: Buncombe, Clay, Henderson, Macon, Madison and Transylvania.

The EBCI Tribal Option has a strong focus on primary care, preventive health and chronic disease management and provides care management for all members and support services for high-need members. The EBCI Tribal Option coordinates all medical, behavioral health and pharmacy services in North Carolina Medicaid plans, including monitoring the quality of services offered.

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[15] More information In the Transition of 1915(b)(3) Services to 1915(i) Authority bulletin.
[16] State-funded services are not Medicaid services and are not considered entitlements—this means that funding is limited and services are not available for everyone who may qualify.
[17] This Quality Strategy does not address the role of Tailored Plans for individuals receiving state-funded services.
[18] Section 9E.22 of Session Law 2023-134.
[19] Available in the EBCI Tribal Option Fact Sheet.

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As a non-risk-bearing PCCM entity, the EBCI Tribal Option is not subject to all federal managed care requirements. However, these requirements still play a strong role in ensuring that the EBCI Tribal Option delivers high-quality care in a manner that is consistent with the state's overall Quality Strategy. Areas where the EBCI Tribal Option interacts specifically with the Quality Strategy are noted throughout this document.

b. CCNC

For most Medicaid enrollees who are excluded or exempt from integrated managed care, physical health services continue to be delivered by providers under NC Medicaid Direct and managed by the CCNC PCCM program,[20] except for individuals enrolled in the EBCI Tribal Option PCCM. The CCNC PCCM program provides enhanced and coordinated care for patients through multiple activities, including preventive services, data analysis, community-based care coordination and care management.

4. Other

a. Behavioral Health and I/DD Services for Medicaid Direct PIHP

Members who remain enrolled in NC Medicaid Direct PIHP have access to physical health services and LTSS the capitated PIHP services [21,22] PIHP enrollees can also access Tailored Care Management if they are eligible.[23]

5. Populations Exempt, Excluded and Delayed From Enrollment in Integrated Managed Care

As described above, there are limited exceptions to mandatory enrollment in Medicaid managed care for some populations that may be better served outside managed care. These populations are either *exempt* or are *excluded*. Medicaid Direct members receive physical health services through the CCNC PCCM program and behavioral health and I/DD services through PIHPs, as noted in the section above.

Table 3. Populations Exempt, Excluded and Delayed From Enrollment in Integrated Managed Care

Exempt Populations
Members eligible to receive services from the Indian Health Service, including members of the EBCI As noted above, these individuals will have the opportunity to enroll in the EBCI Tribal Option and may access enhanced behavioral health and I/DD services without enrolling in the Tailored Plan
Excluded Populations[24]
Medically needy members (also known as spend down), except for those enrolled in the Innovation waiver, and TBI waivers

[20] Individuals remaining in NC Medicaid Direct who are exempt, excluded, or delayed from managed care and have significant behavioral health conditions and I/DD or TBI will be eligible for Tailored Care Management—a specialized care management program targeted toward individuals with these needs—instead of the CCNC PCCM program.
[21] As of July 1, 2023, the PIHP covers 1915(i) services.
[22] As of April 1, 2023, the PIHP covers members who are legal aliens, children aged 0–3 and members formerly enrolled in NC Health Choice.
[23] More information on the PIHP is available in the PIHP contract, available on the Health Plan Contracts webpage. This document explicitly references the PIHP in key sections but primarily focuses on Standard Plans and Tailored Plans.
[24] North Carolina Session Law 2015-245, as amended by Session Law 2016-121 and Session Law 2018-49.

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Members residing in carceral settings and/or prison

Members who meet the definition of Indian under 42 C.F.R. 438.14(a) shall have the option to enroll voluntarily in PHPs

Health Insurance Premium Payment members, except for those enrolled in the Innovations and TBI waivers

Members being served through CAP/C

Members being served through CAP/DA, including members receiving services under the Community Alternatives Choice Program, the consumer-directed care option under the CAP/DA program

Program of All-Inclusive Care for the Elderly (PACE) participants

- Members who are enrolled in both Medicare and Medicaid for whom North Carolina Medicaid coverage is limited to the coverage of Medicare premiums and cost sharing

Qualified aliens subject to the five-year bar for means-tested public assistance under Title 8 of the United States Code (USC), Section 1613, and who qualify for emergency services under 8 USC Section 1611

Undocumented aliens who qualify for emergency services under 8 USC Section 1611

Presumptively eligible members, during the period of presumptive eligibility

Members enrolled under the Medicaid Family Planning program

Within this document, the term "health plans" is used as a shorthand to refer to the specific health plans previously mentioned for a requirement. For example, if it is stated that a requirement applies to Standard Plans and BH I/DD Tailored Plans, then subsequent mentions of the requirement will use the terminology "health plans."

II. Quality Strategy Aims, Goals, Objectives and Measures

Since 2017, North Carolina's vision for an innovative, whole-person, well-coordinated system of care is distilled into three central Aims:

A. Better Care Delivery: Make health care more person-centered, coordinated and accessible.

B. Healthier People, Healthier Communities: Improve the health of North Carolinians through prevention, better treatment of chronic conditions and better behavioral health care, working collaboratively with community partners.

C. Smarter Spending: Pay for value rather than volume, incentivizing appropriate care (right place, right time) and encouraging innovation.

The Aims emphasize the centrality of patient experiences and the importance of accountability for achieving measurable improvements in health outcomes. Included within each of these three Aims is a series of Goals and Objectives intended to highlight key areas of expected progress and quality focus. Together, as shown in Table 4 below, these Aims, Goals and Objectives create a framework through

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which North Carolina defines and drives its overall mission and vision for advancing the quality of care provided to Medicaid members in the state. These Aims, Goals and Objectives were designed to closely align with the Centers for Medicare & Medicaid Services (CMS) Quality Strategy,[25] adapted to address local priorities, challenges and opportunities for North Carolina's Medicaid program.

Table 4. North Carolina's Quality Strategy Aims, Goals and Objectives

Aims	Goals	Objectives
Aim 1: Better Care Delivery. *Make health care more person-centered, coordinated and accessible.*	**Goal 1: Ensure appropriate access to care**	Objective 1.1: Ensure equitable, timely access to care
		Objective 1.2: Maintain Medicaid provider engagement
	Goal 2: Drive whole-person care	Objective 2.1: Promote patient engagement in care
		Objective 2.2: Link patients to effective care management and care coordination services
		Objective 2.3: Address behavioral and physical health comorbidities
Aim 2: Healthier People, Healthier Communities. *Improve the health of North Carolinians through prevention, better treatment of chronic conditions and better behavioral health care, working collaboratively with community partners.*	**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
		Objective 3.3: Maximize LTSS populations' quality of life and community inclusion
	Goal 4: Improve chronic condition management	Objective 4.1: Improve behavioral health care
		Objective 4.2: Improve diabetes management
		Objective 4.3: Improve asthma management
		Objective 4.4: Improve hypertension (HTN) management
		Objective 4.5: Improve pharmacotherapy for opioid use disorder
	Goal 5: Work with communities to improve population health	Objective 5.1: Address unmet HRRN
		Objective 5.2: Address SUD crises
		Objective 5.3: Address Rates of Low Birth Weight
Aim 3: Smarter Spending. *Pay for value rather than volume, incentivize*	**Goal 6: Pay for value**	Objective 6.1: Ensure high-value, appropriate care
		Objective 6.2: Reduce Plan All-Cause Readmission

[25] Available on the Medicaid State Managed Care Quality webpage..

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innovation and ensure appropriate care.		Objective 6.3: Reduce Avoidable Pediatric Utilization Rates
		Objective 6.4: Reduce Avoidable Adult Utilization
		Objective 6.5: Improve Total Cost of Care

A. Development of the Quality Strategy Aims, Goals and Objectives

These Aims, Goals and Objectives reflect years of consistent and significant community and stakeholder input, as well as thoughtful consideration of the quality issues that are most significant to North Carolina. This strategy version reflects stakeholder feedback, and the evolution of the Medicaid program as new data and insights are identified and applied. The Department remains dedicated to identifying goals and objectives for the program that advance health care quality for its members. The Department contracted with the North Carolina Institute of Medicine (NCIOM) Task Force on Health Care Analytics (NCIOM Task Force) to convene stakeholders across the state to issue recommendations on the specific quality metrics North Carolina Medicaid should focus on throughout the transition to managed care. The NCIOM Task Force brought together a statewide group of providers, members, quality experts and current health plan representatives who recommended a set of Medicaid quality measures to be used to drive improvement in the health of NC [26] In recognition of the significant deliberative process of the NCIOM Task Force, this Quality Strategy and its Objectives align closely with the NCIOM recommendations. As needed, the Department has further refined the Quality Strategy objectives to ensure ongoing alignment with quality measures tracked to each Quality Strategy goal (described further in Appendix B).

The Department additionally considered the quality areas of greatest significance, specifically to the North Carolina Medicaid population and where current performance showed an opportunity for targeted improvement. The Department also considered areas where there may be disparities or gaps in outcomes for certain populations, as a cross-cutting consideration across all the goals, aims and objectives. Understanding and addressing areas where specific populations experience disparate outcomes is important to improving the health of the North Carolina Medicaid population as a whole and ensuring access to fair and effective health care. The Objectives set forth are similarly aligned to ensure member access to services, particularly in the state's transition to managed care, and include access to historically underfunded services and secondary and tertiary providers. For example:

Goal 1 (Ensure Appropriate Access to Care) recognizes the need to maintain North Carolina's historically high rate of provider participation in Medicaid across all of North Carolina's communities to fully meet members' needs, including convenient access to the appropriate range of providers in a timely manner.

Objectives related to **Goal 2 (Drive Whole-Person Care)** seek to ensure that members are engaged in their health care and are satisfied with their managed care plan (assessed as part of the Consumer Assessment Health Plan Survey), in addition to ensuring that they are linked to a care management option, including an Advanced Medical Home (AMH) or, for Tailored Plan members, an entity that

[26] More information is available on the Medicaid State Managed Care Quality webpage.

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provides Tailored Care Management (e.g., an Advanced Medical Home Plus (AMH+) or Care Management Agency (CMA) provider, as described further in Section III(C)).

Objectives aligned with **Goal 3 (Promote Wellness and Prevention)** reflect a continued emphasis on preventive health, development and wellness, including for children and women. Additional emphasis is placed on maximizing service delivery to the Long-Term Services and Supports population to improve quality of life and increase community inclusion as significant disparities exist this priority population.

Objectives related to **Goal 4 (Improve Chronic Condition Management)** focus on conditions that significantly affect the North Carolina Medicaid population, including asthma, behavioral health disorders, substance use and treatment, diabetes and hypertension. While other chronic conditions were additionally considered for inclusion, the Department sought to focus on select, targeted priorities that allow for demonstrable progress, reinforced by the NCIOM Task Force's recommendations and relevance to existing and newly covered populations in managed care.

Multiple Objectives tie to **Goal 5 (Work With Communities To Improve Population Health)**, emphasizing areas where community engagement remains critical to advancing a high-quality health system, such as meeting unmet health-related resource needs and combating substance use disorder treatment, or addressing conditions leading to low-birth weight outcomes. Community collaboration is essential for building trust, identifying local priorities, and codeveloping solutions that resonate with the lived experiences of Medicaid members. These Objectives recognize and build upon the progress that has been made at a local level throughout the Department.

Objectives identified in **Goal 6 (Pay for Value)** focus on high-value and appropriate care through a quality lens of reducing avoidable readmission and utilization rates, examining outcomes in relation to total cost and are fully encompassing of the five previous Goals outlined.

Behavioral health is identified in multiple areas throughout these Objectives in recognition of the complexity of delivering high-quality care for populations with behavioral health needs and the prevalence and cost of coexisting behavioral and physical health disorders.

Similarly, the Quality Strategy highlights a key Objective related to populations with **LTSS needs**; most quality Objectives and measures in this Quality Strategy are relevant to populations with LTSS needs.

Each of the 21 Objectives is tied to a series of focused interventions (described in detail in Section III(C)) used to drive improvements or address gaps within, and in many cases across, the Goals and Objectives set forth in this Quality Strategy. To assess the effect of these interventions and continue to identify opportunities for improving the quality of care delivered under Medicaid managed care, in compliance with the requirements set forth in 42 CFR 438.340(b)(2), the interventions are tied to a set of metrics to assess overall and priority population progress (see Appendix B).

As more data for health plan performance becomes available, the Department intends to further refine these Objectives to target specific improvement goals. To facilitate quality measurement, Standard Plans, BH I/DD Tailored Plans and the CFSP are required to maintain systems that collect, analyze, integrate and report encounter data in a timely, accurate and complete manner. These data are used for several purposes and will be key to the quality of the NC Medicaid Managed Care program, directly related to quality performance and otherwise. The External Quality Review Organization (EQRO), further discussed in Section V(A) and Appendix D of this Quality Strategy, will play a critical role in ensuring the

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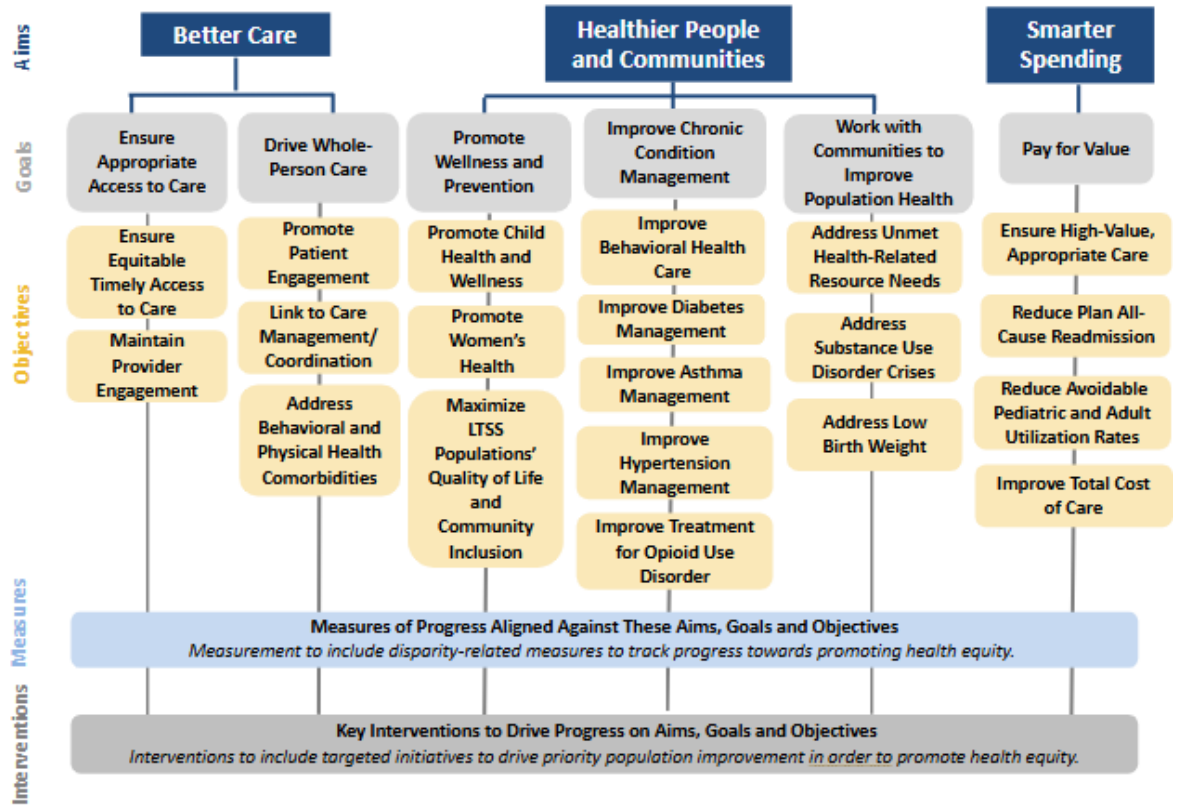
validity of health plans' reported encounter data and in the validation and calculation of quality measures. The Department is committed to using these reports to assess opportunities for continued improvement and evolution of priorities as additional populations are enrolled in managed care.

Together, this framework represents a comprehensive plan for delivering high-quality, accessible and timely care to NC Medicaid Managed Care members, as shown in Figure 1.

Figure 1. Overview of the Quality Strategy Framework



B. Overview of Quality Measures

North Carolina has developed standard performance measures, as required by 42 CFR 438.330(c), some of which Standard Plans, BH I/DD Tailored Plans and the CFSP are required to measure and report to the Department. Others will be directly measured by the Department, as outlined below and in Appendix A. Consistent with the Department's desire to benchmark its progress against other states' performance and assess key priorities to drive continuous quality improvement efforts, nearly all these measures are nationally recognized.

The Department, Standard Plans, BH I/DD Tailored Plans and the CFSP will be accountable for performance on the following:

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- A select set of measures that align with the Aims, Goals and Objectives of the Quality Strategy, as identified in Appendix B;
- All **Healthcare Effectiveness Data and Information Set (HEDIS) measures** required for National Committee for Quality Assurance (NCQA) Health Plan Accreditation, regardless of whether the health plan has achieved accreditation to date (see Section III(C)(10) for more information on accreditation); and
- A select set of **CMS Adult, Child and Health Home Core** measures, including all measures required for reporting under regulation (see Appendix A, Tables 7-9).[27]

In some cases, the Department may directly report measures using data provided by Standard Plans, Tailored Plans, the PIHPs and the CFSP linked to data from other sources (for example, Vital Statistics data).

The Department has set benchmarks for each measure (with the exception of measures of contraceptive care).[28] Through Measurement Year (MY) 2025, the Department set benchmarks using a 5% relative improvement every two years in measure performance (or 5% reduction for measures where a lower rate is better). For example, if MY2020 performance was 50%, the target for MY2022 would be 52.5% (50% * 1.05). In 2025 the Department worked alongside prepaid health plans to develop an updated benchmarking approach that is more responsive to measure trends, differences between measures, and differences in health plan baseline performance. The Department has proposed a gap-to-goal approach, in which a target is set based on a 10% gap reduction from baseline toward the goal of a national Medicaid HMO performance rate for that measure. The Department has proposed to apply this new approach beginning with MY2026 targets. Current information on the benchmarking methodology can be found in the North Carolina's Medicaid Quality Measurement Technical Specifications Manual (the Technical Specifications).[29]

Additionally, the Department will use tools such as the 5.1 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Adult and Child surveys, Mental Health Statistics Improvement Program Consumer Satisfaction Survey, North Carolina Treatment Outcomes and Program Performance System, National Core Indicators, and other surveys to assess patient experience in receiving care and quality of life. In future years, the Department may develop other surveys to capture additional outcomes of interest or may adapt existing surveys to support more in-depth tracking of patient-reported outcomes.

The Department uses patient-reported surveys as part of its evaluation of health plan performance and to consider areas that may require additional focus and prioritization as NC Medicaid Managed Care programs and their members' needs evolve.[30] Patient-reported outcomes are a cornerstone of whole person care, enabling the Department to capture insights on quality of life, care satisfaction and

[27] More information on Core sets is available on the Medicaid Child and Adult Health Care Quality Measures webpage.
[28] For measures of contraceptive care, the Department will not apply an external performance benchmark, reflecting the preference-sensitive nature of contraceptive care. The Department will, however, monitor measure results to assess where contraceptive access may be problematic.
[29] Available on the NC Medicaid Quality Management and Improvement webpage.
[30] The NQF defines patient-reported outcomes as a performance measure that is based on patient-reported outcome data aggregated for an accountable health care entity (e.g., percentage of patients in an accountable care organization whose depression score as measured by Patient Health Questionnaire-9 improved). More information is available on the National Quality Forum webpage.

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member experiences. These data will be used to design interventions that reflect patient priorities and foster continuous quality improvement. As other special plans and programs are included in managed care, the Department will assess the incorporation of special population-targeted quality measures.

The Department requires that all entities delivering health care services within managed care (with the exception of the EBCI Tribal Option) report on access and compliance with state standards, among other areas (as noted in Section IV). The Department will review these reports for quality assurance and improvement purposes.

1. Behavioral Health Measures—Focusing on Screening and Timely Treatment

As described above, the state has selected multiple Objectives focused specifically on behavioral health, each of which is tied to quality measures described in Appendix B. These Objectives and the related measures were selected based on alignment with previous Department-level reporting on behavioral health measures (both through LME/MCOs and CMS Adult and Child Core measures). The Objectives reflect emerging best practices from leaders on behavioral health measurement, including the National Quality Forum (NQF), the Institute for Healthcare Improvement, the Agency for Healthcare Research and Quality (AHRQ), and the Substance Abuse and Mental Health Services Administration (SAMHSA).

2. LTSS Measures—Focusing on Quality of Life and Access to Care

As described above, the Department has set forth an Objective focused on LTSS populations. The LTSS Objective was selected knowing this population often experiences gaps in care, access and outcomes. The Department will review all quality measures in Appendix A and stratify outcomes by LTSS needs status. The Department requires health plans to submit the measures separately for any individuals who have been identified as having an LTSS need, as defined by the Comprehensive Assessment. Through analyzing these stratified data elements, the Department will ensure that LTSS individuals have access to care and that health plans are reducing disparities in health outcomes. In future years, the Department will seek to identify an appropriate quality-of-life metric.

3. Opioid Measures—Focusing on Drug Monitoring and Substance Use Treatment

The Department has set forth an Objective focused on addressing the opioid crisis and has selected multiple quality measures tied to this Objective (see Appendix A). Selected opioid-related quality measures focus on opioid prescribing patterns, initiation and engagement of treatment for individuals with substance dependency and follow-up after substance-related emergency department (ED) visits. These measures were selected to encourage both treatment and prevention of opioid addiction and to align with quality reporting requirements for 2024 set forth in the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018. In addition, the Department has obtained a waiver of the Institution for Mental Diseases exclusion to improve access to residential treatment for SUD. As part of the state's implementation and monitoring plan for this waiver, the state will report multiple substance-use and opioid-related measures to CMS.

4. EBCI Tribal Option Measures

The EBCI Tribal Option will adhere to a separate EBCI Tribal Option Quality Measure Set (see Appendix A, Table 10), which aligns with the overall Medicaid Quality Strategy Framework. The EBCI Tribal Option

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measures are aligned to a range of specific Goals and Objectives used to drive quality improvement and operational excellence for the members they serve. The EBCI Tribal Option works closely with the EBCI Public Health and Human Services Department to align population health initiatives and measures with the areas identified in the Tribal Health Assessment.

The EBCI Tribal Option measures have the following performance targets, as shown in Table 5.

Table 5. EBCI Tribal Option Clinical Measures and Performance Targets

Clinical Measures	Performance Target
Glycemic Status Assessment for Patients with Diabetes	The percentage of members ages 18–75 with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c (HbA1c) or glucose management indicator (GMI)) was at the following levels during the measurement year: • Glycemic Status <8.0%. • Glycemic Status >9.0%.
Controlling High Blood Pressure (BP)	The percentage of members ages 18–85 who had a diagnosis of hypertension and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
Childhood Immunization Status	The percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenzae type B; three hepatitis B (HepB), one chicken pox; four pneumococcal conjugates; one hepatitis A (HepA); two or three rotavirus; and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates.

5. CCNC PCCM Measures

CCNC will work with the Department to review performance measures and other metrics to compare performance with quality, access, cost and utilization benchmarks. CCNC is producing an annual Program Performance Metrics report, including outcomes for a separate measure set (see Appendix A, Table 11). Performance targets are set according to the benchmarking methodology described above.

6. PIHP Measures

The PIHP quality measures cover a specific subset of behavioral health and waiver services (see Table 13). Because these health plans only cover a limited subset of services, the Department and administering health plans do not have the encounter data required to calculate most Medicaid Core and HEDIS quality measures. The Behavioral Health and I/DD Services for Medicaid Direct PIHP is only required to report measures for which it collects all required data elements.

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

C. Development and Review of the Quality Strategy

1. Development of the Quality Strategy

The Department has relied on extensive stakeholder feedback of North Carolina's Medicaid program to managed care in addition to reflecting changes in the federal standards. The 2025 update to the Quality Strategy included a number of additions intended to ensure conformance with federal requirements. In particular, these additions increased focus on details to the performance targets for specific quality measures associated with the aims, goals and objectives of the Quality Strategy. Network adequacy standards were included in the update. This update provides additional information on the process for determining the effectiveness of North Carolina's Quality Strategy, including reviews of the quality and effectiveness of services delivered, developed in coordination with the Department's External Quality Review Organization. The 2025 update to the Quality Strategy incorporates stakeholder feedback received during the required public commenting period. In addition to the stakeholder engagement activities critical to North Carolina Medicaid Managed Care, the following steps were taken to receive input on the Quality Strategy, consistent with the standards set forth in 42 CFR 438.340(c):

- Consultation with the Medical Care Advisory Committee (MCAC);
- Consultation with the EBCI and CIHA in accordance with the state's tribal consultation policy;
- Evaluation of the effectiveness of the previous Quality Strategy by the Department's EQRO; and the Department incorporated comments from all groups as noted and made its final Quality Strategy available on its website upon CMS approval.

