

Managed Care Program Annual Report (MCPAR) for North Carolina: BH IDD Tailored Plan

Due date	Last edited	Edited by	Status
12/27/2025	12/23/2025	Dawn Johnson	Submitted

Indicator	Response
Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected
Did you submit or do you plan on submitting a Network Adequacy and Access Assurances (NAAAR) Report for this program for this reporting period through the MDCT online tool? If "No", please complete the following questions under each plan.	No

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	State name Auto-populated from your account profile.	North Carolina
A2a	Contact name First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Kelsi Knick
A2b	Contact email address Enter email address. Department or program-wide email addresses ok.	kelsi.knick@dhhs.nc.gov
A3a	Submitter name CMS receives this data upon submission of this MCPAR report.	Dawn Johnson
A3b	Submitter email address CMS receives this data upon submission of this MCPAR report.	dawn.johnson@dhhs.nc.gov
A4	Date of report submission CMS receives this date upon submission of this MCPAR report.	12/23/2025

Reporting Period

Number	Indicator	Response
A5a	Reporting period start date Auto-populated from report dashboard.	07/01/2024
A5b	Reporting period end date Auto-populated from report dashboard.	06/30/2025
A6	Program name Auto-populated from report dashboard.	BH IDD Tailored Plan

Add plans (A.7)

Enter the name of each plan that participates in the program for which the state is reporting data.

Indicator	Response
Plan name	Alliance
	Partners
	Trillium
	Vaya


Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71. See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Independent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

Indicator	Response
BSS entity name	NC Medicaid Ombudsman
	NC Medicaid Enrollment Broker

Add In Lieu of Services and Settings (A.9)

 **Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

This section must be completed if any ILOSs *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** Guidance on In Lieu of Services on Medicaid.gov.

Indicator	Response
ILOS name	ACT - Step Down
	Behavioral Health Crisis Assessment and Intervention
	Behavioral Health Urgent Care
	Child ACT
	Child First
	Community Living Facilities and Support
	Critical Time Intervention
	Enhanced Crisis Response
	Family Centered Treatment
	Family Navigator
	High Fidelity Wraparound
	In-Home Therapy Services
	Individual Rehabilitation, Coordination, and Support
	Long Term Community Supports
	Outpatient Plus
	Rapid Care
	Rapid Response
	Residential Services - Complex Needs
	Short Term Residential Stabilization
	Transitional Youth Services

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	Statewide Medicaid enrollment Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	3,127,610
BI.2	Statewide Medicaid managed care enrollment Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	2,858,789

Topic III. Encounter Data Report

Number	Indicator	Response
BIII.1	<p>Data validation entity</p> <p>Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs.</p> <p>Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.</p>	<p>State Medicaid agency staff</p> <p>State actuaries</p> <p>EQRO</p> <p>Proprietary system(s)</p>
BIII.2	<p>HIPAA compliance of proprietary system(s) for encounter data validation</p> <p>Were the system(s) utilized fully HIPAA compliant? Select one.</p>	<p>Yes</p>

Topic X: Program Integrity

Number	Indicator	Response
BX.1	<p>Payment risks between the state and plans</p> <p>Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter "No PI activities were performed during the reporting period" as your response. "N/A" is not an acceptable response.</p>	<p>OCPI Compliance Analytics conducted cross-payer Payment Integrity analyses with a focus on cross payer over-billing and persistent high risk behaviors covering July 2024 - June 2025. Provider risk analysis identified the providers with the most outlier behavior in their peer group and performed a comparison to whole provider peer group. Analysis supported education prioritization across the providers, as well as provider referrals for investigation that were underway as of 30Jun2025. 1. Personal Care Services 2. Home Health 3. Community Alternatives Program. OCPI Compliance Analytics conducted cross-payer payment reviews of the following service areas: 1. Speech Therapy peer group review: Reviewed 16 providers with at least one risk identified and 6 were referred for investigation. 2. E&M peer group review focused on Telehealth: Reviewed 38 providers with at least one risk identified and 4 were referred for investigation. 3. Durable Medical Equipment peer group reviews across Incontinence Supplies, Diabetic Supplies, and Enteral nutrition: Reviewed 20 providers with at least one risk and 6 providers were in progress for referral for investigation by 6/30/2025. 4. Personal Care Services peer group review: Reviewed 20 providers with at least one risk identified and 2 providers were in progress for referral for investigation by 6/30/2025. 4. OBGYN, Pediatric, and Physician Assistant and Nurse Practitioner peer group reviews ongoing. OCPI Compliance Analytics conducted cross-payer payment reviews of individual high risk providers in tandem with the MFCU on the following service areas: 1. Home Health - 1 provider 2. Personal Care Services - 1 provider 3. Behavioral Health - 1 provider 4. Drug Testing Labs - 1 provider</p>
BX.2	<p>Contract standard for overpayments</p> <p>Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.</p>	<p>Allow plans to retain overpayments</p>
BX.3	<p>Location of contract provision stating</p>	<p>V.A.3(iii)</p>

overpayment standard

Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).

BX.4**Description of overpayment contract standard**

Briefly describe the overpayment standard selected in indicator B.X.2.

(iii) The BH I/DD Tailored Plan's Compliance Program shall comply with 42 C.F.R. § 438.608, and must include for Medicaid and State-funded Services: (a) Written policies, procedures, and standards of conduct that articulate the BH I/DD Tailored Plan's commitment to comply with all applicable requirements and standards under the Contract, and all applicable federal and state requirements, including: (1) Implementation and maintenance arrangements or procedures for notification to the Department when it receives information about a change in a Network provider's circumstances that may affect the Network provider's eligibility to participate in the Medicaid Managed Care program or State-funded Services, including termination of the provider agreement with the BH I/DD Tailored Plan. 42 C.F.R. § 438.608(a)(4) (2) Retention policies for the treatment of recoveries of all overpayments from the BH I/DD Tailored Plan to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse. 42 C.F.R. § 438.608(d)(1)(i). (3) Processes, timeframes, and documentation required for payment of recoveries of overpayments to the Department in situations where the BH I/DD Tailored Plan is not permitted to retain some or all of the recoveries of overpayments. 42 C.F.R. § 438.608(d)(1)(iii)). (4) Reporting to the Department within sixty (60) Calendar Days when it has identified the capitation payments or other payments in excess of amounts specified in the Contract. 42 C.F.R. § 438.608(c)(3).

BX.5**State overpayment reporting monitoring**

Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness

The State Medicaid Agency have the Plans report their overpayments and recoveries on an Annual Overpayment Recoveries Report and the Quarterly FWA Provider Report. The Plans share overpayment and recoveries during their monthly Oversight and Monitoring meeting with the State and on their Quarterly FWA

	<p>of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.</p>	<p>Provider Report of all provider audits and Investigations to include disposition of overpayments and recoveries.</p>
BX.6	<p>Changes in beneficiary circumstances</p> <p>Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).</p>	<p>Daily 834 files with member changes. - Monthly 834 Files with all members - A monthly reconciliation process that compares member enrollment data across systems, such as health plans, the Enrollment Broker, and state eligibility systems.</p>
BX.7a	<p>Changes in provider circumstances: Monitoring plans</p> <p>Does the state monitor whether plans report provider “for cause” terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.</p>	<p>Yes</p>
BX.7b	<p>Changes in provider circumstances: Metrics</p> <p>Does the state use a metric or indicator to assess plan reporting performance? Select one.</p>	<p>Yes</p>
BX.7c	<p>Changes in provider circumstances: Describe metric</p> <p>Describe the metric or indicator that the state uses.</p>	<p>Yes (started post Oct 2024, as applicable) - Provider removed from network - Provider removed from claims payment system</p>
BX.8a	<p>Federal database checks: Excluded person or entities</p> <p>During the state’s federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any</p>	<p>No</p>

subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.

