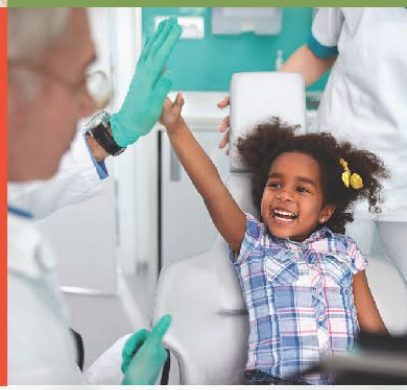
NC MEDICAID

ANNUAL TECHNICAL REPORT

March 2024

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES




HSAG
HEALTH SERVICES ADVISORY GROUP

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Appendices

EXECUTIVE SUMMARY

Introduction to the Annual Technical Report

Title 42 of the Code of Federal Regulations (42 CFR) at §438.364 requires that state Medicaid programs use an external quality review organization (EQRO) to prepare an annual, independent technical report that provides a description of how the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the Medicaid managed care organizations (MCOs). Appendix A lists the required and recommended elements for the external quality review (EQR) technical report.

The North Carolina (NC) Department of Health and Human Services' (DHHS') Division of Health Benefits (DHB or the Department) is the state agency responsible for the overall administration of NC's Medicaid managed care program. This state fiscal year (SFY) 2023 (July 1, 2022, to June 30, 2023) EQR technical report was prepared for the Department by Health Services Advisory Group, Inc. (HSAG), the Department's EQRO. HSAG contracted with the Department as of May 24, 2021.

For a list of acronyms and abbreviations used in this report, please reference Appendix B.

Overview of NC's Managed Care Program

Statewide Medicaid Managed Care

In September 2015, the NC General Assembly enacted Session Law 2015-245, directing the transition of the State's Medicaid program from a predominantly fee-for-service (FFS) structure to a capitated managed care structure. Since that time, the Department has collaborated with the General Assembly and stakeholders to plan the implementation of this directive. The Department is committed to transitioning NC to Medicaid managed care to advance high-value care, improve population health, engage and support beneficiaries and providers, and establish a sustainable program with predictable costs.

Healthcare Programs Offered by NC Medicaid

Type	Population Served	Description
Standard Plans	Most Medicaid beneficiaries, including those with low to moderate intensity behavioral health needs.	Provides integrated physical health, pharmacy, care coordination, and basic behavioral health services. Launched on July 1, 2021.
Eastern Band of Cherokee Indians (EBCI) Tribal Option	Federally recognized tribal members and others who qualify for services through Indian Health Service (IHS) who live in the following counties: Buncombe, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, Swain, Transylvania.	A primary care case management entity created by the Cherokee Indian Hospital Authority (CIHA) that provides care coordination and management of medical, behavioral health, pharmacy, and support services. Launched on July 1, 2021.
Future Program: Tailored Plans	Members with significant mental health needs, severe substance use disorders, intellectual/developmental disabilities (I/DDs) or traumatic brain injuries (TBIs).	Offers the same integrated health services as Standard Plans but also provides enhanced I/DD, TBI, and behavioral health services.[1] The Tailored Plans are projected to launch in July 2024.
NC Medicaid Direct	Beneficiaries who are not enrolled in managed care Health Plans.[2]	The new name for the traditional Medicaid fee-for-service program. Provides care management for physical health services through Community Care of North Carolina (CCNC) and care coordination for behavioral health, I/DD, or TBI through six Local Management Entity-Managed Care Organizations (LME-MCOs), also described as prepaid inpatient health plans (PIHPs).
Future Program: Children and Families Specialty Plan (CFSP)	The Department intends to launch a single statewide CFSP to mitigate disruptions in care and coverage for children, youth, and families served by the child welfare system.	The CFSP will ensure access to comprehensive physical and behavioral health (BH) services while maintaining treatment plans when placements change. The CFSP will include care management services to improve coordination among service providers, families, involved entities (e.g., Department of Social Services, Division of Juvenile Justice, schools), and other stakeholders involved in serving the CFSP's members.

1 Behavioral health services = mental health disorder and substance use disorder services.
2 In this document, references to "Health Plans" include Prepaid Health Plans/Standard Plans.

A full list of health plans can be found in Appendix C.

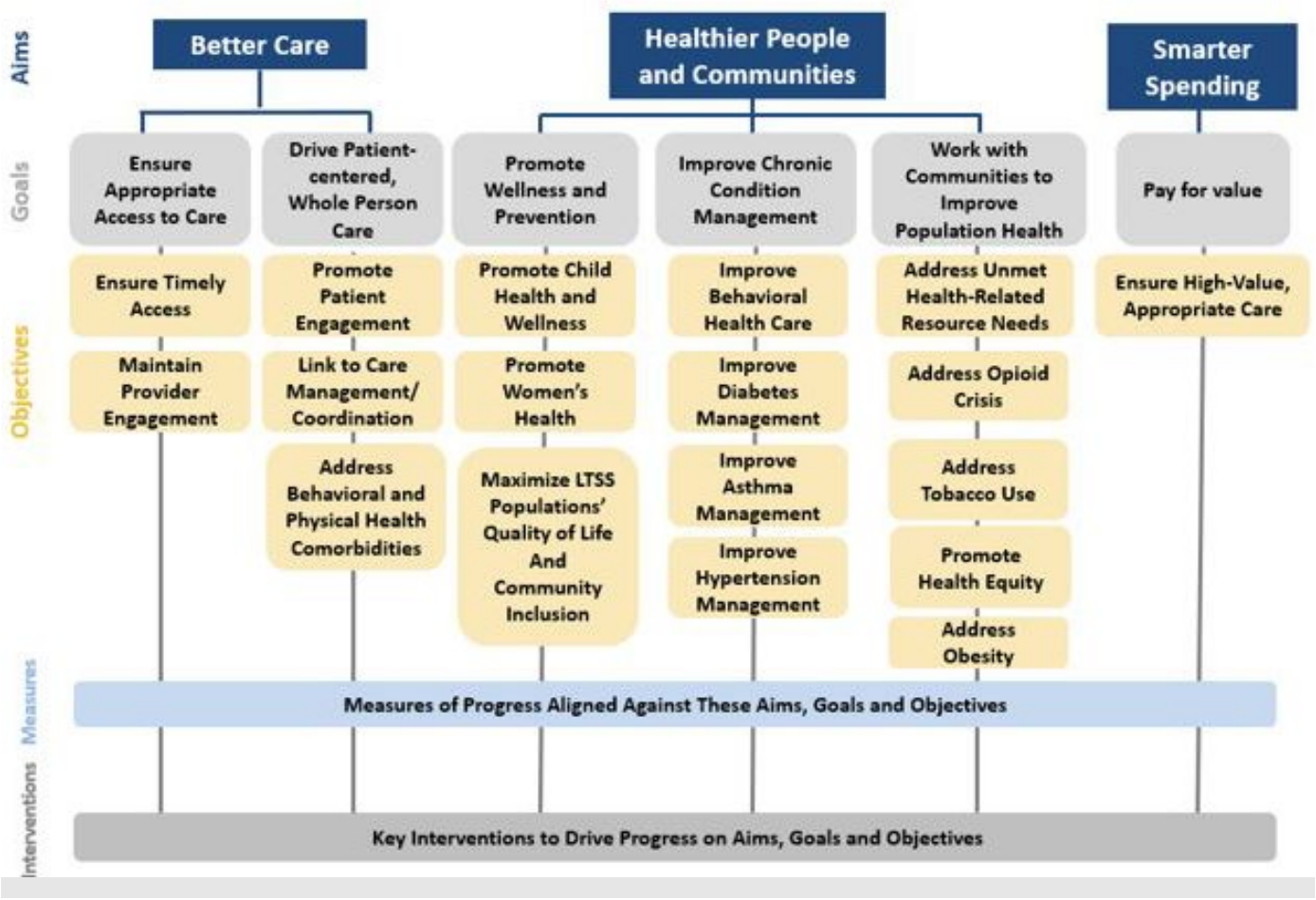
Quality Strategy

The Centers for Medicare & Medicaid Services (CMS) Medicaid managed care regulations at 42 CFR §438.340 require state Medicaid agencies operating Medicaid managed care programs to develop and implement a written quality strategy for assessing and improving the quality of healthcare services offered to their enrollees.

The Department's Medicaid Managed Care Quality Strategy (Quality Strategy), first published in 2018 and most recently updated in 2023, details NC Medicaid managed care's aims, goals, and objectives for quality management and improvement and details specific quality improvement initiatives that are priorities for the Department. The Quality Strategy includes a framework reflecting the Department's commitment to three broad aims: Better Care Delivery, Healthier People and Healthier Communities, and Smarter Spending.[3] As depicted in Figure 1, a series of goals and objectives is included with each aim, highlighting key areas of expected progress and quality focus.

[3] North Carolina Department of Health and Human Services, Department of Health Benefits. *North Carolina's Medicaid Managed Care Quality Strategy*, April 11, 2023. Available at: https://medicaid.ncdhhs.gov/nc-medicaid-2023-quality-strategy/download?attachment Accessed on: Jan 8, 2024.

Figure 1—Overview of the Quality Strategy Framework



Each of the 18 objectives are tied to a series of focused interventions used to drive improvements within and, in many cases, across the goals and objectives set forth in the Quality Strategy. To assess the impact of these interventions and continue to identify opportunities for improving the quality of care delivered under Medicaid managed care, these interventions are tied to a set of metrics to assess progress. As baseline data for health plan performance becomes available, the Department intends to further refine the objectives to target specific improvement goals, including additional strategies that promote health equity.

Scope of External Quality Review Activities

As the Department implements managed care, HSAG will conduct mandatory and optional EQR activities, as described in 42 CFR §438.358, in a manner consistent with the associated *CMS External*

Quality Review (EQR) Protocols, February 2023 (CMS EQR Protocols).[4] The purpose of these activities, in general, is to improve states' ability to oversee and manage health plans they contract with for services and help health plans improve their performance with respect to the quality, timeliness, and accessibility of care. Effective implementation of the EQR-related activities will facilitate State efforts to purchase high-value care and to achieve higher-performing healthcare delivery systems for their Medicaid and Children's Health Insurance Program (CHIP) members. For SFY 2023, HSAG conducted activities with the Department for the mandatory EQR activities displayed in Table 1 and the optional activities described in the Optional EQR Activities section.

Table 1—EQR Activities

Activity	Description	CMS EQR Protocol
Mandatory Activities		
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by a health plan used sound methodology in its design, implementation, analysis, and reporting.	**Protocol 1.** Validation of Performance Improvement Projects
Performance Measure Validation (PMV)	This activity assesses whether the performance measures (PMs) calculated by a health plan are accurate based on the measure specifications and State reporting requirements.	**Protocol 2.** Validation of Performance Measures
Compliance With Standards	This activity determines the extent to which a Medicaid and CHIP health plan is in compliance with federal standards and associated state-specific requirements, when applicable.	**Protocol 3.** Review of Compliance With Medicaid and CHIP Managed Care Regulations
Validation of Network Adequacy	This activity assesses the extent to which an managed care plan (MCP) has adequate provider networks in coverage areas to deliver healthcare services to its managed care members.	**Protocol 4.** Validation of Network Adequacy*

** CMS published this protocol in February 2023; results of the activity will be reported in future reports.*

Health Plans

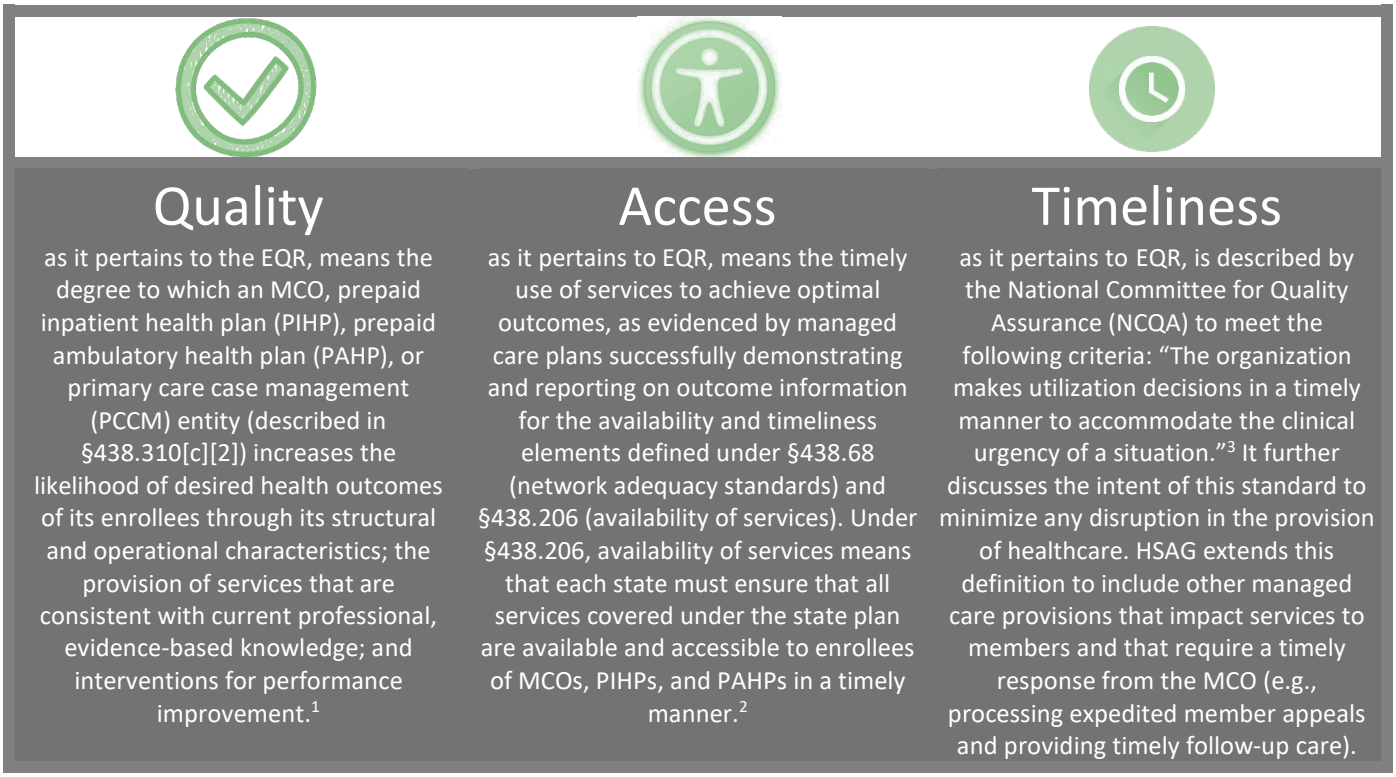
A list of health plans is located in Appendix C. As noted in the overview, Standard Plans are currently in operation and Tailored Plans are expected to launch in 2024. The PIHPs launched in April 2023; however, they were not within scope of EQR activities during this reporting cycle.[5] Therefore, HSAG conducted EQR activities with the Standard Plans.

[4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols,* February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Jan 23, 2024.

[5] Results of activities conducted by the Department's previous EQRO for the LME/MCOs (now PIHPs) were not considered for this report. Future reports will include the EQRO's activity results and assessment of strengths and opportunities for improvement for the PIHPs.

Quality, Access, and Timeliness

CMS identified the domains of quality, access, and timeliness as keys to evaluating MCO performance. HSAG used the following definitions for these domains.



[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.

[2] Ibid.

[3] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs.*

NC Managed Care Program Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from SFY 2023 to assess each Standard Plan's performance in providing quality, timely, and accessible healthcare services to beneficiaries as required in 42 CFR §438.364. The overall findings and conclusions regarding quality, timeliness, and access for all Standard Plans were analyzed to develop overarching conclusions and recommendations for the NC managed care program. In accordance with 42 CFR §438.364(a)(1), HSAG provides a description of how the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and accessibility of care furnished by the health plans.

Step 1: HSAG analyzed the quantitative results obtained from each EQR activity for each health plan to identify strengths and weaknesses in each domain of quality, timeliness, and access to services furnished by the health plan for the EQR activity.

Step 2: From the information collected, HSAG identified common themes and the salient patterns that emerged across EQR activities **for each domain** and drew conclusions about the overall quality, timeliness, and accessibility of care and services furnished by the health plans.

Step 3: From the information collected, HSAG identified common themes and the salient patterns that **emerged across ALL EQR activities related to strengths and opportunities for improvement in one or more of the domains** of quality, timeliness, and access to care and services furnished by the health plans.

Step 4: HSAG identified any patterns and commonalities across the program to draw conclusions about the quality, timeliness, and accessibility of care for the program.

Table 2 provides the overall strengths and opportunities for improvement of the NC managed care program that were identified as a result of the EQR activities. Health plan-specific conclusions and recommendations are located in the Health Plan-Specific Conclusions and Recommendations section.

Table 2—Overall NC Medicaid Program Conclusions: Quality, Access, and Timeliness

EQR Results	
Domain	**Conclusion**
Quality	**Strength:** The Department focused on promoting wellness and prevention among Medicaid members through interventions developed in the PIPs and focus studies. The PIPs and focus studies addressed the management of emerging health risks, keeping members healthy, and managing chronic illnesses. **Strength:** Performance measure validation identified that the Standard Plans had implemented member- and provider-centric approaches to serving the Medicaid population, including initiatives and incentives to drive performance. **Strength:** The Department made significant investments in understanding the multiple forms of health information technology used to facilitate coordination of care, interdisciplinary collaboration, coordination with community partners, and other essential provider-based functions, as evidenced by the performance measure validation and care management performance evaluation activities. **Strength:** Compared to the NCQA national percentiles, parents/caretakers of general child members and adult member survey respondents reported high levels of experience for *Rating of Specialist Seen Most Often*. **Strength:** All five Standard Plans achieved a PIP validation status of *Met*; four of the five Standard Plans also achieved 100 percent for all applicable evaluation elements validated. **Strength:** All six Tailored Plans achieved a PIP validation status of *Met*; three of the six Tailored Plans also achieved 100 percent for all applicable evaluation elements validated. **Strength:** The encounter data validation (EDV) activity identified that data for the Standard Plans were largely complete and valid when populated, indicating that data would support most downstream uses. In additional, all five Standard Plans submitted professional and institutional encounters in a timely manner from the payment date.

EQR Results	
Domain	**Conclusion**
	Strength: The EDV activity identified that, for all Standard Plans, referential integrity between all encounters and enrollment data and between all encounters and provider data were greater than 99 percent accurate, indicating that data can easily be linked to each other on key unique identifiers (e.g., unique beneficiary ID and unique provider NPIs [national provider identifiers]). This allows for analyses that require linking datasets together, such as calculating performance measures, to occur. **Opportunity for Improvement:** Adult and child customer experience survey respondents reported low levels of experience related to *Rating of Health Plan*, *Getting Needed Care*, and *Customer Service*. **Opportunity for Improvement:** Although the Standard Plans largely submitted data in a timely manner during the EDV study, the contractual obligation of submitting professional and institutional encounters within 30 days and pharmacy encounters within seven days was not met. The Standard Plans also had opportunities for improvement related to the completeness of Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) codes in submitted encounter data and timely submission of pharmacy encounters.
Access	**Strength:** The Department continued preparations to launch Tailored Plans, which will provide Medicaid managed care and additional specialized services for individuals with significant behavioral health conditions, I/DD, and TBI. The Tailored Plans are projected to launch in July 2024. **Strength:** Time and distance study results demonstrated that the Standard Plans met access standards for most provider types. **Strength:** The Department's validation of Standard Plan provider directories demonstrated high accuracy for all health plans. Since enrollees rely on provider directory information when accessing care and services, accuracy of provider directory information can reduce delays in treatment and increased healthcare costs resulting from enrollees seeking care from out-of-network providers. **Opportunity for Improvement:** The case management performance evaluation activity identified an opportunity for the Standard Plans to establish data exchange agreements to share Advanced Medical Home (AMH) provider information with the Clinically Integrated Networks (CINs) to ensure accuracy of data between parties. **Opportunity for Improvement:** The Department reported that NC Medicaid was underperforming relative to national trends for *Prenatal and Postpartum Care*, which was impacted by the global billing policy. To address performance, the Department will implement new codes to assist in identifying and capturing the first prenatal visit. **Opportunity for Improvement:** When reviewing 2021 rates, the Department reported disparities in *Childhood Immunization Status Combination 10* for Black enrollees. Although the overall rate was showing improvement, NC Medicaid was close to but underperforming relative to national trends.
Timeliness	**Strength:** There was strong participation in EQR activities, with consistent and timely submission of information that provided evidence of progress toward goals and continued improvement. **Opportunity for Improvement:** As the Department continues efforts to launch Tailored Plans, the Tailored Plans should continuously and consistently assess network adequacy to identify and address any network gaps.

Recommendations for Targeting Goals and Objectives in the Quality Strategy

The NC Quality Strategy is designed to build an innovative, whole-person, well-coordinated system of care that addresses both medical and non-medical drivers of health and an enhanced focus on promoting health equity. In consideration of the goals of the Quality Strategy and the comparative review of findings for all activities, HSAG's recommendations for quality improvement (QI) that target the identified goals within the NC Quality Strategy are included in Table 3.