Table 6: Updates to the Quality Strategy

Year of Update	Quality Strategy Updates
2019	• Removed interventions that were not approved as part of the waiver, such as the Workforce initiative.
2021	• Integrated BH I/DD Tailored Plan design components into the Quality Strategy; • Reframed references to the quality measure set to align with recent Standard Plan and BH I/DD Tailored Plan managed care contract changes, including addition of all relevant measure sets (e.g., Standard Plan, BH I/DD Tailored Plan, AMH, EBCI Tribal Option and CCNC PCCM; • Updated the list of interventions that align with the Objectives, Aims and Goals of the Quality Strategy; and • Incorporated the CFSP, EBCI Tribal Option and CCNC PCCM into the Quality Strategy.
2022/23	• Updated the managed care implementation timeline and associated included, exempt, excluded and delayed populations;

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	• Incorporated additional information related to Tailored Care Management, 1915(i) services and the PIHP; • Updated relevant quality measure sets; and • Included a new appendix with Standard Plan performance improvement project (PIP) examples.
2024/25	• Updated the managed care implementation timeline and associated included, exempt, excluded and delayed populations; Updated the language related to BH I/DD Tailored Plans and CFSP; • Included information related to Medicaid expansion population; and • Updated relevant quality measure sets and benchmarking approach.

a. Future Updates

The Department will continue to review and update the Quality Strategy as needed or upon a significant change, and no less than once every three years.

For the purposes of updating and reviewing the Quality Strategy, "significant change" is defined as:

- Significant new program changes (e.g., launch of new managed care plan products);
- A pervasive pattern of quality deficiencies identified through analysis of the quality performance data submitted by the health plans that results in a change to the Goals or Objectives of the Quality Strategy;
- Overarching changes to quality standards resulting from regulatory authorities or legislation at the state or federal level; or
- A change in membership demographics or the provider network of 50% or greater within one year.[31]

b. Evaluation of the Effectiveness of the Quality Strategy

The process for reviewing the Quality Strategy includes an evaluation of its effectiveness in the previous three years (or, if updated sooner, since the Quality Strategy's implementation), the results of which are be made publicly available on the Department website. The Department worked with the state's External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG) to produce the evaluation.

The EQRO evaluation of North Carolina's 2023 Quality Strategy determined the following key findings:

- The Department's quality provisions for improvement, as detailed in its Quality Strategy Aims, were tied to a Quality Strategy program objective (performance measure).

[31] The Department will monitor membership demographics as part of required stratifications health plans must report (more information in Section V(A)(1)). The EQRO also monitors network adequacy reporting.

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- The Quality Strategy program objectives were assessed and reported annually.
- The Department included consistent measures across its goals and objectives used to measure health plan performance and improvement.
- Performance improvements were realized in all three Quality Strategy Aims.
- The EQRO noted that the Department identified barriers and a viable strategy for continued improvement or overcoming those barriers for measures that did not demonstrate improvement.

Overall results show that, while the Department made considerable progress in addressing its Quality Strategy goals, opportunities for improvement remain available. The Department is committed to continuous quality improvement and is maintaining quality goals and associated measures in its Quality Strategy, with modifications to reflect updates to statewide priorities and new program launches.

Changes to formatting or dates and other similar edits are defined as "insignificant," as are regulatory/legislative changes that do not change the intent or content of the requirements contained in the Quality Strategy. Changes to the details included in the appendices are also considered insignificant, but appendices are regularly updated as needed in the version of the Quality Strategy posted online.

The full 2024 Quality Strategy Evaluation Report can be found here: NC2024 Quality Strategy Evaluation

Future updates to the Quality Strategy will be a part of North Carolina's continuous quality improvement process, as required by 42 CFR 438.340(c)(2)(iii), and will consider the recommendations provided by the EQRO. EQRO recommendations include (1) improving the quality of health care services provided by each health plan; and (2) identifying how the Department can target Goals and Objectives in the Quality Strategy to better support improvement in the quality, timeliness and access to health care services rendered to Medicaid members. Additional information regarding the EQRO's quality functions can be found in Section V(A) and Appendix D of this Quality Strategy.

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III. Improvements and Interventions

A. Quality Assurance and Performance Improvement Programs

The Department requires that Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP, in compliance with 42 CFR 438.330, establish and implement an ongoing and comprehensive Quality Assurance and Performance Improvement program (QAPI). The QAPI must be reviewed and approved by the Department and will include the following:

- Completion of Department-specified Performance Improvement Projects (further described under "PIPs" below);
- Collection and submission of all designated quality performance measurement data (outlined in Section II(B) and Appendix A);
- Mechanisms to detect both underutilization and overutilization of services;
- Mechanisms to assess the quality and appropriateness of care for members with special health care needs (defined in Section IV(A)(5));
- Mechanisms to assess and address health disparities, including findings from the Department-developed annual health disparities report (further discussed in Section V(A)(1));
- Mechanisms to incorporate population health programs targeted to improve outcome measures;
- Mechanisms to assess the quality and appropriateness of care provided to members needing LTSS, including assessment of care between settings and a comparison of services and supports received with those set forth in the member's treatment/service plan;
- Participation in efforts by the state to prevent, detect and remediate critical incidents, including in LTSS services and programs; and
- Contributions to health-related resources that can support or align with broader improvement in particular health outcomes outlined within this document. In order for the Department to monitor and ensure the accuracy of managed care plan reporting and assess performance against quality measures on a plan-specific and program-wide basis (as described in Section V(A)), Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP (as applicable) must:
- Provide all quality data designated for health plan reporting at least annually to the Department and the EQRO, or more frequently if specified;
- Provide all accreditation reports; and
- Provide all information required by the EQRO in compliance with the protocols set forth by CMS for the EQRO activities outlined in Appendix D.[32]

The Department and the EQRO will conduct assessments to oversee health plans' performance against the quality Aims, Goals, Objectives and measures further described in Section II(B). In addition, Standard

[32] CMS protocols for EQRO-related activities are available at the Medicaid Quality of Care External Quality Review webpage

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Plans, PIHPs, BH I/DD Tailored Plans and the CFSP are required to develop a process to evaluate the impact and effectiveness of their own QAPIs. A description of this process must be submitted to and approved by the Department with submission of the QAPI and be closely aligned with this Quality Strategy.

Further, Standard Plans, PIHPs, BH/ I/DD Tailored Plans and the CFSP are required to participate in ongoing cross-industry meetings with the Department and Quality Directors, which are designed to exchange and build on identified best practices. Participants in the meetings discuss emerging issues and plans for upcoming projects. Standard Plans are also required to facilitate an annual Quality Forum for providers in their region of the state.

The EBCI Tribal Option also has distinct quality elements. The EBCI Tribal Option will establish a Quality Committee to oversee quality of care for members and has a designated Quality Director who is responsible for all PCCM quality management and quality improvement activities. The EBCI Tribal Option will also submit an annual Quality Improvement Plan to the Department for review and approval.

Performance Improvement Projects (PIPs)[33]

In compliance with 42 CFR 438.330(d), and as part of each QAPI, health plans are required to conduct PIPs that:

- Are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction;
- Include measurement of performance using objective quality indicators;
- Include implementation of interventions to achieve improvement in access to and quality of care;
- Include planning and initiation of activities for increasing or sustaining improvement; and
- Include evaluation of the effectiveness of the interventions.

Standard Plans are required to conduct at least three clinical PIPs and one nonclinical PIP annually, which must be approved by the Department. The state may also mandate PIPs to support statewide priorities. Mandatory clinical and nonclinical PIPs in Contract Year 3 include:

- Diabetes management (i.e., Glycemic Status Assessment for Patients with Diabetes With Diabetes (GSD): Glycemic Status <8.0% and Glycemic Status >9.0%));
- Child and Adolescent Immunizations s (i.e., Childhood Immunization Status (CIS-E) (Combination10));
- Timeliness of Prenatal and Postpartum Care; and
- Health Related Resource Needs (HRRN) Screening.

[33] CMS has not specified standard, nationally required PIPs to date.

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PIHPs are required to conduct at least three PIPs annually, which must be approved by the Department.[34] The state may also mandate PIPs to support statewide priorities. Mandatory Clinical and nonclinical PIPs in Contract Year 1 include:

- Follow-Up After ED Visit for Mental Illness (FUM) (i.e., Follow-Up Within Seven Days Post-Discharge);
- Follow-Up After Hospitalization for Mental Illness (FUH) (i.e., Follow-Up Within Seven Days of ED Visit)
- Transition to Community Living—Supportive Housing (Completed in 2024 for CMS Reporting); and
- The Department and PIHP are aligning on the next nonclinical PIP for 2025.

The BH I/DD Tailored Plans are required to conduct at least three PIPs annually (two clinical, one non-clinical) that must be approved by the Department and related to:

- Maternal health, tobacco cessation, diabetes prevention, birth outcomes, early childhood health and development, hypertension, or behavioral-physical health integration.

The Child and Family Specialty Plan is required to conduct at least four PIPs annually that must be approved by the Department and include:

- One nonclinical PIP that must be related to one or more of the following areas:
- Improving timeliness of health assessment completion and Care Plan development;
- Improving supports to promote diversion, in-reach and/or transition for populations in or at risk of entrance into residential treatment facilities (RTF), adult care homes (ACH) or other congregate care settings;
- Improving the adequacy of the behavioral health network with regards to geographic and virtual accessibility to members, as applicable, and representation of historically underrepresented groups among providers in the network; and/or
- Improving educational outcomes by addressing underlying health needs/learning disabilities that contribute to poor school performance.
- Two clinical PIPs. The first of the two PIPs must describe the CFSP's efforts to implement a comprehensive program to reduce overutilization of psychotropic medications and underutilization of evidence-based psychotherapies for children and youth involved in the child welfare system, including but not limited to members in Foster Care. The second of the two PIPs must be related to one or more of the following areas, and the CFSP must consider how innovative use of Care Management can contribute to clinical performance improvement in the selected area(s):
- Improving prevention and management of acute and chronic conditions;
- Improving identification of and treatment for primary diagnoses of Trauma- and Stressor-Related Disorders, including Post-Traumatic Stress Disorder (PTSD), and underlying diagnoses;
- Improving identification of and care for Children with Special Health Care Needs; and

[34] Form CMS-416 is a required annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) evaluation and participation performance report for state Medicaid agencies to assess the effectiveness of EPSDT services.

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- Enhancing incorporation of trauma-informed competence and services into physical and behavioral health care delivery, particularly for children/young adults who have a history of abuse/neglect and children/young adults who are at risk for juvenile justice involvement.
- One PIP that is related to care and continuity across Foster Care placements and institutional settings (e.g., PRTFs, juvenile justice system, from one Foster Care placement to another and out-of-state placements) for this population. The CFSP must focus on care while the Member is in a placement, is transitioning between placements or is transitioning out of Foster Care (e.g., Member Aging Out of County Department of Social Services (DSS) Custody, Member Exiting County DSS Custody and is reunified with family):

In addition to the required PIPs, if a Standard Plan, PIHP, BH I/DD Tailored Plan and the CFSP performs below 75% for overall Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening rates, the health plan will be required to submit an additional PIP on EPSDT screening and community outreach plans.

Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP are required to report the status and results of each PIP conducted no less than once annually, as specified; these results, as noted in this section and Section V(A), will be validated by the EQRO and reviewed by the Department. As part of required PIP reporting, health plans must describe the details of interventions used, including a description of how improvement strategies/interventions will address gaps in access or outcomes. Quarterly PIP Progress reports will be conducted to ensure health plans are on track for the annual PIP reporting.

The EBCI Tribal Option is required to conduct two PIPs: one for operations and one for a clinical measure. The PIPs selected shall be described in the annual Quality Improvement Plan. The EBCI Tribal Option is required to send a quarterly report to the Department outlining progress on PIPs beginning the first federal fiscal year of EBCI Tribal Option PCCM entity operations.

The CCNC PCCM establishes PIPs in the event that any performance measure (see Appendix A, Table 11) fails to achieve its designated benchmark value due to preventable gaps in care. Behavioral Health and I/DD Services for NC Medicaid Direct PIPs will be restricted to measures for which the health plan collects all required data elements.

B. The Department's Quality Management and Improvement Structure

The Department's quality management approach is designed to measure and monitor health plan performance against health plan requirements through quality assurance, quality improvement and innovation activities for all enrollees, including those with special health care needs.[35] Through

[35] Adults and children with special health care needs are defined as follows:

- Children with special health care needs are those who have or are at increased risk of having a serious or chronic physical, developmental, behavioral or emotional condition and who require health and related services of a type or amount beyond that usually expected for the child's age. This includes, but is not limited to, children or infants in foster care; requiring care in neonatal intensive care units; with neonatal abstinence syndrome; in high-stress social

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Medicaid's Quality and Population Health and Evaluation team, the Department monitors and reviews health plan performance across quality efforts. The Department will leverage the internal Quality Health Outcomes Committee and the NC Medicaid Advisory Committee and Beneficiary Advisory Council (MAC/BAC)[36] to support key decision-making and ongoing assessment of health plan performance against the Aims, Goals and Objectives previously noted. The MAC/BAC includes health plan representatives, providers and other stakeholders such as Medicaid members. All MAC meetings are open to the public, while the BAC will remain closed to the public unless the new members vote to make them open. The Department invites all organizations and stakeholders to attend the meetings, including those representing the interests of different population groups such as children and North Carolina's aging network (e.g., Area Agencies on Aging, human services organizations and community-based organizations). The Quality Management Team is charged with the following responsibilities:

- Review and provide feedback on the QAPI plans proposed for Standard Plans, PIHPs, Tailored Plans, the CFSP and the EBCI Tribal Option (discussed in Section III(A));
- Provide input on updates to the quality measures health plans are required to report to the Department based on statewide priorities and clinical advancements;
- Provide feedback on updates to and revisions of the written Quality Strategy, including accounting for the recommendations put forth by the EQRO; and
- Provide feedback on development and changes to key Department programs designed to assess health plan performance, reward quality improvement and ensure health plan accountability, including the Withhold Program (discussed in Section V(A)(2)).

The MAC/BAC structure is designed to work closely with the Department, Quality Management team and staff involved in the development of the interventions described throughout this Quality Strategy that rely on stakeholder engagement for implementation and ongoing review.

C. Interventions

North Carolina has developed interventions that are closely aligned with this Quality Strategy and designed to build an innovative, whole-person, well-coordinated system of care to address both medical and nonmedical drivers of health. The role of interventions in achieving progress in the Aims, Goals and Objectives will be assessed using measures defined in Appendix A and Appendix B. Each intervention is briefly described below.

environments/experiencing toxic stress; receiving early intervention; with an SED, I/DD or SUD diagnosis; and/or receiving 1915(i), 1915(b)(3), Innovations or TBI waiver services.

- Adults with special health care needs are those who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that usually expected for individuals of a similar age. This includes, but is not limited to, individuals with HIV/AIDS; with an SMI, SED, I/DD or SUD diagnosis (including opioid addiction); suffering chronic pain; or receiving 1915(i), 1915(b)(3), Innovations or TBI waiver services.

[36] The Department is currently transitioning MCAC to the MAC/BAC to meet requirements in the CMS Final Rule.

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1. Opioid and SUD Strategy

As in many states, North Carolina's opioid epidemic continues to evolve into a more deadly and complex epidemic of polypharmacy and drug overdose. The Quality Strategy, in recognition of this crisis, includes a specific Objective (Objective 5.2) related to addressing the opioid crisis as well as broader Objectives tied to behavioral health, including SUD. North Carolina's Medicaid strategy builds on the North Carolina Opioid and Substance Use Action Plan (OSUAP), which was first released in 2017 and updated in June 2019 and May 2021. North Carolina's OSUAP 3.0 updates the 2019 plan to include a broadened focus on polysubstance use, as well as centering lived experiences to ensure that strategies addressing the overdose epidemic are led by those closest to the issue.[37] Further, the state's 1115 SUD demonstration, approved in April 2019, expands coverage and access to the full American Society of Addiction Medicine (ASAM) continuum of care, including residential treatment.[38]

To align with the state's Medicaid strategy, Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP are required to implement an Opioid Misuse Prevention and Treatment Program that contains interventions intended to prevent addiction and expand access to treatment.

Prevention strategies include establishing quantity limits; supporting and promoting safer prescribing of opioids; increasing access to screening, brief intervention, and referral to treatment; and management of acute and chronic pain with opioid-sparing medication therapies, non-narcotic medications and non-medication modalities.

Standard Plans, BH I/DD Tailored Plans and the CFSP will also be required to increase access to SUD treatment, including medication-assisted treatment, and support programs focused on treatment and transportation to alternative sites of care for individuals with SUD.

To ensure that enrollees with SUD are linked to care that meets their needs, Standard Plans, BH I/DD Tailored Plans and the CFSP will conduct care needs screenings to identify enrollees with SUD and coordinate SUD treatment across all levels of care, as well as recovery and other supports. The EBCI Tribal Option also screens to identify individuals with SUD needs and coordinates SUD treatment.

Finally, BH I/DD Tailored Plans are required to ensure in their network access planning that they have sufficient network capacity across SUD treatment and pain management services and include plans to expand network capacity as needed. Standard Plans cover a more limited set of SUD services and are required to meet network access standards as described in Section IV(A)(1).

2. Healthy Opportunities Strategy[39]

While access to high-quality medical care is critical, research shows that 80% of a person's health is determined by social and environmental factors and the outcomes that emerge as a result of these

[37] More information is available on North Carolina's Opioid and Substance Use Action Plan webpage.
[38] In January 2022, the state submitted an 1115 waiver amendment application to extend the demonstration until 2026 and make additional changes to the program.
[39] More information is available on the Healthy Opportunities Pilots webpage.

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factors.[40,41] Central to North Carolina's effort to improve access, quality and timeliness of care is a commitment to address the social and environmental factors that directly affect health outcomes and health care costs. The Department is addressing the social determinants of health (SDOH)—"the conditions in which people are born, grow, live, work and age," which it considers to be opportunities for health, within the Healthy Opportunities portfolio.[42] Research and stakeholder feedback has consistently cited food insecurity, housing instability and transportation challenges as critical barriers to health, as well as other risks important to underlying health status, such as interpersonal violence and trauma. These and other social factors disproportionately impact Medicaid members, increasing the risk that patients will develop chronic conditions, experience disparate health outcomes and drive cost.

To address these challenges, the Department has embedded statewide infrastructure as part of a strategy to promote Healthy Opportunities in its Medicaid program in several ways, including but not limited to:[43]

- **Screening for SDOH:** NCDHHS worked with a technical advisory group to develop a standardized set of SDOH screening questions and now requires that health plans screen all members annually for unmet SDOH needs using these questions. Strengthening reporting of the SDOH screenings performed by Standard Plans was included as a pay-for-reporting measure in the Standard Plan Withhold Program, where health plans may earn back withheld capitation funds (full or partial amount) according to their performance against specified targets.
- **Managing SDOH Needs:** As part of a public-private partnership, NCDHHS created NCCARE360, the first in the nation statewide coordinated care platform to electronically connect individuals to community resources and establish a dedicated closed loop process so providers can track whether those important connections happened.[44] NC Medicaid also requires all AMH Tier 3 practices to perform Comprehensive Assessments on each member identified as a priority for care management. This Comprehensive Assessment includes assessing the member's housing, food, transportation and interpersonal safety needs. Furthermore, NCDHHS expanded the footprint of Community Health Workers across North Carolina, which serve as critical community-based care team members who help individuals navigate to needed SDOH services statewide**.**
- **Paying for SDOH Services and Other Investments:** NC Medicaid launched the Healthy Opportunities Pilots which established a model for the delivery, payment and evaluation of supports to address nonmedical needs of qualifying members in three regions of the state. Innovative entities known as Network Leads develop and manage networks of Human Service Organizations (HSOs) that are contracted to deliver Healthy Opportunities Pilot services. Health plan staff, community-based care managers and HSOs screen members to identify who qualifies for services. Qualifying members are

[40] Linkins KW, Brya JJ, Chandler DW. Frequent users of health services initiative: final evaluation report. 2008; Institute of Medicine. 2015. Capturing Social and Behavioral Domains and Measures in Electronic Health Records: Phase 2. Washington, D.C.: National Academies Press.
[41] McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. Health Aff (Millwood) 2002;21:78-93; Galea S, Tracy M, Hoggatt KJ, Dimaggio C, Karpati A. Estimated deaths attributable to social factors in the United States. Am J Public Health. 2011;101:1456-65.
[42]Michael Marmot et al., "Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health," The Lancet 372, no. 9650 (Nov. 8, 2008):1661-1669.
[43] Certain SDOH initiatives are pending waiver authority; more information is detailed in the press release.
[44] NCCARE360. Building Connections for a Healthier North Carolina. 2024. https://nccare360.org/.

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enrolled in the program and referred for services which are approved and paid by health plans. In December 2024, NC Medicaid was granted federal authority to renew the Healthy Opportunities Pilots for an additional five years.[45]

Early results from the Healthy Opportunities Pilots are impressive. In the first two years, independent evaluators found North Carolina participants have: a reduced risk of food insecurity, housing instability, and lack of access to transportation and fewer ED visits and inpatient hospitalizations, resulting in overall cost savings of $85 per member per month, after considering the cost of the Healthy Opportunities Pilots services. The longer a person was enrolled in the Healthy Opportunities Pilots, the greater the reduction of risk and the higher the cost savings.[46]

3. Care Management (AMHs, AMH+s, CMAs)

A key strategy in the transition to managed care is to build on the successes of North Carolina's PCCM program through the implementation of an AMH model. The AMH model is designed to strengthen the ability of primary care practices to offer access to care for managed care members (including extended office hours and remote forms of access), enhance comprehensiveness of primary care, ensure care management at the local level and reinforce preventive care.

The AMH model includes several tiers delineating different provider choices and roles regarding certain data/analytic, care coordination and care management functions that affect Medicaid managed care members.

- Tier 1 and Tier 2: Standard Plans have primary responsibility for care management functions. Tier 1 and Tier 2 practices are the medical home and are required to closely coordinate with their contracted Standard Plan(s) who deliver the care management services.
- Tier 3: AMH Tier 3 practices lead in organizing and delivering care management services for their Standard Plan members in addition to serving as the medical home. Care management oversight and support is provided by the Standard Plans with which they contract. BH I/DD Tailored Plans will provide care management oversight and support for AMH Tier 3 practices that become certified to provide Tailored Care Management (described further below). Some Tier 3 practices will perform these functions in partnership with individually selected third-party partners.

AMHs provide comprehensive primary and preventive care services to managed care members, including member access, team-based care, population health management, care coordination across medical and social settings, and care management for high-risk populations. For most Medicaid populations, care management—whether episodic or chronic—directly involves the AMH care team.

AMH Tier 3 practices are eligible to earn negotiated Performance Incentive Payments based on the set of measures in Appendix A, Table 8, which were selected for their relevance to primary care and care coordination. Standard Plans are required to offer opportunities for such payments to Tier 3 AMHs and

[45] The Healthy Opportunities Pilots Program was authorized by the CMS for a five-year period, from Nov. 1, 2019, through Oct. 31, 2024, as part of North Carolina's Section 1115 Medicaid Demonstration Waiver. North Carolina intends to build on early successes and lessons learned from the first demonstration period to continue to improve health and well-being for all North Carolinians. The State submitted the renewal application on Oct. 31, 2023, and received approval from CMS to extend the 1115 Demonstration Waiver after its expiration on Oct. 31, 2024.

[46] Healthy Opportunities Pilots Interim Evaluation Report Summary, April 4, 2024.

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

may, at their discretion, offer them to AMH Tier 1 and 2 practices. For more information on practice-level quality measurement, please refer to the Technical Specifications.[47]

a. Standard Plan Care Management Model

Standard Plans play a crucial role in monitoring care management activities. They take responsibility for managing the care of any member not enrolled in an AMH Tier 3 and whose needs an AMH is not able to meet. Standard Plans are further required to achieve Department-determined thresholds for the provision of care management at the local level.

b. Tailored Care Management Model

The Department expects BH I/DD Tailored Plans and PIHPs to meet additional, more intensive standards related to Tailored Care Management and the unique aspects of their population, such as federal health home requirements and requirements related to North Carolina's 1915(c) Innovations and TBI waivers and 1915(i) State Plan Amendment, while maintaining all standards relevant to the Standard Plans. The goal for the Tailored Care Management model is to advance the delivery of high-quality, integrated, whole-person care through better coordination and collaboration across all of a member's needs. Members enrolled in PIHPs can also access Tailored Care Management if they would have been clinically eligible for a BH I/DD Tailored Plan if not for being part of a group that is exempt, delayed or excluded from managed care. To meet the care management needs of the BH I/DD Tailored Plan population and eligible members of PIHPs, the State has created two certifications called AMH+ and CMA, which will act as the provider-based sites for care management. AMH+ practices are Tier 3 AMHs that have demonstrable experience serving the Tailored Plan population and successfully apply for and are certified to provide Tailored Care Management.[48] CMAs are behavioral health, I/DD or TBI Medicaid providers that have demonstrable experience serving the BH I/DD Tailored Plan population and successfully apply for and are certified to provide Tailored Care Management. LME/MCOs in their role as BH I/DD Tailored Plans or PIHPs also provide Tailored Care Management.