BX.9a	Website posting of 5 percent or more ownership control Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to 42 CFR 438.602(g)(3) and 455.104.	No
BX.10	Periodic audits If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter "No such audits were conducted during the reporting year" as your response. "N/A" is not an acceptable response.	Report Name: August 2025 Legislative Reports NCDHHS Report Desc: A summary report of the findings for fiscal solvency, clean claims payment, and HIPAA compliance for the Local Management Entities/Managed Care Organizations. Report Link: https://www.ncdhhs.gov/about/administrative-offices/office-government-affairs/legislative-reports/2025-legislative-reports/august-2025-legislative-reports Report Name: 2024-2025 Encounter Data Validation Report Report Desc: Encounter data validation process is completed with an external quality review organization HSAG (Human Services Advisory Group). We have the Information Systems Capability Assessment that was completed by the external quality review organization HSAG. DHHS internal audit has also reviewed the encounter data validation reports. Report Link: https://medicaid.ncdhhs.gov/2024-2025-encounter-data-validation-information-systems-review-aggregate-report/download?attachment

Topic XIII. Prior Authorization



Beginning June 2026, Indicators B.XIII.1a-b-2a-b must be completed. Submission of this data before June 2026 is optional.

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026?	Not reporting data

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C11.1	Program contract Enter the title of the contract between the state and plans participating in the managed care program.	BH I/DD Tailored Plan Contract #30-2020-052-DHB
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	07/01/2024
C11.2	Contract URL Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://medicaid.ncdhhs.gov/about-nc-medicare/health-plans#health-plan-contracts
C11.3	Program type What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C11.4a	Special program benefits Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Long-term services and supports (LTSS) Transportation
C11.4b	Variation in special benefits What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	N/A
C11.5	Program enrollment Enter the average number of individuals enrolled in this managed care program per	236,470

month during the reporting year (i.e., average member months).

C11.6

Changes to enrollment or benefits

There were no major changes to the population or benefits during the reporting year

Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter "There were no major changes to the population or benefits during the reporting year" as your response. "N/A" is not an acceptable response.

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	<p>Uses of encounter data</p> <p>For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more.</p> <p>Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).</p>	<p>Rate setting</p> <p>Quality/performance measurement</p> <p>Monitoring and reporting</p> <p>Contract oversight</p> <p>Program integrity</p> <p>Policy making and decision support</p> <p>Other, specify – TMSIS reporting to CMS State and Federal Audit Requests</p>
C1III.2	<p>Criteria/measures to evaluate MCP performance</p> <p>What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more.</p> <p>Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).</p>	<p>Timeliness of initial data submissions</p> <p>Timeliness of data certifications</p> <p>Use of correct file formats</p> <p>Provider ID field complete</p> <p>Overall data accuracy (as determined through data validation)</p>
C1III.3	<p>Encounter data performance criteria contract language</p> <p>Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.</p>	V.B.6.2
C1III.4	<p>Financial penalties contract language</p> <p>Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality</p>	VII.P Table 4 LD# 4,15,16,17,18,19

C1III.5	Incentives for encounter data quality Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	N/A
C1III.6	Barriers to collecting/validating encounter data Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter "The state did not experience any barriers to collecting or validating encounter data during the reporting year" as your response. "N/A" is not an acceptable response.	For the EPS system, the business rules drive the validation of the data being submitted. In order to ensure the business rules align with the policies of DHB, processes have been established to have a clinical review of any changes to those rules. Sometimes this process is lengthy. However, through the External Quality Review Vendor, HSAG, NC has completed the Encounter Data Validation process. Most plans are in full compliance with the CMS Encounter Data Validation protocol.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	<p>State’s definition of “critical incident”, as used for reporting purposes in its MLTSS program</p> <p>If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for “critical incidents” within the managed care program? Respond with “N/A” if the managed care program does not cover LTSS.</p>	<p>An alleged, suspected, or actual occurrence of: (a) abuse (including physical, sexual, verbal and psychological abuse); (b) mistreatment or neglect; (c) exploitation; (d) serious injury; (e) death other than by natural causes; (f) other events that cause harm to an individual; and, (g) events that serve as indicators of risk to participant health and welfare such as hospitalizations, medication errors, use of restraints or behavioral interventions.</p>
C1IV.2	<p>State definition of “timely” resolution for standard appeals</p> <p>Provide the state’s definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.</p>	<p>Within thirty (30) calendar days of receiving a complete appeal request.</p>
C1IV.3	<p>State definition of “timely” resolution for expedited appeals</p> <p>Provide the state’s definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.</p>	<p>No later than seventy-two (72) hours of receipt of the expedited appeal request.</p>

C1IV.4	State definition of “timely” resolution for grievances Provide the state’s definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	Within thirty (30) calendar days from the date the grievance is received.
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Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	<p>Gaps/challenges in network adequacy</p> <p>What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter "No challenges were encountered" as your response. "N/A" is not an acceptable response.</p>	<p>1) The consistency and reliability of provider data reported by providers to the State, which is transmitted to the TPs for ingestion and provider network reporting back to the State is a challenge for Network Adequacy. While this has greatly improved, there are still areas for improvement. Providers are traditionally poor at updating demographic information and stressing its importance to member choice and claims payment. 2) In many areas of the state, Tailored Plan struggle with contracting with providers in general due to a limited supply of providers. This is especially true in the more rural areas of the state and is particularly acute for pediatric specialist, Behavioral Health providers and MH/SUD facilities. This lack of providers is evident in the network adequacy geomapping results relating to the MCPs networks but also evident in the geomapping results of the network of all enrolled Medicaid providers.</p>
C1V.2	<p>State response to gaps in network adequacy</p> <p>How does the state work with MCPs to address gaps in network adequacy?</p>	<p>The state works with all health plans to confirm that for the gaps identified by analysis an appropriate network adequacy exception request is submitted for the state's review and approval. As part of the request for an exception the MCPS must indicate how the plan will make sure that members have access to the services on a timely basis and their plan to mitigate the provider gap. Additionally, the state engages the MCPS around provider supply issues and discusses ways in which improvements can be made to encourage more provider participation in Medicaid.</p>

Access Measures

Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level.

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

42 CFR 438.66(e) specifies that the MCPAR must provide information on and an assessment of the availability and accessibility of covered services within the MCO, PHIP, or PAHP contracts, including network adequacy standards for each managed care program.



Complete

C2.V.3 Standard type: Maximum time or distance

1 / 61

C2.V.2 Measure standard

≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care

C2.V.5 Region

Urban

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

2 / 61

C2.V.2 Measure standard

≥ 2 providers within 30 minutes or 30 miles for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care

C2.V.5 Region

Rural

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

3 / 61

C2.V.2 Measure standard

≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care

C2.V.5 Region

Urban

C2.V.6 Population

Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

4 / 61

C2.V.2 Measure standard

≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care

C2.V.5 Region

Rural

C2.V.6 Population

Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

5 / 61

C2.V.2 Measure standard

≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

OB/GYN

C2.V.5 Region

Urban

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

6 / 61

C2.V.2 Measure standard

≥ 2 providers within 30 minutes or 30 miles for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

OB/GYN

C2.V.5 Region

Rural

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

7 / 61

C2.V.2 Measure standard

≥ 2 providers of each outpatient behavioral health service within 30 minutes or 30 miles of residence for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health:
Behavioral Health

C2.V.5 Region

Urban

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

8 / 61

C2.V.2 Measure standard

≥ 2 providers of each outpatient behavioral health service within 45 minutes or 45 miles of residence for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health:
Behavioral Health

C2.V.5 Region

Rural

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

9 / 61

C2.V.2 Measure standard

≥ 2 providers of each outpatient behavioral health service within 30 minutes or 30 miles of residence for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health:
Behavioral Health

C2.V.5 Region

Urban

C2.V.6 Population

Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

10 / 61

C2.V.2 Measure standard

≥ 2 providers of each outpatient behavioral health service within 30 minutes or 30 miles of residence for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health:
Behavioral Health

C2.V.5 Region

Rural

C2.V.6 Population

Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

11 / 61

C2.V.2 Measure standard

≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist

C2.V.5 Region

Urban

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

12 / 61

C2.V.2 Measure standard

≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist

C2.V.5 Region

Rural

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

13 / 61

C2.V.2 Measure standard

≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist

C2.V.5 Region

Urban

C2.V.6 Population

Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

14 / 61

C2.V.2 Measure standard

≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist

C2.V.5 Region

Rural

C2.V.6 Population

Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

15 / 61

C2.V.2 Measure standard

≥ 1 hospitals within 30 minutes or 15 miles for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Hospital