Table 3–Quality Strategy Recommendations for the NC Medicaid Managed Care Program

Program Recommendations	
Recommendation	**Associated Quality Strategy Goal and/or Objective**
To improve program wide performance in support of Goals 1 and 3, HSAG recommends the following: • Require the PHPs to continue PIP efforts to address childhood immunization and prenatal/postpartum care rates. • Consider efforts to address vaccine hesitancy or any other barriers impacting performance on childhood immunization rates, especially for influenza vaccine rates. • Consider continued efforts to provide education, resources, and discussion of best practices to encourage improvements to measures that capture access to care and promotion of wellness and prevention.	**Goal 1: Ensure appropriate access to care** Objective 1.1: Ensure equitable, timely access to care **Goal 3: Promote wellness and prevention** Objective 3.1: Promote child health, development, and wellness Objective 3.2: Promote women's health
To address adult and child customer experience survey results related to *Rating of Health Plan*, *Getting Needed Care*, and *Customer Service*, the Department should encourage the health plans to review and adopt best practices for promoting enrollee engagement in care, including seeking input and observations and considering opportunities for positive and strategic messaging to enrollees about the health plan and how to address care gaps.	**Goal 2: Drive equitable, patient-centered, whole person care** Objective 2.1: Promote patient engagement in care
To improve access to care, the health plans should conduct an in-depth review of provider types for which time and distance standards were not met and use analysis results to guide contracting efforts or implement additional strategies to address network gaps.	**Goal 1: Ensure appropriate access to care** Objective 1.1: Ensure equitable, timely access to care Objective 1.2: Maintain Medicaid provider engagement

Program Recommendations	
Recommendation	**Associated Quality Strategy Goal and/or Objective**
Ensure performance measure validation is conducted for the NC Medicaid Direct and Tailored Plans when data are available.	**Goal 2: Drive equitable, patient-centered, whole person care** Objective 2.3: Address behavioral and physical health comorbidities **Goal 4: Improve chronic condition management** Objective 4.1: Improve behavioral health care
Continue to critically evaluate the accuracy of the health plans' encounter data and ensure the health plans implement standard quality controls and develop standard data extraction procedures to ensure the accuracy of encounter data.	**Goal 6: Pay for value** Objective 6.1: Ensure high-value, appropriate care

REVIEW OF COMPLIANCE

Introduction

According to federal requirements located within 42 CFR §438.358, the state, an agent that is not a Medicaid managed care entity, or its EQRO must conduct a review within a three-year period to determine a health plan's compliance with the standards set forth in 42 CFR Part 438—Managed Care Subpart D and the Quality Assessment and Performance Improvement (QAPI) requirements described in 42 CFR §438.330. These standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR Part 438.

In accordance with §438.358, HSAG conducted the compliance review on a full set of standards for each Standard Plan (health plan) during calendar year (CY) 2023; however, the full review was not completed before the end of the reporting period for this report (SFY 2023). During the reporting period for this report, HSAG completed a series of preparatory activities for the compliance review, as detailed in this section. Results of the full compliance review will be reported in April 2025.

Health Plans

Five Standard Plans were included in the compliance review. The other NC health plans were not included in the compliance review during this reporting cycle. NC Medicaid Direct launched in April 2023; compliance reviews will be conducted in future years and reported in corresponding reports. Tailored Plans did not launch in SFY 2023; compliance reviews will be conducted in future years after implementation and be reported in corresponding reports.

Standards

Table 4 displays the full set of standards reviewed for Standard Plans. The compliance review also included a series of file reviews to assess compliance in various standards, as shown in Table 4.

Table 4—Full Set of Standards

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

Process

The compliance review was conducted in two overall phases: initial review and remediation. As a part of the initial review conducted in SFY 2023, HSAG completed a desk review of documents submitted by the health plan and conducted file reviews.

In SFY 2024, the initial review will conclude with a webinar review, which will be conducted with each health plan to clarify desk review and file review results. During the webinar, HSAG will also assess whether the health plan can demonstrate, and health plan staff were knowledgeable about, the requirements, policies, and procedures associated with each compliance review standard. HSAG will produce a health plan-specific initial compliance review Report of Findings, which will list each element for which HSAG assigned a score of *Not Met*, as well as the associated findings and recommendations to bring the health plan's performance into full compliance with the requirement. DHB will require the health plans to remediate each element for which HSAG assigned a score of *Not Met*. The health plans will have a 30-day remediation period in which to submit additional documentation or implement

policies and procedures that met the requirements. HSAG will then assess all remediation elements to determine if compliance with the requirements had been met and will assign a final score.

Methodology

This section describes the methodology HSAG utilized to complete the compliance review. HSAG followed the guidelines outlined in CMS' *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity* (CMS Protocol 3), February 2023.[6]

Objectives for Conducting the Administrative Review

The primary objective of the compliance review is to provide meaningful information to DHB and the Standard Plans regarding administrative processes to ensure compliance with federal requirements. In preparation for the compliance review, HSAG worked closely with DHB and the Standard Plans to ensure a coordinated and supportive approach to completing the required activities.

Compliance Review Activities

Activity One: Establish Compliance Thresholds

HSAG performs a series of pre-planning steps to define levels of compliance for use throughout the compliance review, as shown in Table 5 below.

Table 5—Activity One: Establish Compliance Thresholds

For this step,	HSAG will…
Step 1:	**Collect information from DHB.**
	Work with DHB to define the scope of the review and applicable federal regulations.
Step 2:	**Prepare the data collection tools for the review standards.**
	In collaboration with DHB, HSAG developed compliance review tools, as well as specific file review tools. The review standards include: • Standard I—Enrollment and Disenrollment • Standard II—Enrollee Rights and Confidentiality • Standard III—Member Information • Standard IV—Emergency and Poststablization Services • Standard V—Adequate Capacity and Availability of Services • Standard VI—Coordination and Continuity of Care

[6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Jan 23, 2024.

For this step,	HSAG will…
	• Standard VII—Coverage and Authorization of Services • Standard VIII—Provider Selection and Program Integrity • Standard IX—Subcontractual Relationships and Delegation • Standard X—Practice Guidelines • Standard XI—Health Information Systems • Standard XII—Quality Assessment and Performance Improvement Program • Standard XIII—Grievance and Appeal Systems
Step 3:	**Define levels of compliance.**
	HSAG assigns each element within the standards in the compliance review tools a score of *Met*, *Not Met*, or *Not Applicable (NA)*. HSAG uses scores of *Met* and *Not Met* to indicate the degree of compliance with the requirements. HSAG uses a designation of *NA* when a requirement was not applicable during the review period of CY 2022. *Met* indicates full compliance defined as both of the following: • All documentation listed under a regulatory provision or component thereof is present. • Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation. *Not Met* indicates noncompliance defined as the following: • Not all documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
Step 4:	**Develop a timeline for the review process.**
	HSAG works with DHB to construct a detailed timeline to ensure completion of all review activities and provides advance notice to each Standard Plan.

Activity Two: Perform Preliminary Review

HSAG performs a series of preliminary steps, including a desk review, as shown in Table 6 below.

Table 6—Activity Two: Perform Preliminary Review

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

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

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

Activity Three: Conduct Virtual Reviews

Due to the coronavirus disease 2019 (COVID-19), DHB and HSAG work with each Standard Plan to schedule virtual webinar review. HSAG conducts staff interviews with each Standard Plan and collects the information necessary to assess the Standard Plans' compliance with federal regulations. The steps of the virtual webinar review process are shown in Table 7 below.

Table 7—Activity Three: Conduct Virtual Reviews

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

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

Activity Four: Compile and Analyze Findings

HSAG documents components of the review and the final compliance determinations for each regulatory provision via the steps outlined in Table 8 below. The documented findings served as evidence of the comprehensiveness of the EQR process and validity of the findings.

Table 8—Activity Four: Compile and Analyze Findings

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

Activity Five: Report Results and Assess Standard Plan Remediation Actions

HSAG drafts reports with the results of the review for each Standard Plans' compliance with federal requirements and monitor remediation using the steps shown in Table 9 below.

Table 9—Activity Five: Report Results

For this step,	HSAG will…
Step 1:	**Submit a report outline to DHB.**
	HSAG develops a report outline and submits it to DHB for approval. The outline is then used by HSAG to draft a report with the results of each Standard Plan.
Step 2:	**Submit an initial Compliance Review Report of Finding.**
	After completing the documentation of findings and scoring for each of the standards, HSAG prepares a draft report for each Standard Plan that described findings, the scores it assigned for each requirement within the standards, and HSAG's assessment of compliance and any areas requiring remediation. The reports are forwarded to DHB and review and approval.
Step 3:	**Receive and assess Standard Plans remediation.**
	DHB requires Standard Plans to remediate each element for which HSAG assigned a score of *Not Met*. The Standard Plans have a 30-day remediation period in which to submit additional documentation or implement policies and procedures that met requirements. HSAG then assesses all remediated elements to determine if compliance with requirements have been met and assign a final score, which is included in this final compliance review report.
Step 4:	**Submit a final Compliance Review report to DHB.**
	Following closure of the remediation period and DHB' approval of each report, HSAG issues final reports to DHB and the applicable Standard Plan.
Step 5:	**Conduct a focused review.**
	For any elements that remain out of compliance following remediation, HSAG will conduct a focused review to monitor the health plan's progress in fully remediating findings. The focused review will conclude upon demonstration of compliance.

Specific methodologies were also created for each file review, as included in the plan-specific reports.

Findings and Recommendations

As the compliance review was not fully completed during the reporting cycle, the results and corresponding recommendations will be presented in next year's technical report.

PERFORMANCE MEASURES

Introduction

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

The purpose of PMV is to assess the accuracy of performance measures reported by health plans and to determine the extent to which those performance measures follow state specifications and reporting requirements.

To ensure that all NC Medicaid managed care beneficiaries receive high-quality care, the Department requires the health plans report on, and ultimately be held accountable for, performance on a select set of measures. These measures are aligned to a range of specific goals and objectives used to drive QI and operational excellence. The Department's use of specific quality requirements to advance toward these goals and objectives will evolve as the health plans' and providers' infrastructure and experience increase, with greater rewards for excellence and more significant penalties for poor performance.

In its Quality Strategy,[7] the Department selected standard performance measures, as required by 42 CFR §438.330(c), some of which Standard Plans and Tailored Plans are required to measure and report to the Department. Others will be directly measured by the Department, or by external partners (e.g., The Cecil G. Sheps Center for Health Services Research). Consistent with the Department's desire to benchmark its progress against other states' performance and assess key priorities to drive continuous QI efforts, nearly all the measures are nationally recognized.

[7] North Carolina Department of Health and Human Services, Department of Health Benefits. *North Carolina's Medicaid Managed Care Quality Strategy*, April 11, 2023. Available at: https://medicaid.ncdhhs.gov/nc-medicaid-2023-quality-strategy/download?attachment Accessed on: Jan 8, 2024.

Quality Strategy Measures

The Department requires the Standard Plans to monitor and evaluate the quality of care through the use of Healthcare Effectiveness Data and Information Set (HEDIS®),[8] non-HEDIS (other measure stewards), and Department-defined performance measures. Table 10 lists performance measures that are outlined in the Quality Strategy for priority focus for Standard Plan accountability and that were in place during HEDIS measurement year (MY) 2021.[9] The table also shows HSAG's assignment of the performance measures into the domains of quality, timeliness, and access.

Table 10—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains

Performance Measure	Quality	Access	Timeliness
Ambulatory Care: Emergency Department Visits (AMB)	NA	NA	NA
Antidepressant Medication Management (AMM)	✓		
Pediatric Asthma Admission Rate (PDI 14)	✓		
Asthma in Younger Adults Admission Rate (PQI 15)	✓		
Asthma Medication Ratio (AMR)	✓		
Breast Cancer Screening (BCS)	✓		
Cervical Cancer Screening (CCS)	✓		
Child and Adolescent Well-Care Visits (WCV)	✓	✓	
Childhood Immunization Status (CIS)	✓	✓	
Chlamydia Screening in Women (CHL)	✓		
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI 05)	✓		
Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing	✓		
Concurrent Use of Prescription Opioids and Benzodiazepines (COB)	✓		
Contraceptive Care—Postpartum Women (CCP)	✓	✓	✓
Controlling High Blood Pressure (CBP)	✓		✓
Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD)	✓	✓	✓
Diabetes Short-Term Complications Admission Rate (PQI01)	✓		

[8] HEDIS® is a registered trademark of the NCQA.

[9] The Standard Plans launched into managed care operations mid-MY 2021. HSAG and the Department worked closely with the Standard Plans to understand several nuances and complexities in the Standard Plans' abilities to produce MY 2021 PM rates for review and validation. Final MY 2021 PM rates were not available until mid-CY 2022 and are, therefore, being included into the SFY 2023 EQR technical report.

Performance Measure	Quality	Access	Timeliness
Follow-Up After Emergency Department Visit for Alcohol and Other Drug (AOD) Abuse or Dependence—7-Day Follow-Up—Total and 30-Day Follow-Up Total (FUA)	✓	✓	✓
Follow-Up After Emergency Department Visit for Mental Illness(FUM)	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness (FUH)	✓	✓	✓
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)	✓	✓	✓
Gastroenteritis Admission Rate (PDI 16)	✓		
Heart Failure Admission Rate (PQI 08)	✓		
Comprehensive Diabetes Care (CDC): Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%) and *HbA1c Poor Control (>9.0%)*	✓		
Immunizations for Adolescents (IMA)	✓		
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)	✓	✓	✓
Low Birth Weight (LBW)	NA	NA	NA
Medical Assistance With Smoking and Tobacco Use Cessation (MSC)	✓		
Plan All-Cause Readmissions (PCR)	✓		
Prenatal and Postpartum Care (PPC)	✓	✓	✓
Urinary Tract Infection Admission Rate (PDI 18)	✓		
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	✓	✓	
Use of Opioids at High Dosage in Persons Without Cancer (OHD)	✓		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)	✓		
Well-Child Visits in the First 30 Months of Life (W30)	✓	✓	

NA indicates this measure is a utilization or a diagnosed prevalence measure and is not assigned to a domain.

Performance Measure Validation

Only the Standard Plans were in operation during the full reporting cycle; therefore, HSAG conducted PMV for the Standards Plans. NC Medicaid Direct and Tailored Plans will participate in PMV activities in future reporting years. HSAG ensured that PMV methods aligned with CMS EQR *Protocol 2.*

Validation of Performance Measures: A Mandatory EQR-Related Activity, February 2023.[10] HSAG conducted a review of PMV activities focused on reviewing data integration, information systems, and measure calculation processes to assess the Standard Plans' performance measure reporting in accordance with CMS EQR Protocol 2.

HSAG validated rates for a set of performance measures selected by DHB for validation. Due to the mid-MY 2021 launch of managed care, DHB allowed the Standard Plans to remove the continuous enrollment criteria for MY 2021 performance measure calculation, and the Standard Plans were required to report only using the administrative methodology for DHB-selected measures in the scope of PMV.

Methodology

HSAG conducted the validation of PMV activities which focused on assessing and evaluating the Standard Plans' performance measure calculation and reporting. The scope of PMV activities evaluated the Standard Plans' data integration, information systems, and measure calculation processes through the collection of information using the Information Systems Capabilities Assessment Tool (ISCAT). In addition, HSAG evaluated the Standard Plans' information systems and processes specific to producing performance measure rates on a set of measures selected by DHB for MY 2021.

Table 11 represents the performance measures used to assess performance measure calculation processes, such as source code validation, and that were used to report the MY 2021 final performance rates. Twelve measures were selected using the *Healthcare Effectiveness Data and Information Set (HEDIS®)2 Measurement Year 2020 & Measurement Year 2021 Volume 2: Technical Specifications for Health Plans and Pharmacy Quality Alliance (PQA)* measure specifications and guidelines.

Table 11—List of Performance Measures for Validation

Performance Measure	Specifications Steward*	Method (Admin**)
Child and Adolescent Well-Care Visits	NCQA	Admin
Childhood Immunization Status—Combination 10	NCQA	Admin
Immunizations for Adolescents—Combination 2	NCQA	Admin
Well-Child Visits in the First 30 Months of Life	NCQA	Admin
Cervical Cancer Screening	NCQA	Admin
Chlamydia Screening in Women	NCQA	Admin
Plan All-Cause Readmissions	NCQA	Admin
Prenatal and Postpartum Care	NCQA	Admin

[10] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: http://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Jan 23, 2024.

Performance Measure	Specifications Steward*	Method (Admin**)
Follow-Up After Hospitalization for Mental Illness	NCQA	Admin
Controlling High Blood Pressure (CBP)	NCQA	Admin
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)	NCQA	Admin
Concurrent Use of Prescription Opioids and Benzodiazepines	PQA	Admin

*DHB has approved the removal of the continuous enrollment criteria for all measures in the scope of PMV due to the mid-MY launch into managed care (July 1, 2021), which may result in variation from the applicable measure steward's technical specifications.
**DHB has approved reporting using the administrative methodology only.

Technical Methods of Data Collection and Analysis

The CMS EQR Protocol 2 identifies key data types that should be reviewed as part of the validation process. The following list describes the types of data collected and how HSAG conducted an analysis of these data:

- **ISCAT:** The Standard Plans were required to submit to HSAG a completed ISCAT that provided information on their information systems; processes used for collecting, storing, and processing data; and processes used for performance measure reporting. Upon receipt, HSAG completed a cursory review of the ISCAT to ensure each section was complete and all applicable attachments were present. HSAG then thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- **Source code (programming language) for performance measures:** The Standard Plans that calculated the performance measures using source code were required to submit the source code used to generate each performance measure being validated. HSAG completed a line-by-line review of the supplied source code to ensure compliance with the measure specifications required by DHB. HSAG identified any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). Standard Plans that did not use source code to generate the performance measures were required to submit documentation describing the steps taken for calculation of each of the required performance measures.
- **Supporting documentation:** HSAG requested documentation to provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.
- **Primary source verification (PSV):** HSAG requested Standard Plans provide output data files that included numerator positive records for performance measures from which auditors selected cases for PSV.

Assessment of Standard Plan Performance

Data Integration, Data Control, and Performance Measure Documentation

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

Validation Results

HSAG evaluated the Standard Plans' data systems for processing the following data types used for reporting performance measure data:

- Claims and Encounter Data Processing
- Membership/Eligibility Data Processing
- Data Integration
- Provider Data Processing

HSAG identified no concerns with the Standard Plans' systems or processes for the above data types; except WellCare's documented processes demonstrated opportunities for improvement in its data integration procedures, as a significant data preproduction and integration issue was identified as a result of the audit. As a result, WellCare was required to produce revised performance measure rates for all performance measures in the scope of the audit. WellCare's revised performance measure rates were approved by HSAG, and WellCare confirmed that the issue was resolved for future MYs.

Performance Measure Specific Findings

Based on all validation activities, HSAG determined results for each of the performance measures. The CMS PMV protocol identifies four possible validation finding designations for performance measures, which are defined in Table 12.

Table 12—Designation Categories for Performance Measures

Reportable (R)	Measure was compliant with measure specifications.
Do Not Report (DNR)	Standard Plan rate was materially biased and should not be reported.
Not Applicable (NA)	The Standard Plan was not required to report the measure.
Not Reported (NR)	Measure was not reported because the Standard Plan did not offer the required benefit.

According to the protocol, the validation designation for the measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be not compliant based on the review findings. Consequently, an error for a single audit element may result in a designation of *DNR* because the impact of the error biased the reported performance measures by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, and the measure could be given a designation of *R*. Table 13 displays the measure-specific review finding and designation for the Standard Plans.

Table 13—Measure-Specific Review Findings and Designations for Standard Plans

Performance Measure	AmeriHealth	Carolina Complete	Healthy Blue	United Healthcare	WellCare
Child and Adolescent Well-Care Visits	R	R	R	R	R
Childhood Immunization Status—Combination 10	R	R	R	R	R
Immunizations for Adolescents—Combination 2	R	R	R	R	R
Well-Child Visits in the First 30 Months of Life	R	R	R	R	R
Cervical Cancer Screening	R	R	R	R	R
Chlamydia Screening in Women	R	R	R	R	R
Plan All-Cause Readmissions	R	R	R	R	R
Prenatal and Postpartum Care	R	R	R	R	R
Follow-Up After Hospitalization for Mental Illness	R	R	R	R	R
Controlling High Blood Pressure (CBP)	R	R	R	R	R
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)	R	R	R	R	R
Concurrent Use of Prescription Opioids and Benzodiazepines	R	R	R	R	R

Strengths, Opportunities for Improvement, and Recommendations

By assessing Standard Plans' performance measure reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each opportunity for improvement, HSAG has also provided a recommendation to help target improvement efforts.

AmeriHealth

Strengths

Strength #1: AmeriHealth demonstrated a great understanding of its membership and the challenges inherent to meeting its members' healthcare needs. AmeriHealth has implemented a provider-centric and data-driven approach to addressing the healthcare needs of its members. During the opening session of the review, AmeriHealth discussed deploying and creating additional resources within the rural regions of North Carolina in order to build toward healthcare equity amongst its members and help elevate some of the access challenges members have in rural regions.

