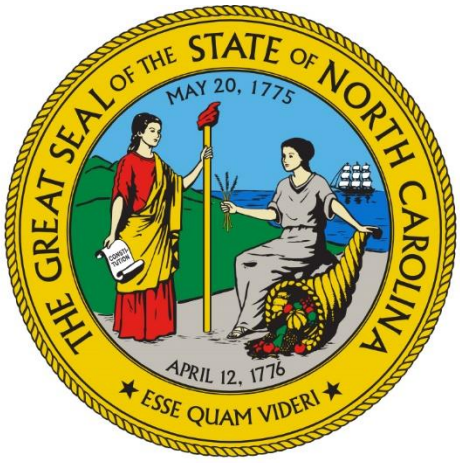

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Office of Communications

North Carolina Medicaid Access Monitoring Review Plan

Analyzing Access to Care for the NC Medicaid Direct Population

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2019-2022

Contents

Acronym List

AAMC..... Association of American Medical Colleges

ADHD.....Attention-Deficit/Hyperactivity Disorder

AHRQ.....Agency for Healthcare Research and Quality

AMH.....Advanced Medical Home

AOD.....Alcohol and Other Drug

BRFSS.....Behavioral Risk Factor Surveillance System

CAHPS.....Consumer Assessment of Healthcare Providers and Systems

CCNC.....Community Care of North Carolina

CDC.....Centers for Disease Control and Prevention

CHIP.....Children's Health Insurance Program

CMHRP.....Care Management for High-Risk Pregnancies

COPD.....Chronic Obstructive Pulmonary Disease

CY.....Calendar Year

DHB.....Department of Health Benefits

ED.....Emergency Department

HEDIS.....Healthcare Effectiveness Data and Information Set

HMO.....Health Maintenance Organization

I/DD.....Intellectual/Developmental Disabilities

LME-MCO.....Local Management Entity-Managed Care Organization

MACPAC..... The Medicaid and CHIP Payment and Access Commission

NC.....North Carolina

NCDHHS.....North Carolina Department of Health and Human Services

NCQA.....National Committee for Quality Assurance

NQF.....National Quality Forum

OB/GYN.....Obstetrician Gynecologist

OSUAP.....Opioid and Substance Use Action Plan

PAU.....Potentially Avoidable Utilization

PCCM.....Primary Care Case Management

PCP.....Primary Care Provider

PHE.....Public Health Emergency

PHP.....Prepaid Health Plan

PIP.....Performance Improvement Projects

PIHP.....Prepaid Inpatient Health Plan

PMH.....Pregnancy Medical Home

PMP.....Pregnancy Management Program

PQA.....Pharmacy Quality Alliance

PQCNC.....Perinatal Quality Collaborative of North Carolina

QRS.....Quality Rating System

Conflict of Interest Statement

This Access Monitoring Review Plan was developed internally by members of the Quality, Population Health and Evaluation team within the North Carolina Department of Health and Human Services (NCDHHS) Division of Health Benefits (DHB). Content was reviewed and approved by subject matter experts and leadership within NC DHHS.

Overview

This Access Monitoring Review Plan (Plan) provides an overview of access to care for North Carolina Medicaid Direct beneficiaries from 2019 through 2022. Medicaid Direct is the traditional fee-for-service Medicaid program in North Carolina. In 2015, the Centers for Medicare and Medicaid Services (CMS) began requiring that states "analyze data and supporting information to reach conclusions on sufficient access for covered services provided under fee-for-service. Every three years, states must conduct the analysis for: primary care services (including those provided by a physician, FQHC, clinic, or dental care); physician specialist services; behavioral health services, including mental health and substance use disorder; pre- and post-natal obstetric services, including labor and delivery; and home health services."[1] In accordance with 42 CFR 447.203(b), North Carolina (NC) Medicaid developed this Plan for the following service categories:

- Primary Care,
- Dental,
- Physician Specialist,
- Behavioral Health, and
- Maternal Health Services, including Obstetric services.

The Plan analyzes the extent to which the health care needs of Medicaid beneficiaries are being met by examining the number of providers, beneficiaries' utilization of services, health care performance measures and measures of patient experience. For this report, NC Medicaid utilized a framework developed by the Urban Institute in 2016.[2] This framework breaks down access into three domains:

- *Domain #1: Provider availability and accessibility (potential access).* This domain measures potential access to providers and services, independent of whether the providers or services are used by the beneficiary.[3]
- *Domain #2: Beneficiary utilization (realized access and access-related outcomes).* This domain addresses beneficiaries' use of the providers and services available to them, thus "realized," as opposed to "potential," access.

[1] Access Monitoring Review Plans. Medicaid.gov. https://www.medicaid.gov/medicaid/access-care/access-monitoring-review-plans/index.html

[2] Urban Institute Health Policy Center. (2016). Proposed Medicaid Access Measurement and Monitoring Plan. https://www.medicaid.gov/sites/default/files/2019-12/monitoring-plan.pdf

[3] Throughout this report the term 'beneficiary' is used when describing a recipient of Medicaid services and 'member' is used when describing a beneficiary in a specific program or health plan.

- *Domain #3: Beneficiary perceptions and experiences.* This domain focuses on beneficiaries' perceptions of their needs, their access barriers and unmet needs, and their care experiences, are based on consumer surveys and program complaints and grievances.

About North Carolina Medicaid

NC Medicaid provides critical health insurance coverage for many individuals and families with low incomes and supports medically fragile children, people with severe mental illness, and those in adult care homes and nursing homes. NC Medicaid helps pay for certain medical expenses including (but not limited to): doctor bills, hospital bills, prescriptions, nursing home care, and behavioral health care.

Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government. In North Carolina, NC Medicaid is administered by the North Carolina Department of Health and Human Services, Division of Health Benefits, referred to in this report as "The Department."

Most NC Medicaid beneficiaries are currently enrolled in "NC Medicaid Managed Care." This health care delivery system means that the state contracts with insurance companies, which are paid a fixed annual fee per enrolled person to cover their healthcare services. This transition started in July of 2021 with the launch of five Standard Plans.[4] However, some beneficiaries remain in traditional fee-for-service Medicaid, called "NC Medicaid Direct", the population of focus for this report. See Table 1 for more detailed information on the NC Medicaid plans.

Table 1: NC Medicaid Plan Structures

Type	Population Served	Description
NC Medicaid Direct	Beneficiaries who are not enrolled in managed care Health Plans (Prepaid Health Plans/Standard Plans)	The new name for the traditional Medicaid fee-for-service program. Provides care management for physical health services through Community Care of North Carolina (CCNC)[5] and care coordination for behavioral health, Intellectual/Developmental Disability (I/DD), or Traumatic Brain Injury (TBI) through Local Management Entity-Managed Care Organizations (LME-MCOs).[6] Offers certain services that Standard Plans do not.
Standard Plans	Most Medicaid beneficiaries, including those with low to	Provides integrated physical health, pharmacy, care coordination, and basic

[4] For more information on North Carolina's transformation to Medicaid managed care, see: https://medicaid.ncdhhs.gov/transformation

[5] CCNC is a primary care case management entity (PCCMe) for the majority of Medicaid beneficiaries who are enrolled in NC Medicaid Direct.

[6] Local Management Entities/Managed Care Organizations (LME/MCOs) manage the care of NC Medicaid beneficiaries who receive services for mental health, developmental disabilities or substance use disorders.

Type	Population Served	Description
	moderate intensity behavioral health needs.	behavioral health services. Launched on July 1, 2021.
Eastern Band of Cherokee Indians (EBCI) Tribal Option	Federally recognized tribal members and others who qualify for services through Indian Health Service (IHS) that live in the following counties: Buncombe, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, Swain, Transylvania.	A primary care case management entity created by the Cherokee Indian Hospital Authority (CIHA) that provides care coordination and management of medical, behavioral health, pharmacy, and support services. Launched on July 1, 2021.

In the state fiscal year (SFY) 2022, NC Medicaid provided services to approximately 2.9 million enrolled beneficiaries and had a total annual expenditure of $21.3 billion. The NC Medicaid budget finished SFY 2022 $49 million under budget.[7]

NC Medicaid values innovating and improving its services for its beneficiaries. For example, NC Medicaid beneficiaries account for more than 54% of all deliveries in NC, and in 2022 NC Medicaid took advantage of a federal option to extend postpartum benefits from six to 12 months and provide full Medicaid benefits to birthing people.[8,9]Additionally, NC Medicaid quickly added telehealth policies to the state Medicaid plan in the wake of the COVID-19 pandemic. The Department also continued to administer new initiatives such as the Healthy Opportunity Pilots (HOP). HOP is the nation's first comprehensive program to test and evaluate the impact of providing select evidence-based, non-medical interventions related to housing, food, transportation and interpersonal safety and toxic stress to high-needs Medicaid enrollees.[10]

Nearly half of all people enrolled in NC Medicaid are children under the age of 18. In 2023 children enrolled in NC Health Choice, funded through the federal Children's Health Insurance Program (CHIP), joined the Medicaid program.[11] This move, impacting approximately 55,000 children in the state, aims to streamline services, save families money, and increase access to care by providing additional physical and behavioral health services. NC Medicaid has done all of this, and much more, with the goal of improving the health of North Carolinians through an innovative, whole person centered, and well-coordinated system of care and measurement of quality, which addresses both medical and non-medical drivers of health.

[7] NC DHHS. (2022). North Carolina Medicaid and NC Health Choice Annual Report for State Fiscal Year 2022. https://medicaid.ncdhhs.gov/ncmedicaid-annual-report-sfy2022/download?attachment

[8] Kaiser Family Foundation (KFF). (2021). Births Financed by Medicaid by State. (KFF) https://www.kff.org/medicaid/state-indicator/births-financed-by medicaid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

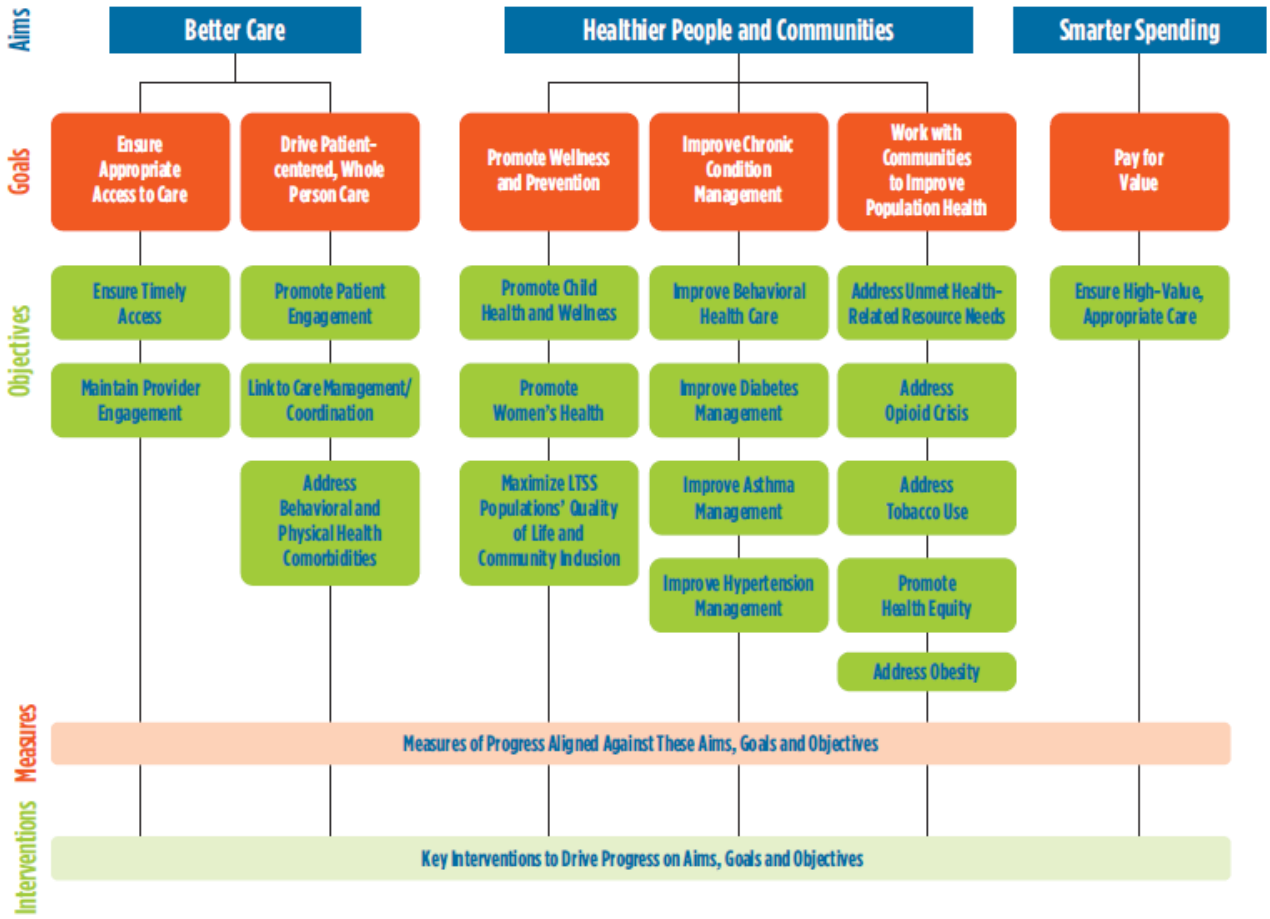
[9] NC DHHS. (2019). Risk Factors and Characteristics for 2019 North Carolina Resident Live Births; Overall, All Mothers. (State Center for Health Statistics) https://schs.dph.ncdhhs.gov/schs/births/matched/2019/2019-Births-Overall.html

[10] NC DHHS. Healthy Opportunities Pilots. Accessed 11.7.2023. https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots

[11] NC DHHS. (2022). North Carolina Medicaid and NC Health Choice Annual Report for State Fiscal Year 2022. https://medicaid.ncdhhs.gov/ncmedicaid-annual-report-sfy2022/download?attachment

The Quality Strategy, first published in 2018 and most recently updated in 2023, details NC Medicaid Managed Care's aims, goals, and objectives for quality management and improvement and details specific quality improvement initiatives that are priorities for the Department.[12] The Quality Strategy includes a framework reflecting the Department's commitment to three broad aims. As depicted in Figure 1, a series of goals and objectives is included with each aim, highlighting key areas of expected progress and quality focus. The first goal of Aim 1, Better Care, is to ensure appropriate access to care for all beneficiaries, with the objective of ensuring timely access. This Plan is one tool NC Medicaid uses to assess Medicaid beneficiaries' access to services, focusing on those beneficiaries enrolled in Medicaid Direct.

Figure 1. Overview of the Quality Strategy Framework



[12] For the full NC DHHS Quality Strategy see here: https://medicaid.ncdhhs.gov/nc-medicaid-2023-quality-strategy/download?attachment

Data Sources

Multiple data sources were used in the development of this Plan. See Table 3 for a summary of all data sources.

Domain #1: *Provider Availability & Accessibility*

To assess provider availability and accessibility, this report draws on NC Medicaid enrollment reports and North Carolina's multi-payer Medicaid Management Information System (MMIS), known as NCTracks.[13]

NC Medicaid has network adequacy standards that measure appointment availability and the travel time and distance to different provider types. The Pilot Provider Call Study measures network adequacy, providers' acceptance of new members, and the accommodations of providers for members within Prepaid Health Plans that promote health equity. However, this study focuses on Standard Plan members and not on Medicaid Direct members. For this report, we will reference network adequacy standards from the Prepaid Inpatient Health Plans' (PIHPs') contracts. PIHPs are the primary vehicle for providing Medicaid Direct behavioral health services.

Domain #2: *Beneficiary Utilization*

To assess beneficiary utilization, this report highlights a set of quality measures that represent service utilization. Most measures in this Plan are from the Healthcare Effectiveness Data and Information Set (HEDIS®), a widely used set of performance measures developed and maintained by the National Committee for Quality Assurance (NCQA). Others are from alternative quality measure stewards, such as the Dental Quality Alliance (DQA), which produces *Oral Evaluation, Dental Services (OEV)*. More information on the HEDIS and non-HEDIS measures mentioned in this Plan can be found in NC Medicaid's Quality Measurement Technical Specifications Manual.

Several data sources were used to calculate the performance rates associated with each measure. The measures in this Plan were calculated by NC Medicaid for the Medicaid Direct population. The quality measures presented are for Medicaid Direct eligible beneficiaries that received services during Calendar Year (CY) 2019 through CY2022. For 2019 and 2020 results the rates were calculated from the entire NC Medicaid population, as everyone was within the traditional fee-for-service system, with only limited benefit populations excluded. In 2021 and 2022, this population was identified by excluding beneficiaries enrolled in a managed care Standard Plan, eligible for the Tribal Option, or only enrolled in NC Medicaid for limited benefits.[14] See Table 2 for more details on how the Medicaid Direct population was identified for the quality measure calculations in 2021 and 2022.

Table 2: Managed Care Status Codes for each Program

Program	Associated Identifiers
Standard Plan (SP)	Any beneficiary enrolled in a SP

[13] NC Tracks, Home Page. NC DHHS. Accessed 11.7.2023. https://www.nctracks.nc.gov/content/public?version=NCTRACKS-Prod-DT20230406&why=Root

[14] See Appendix section "Partial Benefit Exclusions" for more details.

Program	Associated Identifiers
Tribal Option	Tribal Option Managed Care Status Codes (MCS025-MCS041, MCS044-MCS050)
Medicaid Direct	Beneficiaries that are not enrolled in a SP and are not in Tribal Option

Utilization data contained in this Plan are based on dates of service for CY 2019-2022, when available, and include beneficiaries for whom Medicaid is the only source of payment. Medicaid beneficiaries with Medicare (traditional dual-eligible beneficiaries) or other health care coverage have been excluded from the analyses (See Appendix section "Partial Benefit Exclusions" for more information). The data were generated with consistent claims run out of at least three months beyond each reporting period. Four years of data are presented, when available, to help distinguish temporary fluctuations from trends over time.

Where available, NCQA's National Healthcare Quality Reports were used to compare NC Medicaid's Performance from 2019-2021 to the national Medicaid Health Maintenance Organization (HMO) average. NCQA posts national average benchmarks for Medicaid Health Plans, which provide a way to determine how NC Medicaid compares to the rest of the nation's Medicaid Health Plans.[15] This information was used as a tool for examining quality improvement and benchmarking plan performance.

Domain #3: *Beneficiary Perceptions & Experiences.*

To assess beneficiary perceptions and experiences, this Plan utilized measures of patient experience with health care, collected through the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey established by the Agency for Healthcare Research and Quality (AHRQ).