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

16 / 61

C2.V.2 Measure standard

≥ 1 hospitals within 30 minutes or 30 miles for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Hospital

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

17 / 61

C2.V.2 Measure standard

≥ 2 pharmacies within 30 minutes or 10 miles for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Pharmacy

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

18 / 61

C2.V.2 Measure standard

≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Pharmacy

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

19 / 61

C2.V.2 Measure standard

2 LTSS provider types (Home Care providers and Home Health providers identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county)

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

LTSS

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

20 / 61

C2.V.2 Measure standard

2 LTSS provider types (Home Care providers and Home Health providers identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist: SNF

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

21 / 61

C2.V.2 Measure standard

≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider**C2.V.5 Region****C2.V.6 Population**

Specialist:	Urban	Adult and pediatric
Occupational		
Therapy		

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

22 / 61

C2.V.2 Measure standard

≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist:
Occupational
Therapy

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

23 / 61

C2.V.2 Measure standard

≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist: Physical
Therapy

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

24 / 61

C2.V.2 Measure standard

≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist: Physical
Therapy

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

25 / 61

C2.V.2 Measure standard

≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist: Speech
Pathologist

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

26 / 61

C2.V.2 Measure standard

≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist: Speech
Pathologist

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

27 / 61

C2.V.2 Measure standard

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 (Total regional population as estimated by combining NC OSBM county estimates). Facility-based crisis services for children and adolescents: ≥ 1 provider within each PIHP Region Medically Monitored Inpatient Withdrawal Services (non-hospital medical detoxification: ≥ 2 provider within each PIHP Region Ambulatory withdrawal management without extended on-site monitoring (ambulatory detoxification), Ambulatory withdrawal management with extended onsite

monitoring, Clinically managed residential withdrawal (social setting detoxification): ≥ 1 provider of each crisis service within each PIHP Region

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health: Crisis
Services

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

28 / 61

C2.V.2 Measure standard

≥ 1 provider of each inpatient BH service within each PIHP Region

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist: Inpatient
Behavioral Health
Services (Inpatient
Hospital)

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

29 / 61

C2.V.2 Measure standard

≥ 2 providers of each service within 30 minutes or 30 miles of residence for
at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health:
Location Based
Services (BH)

C2.V.5 Region

Urban

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

30 / 61

C2.V.2 Measure standard

≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist: Location
Based Services (BH)

C2.V.5 Region

Rural

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

31 / 61

C2.V.2 Measure standard

≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health:

Partial

Hospitalization (BH)

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

32 / 61

C2.V.2 Measure standard

≥ 1 provider of partial hospitalization within 60 minutes or 60 miles for at least 95% of Members

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health:

Partial

Hospitalization (BH)

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

33 / 61

C2.V.2 Measure standard

≥ 2 providers of community/mobile services within each PIHP Region. Each county in PIHP Region must have access to ≥ 1 provider that is accepting new patients.

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health:
Community/Mobile
Services

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

34 / 61

C2.V.2 Measure standard

Access to ≥ 1 licensed provider per PIHP Region

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Substance Use
Disorder (SUD)

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

35 / 61

C2.V.2 Measure standard

Access to ≥ 1 licensed provider per PIHP Region

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist:
Residential
Treatment: Medically

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

monitored intensive
inpatient services
(substance abuse
medically monitored
community
residential
treatment)

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

36 / 61

C2.V.2 Measure standard

Access to ≥ 1 licensed provider per PIHP Region

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist:
Residential
Treatment: Clinically
managed residential
services (substance
abuse non-medical
community
residential
treatment)

C2.V.5 Region

Statewide

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

37 / 61

C2.V.2 Measure standard

Contract with all designated CASPs statewide

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist:
Residential
Treatment: Clinically
managed residential
services (substance
abuse non-medical
community
residential
treatment)

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

38 / 61

C2.V.2 Measure standard

Contract with all designated CASPs statewide

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist:
Residential
Treatment: Clinically
managed
population-specific
high-intensity
residential program

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Custom method - Plan reporting

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

39 / 61

C2.V.2 Measure standard

Access to ≥ 1 male and ≥ 1 female program per PIHP Region

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist:
Residential
Treatment: Clinically
managed low-
intensity residential
treatment services
(substance abuse
halfway house)

C2.V.5 Region

Statewide

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

40 / 61

C2.V.2 Measure standard

Access to ≥ 1 program per PIHP Region

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist:
Residential
Treatment: Clinically
managed low-
intensity residential
treatment services

C2.V.5 Region

Statewide

C2.V.6 Population

Adolescent

(substance abuse
halfway house)

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

41 / 61

C2.V.2 Measure standard

≥ 2 provider agencies within each PIHP Region. Each county in PIHP Region must have access to ≥1 provider that is accepting new patients.

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist:
Employment and
Housing Services

C2.V.5 Region

Statewide

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

42 / 61

C2.V.2 Measure standard

≥ 2 providers of each Innovations waiver service (Community Living & Support, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living) within each PIHP Region

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist: 1915(c)
HCBS Waiver

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

Services: NC
Innovations

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

43 / 61

C2.V.2 Measure standard

≥ 1 provider of each Innovations waiver service (Crisis Intervention & Stabilization Supports, Day Supports, Financial Support Services) within each PIHP Region

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist: 1915(c)
HCBS Waiver
Services: NC
Innovations

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Maximum time or distance

44 / 61

C2.V.2 Measure standard

≥ 2 providers of In-Home Respite within 45 minutes of the member's residence

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

Specialist: 1915(i)
Services

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

45 / 61

C2.V.2 Measure standard

≥ 2 providers of each 1915(i) service [Community Living and Supports, Individual and Transitional Supports, Out-of-Home Respite, Supported Employment (for Members with I/DD and TBI), Individual Placement and Support (for Members with a qualifying mental health condition or SUD)] within each PIHP Region

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist: 1915(i)
Services

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

46 / 61

C2.V.2 Measure standard

≥ 2 providers of each TBI waiver service (Community Networking, Life Skills Training, Residential Supports, Resource Facilitation, In-Home Respite, Supported Employment) within each BH I/DD Tailored Plan Region

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

C2.V.5 Region

C2.V.6 Population

Specialist: 1915(c)	Statewide	Adult and pediatric
HCBS Waiver		
Services: NC TBI		
Waiver		

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Minimum number of network providers

47 / 61

C2.V.2 Measure standard

≥ 1 provider of each TBI waiver service (Day Supports, Cognitive Rehabilitation, Crisis Intervention & Stabilization Supports) within each BH I/DD Tailored Plan Region

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health:
1915(c) HCBS Waiver
Services: NC TBI
Waiver

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.3 Standard type: Appointment wait time

48 / 61

C2.V.2 Measure standard

Within 30 Calendar days

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

C2.V.5 Region

C2.V.6 Population

Primary care:	Statewide	6 months of age and older
Primary care - Preventive Care Service		

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Appointment wait time

49 / 61

C2.V.2 Measure standard

Within 14 calendar days

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care:
Primary care -
Preventive Care
Service

C2.V.5 Region

Statewide

C2.V.6 Population

Less than 6 months
of age

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Appointment wait time

50 / 61

C2.V.2 Measure standard

Within 24 hours

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care:
Primary Care -

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Appointment wait time

51 / 61

C2.V.2 Measure standard

Within 30 calendar days

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care:
Primary Care -
Routine/Check up
without symptoms

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Appointment wait time

52 / 61

C2.V.2 Measure standard

Immediately (Available 24 hours a day, 365 days a year)

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care:
Primary Care - After
Hours Access
(Emergent and
Urgent)

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Appointment wait time

53 / 61

C2.V.2 Measure standard

Within 14 calendar days

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Primary care:
Prenatal Care - Initial
Appointment (1st or
2nd Trimester)

C2.V.5 Region

Statewide

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Appointment wait time

54 / 61

C2.V.2 Measure standard

Within 5 calendar days

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

OB/GYN

C2.V.5 Region

Statewide

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Appointment wait time

55 / 61

C2.V.2 Measure standard

Within 24 hours

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 ProviderSpecialist: Specialty
Care - Urgent Care
Services**C2.V.5 Region**