Strength #2: AmeriHealth has implemented initiatives to improve performance on quality measures. At the provider level, AmeriHealth has launched or is planning to launch programs to incentivize better performance. At the member level, AmeriHealth has implemented communication campaigns and used rewards to keep members engaged in their healthcare.

Opportunities for Improvement

Opportunity #1: AmeriHealth noted challenges with supplemental data related to the integration of the North Carolina Immunization Registry (NCIR) files into AmeriHealth's systems due to file size, and the quality and data completeness of member information from North Carolina's Health Information Exchange (HIE) for future data ingestion to support rate reporting.

Recommendation: HSAG recommends that AmeriHealth continue to work with NCIR and the North Carolina HIE to help develop defined parameters and expectations of quality data and size of data transfer to help AmeriHealth capture the necessary data to support quality rate reporting. Established workgroups between AmeriHealth staff and external organization staff should work to define timelines and expectations of data to ensure that AmeriHealth can gain timely access to these data in order to incorporate the data for future measure reporting.

Opportunity #2: HSAG identified that AmeriHealth's rates were slightly lower than the rates for some other Standard Plans for the *CIS-10*, *IMA-2*, *W30*, *CCS*, *CDC*, and *WCV* measures.

Recommendation: AmeriHealth confirmed that it is working to improve the measure rates based on member outreach, member incentives, and provider incentives and education. AmeriHealth reported initial challenges related to the mid-MY launch of managed care, considering the removal of the continuous enrollment criteria and retroactive member enrollment, which resulted in the inability to proactively ensure members received preventive services. HSAG recommends that AmeriHealth continue to monitor its performance on all measures and evaluate rates in comparison to national benchmarks (where available) to determine if future MY rates improve once AmeriHealth has more experience serving its North Carolina members. If future MY rates do not improve, AmeriHealth should evaluate additional interventions that will improve access to care across impacted measures.

Carolina Complete

Strengths

Strength #1: Carolina Complete has a member- and provider-centric approach to serving the Medicaid population. Carolina Complete is a provider-led Standard Plan that is focused on building locally resourced teams that know Medicaid members. Additionally, Carolina Complete offers value-added services to Medicaid members to support their health and wellness, including educational support, support for managing chronic conditions (e.g., asthma and diabetes), support for new parents, and incentives for healthy activities.

Strength #2: Carolina Complete has implemented initiatives to improve performance on quality measures. Carolina Complete has launched campaigns to educate and support providers and keep members engaged in their healthcare.

Strength #3: Carolina Complete addressed HSAG's recommendation to explore options within or outside their system, Unified Member View (UMV), where the most current contact information about the member can be stored. When a member or provider notifies Carolina Complete of a change in address and/or contact information, the updated information is entered in the OMNI system and retained as view-only upon the receipt and integration of the 834 file into UMV. The updated member information is then shared with the State as part of a weekly submission to inform the contents of the next 834 file.

Opportunities for Improvement

Opportunity #1: HSAG identified that Carolina Complete's rate was slightly lower than the rate for some other Standard Plans for the *PPC* measure indicators.

Recommendation: Carolina Complete confirmed that outreach calls are made to members to complete notice of pregnancy forms to engage in member services and obtain member health information. Carolina Complete used member demographics, claims with diagnosis or procedure codes relating to pregnancy, service authorizations related to pregnancy, and Medicaid eligibility data stored in the enterprise data warehouse to identify pregnant members for outreach. Members enrolled in the Start for Baby program receive educational materials and incentives for attending prenatal and postpartum visits. Monthly proactive outreach manager phone calls are made to members that previously gave birth to schedule postpartum visits. Carolina Complete reported initial challenges related to the mid-MY launch of managed care, considering the removal of continuous enrollment criteria, which resulted in the inability to proactively ensure members received preventive services. HSAG recommends that Carolina Complete continue to monitor its performance on this measure indicator and evaluate the rate in comparison to national benchmarks (where available) to determine if the future MY rate improves once Carolina Complete has more experience serving its North Carolina members. If the future MY rate does not improve, Carolina Complete should evaluate additional interventions that will improve access to care for these measure indicators.

Healthy Blue

Strengths

Strength #1: Healthy Blue is implementing steps to address HSAG's recommendation for processes to oversee the timeliness of billing by capitated entities, and the correction and resubmission of rejected and/or denied claims from capitated entities. Healthy Blue conducted an audit of claims paid through a capitated arrangement in the past few months to make sure they were processed correctly and in a timely fashion. Healthy Blue will implement a quarterly audit of capitated claims to ensure that there are no gaps in processes.

Strength #2: Healthy Blue has implemented initiatives to improve performance on quality measures. Healthy Blue has campaigns and reward programs in place to encourage members to be engaged in their healthcare. In addition, Healthy Blue is looking to institute additional communication campaigns to engage members in follow-up services.

Opportunities for Improvement

Opportunity #1: Healthy Blue initially defined the measurement period as July 1, 2021 through December 31, 2021 when generating rates for MY 2021. The required measurement period for calculating MY 2021 rates was January 1, 2021 through December 31, 2021. HSAG requested that Healthy Blue recalculate performance measure rates for MY 2021 using the correct measurement period.

Recommendation: HSAG recommends that Healthy Blue reviews the reporting and measurement specifications with operations staff members to ensure the correct measurement period is defined in the HEDIS engine parameters.

Opportunity #2: Healthy Blue's Enterprise Data Warehouse team is still working to address the receipt of duplicate claims from multiple lab data sources, and the Inovalon QSI-XL HEDIS engine continues to reject duplicate lab records. However, Healthy Blue has not yet identified the root cause and source of the duplicate lab claims.

Recommendation: HSAG continues to recommend that Healthy Blue continue to investigate the root cause and source of the duplicate claims to resolve prior to integrating into the Inovalon QSI-XL HEDIS engine. This will reduce the processing time of duplicate data and eliminate any risk of duplicates being counted within a performance measure impacted by lab services.

UnitedHealthcare

Strengths

Strength #1: UnitedHealthcare demonstrated adequate processes in place to receive and process claims and encounters, membership/enrollment, data integration, provider data, and supplemental data.

Strength #2: UnitedHealthcare has extensive experience using supplemental data sources. The Standard Plan leveraged supplemental data sources to support performance measure rate reporting.

Opportunities for Improvement

Opportunity #1: HSAG identified that UnitedHealthcare's rates were slightly lower than the rates for other Standard Plans for the *WCV*, *IMA-2*, *W30*, *PPC*, and *CDC* measures.

Recommendation: UnitedHealthcare reported initial challenges related to the mid-MY launch of managed care, considering the removal of continuous enrollment criteria and retroactive member enrollment, which resulted in the inability to proactively ensure members received preventive services. HSAG recommends that UnitedHealthcare continue to monitor its performance on all measures, and evaluate rates in comparison to national benchmarks (where available), to determine if future MY rates improve once UnitedHealthcare has more experience serving its North Carolina members. If future MY rates do not improve, UnitedHealthcare should evaluate additional interventions that will improve access to care across impacted measures.

WellCare

Strengths

Strength #1: WellCare demonstrated extensive knowledge and experience in claims and encounter, membership/enrollment, data integration, rate production, and medical record procurement and abstraction processes. Individuals responsible for performance measure data integration and reporting have about 15 years of experience working at the Standard Plan.

Strength #2: WellCare has numerous member-facing and provider-facing initiatives and incentives that are intended to improve quality measure performance. HSAG encourages WellCare to track the measure-specific impact of any of these interventions and incentives, so best practice can be identified to share with DHB and to spread to other WellCare preventive services, as applicable.

Opportunities for Improvement

Opportunity #1: WellCare indicated that the North Carolina immunization registry had issues returning records to the Standard Plan; therefore, WellCare was in the process of studying the problem with the State's analysts.

Recommendation: WellCare should continue its efforts working with the State to resolve the ongoing data challenges occurring with the State's immunization registry, as these data are critical to support quality reporting across immunization measures within the scope of PMV: *Childhood Immunization Status—Combination 10* and *Immunizations for Adolescents—Combination 2*.

Opportunity #2: WellCare had used a user-defined system field in a manner that differed from its corporate-defined process, resulting in mismatched members to claims. WellCare was required to produce revised performance measure rates for all performance measures in scope of the audit.

Recommendation: WellCare corrected this issue for future measurement years as it discontinued its use of the user-defined field in its member matching logic. In addition to this correction, WellCare

should conduct ongoing monitoring of member-level details at the measure-level, to ensure that members are not inappropriately reported in measure denominators and numerators.

PERFORMANCE IMPROVEMENT PROJECTS

Introduction

According to federal requirements located within 42 CFR §438.330, the state must require, through its contracts, that each health plan establish and implement an ongoing comprehensive QAPI program for the services it furnishes to its enrollees. For CY 2022, the Department required health plans to conduct PIPs in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i–iv). In accordance with §438.330(d)(2)(i–iv), each PIP must include:

- Measurement of performance using objective quality indicators.
- Implementation of interventions to achieve improvement in the access to and quality of care.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

Objectives

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. PIPs provide a structured method through ongoing measurement and intervention to assess and improve processes, and thereby outcomes, of care for the population that a health plan serves. Health plans conduct PIPs to assess and improve the quality of clinical and nonclinical healthcare and services received. HSAG conducted validation, which verifies whether a PIP conducted by a health plan used sound methodology in its design, implementation, analysis, and reporting.

Validation Overview

HSAG's validation evaluates the technical methods of the PIP (i.e., the design, data analysis, implementation, and outcomes). Based on its review, HSAG determined the overall methodological validity of the PIP. For this year's validation, HSAG used *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023.[11]

For this year's validation, Standard Plans continued four PIP topics. Three clinical PIP topics corresponded to the following HEDIS measures: *Childhood Immunization Status (CIS)—Combination 10* (*CIS—Combo 10*),[12] *Timeliness of Prenatal Care and Postpartum Care (PPC)—Timeliness of Prenatal Care* and *Postpartum Care (PPC—Pre* and *PPC—Post)*, and *Comprehensive Diabetes Care (CDC)—HbA1c Poor Control (>9%)* (*CDC—HbA1c Poor Control*). Additionally, each Standard Plan submitted a nonclinical PIP topic of its choice.

Although the Tailored Plans were not yet in operation, DHB directed these health plans to proceed with the PIP design. Tailored Plans submitted two HEDIS-related clinical PIP topics: *CDC—HbA1c Poor Control* and *Follow-Up-After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up* and *30-Day Follow-Up* (*FUH—7-Day* and *FUH—30-Day*). Tailored Plans also submitted a nonclinical PIP focused on *Transitions to Community Living (TCL)*.

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

Technical Assistance

The health plans may request technical assistance following the initial validation of the PIPs and prior to the resubmissions for the final validation. During technical assistance, the health plans have the opportunity to ask HSAG questions, receive clarification on HSAG's validation feedback, and receive guidance on the PIP design, implementation, and quality improvement strategies and interventions.

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[11] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, February 2023. Available at: http://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Jan 23, 2024.

[12] *Childhood Immunization Status—Combination 10 (Combo 10)* measure indicator includes the following vaccinations: four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR), documented history of the illness or seropositive test result for each antigen; three haemophilus influenza type B (HiB); three hepatitis B (HepB), or documented history of the illness or seropositive test result for antigen; one chickenpox/varicella zoster virus (VZV), or documented history of the illness or seropositive test result for antigen; four pneumococcal conjugate (PCV); one hepatitis A (HepA), or documented history of the illness or seropositive test result for antigen; two or three rotavirus (RV); and two influenza (flu) vaccines.

Data Collection

Methods and Tools

HSAG obtains the information and data needed to conduct the PIP validation from PIP Submission Forms submitted by each plan. This form provides detailed information about each PIP related to the steps completed and evaluated by HSAG for the 2022–2023 validation cycle.

To monitor, assess, and validate PIPs, HSAG uses a standardized scoring methodology to rate a plan's compliance with each of the nine steps listed in the CMS Protocol 1. With the Department's input and approval, HSAG developed a PIP Validation Tool to ensure uniform assessment of PIPs. This tool is used to evaluate each of the PIPs for the following nine CMS Protocol 1 steps:

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

HSAG scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating for the PIP of *Not Met*.

Following the annual PIP validation, HSAG provided the Department and each Standard Plan and Tailored Plan with an annual PIP Validation Report that includes background information for each PIP submitted, specific validation findings, identified strengths, opportunities for improvement, and recommendations.

Standard Plan-Specific Validation Results

Validation Findings

The Standard Plans completed the design of the PIP, reported baseline data, and interventions (Steps 1 through 8). Table 14 summarizes the PIPs validated during the review period with an overall validation status of *Met*, *Partially Met*, or *Not Met*. In addition, Table 14 displays the percentage score of evaluation elements that received a *Met* score, as well as the percentage score of critical elements that received a *Met* score. Critical elements are those within the validation tool that HSAG has identified as essential for producing a valid and reliable PIP. All critical elements must receive a *Met* score for a PIP to receive an overall *Met* validation status. The following table includes the Standard Plan name, PIP topic and Aim statement, and the validation scores and status for each Standard Plan's PIP topic.

Table 14—Standard Plans' Performance for Each PIP Topic

Standard Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met[13]	Percentage Score of Critical Elements Met[14]	Overall Validation Status[15]
AmeriHealth Caritas North Carolina, Inc.	*Improving the Number of Care Needs Screenings Completed for Medicaid Members* Do targeted interventions increase the number of completed initial Care Needs Screenings within 90 days of enrollment in the health plan?	The percentage of members completing an initial care needs screening.	100%	100%	*Met*

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

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

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

Standard Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met[13]	Percentage Score of Critical Elements Met[14]	Overall Validation Status[15]
AmeriHealth Caritas North Carolina, Inc. (cont.)	*Comprehensive Diabetes Care for Members With Hemoglobin A1c Control Over 9.0%* Do targeted interventions decrease the percentage of members with a Hemoglobin A1c result equal to or greater than 9.0%?	The percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had an HbA1c greater than or equal to 9 percent.	100%	100%	*Met*
	Improving CIS—Combo 10 Do targeted interventions increase the percentage of eligible members who complete the *CIS Combo 10* immunization requirements?	The percentage of children 2 years of age who completed the Combo 10 vaccine series in accordance with the HEDIS *CIS* specifications.	100%	100%	*Met*
	PPC—Pre and *PPC—Post* Do targeted interventions increase the percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with AmeriHealth Caritas North Carolina? Do targeted interventions increase the percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery?	1. The percentage of deliveries that received a prenatal visit within the first trimester, on or before the enrollment start date, or within 42 days of enrollment with AmeriHealth Caritas North Carolina. 2. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	100%	100%	*Met*

Standard Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met[13]	Percentage Score of Critical Elements Met[14]	Overall Validation Status[15]
Carolina Complete Health, Inc.	*CIS—Combo 10* Targeted interventions will result in an increase of 5 percent from baseline in the Combo 10 immunization rate for Carolina Complete Health's (CCH's) eligible 2-year-old members.	The percentage of CCH members 2 years of age who completed the *CIS—Combo 10* vaccine series.	100%	100%	*Met*
	CDC—HbA1c Poor Control Targeted interventions will result in a 5 percent decrease from baseline in CCH's members ages 18 to 75 years with diabetes (type 1 and type 2) who have hemoglobin A1c (HbA1c) poor control (>9.0%).	The percentage of CCH members 18 to 75 years of age with a diagnosis of diabetes, type 1 or 2, with poor control (HbA1c > 9.0%).	100%	100%	*Met*
	PPC—Pre and *PPC—Post* Targeted interventions will result in an increase of 5 percent from baseline in the *PPC* rates for CCH's eligible deliveries of live births.	1. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the prepaid health plan (PHP). 2. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	100%	100%	*Met*

Standard Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met[13]	Percentage Score of Critical Elements Met[14]	Overall Validation Status[15]
Carolina Complete Health, Inc. (cont.)	*Improve Provider Satisfaction* Targeted provider interventions will result in an increase of 5 percent from baseline for primary care or obstetrics/gynecology (OB/GYN) providers for CCH who answer "excellent" or "good" to Question #19—How would you describe your overall experience interacting with Carolina Complete Health on the DHB North Carolina Provider Experience Survey?	The percentage of CCH's contracted primary care and OB/GYN providers who responded with "Excellent" or "Good" to their satisfaction with the PHP (survey question #19).	Submission: 88% Resubmission: 100%	Submission: 89% Resubmission: 100%	Submission: *Partially Met* Resubmission: *Met*

Standard Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met[13]	Percentage Score of Critical Elements Met[14]	Overall Validation Status[15]
Healthy Blue of North Carolina	*Method of Counseling and Impact on Sustained Tobacco Cessation* Do targeted interventions result in an increase in Healthy Blue's members ages 13 years and older identified as tobacco users who self-report at least 30 days tobacco cessation?	The percentage of members who self-report at least 30 days of tobacco cessation.	Submission: 63% Resubmission: 100%	Submission: 60% Resubmission: 100%	Submission: *Not Met* Resubmission: *Met*
	Impact of Member Incentives on Adherence to Timely Childhood Immunizations Do targeted interventions result in an increase in the *CIS—Combo 10* rate for Healthy Blue's eligible 2-year-old members?	The percentage of children 2 years of age who had *CIS—Combo 10* vaccines by their second birthday.	Submission: 88% Resubmission: 100%	Submission: 100% Resubmission: 100%	Submission: *Met* Resubmission: *Met*
	Method of Member Outreach and Impact on Timely Prenatal and Postpartum Visits Do targeted interventions result in an increase in Healthy Blue's *PPC—Pre* rate? Do targeted interventions result in an increase in Healthy Blue's *PPC—Post* rate?	1. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization. 2. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	Submission: 52% Resubmission: 100%	Submission: 75% Resubmission: 100%	Submission: *Not Met* Resubmission: *Met*

Standard Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met[13]	Percentage Score of Critical Elements Met[14]	Overall Validation Status[15]
Healthy Blue of North Carolina	*Impact of Care Coordination Delivered by Network Tier 3 Advance Medical Homes on Diabetes Management* Do targeted interventions result in a decrease in Healthy Blue's members ages 18 to 75 years with diabetes (type 1 and type 2) who have HbA1c poor control (>9.0%)?	The percentage of members 18 to 75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at > 9.0%.	Submission: 76% Resubmission: 100%	Submission: 89% Resubmission: 100%	Submission: *Partially Met* Resubmission: *Met*

Standard Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met[13]	Percentage Score of Critical Elements Met[14]	Overall Validation Status[15]
UnitedHealthcare of North Carolina, Inc.	*Increasing CIS—Combo 10 Rates* Do targeted interventions increase the percentage of children that receive the required Combo 10 series of immunizations during the measurement period?	The percentage of eligible children who complete the *CIS—Combo 10* vaccine series by their second birthday.	100%	100%	*Met*
	Improving Timeliness of Prenatal and Postpartum Care Rates Do targeted interventions increase the percentage of deliveries that received a prenatal and postpartum care visit within the required time frame during the measurement period?	1. The percentage of deliveries that received a prenatal visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the PHP. 2. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	Submission: 12% Resubmission: 100%	Submission: 11% Resubmission: 100%	Submission: *Not Met* Resubmission: *Met*
	CDC—HbA1c Poor Control Do targeted interventions decrease the percentage of eligible members who have a HbA1c of greater than 9% during the measurement year?	The percentage of eligible members whose most recent HbA1c level is greater than 9.0%, missing a result, or the HbA1c test was not completed.	100%	100%	*Met*
	Maximizing Care Needs Screening Completion Rates Do targeted interventions increase the percentage of care needs screenings that are completed within 90 days of enrollment during the measurement period?	The percentage of enrollees for whom the PHP completed a care needs screening within 90 days of enrollment.	100%	100%	*Met*

Standard Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met[13]	Percentage Score of Critical Elements Met[14]	Overall Validation Status[15]
WellCare of North Carolina, Inc.	*Access to Preventive/Ambulatory Care (AAP)* WellCare will increase the number of preventive care visits for eligible members through a system of interventions, as evidenced by 5 percent relative improvement over the baseline calendar year 2021 for HEDIS *AAP* measure, by end of calendar year/PIP performance period.	The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.	Submission: 71% Resubmission: 100%	Submission: 78% Resubmission: 100%	Submission: *Partially Met* Resubmission: *Met*
	CIS—Combo 10 WellCare will increase the rate of *CIS—Combo 10* for eligible members through a system of interventions as evidenced by 5 percent relative improvement over the baseline calendar year 2021 for the HEDIS *CIS—Combo 10* measure, by end of calendar year/PIP performance period.	The percentage of enrolled children 2 years of age who completed the *CIS—Combo 10* vaccine series by their second birthday.	Submission: 65% Resubmission: 94%	Submission: 78% Resubmission: 100%	Submission: *Partially Met* Resubmission: *Met*
	CDC—HbA1c Poor Control WellCare will reduce the percentage of members with HbA1c greater than 9% indicating poor control, through a system of interventions, as evidenced by a 5 percent relative improvement over the baseline calendar year 2021 for the HEDIS *CDC—HbA1c Poor Control* measure/sub-measure.	The percentage of members ages 18 to 75 years of age by December 31 of measurement year with diabetes (type 1 and type) who had HbA1c poor control (>9.0%).	Submission: 65% Resubmission: 100%	Submission: 56% Resubmission: 100%	Submission: *Partially Met* Resubmission: *Met*

Standard Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met[13]	Percentage Score of Critical Elements Met[14]	Overall Validation Status[15]
WellCare of North Carolina, Inc. (cont.)	*Timeliness of Prenatal Care and Postpartum Care* WellCare will increase the percentage of women who receive timely prenatal care through a system of interventions as defined by the percentage of women who received prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment. We will increase the percentage of eligible pregnant members that received timely prenatal and postpartum care, as evidenced by a 5 percent relative improvement over the baseline calendar year 2021 for the HEDIS *PPC* measure, by end of calendar year/PIP performance period. Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	1. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the PHP. 2. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	Submission: 53% Resubmission: 94%	Submission: 56% Resubmission: 100%	Submission: *Not Met* Resubmission: *Met*

Analysis of Results

The baseline measurement period for all PIPs is six months in duration due to the delayed launch of the Medicaid managed care program. The Standard Plans became operational on July 1, 2021. The remeasurement periods are 12 months in duration, and the Standard Plans will address and document any identified comparability factors on an annual basis.