Table 3: Access Domains and Related Quality Measures

Domain	Measure	Source
Domain #1	NC Physician Workforce Information	NC Medical Board, AAMC, MACPAC
	Time and Distance Standards	PIHP Contracts
	Enrollment by age, gender, and county	Enrollment Data
Domain #2	Primary Care Provider (PCP) visits per 1,000 beneficiaries	NC DHHS
	Adults' Access to Preventive/Ambulatory Health Services (AAP)	HEDIS®
	Well-Child Visits in the First 30 Months of Life (W30)	HEDIS®
	Child and Adolescent Well-Care Visits (WCV)	HEDIS®

[15] HEDIS Measures and Technical Resources. NCQA. Accessed 11.2.2023. https://www.ncqa.org/hedis/measures/

Domain	Measure	Source
	Follow-Up After Emergency Department Visit for Substance Use (FUA)	HEDIS®
	Annual Dental Visit (ADV)	HEDIS®
	Oral Evaluation, Dental Services (OEV-CH)	DQA
	Initiation and Engagement of Substance Use Disorder Treatment (IET)	HEDIS®
	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)	HEDIS®
	Follow-Up After Hospitalization for Mental Illness (FUH)	HEDIS®
	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	HEDIS®
	Prenatal and Postpartum Care (PPC)	HEDIS®
	Breast Cancer Screening (BCS)	HEDIS®
Domain #3	Customer services (health plans gave necessary info/help)	CAHPS®
	Getting Care quickly (illness/injury, non-urgent)	CAHPS®
	Getting needed care (access to care, tests, treatment & specialists)	CAHPS®

Executive Summary

This Access Monitoring Review Plan (AMRP) looks at access to care for NC Medicaid Direct, traditional fee-for-service, members between 2019 and 2022. Access is defined by three domains: *Provider Availability & Accessibility, Beneficiary Utilization, and Beneficiary Perceptions & Experiences.*

This AMRP tracks different indicators for access to care from 2019 through 2022, a time frame which includes dramatic changes in Medicaid Direct's beneficiary population and a national public health emergency. In 2021, NC Medicaid launched Standard Plans, and a significant portion of Medicaid Direct members moved over to these managed care health plans. The NC Medicaid Direct population went from around 2,400,000 in 2020 to just over one million in 2021 (see Figure 2). The population that left NC Medicaid Direct was made up of mostly children and pregnant women, leaving the NC Medicaid Direct member population older and, in some cases, more complex. In addition to this large shift in the member population, the COVID-19 public health emergency, declared in January of 2020, drastically altered how patients seek and access healthcare. [16] Results from this AMRP should be interpreted with this context in mind, and any notable trends should be viewed with caution.

1. *Provider Availability & Accessibility:* NC Medicaid Direct members are served by PIHPs that have contracted time/distance and appointment wait time standards that protect them from significant delays in access to care. Members have clear and accessible sources of information on covered services, provider selection, and Medicaid rates.
2. *Beneficiary Utilization:* NC Medicaid Direct members saw improved performance in certain quality metrics, including *Follow-Up After Emergency Department Visit for Substance Use (FUA)* and *Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care*. Some utilization measures remained relatively stable over the four-year period, and some, including *Follow-Up After Hospitalization for Mental Health, 7-Days (FUH),* saw worsened performance.
3. *Beneficiary Perceptions & Experiences:* NC Medicaid continues to track the Medicaid Direct population within the CAHPS surveys, revealing Medicaid Direct respondents had relatively positive experiences with their and their child's health plan, personal doctor, and specialist compared to the Non-Medicaid Direct aggregate results.

Domain 1: Potential Access

Network Adequacy Standards

PIHPs are contracted to provide behavioral health care for Medicaid Direct members. These PIHPs have network adequacy standards within their contracts that ensure the PIHP's ability to deliver the benefits promised. The PIHPs are required to provide reasonable access to a sufficient number of in-network providers and all health care services included under the terms of the Contract. See Table 5 for PIHP time and distance standards and Table 4 for appointment wait time standards.[17] Each PIHP develops a Network Access Plan and provides documentation that demonstrates it has the capacity to serve the expected enrollment in its entire catchment area.

[16] Matt McGough, Krutika Amin, and Cynthia Cox. (2023). How Has Health Care Utilization Changed Since the Pandemic? KFF. https://www.kff.org/coronavirus-covid-19/issue-brief/how-has-health-care-utilization-changed-since-the-pandemic/#:~:text=Early%20in%20the%20COVID%2D19,decline%20in%20health%20care%20utilization.

[17] Medicaid Direct Prepaid Inpatient Health Plan Contract. State of North Carolina. Department of Health and Human Services. https://medicaid.ncdhhs.gov/medicaid-direct-prepaid-inpatient-health-plan-contract/download?attachment

At a minimum, the PIHP network shall consist of hospitals, physicians, advanced practice nurses, substance use disorder (SUD) and mental health treatment providers, TBI and I/DD providers, safety net hospitals, and all other provider types necessary to support capacity to make all services sufficiently available.

Table 4: NC Medicaid PIHP Appointment Wait Time Standards

Visit Type	Standard
Mobile Crisis Management Services	Within two (2) hours
Facility-Based Crisis Management Services	Emergency Services available immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Emergency Services for Mental Health	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Emergency Services for SUD	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Urgent Care Services for Mental Health	Within twenty-four (24) hours
Urgent Care Services for SUD	Within twenty-four (24) hours
Routine Services for Mental Health	Within fourteen (14) calendar days
Routine Services for SUDs	Within forty-eight (48) hours

For more details refer to the Medicaid Direct Prepaid Inpatient Health Plan Contract Pages 304-309

Table 5: NC Medicaid PIHP Time & Distance Standards

Service Type	Urban Standard[18]	Rural Standard
Outpatient Behavioral Health (BH) Services	≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of members	≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of members
Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP)	≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members	≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of members

[18] For the purposes of this attachment and the PIHP Network Adequacy Standards, "urban" is defined as non-rural counties, or counties with average population densities of two hundred fifty (250) or more people per square mile. This definition includes twenty (20) counties that are categorized by the North Carolina Rural Economic Development Center as "regional cities or suburban counties" or "urban counties which will be covered by the applicable PIHP." "Rural" is defined as a county with average population density of less than two hundred fifty (250) people per square mile.

Crisis Services: Professional treatment services in facility-based crisis program	The greater of: 2+ facilities within each PIHP Region, OR 1 facility within each Region per 450,000 total regional population	
Inpatient BH Services	≥ 1 provider of each inpatient BH service within each PIHP region	
Partial Hospitalization	≥ 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
1915(i) Home and Community Based Services (HCBS)	Community Living & Support, Individual and Transitional Support, Respite, and Supported Employment (for IDD and MH/SUD): ≥ 2 providers of each (i) Option service within each PIHP Region	

For more details refer to the Medicaid Direct Prepaid Inpatient Health Plan Contract Pages 304-309

NC Medicaid Direct Population

To analyze access to care for the Medicaid Direct population it is important to understand the composition of this population. The size of the NC Medicaid Direct population decreased substantially in 2021 due to the implementation of managed care when a large portion of the beneficiary population shifted to Standard Plans (see Figure 2).[19] However, after NC Medicaid made the transition to managed care a subset of beneficiaries remained in Medicaid Direct, including those that:

1. Receive Family Planning Medicaid, Refugee Medicaid, Foster Care/Adoption Medicaid or must meet a deductible before getting Medicaid benefits,
2. Are part of the Health Insurance Premium Payment (HIPP) or Program of All-Inclusive Care for the Elderly (PACE) programs,
3. Have both Medicare and Medicaid (traditional dual eligible) or receive long-stay nursing home services,
4. Receive Innovations Waiver services, TBI Waiver services, Community Alternatives Program for Children (CAP/C) services, or Community Alternative Program for Disabled Adults (CAP/DA) services, or
5. Request to move to NC Medicaid Direct.

By the end of 2022, the Medicaid Direct population consisted of 1,052,896 beneficiaries, which was about 36.4% of the total NC Medicaid population (see Figure 3).[20]

[19] The continuous enrollment requirement from COVID-19 era policies also impacted enrollment numbers during this time.
[20] For more information on NC Medicaid enrollment reference the NC Medicaid Enrollment Dashboard found here: https://medicaid.ncdhhs.gov/reports/dashboards/enrollment-dashboard

Figure 2: NC Medicaid Direct Enrollment Over Time, December 2019-December 2022

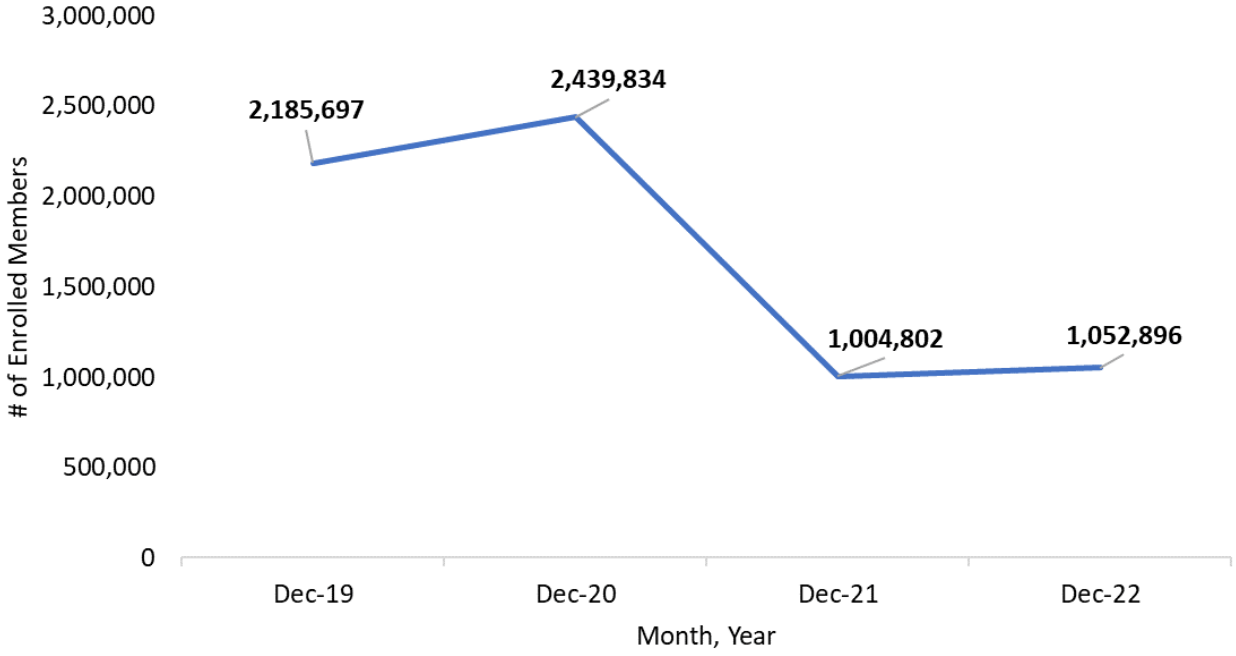
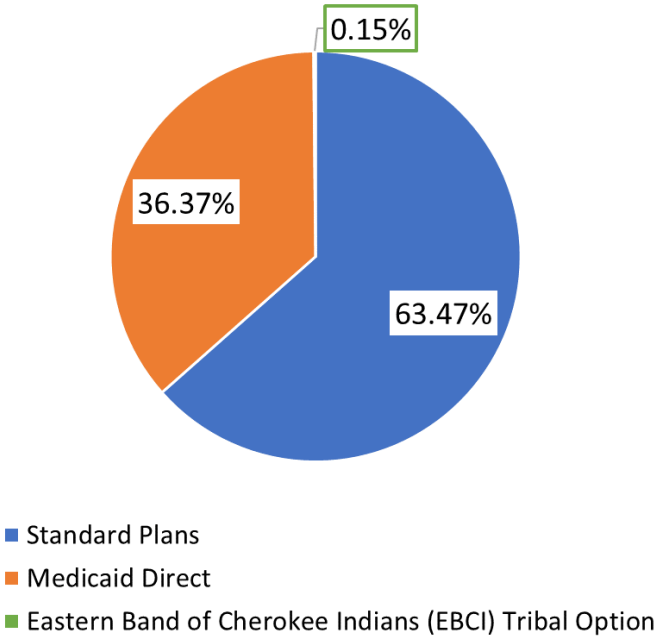
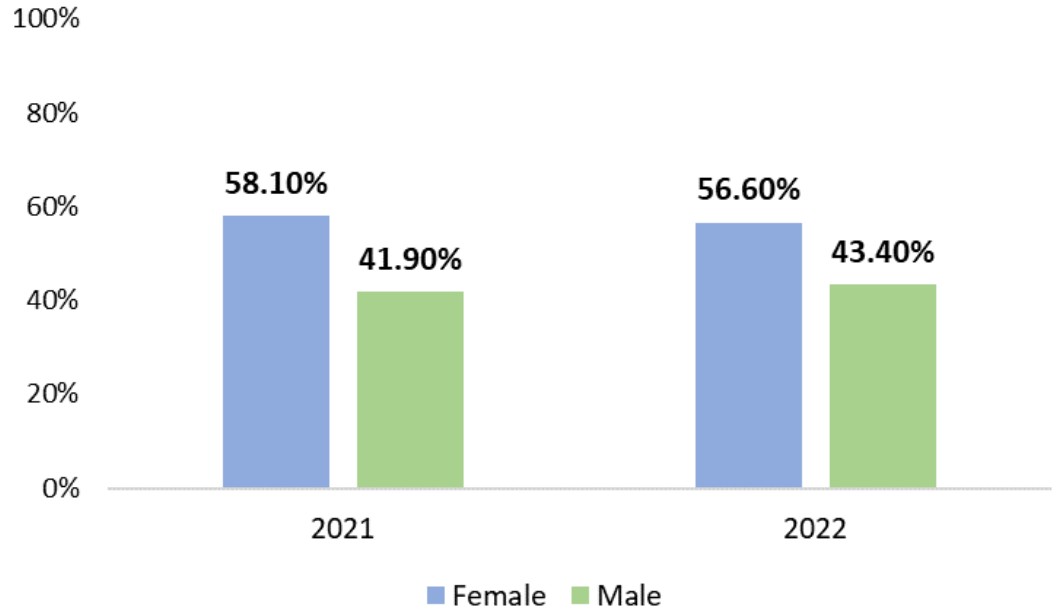


Figure 3: NC Medicaid Enrollment by Line of Business, December 2022



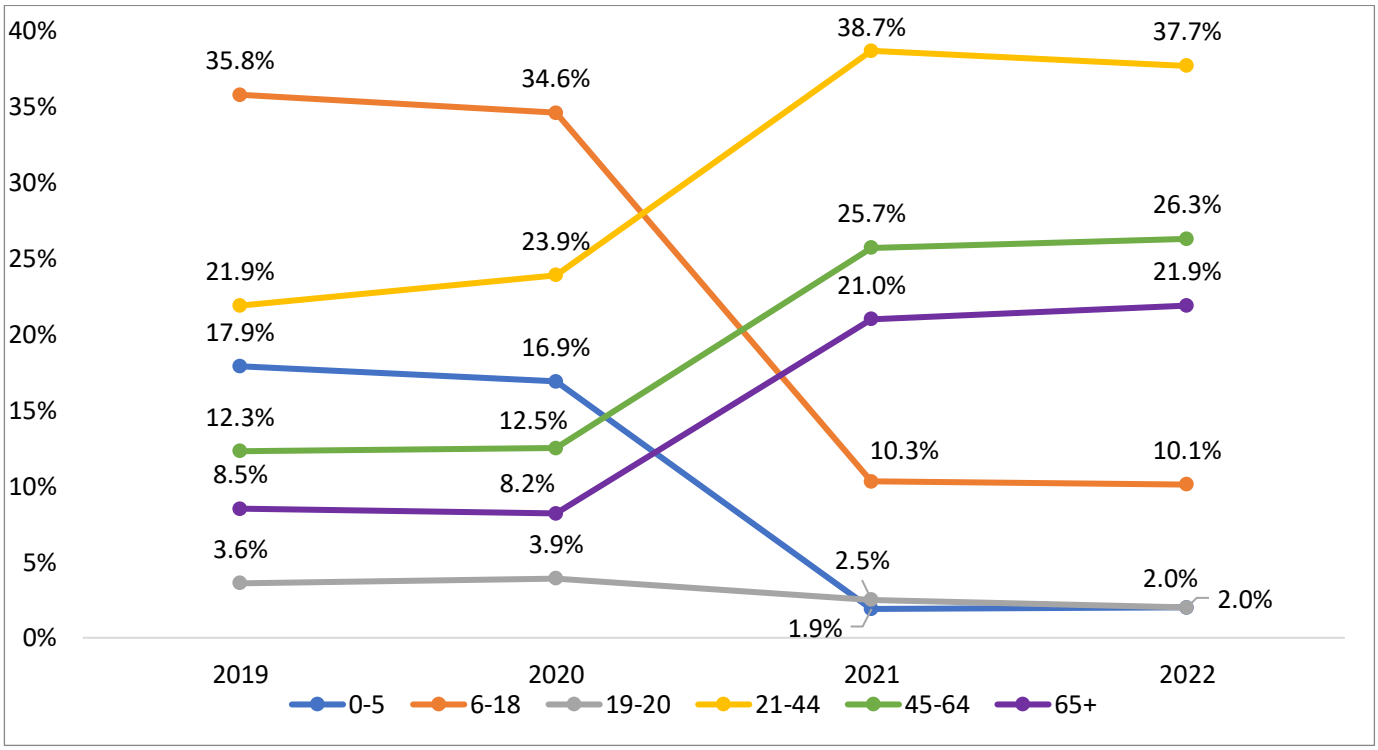
A majority of Medicaid Direct enrollees were female in 2021 and 2022 (see Figure 4). Currently, Male and Female are the only options presented to beneficiaries at enrollment, but the Department intends to add a third gender (Other) option in future years.

Figure 4: Gender Composition of NC Medicaid Direct Enrollees (2021-2022)



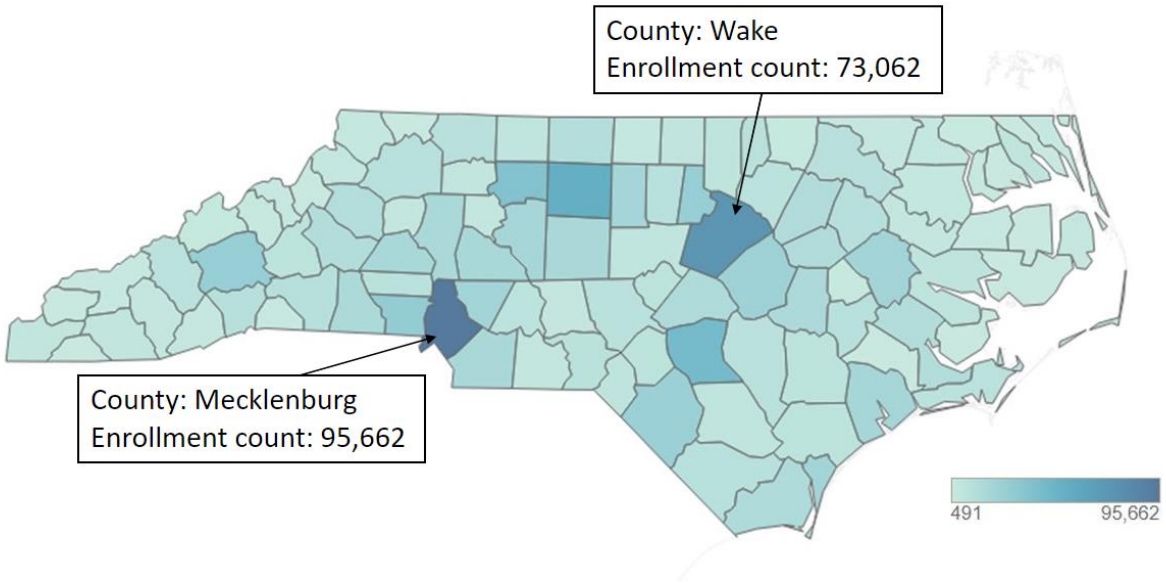
While it has changed over time, around 30 percent of the total NC Medicaid population is aged 6-18, with the next largest group (around 20 precent) being aged 21-44 (see Figure 5). After the shift to Standard Plans, the Medicaid Direct population tended to be older. In 2022, around 21.9 percent of Medicaid Direct beneficiaries were 65+, and 64 percent were between the ages of 21-64 (see Figure 5).