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Appointment wait time

56 / 61

C2.V.2 Measure standard

Within 30 calendar days

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist: Specialty
Care - Routine/Check
up without
symptoms

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Appointment wait time

57 / 61

C2.V.2 Measure standard

Immediately (Available 24 hours a day, 365 days a year)

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Specialist: Specialty
Care - After Hours
Access (Emergent
and Urgent)

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Appointment wait time

58 / 61

C2.V.2 Measure standard

Within 2 hours

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider**C2.V.5 Region****C2.V.6 Population**

Mental health:	Statewide	Adult and pediatric
Behavioral Health -		
Mobile Crisis		
Management		
Services		

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Appointment wait time

59 / 61

C2.V.2 Measure standard

Within 24 hours

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health:
Behavioral Health -
Urgent Care Services

C2.V.5 Region

Metro

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Appointment wait time

60 / 61

C2.V.2 Measure standard

Within 14 days

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health:
Behavioral Health -

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

Routine Services

C2.V.7 Monitoring Methods

Custom method - Plan reporting

C2.V.8 Frequency of oversight methods

Annually



Complete

C2.V.3 Standard type: Appointment wait time

61 / 61

C2.V.2 Measure standard

Immediately (Available 24 hours a day, 365 days a year)

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider

Mental health:
Behavioral Health -
Emergency Services

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Custom method - Plan Reporting

C2.V.8 Frequency of oversight methods

Annually

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	BSS website List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://ncmedicaidombudsman.org/ https://ncmedicaidplans.gov/ https://medicaid.ncdhhs.gov/
C1IX.2	BSS auxiliary aids and services How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2)? 42 CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	NC Medicaid Enrollment Broker: - Accessible via website - Offer free auxiliary aids and services, including information in other languages or formats such as large print or audio. - Live/in-person events - Member resources web page - Toll free phone number, TTY, and free telecom service for deaf, hard of hearing and DeafBlind. - Online chat tool NC Medicaid Ombudsman: - Accessible via website - Toll free phone number - Member resources web page - Interactive monthly webinars (recorded and available on YouTube) -Offers updates on Social Media
C1IX.3	BSS LTSS program data How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	They submit summary reports and trend Monitoring reports to the department highlighting any areas where complaints and grievances are occurring. By supporting the State in measuring the following metrics: - Average Handling Time - Abandonment Rate - Service Level - Average Speed of Answer
C1IX.4	State evaluation of BSS entity performance What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	NC Medicaid Enrollment Broker: - Call Center Service Level Agreement Requirements and Monitoring - Quality Monitoring: Call Listening sessions using calibration template for % of calls - Customer surveys - Enrollments completed - Staffing NC Medicaid Ombudsman - Call Center Service Level Agreement Requirements and Monitoring - Customer surveys - Staffing

Topic X: Program Integrity

Number	Indicator	Response
C1X.3	Prohibited affiliation disclosure Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Topic XII. Mental Health and Substance Use Disorder Parity

Number	Indicator	Response
C1XII.4	<p>Does this program include MCOs?</p> <p>If “Yes”, please complete the following questions.</p>	Yes
C1XII.5	<p>Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system?</p> <p>(i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)</p>	No
C1XII.6	<p>Did the State or MCOs complete the most recent parity analysis(es)?</p>	Other, specify – The State gathered information from the MCOs to complete the analysis. The State also completed an analysis of the Department's Clinical Coverage Policies.
C1XII.7a	<p>Have there been any events in the reporting period that necessitated an update to the parity analysis(es)?</p> <p>(e.g. changes in benefits, quantitative treatment limits (QTLs), non-quantitative treatment limits (NQTLs), or financial requirements; the addition of a new managed care plan (MCP) providing services to MCO enrollees; and/or deficiencies corrected)</p>	Yes
C1XII.7b	<p>Describe the event(s) that necessitated an update to the parity analysis(es).</p> <p>Select all that apply.</p>	<p>Changes in quantitative treatment limits (QTLs), (limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits)</p> <p>Changes in non-quantitative treatment limits (NQTLs), (which otherwise limit the scope or duration of benefits, e.g., utilization management, network admission standards)</p>
C1XII.8	<p>When was the last parity analysis(es) for this program completed?</p> <p>States with ANY services provided to MCO enrollees by an entity other than an MCO</p>	04/01/2025

should report the date the state completed its most recent summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date any MCO sent the state its parity analysis (the state may have multiple reports, one for each MCO).

C1XII.9	When was the last parity analysis(es) for this program submitted to CMS? States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).	04/01/2025
C1XII.10a	In the last analysis(es) conducted, were any deficiencies identified?	No
C1XII.12a	Has the state posted the current parity analysis(es) covering this program on its website? The current parity analysis/analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO enrollees by an entity other than MCO should have a single state summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than the MCO may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A "Yes" response means that the parity analysis for either the state or for ALL MCOs has been posted.	Yes

C1XII.12b	Provide the URL link(s). Response must be a valid hyperlink/URL beginning with "http://" or "https://". Separate links with commas.	https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies/mental-health-parity
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Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	Plan enrollment Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	Alliance 62,918
		Partners 47,715
		Trillium 83,130
		Vaya 42,707
D1I.2	Plan share of Medicaid What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? Numerator: Plan enrollment (D1.I.1)Denominator: Statewide Medicaid enrollment (B.I.1)	Alliance 2%
		Partners 1.5%
		Trillium 2.7%
		Vaya 1.4%
D1I.3	Plan share of any Medicaid managed care What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care?Numerator: Plan enrollment (D1.I.1)Denominator: Statewide Medicaid managed care enrollment (B.I.2)	Alliance 2.2%
		Partners 1.7%
		Trillium 2.9%
		Vaya 1.5%
D1I.4: Parent	Organization: The name of the parent entity that controls the Medicaid Managed Care Plan. If the managed care plan is owned or controlled by a separate entity (parent), report the name of that entity. If the managed care plan is not	Alliance Alliance Health
		Partners Partners Health Management
		Trillium

controlled by a separate entity,
please report the managed
care plan name in this field.

Trillium Health Resources

Vaya

Vaya Health

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	Medical Loss Ratio (MLR) What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.	Alliance
		95.74%
		Partners
		94.28%
D1II.1b	Level of aggregation What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	Trillium
		94.4%
		Vaya
		90.4%
D1II.1b	Level of aggregation What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	Alliance
		Program-specific regional
		Partners
		Program-specific regional
D1II.2	Population specific MLR description Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	Trillium
		Program-specific regional
		Vaya
		Program-specific regional
D1II.2	Population specific MLR description Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	Alliance
		n/a
		Partners
		n/a
D1II.2	Population specific MLR description Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	Trillium
		n/a
		Vaya
		n/a

D1II.3	MLR reporting period discrepancies Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	Alliance
		No
		Partners
		No
		Trillium
		No
		Vaya
		No

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	<p>Definition of timely encounter data submissions</p> <p>Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.</p>	<p>Alliance</p> <p>Medical encounters must be submitted within 30 days of claims payment. Pharmacy encounters must be submitted within 7 days of claims payment. For the purposes of this standard, medical is any 837-P transaction with no lines that contain an NDC OR any 837-I transaction with bill type other than 13x OR any 837-I transaction with bill type of 13x and no lines that contain an NDC. Pharmacy is any NCPDP transaction OR any 837-P transaction where at least one line contains an NDC OR any 837-I transaction with bill type 13x and at least one line that contains an NDC.</p> <p>Partners</p> <p>Medical encounters must be submitted within 30 days of claims payment. Pharmacy encounters must be submitted within 7 days of claims payment. For the purposes of this standard, medical is any 837-P transaction with no lines that contain an NDC OR any 837-I transaction with bill type other than 13x OR any 837-I transaction with bill type of 13x and no lines that contain an NDC. Pharmacy is any NCPDP transaction OR any 837-P transaction where at least one line contains an NDC OR any 837-I transaction with bill type 13x and at least one line that contains an NDC.</p> <p>Trillium</p> <p>Medical encounters must be submitted within 30 days of claims payment. Pharmacy encounters must be submitted within 7 days of claims payment. For the purposes of this standard, medical is any 837-P transaction with no lines that contain an NDC OR any 837-I transaction with bill type other than 13x OR any 837-I transaction with bill type of 13x and no lines that contain an NDC. Pharmacy is any NCPDP transaction OR any 837-P transaction where at least one line contains an NDC OR any 837-I transaction with bill</p>

type 13x and at least one line that contains an NDC.