Table 15 displays baseline data and improvement goals for each Standard Plan for each PIP topic.

Table 15—Standard Plans' PIP Outcomes and Improvement Goals

Standard Plan	Performance Indicator	Baseline	Improvement Goal
AmeriHealth Caritas North Carolina, Inc.	The percentage of members completing an initial care needs screening.	1.74%	Improving the completion rate for the initial care needs screening by 10 percent.
	The percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had an HbA1c greater than or equal to 9 percent.	94.39%	Mandated goal of decreasing performance by 5 percent (lower is better).
	The percentage of children 2 years of age who completed the Combo 10 vaccine series in accordance with the HEDIS *CIS* specifications.	7.31%	Mandated goal of improving performance by 5 percent.
	1. The percentage of deliveries that received a prenatal visit within the first trimester, on or before the enrollment start date, or within 42 days of enrollment with AmeriHealth Caritas North Carolina.	48.57%	Mandated goal of improving both performance indicators by 5 percent.
	2. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	60.71%	

Standard Plan	Performance Indicator	Baseline	Improvement Goal
Carolina Complete Health, Inc.	The percentage of CCH members 2 years of age who completed the *CIS—Combo 10* vaccine series.	32.57%	Mandated goal of improving performance by 5 percent.
	The percentage of CCH members 18 to 75 years of age with a diagnosis of diabetes, type 1 or 2, with poor control (HbA1c > 9.0%).	88.24%	Mandated goal of decreasing performance by 5 percent (lower is better).
	1. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the PHP. 2. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	38.06% 64.71%	Mandated goal of improving both performance indicators by 5 percent.
	The percentage of CCH's contracted primary care and OB/GYN providers who responded with "Excellent" or "Good" to their satisfaction with the PHP (survey question #19).	53.44%	CCH has not yet set its goal for this PIP.
Healthy Blue of North Carolina	The percentage of members who self-report at least 30 days of tobacco cessation.	0%	There is no mandated goal or target for this PIP.
	The percentage of children 2 years of age who had *CIS—Combo 10* vaccines by their second birthday.	39.62%	Healthy Blue set a goal for Remeasurement 1 of 36.77 percent. With the baseline performance exceeding this goal, the PHP will need to adjust its goal.
	1. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization. 2. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	91.97% 79.56%	Healthy Blue set a goal for Remeasurement 1 of 37.31 percent for timeliness of prenatal care visits and 72.20 percent for timely postpartum visits. The baseline performance for both performance indicators exceeded these goals, and the plan will need to adjust its goals.
	The percentage of members 18 to 75 years of age with diabetes (types 1 and 2) whose HbA1c was at > 9.0%.	80.25%	Healthy Blue did not document a goal for this PIP.

Standard Plan	Performance Indicator	Baseline	Improvement Goal
UnitedHealthcare of North Carolina, Inc.	The percentage of eligible children who complete the *CIS—Combo 10* vaccine series by their second birthday.	29.52%	Improving the *CIS—Combo 10* rate by 5 percent.
	1. The percentage of deliveries that received a prenatal visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the PHP.	36.72%	Mandated goal of improving both performance indicators by 5 percent.
	2. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	60.44%	
	The percentage of eligible members whose most recent HbA1c level is greater than 9.0%, missing a result, or the HbA1c test was not completed.	77.32%	Mandated goal of decreasing performance by 5 percent (lower is better).
	The percentage of enrollees for whom the PHP completed a care needs screening within 90 days of enrollment.	3.77%	Mandated goal of increasing performance by 5 percent.
WellCare of North Carolina, Inc.	The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.	74.38%	Mandated goal of 5 percent relative improvement over the baseline.
	The percentage of enrolled children 2 years of age who completed the *CIS—Combo 10* vaccine series by their second birthday.	30.88%	Mandated goal of 5 percent relative improvement over the baseline.
	The percentage of members ages 18 to 75 years of age by December 31 of measurement year with diabetes (type 1 and type 2) who had HbA1c poor control (>9.0%).	91.89%	Mandated goal of 5 percent relative improvement over the baseline.
	1. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the PHP.	72.96%	Mandated goal of improving both performance indicators by 5 percent.
	2. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	67.44%	

Barriers/Interventions

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

AmeriHealth

Table 16 displays the barriers and interventions as documented by AmeriHealth.

Table 16—Barriers and Interventions Implemented/Planned by AmeriHealth

Barriers	Interventions
Improving the Number of Care Needs Screenings Completed for Medicaid Members	
Inconsistent data regarding enrollment and the various member assessments that can be included and considered as a care needs screening.	Care needs screening and health risk assessment (HRA) dashboard development. The population health team is working with the enterprise analytics team to develop a dashboard that includes data to measure performance for the completion of assessments.
Stakeholders not involved in the PIP process.	Established and launched a PIP workgroup to ensure collaboration and contributions across cross-functional teams with the PHP.
Lack of member awareness of the importance of completing the care needs screening.	Welcome text campaign to encourage members to complete the care needs screening.
HEDIS Hemoglobin A1c Control for Patients With Diabetes	
Lack of provider knowledge and utilization of CPT-II codes.	Provider support and education via the HEDIS toolkit was finalized and approved to be shared with the providers. This toolkit will provide education and increase utilization of the CPT-II codes.
Stakeholders not involved in the PIP process.	Established and launched a PIP workgroup to ensure collaboration and contributions across cross-functional teams with the PHP.
Lack of member engagement and/or education about the importance of HbA1c testing.	Telephonic outreach to members with diabetes to educate and encourage them about HbA1c testing and care gap closure.
PHP is not receiving HbA1c values from lab providers.	Acquisition and validation of supplemental data receipt by lab providers.
HEDIS Improving Childhood Immunization With Combo 10	
Lack of member engagement, education, and awareness.	Telephonic outreach to provide parents and guardians education regarding the importance of childhood immunizations.
Stakeholders not involved in the PIP process.	Established and launched a PIP workgroup to ensure collaboration and contributions across cross-functional teams with the PHP.

Barriers	Interventions
Lack of provider education and awareness of the Quality Enhancement Program (QEP) program.	Provider incentive program that offers primary care providers an incentive for gap closure supporting Combo 10 performance.
HEDIS Timeliness of Prenatal and Postpartum Care	
Prenatal Care: Early identification and engagement of pregnant members.	Enhancement of the Early Pregnancy Identification Report to ensure appropriate and timely outreach to pregnant members is conducted.
Prenatal Care: Lack of member engagement, education, and awareness of prenatal care visits and follow-up.	Welcome packets sent to pregnant women to encourage and engage them about timely prenatal care.
Prenatal Care: Stakeholders not involved in the PIP process.	"Keys to Your Care" maternity texting program. Pregnant members receive a text with helpful notifications, reminders to schedule appointments, and education pertaining to what to expect during pregnancy.
Postpartum Care: Lack of member education and awareness of needed postpartum care.	Provide an incentive via CareCard for completing prenatal care visits.
Postpartum Care: Stakeholders not involved in the PIP process.	Established and launched a PIP workgroup to ensure collaboration and contributions across cross-functional teams with the PHP.

Carolina Complete

Table 17 displays the barriers and interventions as documented by Carolina Complete.

Table 17—Barriers and Interventions Implemented/Planned by Carolina Complete

Barriers	Interventions
HEDIS Childhood Immunizations (CIS—Combo 10)	
Vaccination hesitancy.	Member Telephonic Outreach: Outreach members who missed screening and preventive services; engage members; provide education, support, and care coordination until the member reaches 2 years of age or becomes ineligible; and offer assistance to members with barriers.
Parental/guardian lack of awareness regarding wellness checks and vaccination recommendations.	Proactive Outreach Management (POM): Inform the member of the early and periodic screening, diagnostic, and treatment (EPSDT) benefits within the first 60 days of enrollment into the PHP, educate active members on the need for timely well-care visits, and provide support and education on the importance of obtaining the recommended vaccines.
Members lack information on incentives for their preventive screenings or immunizations.	Member Healthy Rewards Program: Members receive a $25.00 gift card when all six infant well-child visits are completed.

Barriers	Interventions
HEDIS CDC—HbA1c Poor Control	
Members are not receiving their annual HbA1c test and many go undiagnosed.	HbA1c Provider Tip Sheet: This sheet provides CPT codes for diabetes care and best practices for using codes. Provider engagement team provides education to providers on how to use the provider portal and how to identify members with care gaps. Care alerts notify member services to address when a diabetic member screening gap is present. Submitted request to the Department to begin implementing the POM calls to diabetic members with diabetic care gaps.
Members receive inadequate treatment plans or follow-up for diabetes control.	Diabetes Prevention and Care Management Program: The diabetes management program team partners with care management staff to engage members in supportive care management, enhanced education with in-depth, web-based, clinical resources, and provides care managers access to specialized endocrinologists via clinical rounds.
Members lack information or incentive about the importance of the timing of preventative screenings or diabetes management.	Member Healthy Rewards Program: Members are eligible for a $20.00 gift card for completing a comprehensive diabetes care screening that consists of a HbA1c test, kidney screening, and retinopathy screening or a $20.00 gift card for completing a care needs screening assessment.
HEDIS Timeliness of Prenatal and Postpartum Care	
Members are not reporting pregnancies to providers.	Notification of Pregnancy (NOP) Assessment: Offer providers quick reference guide on completing the NOP and notifying the PHP. Members identified by the NOP form are automatically enrolled into the Smart Start for Baby program and encouraged to complete all maternal health appointments. Program specialist makes outreach calls to complete the NOP form and to assess members' risks/needs. Three attempts per member are made to complete the NOP form.
Members lack information or incentive about the importance of timely prenatal care.	New members and providers receive newsletters, a welcome packet, provider portal information, and a flyer with web page information that informs and encourages completion of screenings to receive incentives ($20.00 gift card for completing a care needs assessment within 90 days of enrollment and $10.00 gift card for completing timely prenatal and postpartum visits).

Barriers	Interventions
Improve Provider Satisfaction	
Lack of consistent communication—not everyone is given updates on changes to the PHP's policies and procedures.	Joint Operating Committee (JOC) meeting to discuss high priority risk/issues to improve provider satisfaction and provide up-to-date information. Topics include improvement strategies, current issues, and support needs. Monthly provider newsletters and bulletins are emailed to providers and posted on the PHP's provider website. This helps keep providers informed about important information and any changes to policies and procedures.
Providers need additional resources related to provider education and training.	Monthly provider education via on-demand and/or live trainings are offered.
The PHP is unaware of the opportunities for improvement or providers' needs.	Surveys are available to providers regarding every interaction that a provider has with Carolina Complete Health Network. The three surveys are: • Provider training survey • Provider feedback survey (i.e., email survey) • Website feedback survey
Insufficient resolution delivery/communication style.	Help Stat: A provider communication function available on each page of the provider-facing website that allows providers to reach directly to the network via email and is triaged during business hours to allow fast response without the hassle of searching for the right person to reach. The Provider Engagement Team monitors, reviews, and routes provider inquiries to the appropriate department for timely resolution.

Healthy Blue

Table 18 displays the barriers and interventions as documented by Healthy Blue.

Table 18—Barriers and Interventions Implemented/Planned by Healthy Blue

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

Barriers	Interventions
Impact of Member Incentives on Adherence to Timely Childhood Immunizations	
Lack of member incentives to complete the Combo 10 vaccine series, particularly the influenza and rotavirus vaccines.	Provide incentives to members for completing the Combo 10 vaccine series. Proposing a $75.00 incentive for completing the series and a $50.00 incentive for completing the rotavirus vaccine.
Members' lack of awareness related to the Healthy Rewards program and ability to earn rewards for completing *CIS—Combo 10*.	Member engagement via live outbound calls and text messages.
Low enrollment rates in the gift card program.	Members have 12 gift cards to choose from upon successful completion of all required, timely immunizations.
Method of Member Outreach and Impact on Timely Prenatal and Postpartum Visits	
Lack of member awareness of the importance of prenatal and postpartum visits and the available services during the first trimester.	Educate members on the importance of prenatal visits and services during the first trimester and postpartum visits (for first 12 weeks) after they give birth. This program (My Advocate) is part of the New Baby, New Life program; pregnant members are automatically enrolled in the My Advocate OB Screener Call Program. This program assists with the identification of high-risk pregnant women for referral to the local health department's Case Management High Risk Pregnancy Program (CMHRP). This program does not replace the high touch care management approach for high-risk pregnant women; however, it does serve as a supplementary tool to provide health education.
Members are not scheduling and/or attending prenatal appointments.	Initiated the Enterprise Quality Live Telephonic Call Campaign in mid-September 2021. Members are engaged via live telephonic calls. Members receive assistance with making required appointments. During the call, members are provided prenatal education, information on the benefits of completing the annual Care Needs Screener (CNS), and assistance with addressing barriers to accessing healthcare created by social determinants of health (SDOH) factors. Members are reminded to schedule appointments and of upcoming scheduled appointments.
High-risk members are not scheduling and/or attending appointments.	In Quarter 4 2022, Healthy Blue projects to begin to discuss and collaborate with the OB Care Management team about educating high-risk pregnancy members on the importance of prenatal and postpartum visits.

Barriers	Interventions
Low penetration rates in contacting eligible prenatal members.	Healthy Blue continues conversations with the National Quality call team and is prioritizing this campaign. Healthy Blue will continue to monitor results using the "Enterprise Quality Call Report" and will report the results to the Department. Focusing on this barrier will assist Healthy Blue to assess the impact of pregnant members identified and included in the call campaign who were successfully contacted and completed a timely prenatal visit.
Impact of Care Coordination Delivered by Network Tier 3 Advance Medical Homes on Diabetes Management	
Providers cannot easily extract a list of members who are due for HbA1c testing and did not have a follow-up outreach process for these members.	Provider visits were done to offer education to the providers and support for diabetes metrics.
Limited resources/education materials to offer to providers related to Comprehensive Diabetes Care (CDC) HbA1c poor control.	The provider relations team requested additional guidance/education from the Quality Department to offer educational tools and resources to providers.
Members lack knowledge on the importance of maintaining a healthy lifestyle/proper nutritional habits.	The PHP is in the process of developing new training materials.

UnitedHealthcare

Table 19 displays the barriers and interventions as documented by UnitedHealthcare.

Table 19—Barriers and Interventions Implemented/Planned by UnitedHealthcare

Barriers	Interventions
Increasing Childhood Immunization Combination 10 Rates	
Lack of provider awareness around member open care gaps.	The AMH Provider Support Team provides population health and quality improvement education to all AMH tiered providers. • Quarterly newsletter to providers "Immunization Rates- highlighting National Immunization Month. • Provider practices are given care gap report showing childhood immunization rates. • Provider bonus program for helping members become more engaged in preventive health—bonus provided when care gap is closed.

Barriers	Interventions
Lack of education on importance of vaccination completion and available immunization information.	The care management team provides member engagement and education to members/parents/caregivers. • Transportation arrangements • Healthy First Steps Rewards Program • Vaccine hesitancy education document for members and providers
Lack of evening and weekend appointment times.	Provider support and education: Intervention not yet documented.
No methodology to support race and ethnicity to identify and improve disparities.	PHP will analyze data and determine how to address disparities with targeted interventions.
HEDIS Improving the Timeliness of Prenatal and Postpartum Care Rates	
Family planning and preconception/contraception health awareness.	Member engagement and education: Care management team provides members with education about the importance of prenatal and postpartum care. Educational resources were provided.
Lack of education and information.	Member engagement and education: "After Delivery" campaign which focuses on postpartum care. Value-added service (VAS) engagement with member to address SDOH by providing transportation, care management needs, needed resources, etc.
Correct coding and billing.	Provider support and education: The AMH team provides a one-page document with coding and billing guidance to providers.
No methodology to support race and ethnicity to identify and improve disparities.	PHP will analyze data and determine how to address disparities.
HEDIS CDC—HbA1c Poor Control	
Lack of provider awareness around member open care gaps.	The AMH team provides population health and quality improvement education to all AMH tiered providers. • Monthly update for November 2021 was focused on comprehensive diabetes care. • Clinical leadership meetings with a focus on diabetes care, incorporating provider feedback, data overview, and interventions to improve performance. • Provider care gap reports for diabetes care measures. • Provider bonus program for helping members become more engaged in preventive health—bonus provided when care gap is closed.
Workflow, resources, and staffing constraints related to the COVID–19 pandemic.	Intervention(s) not deployed yet for this barrier.

Barriers	Interventions
Lack of self-management to improve diet and lifestyle.	Intervention(s) not deployed yet for this barrier.
No methodology to support race and ethnicity to identify and improve disparities.	PHP will analyze data and determine how to address disparities.
Maximizing Care Needs Screening Completion Rates	
Incorrect phone numbers.	The interdisciplinary team is working on ways to reconcile or supplement member contact information.
Dedicated time to complete screening/potential duplication of questions within SDOH and other care management assessment questions.	Script was enhanced to engage members during phone interactions to discuss potential services available and to complete the care needs screening questions.
Lack of member incentive and participation of care needs screening completion.	Postcards mailed to new members who have not completed the care needs screening within 60 days of enrollment, which included an incentive for completing the screening.

WellCare

Table 20 displays the barriers and interventions as documented by WellCare.

Table 20—Barriers and Interventions Implemented/Planned by WellCare

Barriers	Interventions
HEDIS Access to Preventive/Ambulatory Care	
Provider lacks awareness that member has not received annual visit.	The Quality Practice Advisory Visits (QPA) team explains member-specific care gap reports to the providers, offers consulting services for clinical and office workflow, offers training for staff on best practices for preventive health, and conducts joint operating committees with practice management.
Lack of member recall: Member does not remember the last office visit or forgets to see doctor year to year.	The Care Engagement Specialist performs targeted outreach to members with open care gaps via telephone to educate them about their gaps in care and WellCare's benefits.
Provider lacks awareness that member has not received an annual visit. Lack of knowledge of member benefits.	Provider Relations Team visits providers and offers training for WellCare onboarding and education regarding benefits and care gaps.
HEDIS CIS—Combo 10	
Provider lacks awareness of well-child checks needed (exact dates to meet the Combo 10 timeline).	The QPA Team explains member-specific care gap reports to the providers, offers consulting services for clinical and office workflow, offers training for staff on best practices for preventive health, and conducts joint operating committees with practice management.

Barriers	Interventions
Not as many members are notified of immunizations as expected through care management.	Care managers remind parents of members who are on their caseloads about Combo 10 vaccine series/immunizations needed.
Members are not aware of the last well-child visit to the doctor and need reminders.	Targeted outreach conducted with members monthly via postcard mailings reminding members that immunizations are due.
Specific immunizations that cause lack of compliance to be determined.	Specific immunization(s) causing lack of compliance identified and strategies will be developed to facilitate compliance.
HEDIS CDC—HbA1c Poor Control	
Lack of member recall: Member does not remember when last HbA1c was drawn or last visit for medication monitoring.	The Care Engagement Specialist performs targeted outreach to members with open care gaps via telephone to educate about gaps and WellCare's benefits.
Members are not receiving one-to-one counseling to work with them for as long as necessary to reduce the HbA1c results.	Good Measures Program: WellCare has engaged a vendor that will assess the member for individual needs. Available resources include nutritionists to educate and assist with incorporating better food choices, and when necessary, to provide referrals to address food insecurity and better nutritional options.
Members are not choosing health improvement behaviors such as physical activity and healthy eating that support wellness and diabetes management.	The program also offers a one-to-one counselor to work with the member for as long as necessary to reduce the HbA1c results. These services are available to those members who have been referred by a physician, care manager, or self- referred.
Members have trouble managing their diabetes without support.	Telemedicine for diabetic management and the Weight Watchers program is offered.
HEDIS Timeliness of Prenatal Care and Postpartum Care	
Members' lack of awareness on how receiving timely and adequate prenatal and postpartum care can directly impact the overall health and well- being of themselves and their babies.	Member and provider support via the WellCare Maternity Care Management model: Outreach was conducted and care management services were offered to all PHP managed members who are pregnant via collaboration with local health departments.
COVID-19 has caused a decrease of events planned and attended, but it is anticipated that these will increase in volume, frequency, and anticipated attendance going forward.	Members receive education on pregnancy self-care, the importance of routine provider visits, diagnosis and condition-specific education, program benefits, assessment for SDOH needs, referrals made as needed, and assistance with finding providers.
Provider lacks reporting needed by WellCare to reach out to members for timely follow-up.	Member-focused community outreach and incentives: Care managers, care coordinators, and the Community Engagement Team perform targeted member outreach within the community and provide incentives to all new and expectant mothers. Qualified members receive a free community baby shower that includes a gift basket and raffle. Members are educated on successful parenting techniques while receiving information on how to keep themselves and their babies healthy.