Figure 5: Enrollee Age Composition and Count Over Time for NC Medicaid Direct (2019-2022)



Medicaid Direct members reside in every North Carolina County, with Mecklenburg and Wake counties having the most Medicaid Direct members (see Figure 6). Both Mecklenburg and Wake County have over 80% of their population living in municipalities, or urban areas.[21]

Figure 6: Enrollment by county for all NC Medicaid Direct enrollees, December 2022



Potential Access to Primary Care Services

To promote primary care provider enrollment or re-enrollment as NC Medicaid providers, NC Medicaid offers providers a secure and convenient method to complete and submit provider enrollment applications through the NC Tracks Provider Portal. See Table 6 for information on enrollment and re-enrollment turnaround times for providers.

Table 6: NC Tracks Provider Enrollment/Re-Enrollment Application Processing Turn Around Times.[22]

Month (2023)	June	July	August
Processing Turn Around Times (days)	10.85	14.34	14.57

The Center for Health Workforce in North Carolina, housed within the Cecil G. Sheps Center for Health Services Research found that while the number of physicians in North Carolina has grown over time, the distribution of physicians across the state is not equitable.[23] Most of the growth in physicians per capita has occurred in urban counties. From 2019-2021, the state rate for all physicians per 10,000 population

[21] UNC Carolina Demography. (2020). Is North Carolina Rural or Urban? https://carolinademography.cpc.unc.edu/2020/11/19/is-north-carolina-rural-or-urban/#:~:text=The%20most%20urban%20counties%20form,mountains%20in%20the%20far%20west.

[22] These processing times are for clean applications where the application is error-free and complete and includes any/all required supplemental information at the time of electronic submission.

[23] Sper, Julie. Galloway, Evam. NC's Physician-to-population ratio is increasing, but most of the growth is in urban areas. (2019) Sheps Center for Health Workforce NC. https://nchealthworkforce.unc.edu/blog/physician_growth_metro/

went from 24.3 to 27.7.[24] The rate of physicians per 100,000 population varies drastically by physician type, with a higher rate of primary care physicians compared to active general surgeons (see Table 7).

Table 7: North Carolina Physician Workforce Profile, 2020[25]

Physician Supply	NC Rate (per 100,000)
Active Physicians	263.6
Active Primary Care Physicians	87.8
Active General Surgeons	7.1

Between 2019 and 2022, the total number of individual PCPs, including physicians and advanced practice providers, increased from 37,325 to 39,869 statewide (see Table 8 for count of physicians in the state, by year). Although it varies by state and specialty, research has shown that physicians are less likely to accept new patients covered by Medicaid than those with Medicare or private insurance. Between 2014 and 2017, 85.7% of physicians in NC were accepting new Medicaid patients, compared to the national average of 74%.[26] For the same time period, among physicians accepting new patients, 84.6% NC physicians accepted Medicare and 97.5% accepted private insurance. This acceptance rate also varies by care setting, with clinics having the highest acceptance rate at 100% and private practices having the lowest at 83%. [27]

Table 8: Number of MDs Practicing in NC Between 2019-2022[28]

Year	2019	2020	2021	2022
# of MDs	37,325	39,808	40,643	39,869

NC Medicaid Provider Ombudsman

Any provider inquiries, concerns or complaints can be submitted to Medicaid.ProviderOmbudsman@dhhs.nc.gov, or providers may utilize the Provider Ombudsman line at 866-304-7062.

[24] North Carolina Health Professional Supply Data. Sheps Health Workforce NC. Accessed October 17, 2023. https://nchealthworkforce.unc.edu/interactive/supply/

[25] North Carolina Physician Workforce Profile. 2020. Association of American Medical Colleges (AAMC). https://www.aamc.org/media/58286/download

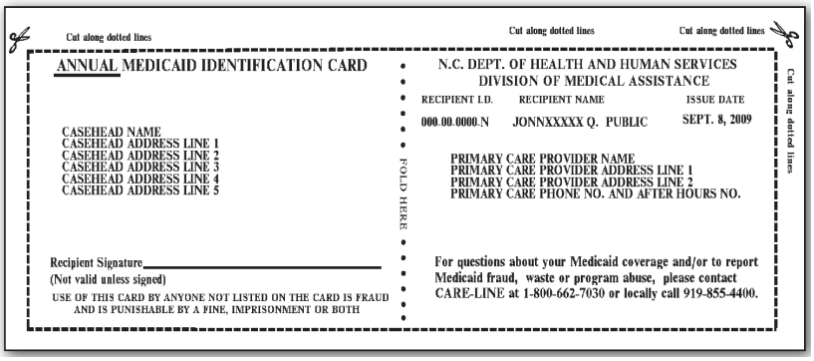
[26] MACPAC. (2021). Physician Acceptance of New Medicaid Patients: Findings from the National Electronic Health Records Survey. https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf

[27] MACPAC. (2021). Physician Acceptance of New Medicaid Patients: Findings from the National Electronic Health Records Survey. https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf

[28] Each year in the table is linked with relevant report from the NC Medical Board

Accessing Information About Care

Beneficiaries can access information about providers and covered services by calling the NC Medicaid Contact Center or by reviewing the NC Medicaid website which has pages dedicated to beneficiary information.[29] In addition, a list of primary care practitioners (PCPs) or medical homes and specialty providers is available with the online "Find a Doctor" feature.[30] Beneficiaries are informed of the online list of providers when they call the Contact Center for information about providers. Most Medicaid beneficiaries choose or are assigned a PCP upon enrollment into Medicaid. Medicaid contact information, PCP information, and LME-MCO information is displayed on the beneficiary's Medicaid card (example shown below).



Change in Medicaid Rate Methodology

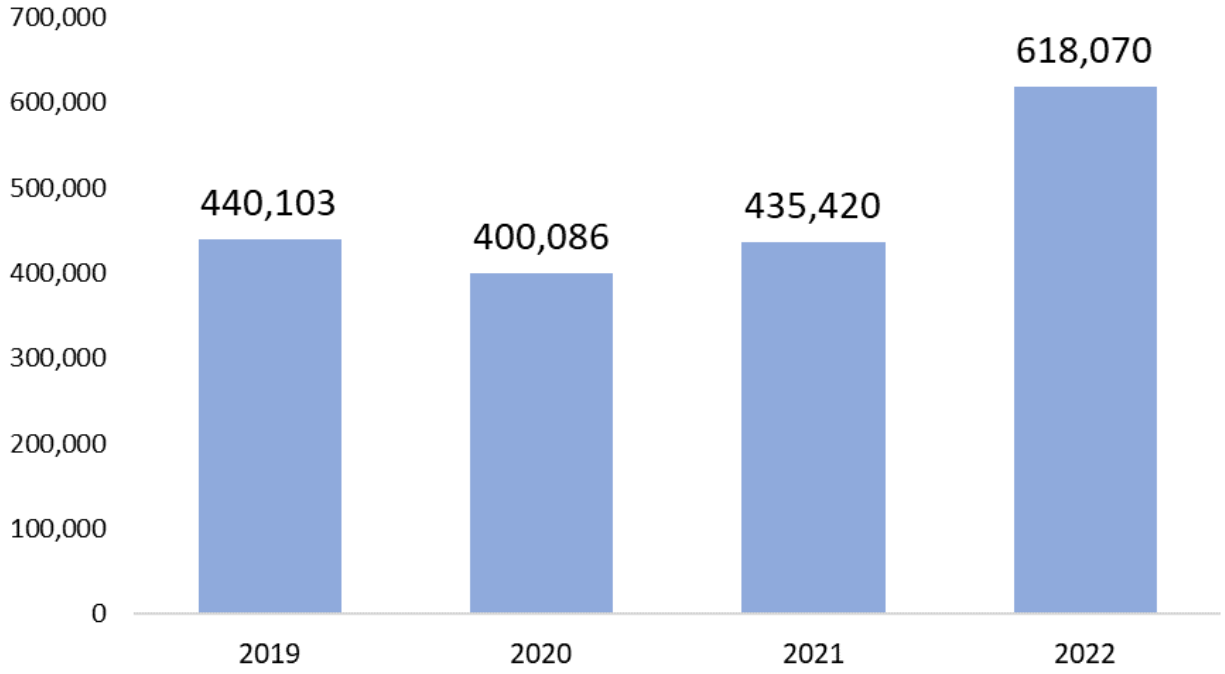
Rate floors are the established NC Medicaid Direct (fee-for-service) rate that SPs are required to reimburse Medicaid providers (no less than 100% of the applicable NC Medicaid Direct rate), unless the SP and provider mutually agree to an alternative reimbursement arrangement. The NC Medicaid provider rates have been stagnant since 2012, but it is priority for leadership of The Department to invest in updated rates.[31] The Medicaid Fee Schedule download site[32] has updated fee schedules and can be paired with the NC Medicaid Bulletins for additions, changes and deletions to these schedules. See Table 9 for Medicaid to Medicare comparisons of fee index.

Table 9: Medicaid-to-Medicare Fee Index (2019) [33]

State	All Services	Primary Care	Obstetric Care	Other Services
North Carolina	0.78	0.78	0.68	0.92

[29] NC Medicaid Beneficiary Portal. NC DHHS. Accessed 11.7.2023. https://medicaid.ncdhhs.gov/beneficiaries
[30] Find a Doctor. NC DHHS. Accessed 11.7.2023. https://medicaid.ncdhhs.gov/find-doctor
[31] For more detailed information, the Fee Schedule Archive contains all updates to the NC Medicaid Fee Schedules. Found here: https://medicaid.ncdhhs.gov/providers/fee-schedules-archive
[32] Fee Schedules. NC DHHS. Accessed 11.20.2023. https://medicaid.ncdhhs.gov/document-collection/fee-schedules
[33] https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22north-carolina%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Figure 7: Number of Patients Served by the NC DHHS Office of Rural Health Over Time (2019-2022)



Call Out: Rural Access to Health Services

For this Plan, NC Medicaid wanted to highlight the work of the NC DHHS Office of Rural Health (ORH), which supports equitable access to health in rural and underserved communities. This office has many programs, including placement services which works to recruit and retain primary care providers, dental professionals, and behavioral health providers to the rural and underserved areas of NC. Another program, the Rural Hospital Program, supports 12 Small Rural Hospitals and 20 Critical Access Hospitals (CAHs) by administering federal grants that improve their viability, quality of services, and integration with existing health care systems.[1] While these services are not exclusive to NC Medicaid Direct members, it is an important piece to include when discussing access to care for NC Medicaid beneficiaries.

The ORH has defined and currently tracks over 50 distinct performance measures to assist in the monitoring and evaluation of its programs as well as to enhance its ability to inform partners and grantees about progress regarding programs and selected services rendered. In March of 2022, 93 out of 100 counties in North Carolina had a population or geographic primary care health professional shortage area. In 2022, the ORH supported over 260 federally qualified health centers (FQHCs), 140 school based health centers, 86 rural health clinics, and 61 NC Statewide Telepsychiatry Program (NC-SteP) sites. The number of patients served by the ORH in NC has grown substantially between 2020 and 2022, reaching over 618,000 (see Figure 7). These efforts are essential in guaranteeing equitable and sufficient access to care.

Domain 2: Beneficiary Utilization

Context for Result Interpretation

When interpreting the results of this section it is critical to have three pieces of context.

1. The NC Medicaid Direct population has changed over the timeframe of this report, from 2019 to 2022. In 2021, NC Medicaid launched Standard Plans, and a significant portion of Medicaid Direct members moved over to these managed care health plans. This shifting population was made up of mostly children and pregnant women, leaving the NC Medicaid Direct member population older and, in some cases, more complex. Every analysis in this section provides a comparison across that point in time and is therefore affected by the drastic change in member demographics.
2. Quality measurement performance for preventive care measures, which make up the bulk of the measures presented in this report, is typically better for higher risk beneficiaries. This is likely because of their more frequent engagement with the healthcare system.
3. The report covers a timeframe that includes the COVID-19 pandemic, which drastically altered how patients seek and access healthcare. [34] During the pandemic there was an overall decline in health care utilization, which could partially explain decreases in certain utilization focused quality measure performance.

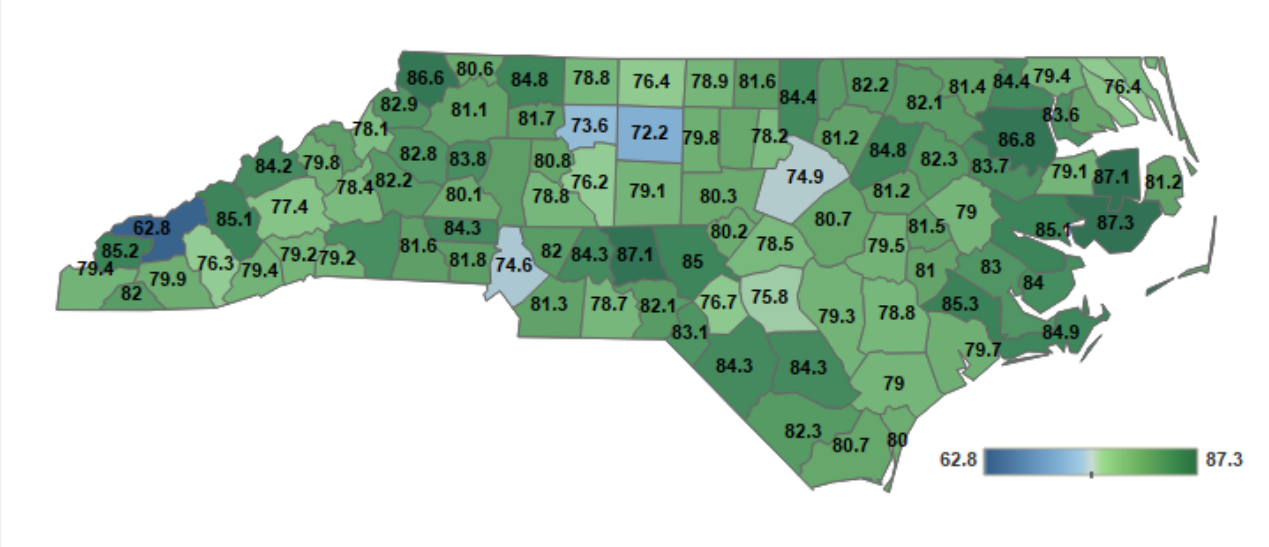
It is advised that readers keep this information in mind when interpreting NC Medicaid Direct's performance in this beneficiary utilization section.

[34] How Has Health Care Utilization Changed Since the Pandemic? Matt McGough, Krutika Amin, and Cynthia Cox. (2023) KFF. https://www.kff.org/coronavirus-covid-19/issue-brief/how-has-health-care-utilization-changed-since-the-pandemic/#:~:text=Early%20in%20the%20COVID%2D19,decline%20in%20health%20care%20utilization.

Adult Access to Primary Care

Primary care is critical for people's health and wellbeing, it focuses on people's needs early on the continuum of care including health promotion and disease prevention and serves as a usual source of care.[35] One indicator for access to primary care services is the rate of PCP visits. Between 2019 and 2021, certain counties had lower rates of adult Medicaid Direct members having a PCP visit within a 12-month period. Wake, Guilford, Forsyth, Mecklenburg, and Swain counties were among the counties with less than 75 percent of their Medicaid Direct members having a PCP visit within 12 months (see Figure 8).

Figure 8: Percentage of Adult Medicaid Direct Beneficiaries with a Primary Care Provider Visit Within 12 Months by County, (2019-2021)

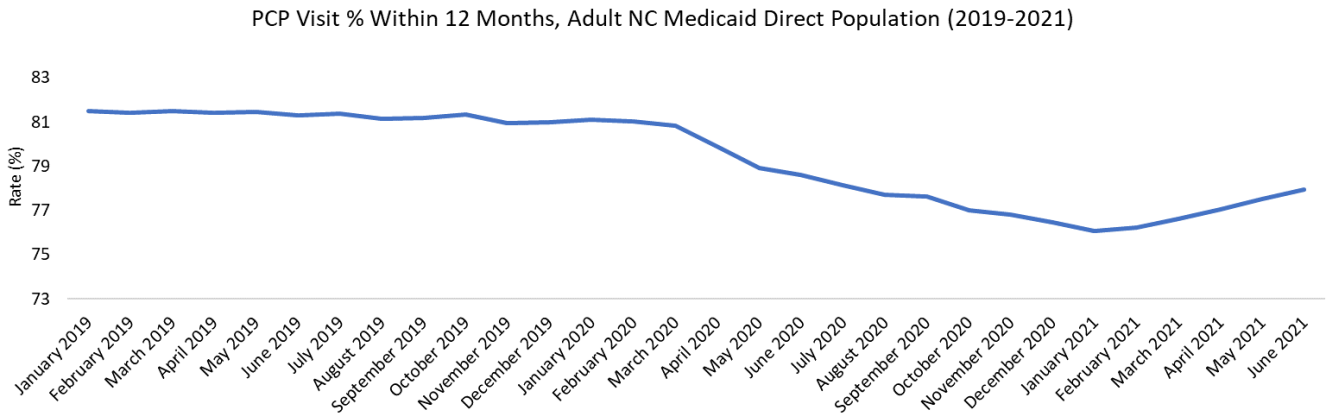


There was a decrease in PCP visits over time for the adult Medicaid Direct population. The largest drop in performance occurred between March 2020 and January 2021 (see Figure 9). This decrease in primary care utilization can be partially explained by the COVID-19 pandemic.[36]

[35] Access to Primary Care, (2023). Healthy People 2023. U.S. Department of Health and Human Services. https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-primary-care#:~:text=Primary%20care%20is%20critical%20for%20improving%20population%20health%20and%20reducing%20health%20disparities.&text=Therefore%2C%20addressing%20barriers%20to%20accessing,risk%20of%20poor%20health%20outcomes.

[36] How Has Health Care Utilization Changed Since the Pandemic? Matt McGough, Krutika Amin, and Cynthia Cox. (2023) KFF. https://www.kff.org/coronavirus-covid-19/issue-brief/how-has-health-care-utilization-changed-since-the-pandemic/#:~:text=Early%20in%20the%20COVID%2D19,decline%20in%20health%20care%20utilization.

Figure 9: Percentage of Adult Medicaid Direct Beneficiaries with a Primary Care Provider Visit Within 12 Months (2019-2021)



While the data above describe broad primary care utilization, it is important to look at national standard-of-care access and utilization measures to understand appropriate access. NC Medicaid Direct's historical performance for *Adults' Access to Preventive/Ambulatory Health Services (AAP)*, which is a part of the HEDIS Access/Availability of Care measure set, is provided in Figure 10. This measure captures the percentage of members 20-64 years who had an ambulatory or preventive care visit during the measurement year. The NC Medicaid Direct population performed just below the national average of Medicaid HMOs in 2019 and 2020 (See Figure 10). However, NC Medicaid Direct population performed slightly above the national average in 2021 (see Figure 10). The proportion of beneficiaries who had an ambulatory or preventive care visit decreased over this four-year period, with some variation across age cohorts, and in both urban and rural counties (see Figures 10-12). There has been around a four percent difference between urban and rural AAP rates for the NC Medicaid Direct population since 2019, with rural populations performing better than urban populations (see Figure 12). Between 2020 and 2022, the older age group, aged 45-64, accessed preventive/ambulatory health services at a higher frequency as compared with the 20–44-year-old age group (see Figure 11). However, it is important to note that the total eligible population in Medicaid Direct for this measure decreased from around 661,000 in 2020 to 434,000 in 2021, given the shift to managed care in North Carolina.