Vaya

Medical encounters must be submitted within 30 days of claims payment. Pharmacy encounters must be submitted within 7 days of claims payment. For the purposes of this standard, medical is any 837-P transaction with no lines that contain an NDC OR any 837-I transaction with bill type other than 13x OR any 837-I transaction with bill type of 13x and no lines that contain an NDC. Pharmacy is any NCPDP transaction OR any 837-P transaction where at least one line contains an NDC OR any 837-I transaction with bill type 13x and at least one line that contains an NDC.

D1III.2

Share of encounter data submissions that met state's timely submission requirements

What percent of the plan's encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.

Alliance

121.43%

Partners

133.88%

Trillium

121.23%

Vaya

100%

D1III.3

Share of encounter data submissions that were HIPAA compliant

What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed

Alliance

100%

Partners

100%

Trillium

100%

Vaya

100%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	Appeals resolved (at the plan level) Enter the total number of appeals resolved during the reporting year. An appeal is “resolved” at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary’s representative) chooses to file a request for a State Fair Hearing or External Medical Review.	Alliance
		160
		Partners
		848
		Trillium
		625
		Vaya
		352
D1IV.1a	Appeals denied Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee.	Alliance
		90
		Partners
		522
		Trillium
		188
		Vaya
		251
D1IV.1b	Appeals resolved in partial favor of enrollee Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee.	Alliance
		11
		Partners
		12
		Trillium
		65
		Vaya
		10
D1IV.1c	Appeals resolved in favor of enrollee Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee.	Alliance
		65
		Partners
		314

		Trillium
		382
		Vaya
		91
D1IV.2	Active appeals	
	Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	Alliance
		0
		Partners
		0
		Trillium
		0
		Vaya
		0
D1IV.3	Appeals filed on behalf of LTSS users	
	Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter "N/A" if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	Alliance
		1
		Partners
		111
		Trillium
		23
		Vaya
		319
D1IV.4	Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal	
	For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A". Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the	Alliance
		2
		Partners
		3
		Trillium
		0
		Vaya
		6

reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter “N/A”. The appeal and critical incident do not have to have been “related” to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.

D1IV.5a	Standard appeals for which timely resolution was provided	Alliance
	Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	143
		Partners
		760
		Trillium
		572
		Vaya
		272
D1IV.5b	Expedited appeals for which timely resolution was provided	Alliance
	Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	23
		Partners
		78
		Trillium
		62
		Vaya
		73

D1IV.6a	Resolved appeals related to denial of authorization or limited authorization of a service	Alliance
		161
		Partners
		847
		Trillium
	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service.(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	630
		Vaya
		304
D1IV.6b	Resolved appeals related to reduction, suspension, or termination of a previously authorized service	Alliance
		3
		Partners
		1
		Trillium
	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	0
		Vaya
		43
D1IV.6c	Resolved appeals related to payment denial	Alliance
		2
		Partners
		0
		Trillium
	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	5
		Vaya
		5
D1IV.6d	Resolved appeals related to service timeliness	Alliance
		0
		Partners
		0
		Trillium
	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	0

Vaya

0

D1IV.6e

Resolved appeals related to lack of timely plan response to an appeal or grievance

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

Alliance

0

Partners

0

Trillium

0

Vaya

0

D1IV.6f

Resolved appeals related to plan denial of an enrollee's right to request out-of-network care

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).

Alliance

0

Partners

0

Trillium

0

Vaya

0

D1IV.6g

Resolved appeals related to denial of an enrollee's request to dispute financial liability

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.

Alliance

0

Partners

0

Trillium

0

Vaya

0

Appeals by Service

Number of appeals resolved during the reporting period related to various services.

Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Number	Indicator	Response
D1IV.7a	Resolved appeals related to general inpatient services Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter “N/A”.	Alliance
		10
		Partners
		3
D1IV.7b	Resolved appeals related to general outpatient services Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter “N/A”.	Trillium
		4
		Vaya
		0
D1IV.7c	Resolved appeals related to inpatient behavioral health services Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter “N/A”.	Alliance
		8
		Partners
		32
D1IV.7d	Resolved appeals related to outpatient behavioral health services Enter the total number of appeals resolved by the plan during the reporting year that	Trillium
		11
		Vaya
		3
D1IV.7c	Resolved appeals related to inpatient behavioral health services Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter “N/A”.	Alliance
		0
		Partners
		1
D1IV.7d	Resolved appeals related to outpatient behavioral health services Enter the total number of appeals resolved by the plan during the reporting year that	Trillium
		3
		Vaya
		0
D1IV.7a	Resolved appeals related to general inpatient services Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter “N/A”.	Alliance
		63
		Partners

	<p>were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".</p>	<p>92</p> <p>Trillium</p> <p>12</p> <p>Vaya</p> <p>123</p>
D1IV.7e	<p>Resolved appeals related to covered outpatient prescription drugs</p> <p>Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".</p>	<p>Alliance</p> <p>14</p> <p>Partners</p> <p>464</p> <p>Trillium</p> <p>548</p> <p>Vaya</p> <p>104</p>
D1IV.7f	<p>Resolved appeals related to skilled nursing facility (SNF) services</p> <p>Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".</p>	<p>Alliance</p> <p>0</p> <p>Partners</p> <p>0</p> <p>Trillium</p> <p>0</p> <p>Vaya</p> <p>0</p>
D1IV.7g	<p>Resolved appeals related to long-term services and supports (LTSS)</p> <p>Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A". (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).</p>	<p>Alliance</p> <p>43</p> <p>Partners</p> <p>117</p> <p>Trillium</p> <p>4</p> <p>Vaya</p> <p>118</p>

D1IV.7h	<p>Resolved appeals related to dental services</p> <p>Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".</p>	<p>Alliance</p> <p>N/A</p> <p>Partners</p> <p>N/A</p> <p>Trillium</p> <p>N/A</p> <p>Vaya</p> <p>N/A</p>
D1IV.7i	<p>Resolved appeals related to non-emergency medical transportation (NEMT)</p> <p>Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".</p>	<p>Alliance</p> <p>0</p> <p>Partners</p> <p>0</p> <p>Trillium</p> <p>0</p> <p>Vaya</p> <p>2</p>
D1IV.7k:	<p>Resolved appeals related to durable medical equipment (DME) & supplies</p> <p>Enter the total number of appeals resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter "N/A".</p>	<p>Alliance</p> <p>26</p> <p>Partners</p> <p>126</p> <p>Trillium</p> <p>20</p> <p>Vaya</p> <p>0</p>
D1IV.7l:	<p>Resolved appeals related to home health / hospice</p> <p>Enter the total number of appeals resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter "N/A".</p>	<p>Alliance</p> <p>0</p> <p>Partners</p> <p>11</p> <p>Trillium</p> <p>29</p>

D1IV.7m:	Resolved appeals related to emergency services / emergency department	Alliance
	Enter the total number of appeals resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include appeals related to emergency outpatient behavioral health – those should be included in indicator D1.IV.7d. If the managed care plan does not cover this type of service, enter “N/A”.	0
		Partners
		0
		Trillium
		0
		Vaya
		0
D1IV.7n:	Resolved appeals related to therapies	Alliance
	Enter the total number of appeals resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter “N/A”.	1
		Partners
		0
		Trillium
		2
		Vaya
		2
D1IV.7o	Resolved appeals related to other service types	Alliance
	Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-n paid primarily by Medicaid, enter “N/A”.	1
		Partners
		2
		Trillium
		2
		Vaya
		0

Number	Indicator	Response
D1IV.8a	State Fair Hearing requests Enter the total number of State Fair Hearing requests resolved during the reporting year with the plan that issued an adverse benefit determination.	Alliance
		9
		Partners
		70
		Trillium
D1IV.8b	State Fair Hearings resulting in a favorable decision for the enrollee Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	Alliance
		2
		Partners
		0
		Trillium
D1IV.8c	State Fair Hearings resulting in an adverse decision for the enrollee Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	Alliance
		0
		Partners
		0
		Trillium
		Vaya
		55
		Vaya
		4
		Vaya
		0
		Vaya
		0