More information on the model is available on the Tailored Care Management web page.

c. *CFSP Care Management Model*

All CFSP members will have access to robust care management directed by the CFSP. Under the CFSP care management model, the CFSP will serve as the central point of accountability for managing the health of members and ensuring access to needed physical health, behavioral health and I/DD services, as well as unmet health related resource needs, regardless of geographic location or type of transition the member is experiencing. While CFSP care management will be health plan-based, with Department approval, the CFSP may—at its discretion—delegate care management functions to community-based entities, provided that those entities are meaningfully and increasingly integrated into the CFSP's statewide model while maintaining a seamless member experience.

[47] Available on the NC Medicaid Quality Management and Improvement webpage.
[48] The Provider Manual for Tailored Care Management is available on the Tailored Care Management webpage.

The CFSP will assign each member to a care manager who will be required to coordinate closely with each member's primary care provider (PCP) and, as appropriate, care manager extenders, assigned County Child Welfare worker, EBCI Family Safety Program staff, CIHA Care Team, family members and guardians to manage the member's health care needs throughout their time enrolled in the CFSP. The Department will allow the use of care manager extenders, including but not limited to Certified Family Peer Specialists (Family Partners), Certified Peer Support Specialists, and community health workers, to support certain CFSP care management functions.

4. Maternal and Infant Health

North Carolina is nationally known for its (1) high participation rate of perinatal providers in the Medicaid program, (2) approach to high-risk pregnancy management and (3) its efforts to improve maternal and child health for all.

In November 2021, North Carolina's biennial budget, approved by the North Carolina General Assembly and signed into law by Governor Cooper, included a new benefit providing 12 months of continuous postpartum coverage to eligible Medicaid members at or below 196% of the FPL.

Starting April 1, 2022, pregnant women have coverage for full Medicaid benefits beyond the maternity-focused benefits previously included in the Medicaid for Pregnant Women program. The extended coverage is currently authorized for birth events that occur through March 2027.[49]

NCDHHS was selected for the U.S. Department of Health and Human Services' Health Resources and Services Administration investment in increasing access to maternal care, addressing maternal mental health and growing the maternal health workforce in North Carolina.[50] The Department will invest in the Healthy Start Initiative, which focuses on addressing factors like housing and nutrition in order to improve infant health outcomes. Funds will also be used for the screening and treatment of maternal depression and related behavioral health disorders in the NC Maternal Mental Health MATTERS Program.[51]

The Pregnancy Management Program seeks to improve maternal health and birth outcomes via alignment of practice requirements, incentives and quality reporting for perinatal providers across Standard Plans, BH I/DD Tailored Plans and the CFSP. At the practice level, the initiative consists of financial incentives tied to use of a standardized pregnancy risk screening tool and postpartum follow-up,[52] standard contracting requirements (e.g., committing to maintaining or lowering the rate of elective delivery prior to 39 weeks), quality measures, quality improvement activities and provider engagement activities.

The Department provides care for high-risk pregnant women through the Care Management for High-Risk Pregnancies (CMHRP) program, which is often a primary vehicle for delivering care management to pregnant women who may be at risk for adverse birth outcomes. Pregnant women may be referred into

[49] More information is available on the Extension of Postpartum Coverage webpage.
[50] More information is available in this press release.
[51] More information is available on the NC Maternal Mental Health MATTERS webpage.
[52] At the start of managed care, Standard Plans and Tailored Plans are required to pay practices $50 for every risk-screening tool completed at the initial visit and $150 for every postpartum visit. Additionally, Standard Plans and Tailored Plans must provide an increased rate for vaginal deliveries.

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

the program by maternity or other providers through use of the standardized screening tool or identified through claims analysis. For more information on CMHRP, please refer to the Program Guide and Program Update.[53]

Managed care plans are also permitted to develop their own maternity programs to complement the required programs noted above. The Department also participates in the Perinatal Quality Collaborative of North Carolina.[54]

Where EBCI Tribal Option members are concerned, it is important to note that the EBCI has similar support programs for high-risk pregnant women through CIHA. For these women, who may elect to enroll in a Standard Plan, the Department is working with the EBCI to facilitate opportunity for them to pursue services through CIHA.

Managed care plan performance is linked to the Quality Strategy through the quality measures noted in Section II(B) and Appendix A, Tables 7-9, which target specific maternal health outcomes. To improve maternal and infant health outcomes, health plans must track and report on key measures by demographic group, with a focus on addressing the disproportionate rates of maternal morbidity and mortality among known disparities within the maternal population. Standard Plans, BH I/DD Tailored Plans and the CFSP will also be accountable for performance on select process and quality improvement measures.

North Carolina has long been committed to supporting children who were exposed to toxic stress in early childhood or otherwise have complex social or health needs. The Care Management for At-Risk Children (CMARC) program serves children from birth to age 5 who meet specific risk criteria, providing them with a comprehensive health assessment and dedicated case management services. Consistent with the goals of this Quality Strategy, the program aims to improve health outcomes and reduce costs for enrolled children.[55,56]

In managed care, Standard Plans are responsible for care management for high-risk young children and are required to preserve the strengths of the current model, which integrates social supports and provides local care/case management services. BH I/DD Tailored Plans and PIHPs cover similar services for high-risk young children assigned to their health plans through Tailored Care Management. For more information on CMARC, please refer to the Program Guide and Program Update.[57] For more information on Tailored Care Management, please refer to the Tailored Care Management Provider Manual.[58]

The EBCI Tribal Option has similar support programs for at-risk children through CIHA. For these children, whose parents may elect to enroll them in a Standard Plan, the Department is working with the EBCI to facilitate opportunity for eligible members to receive services through CIHA.

[53] More information about the program is available on the NC Medicaid Care Management for High-Risk Pregnancies (CMHRP) webpage.
[54] More information is available the Perinatal Quality Collaborative of North Carolina webpage.
[55] More information about the program is available the NC Medicaid Care Management for At-Risk Children (CMARC) webpage.

[57] More information is available on the NC Medicaid Care Management for At-Risk Children (CMARC) webpage..
[58] Tailored Care Management Provider Manual available at: https://medicaid.ncdhhs.gov/tcm-provider-manual-012025/download?attachment.

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

Standard Plans are also accountable for performance on quality measures that promote child health, wellness and prevention, and are encouraged to develop broader models of care for addressing at-risk children.

5. Integrated Care for Kids Model

The North Carolina Integrated Care for Kids (NC InCK) model is a child-centered local service delivery and state payment model in Alamance, Orange, Durham, Granville and Vance counties. The program is supported by funding from CMS and aims to reduce expenditures and improve the quality of care for children under age 21 covered by Medicaid and CHIP through prevention, early identification and treatment of behavioral and physical health needs.

The NC InCK model is designed to build and support the infrastructure needed to integrate health and human services for Medicaid-enrolled members from birth through age 20 and covers approximately 95,000 children across the five-county model service area. Work on NC InCK began in January 2020 with a two-year planning period. NC InCK officially launched in January 2022 and runs through December 2026.

NC InCK supports whole-person care by identifying and addressing core child health care and unmet HRRN. NC InCK integrates care across clinical care (physical and behavioral health), school-based care, early care and education, food, housing, child welfare, Title V, mobile crisis response, juvenile justice and legal services.[59]

The InCK model further identifies the unmet health care and social service needs of InCK-attributed children and has deployed Service Integration Consultants across these sectors. NC InCK collaborates with children's existing care coordinators and care managers. In addition, NC InCK supports more holistic, integrated care by sharing information among caregivers, providers, care managers and case managers in accordance with federal and state rules.

The NC InCK model has added additional elements to the care needs screening, risk stratification and care management approaches NC Medicaid has developed. North Carolina Medicaid payers and delegated care management organizations have developed a standardized assessment for children in the model service area. Data and results from these multigenerational and cross-sector data sources determine the assignment of children to one of three service integration levels, ranging from routine care to progressively more complex integrated care.

Within NC InCK, quality of care is measured and improved using both standard health care measures (e.g., proportion of children receiving well-child checks) and novel cross-sector well-being measures (e.g., kindergarten readiness, food insecurity, housing instability).[60] To link incentive payments to meaningful measures of child well-being, NC InCK includes an alternative payment model. The first

[59] NC InCK members are not eligible to receive Tailored Care Management.

[60] See Appendix A, Table 12. The novel Primary Care Kindergarten Readiness Promotion Bundle encourages providers to promote kindergarten readiness by implementing at least five of 12 designated interventions within a primary care visit. Examples of activities promoted through the bundle include office-based literacy promotion, developmental screening and referral to pre-K. In addition, a new set of three measures aims to promote screening for food- and housing-related needs and track rates of food insecurity and housing instability. Providers began implementing these activities and billing practices in late 2022.

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quality measurement period began in January 2023 and ran through December 2023. Performance measure results from the first measurement period was released in the summer of 2024 and the first incentive payments tied to the APM measures went out to providers in the winter of 2024.

6. Provider Supports

Providers are critical partners in ensuring that the Goals and Objectives of the Quality Strategy are achieved and that interventions are successfully implemented. North Carolina providers accept Medicaid members at a level higher than many other states in NC Medicaid Direct, and with the ongoing transition to managed care, the Department recognizes the critical need to maintain this participation. To build on North Carolina's existing infrastructure to support clinical improvement, the Department is providing, directly and through Standard Plans, BH I/DD Tailored Plans or the PIHPs, additional resources tailored to advance state interventions and ensure providers' ability to achieve the Goals outlined in this Quality Strategy. The supports are offered to assist providers in clinical transformation and care improvement efforts at the regional and practice levels. Bidirectional communication is a cornerstone in engaging providers and meeting their needs.

These supports include state-led training and feedback sessions (e.g., webinars, virtual office hours, fireside chats, clinical/quality updates, AMH/AMH+/CMA webinars and, where feasible, in-person trainings) to keep providers updated on programmatic developments. Additionally, health plans are responsible for training providers on health plan-specific policies and programs and must develop a Provider Support Plan that is reviewed by the Department and updated on an annual basis.

7. Telemedicine, Virtual Patient Communications and Remote Patient Monitoring

As the health care landscape continues to evolve, telemedicine, virtual patient communications and remote patient monitoring will play a crucial role in increasing member access to care, improving outcomes and decreasing costs. Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP may provide these services to Medicaid members as an alternative service delivery model when clinically appropriate and in compliance with all state and federal laws.[61]

The EBCI Tribal Option also delivers services via telemedicine, in an effort to reduce barriers and address access to quality, evidence-based health care.

8. Valued-Based Payment

To ensure payments to providers are increasingly focused on population health outcomes, appropriateness of care and other measures of value, rather than on a fee-for-service basis, the Department encourages adoption of value-based payment (VBP) arrangements between health plans and providers. Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP are required to submit their VBP strategies to the Department and report on their use of VBP contracting arrangements each year. The Department has defined VBP as payment arrangements that meet the criteria of the Health Care

[61] More information on North Carolina's telemedicine program and policies can be found on the NC Medicaid Telehealth webpage.

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Payment (HCP) Learning and Action Network (LAN) Advanced Payment Model (APM) Categories 2 through 4.[62]

The Department continues to develop a longer-term VBP road map and vision and is working with community partners to assess health plans' advancements to date and opportunities to align VBP arrangements across payers and in accordance with statewide priorities. In June 2023, North Carolina was selected as one of eight states to participate in a CMS primary care payment model called Making Care Primary (MCP) – a multi-payer model aimed at strengthening primary care and reducing overall total cost of care by aligning Medicare, Medicaid, and commercial payers.[63] CMS announced in March 2025 that the Making Care Primary model will be terminated by Dec. 31, 2025, ending nine years earlier than planned. The AMH program is already aligned with MCP in several ways, including emphasis on local care management, advanced team-based primary care, quality improvement, incorporating social determinants of health screening, and increasing investments in primary care through payments beyond fee-for-service. While the Medicare Making Care Primary model will not be continuing, the Department's proposal to require managed care plans to offer a standardized pay-for-performance program to primary care providers, originally developed under Making Care Primary, remains an important step to advance NC Medicaid's goals of reducing provider burden and improving health outcomes. The Department continues to engage partners including providers, payers and members regarding its AMH Standardized Performance Incentive program and updates to its VBP programs and requirements.

9. NCQA Accreditation

As a key component of ensuring that Standard Plans, BH I/DD Tailored Plans and the CFSP are held to consistent, current standards for quality access and timeliness of care, Standard Plans, BH I/DD Tailored Plans and the CFSP are required to attain Health Plan Accreditation from the NCQA by end of Contract Year 4 for Standard Plans (2025), the end of Contract Year 4 (2029) for the CFSP, and end of Contract Year 3 for BH I/DD Tailored Plans (2026).[64]

Additionally, Standard Plans are required to obtain NCQA Health Equity Accreditation by end of Contract Year 4 (2025). The BH I/DD Tailored Plans will also be required to achieve NCQA LTSS Distinction by end of Contract Year 3 (2027).

Although health plans are not required to achieve accreditation for several years after launch, they must meet key accreditation milestones starting in Contract Year 1, including:

- Meet the clinical practice guidelines required for Health Plan Accreditation set forth by NCQA (42 CFR 438.236(b)).
- Submit all reports, findings and other results from private accreditation review(s) to the Department and, as determined by the Department, to the EQRO for all accredited health plans.

The Department aims to avoid duplication and inconsistency in quality functions completed across the accrediting body, EQRO and the Department related to health plan operations, quality measurement

[62] More information on the HCP-LAN APM framework is available on the HCP-LAN webpage.
[63] More information on the CMMI MCP model is available CMS MCP webpage.
[64] The PIHP is expected to achieve accreditation with LTSS distinction by Contract Year 3.

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and assessment, and compliance with Department standards. Following Standard Plan and Tailored Plan accreditation, the Department will streamline these activities and, where appropriate, exercise the option to use information provided by the accreditation reports to avoid duplication of mandatory activities as permitted by 42 CFR 438.360.

10. Reducing Health Disparities

The Department expects all entities to deliver health care services to Medicaid members to ensure improvements in quality performance are equitably distributed. The Department continues to focus on identifying and addressing systematic differences in health outcomes that disproportionately impact specific populations based on socioeconomic status, geographic location, and disability status, as examples. In order to improve health outcomes for all North Carolinians, the Department must identify and address gaps in access and outcomes that are experienced by different populations. For example, if rural populations experience consistently worse outcomes on a given metric, the Department would tailor interventions to rural areas as an important strategy to improve that outcome for all North Carolinians. The Department's strategic approach is centered on ensuring that all individuals receive fair and appropriate health care tailored to Medicaid members' specific needs. The Department requires Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP to participate in activities around disparities reduction. Since Contract Year 3, the Department has held Standard Plans financially accountable for addressing disparities in improvements for selected quality measures. Standard Plans are required to obtain NCQA Health Equity Accreditation by the end of Contract Year 4.

Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP are directed to report across select measures by select strata, including by age, race, ethnicity, sex, primary language and disability status, as well as by key population groups (e.g., LTSS, Transitions to Community Living, and by geography (county), where feasible (discussed further in Section V(A)(1)). In evaluating health plan performance on these measures, the Department will assess whether the disparities have narrowed through improving performance specifically for the subpopulation experiencing a health disparity, in addition to considering overall performance improvement. The Department's approach to analyzing performance improvement for quality measures overall and with respect to health disparities is described in detail in the Technical Specifications.[65]

Through a unique partnership, the Department and the EBCI are working together to assist the EBCI in addressing the health needs of American Indian/Alaskan Native (AIAN) members and to raise their health status to the highest possible level through creation of a first-in-the-nation Indian managed care entity, the EBCI Tribal Option.

Annually, the Department is developing a health disparities report documenting progress toward the goal of reducing disparities and improving health for all beneficiaries, sharing overall NC Medicaid stratified quality performance. The report identifies disparities most closely associated with disparate health outcomes. In future years, the Department will include Standard Plan, PIHP, Tailored Plan and the CFSP performance in its health disparities report. The Department has incorporated rewards for addressing disparities through priority population improvement into the Standard Plan Withhold

[65] Available on the NC Medicaid Quality Management and Improvement webpage.

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Program measure set.[66] In addition, contract requirements exist for Standard Plans to have health equity accreditation by July 1, 2025.

D. Health Information Technology

Data plays a crucial role in North Carolina's Medicaid transformation, including driving a continuous quality improvement process. North Carolina's Health Information Technology (HIT) system and initiatives support the overall Quality Strategy aims, goals, and objectives.[67] The Department is responsible for ensuring its information technology vendors are communicating and coordinating with the Department and with one another to create a successful and well-integrated system. In support of the overall strategy to improve the quality of care delivery to Medicaid members and supporting Medicaid providers, the Department is leveraging existing technology tools and considering new capabilities. These tools and new capabilities will help clinicians and care managers access a range of information, including patient-level data, alerts on hospital admissions/discharges, patient assessments, risk stratification, care plans and health related resource needs. The Department is consulting with stakeholders to establish communication between parties involved in encounter data exchange and to plan other types of information exchange and required reporting.

The Department aims to work with the state's designated Health Information Exchange (HIE), NC HealthConnex, to create a clinical data conduit for NC Medicaid Managed Care. Through NC HealthConnex, the Department envisions that Standard Plans and BH I/DD Tailored Plans will access clinical data needed for quality measurement instead of collecting data directly from providers. This will significantly reduce providers' workload, as they will only need to adhere to existing requirements to submit clinical data to NC HealthConnex, rather than reporting clinical data to multiple managed care plans and to the Department. NC HealthConnex data will be used to improve the Department's understanding of specific care needs, such as diabetes or hypertension care, by providing specific clinical data elements such as BP values and glycemic status for individual patients. Additionally, NC HealthConnex will serve as a central point for providers and health plans to access members' clinical records, particularly during transitions in care, to ensure that members do not have interruptions in essential services.

The Department is currently working with NC HealthConnex to:

1. Validate the extent to which the data it receives are complete and accurate enough to be used in quality measurement by leveraging NCQA's Data Aggregator Validation program and continuing internal efforts to reconcile measures and monitoring produced with NC HealthConnex data.
2. Produce an extract that contains clinical data elements needed for clinical quality measures. NC HealthConnex sends this clinical data to the Department and health plans monthly, so they can be used for population health monitoring and evaluation, member outreach, and the production of annual HEDIS measures.

[66] More information available on the NC Medicaid Quality Management and Improvement webpage.
[67] More information is available in the Data Strategy to Support the Advanced Medical Home Program in North Carolina policy paper and North Carolina's Data Strategy for Tailored Care Management policy paper.

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

3. Foster a hub for exchange of essential population health data for care management, such as care plans, clinical assessments, patient risk lists, patient medical histories, patient registries and patient attribution lists.
4. Develop the capacity to collect and exchange health-related resource needs screening data.
5. Ensure that all Medicaid providers with the capacity to do so, including labs, registries and long-term care facilities, are submitting complete, accurate data to the HIE.
6. Develop the capacity to join member health information, such as clinical data submitted by providers, with North Carolina Medicaid claims, encounters and enrollment data provided by the Department to produce Digital Quality Measures (dQMs). This aligns with CMS' goal of transitioning all quality measures used in reporting programs to dQMs.[68] Transitioning to dQMs will allow measure performance and gaps in care to be exchanged with providers, health plans and the Department in real time, thereby reducing the burden associated with manual reporting. dQMs can be used to close gaps in care and improve performance by providing patient-specific information at the point of care. The initial focus of this strategy will be on the following measures:
    - Controlling High Blood Pressure (CBP)
    - Glycemic Status Assessment for Patients with Diabetes (GSD)
    - Screening for Depression and Follow-up Plan (CDF)

The Department, Standard Plans, PIHPs, BH I/DD Tailored Plans, the CFSP and the EBCI Tribal Option are working on allowing access to clinical data needed for quality measurement through NC HealthConnex to reduce providers' workload. The Department's vision is that health plans, the EBCI Tribal Option and providers can share clinical information about patients enrolled in a variety of care management and population health programs, improving coordination of care for patients, and reducing administration burden for providers and health plans.

[68] More information is available on CMS' Digital Quality Measurement Strategic Roadmap webpage

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IV. State Standards for Access, Structure and Operations for Standard Plans, BH I/DD Tailored Plans and the CFSP

North Carolina's managed care contracts include robust requirements to ensure that Standard Plans, Tailored Plans, the CFSP and the PIHPs meet and, in many cases, exceed the managed care standards outlined in 42 CFR Part 438, Subpart D, and as specified by the Department. These standards are detailed throughout this section of the Quality Strategy and include requirements for member access to care. Requirements include network adequacy, availability of services, access to care during transitions of coverage, assurances of adequate capacity and services, coordination and continuity of care and coverage, and authorization. Further, these requirements focus on the structure and operations that Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP must have in place to ensure the provision of high-quality care. The structure and operations requirements include provider selection requirements, practice guidelines, information made available to members, and enrollment and disenrollment processes. Contracts for Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP also require confidentiality, appeals and grievance systems, sub-contractual relationships and delegation, and identifying the type of information technology used by each health plan.

The Department recognizes these managed care requirements as important assurances that member services are adequately and appropriately provided and further recognizes the significance of monitoring and responding to key indicators of the success of such requirements. The Department will use tools to assess member and provider perceptions of the effectiveness of these efforts, such as:

- The CAHPS Plan Survey (Adult 5.1, Children 5.1), which assesses members' experience of care.
- A standard provider survey tool for PCPs, Behavioral Health providers, and ObGyns, which measures provider experience.

A. State Access Standards

1. Network Adequacy Standards

Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP are expected to maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to all services the health plans cover under the Medicaid program for all members, including those with limited English proficiency or with physical or mental disabilities, based on standards developed by the Department. Parameters include time and distance requirements and cannot be provided exclusively through telemedicine or remote services. To recognize the special need for accessibility with regard to behavioral health services, the standards include specific measurements for those services. Per federal regulations at 42 CFR § 438.68, health plan networks must meet network adequacy standards developed by the state and published online. Network adequacy standards are important tools for ensuring that members have access to providers and care. North Carolina's network adequacy standards vary by

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geographic area and include **time and distance standards** for providers who serve adult and pediatric member needs, as described in Table 14, and **appointment wait-time standards**, as described in Tables 15-18 in Appendix E.

The information in this section is subject to change based on updates to contracting and regulatory requirements.

The adult and pediatric providers who are subject to the state's specialty care standards include:

- Allergy/Immunology
- Anesthesiology
- Cardiology
- Dermatology
- Endocrinology
- ENT/Otolaryngology
- Gastroenterology
- General Surgery
- Gynecology
- Obstetrics
- Hematology
- Infectious Disease
- Nephrology
- Neurology
- Oncology
- Ophthalmology
- Optometry
- Orthopedic Surgery
- Pain Management (Board-Certified)
- Psychiatry
- Pulmonology
- Radiology
- Rheumatology
- Urology

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The state will periodically revisit this list of specialty care providers and revise the list based on utilization and needs of the health plans' enrollee population.

a. Mandatory Network Providers

In addition to meeting the state's network adequacy standards, federal and state statutes and regulations require Standard Plans, BH I/DD Tailored Plans and the CFSP to contract with certain types of providers. Federal regulations require health plan networks to include at least one federally qualified health center (FQHC), at least one rural health clinic (RHC) and at least one freestanding birth center, where available, for the health plan's contracted service area.[69]

North Carolina statute requires Standard Plans, BH I/DD Tailored Plans and the CFSP to contract with all "essential providers" in their geographical coverage area, unless the Department approves an alternative arrangement for securing the types of services offered by the essential providers.[70] Essential providers include FQHCs, free/charitable clinics, RHCs, state veterans' homes and Local Health Departments.

Regardless of network status, Standard Plans, BH I/DD Tailored Plans and the CFSP must allow eligible members access to Indian Health Care Providers, including CIHA and family planning providers.

b. Out-of-Network Services

In the event the Standard Plan's, PIHP's, BH I/DD Tailored Plan's the CFSP's provider network is unable to provide necessary covered services to an enrollee, the health plan must adequately and timely cover these services out-of-network for the enrollee for as long as the health plan's provider network is unable to provide them. Health plans are responsible for communicating administrative requirements (e.g., prior authorization requirements, to the degree prior authorization is not prohibited under federal regulation) and coordinating payment with the out-of-network providers and ensuring the cost to the member is no greater than it would be if the services were furnished within the network. In certain cases where there may be a longer-term need, the health plan and out-of-network provider may engage in single-case agreements to ensure both parties understand what is administratively and financially expected and to minimize potential disputes that may disrupt member care.