Figure 10: *Adults' Access to Preventive/Ambulatory Health Services (AAP)* Performance for the NC Medicaid Direct Population Compared to the National Average of Other State Medicaid Agencies (2019-2022)

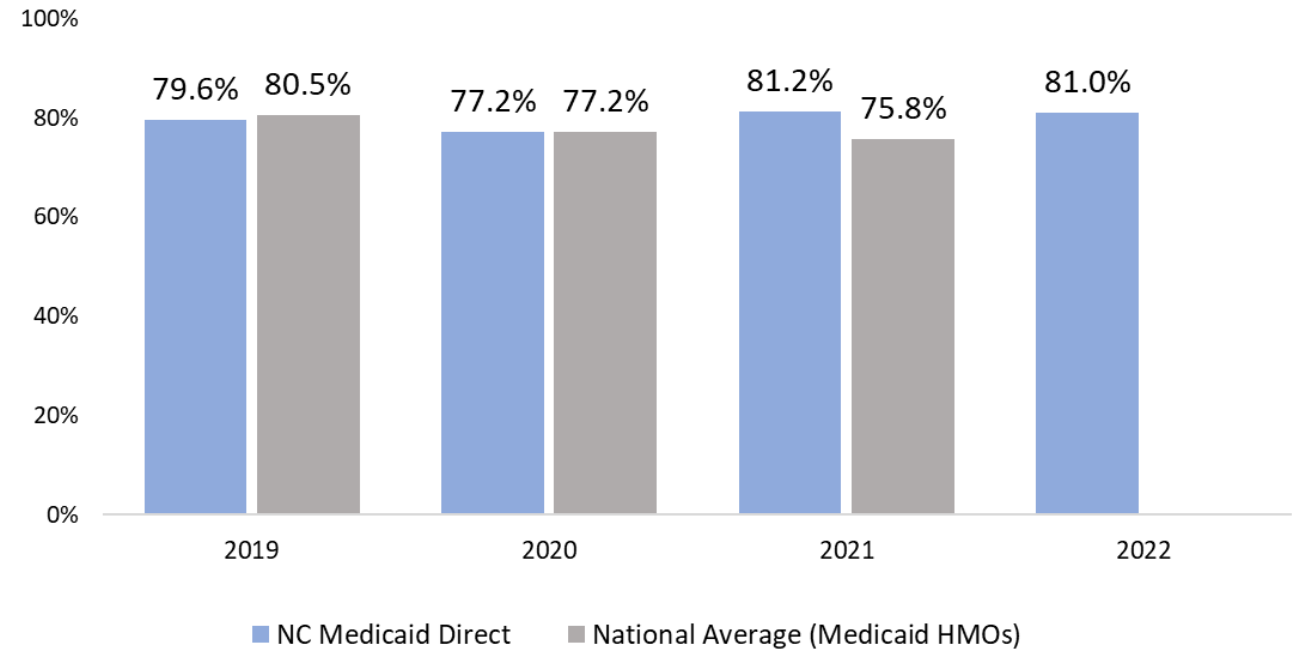


Figure 11: *Adults' Access to Preventive/Ambulatory Health Services (AAP)* Performance for the NC Medicaid Direct Population by Age Group (2012-2022)

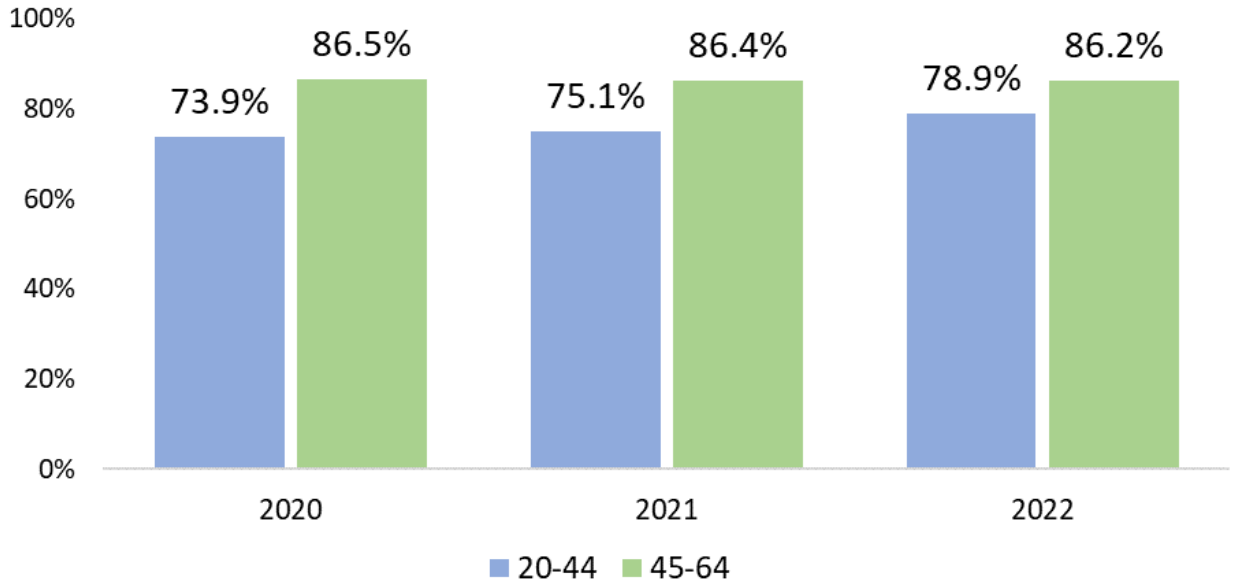
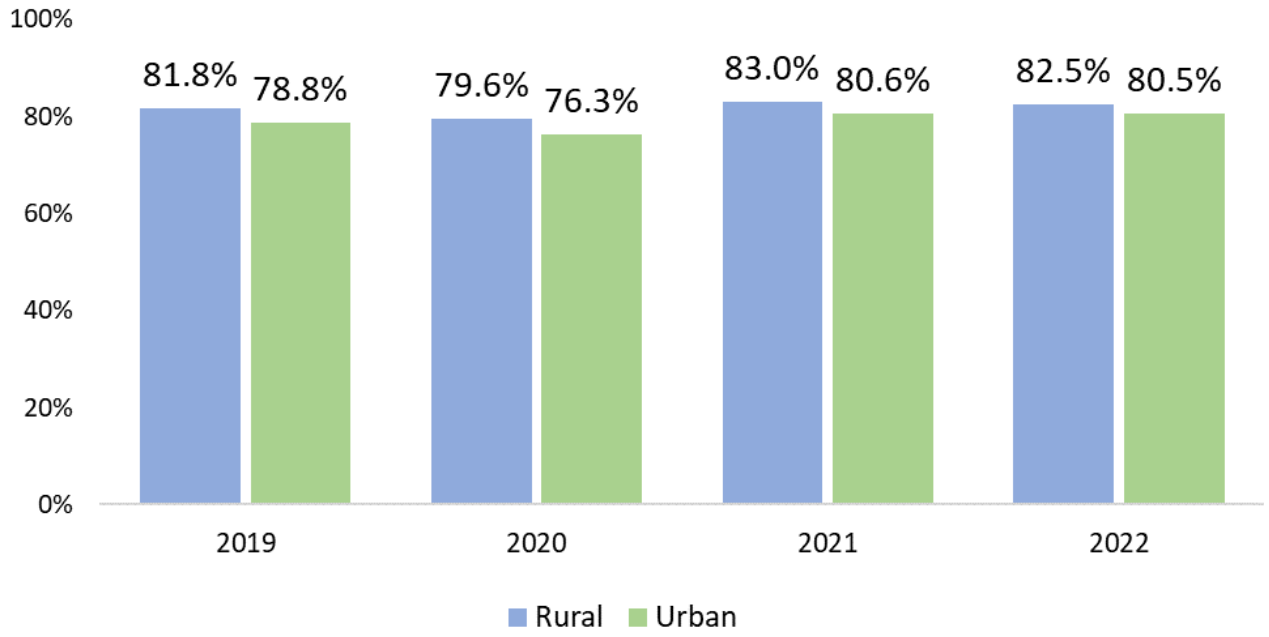


Figure 12: *Adults' Access to Preventive/Ambulatory Health Services (AAP)* Performance for the NC Medicaid Direct Population, By Geography, Rural vs. Urban (2019-2022)



Note: Approximately 500 members who were eligible for this measure for CY-2019 & CY-2020 had an out of state address that was not classified as rural or urban. These individuals were excluded from the analysis.

Child and Adolescent Access to Primary Care

As of 2021, about 84 percent of the state's Medicaid beneficiaries were either women of all ages or children under the age of 21.[37] Given the size of these populations, women and children's health over the life course is critical to the overall health of NC Medicaid's population.

In the spring of 2023, approximately 60,000 children enrolled in the NC Health Choice program moved to Medicaid and began receiving additional physical and behavioral health services. Families with children that moved from NC Health Choice to Medicaid no longer were required to pay enrollment fees or copays for medical visits and prescriptions.[38] They were also eligible for assistance getting to and from medical appointments through non-emergency medical transportation services and had access to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits.

For children and adolescents, access to primary care is particularly important, as consistent well-visits allow providers to monitor growth and development at regular intervals. Figures 13-15 provide NC

[37] NC Medicaid member level enrollment data, 2021. Dashboard: https://medicaid.ncdhhs.gov/reports/dashboards/enrollment-dashboard

[38] Medicaid & NC Health Choice. Annual Report for State Fiscal Year 2022. https://medicaid.ncdhhs.gov/ncmedicaid-annual-report-sfy2022/download?attachment

Medicaid Direct's performance on two measures of well-visits: *Well-Child Visits in the First 30 Months of Life* (W30) and *Child and Adolescent Well-Care Visits* (WCV).

Well-Child Visits in the First 30 Months of Life (W30) has two submeasures. The first assesses children who turned 15 months old during the measurement year and had at least six well-child visits with a PCP during their first 15 months of life. The second assesses children who turned 30 months old during the measurement year and had at least two well-child visits with a PCP in the last 15 months. For both of W30's submeasures NC Medicaid Direct's population has performed close to or above the national average for Medicaid HMOs since 2020 (see Figures 13 and 14). For 2019 only data for the first 15 months is available, as the measure was known as *Well-Child Visits in the First 15 Months of Life (W15*) prior to measurement year 2020.

Figure 13: *Well-Child Visits in the First 30 Months of Life (W30):* First 15 Months, Historical Performance for the NC Medicaid Direct Population Compared to the National Average of Other State Medicaid Agencies (2019-2022)

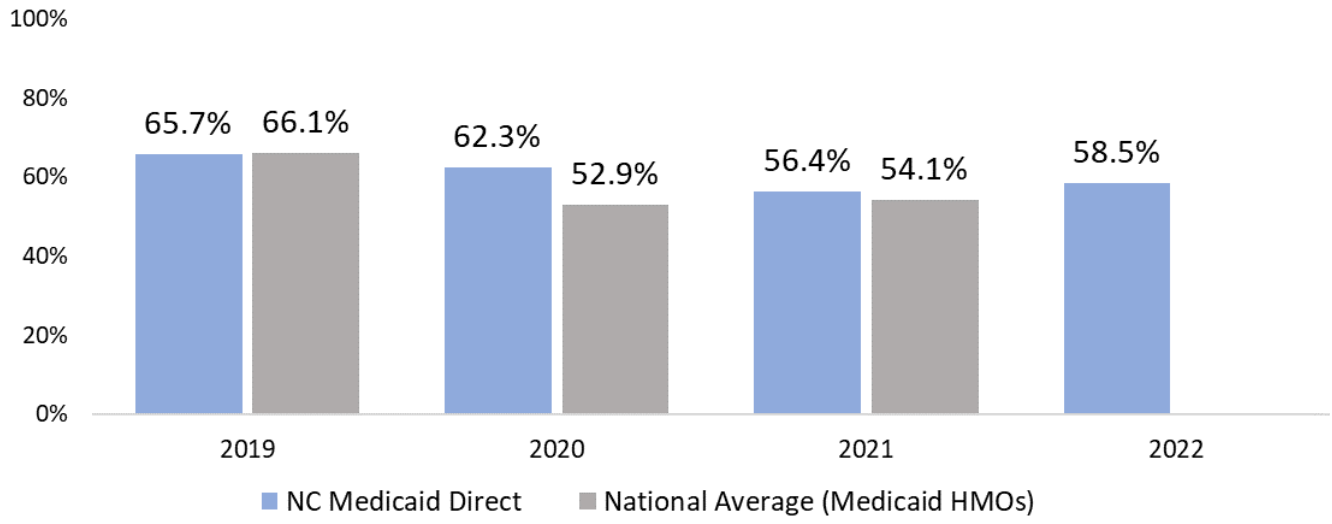
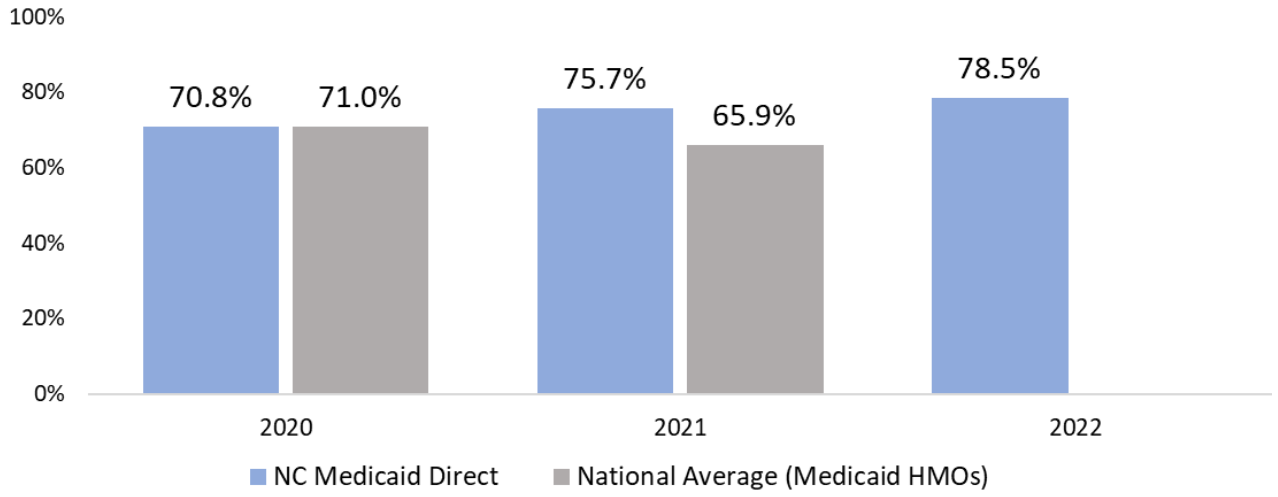
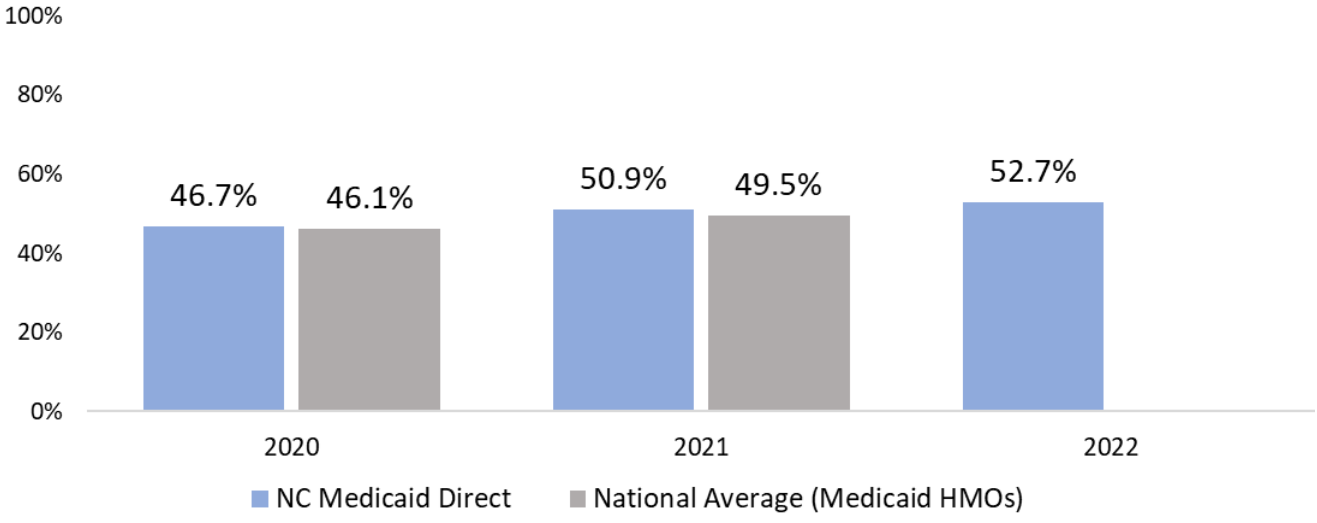


Figure 14: *Well-Child Visits in the First 30 Months of Life (W30):* 15-30 Months, Historical Performance for the NC Medicaid Direct Population Compared to the National Average of Other State Medicaid Agencies (2019-2022)



Child and Adolescent Well-Care Visits (WCV), assesses children three–21 years of age who received one or more well-care visit with a PCP or an Obstetrics and Gynecology (OB/GYN) practitioner during the measurement year. WCV was a new measure in HEDIS MY 2020 to combine two previous measures: *Well-Child Visits in the Third, Fourth, Fifth, and Sixth years of Life (W34, WCV)* and *Adolescent Well-Care Visits (AWC).* Since 2020, the NC Medicaid Direct's population performance has been comparable to the national average for Medicaid HMOs (see Figure 15).

Figure 15: *Child and Adolescent Well-Care Visits (WCV)* Historical Performance for the NC Medicaid Direct Population Compared to the National Average of Other State Medicaid Agencies (2020-2022)



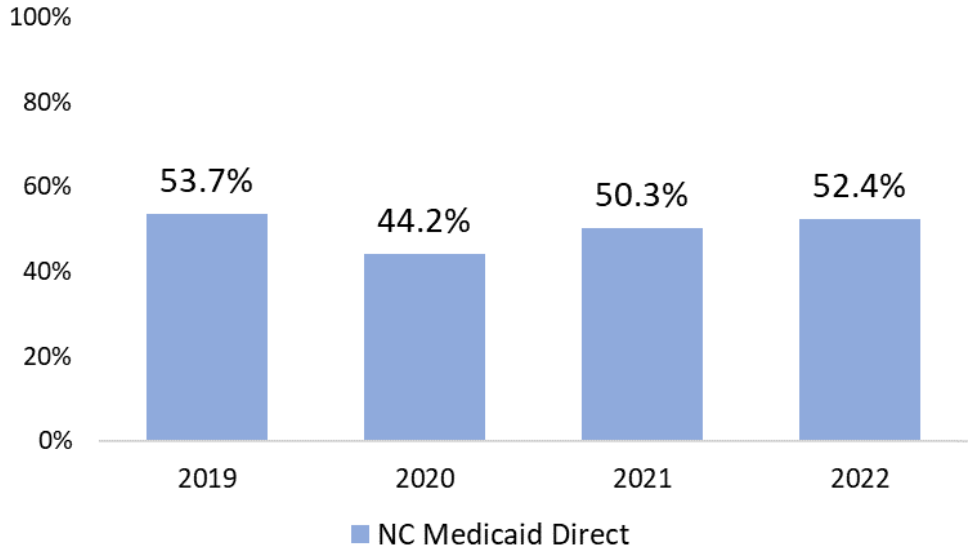
Access to Dental Services

Specific dental services are provided to Medicaid beneficiaries of all ages in most eligibility categories per defined Dental Services Clinical Coverage Policy. Dental services are carved out services and are still paid for under the fee-for-service model for all beneficiaries, even those in managed care.[39] The number of dentists who actively participate in Medicaid is 2,585.