D1IV.8d	<p>State Fair Hearings retracted prior to reaching a decision</p> <p>Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.</p>	<p>Alliance</p> <p>7</p> <p>Partners</p> <p>70</p> <p>Trillium</p> <p>17</p> <p>Vaya</p> <p>49</p>
D1IV.9a	<p>External Medical Reviews resulting in a favorable decision for the enrollee</p> <p>If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).</p>	<p>Alliance</p> <p>N/A</p> <p>Partners</p> <p>N/A</p> <p>Trillium</p> <p>N/A</p> <p>Vaya</p> <p>N/A</p>
D1IV.9b	<p>External Medical Reviews resulting in an adverse decision for the enrollee</p> <p>If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).</p>	<p>Alliance</p> <p>N/A</p> <p>Partners</p> <p>N/A</p> <p>Trillium</p> <p>N/A</p> <p>Vaya</p> <p>N/A</p>

Grievances Overview

Number	Indicator	Response
D1IV.10	Grievances resolved Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. A grievance is “resolved” when it has reached completion and been closed by the plan.	Alliance
		1,520
		Partners
		584
		Trillium
		1,053
		Vaya
		1,143
D1IV.11	Active grievances Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	Alliance
		0
		Partners
		0
		Trillium
		0
		Vaya
		0
D1IV.12	Grievances filed on behalf of LTSS users Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	Alliance
		44
		Partners
		301
		Trillium
		119
		Vaya
		851
D1IV.13	Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on	Alliance
		24
		Partners
		8
		Trillium

behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been “related” to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter “N/A” in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter “N/A” in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.

4

Vaya

15

D1IV.14

Number of grievances for which timely resolution was provided

Enter the number of grievances for which timely resolution was provided by plan during the reporting year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.

Alliance

1,494

Partners

584

Trillium

1,049

Vaya

1,141

Grievances by Service

Report the number of grievances resolved by plan during the reporting period by service.

Number	Indicator	Response
D1IV.15a	Resolved grievances related to general inpatient services Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter “N/A”.	Alliance
		25
		Partners
		0
		Trillium
D1IV.15b	Resolved grievances related to general outpatient services Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Do not include grievances related to outpatient behavioral health services - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter “N/A”.	Alliance
		255
		Partners
		10
		Trillium
D1IV.15c	Resolved grievances related to inpatient behavioral health services Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter “N/A”.	Alliance
		58
		Partners
		8
		Trillium
D1IV.15d	Resolved grievances related to outpatient behavioral health services	Alliance
		507
		Partners
		0
		Trillium
D1IV.15c	Resolved grievances related to inpatient behavioral health services Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter “N/A”.	Alliance
		58
		Partners
		8
		Trillium
D1IV.15d	Resolved grievances related to outpatient behavioral health services	Alliance
		507
		Partners
		0
		Trillium
D1IV.15c	Resolved grievances related to inpatient behavioral health services Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter “N/A”.	Alliance
		58
		Partners
		8
		Trillium
D1IV.15d	Resolved grievances related to outpatient behavioral health services	Alliance
		507
		Partners
		0
		Trillium

	Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	Partners 82 Trillium 222 Vaya 241
D1IV.15e	Resolved grievances related to coverage of outpatient prescription drugs Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	Alliance 16 Partners 9 Trillium 53 Vaya 29
D1IV.15f	Resolved grievances related to skilled nursing facility (SNF) services Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	Alliance 0 Partners 0 Trillium 0 Vaya 1
D1IV.15g	Resolved grievances related to long-term services and supports (LTSS) Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	Alliance 85 Partners 41 Trillium 21 Vaya 54

D1IV.15h	Resolved grievances related to dental services Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	Alliance N/A Partners N/A Trillium N/A Vaya N/A
D1IV.15i	Resolved grievances related to non-emergency medical transportation (NEMT) Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	Alliance 438 Partners 413 Trillium 586 Vaya 351
D1IV.15k	Resolved grievances related to durable medical equipment (DME) & supplies Enter the total number of grievances resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter "N/A".	Alliance 3 Partners 3 Trillium 3 Vaya 7
D1IV.15l	Resolved grievances related to home health / hospice Enter the total number of grievances resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter "N/A".	Alliance 12 Partners 1 Trillium 6

D1IV.15m	<p>Resolved grievances related to emergency services / emergency department</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include grievances related to emergency outpatient behavioral health - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".</p>	<p>Alliance</p> <p>27</p> <p>Partners</p> <p>0</p> <p>Trillium</p> <p>0</p> <p>Vaya</p> <p>3</p>
D1IV.15n	<p>Resolved grievances related to therapies</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter "N/A".</p>	<p>Alliance</p> <p>6</p> <p>Partners</p> <p>2</p> <p>Trillium</p> <p>0</p> <p>Vaya</p> <p>10</p>
D1IV.15o	<p>Resolved grievances related to other service types</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-n paid primarily by Medicaid, enter "N/A".</p>	<p>Alliance</p> <p>88</p> <p>Partners</p> <p>15</p> <p>Trillium</p> <p>107</p> <p>Vaya</p> <p>5</p>

Grievances by Reason

Report the number of grievances resolved by plan during the reporting period by reason.

Number	Indicator	Response
D1IV.16a	Resolved grievances related to plan or provider customer service Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	Alliance
		104
		Partners
		32
		Trillium
		136
		Vaya
		34
D1IV.16b	Resolved grievances related to plan or provider care management/case management Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	Alliance
		97
		Partners
		0
		Trillium
		53
		Vaya
		15
D1IV.16c	Resolved grievances related to network adequacy or access to care/services from plan or provider Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	Alliance
		895
		Partners
		451
		Trillium
		617
		Vaya
		485
D1IV.16d	Resolved grievances related to quality of care Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or	Alliance
		196
		Partners
		52
		Trillium

acceptability of care provided by a provider or the plan.

61

Vaya

143

D1IV.16e

Resolved grievances related to plan communications

Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.

Alliance

22

Partners

3

Trillium

35

Vaya

2

D1IV.16f

Resolved grievances related to payment or billing issues

Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.

Alliance

83

Partners

18

Trillium

62

Vaya

364

D1IV.16g

Resolved grievances related to suspected fraud

Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetrated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.

Alliance

3

Partners

2

Trillium

1

Vaya

1

D1IV.16h

Resolved grievances related to abuse, neglect or exploitation

Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or

Alliance

51

Partners

	exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	11
		Trillium
		37
		Vaya
		32
D1IV.16i	<p>Resolved grievances related to lack of timely plan response to a prior authorization/service authorization or appeal (including requests to expedite or extend appeals)</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).</p>	<p>Alliance</p> <p>10</p> <p>Partners</p> <p>0</p> <p>Trillium</p> <p>3</p> <p>Vaya</p> <p>1</p>
D1IV.16j	<p>Resolved grievances related to plan denial of expedited appeal</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.</p>	<p>Alliance</p> <p>0</p> <p>Partners</p> <p>0</p> <p>Trillium</p> <p>0</p> <p>Vaya</p> <p>0</p>
D1IV.16k	<p>Resolved grievances filed for other reasons</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.</p>	<p>Alliance</p> <p>69</p> <p>Partners</p> <p>21</p> <p>Trillium</p> <p>57</p> <p>Vaya</p> <p>66</p>

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.