Tailored Plan-Specific Findings

Validation Findings

The Tailored Plans completed the design of the PIP, Steps 1 through 6. Table 21 summarizes the PIPs validated during the review period with an overall validation status of *Met*, *Partially Met*, or *Not Met*. In addition, Table 21 displays the percentage score of evaluation elements that received a *Met* score, as well as the percentage score of critical elements that received a *Met* score. The following table includes the Tailored Plan name, PIP topic and Aim statement, and the validation scores and status for each Tailored Plan's PIP topic.

Table 21—Tailored Plans' Performance for Each PIP Topic

Tailored Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Alliance	*CDC—HbA1c Poor Control* Do targeted interventions decrease the percentage of members 18–64 years of age diagnosed with diabetes who had an HbA1c poor control (>9.0%)?	Percentage of diabetic adults with an HbA1c of >9.0 percent or missing test results.	Submission: 86% Resubmission: 100%	Submission: 80% Resubmission: 100%	Submission: *Partially Met* Resubmission: *Met*
	TCL Do targeted interventions increase the percentage of individuals diagnosed with serious mental illness (SMI), 18 years of age and older in the In-Reach and transitioned phase of TCL, that complete an appointment with a primary care provider between the time frames of 90 days housing slot approved and 90 days post housing residency?	Percentage of individuals in the In-Reach and transitioned phase of TCL who have completed an appointment with a primary care provider between the time frames of 90 days pre-housing transition and 90 days post-housing residency.	Submission: 63% Resubmission: 88%	Submission: 40% Resubmission: 80%	Submission: *Partially Met* Resubmission: *Partially Met*

Tailored Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Alliance (cont.)	*FUH—7-Day* and *30-Day* Do targeted interventions increase the number of members 6 years old and older who were hospitalized for treatment of selected mental disorders or intentional self-harm and who had a follow-up visit by a mental health provider within 1–7 days or within 1–30 days after their discharge from the hospital?	Percentage of discharges for members 6 years old and older who received a follow-up visit by a mental health provider within 1 to 7 days (*FUH—7-day*) and within 1 to 30 days (*FUH—30-day*) after discharge from a community-based hospital, state psychiatric hospital, state Alcohol and Drug Abuse Treatment Center (ADATC), or detox/facility-based crisis service.	Submission: 71% Resubmission: 100%	Submission: 60% Resubmission: 100%	Submission: *Partially Met* Resubmission: *Met*
Eastpointe	*CDC—HbA1c Poor Control* Will targeted interventions help to improve member's HbA1c levels?	Percentage of diabetic adults with an HbA1c of >9.0 percent or missing test results.	Submission: 0% Resubmission: 86%	Submission: 0% Resubmission: 80%	Submission: *Not Met* Resubmission: *Partially Met*
	TCL Do targeted interventions decrease the percentage of housed members diagnosed with severe mental illness (SMI)/severe and persistent mental illness (SPMI) from separating from TCL?	Percentage of active TCL members who separate from housing.	Submission: 88% Resubmission: 100%	Submission: 80% Resubmission: 100%	Submission: *Partially Met* Resubmission: *Met*
	FUH—7-Day and *30-Day* Do targeted interventions increase the percentage of follow-up appointments within 7 days or within 30 days for members ages 6 years and older who were hospitalized with a mental illness or intentional self-harm?	Percentage of discharges with a follow-up visit with a mental health practitioner within 7 days (*FUH—7-day*) and within 30 days (*FUH—30-day*) of discharge from an inpatient facility.	Submission: 43% Resubmission: 100%	Submission: 20% Resubmission: 100%	Submission: *Not Met* Resubmission: *Met*

Tailored Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Partners	*CDC—HbA1c Poor Control* Do targeted interventions decrease the percentage of members 18 to 64 years of age with diabetes who had compliance with HbA1c poor control (>9.0%)?	Percentage of Medicaid members 18–75 years as of December 31 of measurement year with diabetes (types 1 and 2) whose HbA1c was at the following levels during the measurement year: HbA1c control (<8.0%); HbA1c poor control (>9.0%).	Submission: 71% Resubmission: 100%	Submission: 60% Resubmission: 100%	Submission: *Partially Met* Resubmission: *Met*
	TCL Do targeting interventions decrease the percentage of members diagnosed with SMI and SPMI in TCL 18 years of age and over of housing separation?	Percentage of members who separated from housing during the measurement period and were not rehoused by the end of the period.	Submission: 50% Resubmission: 88%	Submission: 40% Resubmission: 80%	Submission: *Not Met* Resubmission: *Partially Met*
	FUH—7-Day and *30-Day* Do targeted interventions increase the percentage of discharges for which the member is diagnosed with mental illness or intentional self-harm, 6 years or age and older, having a follow-up visit with a mental health provider within 7 days or within 30 days?	Percentage of discharges for which the member received follow-up within 7 days (*FUH—7-day*) and within 30 days (*FUH—30-day*) after discharge.	Submission: 71% Resubmission: 100%	Submission: 60% Resubmission: 100%	Submission: *Partially Met* Resubmission: *Met*
Sandhills	*CDC—HbA1c Poor Control* Do targeted interventions decrease the percentage of members 18 to 75 years of age diagnosed with diabetes who had an HbA1c poor control (>9.0%)?	Percentage of members 18–75 years of age with diabetes (type 1 and 2) whose HbA1c was in poor control (>9.0%) during the measurement year.	Submission: 43% Resubmission: 100%	Submission: 20% Resubmission: 100%	Submission: *Not Met* Resubmission: *Met*

Tailored Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Sandhills (cont.)	*TCL* Do targeted interventions for members 18 years and older with a diagnosis of SMI in TCL decrease the percentage of individuals who separated from housing and not rehoused?	Percentage of members who separated from housing during the period and were not rehoused by end of the measurement period.	Submission: 38% Resubmission: 100%	Submission: 0% Resubmission: 100%	Submission: *Not Met* Resubmission: *Met*
	FUH—7-Day and *30-Day* Do targeted interventions increase the percentage of follow-up visits after hospitalization for mental illness or intentional self-harm diagnoses with a mental health provider for members 6 years of age and older, within 7 days and within 30 days after discharge?	Percentage of discharges with a follow-up after hospitalization for mental illness within 7 days (*FUH—7-day*) and within 30 days (*FUH—30-day*) of the discharge.	Submission: 57% Resubmission: 100%	Submission: 20% Resubmission: 100%	Submission: *Not Met* Resubmission: *Met*
Trillium	*CDC—HbA1c Poor Control* Will targeted interventions (Member Incentive Program and Population Health Program) decrease the percentage of Trillium Medicaid members 18–75 years of age with diabetes (type 1 and type 2) whose hemoglobin A1c (HbA1c) levels indicate poor control (>9.0%) from the baseline to a 5% relative improvement?	Percentage of members 18–75 years of age with diabetes (type 1 and type 2) whose HbA1c levels indicate poor control (>9.0%) or missing results during the measurement year.	Submission: 100%	Submission: 100%	Submission: *Met*
	TCL Will targeted interventions decrease the housing separation rate of SMI and SPMI TCL members 18 years of age and older in permanent supportive housing in the community?	Percentage of TCL members who move out of permanent supportive housing and are not rehoused on the last day of the measurement period.	Submission: 63% Resubmission: 100%	Submission: 40% Resubmission: 100%	Submission: *Partially Met* Resubmission: *Met*

Tailored Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Trillium (cont.)	*FUH—7-Day* and *30-Day* Will targeted interventions (provider communication and education) increase the percentage of discharges for DHB/Medicaid members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 1) 7 days after discharge from the baseline to a 5% relative improvement, and 2) 30 days after discharge from the baseline to a 5% relative improvement.	Percentage of discharges for DHB/Medicaid members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within 7 days (*FUH—7-day*) and within 30 days (*FUH—30-day*) after discharge.	Submission: 100%	Submission: 100%	Submission: *Met*
Vaya	*CDC—HbA1c Poor Control* Do targeted interventions decrease the incidence of diabetes poor control (Hemoglobin A1c >9.0%) for members ages 18 to 75 with diabetes (types 1 and 2)?	Percentage of members 18–75 years of age with diabetes (type 1 and type 2) whose HbA1c was >9.0% during the measurement period.	Submission: 0% Resubmission: 100%	Submission: 0% Resubmission: 100%	Submission: *Not Met* Resubmission: *Met*
	TCL Do targeted interventions decrease the quarterly housing separation rate for TCL members 18 years or older with SMI/SPMI?	Percentage of members who left TCL-supported housing and were not rehoused within 30 days during the measurement period.	Submission: 50% Resubmission: 100%	Submission: 20% Resubmission: 100%	Submission: *Not Met* Resubmission: *Met*

Tailored Plan	PIP Topic and Aim Statement	Performance Indicator	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Vaya (cont.)	*FUH—7-Day* and *30-Day* Do targeted interventions increase the percentage of discharges for which the member diagnosed with a mental illness or intentional self-harm, 6 years of age and older, had a follow-up visit with a mental health provider within 7 days or within 30 days?	Percentage of discharges that had a follow-up appointment with behavioral health provider within 7 days (*FUH—7-day*) and within 30 days (*FUH—30-day*) after discharge during the measurement period.	Submission: 86% Resubmission: 100%	Submission: 80% Resubmission: 100%	Submission: *Partially Met* Resubmission: *Met*

Analysis of Results

Although the baseline measurement period is CY 2021 for all PIPs, the Tailored Plans were to submit Steps 1 through 6 (Design stage) only for the 2022 annual validation. Due to the delay in the launch of the Tailored Plans, CY 2022 was an interim year, and HSAG will validate the baseline data and all QI activities conducted to date during the 2023 annual validation. Once performance indicator outcomes are reported, HSAG will include performance indicator results in the technical report.

Barriers/Interventions

The Tailored Plans' causal/barrier analysis process and interventions will be reported in the next annual PIP submission and validation report and included in the SFY 2024 technical report.

Conclusions

The validation findings suggest that all Standard Plans developed methodologically sound PIPs and met all validation criteria for this validation cycle. The Standard Plans performed appropriate data analysis and made data-driven decisions related to QI processes and interventions that were developed and initiated.

Strengths and Weaknesses—Standard Plans

AmeriHealth

For this validation cycle, all AmeriHealth PIPs received *Met* validation scores for 100 percent of all applicable evaluation elements and achieved an overall *Met* validation status. There were no identified weaknesses.

Carolina Complete

For this validation cycle, all Carolina Complete PIPs received *Met* validation scores for 100 percent of all applicable evaluation elements and achieved an overall *Met* validation status. There were no identified weaknesses.

Healthy Blue

For this validation cycle, all Healthy Blue PIPs received *Met* validation scores for 100 percent of all applicable evaluation elements and achieved an overall *Met* validation status. There were no identified weaknesses.

UnitedHealthcare

For this validation cycle, all UnitedHealthcare PIPs received *Met* validation scores for 100 percent of all applicable evaluation elements and achieved an overall *Met* validation status. There were no identified weaknesses.

WellCare

For this validation cycle, HSAG identified the following strengths:

- Two of the four PIPs received *Met* validation scores for 100 percent of all applicable evaluation elements validated.
- All four PIPs received an overall *Met* validation status.

There was one opportunity for improvement related to documentation requirements in Step 7, Data Analysis and Interpretation of PIP Results, for both the HEDIS *CIS—Combo 10* and HEDIS *PPC* PIPs. WellCare should ensure that it addresses HSAG's validation feedback related to addressing factors that threaten the validity of the data reported.

Strengths and Weaknesses—Tailored Plans

Alliance

For this validation, two of the three PIPs received *Met* validation scores for 100 percent of all applicable evaluation elements and achieved an overall *Met* validation status. Alliance had an opportunity for improvement related to accurately documenting the eligible population in the *TCL* PIP.

Eastpointe

For this validation, two of the three PIPs received *Met* validation scores for 100 percent of all applicable evaluation elements and achieved an overall *Met* validation status. Eastpointe had an opportunity for improvement related to accurately documenting the Aim statement in the *CDC: HbA1c Poor Control* PIP.

Partners

For this validation, two of the three PIPs received *Met* validation scores for 100 percent of all applicable evaluation elements and achieved an overall *Met* validation status. Partners had an opportunity for improvement related to accurately documenting the eligible population in the *TCL* PIP.

Sandhills

For this validation, all PIPs received *Met* validation scores for 100 percent of all applicable evaluation elements and achieved an overall *Met* validation status. There were no identified weaknesses.

Trillium

For this validation, all PIPs received *Met* validation scores for 100 percent of all applicable evaluation elements and achieved an overall *Met* validation status. There were no identified weaknesses.

Vaya

For this validation, all PIPs received *Met* validation scores for 100 percent of all applicable evaluation elements and achieved an overall *Met* validation status. There were no identified weaknesses.

Recommendations—Standard Plans

Table 22 identifies HSAG's recommendations for the Standard Plans.

Table 22—Recommendations for Standard Plans

Recommendation	AmeriHealth	Carolina Complete	Healthy Blue	United HealthCare	WellCare
Consider short testing and evaluation periods for its current interventions. The testing and evaluation of interventions should allow the PHP to quickly gather data and make data driven decisions on the status of an intervention. If the intervention is not having the desired impact, mid-course revisions can be made or a new intervention can be initiated.	✓	✓	✓		
Revisit its causal/barrier analysis process at least annually to ensure that identified barriers are still relevant and determine if new barriers exist that can impede progress.	✓	✓	✓	✓	✓
Apply lessons learned and knowledge gained during the PIP process to make changes and revisions to current QI processes and activities.	✓	✓	✓	✓	✓
Seek technical assistance from HSAG throughout the PIP process to address any questions or concerns.	✓	✓	✓	✓	✓
Reference the PIP Completion Instructions as it updates its PIP submission forms to ensure that all requirements for each completed step have been addressed.	✓	✓	✓	✓	✓
Ensure to address each of the "Validation Feedback" comments that are associated with *Met* validations scores in the 2023 annual submission.		✓	✓	✓	
Revisit and revise the performance indicator goals that were exceeded by the baseline performance.			✓		
Address any *Partially Met*, *Not Met*, or *Validation Feedback* comments associated with *Met* validation scores in the next annual submission.					✓

Recommendations—Tailored Plans

Table 23 identifies HSAG's recommendations for the Tailored Plans.

Table 23—Recommendations for Tailored Plans

Recommendation	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya
Address any *Partially Met*, *Not Met*, or *Validation Feedback* comments associated with *Met* validation scores in the next annual submission.	✓	✓	✓	✓	✓	✓
Use QI tools such as a causal/barrier analysis, key driver diagram, process mapping, and/or failure mode and effects analysis to determine and prioritize barriers, drivers, and/or weaknesses within processes. The use of these tools will help the plan determine what interventions to test.	✓	✓	✓	✓	✓	✓
Develop active, innovative interventions that have the potential for impacting the performance indicator outcomes.	✓	✓	✓	✓	✓	✓
Develop a process or plan to evaluate the effectiveness of each individual intervention.	✓	✓	✓	✓	✓	✓
Use Plan-Do-Study-Act cycles as part of the improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful.	✓	✓	✓	✓	✓	✓
Revisit the causal/barrier analysis tools used at least annually to ensure that the plan remains on track and that the identified barriers and opportunities for improvement are still relevant and applicable.	✓	✓	✓	✓	✓	✓
Use the PIP Completion Instructions as additional steps of the PIP process are completed. This will help ensure that all documentation requirements have been addressed.	✓	✓	✓	✓	✓	✓
Seek technical assistance from HSAG throughout the PIP process to address any questions or concerns.	✓	✓	✓	✓	✓	✓

NETWORK ADEQUACY

Introduction

Validation of network adequacy is a mandatory EQR activity, and states must begin conducting this activity, described in §438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. CMS Protocol 4 was issued in February 2023;[16] therefore, HSAG collaborated with DHB to select appropriate monitoring activities, develop methodologies, and implement workplans to validate each PHP's provider network to ensure compliance with 42 CFR §§438.68 and 438.358 and assess members' access to care. Results will be provided in future technical reports.

During SFY 2023, HSAG collaborated with DHB to conduct quarterly access and availability "revealed" and "secret shopper" surveys to evaluate the accuracy of provider information and appointment availability for specialists, primary care providers (PCPs), and OB/GYNs. Results of the quarterly surveys were published separately and are available upon request.

[16] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: http://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Feb 5, 2024.

OPTIONAL EQR ACTIVITIES

Introduction

EQR-related activities are the mandatory and optional activities, as set forth in 42 CFR §438.358, which produce the data and information that the EQRO analyzes when performing the EQR. EQR-related activities are intended to improve states' ability to oversee and manage the health plans they contract with for services and help improve their performance with respect to the quality, timeliness, and accessibility of care. In addition to the mandatory sections described in the prior sections of this report, CMS designates five optional activities. The State has discretion to determine which optional EQR-related activities it wishes to conduct and include in the annual EQR. Upon implementation of managed care, the Department contracted HSAG to conduct the following five optional activities:

- EDV
- Administration or validation of consumer or provider surveys of quality of care
- Calculation of PMs
- Focus studies on quality of care
- Rating of health plans

In addition to the mandatory and optional activities recognized by CMS, the Department also contracted HSAG to conduct the following tasks:

- Annual care management performance evaluation
- Collaborative QI forums
- PI reviews
- Quarterly PIP reviews
- Quarterly QAPI reviews
- Total Cost of Care (TCOC)
- Hospital at Home (HaH) evaluation
- Various evaluations and reports

During SFY 2023, HSAG worked with the Department to prepare for the optional and additional EQR activities as described below.

Description of Optional Activities

Encounter Data Validation

Methods

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, DHB requires its health plans to submit high-quality encounter data. During SFY 2022–2023, DHB contracted HSAG to conduct an EDV study.

In alignment with the CMS EQR *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP [Children's Health Insurance Program] Managed Care Plan: An Optional EQR-Related Activity*, February 2023 (CMS EQR Protocol 5),[17] HSAG conducted the following core evaluation activity for the EDV study:

- Administrative profile—analysis of DHB's electronic encounter data completeness, accuracy, and timeliness. The goal of this activity was to evaluate the extent to which the encounter data in DHB's Encounters Processing Solution (EPS) database were complete, accurate, and submitted by the Standard Plans in a timely manner for encounters with dates of service between July 1, 2021, and June 30, 2022, i.e., SFY 2021–2022. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in the CMS EQR Protocol 5.

Findings and Recommendations

Overall, DHB's encounter data should continue to support analyses utilizing encounter data such as HEDIS performance measure calculation and rate setting. Data were largely complete, valid, and reliable. While some gaps and data concerns were identified, this should not preclude the State from conducting further analyses given adequate assessment of encounters prior to analysis. Additionally, the administrative profile identified several potential areas for DHB to address either internally or in consultation with the Standard Plans.

HSAG recommended the following:

- DHB should work with the Standard Plans to ensure pharmacy encounters are submitted after the payment date.
- DHB should work with the Standard Plans to ensure timely submission of encounters. In the interim, DHB should thoroughly assess encounter completeness prior to analysis with a focus on pharmacy encounters. HSAG recommends that DHB continue to monitor timely submission of pharmacy encounters.
- DHB should monitor the completeness of CPT/HCPCS codes in submitted encounter data by all Standard Plans.

HSAG produced an aggregate report that included Standard Plan-specific findings in August 2023.

[17] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity,* February 2023. Available at: http://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Jan 8, 2024.

Consumer Surveys

The Department contracted with HSAG to administer and report the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys.[18] The CAHPS questionnaires were developed under cooperative agreements among the Agency for Healthcare Research and Quality (AHRQ), Harvard Medical School, RAND Corporation, and the Research Triangle Institute (RTI) and are used as a national standard for assessing members' healthcare experience. The goals of the CAHPS surveys are to provide performance feedback that is actionable and will aid in improving overall care.

The standardized survey instruments selected for the 2022 CAHPS (MY 2021) survey included:

- CAHPS 5.1 Adult Medicaid Health Plan Survey with the supplemental HEDIS items.
- CAHPS 5.1 Child Medicaid Health Plan Survey with the supplemental HEDIS items and children with chronic conditions (CCC) measurement set.

The CAHPS surveys ask adult members or the parents/caretakers of child members to report on and evaluate their experiences with the healthcare services received in the last six months. These surveys cover topics that are important to members, such as the communication skills of providers and the accessibility of services. The survey includes a set of measures that can be classified as:

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

Survey Populations

HSAG administered the 2022 surveys to members in the five PHPs (see Table 24). PHPs offer integrated physical health, pharmacy, care coordination, and basic behavioral health services.