Prevailing rates for the Top 10 Covered Dental Services by Expenditure are all below 50% of the 2023 National Dental Advisory Service (NDAS) 50% market-based benchmark. For example, the NC rate for a periodic oral evaluation is $26.96, and the NDAS 50% Median rate is $65. Expenditures on the Top 10 Covered Dental Services make up about 47% of total dental expenditures. Since 2016, NC Medicaid has only had one reimbursement rate increase—a 10% across the board rate increase for all covered services implemented on January 1st, 2019.

Oral Evaluation, Dental Services (OEV-CH) is a Dental Quality Alliance (DQA) measure added to the 2024 Child Core Set measure set. OEV-CH assesses the percentage of children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year. NC Medicaid performance has fluctuated over time, with a decrease in performance in 2020 (see Figure 16). This trend aligns with the national trends reflecting the negative impact COVID-19 had on dental care utilization.[40] OEV also varies by age group, with children aged six through seven years of age having the highest utilization (see Figure 17). The same utilization trends occur in other state Medicaid dental programs. There is also a slight difference in member utilization depending on urban or rural status, with urban members accessing such services more frequently than those living in rural areas (see Figure 18).

Figure 16: *Oral Evaluation, Dental Services (OEV-CH),* NC Medicaid Direct Population, (2019-2022)



[39] More information on dental coverage for NC Medicaid visit the programs and services page here: https://medicaid.ncdhhs.gov/providers/programs-and-services/dental-and-orthodontic

[40] Choi SE, Mo E, Sima C, Wu H, Thakkar-Samtani M, Tranby EP, Frantsve-Hawley J, Barrow JR. Impact of COVID-19 on Dental Care Utilization and Oral Health Conditions in the United States. JDR Clin Trans Res. 2023 Apr 21:23800844231165016. doi: 10.1177/23800844231165016. Epub ahead of print. PMID: 37082861; PMCID: PMC10125887.

Figure 17: *Oral Evaluation, Dental Services (OEV-CH),* NC Medicaid Direct Population (2022), by Age Group

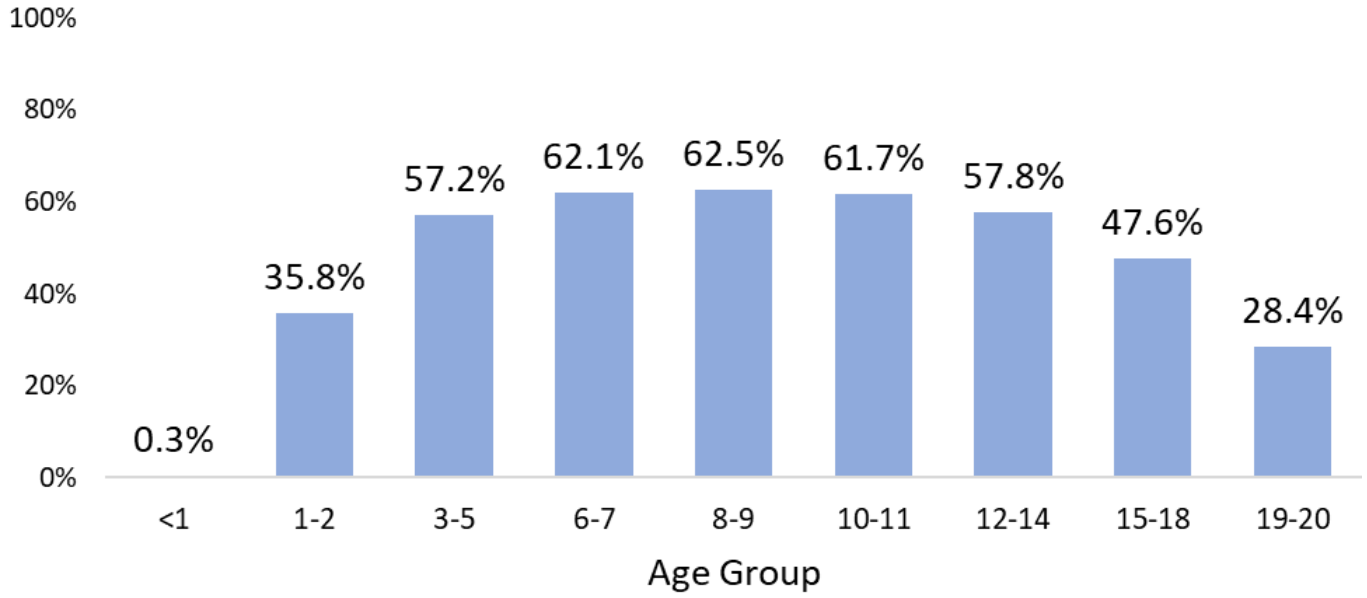
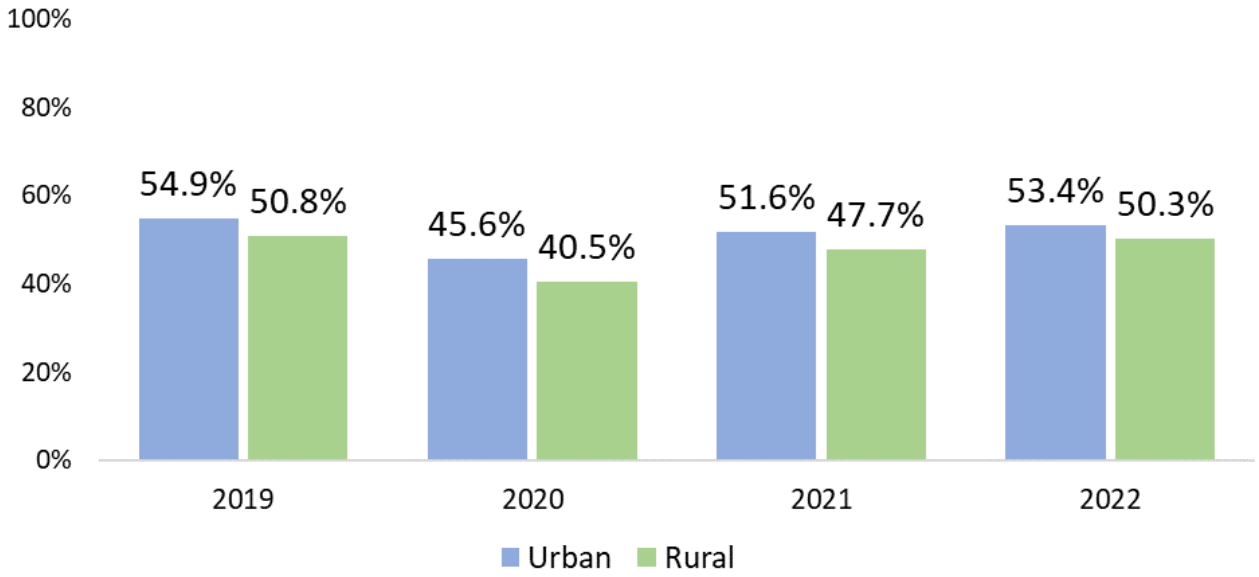


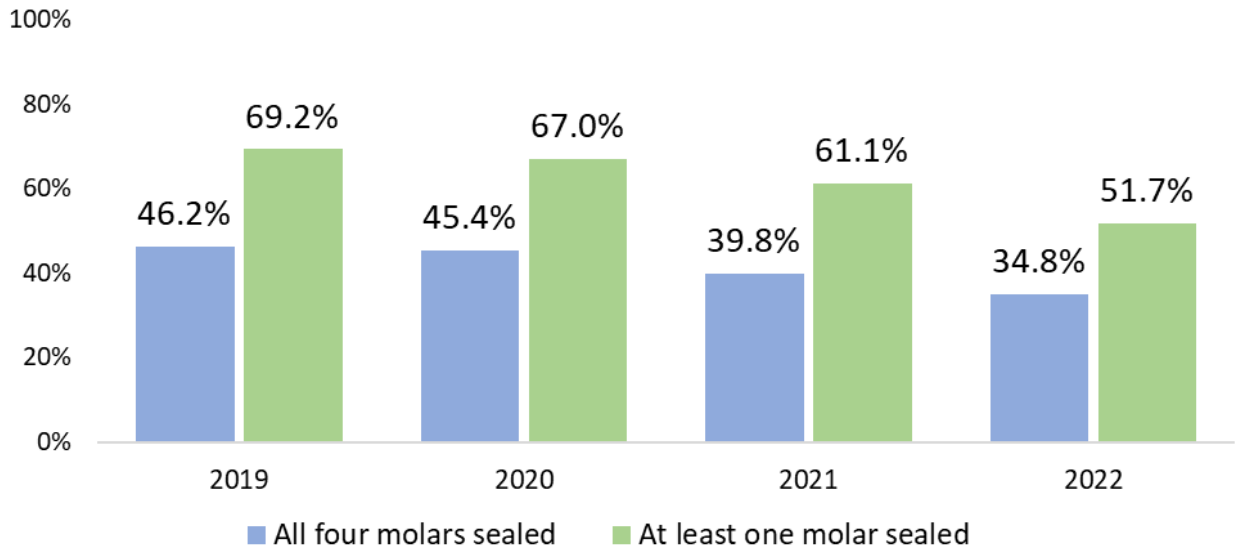
Figure 18: *Oral Evaluation, Dental Services (OEV-CH),* NC Medicaid Direct Population, Geographic Analysis (2019-2022)



Note: Approximately 5,000 members who were eligible for this measure for CY-2019 and CY-2020 had an out of state address that was not classified as rural or urban. These individuals were excluded from the analysis.

Sealant receipt on permanent first molars (SFM) is a quality measure developed by the Dental Quality Alliance. It assesses the percentage of enrolled children who have received sealants on permanent first molar teeth: at least one sealant and all four molars sealed by their 10th birthdate. NC Medicaid had seen a decline in performance for this measure since 2019 (see Figure 19).

Figure 19: *Sealant Receipt on Permanent Fist Molars (SFM),* NC Medicaid Direct Population, (2019-2022)



Access to Behavioral Health Services

NC Medicaid has focused on the integration of behavioral and physical health care through the promotion of adolescent, maternal, and social/emotional screenings and increasing provider support for the appropriate management of depression and other behavioral health conditions.[41]

NC Medicaid tracks measures of standard-of-care utilization specific to behavioral health and substance use disorder (SUD) services. The HEDIS measure *Initiation and Engagement of Substance Use Disorder Treatment (IET)* is an important indicator of access/availability of care.[42] This measure captures the percentage of adolescent and adult members with a new episode of alcohol or other drug abuse or dependence who received initiation of SUD treatment within 14 days of diagnosis, and among those, the percentage that had remained engaged with treatment (had two or more additional services or medication treatment within 34 days). The NC Medicaid Direct population performs slightly better than the national average for Medicaid HMOs for both submeasures in 2019 and 2021 (see Figures 20 and 21). Overall, the NC Medicaid Direct population has superior performance on the initiation submeasure as compared with the engagement submeasure, indicating a need for continued engagement with members in SUD treatment (see Figures 20 and 21). Between 2019 and 2022, NC Medicaid Direct population 's performance on both submeasures increased, which could be a promising indicator of improved access to SUD treatment services or a product of the younger beneficiary population moving to Standard Plans in 2021 (see Figures 20 and 21).

[41] NC Medicaid has also focused on integrating care through integrated health plans, Tailored Care Management, and collaborative care models. Learn more here: https://medicaid.ncdhhs.gov/blog/2022/12/15/nc-medicaid-enhancements-integrated-physical-and-behavioral-health

[42] This measure was revised from *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment* in HEDIS MY 2022.

Figure 20: *Initiation and Engagement of Substance Use Disorder Treatment (IET)*: Initiation of Treatment, Historical Performance for the NC Medicaid Direct Population Compared to the National Average of Other State Medicaid Agencies (2019-2022)

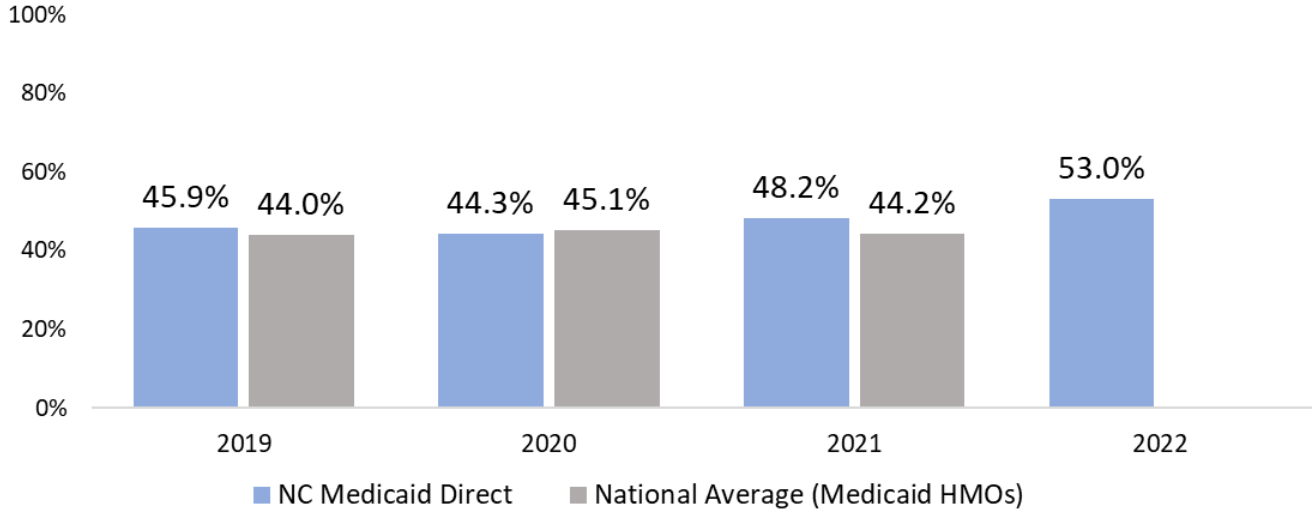
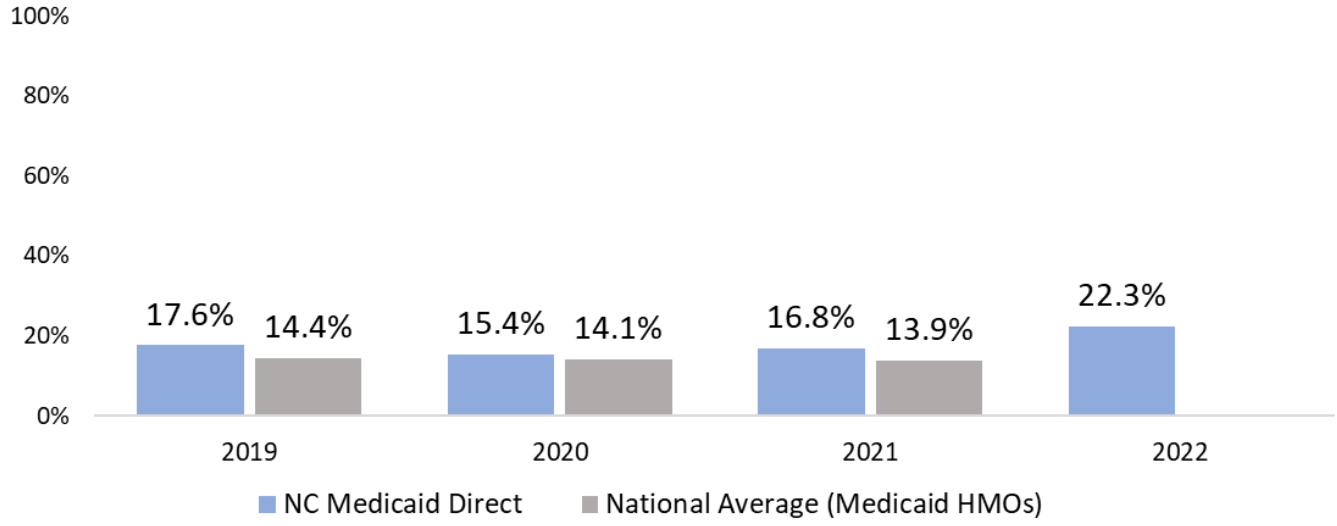


Figure 21: *Initiation and Engagement of Substance Use Disorder Treatment (IET)*: Engagement of Treatment, Historical Performance for the NC Medicaid Direct Population Compared to the National Average of Other State Medicaid Agencies (2019-2022)



The HEDIS measure *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD*) assesses the percentage of children newly prescribed ADHD medication who had a follow-up visit with a practitioner with prescribing authority within 30 days (Initiation Phase), and who remained on the medication for at least 210 days and had an additional two visits within the nine months after the initiation phase (Continuation and Maintenance Phase). The Medicaid Direct population has been performing above the national average for Medicaid HMOs since 2019 in both submeasures (see Figures 22 and 23). This performance is a bright spot for NC Medicaid, highlighting high levels of monitoring and access to healthcare for children diagnosed with ADHD.