D2.VII.1 Measure Name: Follow-up After Hospitalization for Mental Illness (FUH)

1 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0576

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: NC Medicaid Standard Plan Measure Set, NC Medicaid Tailored Plan Measure Set, NC Medicaid PIHP Measure Set

D2.VII.6 Measure Set

Medicaid Adult and Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Alliance

7-Day Follow-Up: 20.41% 30-Day Follow-Up: 39.07%

Partners

7-Day Follow-Up: 22.27% 30-Day Follow-Up: 41.61%

Trillium

7-Day Follow-Up: 19.54% 30-Day Follow-Up: 38.04%

Vaya

7-Day Follow-Up: 20.81% 30-Day Follow-Up: 38.02%



D2.VII.1 Measure Name: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

2 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
2801

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Cross-program rate: NC Medicaid Standard Plan Measure Set, NC Medicaid Tailored Plan Measure Set, NC Medicaid PIHP Measure Set

D2.VII.6 Measure Set
Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description
N/A

Measure results

Alliance
0.4647

Partners
0.4988

Trillium
0.4436

Vaya
0.5653



D2.VII.1 Measure Name: Concurrent Use of Prescription Opioids and Benzodiazepines (COB)*

3 / 20

D2.VII.2 Measure Domain
Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number
3389

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Cross-program rate: NC Medicaid Standard Plan Measure Set, NC Medicaid Tailored Plan Measure Set, NC Medicaid PIHP Measure Set

D2.VII.6 Measure Set
Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Alliance

0.0966

Partners

0.1705

Trillium

0.1241

Vaya

0.1785



Complete

D2.VII.1 Measure Name: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

4 / 20

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

1932

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: NC Medicaid Tailored Plan and PIHP Measure Set

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Alliance

0.8077

Partners

0.8505

Trillium

0.8308

Vaya

0.8564



Complete

D2.VII.1 Measure Name: Follow-up Care for Children Prescribed Attention-Deficity/Hyperactivity Disorder (ADHD) Medication (ADD-E)

5 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0108

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: NC Medicaid PIHP Measure Set, NC Medicaid Tailored Plan Measure Set, NC Medicaid Standard Plan Measure Set

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Alliance

Initiation: 49.19% Continuation: 54.64%

Partners

Initiation: 56.66% Continuation: 63.89%

Trillium

Initiation: 54.86% Continuation: 59.38%

Vaya



Complete

D2.VII.1 Measure Name: Use of Opioids at High Dosage in Persons Without Cancer (OHD)*

6 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

2940

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: NC Medicaid PIHP Measure Set, NC Medicaid Tailored Plan Measure Set

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Alliance

0.0418

Partners

0.0567

Trillium

0.0448

Vaya

0.0305



Complete

D2.VII.1 Measure Name: Use of Pharmacotherapy for Opioid Use Disorder (OUD)- Total Rate

7 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

3400

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: NC Medicaid Tailored Plan Measure Set, NC Medicaid PIHP Measure Set

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results**Alliance**

70.39

Partners

74.79

Trillium

73.08

Vaya

82.38



Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care (PPC)

8 / 20

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

1517

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: NC Medicaid Standard Plan Measure Set, NC Medicaid Tailored Plan Measure Set

D2.VII.6 Measure Set

Medicaid Adult and Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Alliance

Timeliness of Prenatal Care: 45.97% Postpartum Care: 51.09%

Partners

Timeliness of Prenatal Care: 48.01% Postpartum Care: 50.34%

Trillium

Timeliness of Prenatal Care: 42.35% Postpartum Care: 51.96%

Vaya

Timeliness of Prenatal Care: 56.66% Postpartum Care: 52.04%



Complete

D2.VII.1 Measure Name: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)- Total Metabolic Testing

9 / 20

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

2800

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: NC Medicaid Tailored Plan Measure Set, NC Medicaid PIHP Measure Set

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A`

Measure results

Alliance

Total Metabolic Testing: 36.19%

Partners

Total Metabolic Testing: 39.22%

Trillium

Total Metabolic Testing: 34.20%

Vaya

Total Metabolic Testing: 34.29%



Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness (FUM) 10 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

3489

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: NC Medicaid Standard Plan Measure Set, NC Medicaid Tailored Plan Measure Set, NC Medicaid PIHP Measure Set

D2.VII.6 Measure Set

Medicaid Adult and Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Alliance

7-Day Follow-Up: 41.49% 30-Day Follow-Up: 57.31%

Partners

7-Day Follow-Up: 54.20% 30-Day Follow-Up: 67.71%

Trillium

7-Day Follow-Up: 40.68% 30-Day Follow-Up: 59.24%

Vaya

7-Day Follow-Up: 47.56% 30-Day Follow-Up: 61.56%



Complete

D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits (WCV) 11 / 20

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1516

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: NC Medicaid Standard Plan Measure Set, NC Medicaid Tailored Plan Measure Set, NC Medicaid CCNC Measure Set

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Alliance

0.5367

Partners

0.5566

Trillium

0.5322

Vaya

0.5134



Complete

D2.VII.1 Measure Name: Childhood Immunization Status (CIS-E) - Combination 10 12 / 20

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: NC Medicaid Standard Plan Measure Set, NC Medicaid Tailored Plan Measure Set, NC Medicaid CCNC Measure Set

D2.VII.6 Measure Set
Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description
N/A

Measure results

Alliance
Combination 10: 31.33%

Partners
Combination 10: 25.13%

Trillium
Combination 10: 29.25%

Vaya
Combination 10: 19.29%



D2.VII.1 Measure Name: Immunizations for Adolescents (IMA-E) - Combination 2

13 / 20

D2.VII.2 Measure Domain
Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number
1407

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Cross-program rate: NC Medicaid Standard Plan Measure Set, NC Medicaid Tailored Plan Measure Set, NC Medicaid CCNC Measure Set

D2.VII.6 Measure Set
Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description
N/A

Measure results

Alliance

Combination 2: 31.66%

Partners

Combination 2: 30.66%

Trillium

Combination 2: 31.42%

Vaya

Combination 2: 28.22%



Complete

D2.VII.1 Measure Name: Lead Screening in Children (LSC)

14 / 20

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1775

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: NC Medicaid Standard Plan Measure Set, NC Medicaid Tailored Plan Measure Set, NC Medicaid CCNC Measure Set

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Alliance

0.6698

Partners

0.5596

Trillium

0.6192

Vaya
0.6986



D2.VII.1 Measure Name: Cervical Cancer Screening (CCS-E)

15 / 20

D2.VII.2 Measure Domain

Primary care access and preventative care

**D2.VII.3 National Quality
Forum (NQF) number**
0032

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Cross-program rate: NC Medicaid Standard Plan
Measure Set, NC Medicaid Tailored Plan
Measure Set, NC Medicaid CCNC Measure Set

D2.VII.6 Measure Set
Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**
No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Alliance
0.387

Partners
0.3963

Trillium
0.4159

Vaya
0.385



D2.VII.1 Measure Name: Getting Needed Care

16 / 20

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: CAHPS survey used for Standard Plans, EBCI Tribal Option, NC Medicaid Direct, and Tailored Plan population

D2.VII.6 Measure Set

AHRQ CAHPS Health Plan 5.1H Survey

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Percentage responding “Always” or “Usually”

Measure results

Alliance

Adult: 82.12% Child: 86.41%

Partners

Adult: 85.55% Child: 87.49%

Trillium

Adult: 84.84% Child: 87.27%

Vaya

Adult: 89.29% Child: 87.29%



Complete

D2.VII.1 Measure Name: Getting Care Quickly

17 / 20

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: CAHPS survey used for Standard Plans, EBCI Tribal Option, NC Medicaid Direct, and Tailored Plan population

D2.VII.6 Measure Set

AHRQ CAHPS Health Plan 5.1H Survey

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Percentage responding “Always” or “Usually”

Measure results

Alliance

Adult: 84.92% Child: 89.25%

Partners

Adult: 84.66% Child: 93.16%

Trillium

Adult: 84.84% Child: 89.49%

Vaya

Adult: 83.10% Child: 90.80%



Complete

D2.VII.1 Measure Name: How Well Doctors Communicate

18 / 20

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: CAHPS survey used for Standard Plans, EBCI Tribal Option, NC Medicaid Direct, and Tailored Plan population

D2.VII.6 Measure Set

AHRQ CAHPS Health Plan 5.1H Survey

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Percentage responding “Always” or “Usually”

Measure results

Alliance

Adult: 94.68% Child: 94.90%

Partners

Adult: 96.96% Child: 96.33%

Trillium

Adult: 94.19% Child: 94.70%

Vaya

Adult: 96.00% Child: 96.27%



Complete

D2.VII.1 Measure Name: Health Plan Customer Service

19 / 20

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: CAHPS survey used for Standard Plans, EBCI Tribal Option, NC Medicaid Direct, and Tailored Plan population

D2.VII.6 Measure Set

AHRQ CAHPS Health Plan 5.1H Survey

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Percentage responding “Always” or “Usually”

Measure results

Alliance

Adult: 86.03% Child: 87.38%

Partners

Adult: 89.82% Child: 87.28%

Trillium

Adult: 84.57% Child: 90.40%

Vaya

Adult: 91.74% Child: 91.73%

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: CAHPS survey used for Standard Plans, EBCI Tribal Option, NC Medicaid Direct, and Tailored Plan population

D2.VII.6 Measure Set

AHRQ CAHPS Health Plan 5.1H Survey

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Percentage selecting "8", "9", or "10"

Measure results

Alliance

Adult: 77.39% Child: 82.45%

Partners

Adult: 77.52% Child: 86.69%

Trillium

Adult: 71.68% Child: 79.93%

Vaya

Adult: 76.33% Child: 78.17%

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. The state should include all sanctions the state issued regardless of what entity identified the non-compliance (e.g. the state, an auditing body, the plan, a contracted entity like an external quality review organization).