IHS providers and federally recognized tribal providers are considered in-network regardless of contract status or geographic location if they are enrolled as a Medicaid provider. Standard Plans, BH I/DD Tailored Plans and the CFSP must adhere to the Tribal Managed Care contractual standards in defining network status for IHS/tribal providers.

c. Exceptions to Network Adequacy Standards

Standard Plans, PIHPs, BH I/DD Tailored Plans, or the CFSP that are unable to meet network adequacy standards may request an exception for a specific provider type in a specific region. Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP are required to submit a request for an exception to the Department with corresponding information in support of that request.

[69] Available the State Health Official and State Medicaid Director letter.
[70] North Carolina Session Law 2015-245, as amended by Session Law 2016-121.

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

Where exception requests are approved, the Department will monitor member access to the relevant provider types in specific regions on an ongoing basis. The Department will report the findings annually to CMS, in line with federal regulations.

d. Telemedicine, Virtual Patient Communications and Remote Patient Monitoring

As described above in Section III(C)(8), Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP may use telemedicine, virtual patient communications and remote patient monitoring as tools for ensuring access to needed services in accordance with their own telemedicine coverage policies. When an enrollee requires a medically necessary service that is not available within the Department's expected driving distance, the health plan will be expected to ensure that the enrollee has access to that service and can either utilize an out-of-network provider or access the service through telemedicine, if applicable and medically appropriate. The member must have a choice between an out-of-network provider and telemedicine and cannot be forced to receive services through telemedicine. While health plans may not use telemedicine to meet the state's network adequacy standards, they may leverage telemedicine in their request for an exception to the state's network adequacy standards.

2. Availability of Services

Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP must contract with a sufficient number of providers to ensure that all services covered under the contract are available and accessible to members in a timely manner, as required under 42 CFR 438.206. To ensure this, under state law, Standard Plans must include any willing providers in their networks, except when a health plan is unable to negotiate rates. The BH I/DD Tailored Plans and PIHPs must include any willing providers for physical health and pharmacy services but, as set forth in N.C. Gen. Stat §§ 108D-23 and 108D-26, they must have the authority to maintain closed networks for certain behavioral health, I/DD and TBI services not identified by the Department as requiring an open network to improve beneficiary access to services. As authorized by the NC Legislature, the CFSP will have an "any willing provider" network for all services except intensive in-home services, multisystemic therapy, residential treatment services and psychiatric residential treatment facilities.

As described previously, Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP must also contract with all "essential providers" in their area unless the Department approves an alternative arrangement. North Carolina seeks to ensure the availability of services through, among other things, its network adequacy standards, which include both time and distance standards and appointment wait-time standards (see above). Other requirements regarding managed care networks and the availability of services covered under the contract include:

- Direct access to a women's health specialist for covered care necessary to provide women's routine and preventive health care services (note that this is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist);
- Direct access to emergency services, children's screening services, primary care services, school-based clinic services and LHD services;

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

- Direct access to behavioral health services, such that health plans will not require members to obtain a referral or prior authorization for at least one mental health assessment and at least one substance dependence or use disorder assessment from a participating provider in any calendar year;
- Direct access to covered services offered by family planning providers and/or family planning services;
- Direct access to specialists for members with special health care needs (defined under subsection 5, "Coordination and Continuity of Care") in a manner that is appropriate for the members' health condition and age;
- Access to a second opinion from either an in-network provider or an out-of-network provider (to be arranged by the health plan) at no cost to the enrollee;
- Access to necessary covered services from an out-of-network provider for as long as the health plan's network is unable to provide such services;
- Access to covered services 24 hours a day, seven days a week, when medically necessary;
- Access to network providers during hours of operation that are no less than the hours of operation offered to commercial enrollees or, if the provider serves only Medicaid members, comparable to NC Medicaid Direct;
- Timely access to services for the tribal population through use of IHS/federal tribal providers in accordance with federal policy;
- Access to a pharmacy network that fulfills time and distance standards; and
- Access to telemedicine, virtual patient communications and remote patient monitoring as a tool for facilitating timely access to needed services that are not available within the health plan's network and in accordance with Policy 1H: telemedicine, Virtual Patient Communications and Remote Patient Monitoring.

Standard Plans, Tailored Plans, the CFSP, PIHPs and the EBCI Tribal Option must also ensure the availability and delivery of services in a culturally and linguistically sensitive and literate manner to all members, including those with limited English proficiency and literacy, of diverse cultural and ethnic backgrounds, or with disabilities, and regardless of gender, sexual orientation or gender identity. Standard Plans, Tailored Plans and the EBCI Tribal Option must also ensure that network providers provide physical access, reasonable accommodations and accessible equipment for members with physical disabilities or BH I/DD needs.

3. Access to Care During Transitions of Coverage

In compliance with the transition-of-care policy requirements set forth by 42 CFR 438.62, North Carolina has established transition-of-care standards that apply to all members to ensure continuity of care for all members, including those in need of LTSS.

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

In instances where a member transitions into a Standard Plan, PIHP, BH I/DD Tailored Plan or the CFSP (from either NC Medicaid Direct or another health plan or coverage type):[71]

- When a member is participating in an ongoing course of treatment or has an ongoing special condition, the member may continue receiving services from their provider (even if they are out-of-network) for up to 90 days for Standard Plans, BH I/DD Tailored Plans, and PIHPs, where as the CFSP is 180 days; or[72]
- New enrollees who are pregnant may continue receiving services from their behavioral health provider and obstetrician throughout their pregnancy or until loss of Medicaid eligibility during the pregnancy, whichever is later.

When a provider leaves or is terminated from a Standard Plan's, CFSP's or BH I/DD Tailored Plan's network:

- In cases when a provider is terminated or leaves the Standard Plan's, CFSP's or BH I/DD Tailored Plan's network for nonrenewal of the contract:
  - An enrollee participating in an ongoing course of treatment or with an ongoing special condition may continue receiving services from that provider for up to 180 days for the CFSP and 90 days for Standard Plans and BH I/DD Tailored Plans; or
  - In cases where a provider is terminated or leaves the Standard Plan's, PIHP's, BH I/DD Tailored Plan's or the CFSP network because of quality of care or program integrity-related concerns, the health plan shall notify and assist the enrollee in transitioning to an appropriate in-network provider who can meet their needs.

4. Assurances of Adequate Capacity and Services

In accordance with 42 CFR 438.207, North Carolina maintains a monitoring and oversight system to ensure that Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP have adequate capacity to provide care to all members in their respective service areas. Key components of the state's monitoring and oversight activities include, but are not limited to:

- Requiring Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP to submit an access plan and regular documentation (including provider network data and report(s) that summarize findings from Standard Plans', BH I/DD Tailored Plans' the CFSP's own network data analysis) to demonstrate network adequacy;
- Requiring Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP to submit updated machine-readable provider directories in a standardized format;
- Contracting with an EQRO to review and validate health plan data and findings;

[71] The Behavioral Health and I/DD Services for Medicaid Direct PIHP is expected to follow the Department's Transition of Care policy and support the transition of members into Medicaid Direct as well as into Medicaid managed care.
[72] At the time Standard Plans are launched, an enrollee who is participating in an ongoing course of treatment for a benefit only offered through LME/MCOs will be required to remain in NC Medicaid Direct/LME/MCO coverage to continue receiving that benefit.

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

- Requiring that Standard Plans, BH I/DD Tailored Plans, and the CFSP be accredited by Contract Year 4 for Standard Plans (2025), Contract Year 3 for BH I/DD Tailored Plans (2027) and the CFSP (2028);
- Monitoring member complaints related to access to care and provider networks;
- Reviewing quality measurement data to show realized access;
- Reviewing CAHPS survey findings related to member experience of availability and access to services and taking action as needed; and
- When necessary, issuing corrective action plans (CAPs) when health plans are identified as noncompliant with network adequacy standards and access requirements.

As outlined in Appendix D, the Department's contracted EQRO will perform an annual external quality review (EQR) of each Standard Plan, PIHP, BH I/DD Tailored Plan and the CFSP to, among other things, determine health plan compliance with network adequacy and access requirements, confirm the adequacy of each health plan's network, and validate data submitted to the Department. The EQRO must include the findings of the annual EQR in a technical report, which will be posted on the state's website. The Department will monitor member access-to-care issues, including using geographic mapping and other techniques.

5. Coordination and Continuity of Care

a. Care and Coordination of Services

Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP have overall responsibility for ensuring that all members have an ongoing source of care according to their needs and for communicating this responsibility along with a point of contact at the health plan, as required by 42 CFR 438.208(b). Health plans are further responsible for coordinating services between settings of care, including appropriate discharge planning for short- and long-term hospital and institutional stays. In the event a member changes enrollment across managed care plans or NC Medicaid Direct (for example, once a member exceeds 90 days in a nursing home), health plans are required to coordinate with another source (or other sources) of coverage to ensure continuity and non-duplication of services.

Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP are responsible for assessing risk in their enrolled populations, including risk based on SDOH and other risk factors. To address SDOH, health plans should collaborate with community-based organizations and include strategies to link members to housing, nutrition, transportation and other social supports as part of their care coordination efforts. As required by 42 CFR 438.208(b)(3), health plans are required to make best efforts to conduct a universal screening process for newly enrolled members within 90 days of enrollment. The Department requires health plans to include within their initial screening tools standardized questions relating to highest-priority SDOH (housing, food, transportation and interpersonal violence).

In recognition that care management for many individuals is most effective when delivered in the community, health plans are required to meet state requirements to ensure that a specified portion of care management is delivered in predominantly community settings at a local level. As required by 42 CFR 438.208(b)(iv), health plans are required to coordinate their services with those received from community and social support providers.

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

Primary care practices and entities that provide care management (e.g., AMHs, AMH+s, CMAs) play a critical role in care management and care coordination for Standard Plan and BH I/DD Tailored Plan/PIHP enrollees.

Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP are required to deliver care management locally to the maximum extent possible (including by AMHs, AMH+s, CMAs and other local care managers, such as LHDs) while accounting for the diversity of North Carolina's delivery system.

b. Additional Services for Members With Special Health Care Needs or Who Need LTSS

For members who have special health care needs and members who need LTSS (categories that cover a subset of members in Standard Plans and all members enrolled in Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP, are required, in compliance with the parameters set forth in 42 CFR 438.208(c), to conduct a Comprehensive Assessment to identify any ongoing special conditions that require a course of treatment or regular care monitoring.

Adults and children with special health care needs are defined as follows:

- **In the Standard Plan Contract:**
  - **Children with special health care needs** are defined as those who have or are at increased risk of having a serious or chronic physical, developmental, behavioral or emotional condition and who require health and related services of a type or amount beyond that usually expected for the child's age. This includes, but is not limited to, children or infants in foster care; requiring care in the neonatal intensive care units; with neonatal abstinence syndrome; in high-stress social environments/experiencing toxic stress; receiving Early Intervention; with an SED, I/DD or SUD diagnosis; and/or receiving 1915(i), Innovations or TBI waiver services.
  - **Beneficiary with special health care needs** are defined as populations who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that usually expected for individuals of a similar age. This includes, but is not limited to, individuals with HIV/AIDS; with an SMI, SED, I/DD or SUD diagnosis (including opioid addiction); suffering chronic pain; or receiving 1915(i), Innovations or TBI waiver services.
- **In the BH I/DD Tailored Plan and PIHP Contracts:**
  - **Beneficiary with Special Health Care Needs:** Populations who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for individuals of similar age. This includes but is not limited to individuals with: HIV/AIDS; an SMI, I/DD or SUD diagnosis; Chronic Pain; Opioid Addiction; or receiving Innovations or TBI waiver services.

Based on the Comprehensive Assessment, the state requires Standard Plans, PIHPs, BH I/DD Tailored Plans, the CFSP and the EBCI Tribal Option to identify enrollees who require LTSS and to develop a person-centered care plan for such enrollees. The care plan must be developed by a person with expertise in LTSS service coordination and trained in person-centered planning processes. The health plan also shall permit a member with special health care needs determined through assessment to

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

require a course of treatment or regular care monitoring has direct access to a specialist as appropriate for the enrollee's condition and identified needs.

Standard Plans, PIHPs, BH I/DD Tailored Plans, CFSP and the EBCI Tribal Option are responsible for identifying individuals with special health care needs and in need of LTSS primarily using some combination of claims data review, predictive modeling and/or care needs screening to ensure the development of an appropriate treatment/service plan, as described above.

6. Coverage and Authorization of Services

Standard Plans, BH I/DD Tailored Plans and the CFSP are required to cover select physical health, LTSS and pharmacy services as required in NC Medicaid Direct, except for a small number of services carved out of Medicaid managed care by statute.[73,74]The behavioral health and I/DD benefits covered under Standard Plans and Tailored Plans differ in accordance with statute.[75] Standard Plans are required to cover many behavioral health services included in the Medicaid State Plan. BH I/DD Tailored Plans and the PIHPs cover the same behavioral health services as Standard Plans, as well as additional, higher-intensity behavioral health and I/DD services included in the Medicaid State Plan and 1915(c) waiver services for individuals with I/DD and TBI.[76] The CFSP will cover all behavioral health benefits covered by Standard Plans in addition to the majority of BH I/DD Tailored Plan behavioral health services.[77] Consistent with the requirements set forth in 42 CFR 438.210, North Carolina has developed an approach to Standard Plan, BH I/DD Tailored Plan and the CFSP clinical coverage policies and Utilization Management Program (UM Program) that safeguards member access to services while encouraging health plan innovation. Standard Plans, BH I/DD Tailored Plans and the CFSP are required to follow NC Medicaid Direct's clinical coverage policies for a limited set of services to maintain services for specific vulnerable populations, maximize federal funding and comply with state mandates, and are permitted to establish their own clinical coverage policies for all other services within specific guardrails.

[73] N.C. Gen. Stat. § 108D-35, as amended, excludes dental services; services provided through PACE; services documented in an individualized education program and provided or billed by local education agencies; services provided and billed by a Children's Developmental Services Agency that are included on the child's Individualized Family Service Plan; services for Medicaid program applicants during the period of time prior to eligibility determination; and the fabrication of eyeglasses, including complete eyeglasses, eyeglass lenses and ophthalmic frames. The Department also recommends that the fitting and the provider visual aid dispensing fee for eyeglasses be carved out of managed care, which would require a statutory change.
[74] Codified at N.C. Gen. Stat. § 108D-62(c). The CFSP will cover all services in the NC Medicaid State Plan with the exception of services carved out of Medicaid Managed Care under Section 4.(4) of Session Law 2015-245, as amended; Section 9E.22(k) of Session Law 2023-134; and as specified in 42 C.F.R. § 438.210.
[75] N.C. Gen. Stat. § 108D-35, as amended by Session Law 2018-48.
[76] N.C. Gen. Stat. § 108D-35, as amended by Session Law 2018-48, specifies that Standard Plans and Tailored Plans will cover inpatient behavioral health services, outpatient behavioral health ED services, outpatient behavioral health services provided by direct-enrolled providers, mobile crisis management services, facility-based crisis services for children and adolescents, professional treatment services in a facility-based crisis program, outpatient opioid treatment services, ambulatory detoxification services, nonhospital medical detoxification services, partial hospitalization, medically supervised or ADATC detoxification crisis stabilization, research-based intensive behavioral health treatment, diagnostic assessment services and EPSDT services. Other behavioral health, I/DD and TBI services currently covered by the LME/MCOs will only be available in Tailored Plans.
[77] See service limitations under N.C. Gen. Stat. § 108D-62(c). Behavioral Health, I/DD and TBI Services Covered Exclusively by Tailored Plans and not by CFSP include Intermediate care facilities for individuals with intellectual disabilities, innovations waiver services, state-funded services and respite services through TRACK at Murdoch.

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP are required to use the Department definition of medical necessity, defined in 10A NCAC 25A.0201, when making coverage determinations and are prohibited from setting benefit limits that are more stringent than in NC Medicaid Direct. For example, if NC Medicaid Direct covered 10 visits for a specific service, health plans could cover 12 visits but could not limit a member to a number of visits fewer than 10.

The Department requires use of a common prior authorization request form for all services. There is a standard request process for "in-lieu-of services," designed to encourage Standard Plans, BH I/DD Tailored Plans and the CFSP to cover services or settings that are not otherwise covered under the State Plan but are medically appropriate, cost-effective alternatives to a covered service.

B. Structure and Operations Standards

1. Provider Selection

Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP are required to implement written policies and procedures for the selection and retention of network providers.[78] These policies and procedures must meet state and federal requirements, including:

- **"Any willing provider" requirement:** Standard Plans may not exclude providers from their networks except for refusal to accept network rates. BH I/DD Tailored Plans may not exclude physical health and pharmacy providers from their networks except for failure to appear on the Medicaid Provider Enrollment File and/or refusal to accept network rates.[79,80] With the exception of providers of intensive in-home services, multisystemic therapy, residential treatment services and PRTFs, the CFSP may not exclude providers from its network other than for refusal to accept network rates;
- **Credentialing and re-credentialing:** Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP must follow a documented process that is in line with the state's uniform credentialing policy and centralized credentialing verification program for deciding to move to contracting or re-contracting with network providers;[81]
- **Enrolled providers:** Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP may only contract with providers who are enrolled in NC Medicaid Direct;

[78] The EBCI Tribal Option contract includes requirements related to engagement and contracting with IHS/federal tribal providers, regardless of the location of the providers.
[79] North Carolina Session Law 2015-245, as amended by Session Law 2016-121. Note that this state statute also requires Standard Plans and Tailored Plans to contract with all providers in their geographical coverage area that are designated by the Department as "essential providers" (see the "Mandatory Network Providers" section above), unless the Department approves an alternative arrangement for securing the types of services offered by the essential providers.
[80] North Carolina Session Law 2018-48 Section 4.(10)(a)(1)(IV) permits Tailored Plans to maintain a closed network for behavioral health, I/DD and TBI services; pending legislative change, the Tailored Plan must include all essential providers for behavioral health, I/DD and TBI services located in the Tailored Plan region in its network regardless of closed network requirements.
[81] Credentialing for the PIHP aligns with the credentialing process for Tailored Plans. Please see the PIHP Contract for more detail.

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

- **Nondiscrimination:** In selecting and contracting with network providers, Standard Plans, BH I/DD Tailored Plans and the CFSP must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment; and
- **Excluded providers:** Standard Plans, BH I/DD Tailored Plans and the CFSP may not employ or contract with providers that are excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.
- Additionally, health plans must make good faith effort to actively recruit and support providers who reflect the cultural, linguistic and demographic diversity of the populations they serve, particularly in areas with a documented shortage of such providers.

2. Practice Guidelines

Consistent with the requirements of 42 CFR 438.236, Standard Plans, PIHPs, BH I/DD Tailored Plans, and the CFSP are required to develop practice guidelines that:

- Are based on valid and reliable clinical evidence or a consensus of providers in the particular field;
- Consider the needs of members;
- Are adopted in consultation with contracting health care professionals;
- Are reviewed and updated periodically, as appropriate; and

Additionally, the Department requires that Standard Plans, BH I/DD Tailored Plans and the CFSP meet the following standards:

- The health plan's Quality Improvement Committee or other designated committee must approve clinical practice guidelines;
- The health plan must adopt guidelines from recognized sources of feedback of board-certified practitioners from appropriate specialties that would use the guidance;
- The health plan must update guidelines based on clinical evidence at least every two years or more frequently if the national guidelines change within the two-year period;
- The health plan must annually evaluate the consistency with which health care professionals in UM Program apply criteria in decision-making;
- The health plan must act on opportunities to improve consistency, if applicable
- The health plan must distribute clinical practice guidelines and revisions to all practitioners who are likely to use them; and
- As requested by the Department, the health plan must submit to the Department a copy of any required clinical practice guidelines and make the health plan's Chief Medical Office (or designee) available to discuss the coordination of clinical practice guidelines and clinical coverage policies.

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

Additionally, for behavioral health services, Standard Plans, BH I/DD Tailored Plans and the CFSP are required to use the following behavioral health guidelines and tools as part of the health plan's UM Program:[82]

- ASAM criteria for substance use services for medical necessity reviews for all populations except children aged zero through six; and
- EPSDT criteria when evaluating requests for service for children. Health plans must use either the Early Childhood Services Intensity Instrument or Children and Adolescents Needs and Strengths for Infants, Toddlers and Preschoolers to determine medical necessity for children aged zero through five; another validated assessment tool may be used with prior authorization from the Department.

Standard Plans, BH I/DD Tailored Plans and the CFSP are required to disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. Standard Plans, BH I/DD Tailored Plans and the CFSP will make decisions related to UM Program, member education and coverage of services consistent with these guidelines.

3. Enrollee Information

To ensure the capacity for NC Medicaid Managed Care education and health plan/PCP selection support at NC Medicaid, the Department has procured an Enrollment Broker to facilitate outreach, education and consumer assistance to enrollees and potential enrollees.

Furthermore, in accordance with state standards and the federal requirements in 42 CFR 438.10, all informational materials developed by the Department, Enrollment Broker, Ombudsman Program, Standard Plans, the EBCI Tribal Option, PIHPs, BH I/DD Tailored Plans and the CFSP will be made available in formats and languages that ensure their accessibility, to include developing materials that can be understood at an appropriate reading level.

Recognizing the importance of members receiving consistent and accurate information about how to effectively use NC Medicaid Managed Care, the Department will develop a model member handbook that Standard Plans, the EBCI Tribal Option, PIHPs, BH I/DD Tailored Plan and the CFSP must customize and use. The member handbook will include:

- Benefits provided by the health plans, including the amount, duration and scope of those benefits, and guidance on how and where to access benefits, including carved-out services, nonemergency transportation, EPSDT, family planning services and supplies from out-of-network providers;
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the member's AMH/PCP;
- Overview of the continuation of benefits policy, including when, why and how a member or member's authorized representative may file for a continuation of benefits;
- How and where to access any benefits provided by the Department, including carved-out services;
- The extent to which and how both after-hours and emergency coverage are provided;

[82] UM guidelines for the PIHP are available in the PIHP Contract.

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

- Any restrictions on the member's freedom of choice among in-network and out-of-network providers;
- Cost sharing imposed on North Carolina Medicaid members;
- Member enrollment and disenrollment policy and the process of selecting and changing the member's AMH/PCP;
- Grievance, appeal and state fair hearing procedures and time frames;
- How to exercise an advance directive, as set forth in federal requirements;
- The toll-free telephone number for the Member Services Line, Behavioral Health Crisis Line, Nurse Line, Provider Service Line and Prescriber Service Line and how to access auxiliary aids and services, including additional information in alternative formats or languages;
- Information on how to report suspected fraud, waste or abuse;
- Information on the Opioid Misuse Prevention Program;
- Contact information for member support systems, including the Ombudsman Program and the Enrollment Broker;
- Information on the health plan's Transition of Care policy; and
- Information about the health plan's prevention and population health programs.

Standard Plans, the EBCI Tribal Option, PIHPs, BH I/DD Tailored Plans and the CFSP are permitted to provide this information by mail or email (only if the member has expressed consent to email), in addition to posting it online.

Information provided will promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency, with diverse cultural or ethnic backgrounds, or with disabilities, and regardless of gender, sexual orientation or gender identity.

Provider Directories

Standard Plans, the EBCI Tribal Option, PIHPs, BH I/DD Tailored Plans and the CFSP must each compile the following information about all their network providers in a format specified by the Department and made available to enrollees and potential enrollees. The provider directory must be made available in both paper and electronic formats, be easy to understand, and meet language and format requirements in accordance with 42 CFR 438.10, managed care contracts, and as specified by the Department.[83]

- Provider names (first, middle, last);
- Group affiliation(s) (i.e., organization or facility name(s), if applicable);
- Street address(es) of service location(s);
- County(ies) of service location(s);

[83] Per federal regulations, Standard Plans and Tailored Plans must make their provider directories available in the prevalent non-English languages in their particular service areas and in alternative formats upon request of the potential enrollee or enrollee at no cost. Auxiliary aids and services must also be made available upon request of the potential enrollee or enrollee at no cost.

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

- Telephone number(s) at each location;
- Website address;
- Provider specialty;
- Whether provider is accepting new members;
- Provider's linguistic capabilities, i.e., languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office;
- Whether the provider has completed cultural and linguistic competency training;
- Office accessibility (i.e., whether the location has accommodations for people with physical disabilities, including in offices and exam rooms, and any necessary equipment); and
- Telephone number(s) that members can call to confirm the information in the directory.

Per 42 CFR § 438.10, information included in a paper provider directory must be updated at least quarterly if the Standard Plan, BH I/DD Tailored Plan, PIHP, or CFSP has a mobile-enabled directory or thirty (30) calendar days if they do not, and the electronic consumer-facing provider directories must be updated no later than 30 calendar days after the Standard Plan, BH I/DD Tailored Plan or PIHPs receives updated provider information. Provider directories must be posted on the health plans' website in a machine-readable file and format as specified by the state.