Table 24—Participating PHPs

Name	Abbreviation
AmeriHealth Caritas North Carolina, Inc.	AmeriHealth
Carolina Complete Health, Inc.	Carolina Complete
Healthy Blue of North Carolina	Healthy Blue
UnitedHealthcare of North Carolina, Inc.	UnitedHealthcare
WellCare of North Carolina, Inc.	WellCare

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

In addition, HSAG also administered the surveys to four specific NC Medicaid populations in 2022. These populations included:

- Individuals enrolled in a PHP receiving behavioral health services (i.e., Standard Plan Behavioral Health population)
- American Indian or Alaskan Native individuals who were enrolled in the EBCI Tribal Option[19]
- Members receiving healthcare through Medicaid Direct (formally known as fee-for-service)
- Current Medicaid Direct enrollees who would qualify for Tailored Plans (Tailored Plan Eligible) who have mental health needs, I/DD, TBIs, or severe substance use disorders[20]

HSAG grouped respondents to create aggregate results for comparative purposes:

- NC Medicaid Program—Combined results of all five PHPs, EBCI Tribal Option, and Medicaid Direct
- NC PHP Aggregate—Combined results of all five PHPs

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

- Adult members—a general sample of adults from the entire eligible population.
- General child members—a general sample of children from the entire eligible population.
- Children with chronic conditions members (CCC members)—children whose parents/caretakers reported their child needed or used specific services (e.g., specialty therapy, mental health counseling, prescription medicines) or had limitations in the ability to do what other children of the same age do.

Results

National Percentile Comparisons

NC Medicaid Program and NC PHP Aggregate positive ratings were compared to the NCQA's 2022 Quality Compass® Benchmark and Compare Quality Data to determine which NCQA national percentile range the scores fall within.[21,22] Depending on how the scores compared to the NCQA national

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19 The tribal option manages beneficiaries primarily in Cherokee, Graham, Haywood, Jackson, and Swain counties.

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

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

22 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2022.* Washington, DC: NCQA, September 2022. Quality Compass® 2022 data are used with the permission of NCQA. Quality Compass 2022 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of AHRQ.

percentiles, a star rating was assigned from one (★) to five (★★★★★) stars, where one star is below the national 25th percentile and five stars is greater than or equal to the national 90th percentile.

Table 25 provides the star ratings for each measure for the NC Medicaid Program and NC PHP Aggregate when the positive ratings were compared to NCQA national percentiles.

Table 25—NC Medicaid Program and NC PHP Aggregate Star Ratings When Positive Ratings Results Were Compared to NCQA National Percentiles (2022)

	NC Medicaid Program Compared to NCQA National Percentiles			NC PHP Aggregate Compared to NCQA National Percentiles		
Measures	**Adult**	**General Child**	**CCC**	**Adult**	**General Child**	**CCC**
Global Ratings						
Rating of Health Plan	★★ 76.3%	★ 83.5%	★ 80.3%	★ 73.2%	★★ 84.1%	★★ 82.6%
Rating of All Health Care	★★ 74.3%	★★★ 89.0%	★★★★ 88.2%	★★★ 77.0%	★★★ 88.8%	★★★★ 88.8%
Rating of Personal Doctor	★★★★ 87.2%	★★ 89.4%	★★★ 90.1%	★★★ 84.5%	★★ 89.2%	★★★ 90.7%
Rating of Specialist Seen Most Often	★★★★ 86.4%	★★★★ 88.9%	★★★ 88.1%	★★★ 83.8%	★★★★ 88.9%	★★★ 87.1%
Composite Measures						
Getting Needed Care	★★★ 83.9%	★★ 83.6%	★★ 86.5%	★★ 81.2%	★★ 82.8%	★★ 86.4%
Getting Care Quickly	★★★★ 85.0%	★★ 85.6%	★★ 90.7%	★★★ 82.7%	★★ 85.1%	★★ 88.9%
How Well Doctors Communicate	★★★ 93.5%	★ 92.2%	★★★ 95.4%	★★★ 93.5%	★ 91.7%	★★ 94.2%
Customer Service	★★★ 90.3%	★ 82.5%	NA 86.7%	★★ 87.3%	★ 82.0%	NA 86.2%
Individual Item Measures						
Coordination of Care	★★★★ 88.2%	★★ 83.0%	★ 81.5%	★★★ 85.5%	★★ 82.2%	★ 80.6%
Flu Vaccination Received	★★★★ 50.1%	NA	NA	★★ 36.5%	NA	NA
Effectiveness of Care Measures						
Advising Smokers and Tobacco Users to Quit	★★★★★ 82.1%	NA	NA	★★★★★ 82.5%	NA	NA

	NC Medicaid Program Compared to NCQA National Percentiles			NC PHP Aggregate Compared to NCQA National Percentiles		
Measures	**Adult**	**General Child**	**CCC**	**Adult**	**General Child**	**CCC**
Discussing Cessation Medications	★★★★ 56.1%	NA	NA	★★★ 54.9%	NA	NA
Discussion Cessation Strategies	★★★★ 52.5%	NA	NA	★★★ 46.9%	NA	NA
CCC Composite Measures and Items						
Access to Specialized Services	NA	NA	★ 69.6%	NA	NA	★★★★ 73.1%
Family-Centered Care (FCC): Personal Doctor Who Knows Child	NA	NA	★ 90.8%	NA	NA	★ 90.1%
Coordination of Care for Children with Chronic Conditions	NA	NA	★ 74.7%	NA	NA	★ 74.3%
FCC: Getting Needed Information	NA	NA	★★★ 93.1%	NA	NA	★★★ 92.8%
Access to Prescription Medicines	NA	NA	★★★ 91.5%	NA	NA	★★★★ 93.0%

Star Assignments Based on Positive Ratings Compared to NCQA National Percentiles: ★★★★★ 90th Percentile or Above ★★★★ 75th–89th Percentiles ★★★ 50th–74th Percentiles ★★ 25th–49th Percentiles ★ Below 25th Percentile
NA indicates the measure is not applicable for the population or the NCQA National Percentiles are not available.

Overall, compared to NCQA national percentiles, adult members reported higher levels of experience across a majority of the areas compared to general child members. Compared to the NCQA national percentiles, parents/caretakers of general child members and adult members reported high levels of experience for *Rating of Specialists Seen Most Often*.

Compared to the NCQA national percentiles, adult members and parents/caretakers of general child and CCC members reported low levels of experience in the following areas:

- *Rating of Health Plan*
- *Getting Needed Care*
- *Customer Service*

Additional Results

In July 2023, the 2022 Adult and Child Medicaid CAHPS Aggregate Report was published (available upon request). This report contained additional results beyond the national percentile comparisons presented above. The report compared the individual PHPs' and populations' positive ratings to the overall NC Medicaid Program and NC PHP aggregate, displayed race and ethnicity comparisons, and presented trended data for each CAHPS measure to indicate results from 2018 to 2022.

Conclusions

Based on all the results presented in the 2022 Adult and Child Medicaid CAHPS Aggregate Report, HSAG drew the following conclusions. There is no indication in these survey data that the transition to managed care in July of 2021 has significantly impacted the overall experience of care being provided to Medicaid members relative to the quality of care received prior to the transition. Overall, adult respondents' positive experiences with their health plan, personal doctor, health plan's customer service, and getting care quickly have consistently increased from 2019 to 2022 for the NC Medicaid Program. For parents/caretakers of general child members, positive experiences with their child's overall healthcare consistently increased from 2018 to 2022, and their experiences with their child's personal doctor, receiving needed care for their child, and receiving care quickly for their child consistently decreased from 2019 to 2022 for the NC Medicaid Program. For parents/caretakers of CCC members, positive experiences for getting needed information for their child consistently increased from 2018 to 2022, and their experiences for accessing specialized services and prescription medications for their child consistently decreased from 2018 to 2022 for the NC Medicaid Program. Medicaid Direct respondents reported significantly more positive experiences with care when compared to the NC PHP aggregate and NC Medicaid Program. When compared to NCQA national percentiles, the NC Medicaid Program and NC PHP Aggregate scored fairly well across the measure domains for the adult populations; however, both the NC Medicaid Program and NC PHP Aggregate scored poorly across the measure domains for the general child and CCC populations. The *Rating of Health Plan* and *Getting Needed Care* measures were the lowest performing measures.

Calculation of Performance Measures

Regulations at 42 CFR §438.358(c)(3) specify that the EQRO may calculate PMs in addition to those specified by the state for inclusion in the PHPs' QAPI programs. Calculation of these additional PMs are an optional EQR-related activity.

HSAG and the Department selected 10 measures for HSAG to calculate on behalf of the five Standard Plans with the goal that in SFY 2023, HSAG would calculate the PMs using DHB-provided claims/encounter data in alignment with the applicable administrative technical specifications for MY 2021 and in accordance with CMS EQR *Protocol 7. Calculation of Additional Performance Measures: An Optional EQR-Related Activity*, February 2023.[23] During SFY 2023, HSAG worked with DHB to finalize the methodology, conduct the calculations, and provide the results to DHB.

Focus Studies on Quality

States may direct their EQROs to conduct focus studies for QI, administrative, legislative, or other purposes. Focus studies may examine clinical or nonclinical aspects of care provided by health plans and assess quality of care at a specific point in time. HSAG's EQRO contract with the Department specifies

[23] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 7. Calculation of Additional Performance Measures: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Jan 8, 2023.

the EQRO shall be requested to conduct reviews and studies to ensure that services provided to Medicaid members are medically necessary, appropriate, and provided at the most efficient level of care. When such a request is made by the Department, HSAG will conduct the focus study in accordance with CMS EQR *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*, February 2023.[24]

Quality Rating of Health Plans

Regulations at 42 CFR §438.334 require the development of a Medicaid managed care quality rating system. HSAG stays abreast of CMS' development of an EQRO protocol for this activity. Currently, *Protocol 10. Assist With Quality Rating of Medicaid and CHIP Managed Care Organizations, Prepaid Inpatient Health Plans, and Prepaid Ambulatory Health Plans: An Optional EQR-Related Activity*, is reserved by CMS.

The Department contracted with HSAG to develop an annual PHP Report Card that compares the PHPs to each other in key performance areas to help Medicaid beneficiaries select a PHP. The following key performance areas, which comprise quality PMs and CAHPS survey results, were included in the PHP Report Card: Overall Rating, Doctors' Communication, Getting Care, Keeping Kids Healthy, Living With Illness, and Women's Health.

DHB, in collaboration with HSAG, chose measures for the 2022 PHP Report Card based on a number of factors, including measures that best approximate the reporting categories that are useful to consumers, using data that are available, and using nationally recognized, standardized measures for Medicaid or managed care.

Given the roll out of managed care services during 2021, the 2022 PHP Report Card was a pilot year designed to allow the health plans and DHB the opportunity to review the results (informational only). The ratings were not a true reflection of health plan performance as members spent the first half of the measurement year in Medicaid Direct and, additionally, the measurement year was disrupted by the COVID-19 pandemic and the launch of managed care. For the pilot year, a three-level rating scale and a five-level rating scale were developed to provide consumers with an easy-to-read "picture" of quality performance across health plans and presented data in a manner that emphasized meaningful differences among health plans. The PHP Report Card used stars to display results for each plan and displayed plan performance.

Annual Care Management Performance Evaluation (CMPE)

DHB contracted with HSAG to conduct validation of the transmission of beneficiary data to AMHs according to DHB's published data specifications and time frames. DHB contracted with five privately owned PHPs. In accordance with PHP contract requirements, Section V.C.6.c.iv: Required Data and

[24] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity,* February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Jan 8, 2023.

Information Sharing to Support Care Management, PHPs are required to share beneficiary data with AMH Tier 3 providers according to published data specifications and time frames. AMH providers work with CIN partners to assist in meeting AMH program requirements.

The purpose of the validation was to assess the data collection and exchange of beneficiary data and interim quality performance measure gap reports between the PHPs and CIN partners associated with AMH providers. Accurate beneficiary data serve as the foundation that enables PHPs and AMH Tier 3 providers to perform care management services, report data on care management services, and assess the impact those services have on beneficiaries. In addition, accurate beneficiary data allow for accurate beneficiary assignment to AMH providers and ensure AMH providers are obtaining accurate care gap closure lists. The validation of activities was intended to identify the root cause of determined discrepancies and proposed systemwide resolution by PHP to ensure adequate, reliable, and complete beneficiary data in alignment with published data specifications and timelines, and accurate interim quality performance measure gap reports.

HSAG approached validation activities in two phases to allow for a subset of activities to be conducted through the CY 2022 annual PMV. Phase I focused on gathering information through the PHPs' ISCAT and virtual on-site audit of the systems and processes used to attribute beneficiaries to AMH providers and CIN partners, as well as to generate and distribute interim quality performance measure gap reporting. Phase II focused on gathering information through the CINs' information systems tool, evaluating both the CINs' and PHPs' systems and processes used to generate and report provider roster data, and comparing CIN and PHP files to identify gaps.

HSAG conducted a DHB-approved scope of validation activities to support the first-year validation of the exchange of beneficiary data and interim quality performance measure gap reporting. HSAG validated internal and external processes the CIN partners and PHPs undergo to collect, integrate, and report provider roster data, and compared the CIN and PHP files to determine data misalignment outliers, root cause of data gaps, and opportunities for improvement.

HSAG produced an aggregate report that included PHP-specific findings in May 2023.

Collaborative Quality Forums—Quality Symposium

HSAG subcontracted with Constellation Quality Health (CQH, formerly Carolinas Center for Medical Excellence) to conduct the annual Quality Symposium: Partnering for Performance (Symposium) for the Standard Plans. SFY 2023 topics for the Symposium were (1) Umbrella Program Support of Diabetes Self-Management Education and Support (DSMES) Services, and (2) Increasing Adolescent Immunization Rates—Strategies to Eliminate Missed Vaccination Opportunities.

Symposium participation included Standard Plan senior leadership, managers, front-line staff, network providers, and other statewide stakeholders including NC Medicaid staff. Each topic's duration was one hour and included time for questions from the attendees. All questions and answers for each presentation were captured. In addition, each registered attendee received an email four days after each Symposium topic with a link to the recorded webinar and instructions on requesting the presentation slides.

At the conclusion of each Symposium presentation, an electronic evaluation survey was offered to participants to complete. Of the 242 total attendees for the combined webinars, 118 (49 percent) of the evaluation surveys were completed. Overall satisfaction with the presentations, the clear conveyance of the subject, and the usefulness of the topics were above 98 percent.

Detailed results were included in an annual summary report produced by CQH in July 2023.

Program Integrity Reviews

To meet federal requirements outlined in Section 1902 (a)(68) of the Social Security Act and the requirements outlined in the CMS Medicaid managed care regulations, HSAG's subcontractor conducted Standard Plan PI reviews to determine compliance with PI requirements. The purpose of the review was to assess the degree to which the Standard Plan ensured the effective use and management of public resources in the delivery of services to Medicaid managed care members and how the Standard Plan increased awareness within its organization and across its provider network of methods to prevent, detect, and report potential fraud, waste, or abuse (FWA).

During SFY 2023, HSAG's subcontractor, CQH, conducted desk, file, and webinar reviews with all five Standard Plans. Findings and recommendations for the Standard Plans were provided in final reports that are available on request.

Quarterly PIP Review

DHB requested that HSAG conduct quarterly PIP reviews to assess the Standard Plans' progress on each of the four PIPs. HSAG completed quarterly reviews, providing feedback to DHB and the PHPs, in February and May 2023.

Quarterly QAPI Review

DHB requested that HSAG conduct quarterly QAPI reviews, to assess the Standard Plans' progress on their QAPI workplans and programs. HSAG completed a quarterly review, providing feedback to DHB and the PHPs, in September 2022 and March 2023.

Total Cost of Care (TCOC) Resources

DHB contracted with HSAG to develop and maintain a Medicaid focused TCOC toolkit and reporting suite. HSAG was tasked with providing data analytics on an array of resource use and total cost indices and developing reporting dashboards, as well as building, maintaining, and hosting a web-based portal that providers, health plans, and DHB can access. In SFY 2023, HSAG executed the DHB-approved workplan, which included developing risk adjustment factors for the North Carolina Medicaid population utilizing the Chronic Illness and Disability Payment System (CDPS) risk adjustment methodology and validating results with DHB' actuarial team, as well as working to develop the web-based portal and reporting dashboard.

Hospital at Home (HaH) Evaluation

DHB requested that HSAG provide a proposal to conduct a short-term rapid-cycle impact evaluation of the DHHS' HaH program. The Acute HAH program is an expansion of the CMS Hospital Without Walls initiative as part of a comprehensive effort to increase hospital capacity, maximize resources, and combat COVID-19, and creates flexibility that allows for certain healthcare services to be provided outside of a traditional hospital setting and within a patient's home. DHB submitted data to HSAG throughout the reporting year for analysis. HSAG presented results of four quality-based metrics to evaluate the impact of the HaH program compared to traditional inpatient care.

Access to Care Report

The Annual Access to Care Report provides a profile of access to care using measures as detailed in the Department's Quality Strategy. The purpose of the Annual Access to Care Report is to document the accessibility of the provider networks and perception of access. During SFY 2023, HSAG and its subcontractor collaborated with DHB to develop the report template and completed data analysis for inclusion in the report. A final report is projected to be produced in 2024.

Health Equity Report

The goal of the annual Health Equity Report is to explore and discuss health disparities among adult and child Medicaid beneficiaries in the State of North Carolina. Health disparities were analyzed for indicators within different domains of health and experiences of care. Demographic factors that were assessed include race, binary race, ethnicity, age, primary language, gender, long-term services and supports (LTSS) needs status, disability status, and region. A variety of data sources (administrative data, enrollment information, and self-reported data) were used to identify disparities among NC Medicaid beneficiaries.

During SFY 2023, HSAG developed the first Health Equity Report. A final report is projected to be produced in 2024.

Annual Quality Report

In SFY 2023, HSAG developed the 2022 Annual Quality report which assessed NC Medicaid's 2018–2021 performance on quality measures related to the three aims and associated goals identified in the NC Medicaid Managed Care Quality Strategy. The report included NC Medicaid's recent performance on select measures, both across years and compared to national medians, organized by the goals outlined in the Quality Strategy. A final report is projected to be produced in 2024.

APPENDIX A. EQR TECHNICAL REPORT REQUIREMENTS

Table A-1 lists the required and recommended elements for the EQR technical report, per 42 CFR §438.364 and recent CMS technical report feedback received by states. Table A-1 also identifies the page number where the corresponding information that addresses each element is located in the EQR technical report, if applicable. In the table below, NA represents "not applicable" to indicate that this information will be included in subsequent reports and page numbers will be able to be determined.