Figure 22: *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)*: Initiation Phase, Historical Performance of NC Medicaid Direct Compared to the National Average of Other State Medicaid Agencies (2019-2022)

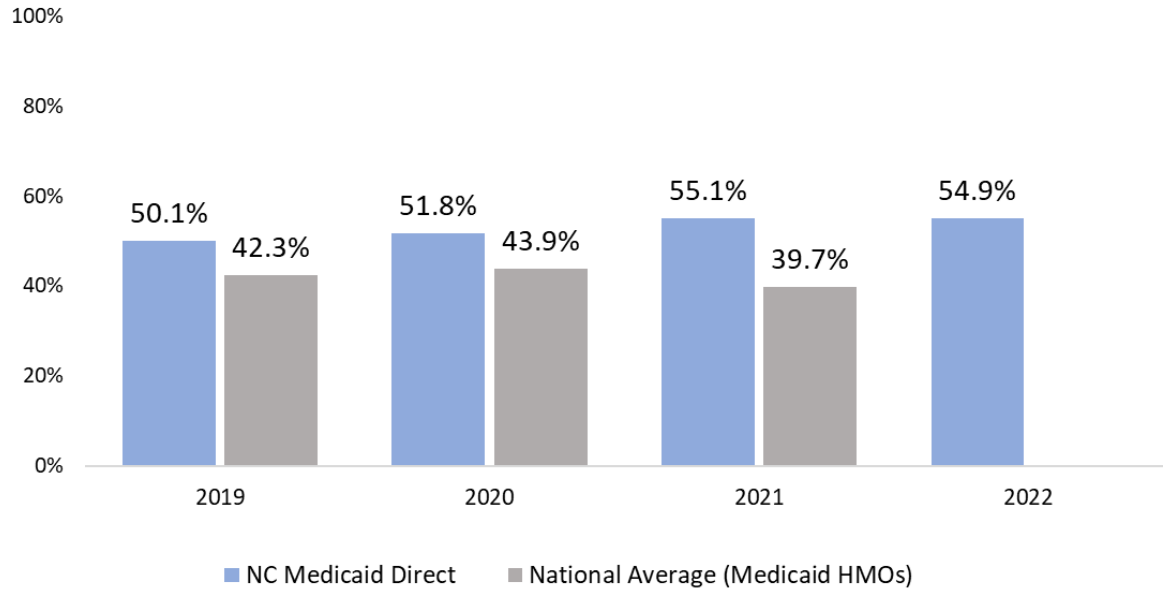
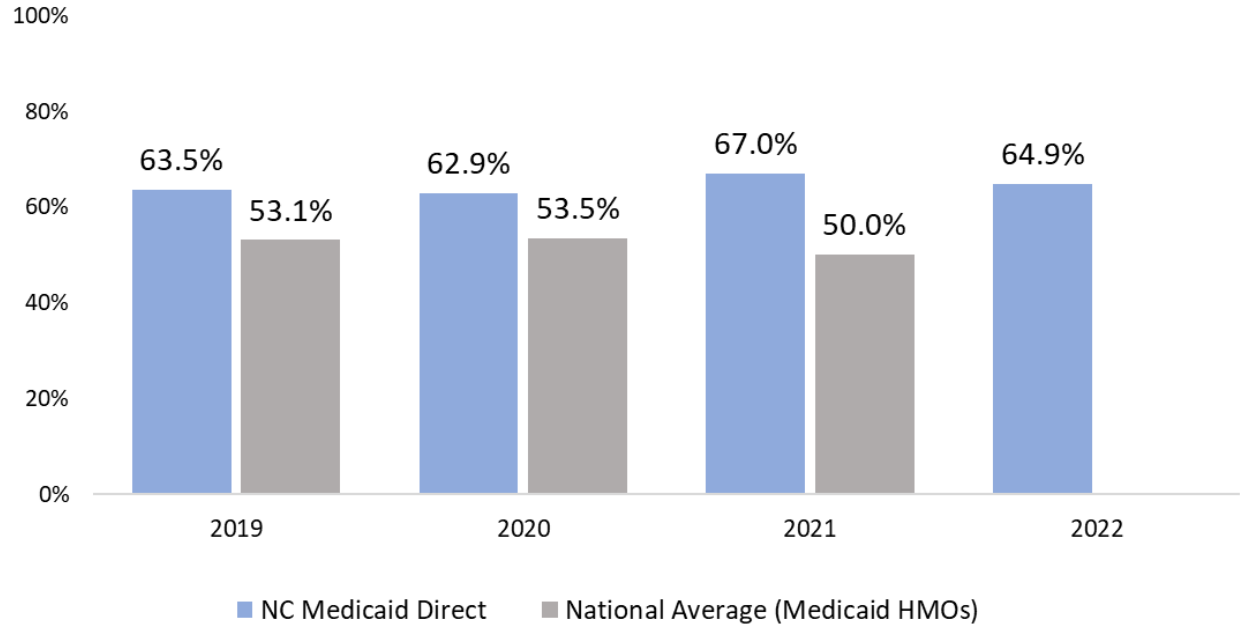
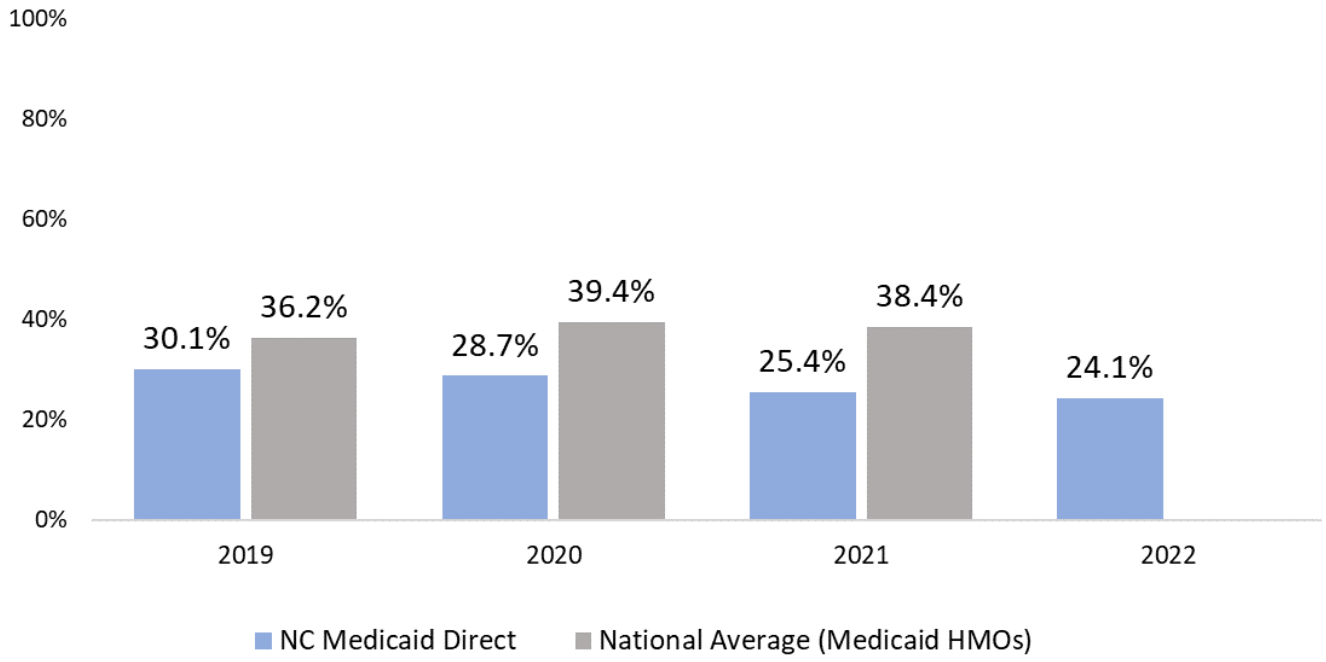


Figure 23: *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)*: Continuation Phase, Historical Performance of NC Medicaid Direct Compared to the National Average of Other State Medicaid Agencies (2019-2022)



Individuals with behavioral health needs or SUD require care management services that coordinate care between both physical and behavioral health providers. Care management ensures that each type of provider is aware of and responsive to individuals' full range of needs. For individuals who are hospitalized for mental illness, follow-up services are critical for monitoring mental wellbeing, detecting potential medication problems, and preventing readmissions.[43] *Follow-Up After Hospitalization for Mental Illness (FUH)* captures the percentage of beneficiaries six years and older who were hospitalized for treatment of mental illness and received a follow-up visit with a mental health practitioner within seven and 30 days of discharge. The NC Medicaid Direct population has performed below the national average for Medicaid HMOs for both submeasures since 2019 (see Figures 24 and 25). NC Medicaid's total population also performs below the national average for these measures. This may be explained, in part, by the behavioral health workforce shortages across the state.[44] NC Medicaid's performance on the FUH measure may be offset by individuals receiving support in other ways not captured in the measure's technical specifications.

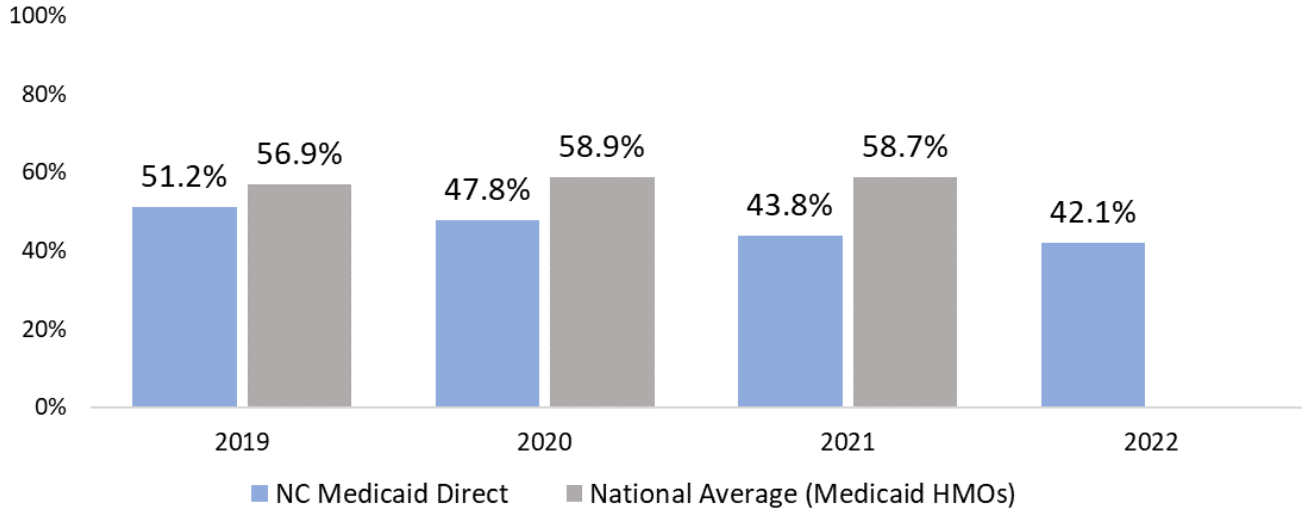
Figure 24: *Follow-Up After Hospitalization for Mental Illness (FUH)*: Follow-Up Within 7 Days Post Discharge, Historical Performance of NC Medicaid Direct Compared to the National Average of Other State Medicaid Agencies (2019-2022)



[43] Barekatain M, Maracy MR, Rajabi F, Baratian H. (2014). Aftercare services for patients with severe mental disorder: A randomized controlled trial. J Res Med Sci. 19(3):240-5.

[44] Brianna Lombardi and Paul Lanier. Responding to North Carolina's Behavioral Health Workforce Crisis. October 2023. https://carolinaacross100.unc.edu/responding-to-north-carolinas-behavioral-health-workforce-crisis/#:~:text=Meanwhile%2C%20the%20chronic%20shortage%20of,mental%20health%20professional%20shortage%20area .

Figure 25: *Follow-Up After Hospitalization for Mental Illness (FUH)*: Follow-Up Within 30-Days Post Discharge, Historical Performance of NC Medicaid Direct Compared to the National Average of Other State Medicaid Agencies (2019-2022)

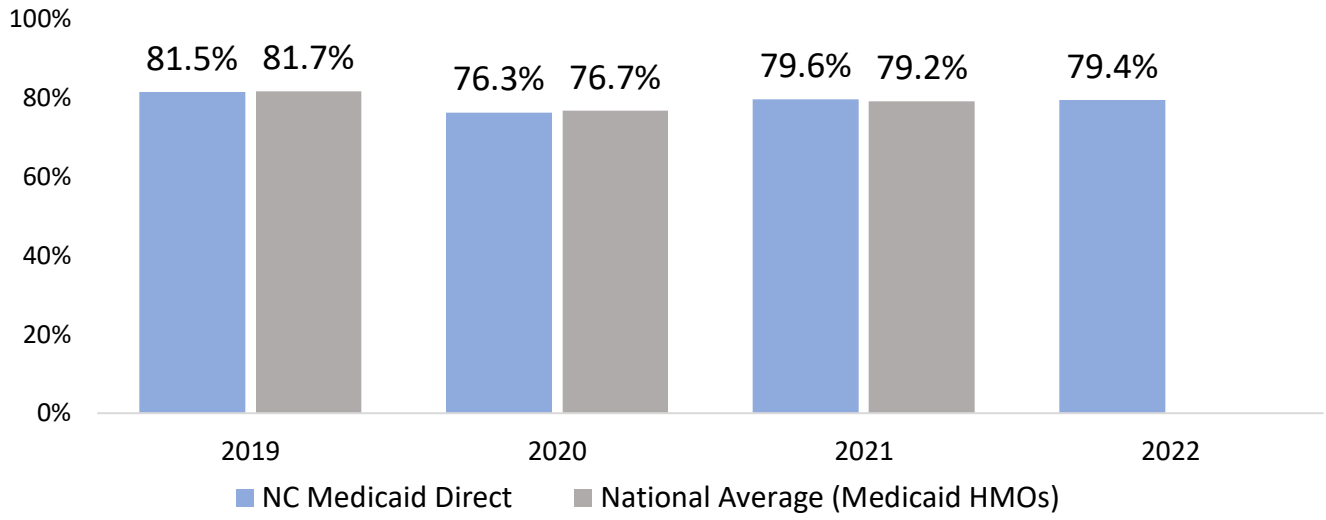


In 2021, 11 percent of adults in NC Medicaid were diagnosed with diabetes compared to 9 percent of North Carolina adults with other health insurance.[45] The prevalence of diabetes is even higher among individuals with schizophrenia, and antipsychotic treatments for schizophrenia can impair glucose regulation, increasing diabetes risk or, for current diabetics, worsening glycemic control.[46] Given this increased risk, regular diabetes screening for individuals with schizophrenia is particularly important. *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* measures the proportion of 18 to 64-year-olds with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and received a diabetes screening during the measurement year. NC Medicaid Direct's population's performance is similar to the national average for Medicaid HMOs since 2019 (see Figure 26). There was around a five percent decrease in both the national average and NC Medicaid Direct performance in 2020, potentially due to the COVID-19 pandemic and its impact on in-person healthcare utilization (see Figure 26).

[45] BRFSS Report: Medicaid, Final 2021. North Carolina Department of Health and Human Services. Accessed May 23, 2023. https://schs.dph.ncdhhs.gov/data/brfss/medicaid/docs/Medicaid-2021-TABLES-FINAL.pdf

[46] North Carolina Center for Health Statistics, https://schs.dph.ncdhhs.gov/data/brfss/medicaid/docs/Medicaid_2018_tables.pdf, 2018.

Figure 26*: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*, Historical Performance of NC Medicaid Direct Compared to the National Average of Other State Medicaid Agencies (2019-2022)



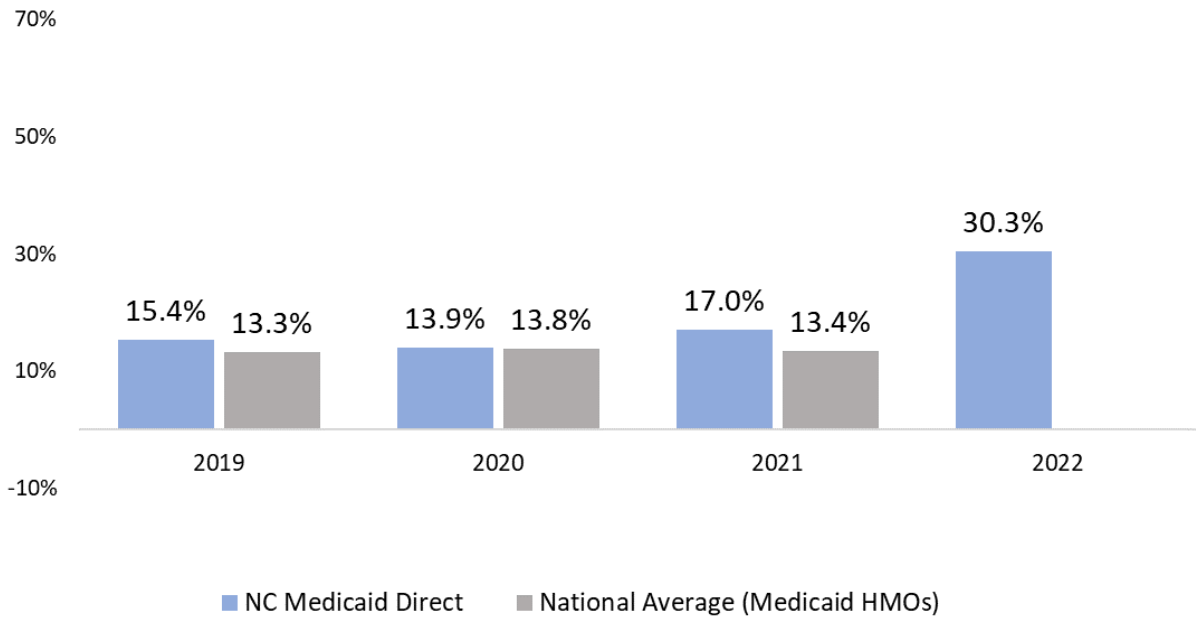
High emergency department (ED) use for individuals with SUD may signal a lack of access to care or issues with continuity of care.[47] Given this increased risk, it is important to monitor the care provided to those diagnosed with SUD. *Follow-Up After Emergency Department Visit for Substance Use (FUA)* measures emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of SUD or any diagnosis of unintentional drug overdose, with a follow-up visit.[48] Two rates are reported: the percentage of ED visits for which the member received a follow-up within seven days of the ED visit, and the percentage of ED visits for which the member received follow-up within 30 days of the ED visit. Between 2019 and 2022, NC Medicaid Direct's performance in FUA increased for both 7 Day and 30 Day submeasures, with the largest increase in performance happening between 2021 and 2022 (see Figures 27 and 28). This increase could be due, in part, to the changes made to the measure's technical specifications in 2022. HEDIS expanded FUA's denominator to include unintentional overdose in "any" diagnosis position and expanded the numerator to include pharmacotherapy and outpatient or telehealth visits.[49] NC Medicaid Direct performed at levels similar to the average of other state Medicaid programs for both submeasures from 2019 through 2021 (see Figures 27 and 28).

[47] New England Health Care Institute (NEHI). 2010. "A Matter of Urgency: Reducing Emergency Department Overuse, A NEHI Research Brief." Available from URL: http://www.nehi.net/writable/publication_files/file/nehi_ed_overuse_issue_brief_032610finaledits.pdf.

[48] This measure name was revised from *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* in HEDIS MY 2022.

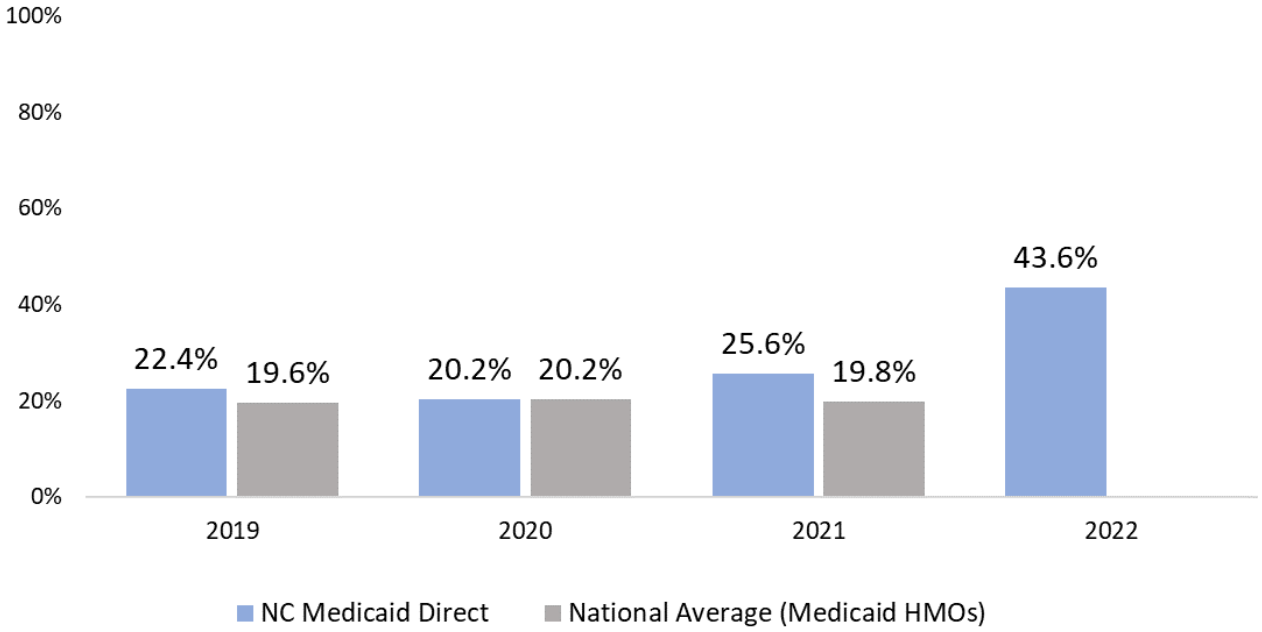
[49] HEDIS 2022: See What's New, What's Changed, and What's Retired. NCQA. August, 2021. https://www.ncqa.org/blog/hedis-2022-see-whats-new-whats-changed-and-whats-retired/

Figure 27: *Follow-Up After Emergency Department Visit for Substance Use (FUA):* 7-Day Follow-Up, Historical Performance of NC Medicaid Direct Compared to the National Average of Other State Medicaid Agencies (2019-2022)



Note: Y-axis has been adjusted for easier viewing

Figure 28: *Follow-Up After Emergency Department Visit for Substance Use (FUA):* 30-Day Follow-Up, Historical Performance of NC Medicaid Direct Compared to the National Average of Other State Medicaid Agencies (2019-2022)

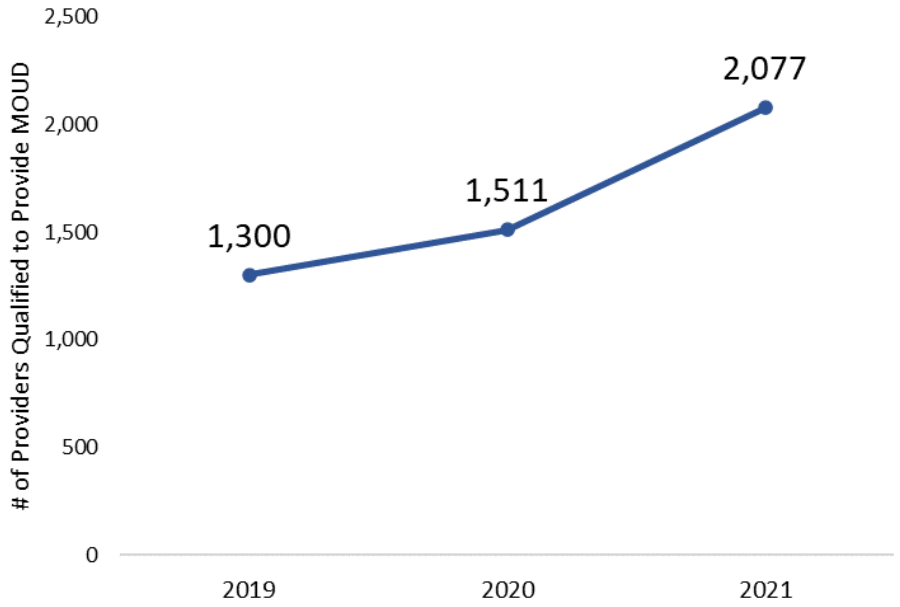


Access to SUD Specialist Care

Access to SUD services has been a priority for the Department in recent years. On October 24, 2018, the CMS approved North Carolina's 1115 Demonstration Waiver application, effective January 1, 2019, through October 31, 2024. The 1115 waiver is a part of a comprehensive strategy to decrease the long-term use of opioids and increase the use of MAT and other opioid treatment services, the waiver helps by providing Medicaid coverage for individuals obtaining short-term residential services for SUD in an institution for mental disease (IMD).