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.



Complete

D3.VIII.1 Intervention type: Corrective action plan

1 / 2

D3.VIII.2 Plan performance issue

Noncompliance with Preferred Drug List (July 2024 to September 2024)

D3.VIII.3 Plan name

Trillium

D3.VIII.4 Reason for intervention

Contractor's failure to meet the performance standard for compliance with the North Carolina Medicaid Preferred Drug List (PDL) for the performance period.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

05/06/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 06/05/2025

D3.VIII.9 Corrective action plan

Yes



Complete

D3.VIII.1 Intervention type: Corrective action plan

2 / 2

D3.VIII.2 Plan performance issue

Noncompliance with Provider Welcome Packet Mailing Timeframes (July 2024 - September 2024)

D3.VIII.3 Plan name

Trillium

D3.VIII.4 Reason for intervention

Contractor's failure to meet the mailing timeframes specified in the Contract for sending provider welcome packets during the performance period.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.7 Date assessed

05/13/2025

D3.VIII.9 Corrective action plan

Yes

D3.VIII.6 Sanction amount

N/A

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 09/26/2025

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	Dedicated program integrity staff Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	Alliance
		37
		Partners
		8
		Trillium
D1X.2	Count of opened program integrity investigations How many program integrity investigations were opened by the plan during the reporting year?	Alliance
		88
		Partners
		54
		Trillium
D1X.4	Count of resolved program integrity investigations How many program integrity investigations were resolved by the plan during the reporting year?	Alliance
		67
		Partners
		35
		Trillium
D1X.6	Referral path for program integrity referrals to the state What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	Alliance
		Makes referrals to the State Medicaid Agency (SMA) only
		Partners

Makes referrals to the State Medicaid
Agency (SMA) only

Trillium

Makes referrals to the State Medicaid
Agency (SMA) only

Vaya

Makes referrals to the State Medicaid
Agency (SMA) only

D1X.7

**Count of program integrity
referrals to the state**

Enter the count of program
integrity referrals that the plan
made to the state in the past
year. Enter the count of
referrals made.

Alliance

29

Partners

12

Trillium

24

Vaya

2

D1X.9a:

**Plan overpayment reporting
to the state: Start Date**

What is the start date of the
reporting period covered by the
plan's latest overpayment
recovery report submitted to
the state?

Alliance

07/01/2024

Partners

07/01/2024

Trillium

07/01/2024

Vaya

07/01/2024

D1X.9b:

**Plan overpayment reporting
to the state: End Date**

What is the end date of the
reporting period covered by the
plan's latest overpayment
recovery report submitted to
the state?

Alliance

06/30/2025

Partners

06/30/2025

Trillium

06/30/2025

Vaya

D1X.9c:	Plan overpayment reporting to the state: Dollar amount From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?	Alliance \$731,871.23 Partners \$19,148.56 Trillium \$1,066,496.41 Vaya \$2,314,586.28
D1X.9d:	Plan overpayment reporting to the state: Corresponding premium revenue What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))	Alliance \$1,782,894,448.38 Partners \$1,351,037,585.50 Trillium \$2,288,363,693.21 Vaya \$1,099,801,244.02
D1X.10	Changes in beneficiary circumstances Select the frequency the plan reports changes in beneficiary circumstances to the state.	Alliance Weekly Partners Weekly Trillium Weekly Vaya Weekly



Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.

If ILOSs are authorized for this program, report for each plan: if the plan offered any ILOS; if "Yes", which ILOS the plan offered; and utilization data for each ILOS offered. If the plan offered an ILOS during the reporting period but there was no utilization, check that the ILOS was offered but enter "0" for utilization.

Number	Indicator	Response
D4XI.1	ILOSs offered by plan Indicate whether this plan offered any ILOS to their enrollees.	<p>Alliance</p> <p>Yes, at least 1 ILOS is offered by this plan</p> <p>Partners</p> <p>Yes, at least 1 ILOS is offered by this plan</p> <p>Trillium</p> <p>Yes, at least 1 ILOS is offered by this plan</p> <p>Vaya</p> <p>Yes, at least 1 ILOS is offered by this plan</p>

D4XI.2a	ILOSs utilization by plan Select all ILOSs offered by this plan during the contract rating period. For each ILOS offered by the plan, enter the deduplicated number of enrollees that utilized this ILOS during the contract rating period. If the plan offered this ILOS during the contract rating period but there was no utilization, enter "0".	<p>Alliance</p> <p>Behavioral Health Crisis Assessment and Intervention:</p> <p>Child ACT:</p> <p>Family Centered Treatment:</p> <p>High Fidelity Wraparound:</p> <p>In-Home Therapy Services:</p> <p>Long Term Community Supports:</p> <p>Residential Services - Complex Needs:</p> <p>Short Term Residential Stabilization:</p> <p>Transitional Youth Services:</p> <p>Partners</p> <p>ACT - Step Down:</p> <p>Behavioral Health Urgent Care:</p> <p>Family Centered Treatment:</p> <p>High Fidelity Wraparound:</p> <p>In-Home Therapy Services:</p> <p>Individual Rehabilitation, Coordination, and Support :</p> <p>Long Term Community Supports:</p> <p>Rapid Care:</p> <p>Residential Services - Complex Needs:</p> <p>Transitional Youth Services:</p> <p>Trillium</p> <p>Behavioral Health Crisis Assessment and Intervention:</p> <p>Child First:</p>
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Community Living Facilities and Support:

Family Centered Treatment:

Family Navigator:

High Fidelity Wraparound:

Vaya

ACT - Step Down:

Behavioral Health Crisis Assessment and Intervention:

Child ACT:

Critical Time Intervention:

Enhanced Crisis Response:

Family Centered Treatment:

Family Navigator:

High Fidelity Wraparound:

In-Home Therapy Services:

Long Term Community Supports:

Outpatient Plus:

Rapid Care:

Residential Services - Complex Needs:

Transitional Youth Services:

Topic XIII. Prior Authorization

⚠ Beginning June 2026, Indicators D1.XIII.1-15 must be completed. Submission of this data including partial reporting on some but not all plans, before June 2026 is optional; if you choose not to respond prior to June 2026, select “Not reporting data”.

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026? If “Yes”, please complete the following questions under each plan.	Not reporting data

Topic XIV. Patient Access API Usage



Beginning June 2026, Indicators D1.XIV.1-2 must be completed. Submission of this data before June 2026 is optional; if you choose not to respond prior to June 2026, select “Not reporting data”.

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026? If “Yes”, please complete the following questions under each plan.	Not reporting data

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Per 42 CFR 438.66(e)(2)(ix), the Managed Care Program Annual Report must provide information on and an assessment of the operation of the managed care program including activities and performance of the beneficiary support system. Information on how BSS entities support program-level functions is on the Program-Level BSS page.

Number	Indicator	Response
EIX.1	BSS entity type What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	NC Medicaid Ombudsman Ombudsman Program
		NC Medicaid Enrollment Broker Enrollment Broker
EIX.2	BSS entity role What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	NC Medicaid Ombudsman Other, specify – Program Information/Rights & Responsibilities/Referrals
		NC Medicaid Enrollment Broker Enrollment Broker/Choice Counseling

Section F: Notes

Notes

Use this section to optionally add more context about your submission. If you choose not to respond, proceed to “Review & submit.”

Number	Indicator	Response
F1	Notes (optional)	Not answered