4. Enrollment and Disenrollment[84]

In designing the managed care enrollment and disenrollment policies, the Department recognizes the importance of ensuring North Carolina Medicaid applicants and their families experience a simple, streamlined eligibility and enrollment process that ensures a timely and accurate determination of Medicaid eligibility and a user-friendly health plan and PCP selection process. In the future, the Department envisions members applying for health coverage, receiving an eligibility determination and selecting a health plan based on their preferred PCP with the help of educational resources in one single process. The state and the Enrollment Broker will be jointly responsible for enrollment and disenrollment requirements, consistent with those set forth in 42 CFR §§ 438.54 and 438.56.

County DSS offices and the Department/EBCI Medicaid and Food and Nutrition Services Eligibility Office will continue to conduct Medicaid eligibility determinations and will assess whether members are required to enroll in a health plan. The DSS offices will then share that information with the Enrollment Broker, who will be tasked with supporting members with health plan and PCP selection, if applicable. The Department will routinely analyze their data to find individuals who qualify for specific assistance provided by the CIHA, and to do so, they will verify if each member is eligible for IHS benefits by checking their federal tribal status. As detailed below, the Department has established different health plan enrollment and disenrollment processes for Standard Plans, the EBCI Tribal Option, the CFSP and BH I/DD Tailored Plans in accordance with statute.[85]

[84] More information can be found in the NC Medicaid Transition of Care policy.
[85] North Carolina Session Law 2015-245, as amended by Session Law 2018-48.

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

a. Standard Plan Enrollment

As part of the transition to NC Medicaid Managed Care and prior to the launch of Standard Plans in July 2021, the Department established a 60-day choice period for current Medicaid members. Members were sent notices from the Department/Enrollment Broker about their Standard Plan options. Letters told members how many days they had to select a Standard Plan and a PCP.

When NC Medicaid Managed Care launched, new Medicaid applicants determined to be managed care-eligible were provided an opportunity to select a Standard Plan as part of the Medicaid application process. Individuals who do not select a Standard Plan at application are auto-enrolled by the Department into a Standard Plan based on an algorithm that accounts for available information, including the applicant's geographic location, provider-member relationship, Standard Plan assignments for other family members and equitable Standard Plan distribution, with enrollment ceilings and floors for each Standard Plan to be used as guidelines. The member is sent a notice informing them of the Standard Plan auto-enrollment and given 90 days to change their health plan for any reason.

North Carolina has a long history of serving members through the medical home model and recognizes the importance of preserving member-provider relationships in the transition to managed care. The Department is committed to creating a one-stop-shop experience that allows members to select a Standard Plan and PCP during the application process, whether the individual applies online, over the phone, through the mail or in person. Applicants will be encouraged and given tools (such as a provider search tool) to help them base their Standard Plan selection on their provider relationships and select their PCP at the time they select their Standard Plan. Applicants who do not select a PCP will be auto assigned to one by their Standard Plan. IHS-eligible individuals residing in tribal trust lands will be assigned to the EBCI Tribal Option and a CIHA PCP unless the individual selects otherwise.

b. Standard Plan Disenrollment

All NC Medicaid Managed Care members—whether they select or are assigned to a Standard Plan—have a 90-day period following the effective coverage date to change health plans "without cause." After the completion of the 90-day period, most members must remain enrolled in their Standard Plan for the remainder of their eligibility period unless they can demonstrate a "with cause" reason for switching.[86] Certain special populations may change Standard Plans without cause at any time, including members of a federally recognized tribe and IHS-eligible members receiving LTSS in institutional and community-based settings. All members have the option to change health plans annually at the time of eligibility redetermination. Standard Plan members who are not identified as eligible for BH I/DD Tailored Plans by the Department will be able to request to enroll in a BH I/DD Tailored Plan (discussed further below).

In rare cases, Standard Plans are permitted to request of the Department member disenrollment, but only if the enrollee's behavior seriously hinders the Standard Plan's ability to care for the member or other members and the health plan has documented efforts to resolve the enrollee's issues. Consistent

[86] In addition to the reasons specified in 42 CFR 438.56(d)(2)(i-iv), the Department considers the following as cause for disenrollment: the enrollee's complex medical conditions would be better served under a different health plan; a family member becomes newly eligible and is enrolled in a different health plan; poor performance of health plan, upon launch of evaluations of health plan performance; or a health plan was sanctioned, resulting in a suspension of all new enrollment.

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

with 42 CFR 438.56, Standard Plans are prohibited from requesting member disenrollment because of an adverse change in the enrollee's health status or the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the enrollee's special needs.

c. BH I/DD Tailored Plan Enrollment[87]

Following BH I/DD Tailored Plan implementation, the Department regularly reviews encounter, claims and other relevant and available data to determine whether BH I/DD Tailored Plan enrollees remain eligible for BH I/DD Tailored Plans, as well as to identify Standard Plan members who newly meet BH I/DD Tailored Plan data-based eligibility criteria. BH I/DD Tailored Plan enrollees who are no longer eligible for BH I/DD Tailored Plan enrollment will be notified and transferred to a Standard Plan at renewal. Standard Plan members identified as eligible for a BH I/DD Tailored Plan will receive a notice informing them of their eligibility and that they will be auto-enrolled into the BH I/DD Tailored Plan in their region and can elect to transfer to a Standard Plan at any point during the coverage year.

Members who are not identified as eligible for BH I/DD Tailored Plans by the Department will be able to request to enroll in a BH I/DD Tailored Plan in the period after BH I/DD Tailored Plan launch. The Enrollment Broker will provide information to members and providers by phone, online chat, website and mail about how to request to enroll in a BH I/DD Tailored Plan. Upon approval, the Department, working with the Enrollment Broker, will process the transfer and, as appropriate, transition the member from the Standard Plan to the BH I/DD Tailored Plan in their region and will notify them of the transfer.

d. BH I/DD Tailored Plan Disenrollment[88]

BH I/DD Tailored Plan enrollees may request disenrollment from a BH I/DD Tailored Plan and transfer to a Standard Plan or the EBCI Tribal Option (if eligible) at any time during the coverage year. Because there is only one health plan per region, a BH I/DD Tailored Plan will not be permitted to request member disenrollment.

e. *EBCI Tribal* Option *Enrollment and Disenrollment*

Most individuals are auto enrolled in the EBCI Tribal Option and will have the option to change their enrollment at any time during the coverage year for any reason. The Department will ensure that EBCI members and other individuals eligible for IHS are educated about their options to enroll in Standard Plans, BH I/DD Tailored Plans (when eligible) and the EBCI Tribal Option.

f. CFSP Enrollment[89]

A subset of CFSP-eligible children and youth served by the child welfare system will be auto-enrolled at CFSP launch. All other CFSP-eligible populations will have the option to enroll in the CFSP no sooner than July 2026. If these individuals do not opt-in to the CFSP, they will remain in a Standard Plan, BH I/DD

[87] Enrollment details can be found in the PIHP Contract.
[88] The Department is seeking a waiver amendment from CMS that would limit Tailored Plan disenrollment for certain groups (e.g., Innovations/TBI waiver enrollees).
[89] Enrollment details can be found in the CFSP RFP.

Tailored Plan, EBCI Tribal Option or NC Medicaid Direct, as eligible. All individuals eligible to participate in both the CFSP and the EBCI Tribal Option will be enrolled in the EBCI Tribal Option but will be given the choice to opt into the CFSP.[90]

g. *CFSP* Disenrollment

Individuals will have the option to opt out of the CFSP and transfer to a Standard Plan, BH I/DD Tailored Plan, EBCI Tribal Option or NC Medicaid Direct, if eligible, at any point during the coverage year. For those children and youth in county DSS agency custody, the County DSS Director or Director's designee will be authorized to determine which managed care plan the individual should be enrolled in consultation with the child's care team.[91]

5. Confidentiality

To ensure compliance with 42 CFR 438.224, Standard Plan, EBCI Tribal Option, PIHPs, BH I/DD Tailored Plan and the CFSP contracts will require that the health plan ensure that it, its network providers and any subcontractors comply with the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, the Health Information Technology for Economic and Clinical Health Act of 2009 and its implementing regulations, and all applicable federal and state privacy laws that are more restrictive. Accordingly, members must be notified of any inappropriate disclosures as required by law.

6. Grievance and Appeals Systems

The Department is committed to ensuring that members can address their problems quickly and with minimal burden and requires Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP to meet the standards set forth in 42 CFR Part 438 Subpart F. North Carolina is committed to honoring and supporting the right of members to pursue a formal appeal of an adverse benefit determination through their health plan or, upon exhaustion of the health plan appeal process, through timely access to a state fair hearing, as set forth in 42 CFR § 438.228 and 42 Part 438 Subpart F. Additionally, members will also be able to appeal enrollment and disenrollment determinations by the Enrollment Broker under a similar process.

Members also will be provided with the opportunity to file a grievance with their health plan to express their dissatisfaction with any issue that does not relate to an adverse benefit determination (e.g., concerns regarding quality of care or behavior of a provider or health plan employee). The Department will require health plans to report on their appeal and grievance processes and outcomes, monitor health plan performance to ensure compliance with related requirements, and address any issues that may arise. The EBCI Tribal Option will file a report with the Department on grievances only.

[90] The EBCI Tribal Option is available to beneficiaries who live in the following counties: Buncombe, Clay, Cherokee, Graham, Haywood, Henderson, Jackson, Macon, Madison, Swain and Transylvania. The EBCI Tribal Option is primarily offered in these counties: Cherokee, Graham, Haywood, Jackson and Swain. Individuals located outside of these counties will remain in NC Medicaid Direct. See the ECBI Tribal Option Fact Sheet for more information on EBCI Tribal Option eligibility and enrollment.
[91] For children and youth in the EBCI Family Safety Program, the Director of the EBCI Human Services Division, in collaboration with legally responsible persons shall make the decision in consultation with the child's care team.

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

a. Member Grievances

Members may file a grievance with a health plan at any time, either orally or in writing. Standard Plans, PIHPs, BH I/DD Tailored Plans, the CFSP and the EBCI Tribal Option are required to acknowledge receipt of each grievance in writing within five (5) calendar days and must resolve the grievance within thirty (30) calendar days from the date the health plan receives the grievance. The EBCI Tribal Option is also required to make a decision regarding the grievance and provide notice to the member of its decision within 21 calendar days from the date the health plan receives the grievance. In instances in which the grievance relates to the denial of an expedited appeal request, Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP are required to resolve the grievance and provide notice to all affected parties within five (5) calendar days from the date the health plan receives the grievance, and include within the notice Department-specified content. These standards comply with federal requirements for member grievances as set forth in 42 CFR §§ 438.402 and 438.406.

b. Member Appeals

Federal law sets forth the specific standards for member rights for appeals, which all Standard Plans, Tailored Plans, the CFSP and PIHPs are expected to follow, as set forth in 42 CFR Part 438 Subpart F. Specifically, in North Carolina, members in NC Medicaid Managed Care must first seek to resolve appeals with their health plan and will have 60 days from the date of the notice of an adverse benefit determination to file a request for an appeal with the health plan. Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP are required to send written acknowledgement of the request within five calendar days for a standard appeal request. To ensure access to services, members may request their benefits be continued or reinstated while the appeal is pending.

Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP must provide written notice of resolution as expeditiously as the appellant's health condition requires and within 30 calendar days of receipt of a standard appeal request, unless the Plan has notified the Member that it is extending the timeframe for a decision by no more than fourteen (14) calendar days in accordance with 42 CFR § 438.408(c). For an expedited appeal request, Standard Plans, BH I/DD Tailored Plans and PIHPs must provide written notice of resolution and make a "reasonable effort" to provide oral notice within 72 hours of receipt of an appeal, unless the Plan notifies the Member that the timeframe for resolving the appeal is extended by no more than fourteen (14) calendar days in accordance with the requirements at 42 CFR § 438.408(c).

If the health plan upholds the adverse benefit determination, the member may request a fair hearing through the Office of Administrative Hearings; based on federal regulations, the enrollee has 120 calendar days from the date of the notice to request a fair hearing (the state is determining the exact time frame that will be used). Members will have the right to request a continuation of benefits while the appeal is pending, in accordance with 42 CFR § 438.420.

In order to ensure health plan compliance with the appeals and grievance requirements set forth by the Department, Standard Plans, BH I/DD Tailored Plans, the CFSP and PIHPs are required to report:

- Each notice of adverse benefit determination, including Department-specified data points related to the determination;
- Department-specified information related to the outcome of the appeal;

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- The number of expedited appeal requests and number of expedited appeal request denials;
- The number of and reason for any extensions of appeal resolution time frames;
- The number of administrative denials of benefits and "inability to process" denials; and
- Department-specified data elements related to the reasoning for grievances, timing of receipt and review/review meetings, and the date of grievance resolution.

c. Ombudsman Program

North Carolina is committed to providing members with support and active preparation for the appeals, grievance and state fair hearing process, as well as to facilitating real-time issue resolution. The Department established an Ombudsman Program external to the Department focused on providing advocacy, assistance and education to members as they navigate NC Medicaid Managed Care and the appeals, grievance and fair hearing process.[92]

The Ombudsman Program serves an oversight function, monitoring trends in health plan performance or member concerns and proactively providing feedback to the Department regarding any issues that arise.

7. Sub-Contractual Relationships and Delegation

All Standard Plan, EBCI Tribal Option, PIHP, BH I/DD Tailored Plan and the CFSP sub-contractual relationships and delegations of services or functions on behalf of the health plan under the health plan contracts are required to comply with 42 CFR 438.230. Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP are accountable for all contract terms that are performed by subcontractors and delegates. Plans are required to complete pre-delegation assessments or reviews prior to the effective delegation date to assess readiness, as applicable. As part of the readiness review, the Department confirms that health plans have the necessary policies, procedures and documents to evidence such compliance and periodically audit health plans' compliance with this requirement during the term of the contract.

8. Health Information Technology (HIT)

As required under 42 CFR 438.242, North Carolina requires each Standard Plan, PIHPs, BH I/DD Tailored Plan and the CFSP to maintain health information systems that collect, analyze, integrate and report encounter data and other types of information to support utilization, grievances and appeals, and disenrollment for reasons other than loss of Medicaid eligibility. Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP will also be expected to support effective and efficient care management and coordination through their HIT systems working in concert with Medicaid providers and other entities. State law mandates that all Medicaid providers—including hospitals, physicians, physician assistants and nurse practitioners—who provide Medicaid services and who have an electronic health record system be connected to the designated statewide HIE, HealthConnex (described above in Section III(D)).

[92] More information can be found on the North Carolina Ombudsman webpage.

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

V. Assessment

The Department uses several mechanisms to monitor and enforce managed care plan compliance with the standards set forth throughout this Quality Strategy, and to assess the quality and appropriateness of care provided to NC Medicaid Managed Care members. The following sections provide an overview of the key mechanisms used by the Department to enforce these standards and identify ongoing opportunities for improvement.

A. Assessment of Quality and Appropriateness of Care

Section III(A) describes the QAPIs Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP are required to implement to comply with federal and Department standards. The Department uses these health plan-required reports and data elements, as well as those developed by the Department and the EQRO, to assess and, when needed, correct the quality of care provided by health plans. Further, this information is used to drive continuous quality improvement activities, including those related to monitoring performance against and updating this Quality Strategy.

To monitor and ensure the accuracy of managed care plan reporting and performance against quality measures on a health plan-specific and program-wide basis, the Department:

- Reviews annual performance against measure benchmarks;
- Requires, reviews and approves each Standard Plan, EBCI Tribal Option, the CFSP, CCNC, BH I/DD Tailored Plan and PIHP QAPI, including how the managed care plan will assess and improve upon its own performance against its QAPI on an annual basis;
- Sets parameters for the PIPs described in Section III(A)(1), including changes to such programs based on Department-identified quality priorities and opportunities for targeted improvement;
- Conducts monthly and as otherwise needed Quality Director meetings to engage with Standard Plan, PIHP, BH I/DD Tailored Plan, and the CFSP to address issues as they arise;
- Conducts Quality Director meetings as needed to engage with EBCI and CCNC to address issues as they arise;
- Reviews all accreditation and EQRO compliance reports to determine areas of deficiency and, as needed, sets forth and monitors CAPs;
- Develop requirements and understand opportunities for improvement as a result of the health disparities report discussed within this section of the Quality Strategy;
- Publishes the quality data described in Section III(A) to promote transparency regarding health plan performance and engage stakeholders in opportunities for improvement;
- In collaboration with the NC Medicaid Population Health team, designs and administers the quality Withhold Program, further discussed below; and

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- Uses the EQRO quality performance reports, outlined below, to drive improvement and performance against the Quality Strategy.

Any requirements deemed met by completion of accreditation requirements will be implemented in compliance with the standards set forth in 42 CFR § 438.360 related to the non-duplication of mandatory activities with accreditation review.

1. EQRO Functions Related to QAPI[93]

- Validate Standard Plans', PIHPs, BH I/DD Tailored Plans' and the CFSP's PIPs, outlined in Section III(A)(1) of this Quality Strategy;
- Validate elected health plan-submitted quality performance measures outlined in Appendix A, Tables 7–9, and aggregate measures for collective review by the Department;
- Calculate performance measures in addition to those reported by the health plans and validated by the EQRO, as requested by the Department;
- Conduct the CAHPS Health Plan Survey;
- Validate the encounter data reported by the health plans, as requested by the Department;
- Produce an annual technical report that summarizes findings on access to and quality of care, including the following:
- A description of the manner in which the data from all activities conducted were aggregated and analyzed and conclusions were drawn as to the quality of care provided by each health plan;
- An assessment of each health plan's strengths and weaknesses regarding the quality of care provided;
- Recommendations for improving the quality of health care services provided by each health plan;
- Comparative information about all health plans; and
- Starting in Year 2 of the Standard Plan, PIHP, BH I/DD Tailored Plan and the CFSP operations, an assessment of the degree to which each health plan has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.
- Provide technical assistance, as directed by the Department, to health plans for conducting PIPs, quality reporting and accreditation preparedness.

2. Addressing Disparities in Care and Outcomes

In compliance with the requirements set forth in 42 CFR 438.340(b)(6) and discussed in Section II(B), Standard Plans, PIHPs, BH I/DD Tailored Plans, the CFSP and CCNC must report select measures outlined in Appendix A based on select strata including age, race, ethnicity, sex, primary language, geography (county) and disability status, *where feasible* (see the Technical Specifications for the full list of

[93] Contains only those EQRO activities related to the quality improvement activities described within this section of the Quality Strategy. For a full list of the activities conducted by the EQRO and discussed throughout this document, see Appendix D.

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

stratification requirements).[94,95] This information is used by the Department to better understand disparities in care within and across health plans so that the Department can improve overall measure performance by addressing gaps in care. The information is being used to develop an annual health disparities report that identifies trends and variations in the use of health services and outcomes based on the demographic stratifications noted above. This analysis supports the Department's development of an action plan for measuring and evaluating efforts to address disparities in the Medicaid program. This is an important part of ensuring fair and effective services that are tailored to each member's unique needs. The Department will consider the analysis and develop focused interventions. As appropriate, these interventions will include the following:

- Developing disparity-specific quality measure improvement targets on a program-wide and/or health plan-specific basis;
- Making adjustment(s) to or introducing new program-wide interventions and/or policies focused on the needs of those identified populations;
- Developing modified or additional health plan PIP requirements;
- Include priority population improvement measures focused on addressing disparities as part of the Plan Withhold Program; and
- Additional requirements for health plan QAPIs, further described in Section III(A) of this Quality Strategy.

The Department will use the health disparities analysis, with other reports such as those from accrediting bodies and generated within the Department, in its annual review of each health plan's proposed QAPI. This will ensure that each health plan is actively assessing—and responding to—opportunities to address health disparities in collaboration with Department-developed, cross-plan interventions.

As described in Section III(C)(11), the Department is committed to developing measure targets that not only address overall continuous quality improvement but also target opportunities to address health disparities.

3. Withhold Program

Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP are required to meet several quality performance and reporting thresholds (which may be met through hybrid reporting, where appropriate) to remain in compliance with the Department's contract provisions. Failure to achieve these minimum performance thresholds may result in sanctions. Additionally, the Department may encourage health plans to perform beyond compliance thresholds through a withhold program, in which a portion of each health plan's capitation rate is withheld and paid when the health plan meets reasonably achievable performance targets on priority measures.

[94] Consistent with the requirements set forth in 42 CFR 438.340(b)(6), "disability status" indicates whether the individual qualified for Medicaid on the basis of a disability.
[95] This demographic information is collected via the Medicaid application and transmitted to Standard Plans and Tailored Plans at the time of enrollment.

The first measurement year for the Standard Plan Withhold Program is 2024. Timing for BH I/DD Tailored Plan and CFSP withholds is to be determined.

The Department has identified a set of quality measures to be subject to a withhold for measurement year 2024 and 2025 for Standard Plans. These measures focus on addressing Quality Strategy priorities, such as promoting the health of women and children, improving connections to resources to address health-related social needs, and addressing health disparities. The metrics are the following:

- Childhood Immunization Status (CIS) (CBE #0038)—Combination 10
- Prenatal and Postpartum Care (PPC) (CBE #1517)[96]
- Rate of Screening for HRRN[97]

For the 2024 and 2025 performance periods, the Department withheld 1.5% of each Standard Plan's total risk-adjusted capitation for the corresponding Rating Period.[98] Because managed care contracting occurs in the state fiscal year and quality measure reporting occurs in the calendar year, quality measure performance is attributed to contract years on an offset basis. The Department set targets for each performance measure to determine repayment of withheld funds to each Standard Plan (either according to performance improvement or improvement for a specified priority population, as applicable). Standard Plans may earn back either the full amount or a partial amount of withheld funds based on performance.

The Department includes changes to Standard Plan Withhold Program performance measures in the update of the NC Medicaid Quality Measurement Technical Specifications Manual released approximately 11 months prior to the start of each new measurement year. An annual process informs selection of measures for Withhold Program Year 3 (i.e., calendar year 2026) and onwards, including soliciting nominations for new performance measures from internal and external stakeholders and applying a rubric with criteria for performance measure selection and retirement. Additional details on withhold amounts, scoring and targets are released in the NC Medicaid Standard Plan Withhold Program Guidance prior to the start of each measurement year.[99]

B. Monitoring and Compliance of Access, Structure and Operations

Standard Plans, Tailored Plans, the CFSP and the PIHP are contractually required to collect and submit timely encounter, quality and performance data to the Department. Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP are also required to submit reports on a range of other metrics, as discussed throughout this Quality Strategy, including demonstration of network adequacy; value-based contracting arrangements; and volume, nature and outcomes of grievances and appeals.[100] These

[96] This measure was added to the AMH set in the 2023 NC Medicaid Quality Measurement Technical Specifications Manual. As such, the first measurement year in which this measure can be incentivized as an AMH measure is the claims-year running from January 2024 through December 2024.
[97] This measure is scored according to pay for reporting in Year 1 of the Withhold Program.
[98] State law stipulates that the withhold arrangement must not exceed 3.5% of the PHP's total capitation payment (N.C.G.S. 108D-65).
[99] More information can be found in the 2024 Withhold Guidance document.
[100] The PIHP is also contractually obligated to report select metrics to the Department.

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reports are essential to the Department's ability to evaluate the program and hold health plans' accountable for meeting goals, performance measurement priorities and expectations. In addition to the Department's monitoring, the North Carolina Department of Insurance (DOI) licenses Standard Plans and will ensure they meet solvency standards through processes similar to those used for existing commercial health plans. The DOI intends to license BH I/DD Tailored Plans as well in the future, pending legislative action granting this authority. CFSP licensure requirements are contingent upon the entity awarded.

The Department requires approval of and performs monitoring against Standard Plans, PIHPs, BH I/DD Tailored Plan's and the CFSP's compliance with access, structure and operations through a variety of concurrent mechanisms, including those housed within the Department and those conducted through EQR (as outlined in Appendix D). The Department ensures that Standard Plans, PIHPs BH I/DD Tailored Plans, the CFSP and the EBCI Tribal Option (as applicable) comply with the standards set forth in this Quality Strategy and required by managed care contracts by doing the following:

- Reviewing the health plan's governing policies and procedures during readiness and EQRs, and as necessary to ensure compliance with the health plan contract;
- Requiring the reports set forth throughout this Quality Strategy and within health plan contracts. The Department reviews each report to ensure continued compliance with the relevant contractual requirement and tracks and trends any potential noncompliance to engage the managed care plan in corrective action prior to the determination that the health plan is being noncompliant. For example, the Department requires Standard Plans, BH I/DD Tailored Plans and the CFSP to submit a quarterly report on member grievances and appeals to ensure timeliness of those required processes; PIHPs reports grievances and appeals on a quarterly basis to the Department.
- Auditing Standard Plans, PIHPs, BH I/DD Tailored Plans the CFSP at any time, for any reason, if there is a suspicion of noncompliance or deficiency. In such instances, the Department may require the managed care plan to submit a CAP or take other corrective action, including imposing liquidated damages and/or intermediate sanctions;
- Reviewing, as determined by the Department, Standard Plans, BH I/DD Tailored Plans and the CFSP's Compliance Plans and any other policy and procedure governing how Standard Plans, BH I/DD Tailored Plans and the CFSP monitor compliance and quality of services provided by their networks at any time;[101] and
- Annually reviewing Standard Plans, BH I/DD Tailored Plans and the CFSP required Fraud Prevention Plans and requiring modifications; the state may also require a health plan to perform specific and/or targeted monitoring or auditing activities in addition to those outlined in the Fraud Prevention Plan. Standard Plans, BH I/DD Tailored Plans the CFSP will also each submit an annual Fraud Prevention Report outlining the outcome and scope of the activities set forth in its Fraud Prevention Plan, including, at a minimum, the items listed in Appendix F.