The Department originally published North Carolina's opioid and substance use action plan (OSUAP) in 2017 and updated it in 2019 and 2021.[50] North Carolina's OSUAP 3.0 includes a broadened focus on polysubstance use as well as centering equity and lived experiences. This plan ensures that the strategies that address the overdose epidemic will be led by those closest to the issue and aims to increase the number of waivered providers that are prescribing medications for opioid use disorder (MOUD), including through technical assistance and training opportunities. Since 2018, the number of providers enrolled in NC Medicaid and qualified to provide MOUD has increased significantly (see Figure 29).

Figure 29: Number of Providers Enrolled in NC Medicaid and Qualified to Provide Medication for Opioid Use Disorder (MOUD) (2019-2021)



Access to Maternal Health Services

NC Medicaid beneficiaries account for more than 54 percent of all deliveries in North Carolina.[51] NC Medicaid has a collection of programs that support birthing people. In 2011, NC Medicaid established the Pregnancy Medical Home (PMH) program, which provided pregnant recipients with comprehensive and coordinated perinatal care and care management services to high-risk patients. When managed care launched in 2021, the names of programs for pregnant women changed to distinguish fee-for-service

[50] North Carolina's opioid and substance use action plan (OSUAP) 3.0 (2021). https://www.ncdhhs.gov/nc-osuapopioid-and-substance-use-action-plan-3010192021/download?attachment

[51] The 54 percent stated here includes 6.2 percent of births that were covered by emergency Medicaid but did not have access to prenatal care through Medicaid https://schs.dph.ncdhhs.gov/schs/births/matched/2019/2019-Births-Overall.html.

programs from managed care programs. NC Medicaid transitioned the PMH program to the Pregnancy Management Program (PMP) to account for the role of the SPs. PMP offers similar coordinated maternity care services, focusing on preventing preterm births. The Care Management for High-Risk Pregnancies (CMHRP) program also began in 2021 and offers care management services through local health departments (LHDs). This program uses a pregnancy risk screening tool to identify Medicaid recipients at risk for adverse birth outcomes.

The Department also continues its partnership with the University of North Carolina at Chapel Hill's Perinatal Quality Collaborative of North Carolina (PQCNC). In the past several years, PQCNC has identified key opportunities for improvement to hospital and community-based perinatal care and has executed time-limited statewide quality initiatives to capitalize on these opportunities. Care for pregnant women experiencing opioid use disorder and their infants has been an ongoing area of PQCNC focus. The Department continues to partner with PQCNC to share best practices, promote health equity, reduce unnecessary variations in care, encourage partnership with families and patients, and optimize resources.

Women's preconception, interconception, and maternal care is essential to improving women and children's health and birth outcomes. Health care visits prior to and early in pregnancy help promote safe deliveries and address potential risks for both mothers and babies. Similarly, health care visits in the weeks after delivery allow providers to screen for and treat potential postpartum care needs, such as postpartum depression or physical complications.

Per state legislation and the American Rescue Plan Act of 2021, North Carolina extended Medicaid postpartum health care coverage from 60 days to 12 months beginning April 1, 2022. Beneficiaries who gave birth between February 1, 2022, and March 31, 2022, also became eligible for 12 months of continuous postpartum coverage. Additionally, the Medicaid for Pregnant Women (MPW) program was improved to provide full coverage Medicaid benefits for the duration of pregnancy through the end of the aforementioned 12-month postpartum period.[52]

To assess access to pre- and post-natal obstetric services, NC Medicaid leverages the *Prenatal and Postpartum Care (PPC)* measure. This measure includes two submeasures: Timeliness of Prenatal Care and Postpartum Care. Timeliness of Prenatal Care assesses the percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. Postpartum Care assesses the percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery.

As shown in Figures 30 and 31, NC Medicaid Direct's performance for Timeliness of Prenatal Care has improved over time, while performance for Postpartum Care has decreased. Performance in both submeasures is markedly below the national average for state Medicaid agencies. While this low performance is an opportunity for NC to improve, it is also an opportunity to assess the accuracy and completeness of prenatal and postpartum care administrative data. Provider and practice engagement revealed that prenatal and postpartum related services are often recorded using global billing codes. Global billing codes for pregnancy related services are not billed until the end of the pregnancy. This means the first instance of prenatal care and subsequent postpartum care are often not adequately

[52] Medicaid & NC Health Choice. Annual Report for State Fiscal Year 2022. https://medicaid.ncdhhs.gov/ncmedicaid-annual-report-sfy2022/download?attachment

captured in claims and encounters data. To support more complete and accurate data, two new F codes will be added to NC Medicaid's clinical policy in 2023 (revision of NC Medicaid Obstetrical Services Clinical Coverage Policy, No: 1E-5). The two F codes include 0500F for Initial Prenatal Visits and 0503F for Postpartum Care Visits.

Figure 30: *Prenatal and Postpartum Care (PPC):* Timeliness of Prenatal Care, Historical Performance NC Medicaid Direct Population Compared to the National Average of Other State Medicaid Agencies (2019-2022)

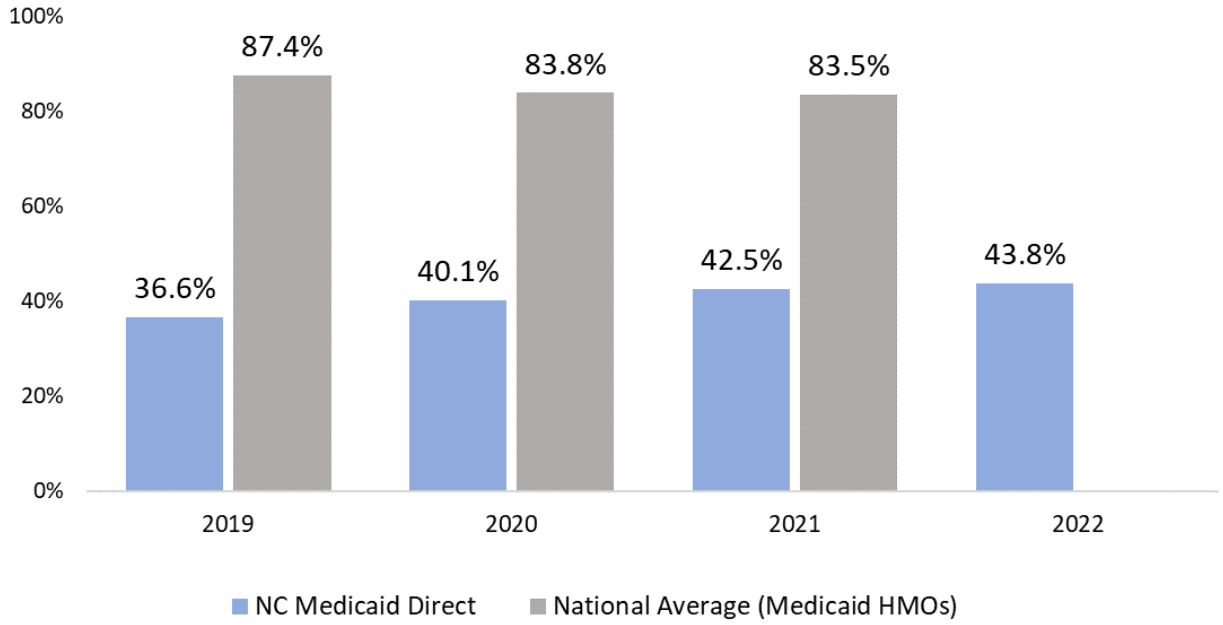
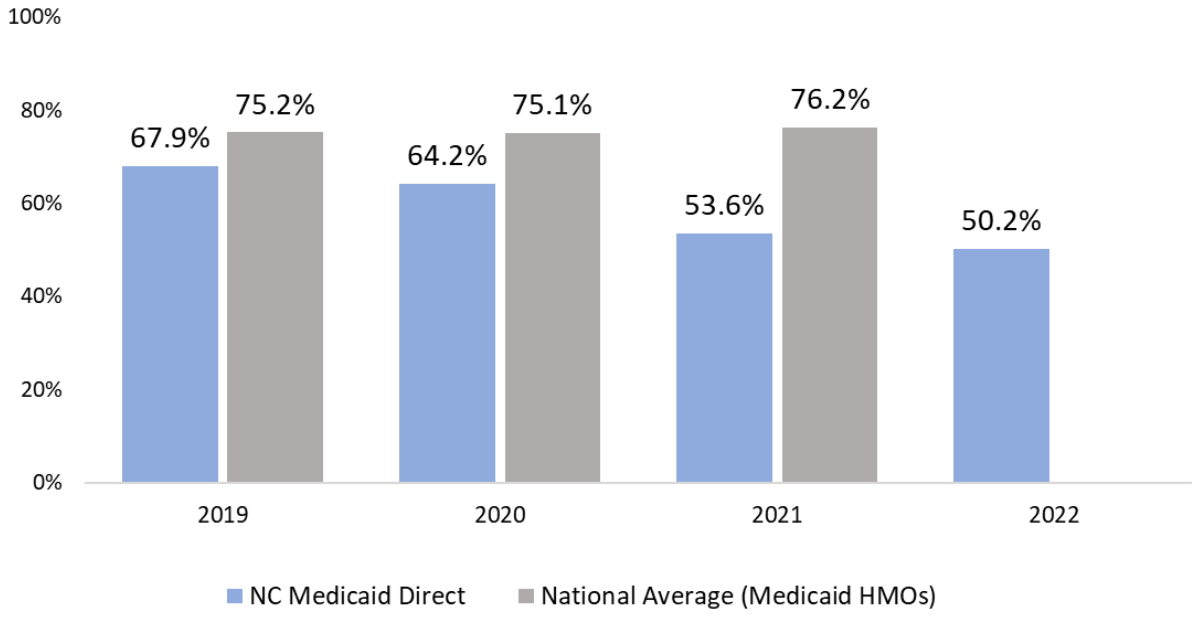
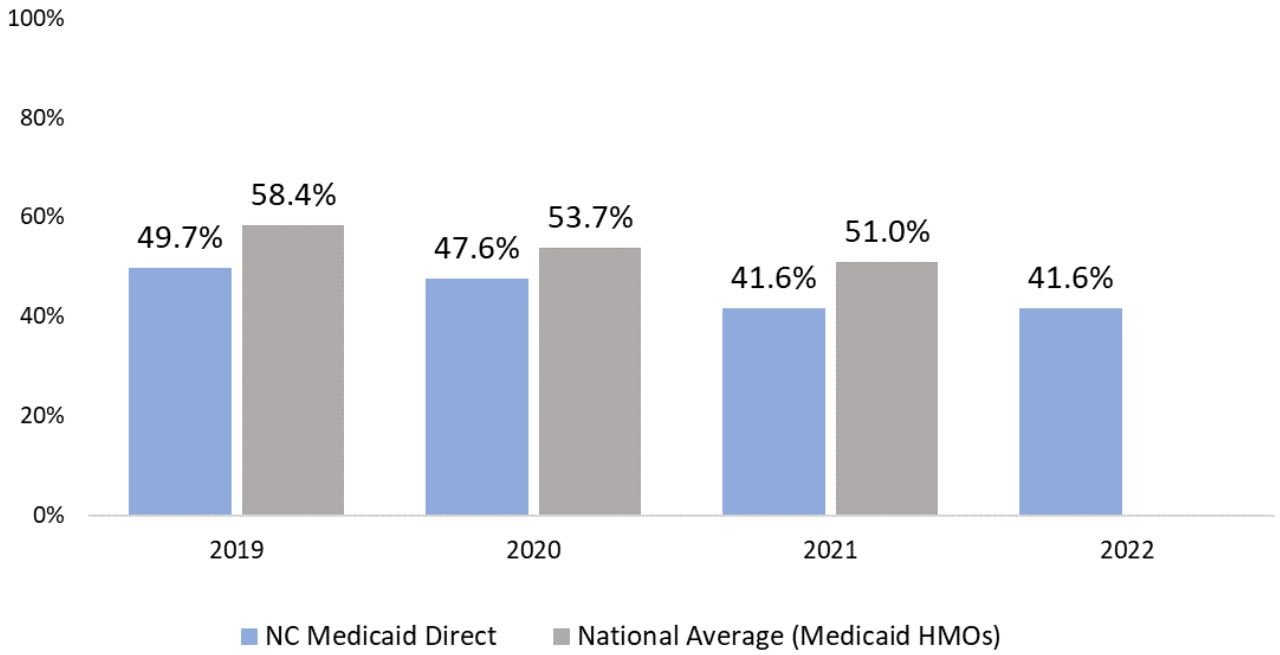


Figure 31: *Prenatal and Postpartum Care (PPC):* Postpartum Care, Historical Performance NC Medicaid Direct Population Compared to the National Average of Other State Medicaid Agencies (2019-2022)



Breast Cancer Screening (BCS) is a HEDIS measure that assesses women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years. BCS is an important measure of healthcare access for women, as breast cancer is the most common cancer among American women, regardless of race or ethnicity.[53] NC Medicaid Direct's performance has decreased significantly between 2019 and 2022 (see Figure 32). This downward trend is an opportunity for improvement within the Medicaid Direct population. It is also possible that some breast cancer screenings are not accurately captured by Medicaid's administrative data as many young women will alternate between Family Planning Medicaid, private coverage, and no coverage. The churn these beneficiaries experience may be mitigated by the broadened eligibility criteria under Medicaid Expansion, which NC implemented on December 1, 2023. 2023.

Figure 32: *Breast Cancer Screening (BCS)* Historical Performance for the NC Medicaid Direct Population Compared to the National Average of Other State Medicaid Agencies (2019-2022)



[53] Centers for Disease Control and Prevention (CDC). 2018. "Breast Cancer Statistics." http://www.cdc.gov/cancer/breast/statistics/index.htm

Domain 3: Beneficiary Experience

The Department's External Quality Review Organization (EQRO) administers and reports the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Surveys annually (see size of sampled population and response rates in Table 10 and Figure 33). The CAHPS survey instruments are used as a national standard for assessing members' health care experience. For this Plan the CAHPS questions have been organized into three categories:

1. *Effectiveness of Care Measures*
2. *Composite Measures*
3. *Global Ratings*

The EQRO calculated positive ratings for each measure, representing the percentage of respondents with survey responses that are classified as "positive" (i.e., responses rating their experience of care higher). These positive ratings include respondents who:

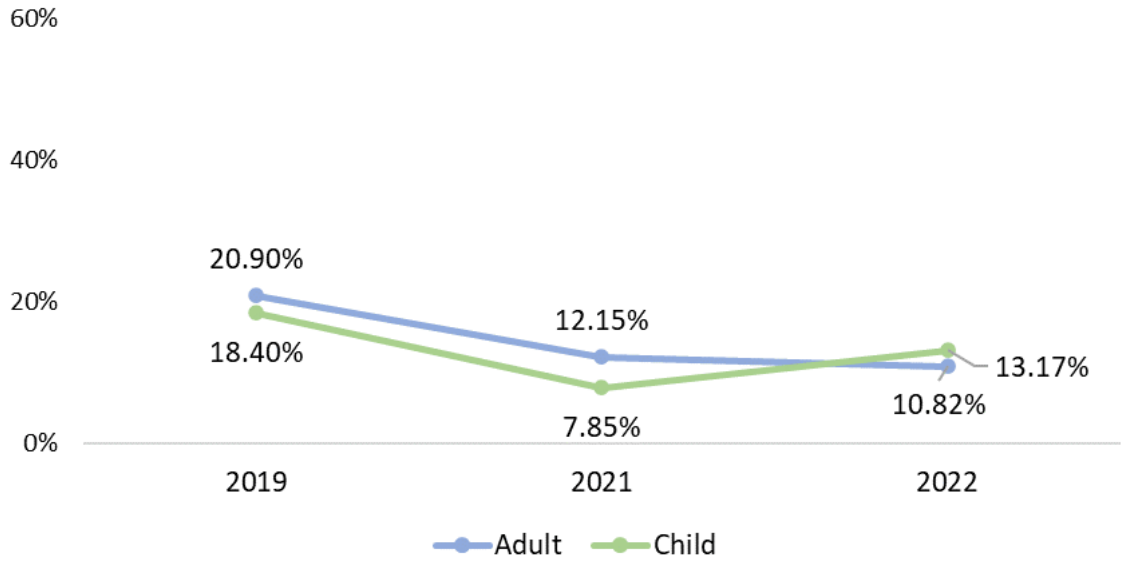
- "Usually" or "always" received and/or had access to the care and services they/their child needed,
- Reported their child's doctor/provider knew their child and coordinated care for their child's chronic conditions, or
- Provided a rating of 8, 9, or 10 on the global ratings.

To determine significance, two types of hypothesis tests were applied to the results. First, a global F test was calculated to determine whether the difference between the comparison populations' ratings was statistically significant. If the F test demonstrated differences (i.e., p value < 0.05), then a t test was performed. The t test determined whether each population's rating was statistically significantly different from the reference group, for this analysis the reference group is the Non-Medicaid Direct Aggregate. This analytic approach follows AHRQ's recommended methodology for identifying statistically significant performance differences.