Table A-1—EQR Technical Report Elements

	Required Elements	Page Number
1	The state submitted its EQR technical report by April 30.	NA
2	All eligible Medicaid and CHIP health plans are included in the report.	83
3	Required elements are included in the report:	
3a	Describe the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and accessibility of the care furnished by the MCO, PIHP, PAHP, or PCCM entity.	6–7
3b	An assessment of the **strengths and weaknesses of each MCO, PIHP, PAHP) and PCCM entity** with respect to (a) quality, (b) timeliness, and (c) access to the healthcare services furnished by each MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR §438.310[c][2]) furnished to Medicaid and/or CHIP beneficiaries. Contain specific recommendations for improvement of identified weaknesses.	85–97
3c	Describe how the state can **target goals and objectives in the quality strategy**, under 42 CFR §438.340, to better support improvement in the quality, timeliness, and access to healthcare services furnished to Medicaid and/or CHIP enrollees.	9–10
3d	Recommends improvements to the quality of healthcare services furnished by each MCO.	9–10, 85–97
3e	Provides state-level recommendations for performance improvement.	Various
3f	Ensures methodologically appropriate, comparative information about all MCOs.	Various
3f	Assesses the degree to which each MCO has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR.	98–115
4	Validation of PIPs: A description of **PIP interventions** associated with each state-required PIP topic for the current EQR review cycle, and the following for the validation of PIPs: **objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.**	31–64
4a	**Interventions.**	46–54

	Required Elements	Page Number
4b	**Objectives.**	31
4c	**Technical methods of data collection and analysis.**	33
4d	**Description of data obtained.**	33
4e	**Conclusions drawn from the data.**	61–62
5	Validation of performance measures: A description of **objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.**	19–23
5a	**Objectives.**	19–23
5b	**Technical methods of data collection and analysis.**	
5c	**Description of data obtained.**	
5d	**Conclusions drawn from the data.**	
6	**Review for compliance**: 42 CFR §438.358(b)(1)(iii) (cross-referenced in CHIP regulations at 42 CFR §457.1250[a]) requires the technical report include information **on a review, conducted within the previous three-year period**, to determine each MCO's, PIHP's, PAHP's or PCCM's compliance with the standards set forth in Subpart D and the QAPI requirements described in 42 CFR §438.330. Additional information that needs to be included for compliance is listed below:	11–18
6a	**Objectives.**	13
6b	**Technical methods of data collection and analysis.**	13–18
6c	**Description of data obtained.**	13–18
6d	**Conclusions drawn from the data.**	NA
7	**Each remaining activity** included in the technical report must include a **description of the activity** and the following information:	66–77
7a	**Objectives.**	66–77
7b	**Technical methods of data collection and analysis.**	66–77
7c	**Description of data obtained.**	66–77
7d	**Conclusions drawn from the data.**	66–77

APPENDIX B. GLOSSARY OF ACRONYMS

42 CFR ..... Title 42 of the Code of Federal Regulations
AAP ..... *Adults' Access to Preventive/Ambulatory Health Services*
ADHD ..... *Attention-Deficit/Hyperactivity Disorder*
AHRQ ..... Agency for Healthcare Research and Quality
AMH ..... Advanced Medical Home
AOD ..... *Alcohol and Other Drug*
BH ..... Behavioral Health
CAHPS ..... Consumer Assessment of Healthcare Providers and Systems
CBP ..... *Controlling High Blood Pressure*
CCC ..... Children With Chronic Conditions
CCH ..... Carolina Complete Health, Inc.
CCNC ..... Community Care of North Carolina
CCS ..... *Cervical Cancer Screening*
CDC ..... *Comprehensive Diabetes Care*
CDPS ..... Chronic Illness and Disability Payment System
CFSP ..... Children and Families Specialty Plan
CHIP ..... Children's Health Insurance Program
CIHA ..... Cherokee Indian Hospital Authority
CIN ..... Clinically Integrated Network
CIS-10 ..... *Childhood Immunization Status—Combination 10*
CMHRP ..... Case Management High Risk Pregnancy Program
CMPE ..... Case Management Program Evaluation
CMS ..... Centers for Medicare & Medicaid Services
CNS ..... Care Needs Screener
COPD ..... *Chronic Obstructive Pulmonary Disease*
COVID-19 ..... Coronavirus Disease 2019
CPT ..... Current Procedural Terminology
CQH ..... Constellation Quality Health
CY ..... Calendar Year
DHB ..... North Carolina Division of Health Benefits
DHHS ..... Department of Health and Human Services
DNR ..... Did Not Report
DSMES ..... Diabetes Self-Management Education and Support
DTaP ..... Diphtheria, Tetanus, and Acellular Pertussis
EBCI ..... Eastern Band of Cherokee Indians

EDV ..... Encounter Data Validation
EPSDT ..... Early and Periodic Screening, Diagnostic, and Treatment
EQR ..... External Quality Review
EQRO ..... External Quality Review Organization
FFS ..... Fee-for-Service
FUH ..... *Follow-Up-After Hospitalization for Mental Illness*
FWA ..... Fraud, Waste, or Abuse
HaH ..... Hospital at Home
HbA1c ..... Hemoglobin A1c
HCPCS ..... Healthcare Common Procedure Coding System
HEDIS ..... Healthcare Effectiveness Data and Information Set
HepA ..... Hepatitis A
HepB ..... Hepatitis B
HiB ..... Haemophilus Influenza Type B
HRA ..... Health Risk Assessment
HSAG ..... Health Services Advisory Group, Inc.
I/DD ..... Intellectual/Developmental Disability
IHS ..... Indian Health Service
IMA ..... *Immunizations for Adolescents*
IMCE ..... Indian Managed Care Entity
IPV ..... Polio Vaccine
ISCAT ..... Information Systems Capabilities Assessment Tool
JOC ..... Joint Operating Committee
LME ..... Local Management Entity
LTSS ..... Long-Term Services and Supports
MCO ..... Managed Care Organization
MCP ..... Managed Care Plan
MMR ..... Measles, Mumps, Rubella
MY ..... Measurement Year
NA ..... Not Applicable
NC ..... North Carolina
NCIR ..... North Carolina Immunization Registry
NCQA ..... National Committee for Quality Assurance
NOP ..... Notification of Pregnancy
NPI ..... National Provider Identifier
NR ..... Not Reportable
OB/GYN ..... Obstetrics/Gynecology
PAHP ..... Prepaid Ambulatory Health Plan

PCCM ..... Primary Care Case Management
PCP ..... Primary Care Providers
PCV ..... Pneumococcal Conjugate Vaccine
PEF ..... Provider Enrollment File
PHP ..... Prepaid Health Plan
PIHP ..... Prepaid Inpatient Health Plan
PIP ..... Performance Improvement Project
PM ..... Performance Measure
PMV ..... Performance Measure Validation
POM ..... Proactive Outreach Management
PPC ..... *Prenatal and Postpartum Care*
PQA ..... *Pharmacy Quality Alliance*
QAPI ..... Quality Assessment and Performance Improvement
QEP ..... Quality Enhancement Program
QI ..... Quality Improvement
QPA ..... Quality Practice Advisory
R ..... Reportable
RV ..... Rotavirus Vaccine
SDOH ..... Social Determinants of Health
SFY ..... State Fiscal Year
SMI ..... Serious Mental Illness
TBD ..... To Be Determined
TBI ..... Traumatic Brain Injury
TCL ..... *Transitions to Community Living*
TCOC ..... Total Cost of Care
VAS ..... Value-Added Service
VZV ..... Varicella Zoster Virus (Chickenpox) Vaccine
W30 ..... *Well-Child Visits in the First 30 Months of Life*
WCV ..... *Child and Adolescent Well-Care Visits*

APPENDIX C. HEALTH PLAN LIST

NC Medicaid Standard Plans

Table C-1 and Table C-2 display the Medicaid managed care health plans in operation during SFY 2023.

Table C-1—NC Medicaid Managed Care Standard Plans

Health Plan Name	Short Name	Health Plan Type
AmeriHealth Caritas North Carolina, Inc.	AmeriHealth	PHP
Carolina Complete Health, Inc.	Carolina Complete	PHP
Healthy Blue of North Carolina	Healthy Blue	PHP
UnitedHealthcare of North Carolina, Inc.	UnitedHealthcare	PHP
WellCare of North Carolina, Inc.	WellCare	PHP

Table C-2—EBCI Tribal Option Plans

EBCI Tribal Option[25]		
Category	**Abbreviation**	**Health Plan Type**
EBCI Tribal Option	EBCI	IMCE

[25] EQR activities are not conducted for the Tribal Option.

Table C-3 displays additional health plan types scheduled to operate in subsequent contract years. DHB implemented PIHP contracts with six health plans in April 2023; health plan consolidation will reduce the number of health plans to four in 2024. The Tailored Plans (listed as LME/MCO) are projected to go live in 2024.

Table C-3—PIHPs and Tailored Plans

BH I/DD Tailored Plans		
Health Plan Name	**Short Name**	**Health Plan Type**
Alliance Health	Alliance	LME/MCO and PIHP
Eastpointe	Eastpointe	LME/MCO and PIHP
Partners Health Management	Partners	LME/MCO and PIHP
Sandhills Center	Sandhills	LME/MCO and PIHP
Trillium Health Resources	Trillium	LME/MCO and PIHP
Vaya Health	Vaya	LME/MCO and PIHP

APPENDIX D. HEALTH PLAN-SPECIFIC CONCLUSIONS AND RECOMMENDATIONS

Introduction

This section summarizes an assessment of each health plan's strengths and opportunities for improvement for the quality, timeliness, and accessibility of healthcare services furnished to Medicaid beneficiaries and recommendations for improving the quality of healthcare services furnished by each health plan, as required by 42 CFR §438.364.

Methodology

42 CFR §438.364 requires a description of how the data from all activities conducted were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and accessibility of the care furnished by each health plan. EQR activities typically measure program performance through quantitative data (i.e., data are numeric and consist of frequency counts, percentages, or other statistics) that provide evidence of outcomes and help assess a health plan's or a program's progress toward its stated goals. While data demonstrate what is occurring, these data do not necessarily indicate what caused the occurrence.

The EQRO is tasked with drawing conclusions from the data for an overall assessment that distinguishes successful efforts from ineffective activities and services and providing recommendations for improving results. HSAG analyzes the quantitative results obtained from each EQR activity for each health plan to identify strengths and opportunities for improvement for providing healthcare timeliness, access, and quality across activities. HSAG then identifies whether common themes or patterns exist across the data and conducts a qualitative analysis to draw conclusions about overall quality of, access to, and timeliness of care and services to be drawn for each health plan independently and the overall statewide Medicaid managed care program.

HSAG identified the following strengths and opportunities for improvement based on the activities completed during SFY 2023.

Standard Plan-Specific Conclusions and Recommendations

AmeriHealth Caritas North Carolina, Inc.

Strengths Related to Quality and/or Access and/or Timeliness	
+	For this validation cycle, all AmeriHealth PIPs received *Met* validation scores for 100 percent of all applicable evaluation elements validated and a *Met* validation status.
+	PMV identified that AmeriHealth demonstrated a great understanding of its membership and the challenges inherent to meeting its members' healthcare needs. AmeriHealth has implemented a provider-centric and data-driven approach to addressing the healthcare needs of its members.
+	For PMV, AmeriHealth has implemented initiatives to improve performance on quality measures. At the provider level, AmeriHealth has launched or is planning to launch programs to incentivize better performance. At the member level, AmeriHealth has implemented communication campaigns and used rewards to keep members engaged in their healthcare.
+	During the EDV study, data for AmeriHealth were largely complete, and all data elements were greater than 94 percent valid when populated, indicating that data would support most downstream uses.
+	Referential integrity between all encounters to enrollment data and between all encounters and provider data were greater than 99 percent accurate, indicating that data can easily be linked to each other on key unique identifiers (e.g., unique beneficiary ID and unique provider NPIs).
+	AmeriHealth submitted professional and institutional encounters in a timely manner from the payment date, with greater than 96 percent of encounters submitted within 30 days. Additionally, greater than 93 percent of pharmacy encounters were submitted within 30 days of the payment date.
+	During case management program evaluation (CMPE), AmeriHealth noted that any discrepancy between the provider enrollment file (PEF) and provider data within its Facets system was reviewed with providers. Those providers were encouraged to update their information in NCTracks. AmeriHealth monitored updates to provider information through the daily PEF.

Weaknesses and Recommendations	
−	**Weakness:** Although there were no identified weaknesses in AmeriHealth's PIP submission, HSAG provided best practice recommendations for the PIP process. **Recommendation:** See plan-specific report for recommendations.
−	**Weakness:** For PMV, AmeriHealth noted challenges with supplemental data related to the integration of the NCIR files into AmeriHealth's systems due to file size, and the quality and data completeness of member information from North Carolina's HIE for future data ingestion to support rate reporting. **Recommendation:** HSAG recommends that AmeriHealth continue to work with NCIR and the North Carolina HIE to help develop defined parameters and expectations of quality data and size of data transfer to help AmeriHealth capture the necessary data to support quality rate reporting.

Weaknesses and Recommendations	
−	**Weakness:** During PMV, HSAG identified that AmeriHealth's rates were slightly lower than the rates for some other Standard Plans for the *CIS-10*, *IMA-2*, *W30*, *CCS*, *CDC*, and *WCV* measures. **Recommendation:** HSAG recommends that AmeriHealth continue to monitor its performance on all measures and evaluate rates in comparison to national benchmarks (where available) to determine if future MY rates improve once AmeriHealth has more experience serving its North Carolina members. If future MY rates do not improve, AmeriHealth should evaluate additional interventions that will improve access to care across impacted measures.
−	**Weakness:** Although AmeriHealth largely submitted data in a timely manner during the EDV study, the contractual obligation of submitting professional and institutional encounters within 30 days and pharmacy encounters within seven days was not met. **Recommendation:** AmeriHealth should work with DHB to ensure timely submission of encounters.
−	**Weakness:** AmeriHealth submitted CPT/HCPCS codes about 83 percent of the time in the institutional encounters. **Recommendation:** AmeriHealth should work with DHB to monitor the completeness of CPT/HCPCS codes in submitted encounter data.
−	**Weakness:** AmeriHealth contracted with AMH providers. AMHs, at the time of contracting, designated or identified their CINs for AmeriHealth to establish connectivity for data exchanges. **Recommendation:** To ensure CINs and PHPs have the same provider data between the entities, HSAG recommends that PHPs establish data exchange agreements to share AMH provider information with the CINs to ensure accuracy of data between parties.
−	**Weakness:** During the CMPE, AmeriHealth found instances wherein the termination of eligibility and then subsequent reinstatement and extension of eligibility via the 834 file created issues for the auto-assignment algorithm. **Recommendation:** HSAG recommends that AmeriHealth determine if the algorithm needs updating to ensure beneficiaries can be reassigned to the same provider if parameters for reassignment are met.

Carolina Complete Health, Inc.

Strengths Related to Quality and/or Access and/or Timeliness	
+	For this validation cycle, all Carolina Complete PIPs received *Met* validation scores for 100 percent of all applicable evaluation elements validated and a *Met* validation status.
+	PMV identified that Carolina Complete has a member- and provider-centric approach to serving the Medicaid population.

Strengths Related to Quality and/or Access and/or Timeliness	
+	Carolina Complete has implemented initiatives to improve performance on quality measures and launched campaigns to educate and support providers and keep members engaged in their healthcare.
+	During PMV, Carolina Complete addressed HSAG's recommendation to explore options within or outside UMV where the most current contact information about the member can be stored.
+	EDV identified that data for Carolina Complete were largely complete, and all data elements were greater than 93 percent valid when populated, indicating that data would support most downstream uses.
+	Referential integrity between all encounters to enrollment data and between all encounters and provider data were greater than 99 percent accurate, indicating that data can easily be linked to each other on key unique identifiers (e.g., unique beneficiary ID and unique provider NPIs). This allows for analyses that require linking datasets together, such as calculating performance measures, to occur.
+	Carolina Complete submitted professional and institutional encounters in a timely manner from the payment date, with greater than 96 percent of encounters submitted within 30 days.
+	During CMPE, Carolina Complete reviewed the provider data in the PEF file for completeness and accuracy. The provider relations team at Carolina Complete informed providers of errors in the PEF file and encouraged providers to update their information in NCTracks. Carolina Complete monitored updates to provider information through the daily PEF.

Weaknesses and Recommendations	
−	**Weakness:** Although there were no identified weaknesses in Carolina Complete's PIP submission, HSAG provided best practice recommendations for the PIP process. **Recommendation:** See plan-specific report for recommendations.
−	**Weakness:** HSAG identified that Carolina Complete's rate was slightly lower than the rate for some other Standard Plans for the *PPC* measure indicators.
	Recommendation: Carolina Complete confirmed that outreach calls are made to members to complete notice of pregnancy forms to engage in member services and obtain member health information. Carolina Complete used member demographics, claims with diagnosis or procedure codes relating to pregnancy, service authorizations related to pregnancy, and Medicaid eligibility data stored in the enterprise data warehouse to identify pregnant members for outreach.
−	**Weakness:** Although Carolina Complete largely submitted professional and institutional data in a timely manner, the contractual obligation of submitting these encounters within 30 days of payment was not met. Additionally, Carolina Complete submitted 52 percent of pharmacy encounters within seven days of payment, which is below the contractual obligation of submitting pharmacy encounters within seven days of payment. **Recommendation:** Carolina Complete should work with DHB to ensure timely submission of encounters. In the interim, DHB should thoroughly assess encounter completeness prior to analysis with a focus on pharmacy encounters. HSAG recommends that DHB continue to monitor timely submission of pharmacy encounters.

Weaknesses and Recommendations	
−	**Weakness:** Carolina Complete submitted greater than 40 percent of pharmacy encounters prior to the payment date. **Recommendation:** Carolina Completed should work with DHB to ensure pharmacy encounters are submitted after the payment date.
−	**Weakness:** Carolina Complete submitted CPT/HCPCS codes about 83 percent of the time in institutional encounters. **Recommendation:** DHB should monitor the completeness of CPT/HCPCS codes in submitted encounter data by all PHPs.

Healthy Blue of North Carolina

Strengths Related to Quality and/or Access and/or Timeliness	
+	For this validation cycle, all Healthy Blue PIPs received *Met* validation scores for 100 percent of all applicable evaluation elements validated and a *Met* validation status.
+	PMV identified that Healthy Blue is implementing steps to address HSAG's recommendation for processes to oversee the timeliness of billing by capitated entities, and the correction and resubmission of rejected and/or denied claims from capitated entities.
+	Healthy Blue has implemented initiatives to improve performance on quality measures. Healthy Blue has campaigns and reward programs in place to encourage members to be engaged in their healthcare. In addition, Healthy Blue is looking to institute additional communication campaigns to engage members in follow-up services.
+	During the EDV study, all data elements were greater than 94 percent valid when populated, indicating that data would support most downstream uses.
+	Referential integrity between all encounters to enrollment data and between all encounters and provider data were greater than 99 percent accurate, indicating that data can easily be linked to each other on key unique identifiers (e.g., unique beneficiary ID and unique provider NPIs). This allows for analyses that require linking datasets together, such as calculating performance measures, to occur.
+	Healthy Blue submitted professional and institutional encounters in a timely manner from the payment date, with greater than 93 percent of encounters submitted within 30 days.
+	During CMPE, Healthy Blue's healthcare networks team communicated provider data issues to providers and instructed providers to correct their information in NCTracks. Additionally, Healthy Blue's healthcare networks team communicated PEF issues to DHHS through the ServiceNow application. Healthy Blue monitored updates to provider information through the daily PEF.
+	During CMPE, Healthy Blue established the Panel Management Workgroup this CY to encourage providers to maintain their information in NCTracks. Healthy Blue also hosted training with newly onboarded providers to emphasize the need to maintain accurate and complete information on NCTracks.

Weaknesses and Recommendations	
–	**Weakness:** Although there were no identified weaknesses in Healthy Blue's PIP submission, HSAG provided best practice recommendations for the PIP process. **Recommendation:** See plan-specific report for recommendations.
–	**Weakness:** Healthy Blue initially defined the measurement period as July 1, 2021, through December 31, 2021, when generating rates for MY 2021. The required measurement period for calculating MY 2021 rates was January 1, 2021, through December 31, 2021. HSAG requested that Healthy Blue recalculate performance measure rates for MY 2021 using the correct measurement period. **Recommendation:** HSAG recommends that Healthy Blue reviews the reporting and measurement specifications with operations staff members to ensure the correct measurement period is defined in the HEDIS engine parameters.
–	**Weakness:** Healthy Blue's Enterprise Data Warehouse team is still working to address the receipt of duplicate claims from multiple lab data sources, and the Inovalon QSI-XL HEDIS engine continues to reject duplicate lab records. However, Healthy Blue has not yet identified the root cause and source of the duplicate lab claims. **Recommendation:** HSAG continues to recommend that Healthy Blue continue to investigate the root cause and source of the duplicate claims to resolve prior to integrating into the Inovalon QSI-XL HEDIS engine. This will reduce the processing time of duplicate data and eliminate any risk of duplicates being counted within a performance measure impacted by lab services.
–	**Weakness:** Although Healthy Blue largely submitted professional and institutional data in a timely manner, the contractual obligation of submitting these encounters within 30 days of payment was not met. Additionally, Healthy Blue submitted 54 percent of pharmacy encounters within seven days of payment, which is below the contractual obligation of submitting pharmacy encounters within seven days of payment. **Recommendation:** Healthy Blue should work with DHB to ensure timely submission of encounters. In the interim, DHB should thoroughly assess encounter completeness prior to analysis with a focus on pharmacy encounters. HSAG recommends that DHB continue to monitor timely submission of pharmacy encounters.
–	**Weakness:** Healthy Blue submitted greater than 40 percent of pharmacy encounters prior to the payment date. **Recommendation:** Healthy Blue should work with DHB to ensure pharmacy encounters are submitted after the payment date.
–	**Weakness:** Healthy Blue submitted CPT/HCPCS codes about 83 percent of the time in institutional encounters. **Recommendation:** Healthy Blue should work with DHB to monitor the completeness of CPT/HCPCS codes in submitted encounter data.

Weaknesses and Recommendations	
−	**Weakness:** Healthy Blue contracted with AMH providers. AMHs, at the time of contracting, designated or identified their CINs for Healthy Blue to establish connectivity for data exchanges. **Recommendation:** To ensure CINs and PHPs have the same provider data between the entities, HSAG recommends that PHPs establish data exchange agreements to share AMH provider information with the CINs to ensure accuracy of data between parties.

UnitedHealthcare of North Carolina, Inc.

Strengths Related to Quality and/or Access and/or Timeliness	
+	For this validation cycle, all UnitedHealthcare's PIPs received *Met* validation scores for 100 percent of all applicable evaluation elements validated and a *Met* validation status.
+	UnitedHealthcare demonstrated adequate processes in place to receive and process claims and encounters, membership/enrollment, data integration, provider data, and supplemental data.
+	UnitedHealthcare has extensive experience using supplemental data sources. The Standard Plan leveraged supplemental data sources to support performance measure rate reporting.
+	EDV identified that data for UnitedHealthcare, and all data elements were greater than 93 percent valid when populated, indicating that data would support most downstream uses.
+	Referential integrity between all encounters to enrollment data and between all encounters and provider data were greater than 99 percent accurate, indicating that data can easily be linked to each other on key unique identifiers (e.g., unique beneficiary ID and unique provider NPIs). This allows for analyses that require linking datasets together, such as calculating performance measures, to occur.
+	UnitedHealthcare submitted professional and institutional encounters in a timely manner from the payment date, with greater than 96 percent of encounters submitted within 30 days.
+	During CMPE, UnitedHealthcare demonstrated that appropriate processes were in place to ensure its Facets provider data aligned with the state-mandated PEF.