Based on the EQRO's review of Standard Plans, PIHPs, BH I/DD Tailored Plans, and CFSP compliance with contractual requirements and/or any deficiencies identified regarding requirements that result in a

[101] Standard Plans and Tailored Plans are required to have in effect a Compliance Plan that complies with 42 CFR 438.608.

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Notice of Deficiency (NOD) issued by the Department to the managed care plan, the health plan, at a minimum, is required to submit a CAP. The CAP must address each deficiency specifically and provide a timeline for the corrective action to be completed. Follow-up reviews may be conducted, as appropriate, to assess the managed care plan's progress in implementing and/or validate its implementation of the CAP. This issuance of a NOD will not preclude the state from imposing intermediate sanctions—for instance, if potential member harm, fraud or abuse, or substantial noncompliance with contractual requirements is identified.

1. Provider Screening

The Department also serves as the gatekeeper to the Medicaid program by screening providers for enrollment. This is based on each provider's assignment into risk categories, collection and evaluation of the provider's ownership and control disclosure forms, and performance of monthly screenings of all Medicaid providers against:

- The Social Security Administration's Death Master File;
- The National Plan and Provider Enumeration System;
- The List of Excluded Individuals/Entities;
- The System for Award Management; and
- The Department's Excluded Provider List (collectively, the Exclusion Lists).

Additionally, all providers are subject to criminal background checks by the Department. Providers must be enrolled in NC Medicaid and have gone through North Carolina's centralized credentialing verification program to participate in the managed care program. Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP must disclose to the Department if it learns of disciplinary actions or exclusions not communicated on the Provider Enrollment File,

2. Program Integrity

The Department oversees required program integrity activities through frequent communication and receipt of detailed reports of the Standard Plans, EBCI Tribal Option's, PIHPs, BH I/DD Tailored Plan's and the CFSP compliance and program integrity activities. The Department conducts operational audits and data reviews of Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP and providers and, through these activities, as appropriate, will share any information between Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP regarding potential fraud, waste or abuse by providers or members. The Department will require certain monitoring and auditing activities; Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP will describe the specifics of those activities in their Fraud Prevention Plan. The Department will review credible allegations of fraud, while each health plans' Special Investigations Unit (SIU) is legally and contractually required to promptly refer those matters to the Department. Should the Department determine that fraud allegations appear credible, as required under federal regulation, the Department will refer the matter to the North Carolina Department of Justice Medicaid Investigations Division (MID) or other law enforcement agencies for review. MID will evaluate the matter and determine whether it or the health plan should continue the investigation.

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

As noted in Appendix D, the Department performs a full review of the Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP compliance program and program integrity activities at least every three years through its EQR process. On an annual basis, the Department performs tracer audits of each health plan to ensure that the health plan is following its Department-approved processes and Fraud Prevention Plan in carrying out its program integrity obligations.

While providing oversight and compliance auditing of the fraud, waste and abuse efforts, the Department Office of Compliance and Program Integrity will continue to provide mandated fraud, waste and abuse investigations and auditing services for NC Medicaid Direct not transitioned to NC Medicaid Managed Care.

C. Use of Sanctions

The state may impose any or all sanctions permitted under the applicable Contract, including requiring a Standard Plan, PIHP, BH I/DD Tailored Plan or the CFSP to take remedial action, imposing intermediate sanctions and/or assessing liquidated damages, to address the Plan's noncompliance with contract requirements or applicable federal or state law; this includes, but is not limited to, a finding by the Department that a Standard Plan, PIHP, BH I/DD Tailored Plan or the CFSP acts or fails to act as follows:

- Failure to substantially and materially provide medically necessary covered services;
- Imposes on Members (and/or Recipients, as applicable) premiums or cost sharing in excess of the premiums or charges permitted by the Department;
- Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to re-enroll a member except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by members whose medical condition or history indicates probable need for substantial future medical services;
- Misrepresents or falsifies information that it furnishes to CMS or to the Department or Member;
- Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 422.210;
- Distributes, directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information;
- Violates any of the other applicable requirements of Sections 1903(m), 1905(t) or 1932 of the Social Security Act and any implementing regulations; and/or
- For Tailored Plans, violates any of the other applicable requirements of the Substance Abuse Prevention and Treatment Block Grant, Community Mental Health Services Block Grant, or State law or regulation related to State-funded Services.

Upon the discovery of a violation of the terms, conditions, or requirements of the Contract or applicable law, the Department will assign the noncompliance to one of four risk levels. The imposition of specific

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sanctions against a Standard Plan, PIHP, BH I/DD Tailored Plan or the CFSP will be based on the consideration of some or all of the following factors:

- Risk Level assignment based on factors stated in the Contract;
- The nature, severity and duration of the violation;
- The type of harm suffered due to the violation (e.g., impact on the quality of care, access to care or program integrity);
- Whether the violation resulted from negligent or willful conduct;102
- Whether the violation (or one that is substantially similar) has previously occurred;
- The timeliness with which the Standard Plan, PIHP, BH I/DD Tailored Plan or the CFSP self-reports a violation;
- The Standard Plan's, PIHPs, BH I/DD Tailored Plan's or the CFSP's history of compliance;
- The good faith exercised by the Standard Plan, PIHP, BH I/DD Tailored Plan or the CFSP in attempting to stay in compliance (including self-reporting by the health plan); and/or
- Any other factor that the Department deems relevant based on the nature of the violation.

[102] This consideration is not currently included in the Standard Plan contract.

VI. Conclusion and Opportunities

1. Opportunities for Improvement in Data Collection and Measurement

NC Medicaid is committed to a comprehensive Quality Strategy that improves the health and well-being of North Carolinians. Through this commitment, NC Medicaid conducts continuous assessments of progress against this Quality Strategy. As NC Medicaid continues to evolve in managed care, new roles and responsibilities will create new processes and potential challenges to data collection, storage and use.

To address potential challenges with the state's collection of encounter data, Standard Plans, PIHPs, and BH I/DD Tailored Plans will be regularly held accountable for submitting timely and accurate encounter data. The CFSP will be held accountable to the same standards for submitting timely and accurate encounter data after launch of the CFSP. The Department's managed care contracts provide guidance specifying the format, frequency, quality review and other standards for encounter data submission. The contracts also specify incentives for health plans to submit timely and accurate encounter data. The Department's systems track the current portfolio of statewide quality measures. As additional measures are identified, including metrics that require the collection of data beyond those captured in claims and encounter data or described in this Quality Strategy, the Department will continue to work with stakeholders to enhance existing capabilities. The Department will further develop new data collection processes and systems to accommodate the need for accurate, focused and high-quality data to guide ongoing work to best serve the needs of members and the Medicaid population.

To enhance the ability of managed care plans and Medicaid providers to improve the effectiveness and efficiency of care, the Department will explore opportunities to reduce the costs and complexity of data collection by (1) creating consistent approaches to data collection and reporting, and (2) aggregating the collection of data from multiple sources into single, statewide systems, as exemplified by the Department's work with NC HealthConnex (described in Section III(D)).

2. Opportunities for Advancing Quality of Care

In addition to implementation and assessment of the components of North Carolina's Quality Strategy, the Department looks forward to several opportunities to streamline, expand and drive quality improvements within NC Medicaid Managed Care. Key elements of this transformation and opportunities as the Department looks to the future include the following:

- Refining the Objectives outlined within this Quality Strategy through identification of opportunities for improvement based on managed care plan and program-wide performance results from managed care implementation, including identified health disparities;
- Continuing to integrate social determinants of health and address unmet health-related resource needs in treatment planning, provision of services and improvements in overall health outcomes;
- Advancing the Department's vision for value-based payment to build upon experience gained in the first years of managed care; and

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

- Building on the integration of behavioral health and physical health services, a key element of driving whole-person care forward.

Further, described throughout this Quality Strategy are requirements, standards and protocols built to ensure the Department, Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP, the EQRO, and other key entities and stakeholders remain engaged in continuous quality improvement efforts. For example, Standard Plans, PIHPs, BH I/DD Tailored Plans and the CFSP are required to report several Department-defined quality measures, as shown in Appendix A, Tables 7–9; these measures will be assessed and validated by the EQRO, and the Department will collaborate with the EQRO, Standard Plans, PIHPs, BH I/DD Tailored Plans the CFSP and other key experts and stakeholders to continually review progress on these measures, identify opportunities for improvement and maintain the Quality Strategy as a living documentation of these efforts.

This Quality Strategy aligns the many Medicaid improvement efforts taking place in North Carolina—particularly the state's transition to managed care and the interventions described in Section III(C)—with the state's goal of building an innovative, whole-person, well-coordinated system of care addressing both medical and non-medical drivers of health. The Quality Strategy recognizes the importance of continuous quality improvement, and the Department anticipates that, over time, the Goals, Objectives and measures will be modified to drive continued improvements against the greatest areas of opportunity and need. Further, this Quality Strategy—through several interventions and mechanisms described within—recognizes the importance of continued provider and member engagement, and the value of building upon program successes.

Engagement and feedback are critical to the success of this Quality Strategy, to the Department's future quality efforts and to Medicaid's transformation efforts. The Department will establish an annual stakeholder feedback process, including listening sessions with community representatives, providers and advocacy groups to incorporate diverse perspectives into quality strategy revisions. Stakeholder feedback will directly inform updates on quality metrics and performance improvement initiatives. The Department welcomed and encouraged stakeholder comments on this Quality Strategy prior to its publication and continues to welcome feedback for the advancement of future Quality Strategies. The Department also appreciates comments as it conducts its continuous quality improvement processes. The Department will engage Medicaid Advisory Committee and Beneficiary Advisory Committee and with members, providers, health plans, elected officials, local agencies, communities, partners, constituents and other stakeholders throughout the health care and social services systems to shape, address, implement and monitor Medicaid program changes to ensure the program represents the needs of North Carolinians.

North Carolina's most current policies are located on the NC Medicaid Program Specific Clinical Coverage Policies web page and in the Quality Measurement Technical Specifications.

Appendices

Appendix A. Quality Measure Sets[103]

Table 7. Standard Plan Medicaid Measure Set (Measurement Year 2024)

The following table lists quality measures that will be the priority focus for Standard Plan accountability. All measures are reported annually unless otherwise noted. This list is subject to change. Current information on the measures can be found in the Technical Specifications. Italicized measures are included in the AMH Measure Set.

CBE #	CMIT #	Measure	Steward	Standard Plan Reported	Department Calculated
N/A	20	Admission to a Facility from the Community (AIF)	CMS		**X**
3620	26	Adult Immunization Status (AIS-E)	NCQA	**X**	
N/A	N/A	Antibiotic Utilization for Respiratory Conditions (AXR)	NCQA	**X**	
1800	80	Asthma Medication Ratio (AMR)	NCQA	**X**	
0272/ 0275/ 0277/ 0283	577/ 578/ 579/ 580	Avoidable Adult Utilization • PQI 01: Diabetes Short-term Complication Admission Rate • PQI 05: COPD or Asthma in Older Adults Admission Rate • PQI 08: Heart Failure Admission Rate • PQI 15: Asthma in Younger Adults Admission Rate	AHRQ		**X**
0727/ 0728/ N/A/ N/A	N/A	Avoidable Pediatric Utilization: • PDI 14: Asthma Admission Rate • PDI 15: Diabetes Short-term Complications Admission Rate • PDI 16: Gastroenteritis Admission Rate	AHRQ		**X**

[103] For information about quality performance, please refer to the Annual Quality Report.

CBE #	CMIT #	Measure	Steward	Standard Plan Reported	Department Calculated
		• PDI 18: Urinary Tract Infection Admission Rate			
0058	84	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	NCQA	**X**	
N/A	N/A	Blood Pressure Control for Patients with Diabetes (BPD)	NCQA		**X**
2372	93	Breast Cancer Screening (BCS-E)	NCQA	**X**	
0032	118	*Cervical Cancer Screening (CCS/CCS-E)*	NCQA	**X**	
1516	123	*Child and Adolescent Well-Care Visits (WCV)*	NCQA	**X**	
0038	124	*Childhood Immunization Status (Combination 10) (CIS/CIS-E)*[104]	NCQA	**X**	
0033	128	*Chlamydia Screening (CHL)*	NCQA	**X**	
0034	139	*Colorectal Cancer Screening (COL-E)*	NCQA	**X**	
3389	150	Concurrent Use of Prescription Opioids and Benzodiazepines (COB)	Pharmacy Quality Alliance (PQA)	**X**	
2903/ 2904	1002	Contraceptive Care: All Women (CCW)	U.S. Office of Population Affairs		**X**
2902	166	Contraceptive Care: Postpartum (CCP)	U.S. Office of Population Affairs		**X**
0018	167	*Controlling High Blood Pressure (CBP)*[105]	NCQA	**X**	
1448	1003	Developmental Screening in the First Three Years of Life (DEV)	OHSU		**X**
N/A	N/A	EPSDT Screening Ratio	DHHS		**X**
3489	265	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	NCQA	**X**	
0576	268	Follow-Up After Hospitalization for Mental Illness (FUH)	NCQA	**X**	
0108	271	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-E)	NCQA	**X**	

[104] This measure is a 2024 Standard Plan Withhold measure.
[105] The Department requires both administrative and hybrid reporting for this measure.

CBE #	CMIT #	Measure	Steward	Standard Plan Reported	Department Calculated
0059/ 0057	147/204	*Glycemic Status Assessment for Patients with Diabetes (GSD)*[106]	NCQA	**X**	
1407	363	*Immunizations for Adolescents (Combination 2) (IMA/IMA-E)*	NCQA	**X**	
N/A	397	Inpatient Utilization (IPU)	NCQA		**X**
N/A	N/A	Lead Screening in Children (LSC)	NCQA		**X**
1382	413	Live Births Weighing Less Than 2,500 Grams	CDC		**X**
N/A	N/A	Low Birth Weight[107]	DHHS		**X**
0027	432	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)	NCQA		**X**
2517	897	Oral Evaluation, Dental Services (OEV)	DQA (ADA)		**X**
1768	561	*Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]*	NCQA		**X**
1517	581/582	*Prenatal and Postpartum Care (PPC)*[108]	NCQA	**X**	
N/A	N/A	Prenatal Depression Screening and Follow-Up (PND-E)	NCQA		**X**
N/A	N/A	Rate of Screening for Pregnancy Risk[109]	DHHS		**X**
N/A	N/A	Rate of Screening for Health-Related Resource Needs (HRRN)[110]	DHHS		**X**
0418/ 0418e61	672	*Screening for Depression and Follow-Up Plan (CDF)*	CMS	**X**	
N/A	830	Sealant Receipt on Permanent First Molars (SFM)	DQA (ADA)		**X**
N/A	700	Statin Therapy for Patients with Cardiovascular Disease (SPC)	NCQA		**X**
2528/ 3700/ 3701	1672	Topical Fluoride for Children (TFL)	DQA (ADA)		**X**

[106] The Department requires both administrative and hybrid reporting for this measure.
[107] The PHPs will submit a quarterly operational report that contains all live singleton births during the measurement year to date to support the production of this measure. See Appendix B for more information about this measure.
[108] This measure is a 2024 Standard Plan Withhold measure. The Department requires both administrative and hybrid reporting for this measure.
[109] The Department will work jointly with health plans and CCNC to collect pregnancy risk screening data and report this measure.
[110] The Department is exploring potential adoption of HEDIS' new Social Needs Screening and Intervention (SNS-E) measure.

CBE #	CMIT #	Measure	Steward	Standard Plan Reported	Department Calculated
N/A	N/A	*Total Cost of Care (TCOC)*	Health Partners		**X**
2801	743	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	NCQA	**X**	
0024	760	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	NCQA		**X**
1392	761	*Well-Child Visits in the First 30 Months of Life (W30)*	NCQA	**X**	
Member Experience					
0006		CAHPS Survey	AHRQ		**X**
Provider Experience					
N/A		Provider Survey	DHHS		**X**

Table 8. AMH Measure Set (2024)

The following table lists the quality measures that health plans can use in VBP arrangements with AMHs. This list is subject to change. Current information on the measures can be found in the Technical Specifications.

CBE #	CMIT #	Measure Name	Steward	Frequency
0032	118	Cervical Cancer Screening (CCS/CCS-E)	NCQA	Annually
1516	123	Child and Adolescent Well-Care Visits (WCV)	NCQA	Annually
0038	124	Childhood Immunization Status (Combination 10) (CIS/CIS-E)	NCQA	Annually
0033	128	Chlamydia Screening (CHL)	NCQA	Annually
0034	139	**NEW in 2024**: Colorectal Cancer Screening (COL-E)[111]	NCQA	Annually
0018	167	Controlling High Blood Pressure (CBP)	NCQA	Annually

[111] This measure was added to the AMH set in the 2024 version of North Carolina's Medicaid Quality Measurement Technical Specifications Manual. As such, the first measurement year in which this measure can be incentivized as an AMH measure is the claims-year running from January 2025 through December 2025.

CBE #	CMIT #	Measure Name	Steward	Frequency
0059/0575	147/204	Glycemic Status Assessment for Patients with Diabetes (GSD)[112]	NCQA	Annually
1407	363	Immunizations for Adolescents (Combination 2) (IMA/IMA-E)	NCQA	Annually
1768	561	Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]	NCQA	Annually
1517	582/581	Prenatal and Postpartum Care (PPC)[113]	NCQA	Annually
0418/ 0418e	672	Screening for Depression and Follow-Up Plan (CDF)	CMS	Annually
N/A	N/A	Total Cost of Care (TCOC)	Health Partners	Annually
1392	761	Well-Child Visits in the First 30 Months of Life (W30)	NCQA	Annually
Beneficiary Experience				
0006		CAHPS Survey	AHRQ	Annually
Provider Experience				
N/A		Provider Survey	DHHS	Annually

Table 9. BH I/DD Tailored Plan Medicaid Measure Set (Measurement Year 2024)

The following table lists quality measures that will be the priority focus for BH I/DD Tailored Plan accountability. The BH I/DD Tailored Plan state-funded measures set is included in the Technical Specifications. This list is subject to change. Current information on the measures can be found in Technical Specifications. All measures are reported annually unless otherwise noted. BH I/DD Tailored Plans will also be required to report 1915(i) measures. Italicized measures are included in the AMH Measure Set.

CBE #	CMIT #	Measure	Steward	Tailored Plan Reported	Department Calculated
N/A	18	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	NCQA	**X**	
N/A	20	Admission to a Facility from the Community (AIF)	CMS		**X**
3620	26	Adult Immunization Status (AIS-E)	NCQA	**X**	

[112] The Department requires both administrative and hybrid reporting for this measure.
[113] This measure was added to the AMH set in 2023 to align with the Department's priorities related to improving maternal health outcomes.

CBE #	CMIT #	Measure	Steward	Tailored Plan Reported	Department Calculated
N/A	N/A	Antibiotic Utilization for Respiratory Conditions (AXR)	NCQA	**X**	
1800	80	Asthma Medication Ratio (AMR)	NCQA	**X**	
0272/0275/ 0277/ 0283	577/578/ 579/580	Avoidable Adult Utilization • PQI 01: Diabetes Short-term Complication Admission Rate • PQI 05: COPD or Asthma in Older Adults Admission Rate • PQI 08: Heart Failure Admission Rate • PQI 15: Asthma in Younger Adults Admission Rate	AHRQ		**X**
0727/0728/ N/A/ N/A	N/A	Avoidable Pediatric Utilization: • PDI 14: Asthma Admission Rate • PDI 15: Diabetes Short-term Complications Admission Rate • PDI 16: Gastroenteritis Admission Rate • PDI 18: Urinary Tract Infection Admission Rate	AHRQ		**X**
0058	84	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	NCQA	**X**	
N/A	N/A	Blood Pressure Control for Patients with Diabetes (BPD)	NCQA		**X**
2372	93	Breast Cancer Screening (BCS-E)	NCQA	**X**	
0032	118	*Cervical Cancer Screening (CCS/CCS-E)*	NCQA	**X**	
1516	123	*Child and Adolescent Well-Care Visits (WCV)*	NCQA	**X**	
0038	124	*Childhood Immunization Status (Combination 10) (CIS/CIS-E)*	NCQA	**X**	
0033	128	*Chlamydia Screening (CHL)*	NCQA	**X**	
0034	139	*Colorectal Cancer Screening (COL-E)*	NCQA	**X**	
3389	150	Concurrent Use of Prescription Opioids and Benzodiazepines (COB)	PQA	**X**	
3175	N/A	Continuity of Pharmacotherapy for Opioid Use Disorder	USC	**X**	
2903/ 2904	165	Contraceptive Care: All Women (CCW)	US Office of Population Affairs		**X**

CBE #	CMIT #	Measure	Steward	Tailored Plan Reported	Department Calculated
2902	166	Contraceptive Care: Postpartum (CCP)	US Office of Population Affairs		**X**
0018	167	*Controlling High Blood Pressure (CBP)*[114]	NCQA	**X**	
2607	196	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI)	NCQA		**X**
1932	202	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	NCQA	**X**	
1448	1003	Developmental Screening in the First Three Years of Life (DEV)	OHSU		**X**
N/A	N/A	EPSDT Screening Ratio	DHHS		**X**
3489	265	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	NCQA	**X**	
3488	264	Follow-Up After Emergency Department Visit for Substance Use (FUA)	NCQA		**X**
0576	268	Follow-Up After Hospitalization for Mental Illness (FUH)	NCQA	**X**	
0108	271	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-E)	NCQA	**X**	
0059/ 0057	147/204	*Glycemic Status Assessment for Patients with Diabetes (GSD)*[115]	NCQA	**X**	
1407	363	*Immunizations for Adolescents (Combination 2) (IMA/IMA-E)*	NCQA	**X**	
0004	394	Initiation and Engagement of Substance Use Disorder Treatment (IET)	NCQA		**X**
N/A	397	Inpatient Utilization (IPU)	NCQA		**X**
N/A	N/A	Lead Screening in Children (LSC)	NCQA		**X**
1382	413	Live Births Weighing Less Than 2,500 Grams	CDC		**X**
N/A	N/A	Low Birth Weight[116]	DHHS		**X**

[114] The Department requires both administrative and hybrid reporting for this measure.
[115] The Department requires both administrative and hybrid reporting for this measure.
[116] The PHPs will submit a quarterly operational report that contains all live singleton births during the measurement year to date to support the production of this measure. See Appendix B for more information about this measure.

CBE #	CMIT #	Measure	Steward	Tailored Plan Reported	Department Calculated
0027	432	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)	NCQA		**X**
2800	448	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	NCQA	**X**	
2517	897	Oral Evaluation, Dental Services (OEV)	DQA (ADA)		**X**
1768	561	*Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]*	NCQA		**X**
N/A	N/A	Prenatal Depression Screening and Follow-Up (PND-E)	NCQA		**X**
1517	581/582	*Prenatal and Postpartum Care (PPC)*[117]	NCQA	**X**	
N/A	N/A	Rate of Screening for Pregnancy Risk[118]	DHHS		**X**
N/A	N/A	Rate of Screening for Health-Related Resource Needs (HRRN)	DHHS		**X**
0418/ 0418e	672	*Screening for Depression and Follow-Up Plan (CDF)*	CMS	**X**	
N/A	830	Sealant Receipt on Permanent First Molars (SFM)	DQA (ADA)		**X**
N/A	700	Statin Therapy for Patients with Cardiovascular Disease (SPC)	NCQA		**X**
2528/ 3700/ 3701	1672	Topical Fluoride for Children (TFL)	DQA (ADA)		**X**
N/A	N/A	*Total Cost of Care (TCOC)*	Health Partners		**X**
2801	743	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	NCQA	**X**	
2940	748	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	PQA		**X**
2950	N/A	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	PQA		**X**
3400	750	Use of Pharmacotherapy for Opioid Use Disorder (OUD)	CMS		**X**
0024	760	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	NCQA		**X**
1392	761	*Well-Child Visits in the First 30 Months of Life (W30)*	NCQA	**X**	

[117] This measure was added to the AMH set in 2023 to align with the Department's priorities related to improving maternal health outcomes.
[118] The Department will work jointly with health plans and CCNC to collect pregnancy risk screening data and report this measure.