Table 10: NC Medicaid Direct sample sizes and response rates for CAHPS (2019, 2021, 2022)

Program-Specific Populations	Population	Total Number of People Sampled (i.e., General Samples)		
Medicaid Direct		2019	2021	2022
	Adult Sample	1,296	5,862	1,350
	General Child Sample	3,461	5,971	1,650
2019 and 2021 samples represent all NC Medicaid (pre-managed care implementation). *2022 samples include the general sample only (i.e., race and ethnicity oversamples are not included here).*				

Figure 33: NC Medicaid Direct Sample Response Rates by Population (2019, 2021, 2022)



Note: Due to the COVID-19 pandemic, CAHPS was not fielded in 2020.

Due to the COVID-19 pandemic, CAHPS was not fielded in 2020. This Plan utilizes available data for 2019, 2021, and 2022 CAHPS. For the purposes of this Plan, the NC Medicaid Direct population, formally known as fee-for-service coverage, are compared to Non-Medicaid Direct Aggregate—Combined results of all five SPs and EBCI Tribal Option.

Effectiveness of Care Measures

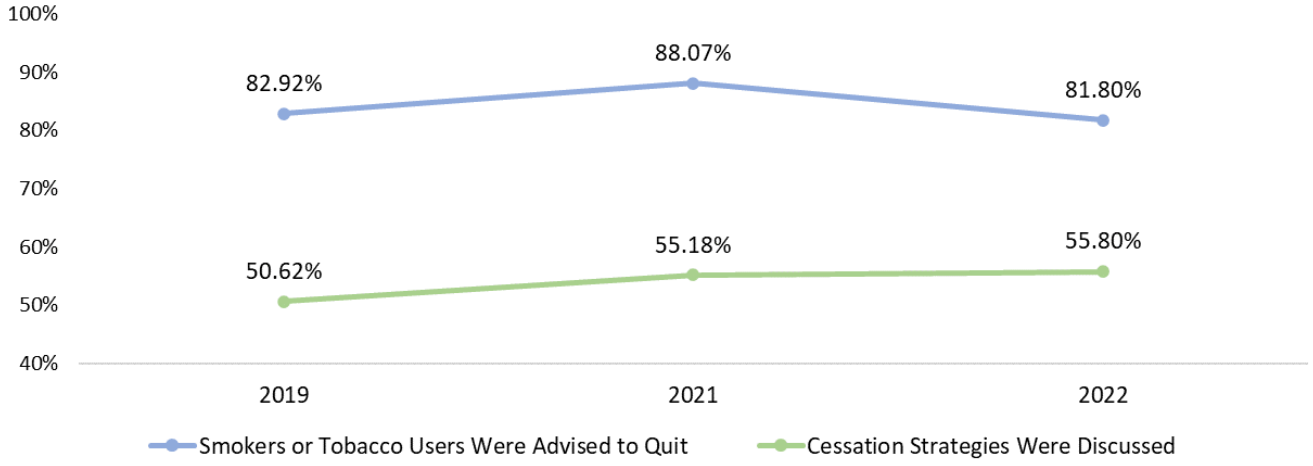
Adult Medicaid Direct respondents and the Non-Medicaid Direct Aggregate had high percentages of positive responses for questions relating to the provision of medical assistance with smoking and tobacco use cessation (see Table 11). Over 81 percent of Medicaid Direct respondents who were tobacco users of smokers reported their providers advised them to quit in 2019, 2021, and 2022 (see Figure 34).

Table 11: CAHPS Effectiveness of Care measures for the NC Medicaid Direct Population Compared to the Non-Medicaid Direct Aggregate Among Tobacco Users and Smokers (2022)

CAHPS Measures	Medicaid Direct Results	Non-Medicaid Direct Aggregate
Percent of adult smokers who were advised to quit**	81.8%	82.5%
Percent of adults whose provider discussed cessation medications**	56.8%+	54.9%
Percent of adults whose provider discussed cessation strategies**	55.8%+	46.9%

+Indicates fewer than 100 responses. Caution should be exercised when evaluating these results
***Percent represents respondents who reported this event happened sometimes, usually, or always*

Figure 34: Percentage of Adult Medicaid Direct Respondents Who Reported the Care they Received was Effective at Addressing Health Behaviors, Among Tobacco Users and Smokers (2019, 2021, 2022)



Note: Due to the COVID-19 pandemic, CAHPS was not fielded in 2020.

Composite Measures

Composite measures contain groups of related questions that are combined to form a composite. Despite small sample sizes, significantly higher percentages of Medicaid Direct respondents reported that they were usually or always able to get the care they needed for their child, that their child's personal doctor usually or always communicated with them and coordinated their child's care with other providers compared to the Non-Medicaid Direct respondents (see Table 12). The percentage of respondents who responded "Always" or "Usually" to getting care quickly for their child dropped over six percentage points from 2019 to 2021, possibly reflecting less availability during the public health emergency (see Figure 35). However, in 2022 the rates started to increase again. NC Medicaid Direct members also reported significantly higher rates of always or usually getting needed care for their child in 2022 compared to the Non-Medicaid Direct aggregate (see Figure 36 and Table 12).

Table 12: CAHPS Composite Measures for the NC Medicaid Direct population and Non-Medicaid Direct Aggregate, 2022

CAHPS Measures	NC Medicaid Direct Results	Non-Medicaid Direct Aggregate
Adult Population		
Percent of adults who usually or always got care they needed	*85.5%+*	*81.1%*
Percent of adults who usually or always got care quickly	*86.4%+*	*82.6%*
Percent of adults whose personal doctor usually or always communicated with them	*93.5%+*	*93.5%*
Percent of adults who usually or always had a positive experience with health plan's customer service	*92% +*	*87.3%*

CAHPS Measures	NC Medicaid Direct Results	Non-Medicaid Direct Aggregate
General Child Population		
Percent of respondents who usually or always got care they needed for their child	*91.4% ▲*	*82.8%*
Percent of respondents who usually or always got care quickly for their child	*90.4%*	*85.1%*
Percent of respondents whose child's personal doctor usually or always communicated well with them	*96.7% ▲*	*91.7%*
Percent of respondents who usually or always had a positive experience with their child's health plan customer service	*87.1% +*	*82.0%*
Percent of respondents who reported their child's personal doctor usually or always coordinated their child's care with other providers	*91.2% ▲*	*82.1%*

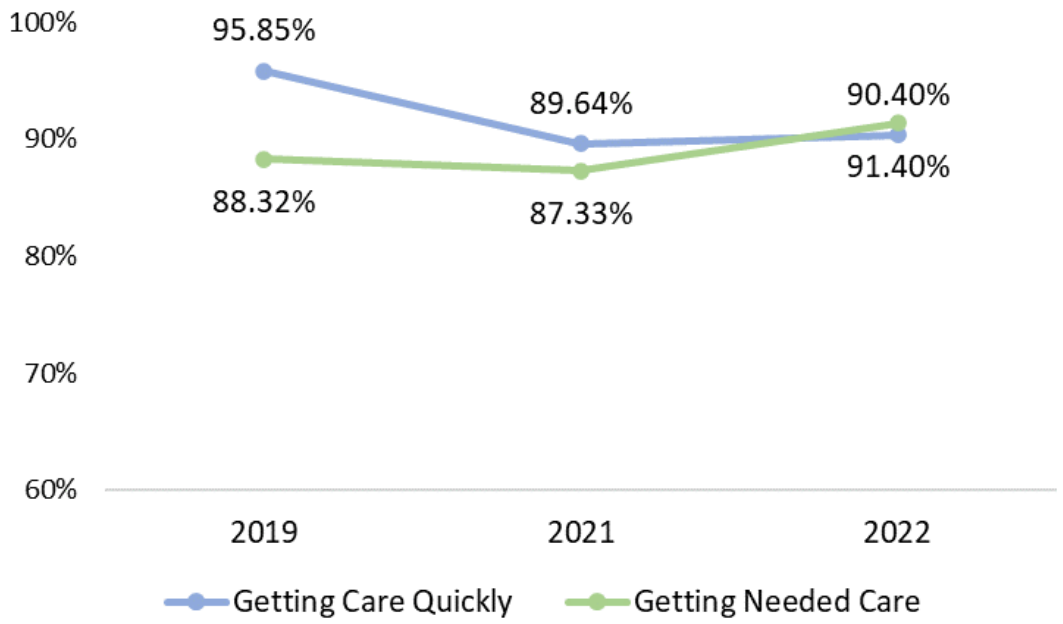
+Indicates fewer than 100 responses. Caution should be exercised when evaluating these results
▲ *Indicates the score is significantly higher than the* Non-Medicaid Direct Aggregate

Table 13: CAHPS Individual Item Measures for the NC Medicaid Direct population and Non-Medicaid Direct Aggregate 2022

CAHPS Measures	NC Medicaid Direct Results	Non-Medicaid Direct Aggregate
Adult Population		
Percent of adults who reported receiving the flu vaccination since July 1, 2021	58.2% ▲	36.5%
Percent of adults whose personal doctor usually or always coordinated care with other providers	*89.8%+*	*85.4%*

+Indicates fewer than 100 responses. Caution should be exercised when evaluating these results
▲ *Indicates the score is significantly higher than the* Non-Medicaid Direct Aggregate

Figure 35: Percent of Respondents that Reported "Always" or "Usually" Getting Care Quickly and Getting Needed Care for Their Child by Service Delivery Category, 2019, 2021, and 2022
Note: Due to the COVID-19 pandemic, CAHPS was not fielded in 2020.



Note: Due to the COVID-19 pandemic, CAHPS was not fielded in 2020.

Global Ratings

Global Ratings are measures that contain ratings of member experience on a scale of 0 to 10. Positive ratings for these measures include ratings of 8 ,9, or 10. NC Medicaid Direct respondents rated their personal doctor and the specialist they see most often positively more often than the Non-Medicaid Direct aggregate (see Table 14). Adult Medicaid Direct respondents' ratings for their health plans and personal doctors continued to increase over time (see Figure 36).

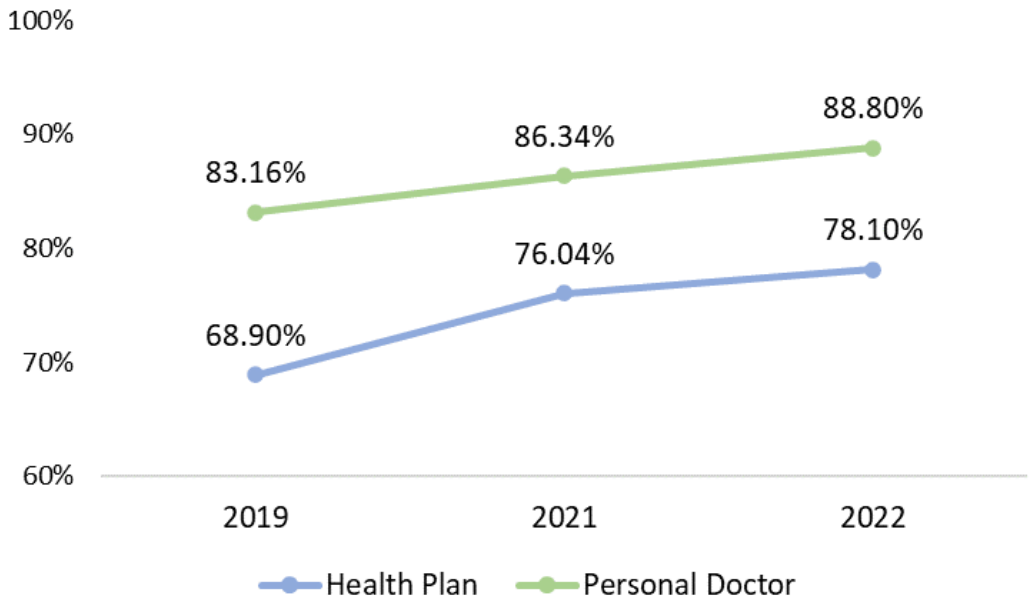
Table 14: CAHPS Global Ratings measures for the NC Medicaid Direct population and Non-Medicaid Direct Aggregate, 2022

CAHPS Measures	NC Medicaid Direct Results	Non-Medicaid Direct Aggregate
Adult Population		
Percent of respondents who rate their health plan positively	*78.1%*	*73.2%*
Percent of respondents who rate all their health care positively	*72.7%+*	*76.9%*
Percent of respondents who rate their personal doctor positively	*88.8%*	*84.5%*
Percent of respondents who rate the specialist they saw most often positively	*87.9%+*	*83.8%*
General Child Population		

CAHPS Measures	NC Medicaid Direct Results	Non-Medicaid Direct Aggregate
Percent of respondents who rate their child's health plan positively	*78%*	*84.1%*
Percent of respondents who rate all their child's health care positively	*90.8%*	*88.8%*
Percent of respondents who rate their child's personal doctor positively	*91.1%*	*89.2%*
Percent of respondents who rate the specialist their child saw most often positively	*88.5% +*	*88.9%*

▲ *Indicates the score is significantly higher than the* Non-Medicaid Direct Aggregate
+Indicates fewer than 100 responses. Caution should be exercised when evaluating these results

Figure 36: Percent of Adult Respondents who rate their health plan and personal doctor an 8, 9, or 10, in 2019, 2021, and 2022



Note: Due to the COVID-19 pandemic, CAHPS was not fielded in 2020.

The NC Medicaid Ombudsman

The Ombudsman provides free, confidential support and education for Medicaid beneficiaries. Learn more about the Ombudsman at ncmedicaidombudsman.org. You can call at 877-201-3750 from 8 a.m. to 5 p.m., every Monday through Friday except for State holidays.

Conclusion

Each domain of access to care for beneficiaries served by NC Medicaid Direct had areas for growth and areas of high performance. These results should be paired with an understanding of the massive shifts in coverage between 2019 and 2022, due to a large portion of NC Medicaid Direct members moving over to Standard Plans. Even with these coverage shifts and the PHE the Medicaid Direct population's access and utilization of care remained promising.

For Domain 1, potential access to care, there are contracted time/distance and appointment wait time standards for PIHPs and clear and accessible sources of information on covered services, provider selection, and Medicaid rates.

For Domain 2, beneficiary utilization, there were certain quality measures, such as *Follow-Up After Emergency Department Visit for Substance Use (FUA)* and *Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care,* which had increases in performance over the four-year period. While other measures, such as *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* and *Child and Adolescent Well-Care Visits (WCV),* remained relatively consistent over the four-year period. However, *Adults' Access to Preventive/Ambulatory Health Services (AAP)* decreased between 2019 and 2022, indicating a need for improvement in this space and likely reflecting PHE impact.

For Domain 3, beneficiary perception, the CAHPS surveys revealed that Medicaid Direct respondents had relatively positive experiences with their own and their child's health plan, personal doctor, and specialist compared to the Non-Medicaid Direct respondents' aggregate results.

Some results in Domain 2 and Domain 3 saw slight decreases in performance during 2020 and 2021, possibly reflecting less access to and availability of services during the public health emergency. It is promising to see most of these metrics improving in 2022. NC Medicaid will continue to track how to quality measures trend post-pandemic to identify areas of focused investment.

As NC Medicaid continues to stand up its managed care structure, beneficiaries will continue to transition from traditional fee-for-service Medicaid to different managed care plans. Upon the launch of Tailored Plans, beneficiaries with significant behavioral health needs, intellectual and developmental disabilities (I/DD), or traumatic brain injuries (TBI) will transition from Medicaid Direct into these new plans. In addition, NC expanded Medicaid in December of 2023. This change means a large portion of members enrolled in the Family Planning Program (a partial benefit program within Medicaid Direct) will be eligible to receive full coverage, likely under a Standard Plan. Despite these shifts, NC Medicaid is still dedicated to ensuring equitable and sufficient access for covered services provided under fee-for-service. NC Medicaid will continue to track this current set of quality measures and strategize for how to adapt the set of measures to account for the changing health care delivery system. The current system still focuses primarily on face-to-face encounters between patients and providers but is evolving to rely more on care management and less traditional sources of care, such as telehealth, e-mail, text, and telephonic communications.[54]

[54] Kenney, G., Gifford, K., Wishner, J., Forsberg, V., Napoles, A., & Pavliv, D. (2016). *Proposed Medicaid Access Measurement and Monitoring Plan*. https://www.medicaid.gov/sites/default/files/2019-12/monitoring-plan.pdf

Appendix

Partial Benefit Group Exclusions

Partial benefit groups receive only select coverage for services due to different eligibility status. This section describes five different partial benefit groups, their covered services, and whether they were excluded from quality measurement calculations in this Plan.

Family Planning

Managed Care Status Code: MCS018

Description: Family planning, reproductive health and contraceptive services are provided to eligible men and women, whose income is at or below 195% of the federal poverty level, with no age restrictions. For more information on the Family Planning Medicaid program visit this site.

The following general services are covered through the "Be Smart" program when provided as part of a family planning visit:

- Preventive annual exam and six inter-periodic office visits (including counseling, patient education, and treatment)
- Specific laboratory procedures (i.e., pap tests, pregnancy tests)
- FDA-approved and Medicaid-covered birth control methods, procedures, pharmaceutical supplies, and devices
- Screening for HIV (Human Immunodeficiency Virus)
- Screening and treatment for specific Sexually Transmitted Infections (STIs)
- Voluntary male and female sterilization (in accordance with federal sterilization guidelines)
- Non-emergency medical transportation, as needed, to and from family planning appointments

Partial Dual Eligible

Managed Care Status Code: MCS020

Description: Partial dual eligibles receive Medicare financial support from Medicaid but no Medicaid services such as LTSS. These partial dual aid categories include comprehensive Medicare Aid (MQB-Q), limited Medicare aid (MQB-B), Medicaid working disabled (MWB), and limited Medicare-Aid capped enrollment (MQB-E).

Emergency Services Only

Managed Care Status Code: MCS021

Description: Emergency services include labor and delivery, including caesarean section. It can also include any treatment after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical

attention could reasonably be expected to result in placing the patient's life at jeopardy. Certain groups, such as Deferred Action for Childhood Arrivals (DACA) individuals, are eligible for these services.

Incarcerated

Managed Care Status Code: MCS023

Description: The only services that are covered while a beneficiary's Medicaid is in suspension for incarceration are medical services received during an inpatient stay. Inpatient stay services include the care of patients whose condition requires admission to a hospital.

Presumptive Eligibility

Managed Care Status Code: MCS024

Description: Presumptive eligibility for pregnant women is determined by Health Departments and Rural Health Centers. This eligibility covers only ambulatory prenatal care. Ambulatory prenatal care services are defined as outpatient services related to pregnancy, including prenatal care services and services related to other conditions that may complicate the pregnancy. To receive this eligibility the patient must attest to pregnancy, income level, and NC residency. The patient cannot be an inmate of a public institution. The patient does not have to attest to U.S. citizenship.

COVID-19 MCV Coverage
Managed Care Status Code: MCS043
Description: NC Medicaid reimbursed COVID-19 testing, treatment, and vaccination costs for individuals without insurance who enroll in the NC Medicaid Optional COVID-19 Testing, Treatment and Vaccination (MCV) program.

Table 14: Eligibility Group Exclusion in Quality Measure Calculation

Quality Measure	Partial Eligibility Group					
	Family Planning	Partial Dual Eligible	Emergency Services Only	Incarcerated	Presumptive Eligibility	Covid-19 MCV
AAP	X	X	X	X	X	X
W30	X	X	X	X	X	X
WCV	X	X	X	X	X	X
FUA	X	X	X	X	X	X
ADV	X	X	X	X	X	X
OEV	X	X	X	X	X	X
IET	X	X	X	X	X	X
ADD	X	X	X	X	X	X
FUH	X	X	X	X	X	X
SSD	X	X	X	X	X	X
PPC	X	X	X	X		X
BCS	X	X	X	X	X	X

**X indicates the relevant group was excluded from the quality measure calculations*