CBE #	CMIT #	Measure	Steward	Tailored Plan Reported	Department Calculated
Member Experience					
0006		CAHPS Survey*	AHRQ		**X**
Provider Experience					
N/A		Provider Survey*	DHHS		**X**

Table 10. EBCI Tribal Option Measure Set (Measurement Year 2024)

The following table lists the quality measures that the EBCI Tribal Option calculates and reports. Current information on the measures can be found in the Technical Specifications. All measures are reported annually unless otherwise noted.

CBE #	CMIT #	Measure	Steward	EBCI Reported	Department Calculated
0038	124	Childhood Immunization Status (Combination 10) (CIS/CIS-E)	NCQA	**X**	
0018	167	Controlling High Blood Pressure (CBP)	NCQA	**X**	
0059/ 0057	147/204	Glycemic Status Assessment for Patients with Diabetes (GSD)	NCQA	**X**	
Member Experience					
0006		CAHPS Survey	AHRQ		**X**

Table 11. CCNC PCCM Measure Set (Measurement Year 2024)

The following table lists the quality measures that the CCNC PCCM is required to calculate and report annually to the Department. Current information on the measures can be found in the Technical Specifications. All measures are reported annually unless otherwise noted.

CBE #	CMIT #	Measure	Steward	CCNC Reported	Department Calculated
N/A	20	Admission to a Facility from the Community (AIF)	CMS		**X**

CBE #	CMIT #	Measure	Steward	CCNC Reported	Department Calculated
0272/0275/ 0277/ 0283	577/578/ 579/580	Avoidable Adult Utilization • PQI 01: Diabetes Short-term Complication Admission Rate • PQI 05: COPD or Asthma in Older Adults Admission Rate • PQI 08: Heart Failure Admission Rate • PQI 15: Asthma in Younger Adults Admission Rate	AHRQ		**X**
0727/0728/ N/A/ N/A	N/A	Avoidable Pediatric Utilization: • PDI 14: Asthma Admission Rate • PDI 15: Diabetes Short-term Complications Admission Rate • PDI 16: Gastroenteritis Admission Rate • PDI 18: Urinary Tract Infection Admission Rate	AHRQ		**X**
N/A	N/A	Blood Pressure Control for Patients with Diabetes (BPD)	NCQA		**X**
0032	118	Cervical Cancer Screening (CCS/CCS-E)	NCQA	**X**	
1516	123	Child and Adolescent Well-Care Visits (WCV)	NCQA	**X**	
0038	124	Childhood Immunization Status (Combination 10) (CIS/CIS-E)	NCQA	**X**	
0033	128	Chlamydia Screening (CHL)	NCQA	**X**	
2903/ 2904	1002	Contraceptive Care: All Women (CCW)	US Office of Population Affairs		**X**
2902	166	Contraceptive Care: Postpartum (CCP)	US Office of Population Affairs		**X**
0018	167	Controlling High Blood Pressure (CBP)	NCQA	**X**	
1448	1003	Developmental Screening in the First Three Years of Life (DEV)	OHSU		**X**
N/A	N/A	EPSDT Screening Ratio	DHHS		**X**
0059/ 0057	147/204	Glycemic Status Assessment for Patients with Diabetes (GSD)	NCQA	**X**	
1407	363	Immunizations for Adolescents (Combination 2) (IMA/IMA-E)	NCQA	**X**	

CBE #	CMIT #	Measure	Steward	CCNC Reported	Department Calculated
N/A	397	Inpatient Utilization (IPU)	NCQA		**X**
N/A	N/A	Lead Screening in Children (LSC)	NCQA		**X**
2517	897	Oral Evaluation, Dental Services (OEV)	DQA (ADA)		**X**
1768	561	Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]	NCQA		**X**
N/A	N/A	Prenatal Depression Screening and Follow-Up (PND-E)	NCQA		**X**
N/A	N/A	Rate of Screening for Pregnancy Risk[119]	DHHS		**X**
N/A	830	Sealant Receipt on Permanent First Molars (SFM)	DQA (ADA)		**X**
N/A	700	Statin Therapy for Patients with Cardiovascular Disease (SPC)	NCQA		**X**
2528/3700/3701	1672	Topical Fluoride for Children (TFL)	DQA (ADA)		**X**
N/A	N/A	Total Cost of Care (TCOC)	Health Partners		**X**
0024	760	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	NCQA		**X**

Table 12. Table 12. InCK Quality Measures

The following table lists quality measures for the InCK program. All measures are reported annually.

CBE #	Measure Name	Steward
N/A	Food Insecurity Rate	NC InCK
N/A	Housing Instability Rate	NC InCK
N/A	Kindergarten Readiness Rate	NC Department of Public Instruction
N/A	Primary Care Kindergarten Readiness Bundle	NC InCK
0418/0418e	Screening for Clinical Depression and Follow-up Plan (CDF)	CMS*
N/A	Food Insecurity and Housing Instability Screening	NC InCK
N/A	Shared Action Plan for Children in SIL-2 and SIL-3	NC InCK

[119] The Department will work jointly with health plans and CCNC to collect pregnancy risk screening data and report this measure.

CBE #	Measure Name	Steward
N/A	Total Cost of Care (TCOC)	Health Partners
1392	Well-Child Visits in the First 30 Months of Life (Disparity Measure) (W30)	NCQA

Table 13. PIHP Measure Set[120] (Measurement Year 2024)

The following table lists quality measures for the PIHP. Current information on the measures can be found in the Technical Specifications. All measures are reported annually.

CBE #	CMIT #	Measure	Steward	PIHP Reported	Department Calculated
N/A	20	Admission to a Facility from the Community (AIF)	CMS		**X**
3389	150	Concurrent Use of Prescription Opioids and Benzodiazepines (COB)	PQA	**X**	
3175	N/A	Continuity of Pharmacotherapy for Opioid Use Disorder	USC	**X**	
2607	196	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI)	NCQA		**X**
1932	202	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	NCQA	**X**	
N/A	N/A	EPSDT Screening Ratio	DHHS		**X**
3489	265	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	NCQA	**X**	
3488	264	Follow-Up After Emergency Department Visit for Substance Use (FUA)	NCQA		**X**
0576	268	Follow-Up After Hospitalization for Mental Illness (FUH)	NCQA	**X**	
0108	271	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-E)	NCQA	**X**	
0004	394	Initiation and Engagement of Substance Use Disorder Treatment (IET)	NCQA		**X**

[120] The measure set also includes the Innovations Waiver Performance measures, see Section VI Attachment D here.

CBE #	CMIT #	Measure	Steward	PIHP Reported	Department Calculated
2800	448	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	NCQA	**X**	
N/A	N/A	Total Cost of Care (TCOC)	Health Partners		**X**
2801	743	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	NCQA	**X**	
2940	748	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	PQA		**X**
2950	N/A	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	PQA		**X**
3400	750	Use of Pharmacotherapy for Opioid Use Disorder (OUD)	CMS		**X**

Appendix B. Standard Plan, PIHP, BH I/DD Tailored Plan, Medicaid Direct and the CFSP Measures Tracked to Quality Strategy Goals

Standard Plans, PIHPs, BH I/DD Tailored Plans, Medicaid Direct and the CFSP are required to annually submit quality data to the Department, further outlined in Section III(A). Italicized measures are calculated by the Department and are not required as part of managed care plan reporting requirements.

The source of the statewide performance baselines is the total NC Medicaid performance for measure year 2023. To set 2026 statewide performance targets, the Department has proposed an updated benchmarking approach using a gap-to-goal methodology. Statewide and health plan performance targets would be set based on a specified gap reduction between MY2024 performance and a benchmark. NCQA HEDIS Quality Compass data on national Medicaid managed care organization performance may be used to set performance goals for some measures. More detailed information on the Department's proposed gap-to-goal benchmarking methodology for MY2026 is forthcoming. Some of the measures in this Appendix are 2025 (*) and proposed 2026 (+) Standard Plan Withhold Program measures. The proposed benchmarking methodology to begin in 2026 using a gap-to-goal approach will inform Withhold targets 2026 onwards.

This Appendix does not depict the full universe of quality measures that Standard Plans, PIHPs, BH I/DD Tailored Plans, NC Medicaid Direct and the CFSP are required to report or may be required to report in the future; rather, it is intended to outline select quality measures that meet the state's quality goals. Measure sets are subject to change; current information can be found in the NC Medicaid Technical Specifications Manual. As the continuous quality improvement process evolves, the Department will refine the measures that Standard Plans, BH I/DD Tailored Plans and the CFSP are accountable for. These decisions will be guided by health plan performance, the evolution of national clinical standards and North Carolina-specific opportunities for improvement.

Table 14. Measures Tracked to Quality Strategy Goals

Measure Name & Acronym	Measure Description *(for quality and CAHPS survey measures)*	Responsible Entity	Data Source	Measure Steward *(if applicable)*	Statewide Performance Baseline (2023)	2026 Statewide Performance Target
Goal 1: Ensure Appropriate Access to Care						
Getting Care Quickly **CBE #: 0006**	The survey asks beneficiaries how often they received care as soon	EQRO1H1H	CAHPS Health Plan Survey	AHRQ	Adult: ★★★★ 85.2%	★★★★★ (90th percentile or above)

	as needed when they needed care right away and for routine care as soon as needed, and allows the following response options: never, sometimes, usually or always. • Q4: Respondent got care as soon as needed (or, for the Child Version: Child got care as soon as needed). • Q6: Respondent got routine care as soon as needed (or, for the Child Version: Child got routine care as soon as needed).		5.0, Adult Version, and CAHPS Health Plan Survey 5.0, Child Version		Child: ★★★ 87.95%	★★★★ (75th–89th percentiles)
Getting Needed Care **CBE #: 0006**	The survey asks beneficiaries how often it was easy for them to get appointments with specialists and get the care, tests or treatment they needed, and allows the following response options: never, sometimes, usually or always.	EQRO1H	CAHPS Health Plan Survey 5.0, Adult Version, and CAHPS Health Plan Survey 5.0, Child Version	AHRQ	Adult: ★★★★ 85.95%	★★★★★ (90th percentile or above)
					Child: ★★★ 85.96%	★★★★ (75th–89th percentiles)
Goal 2: Drive Whole-person Care						
Rating of All Health Care **CBE #: 0006**	The survey asks beneficiaries for a rating on a scale of 0 to 10, with 0 being the worst and 10 being the best. • Q8: Rating of all health care (or, for the Child Version: Q8: Rating of all health care).	EQRO1H1H	CAHPS Health Plan Survey 5.0, Adult Version, and CAHPS Health Plan Survey 5.0, Child Version	AHRQ	Adult: ★★★★ 78.16%	★★★★★ (90th percentile or above)
					Child: ★★★ 88.04%	★★★★ (75th–89th percentiles)
	The survey asks beneficiaries for a rating on a scale of 0 to 10, with 0	EQRO1H1H	CAHPS Health Plan Survey	AHRQ	Adult: ★★★★ 86.63%	★★★★★ (90th percentile or above)

Rating of Personal Doctor **CBE #: 0006**	being the worst and 10 being the best. • Q16: Rating of personal doctor (or, for the Child Version: Q19: Rating of personal doctor).		5.0, Adult Version, and CAHPS Health Plan Survey 5.0, Child Version		Child: ★★★ 90.07%	★★★★ (75^{th}–89^{th} percentiles)
Customer Service **CBE #: 0006**	The survey asks beneficiaries how often health plan's customer service staff were helpful and treated them with courtesy and respect and allows the following response options: never, sometimes, usually or always. • Q22: Health plan customer service gave needed information/help (or, for the Child Version: Q25: Health plan customer service gave needed information/help). • Q23: Health plan customer service was courteous and respectful (or, for the Child Version: Q26: Health plan customer service was courteous and respectful).	EQRO1H1H	CAHPS Health Plan Survey 5.0, Adult Version, and CAHPS Health Plan Survey 5.0, Child Version	AHRQ	Adult: ★★★★ 91.9%	★★★★★ (90^{th} percentile or above)
					Child: ★★★★ 88.73%	★★★★ (75^{th} –89^{th} percentiles)
Coordination of Care **CBE #: 0006**	The survey asks beneficiaries how often their personal doctor	EQRO1H	CAHPS Health Plan Survey	AHRQ	Adult: ★★★★ 87.66%	★★★★★ (90^{th} percentile or above)

	seemed informed and up to date about the care they received from these doctors or other health providers. • Q17: Personal doctor seemed informed and up to date about care received from them and other health providers (or, for the Child Version: Q20: Child's personal doctor seemed informed and up to date about care Child received from them and other health providers).		5.0, Adult Version and CAHPS Health Plan Survey 5.0, Child Version		Child: ★★★ 84.71%	★★★★ (75th–89th percentiles)
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) **CBE #: 1932**	The percentage of patients ages 18–64 with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	BH I/DD Tailored Plans and the CFSP	Claims Data	NCQA	79.78%	85.52% (90th percentile) or 10% gap reduction between the baseline and the benchmark
Goal 3: Promote Wellness and Prevention						
Childhood Immunization Status (CIS) (Combination 10)[*; †] **CBE #: 0038**	The percentage of children age 2 who had four DTaP; three IPV; one measles, mumps and rubella; three Haemophilus influenzae type B; three HepB; one chicken pox; four pneumococcal conjugate; one HepA; two or three RV; and two flu vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	Standard Plans, BH I/DD Tailored Plans and the CFSP	Claims Data, Supplemental Data from NCIR	NCQA	25.25%	27.49% (50th percentile) or 10% gap reduction between the baseline and the benchmark

Well-Child Visits in the First 30 Months of Life (W30)† **CBE #: 1392**	The percentage of members who had the following number of well-child visits during the past 30 months. Two rates will be reported: • Well-Child Visits in the First 15 Months: Six or more well-child visits. • Well-Child Visits for Age 15 Months–30 Months: Two or more well-child visits.	Standard Plans, BH I/DD Tailored Plans and the CFSP	Claims Data	NCQA	First 15: 63.46%	69.67% (90th percentile) or 10% gap reduction between the baseline and the benchmark
					15-30: 68.84%	79.94% (90th percentile) or 10% gap reduction between the baseline and the benchmark
Immunizations for Adolescents (IMA) (Combination 2)† **CBE #: 1407**	The percentage of adolescents age 13 who have had one dose of meningococcal conjugate vaccine and one tetanus, diphtheria, toxoids and acellular pertussis vaccine; and have completed the human papillomavirus (hrHPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.	Standard Plans, BH I/DD Tailored Plans and the CFSP	Claims Data	NCQA	29.66%	34.30% (50th percentile) or 10% gap reduction between the baseline and the benchmark

Cervical Cancer Screening (CCS)† CBE #: 0032	The percentage of women ages 21–64 who were screened for cervical cancer using either of the following criteria: • Members ages 21–64 who were recommended for routine CCS and had cervical cytology performed within the last 3 years. • Members ages 30–64 were recommended for routine CCS and had cervical high-risk hrHPV testing performed within the last 5 years. • Members ages 30–64 who were recommended for routine CCS and had cervical cytology/high-risk hrHPV co-testing within the last 5 years.	Standard Plans, BH I/DD Tailored Plans, and the CFSP	Claims Data	NCQA	39.16%	57.18% (50th percentile) or 10% gap reduction between the baseline and the benchmark
Chlamydia Screening (CHL) CBE #: 0033	The percentage of members ages 16–24 who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	Standard Plans, BH I/DD Tailored Plans and the CFSP	Claims Data	NCQA	59.17%	69.07% (90th percentile) or 10% gap reduction between the baseline and the benchmark
Prenatal and Postpartum Care (PPC)*;† CBE #: N/A	The percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement	Standard Plans, BH I/DD Tailored Plans and the CFSP	Claims Data	NCQA	Prenatal: 43.90%	84.55% (50th percentile) or 10% gap reduction between the baseline and the benchmark

	year. For these women, the measure assesses the following facets of prenatal and postpartum care: • Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization. • Postpartum Care. The percentage of deliveries that had a postpartum visit on or between seven and 84 days after delivery.				Postpartum: 60.66%	80.23% (50th percentile) or 10% gap reduction between the baseline and the benchmark
Screening for Depression and Follow-Up Plan (CDF) CBE #: 0418/0418e	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to 2 days after the date of the qualifying encounter.	Standard Plans, BH I/DD Tailored Plans and the CFSP	Claims Data	NCQA	N/A	N/A
Child and Adolescent Well-Care Visits (WCV) CBE #: 1516	The percentage of members ages 3–21 years who had at least one comprehensive well-care visit with a primary care provider (PCP) or an obstetrician/gynecologist practitioner during the measurement year.	Standard Plans, BH I/DD Tailored Plans and the CFSP	Claims Data	NCQA	51.29%	64.74% (90th percentile) or 10% gap reduction between the baseline and the benchmark

Goal 4: Improve Chronic Condition Management						
Follow-Up After Hospitalization for Mental Illness (FUH) CBE #: 0576	The percentage of discharges for members age 6 and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: • The percentage of discharges for which the member received follow-up within 30 days after discharge. – The percentage of discharges for which the member received follow-up within 7 days after discharge.	Standard Plans, BH I/DD Tailored Plans and the CFSP	Claims Data	NCQA	7-day follow-up: 20.17% 30-day follow-up: 37.18%	36.94% (50th percentile) or 10% gap reduction between the baseline and the benchmark 59.85% (50th percentile) or 10% gap reduction between the baseline and the benchmark
Glycemic Status Assessment for Patients With Diabetes (GSD) CBE #: 0059/0575	The percentage of members ages 18–75 with diabetes (types 1 and 2) whose most recent glycemic status (HbA1c or GMI) was at the following level during the measurement year: Glycemic Status >9.0%.	Standard Plans, BH I/DD Tailored Plans and the CFSP	Claims Data	NCQA	N/A - GSD measure is replacing the CBP measure as of MY2024	N/A - GSD measure is replacing the CBP measure as of MY2024
Controlling High Blood Pressure (CBP)* CBE #: 0018	The percentage of members ages 18–85 who had a diagnosis of hypertension and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.	Standard Plans, BH I/DD Tailored Plans and the CFSP	Claims Data	NCQA	50.32%	64.48% (50th percentile) or 10% gap reduction between the baseline and the benchmark

Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD) CBE #: 3400	Percentage of members ages 18—64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year. Five rates are reported: • A total (overall) rate capturing any medications used in medication assisted treatment of opioid dependence and addiction (Rate 1) • Four separate rates representing the following types of FDA-approved drug products: – Buprenorphine (Rate 2) – Oral naltrexone (Rate 3) – Long-acting, injectable naltrexone (Rate 4) – Methadone (Rate 5)	BH I/DD Tailored Plans and PIHPs	Claims Data	CMS	57.79%	57.9% (CMS Adult Core Set median)
Goal 5: Work with Communities to Improve Population Health						
Rate of Screening for Health-Related Resource Needs (HRRN)*;†;^□	The percentage of enrollees who completed a screening for HRRN within the calendar year	Standard Plans, BH I/DD Tailored Plans and the CFSP	Standardized Screening Tool	DHHS	N/A - Measure is still in Pilot status	N/A - Measure is still in Pilot status
Concurrent Use of Prescription Opioids and Benzodiazepines (COB)^□ CBE #: 3389	The percentage of individuals age 18 and older with COB during the measurement year.	Standard Plans, BH I/DD Tailored Plans and the CFSP	Claims Data	PQA	12.37%	12.12% (2% relative improvement)

Low Birth Weight (LBW) [125] **CBE #: N/A**	Percentage of live births, during the measurement year, where the baby weighed <2,500 grams and <1,500 grams at birth.	Standard Plans, BH I/DD Tailored Plans	State Vital Records	DHHS	12.26%	12.01% (2% relative improvement)
Initiation and Engagement of Substance Use Disorder Treatment (IET) CBE #: 0004	The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported: 1. Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telemedicine visit or medication treatment within 14 days. 2. Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.	BH I/DD Tailored Plans and PIHPs	Claims data	NCQA	Initiate: 39.25% Engage: 12.69%	44.51% (50th percentile) or 10% gap reduction between the baseline and the benchmark 14.39% (50th percentile) or 10% gap reduction between the baseline and the benchmark
Goal 6: Pay for Value						

Total Cost of Care (TCOC)^□ **CBE #: N/A**	The HealthPartners TCOC measure is a person-centered tool that accounts for 100% of the care provided to a patient. All administrative claims—for inpatient, outpatient, clinic, ancillary, pharmacy and all other types of services—contribute to the total cost measure for continuously enrolled members. More information is available in the Technical Specifications.	Standard Plans and BH I/DD Tailored Plans	Claims Data	HealthPartners	N/A	N/A
Plan All-Cause Readmissions (PCR) **CBE#: 1768**	For patients age18 and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	Standard Plans, BH I/DD Tailored Plans and the CFSP	Claims Data	NCQA	0.767	0.752 (2% relative improvement)
Avoidable Pediatric Utilization^□	Discharges for patients aged 6 to 17 years that meet the inclusion and exclusion rules for any of the following PDIs: • PDI 14: Asthma Admission Rate†; • PDI 15: Diabetes Short-Term Complications Admission Rate	Standard Plans and BH I/DD Tailored Plans	Claims Data	AHRQ	PDI 14: 52.55	48.53 (ARHQ benchmark) or 10% gap reduction between the baseline and the benchmark
					PDI 15: 26.43	25.90 (2% relative improvement)
Avoidable Adult Utilization^□	Discharges, for patients aged 18 years and older, that meet the inclusion and exclusion rules for the numerator in any of the following PQIs:	Standard Plans and BH I/DD Tailored Plans	Claims Data	AHRQ	PQI 01: 155.47	82.00 (ARHQ benchmark) or 10% gap reduction between the baseline and the benchmark

	• PQI 01: Diabetes Short-term Complication Admission Rate; • PQI 05: COPD or Asthma in Older Adults Admission Rate; • PQI 08: Heart Failure Admission Rate; and/or • PQI 15: Asthma in Younger Adults Admission Rate.				PQI 05: 441.25	195.80 (ARHQ benchmark) or 10% gap reduction between the baseline and the benchmark
					PQI 08: 395.29	387.38 (2% relative improvement)
					PQI 15: 24.02	18.49% (ARHQ benchmark) or 10% gap reduction between the baseline and the benchmark

Appendix C. EQRO Activities

As noted throughout this Quality Strategy, the EQRO plays a critical role in reporting Standard Plans', PIHPs', BH I/DD Tailored Plans' and the CFSP performance in several areas that are required (meaning federal regulations require that these activities are completed by the EQRO) and some that are optional (meaning that the state has elected to use the EQRO for these activities) under 42 CFR 438.352 and 438.364. A collective overview of those functions discussed throughout the Quality Strategy is included below.

Table 15. EQRO Activities

Mandatory EQRO Activities
• Validation of PIPs conducted by each health plan
• Validation of each health plan's reported performance measures
• Review of each health plan's compliance with the standards set forth in 42 CFR 438 Subpart D
• Validation of health plan network adequacy[121]
• Annual technical report that summarizes findings on access and quality of care, including the requirements set forth in 42 CFR 438.364
Optional Activities
• Validation of encounter data reported by each health plan
• Administration of the CAHPS Health Plan Survey and Provider Survey
• Calculation of performance measures in addition to those reported by Standard Plans and BH I/DD Tailored Plans at the direction of the Department
• Completion of studies on quality that focus on an aspect of clinical or nonclinical services at a point in time (e.g., specific assessment of the interventions described within this Quality Strategy) at the direction of the Department
• **Additional Activities**
• Provision of technical assistance to Standard Plans and BH I/DD Tailored Plans as related to conducting PIPs, quality reporting and accreditation preparedness, as directed by the Department
• Conducting of tracer audits of each health plan for program integrity

[121] Validation of network adequacy is required by 42 CFR 438.358(b)(iv), pending release of EQRO protocols related to this requirement. In the interim, the Department utilizes the EQRO for this function as an additional activity. Additional information can be found in this June 2016 CMS informational bulletin.

Appendix D. State Access Standards

Time/Distance Standards for Medicaid

Table 16. Network Adequacy Standards: Time and Distance Standards for Adults and Children

Service Type	Applicable Plans	Urban Standard	Rural Standard
Primary Care	Standard Plan, BH I/DD Tailored Plan, CFSP	≥2 providers within 30 minutes or 10 miles of residence for at least 95% of members	≥2 providers within 30 minutes or 30 miles of residence for at least 95% of members
Specialty Care	Standard Plan, BH I/DD Tailored Plan, CFSP	≥2 providers (per specialty type) within 30 minutes or 15 miles of residence for at least 95% of members	≥2 providers (per specialty type) within 60 minutes or 60 miles of residence for at least 95% of members
Hospitals	Standard Plan, BH I/DD Tailored Plan, CFSP	≥1 hospital within 30 minutes or 15 miles of residence for at least 95% of members	≥1 hospital within 30 minutes or 30 miles of residence for at least 95% of members
Pharmacies	Standard Plan, BH I/DD Tailored Plan, CFSP	≥2 pharmacies within 30 minutes or 10 miles of residence for at least 95% of members	≥2 pharmacies within 30 minutes or 30 miles of residence for at least 95% of members
Obstetrics[128]	Standard Plan, BH I/DD Tailored Plan, CFSP	≥2 providers within 30 minutes or 10 miles for at least 95% of members	≥2 providers within 30 minutes or 30 miles for at least 95% of members
Occupational, Physical or Speech Therapists	Standard Plan, BH I/DD Tailored Plan, CFSP	≥2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of members	≥2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of members

Service Type	Applicable Plans	Urban Standard	Rural Standard
Outpatient Behavioral Health Services	Standard Plan, BH I/DD Tailored Plan, PIHPs, CFSP	• ≥2 providers of each outpatient behavioral health service within 30 minutes or 30 miles of residence for at least 95% of members • Research-based behavioral health treatment for autism spectrum disorder (ASD): not subject to standard	• ≥2 providers of each outpatient behavioral health service within 45 minutes or 45 miles of residence for at least 95% of members • Research-based behavioral health treatment for ASD: not subject to standard
Location-based Services	Standard Plan, BH I/DD Tailored Plan, PIHPs, CFSP	• Psychosocial rehabilitation, Substance Use Comprehensive Outpatient Treatment, Substance Use Intensive Outpatient Program and Outpatient Opioid Treatment: ≥2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members • Child and Adolescent Day Treatment Services: not subject to standard	• Psychosocial rehabilitation, Substance Use Comprehensive Outpatient Treatment, Substance Use Intensive Outpatient Program and Outpatient Opioid Treatment: ≥2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of members • Child and Adolescent Day Treatment Services: not subject to standard
Crisis Services	Standard Plan, BH I/DD Tailored Plan, PIHPs, CFSP	• Standard Plan: ≥1 provider of each crisis service within each PHP region • Tailored Plan and PIHP: Professional treatment services in a facility-based crisis program—the greater of: – ≥2 facilities within each health plan region; OR – 1 facility within each health plan region per 450,000 total regional population (total regional population as estimated by combining North Carolina Office of State Budget and Management County estimates) • Tailored Plan and PIHP: Facility-based crisis services for children and adolescents: ≥1 provider within each health plan region	

Service Type	Applicable Plans	Urban Standard	Rural Standard
		• Tailored Plan and PIHP: Nonhospital medical detoxification: ≥2 providers within each health plan region • Tailored Plan and PIHP: Ambulatory detoxification, ambulatory withdrawal management with extended on-site monitoring and clinically managed residential withdrawal: ≥2 provider of each crisis service within each health plan region Medically supervised or ADATC detoxification crisis stabilization: not subject to standard	
Inpatient Behavioral Health Services	Standard Plan, BH I/DD Tailored Plan, PIHPs, CFSP	≥1 provider of each inpatient behavioral health service within each health plan service area	
Partial Hospitalization	Standard Plan, BH I/DD Tailored Plan, PIHPs, CFSP	≥1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of members	≥1 provider of partial hospitalization within 60 minutes or 60 miles for at least 95% of members
Community/ Mobile Services	BH I/DD Tailored Plan, PIHPs, CFSP	≥2 providers of community/mobile services within each health plan service area; each county in the service area must have access to ≥1 provider that is accepting new patients	
All State Plan LTSS (except nursing facilities)	Standard Plan, BH I/DD Tailored Plan, PIHP, CFSP	≥2 LTSS provider types (home care providers and home health providers, including home health services, private duty nursing services, personal care services and hospice services), identified by distinct National Provider Identifiers, accepting new patients and available to deliver each State Plan LTSS in every county	
Nursing Facilities	Standard Plan, BH I/DD Tailored Plan, CFSP	≥1 nursing facility accepting new patients in every county	
Residential Treatment Services	BH I/DD Tailored Plan, PIHPs	• Residential Treatment Facility Services: Access to ≥1 licensed provider per health plan service area • Substance Use Medically Monitored Residential Treatment: Access to ≥1 licensed provider per health plan service area (refer to Title 10A of the North Carolina Administrative Code (NCAC), Subchapter 27G, Section .3400)	

Service Type	Applicable Plans	Urban Standard	Rural Standard
		• Substance Use Nonmedical Community Residential Treatment: – Adult: Access to ≥1 licensed provider per health plan service area (refer to licensure requirements to be determined by the Department) – Adolescent: Contract with all designated CASPs statewide – Women and Children: Contract with all designated CASP statewide • Substance Use Halfway House: – Adult: Access to ≥1 male and ≥1 female program per health plan service area (refer to 10A NCAC 27G.5600E)~~129~~ – Adolescent: Access to ≥1 program per health plan service area (Refer to 10A NCAC 27G.5600E) • Psychiatric Residential Treatment Facilities and Intermediate Care Facilities for individuals with intellectual disabilities: not subject to standard	

Service Type	Applicable Plans	Urban Standard	Rural Standard

	CFSP	• Residential Treatment Services: Contract with 100% of providers statewide for each of the following service levels:
		  ○ Level I /Level II Family Type
		  ○ Level II Program Type
		  ○ Level III
		  ○ Level IV Secure
		• Substance Abuse Medically Monitored Residential Treatment: At least 1 provider per health plan service area (refer to 10A NCAC 27G.3400)
		• Substance Abuse Nonmedical Community Residential Treatment:
		  ○ Adult: Contract with 100% of providers statewide (refer to licensure requirements to be determined by the Department). Standard does not apply until 90 Calendar Days following the establishment of licensure requirements as determined by the Department.
		  ○ Adolescent: Contract with all designated CASP statewide
		  ○ Women & Children: Contract with all designated CASP statewide
		• Substance Abuse Halfway House:
		  ○ Adult: At least 1 male program and 1 female program per health plan service area (Refer to 10A NCAC 27G.5600E)
		  ○ Adolescent: At least 1 provider per health plan service area (Refer to 10A NCAC 27G.5600E)
		• Psychiatric Residential Treatment Facilities (PRTFs): Contract with 100% PRTF providers statewide	

1915(c) HCBS Waiver Services: NC Innovations	BH I/DD Tailored Plan, PIHPs	• Community Living and Support, Community Navigator, Community Networking, Residential Supports, Respite, Supported Employment, and Supported Living: ≥2 providers of each Innovations Waiver service within each health plan service area • Crisis Intervention and Stabilization Supports, Day Supports, and Financial Support Services: ≥1 provider of each Innovations Waiver service within each health plan service area • Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Individual Directed Goods and Services, Natural Supports Education, Specialized Consultation, and Vehicle Modification: not subject to standard	
1915(i) Services	BH I/DD Tailored Plan, PIHPs	• Community Living and Support, Individual and Transitional Support, In-Home Respite and Supported Employment (for I/DD and MH/SUD): ≥2 providers of each (i) Option service within each health plan service area	

Service Type	Applicable Plans	Urban Standard	Rural Standard
	CFSP	• Community Living and Supports, Individual and Transitional Supports, Out-of-Home Respite, Supported Employment (for Members with I/DD and TBI), Individual Placement and Support (for Members with a qualifying mental health condition or SUD): ≥ 2 providers of each 1915(i) Service within each Standard Plan Region • In-Home Respite: ≥ 2 providers within 45 minutes of the Member's residence • Community Transition: Not subject to standard	
1915(c) HCBS Waiver Services: North Carolina TBI Waiver (applicable to TBI Waiver participating counties only)	BH I/DD Tailored Plan	• Community Networking, Life Skills Training, Residential Supports, Resource Facilitation, In-Home Respite and Supported Employment: ≥2 providers of each TBI Waiver service within each health plan service area • Day Supports, Cognitive Rehabilitation, and Crisis Intervention and Stabilization Supports: ≥1 provider of each TBI Waiver service within each health plan service area • Adult Day Health, Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Natural Supports Education, Occupational Therapy, Physical Therapy, Speech and Language Therapy, and Vehicle Modification: N/A	
Employment and Housing Services	BH I/DD Tailored Plan, PIHPs	• Individual Placement and Supports (IPS) – Supported Employment (Adult MH): Eligible individuals shall have the choice of at least 2 provider agencies within each health plan Region. Each county in health plan's Region must have access to ≥1 provider that is accepting new patients	
Indian Health Care Providers (IHCPs)	Standard Plan, BH I/DD Tailored Plan, CFSP	• Contract with 100% of IHCPs statewide	

Standard Plan, BH I/DD Tailored Plan and the CFSP Access Standards for Medicaid

Primary Care Access Standards: "Primary care" means basic or general health care provided by a medical professional (such as a general practitioner, pediatrician or nurse) with whom a patient has initial contact and by whom the patient may be referred to a specialist. Utilization of an ED is not considered primary care.

Table 17. Standard Plan, BH I/DD Tailored Plan and CFSP[122] Access Standards for Primary Care

Visit Type	Definition	Standard
Preventive Care Services—adult, 21 years of age and older	Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and Pap tests	Within 30 calendar days
Preventive Care Services—child, birth through 20 years of age		Within 14 calendar days for members less than 6 months of age Within 30 calendar days for members 6 months of age and older
Urgent Care Appointment	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains; flu symptoms; minor cuts and wounds; sudden onset of stomach pain; and severe, non-resolving headache	Within 24 hours
Routine/Checkup Appointment Without Symptoms	Non-symptomatic visits for health check	Within 30 calendar days
After-Hours Access—Emergent and Urgent	Care requested after normal business office hours	Immediately (available 24 hours a day, 365 days a year)

Table 18. Standard Plan, BH I/DD Tailored Plan and CFSP[123] Access Standards for Prenatal Care

Visit Type	Definition	Standard
Initial Appointment—1st or 2nd Trimester	Care provided to a member while the member is pregnant to help keep member and future baby healthy, such as checkups and prenatal testing	Within 14 calendar days
Initial Appointment—High-Risk Pregnancy or 3rd Trimester		Within 5 calendar days

[122] Updates on CFSP can be found at https://medicaid.ncdhhs.gov/beneficiaries/children-and-families-specialty-plan.
[123] Updates on CFSP can be found at https://medicaid.ncdhhs.gov/beneficiaries/children-and-families-specialty-plan.

Specialty Care Access Standards: "Specialty care" means specialized health care provided by physicians whose training is focused primarily within a specific field, such as neurology, cardiology, rheumatology, dermatology, oncology, orthopedics and other specialized fields.

Table 19. Standard Plan, BH I/DD Tailored Plan and CFSP[124] Access Standards for Specialty Care

Visit Type	Definition	Standard
Urgent Care Appointment	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains; flu symptoms; minor cuts and wounds; sudden onset of stomach pain; and severe, non-resolving headache	Within 24 hours
Routine/Checkup Appointment Without Symptoms	Non-symptomatic visits for health checks	Within 30 calendar days
After-Hours Access—Emergent and Urgent Instructions	Care requested after normal business office hours	Immediately (available 24 hours a day, 365 days a year)

Behavioral Health Care Access Standards: "Behavioral health care" means health care services and treatment provided in the community for behavioral disorders and/or SUDs. Standard Plans and Tailored Plans cover certain behavioral health care services for individuals with mild to moderate behavioral health care needs.[125]

Table 20. Access Standards for Behavioral Health Care Table, 20a. Standard Plan Access Standards

Visit Type	Definition	Standard
Mobile Crisis Management Services	Mobile crisis services for adults and children, which are direct and periodic services available at all times, 24 hours a day, 7 days a week, 365 days a year, and primarily delivered face-to-face with the individual and in locations outside the agency's facility	Within 2 hours

[124] Updates on CFSP can be found at https://medicaid.ncdhhs.gov/beneficiaries/children-and-families-specialty-plan.
[125] Pending legislative authority.

Visit Type	Definition	Standard
Emergency Services for Mental Health	Services to treat a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking, or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention	Immediately (available 24 hours a day, 365 days a year)
Emergency Services for SUDs	Services to treat a life-threatening condition in which the person is—by virtue of their use of alcohol or other drugs—suicidal, homicidal, actively psychotic, displaying disorganized thinking, or reporting hallucinations and delusions that may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance use; includes crisis intervention	Immediately (available 24 hours a day, 365 days a year)
Urgent Care Services for Mental Health	Services to treat a condition in which a person is not actively suicidal or homicidal and denies having a health plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition that could rapidly deteriorate without immediate intervention; and/or without diversion and intervention, shall progress to the need for emergent services/care Services to treat a condition in which a person has potential to become actively suicidal or homicidal without immediate intervention	Within 24 hours
Urgent Care Services for SUDs	Services to treat a condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the person's substance use is in need of prompt assistance to avoid further deterioration in the person's condition that could require emergency assistance Services to treat a condition in which a person displays a condition that could, without diversion and intervention, progress to the need for emergent services/care	Within 24 hours

Visit Type	Definition	Standard
Routine Services for Mental Health	Services to treat a person who describes signs and symptoms resulting in impaired behavioral functioning that has impacted the person's ability to participate in daily living or markedly decreased the person's quality of life	Within 14 calendar days
Routine Services for SUDs	Services to treat a person who describes signs and symptoms consequent to substance use resulting in a level of impairment that can likely be diagnosed as an SUD according to the current version of the *Diagnostic and Statistical Manual*	Within 48 hours

Table 20b. BH I/DD Tailored Plan/PIHP Access Standards

Visit Type	Description	Standard
Mobile Crisis Management Services	Mobile crisis services for adults and children, which are direct and periodic services available at all times, 24 hours a day, 7 days a week, 365 days a year, and primarily delivered in person with the individual and in locations outside the agency's facility	Within two hours
Facility-based Crisis Management Services (FBC) (FBC for Children and Adolescents, FBC for Adults, Nonhospital Medical Detox)	A Medicaid crisis service	Emergency services available immediately (available 24 hours a day, 7 days a week, 365 days a year)
Emergency Services for Mental Health	Services to treat a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking, or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention	Immediately (available 24 hours a day, 7 days a week, 365 days a year)

Visit Type	Description	Standard
Emergency Services for SUDs	Services to treat a life-threatening condition in which the person is—by virtue of their use of alcohol or other drugs—suicidal, homicidal, actively psychotic, displaying disorganized thinking, or reporting hallucinations and delusions that may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance use; includes crisis intervention	Immediately (available 24 hours a day, 7 days a week, 365 days a year)
Urgent Care Services for Mental Health	Services to treat a condition in which a person is not actively suicidal or homicidal and denies having a health plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition that could rapidly deteriorate without immediate intervention; and/or without diversion and intervention, could progress to the need for emergent services/care	Within 24 hours
Urgent Care Services for SUDs	Services to treat a condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the person's substance use is in need of prompt assistance to avoid further deterioration in the person's condition that could require emergency assistance Services to treat a condition in which a person displays a condition that could, without diversion and intervention, progress to the need for emergent services/care	Within 24 hours
Routine Services for Mental Health	Services to treat a person who describes signs and symptoms resulting in clinically significant distress or impaired functioning that has impacted the person's ability to participate in daily living or markedly decreased the person's quality of life	Within 14 calendar days

Visit Type	Description	Standard
Routine Services for SUDs	Services to treat a person who describes signs and symptoms consequent to substance use resulting in a level of impairment that can likely be diagnosed as an SUD according to the current version of the *Diagnostic and Statistical Manual*	Within 48 hours

Table 20c. CFSP[126] Access Standards

Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
7	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache	Within 24 hours
8	Routine/Check-up without Symptoms	Non-symptomatic visits for health check	Within 30 Calendar Days
Behavioral Health Services			
9	Opioid Treatment Program (Adults Only)	A location-based service for the purpose of Network Adequacy Standards	Routine: Within 48 hours Urgent: Within 24 hours
10	Mobile Crisis Management Services	Mobile crisis services, for adults and children that are direct and periodic services available at all times, 24 hours a day, 7 days a week, 365 days a year, and primarily delivered in-person with the individual and in locations outside the agency's facility for the purposes of the behavioral health appointment wait-time standards	Within 2 hours

[126] Updates on CFSP can be found at https://medicaid.ncdhhs.gov/beneficiaries/children-and-families-specialty-plan.

Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
11	FBC Management Services (FBC for Child & Adolescent, FBC for Adults, Non-Hospital Medical Detox)	A crisis service for the purpose of Network Adequacy Standards	Emergency Services available immediately {available 24 hours a day, 365 days a year}
12	ADATC Detoxification Crisis Stabilization (adults only)	A crisis service for the purpose of Network Adequacy Standards	Emergency Services available immediately {available 24 hours a day, 365 days a year}
13	Residential Treatment Services (Levels I–IV)	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	• Admission within five business days of the member's level of care determination, or sooner based on a member's condition or urgency of treatment need[127] • Admission within 72 hours of the member's level of care determination for members without a therapeutic placement

[127] Session Law 2021-132, SB693.

Appointment Wait Time Standards			
Reference Number	Visit Type	Description	Standard
			who are in County DSS custody
14	PRTFs	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	• Admission within five business days of the member's level of care determination, or sooner based on a member's condition or urgency of treatment need[128] • Admission within 72 hours of the member's level of care determination for members without a therapeutic placement who are in County DSS custody
15	Acute Care Hospitals and Hospitals with Adult/Adolescent Inpatient Psychiatric Beds	Inpatient behavioral health services for the purpose of Network Adequacy Standard	• Urgent: Within 24 hours • Emergency Services: available immediately {available 24 hours a day, 365 days a year}

[128] Session Law 2021-132, SB693.

Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
16	Acute Care Hospitals and Hospitals with Adult/Adolescent Inpatient Substance Use Beds	Inpatient behavioral health services for the purpose of Network Adequacy Standard	• Urgent: Within 24 hours • Emergency Services: available immediately {available 24 hours a day, 365 days a year}
17	Partial Hospitalization	Partial hospitalization for children and adults for the purposes of the Network Adequacy Standards	• Available day/night for a minimum of 4 hours per day, 5 days per week, and 12 months per year
18	Outpatient Mental Health Services	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	• Routine: Within 14 Calendar Days • Urgent: Within 24 hours
19	Post-Psychiatric Hospital Discharge Visit		• Within seven calendar days with providers listed as meeting numerator criteria in the technical specifications for the HEDIS® measure "Follow Up After Hospitalization for Mental Illness"

Appointment Wait Time Standards			
Reference Number	Visit Type	Description	Standard
			(HEDIS is a registered trademark of NCQA)
20	Comprehensive Clinical Assessment (CCA)		• Within five business days of request, or sooner based on a member's condition or urgency of treatment need [129] • Within 24 hours of the request for members with a behavioral health need and without a level of care recommendation who are in County DSS custody or a member who requires a CCA to begin services necessary to discharge from an ED or other emergency/urgent care

[129] Session Law 2021-132, SB693.

Appointment Wait Time Standards			
Reference Number	Visit Type	Description	Standard
			setting to a community or residential setting
21	Emergency Services for Mental Health	Services to treat a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention for the purpose of behavioral health appointment wait-time standards	Immediately (available 24 hours a day, 365 days a year)
22	Emergency Services for SUDs	Services to treat a life-threatening condition in which the person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance use; includes crisis intervention for the purpose of behavioral health appointment wait-time standards.	Immediately (available 24 hours a day, 365 days a year)
23	Urgent Care Services for Mental Health	a) Services to treat a condition in which a person is not actively suicidal or homicidal, denies having a health plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention, shall progress to the need for emergent services/care for appointment wait-time standards. b) Services to treat a condition in which a person has potential to become actively suicidal or homicidal without immediate	Within 24 hours

Appointment Wait Time Standards			
Reference Number	Visit Type	Description	Standard
		intervention for the purposes of the behavioral health appointment wait-time standards.	
24	Urgent Care Services for SUDs	a) Services to treat a condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the person's substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance for behavioral health appointment wait-time standards. b) Services to treat a condition in which a person displays a condition which could without Diversion and intervention, progress to the need for emergent services/care for the purposes of the behavioral health appointment wait-time standards.	Within 24 hours
25	Routine Services for Mental Health	Services to treat a person who describes signs and symptoms resulting in clinically significant distress or impaired functioning, which has impacted the person's ability to participate in daily living or markedly decreased person's quality of life for the purposes of the behavioral health appointment wait-time standards	Within 14 Calendar Days
26	Routine Services for SUDs	Services to treat a person who describes signs and symptoms resulting in clinically significant distress or impaired functioning, which has impacted the person's ability to participate in daily living or markedly decreased person's quality of life for the purposes of the behavioral health appointment wait-time standards.	Within 48 hours

Appendix E. Minimum Required Elements of Standard Plan's, BH I/DD Tailored Plan's and the CFSP's Annual Fraud Prevention Plans and Reports

Fraud Prevention Plan Minimum Requirements
• The name of the Compliance Officer
• Description of the SIU, the roles within the SIU and staffing by title
• Description of the SIU staff qualifications
• The health plan's internal controls, policies and procedures that are designed to prevent, detect and report known or suspected fraud and abuse activities
• The process and procedures to ensure that all suspected fraud and abuse are reported in compliance with the contract
• The process and procedure to ensure that all network provider terminations related to suspected or confirmed fraud and abuse, as well as health plan staff termination(s) for engaging in prohibited marketing conduct, are reported to the Department as required by the contract
• Employee and contractor education on federal and state laws, as well as health plan practices for detection, identification, reporting and prevention of fraud, waste and abuse to ensure that the health plan's officers, directors, employees, contractors, network providers and members know and understand these obligations
• A description of the managed care plan's specific controls to detect and prevent potential fraud and abuse, including, without limitation: – A list of automated prepayment claims edits – A list of automated post-payment claims edits – A list of desk audits on post-processing review of claims planned – A list of reports on network provider profiling used to aid program and payment integrity review – The methods the health plan will use to identify high-risk claims and the health plan's definition of high-risk claims – Visit verification procedures and practices, including sample sizes and targeted provider types or locations – A list of surveillance and/or UM Program protocols used to safeguard against unnecessary or inappropriate use of Medicaid services – Policies and procedures used by the health plan and designed to prevent, detect and report known or suspected fraud and abuse activities – A list of references in provider and enrollee material regarding fraud and abuse referrals (e.g., on member explanation of benefits) – Work plans for conducting both announced and unannounced site visits and field audits of network providers determined to be at high risk to ensure services are rendered and billed correctly – The process by which the SIU shall monitor the health plan's marketing representative activities to ensure that the health plan does not engage in inappropriate activities, such as provision of inducements
• Assurance that the identities of individuals reporting violations by the health plan are protected and that there is no retaliation against such persons

- Description of criminal background exclusion screening process for the health plan's owners, agents, employees, network providers and subcontractors

Annual Fraud Prevention Report Minimum Requirements
• The name of the health plan
• The name of the person and department responsible for submitting the Fraud Prevention Report
• The date the report was prepared
• The date the report was submitted
• Names of persons who have SIU responsibilities, as well as the name of the Compliance Officer
• A list of activities planned but not performed under the approved Fraud Prevention Plan and the reason(s) for nonperformance
• The results of the activities performed pursuant to the approved Fraud Prevention Plan and any additional similar activities performed that were not included in the Fraud Prevention Plan, including trainings provided
• A summary spreadsheet of each audit, on-site review or other activity containing the following: – The managed care plan case number, if any – The name(s) and NPI(s) of the providers subject to the review or activity – The dates when the audit, review or activity commenced and when it was completed – The activity type: Audit, Self-Audit, Investigation or Review; an Audit is defined as a managed care plan performing provider monitoring or audit of a group of providers; a Self-Audit is defined as a provider's conducting its own quality assurance and identifying/self-disclosing billing anomalies, discrepancies or overpayments; an Investigation is defined as a case initiated by a lead, referral, complaint and/or FAMIS data analytics reports; and a Review is defined as any other activity that led to the information, such as a grievance or an appeal – A brief statement about the concern, allegation or complaint – Findings or requests associated with the allegation or complaint; refrain from using "substantiated" or "unsubstantiated" as the only finding statement – The payback amount/overpayment amount, if any – If an appeal was provided and the results of such appeal, including overpayment amount, if any – The amount recouped by the managed care plan, if any – The remaining amount owed to the managed care plan, if any – The date the allegation or complaint was received (the open date) – The date all action on the case was exhausted and/or final determinations were rendered, with the exception of referrals sent to Program Integrity for the closed date – If the matter was referred to PI for potential fraud – Any additional comments related to the case, provider or additional administrative actions taken; also include if the activity was completed outside the SIU

Annual Fraud Prevention Report Minimum Requirements
• Any providers subject to prepayment review, the length of any such review and the outcome
• A description of any predictive modeling used

More information on the model is available on the Tailored Care Management web page.