Weaknesses and Recommendations	
−	**Weakness:** Although there were no identified weaknesses in UnitedHealthcare's PIP submission, HSAG provided best practice recommendations for the PIP process. **Recommendation:** See plan-specific report for recommendations.
−	**Weakness:** HSAG identified that UnitedHealthcare's rates were slightly lower than the rates for other Standard Plans for the *WCV*, *IMA-2*, *W30*, *PPC*, and *CDC* measures. **Recommendation:** HSAG recommends that UnitedHealthcare continue to monitor its performance on all measures and evaluate rates in comparison to national benchmarks (where available), to determine if future MY rates improve once UnitedHealthcare has more experience

Weaknesses and Recommendations	
	serving its North Carolina members. If future MY rates do not improve, UnitedHealthcare should evaluate additional interventions that will improve access to care across impacted measures.
−	**Weakness:** Although UnitedHealthcare largely submitted professional and institutional data in a timely manner, the contractual obligation of submitting these encounters within 30 days of payment was not met. Additionally, UnitedHealthcare submitted 12 percent of pharmacy encounters within seven days of payment, which is below the contractual obligation of submitting pharmacy encounters within seven days of payment. **Recommendation:** UnitedHealthcare should work with DHB to ensure timely submission of encounters. In the interim, DHB should thoroughly assess encounter completeness prior to analysis with a focus on pharmacy encounters. HSAG recommends that DHB continue to monitor timely submission of pharmacy encounters.
−	**Weakness:** UnitedHealthcare submitted greater than 80 percent of pharmacy encounters prior to the payment date. **Recommendation:** UnitedHealthcare should work with DHB to ensure pharmacy encounters are submitted after the payment date.
−	**Weakness:** UnitedHealthcare submitted CPT/HCPCS codes about 83 percent of the time in institutional encounters. **Recommendation:** UnitedHealthcare completed should work with DHB to monitor the completeness of CPT/HCPCS codes in submitted encounter data.
−	**Weakness:** UnitedHealthcare reported a system limitation in assigning beneficiaries to mid-level practitioners (e.g., nurse practitioners and physician assistants) which resulted in incorrect beneficiary assignments at the AMH level. **Recommendation:** Although UnitedHealthcare has indicated it will implement a new process using its Living Data tool to track all provider panel limitations and changes, it should prioritize implementing this solution considering the risk of ongoing incorrect beneficiary assignments will continue to increase until this system issue is corrected.
−	**Weakness:** UnitedHealthcare indicated confidence that its current beneficiary-to-PCP auto-assignment algorithm is working correctly; however, it did not provide any additional information regarding analyses it has conducted to confirm. **Recommendation:** To determine whether its auto-assignment algorithm requires updates, UnitedHealthcare should conduct ongoing analyses of its frequency of reassigning beneficiaries from their auto-assigned PCP to another provider.

WellCare of North Carolina, Inc.

Strengths Related to Quality and/or Access and/or Timeliness	
+	Two of four PIPs received *Met* validation scores for 100 percent of all applicable evaluation elements validated. All four PIPs received an overall *Met* validation status.
+	WellCare demonstrated extensive knowledge and experience in claims and encounter, membership/enrollment, data integration, rate production, and medical record procurement and abstraction processes.
+	PMV identified that WellCare has numerous member-facing and provider-facing initiatives and incentives that are intended to improve quality measure performance. HSAG encourages WellCare to track the measure-specific impact of any of these interventions and incentives, so best practice can be identified to share with DHB and to spread to other WellCare preventive services, as applicable.
+	EDV identified that data for WellCare were largely complete, and all data elements were greater than 93 percent valid when populated, indicating that data would support most downstream uses
+	Referential integrity between all encounters to enrollment data and between all encounters and provider data were greater than 99 percent accurate, indicating that data can easily be linked to each other on key unique identifiers (e.g., unique beneficiary ID and unique provider NPIs). This allows for analyses that require linking datasets together, such as calculating performance measures, to occur.
+	WellCare submitted professional and institutional encounters in a timely manner from the payment date, with greater than 97 percent of encounters submitted within 30 days.
+	During CMPE, WellCare has not yet incorporated changes to its auto-assignment criteria. WellCare has conducted a recent review of auto-assignment results, with more than 18 months of completed claims experience, and will be completing PCP reassignments accordingly. Additionally, WellCare has indicated that it will complete an annual PCP reassignment process to ensure that beneficiaries who are not seeing their assigned PCPs are reassigned to PCPs in the provider groups where they are actually seeking care.

Weaknesses and Recommendations	
−	**Weakness:** There was one opportunity for improvement related to documentation requirements in Step 7, Data Analysis and Interpretation of PIP Results, for both the HEDIS *CIS—Combo 10* and HEDIS *PPC* PIPs. **Recommendation:** WellCare should ensure that it addresses HSAG's validation feedback related to addressing factors that threaten the validity of the data reported.
−	**Weakness:** WellCare indicated that the North Carolina immunization registry had issues returning records to the Standard Plan; therefore, WellCare was in the process of studying the problem with the State's analysts. **Recommendation:** WellCare should continue its efforts working with the State to resolve the ongoing data challenges occurring with the State immunization registry, as these data are critical

Weaknesses and Recommendations	
	to support quality reporting across immunization measures within the scope of PMV: *Childhood Immunization Status—Combination 10* and *Immunizations for Adolescents—Combination 2*.
−	**Weakness:** WellCare had used a user-defined system field in a manner that differed from its corporate-defined process, resulting in mismatched members to claims. WellCare was required to produce revised performance measure rates for all performance measures in scope of the audit. **Recommendation:** WellCare corrected this issue for future measurement years as it discontinued its use of the user-defined field in its member matching logic. In addition to this correction, WellCare should conduct ongoing monitoring of member-level details at the measure-level, to ensure that members are not inappropriately reported in measure denominators and numerators.
−	**Weakness:** Although WellCare largely submitted professional and institutional data in a timely manner, the contractual obligation of submitting these encounters within 30 days of payment was not met. Additionally, WellCare submitted 52 percent of pharmacy encounters within seven days of payment, which is below the contractual obligation of submitting pharmacy encounters within seven days of payment. **Recommendation:** WellCare should work with DHB to ensure timely submission of encounters. In the interim, DHB should thoroughly assess encounter completeness prior to analysis, with a focus on pharmacy encounters. HSAG recommends that DHB continue to monitor timely submission of pharmacy encounters.
−	**Weakness:** In the EDV, WellCare submitted greater than 40 percent of pharmacy encounters prior to the payment date. **Recommendation:** WellCare should work with DHB to ensure pharmacy encounters are submitted after the payment date.
−	**Weakness:** WellCare submitted CPT/HCPCS codes about 83 percent of the time in institutional encounters. **Recommendation:** WellCare should work with DHB to monitor the completeness of CPT/HCPCS codes in submitted encounter data.
−	**Weakness:** During CMPE, multiple CINs noted that WellCare is the PHP with the highest volume of provider data that do not align with the data in NCTracks. **Recommendation:** WellCare should assess its provider data in comparison to the PEF, identifying provider data mismatches from which to assess for root cause.
−	**Weakness:** During CMPE, one CIN noted that a WellCare staff member told the CIN that all PEF data are manually data entered into the WellCare system, without any automation. **Recommendation:** While this may be an isolated incident, it is critical for WellCare to ensure that all staff members who are working with the CINs are correctly trained in the PEF data flow and automation steps that WellCare uses to load and validate the data. Inconsistent WellCare messaging to the CINs can contribute to continued provider abrasion and loss of trust in the PHPs overall.

Tailored Plan-Specific Conclusions and Recommendations

Tailored Plans are expected to launch in 2024. Therefore, HSAG did not conduct most EQR activities with the Tailored Plans. However, although they were not yet in operation, DHB directed these plans to proceed with the PIP design. Therefore, HSAG has included conclusions and recommendations in this section only pertaining to the PIP activities of the Tailored Plans.

Alliance Health

Strengths Related to Quality and/or Access and/or Timeliness
Two of the three PIPs received *Met* validation scores for 100 percent of all applicable evaluation elements validated, and a *Met* validation status.

Weaknesses and Recommendations
Weakness: Alliance had an opportunity for improvement related to accurately documenting the eligible population in the *TCL* PIP.
Recommendation: Alliance should use the PIP completion instructions as additional steps of the PIP process are completed. This will ensure all documentation requirements have been addressed.

Eastpointe

Strengths Related to Quality and/or Access and/or Timeliness
Two of the three PIPs received *Met* validation scores for 100 percent of all applicable evaluation elements validated, and a *Met* validation status.

Weaknesses and Recommendations
Weakness: Eastpointe had an opportunity for improvement related to accurately documenting the Aim statement in the *CDC: HbA1c Poor Control* PIP.
Recommendation: Eastpointe should use the PIP completion instructions as additional steps of the PIP process are completed. This will ensure all documentation requirements have been addressed.

Partners Health Management

Strengths Related to Quality and/or Access and/or Timeliness
Two of the three PIPs received *Met* validation scores for 100 percent of all applicable evaluation elements validated, and a *Met* validation status.

Weaknesses and Recommendations
Weakness: Partners had an opportunity for improvement related to accurately documenting the eligible population in the *TCL* PIP. **Recommendation:** Partners should use the PIP completion instructions as additional steps of the PIP process are completed. This will ensure all documentation requirements have been addressed.

Sandhills Center

Strengths Related to Quality and/or Access and/or Timeliness
All PIPs received *Met* validation scores for 100 percent of all applicable evaluation element validated, and a *Met* validation status.

Weaknesses and Recommendations
Weakness: There were no identified weaknesses. **Recommendation:** No recommendations.

Trillium Health Resources

Strengths Related to Quality and/or Access and/or Timeliness
All PIPs received *Met* validation scores for 100 percent of all applicable evaluation element validated, and a *Met* validation status.

Weaknesses and Recommendations
Weakness: There were no identified weaknesses. **Recommendation:** No recommendations.

Vaya Health

Strengths Related to Quality and/or Access and/or Timeliness	
+	All PIPs received *Met* validation scores for 100 percent of all applicable evaluation element validated, and a *Met* validation status.

Weaknesses and Recommendations	
−	**Weakness:** There were no identified weaknesses. **Recommendation:** No recommendations.

APPENDIX E. PRIOR EQRO RECOMMENDATIONS

Introduction

42 CFR §438.364(a)(6) requires that the EQR technical report include an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR. This appendix provides a summary of the follow-up actions per activity that the health plans reported completing in response to HSAG's SFY 2021–2022 recommendations. Please note, content included in this section is presented verbatim as received from the health plans and has not been edited or validated by HSAG.

Scoring

HSAG developed a methodology and rating system for the degree to which each plan addressed the prior year's EQR recommendations. In accordance with CMS guidance, HSAG used a three-point rating system. The plan's response to each EQRO recommendation was rated as *High*, *Medium,* or *Low* according to the criteria below.

High indicates *all* of the following:

- The plan implemented new initiatives or revised current initiatives that were applicable to the recommendation.
- Performance improvement directly attributable to the initiative was noted *or* if performance did not improve, the plan identified barriers that were specific to the initiative.
- The plan included a viable strategy for continued improvement or overcoming identified barriers.

A rating of *high* is indicated by the following graphic:

Medium indicates one or more of the following:

- The plan continued previous initiatives that were applicable to the recommendation.
- Performance improvement was noted that may or may not be directly attributable to the initiative.
- If performance did not improve, the plan identified barriers that may or may not be specific to the initiative.
- The plan included a viable strategy for continued improvement or overcoming barriers.

A rating of *medium* is indicated by the following graphic:

Low indicates one or more the following:

- The plan did not implement an initiative or the initiative was not applicable to the recommendation.
- No performance improvement was noted *and* the plan did not identify barriers that were specific to the initiative.
- The plan's strategy for continued improvement or overcoming identified barriers was not specific or viable.

A rating of *low* is indicated by the following graphic:

Standard Plan Follow Up

AmeriHealth Caritas North Carolina, Inc

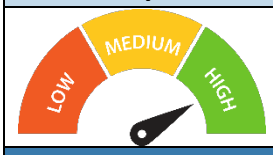
1. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation (PMV):
PMV
HSAG identified the following opportunity: AmeriHealth indicated it had not yet obtained an established data feed for State immunization registry data.
HSAG recommended the following: • HSAG recommends working directly with the NC DHHS/DHB in establishing a direct data feed to support AmeriHealth's quality measure reporting across all immunization measures within the scope of PMV elected measures: *Childhood Immunization Status—Combination 10 and Immunizations for Adolescents—Combination 2.*
PHP Response
a. Describe why this weakness exists: • The AmeriHealth Caritas North Carolina (ACNC) Quality Management (QM) Team experienced a transition in leadership in 2022. It was subsequently discovered that a direct data feed for State immunization registry data had not been established.
b. Describe initiatives implemented based on recommendations: • ACNC moved quickly to establish a direct data feed connection with the North Carolina Immunization Registry in Q2 of 2022. A query file is sent to the immunization registry on a monthly basis. The return file is ingested and loaded into our data warehouse and then fed to our Healthcare Effectiveness Data and Information Set (HEDIS) engine for use in rate calculation and reporting.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Following the establishment of the immunization registry data feed in June of 2022, ACNC noted a subsequent increase in Childhood Immunization Status (CIS) Combo 10 performance of approximately 7 percentage points and an increase in Immunizations for Adolescents (IMA) Combo 2 performance of approximately 2 percentage points.

d. Identify any barriers to implementing initiatives:
- No barriers were identified.

e. Identify strategy for continued improvement or overcoming identified barriers:
- ACNC continues to manage the State immunization registry query process and monitors immunization registry record counts and rate impact on a monthly basis.

HSAG Response



2. Prior Year Recommendation from the EQR Technical Report for Program Integrity (PI) Review:

PI Review

HSAG identified the following opportunity:

The PI review identified some inconsistencies in the health plan's policies, procedures, and committee documents.

HSAG recommended the following:

- The health plan should correct its documentation to accurately reflect staff person responsibility for compliance activities.

PHP Response

a. Describe why this weakness exists:
- There were differing titles within several plan documents for who is responsible for overseeing Compliance functions. There was confusion on the part of prior Compliance leadership as to which title was appropriate, as the contract with NC DHHS states "Chief Compliance Officer," but the title of the position is "Director of Compliance."

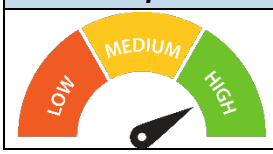
b. Describe initiatives implemented based on recommendations:
- All applicable documents were revised with the correct title. This was reviewed and acknowledged during the 2022 Program Integrity Audit, which occurred in February 2023.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- There is consistency within the documents for who is responsible for oversight.

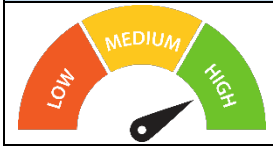
d. Identify any barriers to implementing initiatives:
- No barriers were identified.

e. Identify strategy for continued improvement or overcoming identified barriers:
- All documents going forward will incorporate the appropriate title.

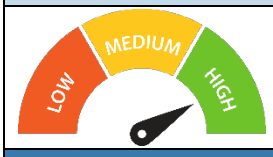
HSAG Response

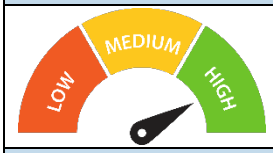


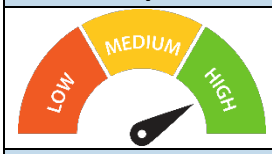
Carolina Complete Health, Inc.

1. Prior Year Recommendations from the EQR Technical Report for Performance Measure Validation (PMV):
PMV
HSAG identified the following opportunity: During the PMV virtual review, Carolina Complete provided a system demonstration of Unified Member View (UMV), which was used to process and store membership and enrollment data received from the State. Key demographic and contact information that came directly through the State daily 834 file was integrated into UMV. If a member or provider notified Carolina Complete of a change in address and/or phone number, UMV did not have the capability to store the updated contact information in fields within UMV that are not overridden by the daily integration of the 834 files. The contact information will only update if the State was informed of the changes and they are updated through the 834 process.
HSAG recommended the following: • HSAG recommends that Carolina Complete explore the feasibility within or outside UMV where most current contact information about the member can be stored. Hosting accurate contact information about the member helps support ensuring that successful member outreach for QI initiatives focused on key PMs and on member satisfaction and experience surveys.
PHP Response
a. Describe why this weakness exists: • This weakness was due to system setup at the time of review.
b. Describe initiatives implemented based on recommendations: • Pursuant to Carolina Complete Health's ("CCH") demographic change work process, when a member calls CCH Member Services, the agent informs the member that they must make the change of address with their local Department of Social Services ("DSS") and provides the member the office contact information. The agent then records the address change in OMNI in the Secondary address field and the record of the change remains in OMNI as view only in the updated address. The demographic record received from OMNI will be available in UMV as well, though the primary record will be the information received in the 834. Each week, CCH runs the MEM009 Change in Circumstance Report through MicroStrategy and compiles the data into the state format for weekly submission. NC DHHS ingests the reported changes and responds to CCH with an 834 file updating the address. The secondary address and notes of the change, when it was made, who made the change, etc., remain in OMNI and are available to anyone reviewing the record.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Process is working as intended and no concerns identified.
d. Identify any barriers to implementing initiatives: • No barriers identified.
e. Identify strategy for continued improvement or overcoming identified barriers: • No barriers identified.
HSAG Response


PMV
HSAG identified the following opportunity: During the PMV virtual review, Carolina Complete confirmed there were no capitated arrangements for facility and professional claims. However, Carolina Complete expressed the potential for establishing capitated agreements over the next two years.
HSAG recommended the following: • Should Carolina Complete consider entering capitated arrangements, HSAG recommends ensuring that strong processes are in place to oversee the timeliness of billing by capitated entity and to ensure that rejected and/or denied claims are corrected and resubmitted. These activities will support ensuring that services rendered which are not tied to an FFS payment arrangement are reported in a timely manner and captured in Carolina Complete's PM calculations.
PHP Response
a. Describe why this weakness exists: • CCH does not currently hold capitated arrangements for facility or professional claims.
b. Describe initiatives implemented based on recommendations: • Should CCH entire into capitated arrangements in the future, it will have appropriate processes in place to ensure claims are reported in a timely manner. CCH anticipates setting up capitated arrangements with the same timeliness guidelines that our FFS payment arrangements have today, as it relates to claim submissions. CCH has a process in place where all rejected Encounters are reviewed. In this review, we will be implementing a process (prior to entering into a capitated arrangement) to identify rejected capitated claims and work directly with our finance department to remediate or recoup dollars as necessary.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A, not implemented yet due to CCH not having capitated arrangements with providers.
d. Identify any barriers to implementing initiatives: • N/A, not implemented yet due to CCH not having capitated arrangements with providers.
e. Identify strategy for continued improvement or overcoming identified barriers: • N/A, not implemented yet due to CCH not having capitated arrangements with providers.
HSAG Response
Not applicable; the recommendation could not be addressed by the health plan during the reporting period.
PMV
HSAG identified the following opportunity: Source code review of the *Concurrent Use of Opioids and Benzodiazepines (COB) and Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)* measures was conducted with Interpreta, CCH's HEDIS certified software engine vendor, and resulted in corrective action. The COB measure defaulted to a 45-day allowable gap, which did not align with specifications. The *OMP* measure did not allow for any gap in continuous enrollment which does not align with measure specifications.
HSAG recommended the following: • HSAG recommends that Carolina Complete provide screen shots from Interpreta to demonstrate that Interpreta has resolved these issues prior to source code review activities performed in CY 2022. HSAG will also conduct source code review directly with Interpreta to confirm changes were made.

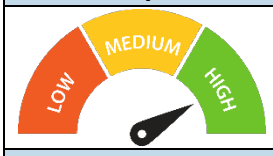
PHP Response
a. Describe why this weakness exists: • During the HSAG audit (Fall 2021), the auditor flagged an exclusion to continuous enrollment logic in the HEDIS engine; however, the engine was using a "relaxed enrollment" feature due to the timing of the Medicaid program. Since the program had begun mid-HEDIS year, two environments, one containing standard HEDIS logic and another with "relaxed enrollment" were initiated to predicate member results. The auditor saw the logic with "relaxed enrollment" there by defaulting to an allowable gap. Screen shots as well as visual presentations of Interpreta's logic were demonstrated to the auditor to witness standard HEDIS logic being applied.
b. Describe initiatives implemented based on recommendations: • CCH provided additional screenshots from Interpreta and confirmed the general source code that was shared contains all requirements for a specific measure including applicable CE and anchor date requirements. CCH launched its HEDIS program utilizing Interpreta's NCQA certified HEDIS engine, R&S, for quality performance and reporting. Interpreta's R&S served in this capacity for Measurement year 2021.In early 2022, Centene made a choice to move forward with Inovalon's certified HEDIS engine, QSI-XL, as our exclusive HEDIS Analytics vendor for reporting & submission. This decision allowed us to streamline operations to support data processing and analytics without competing infrastructures. By combining platforms and data infrastructure, we are also able to provide better turnaround time of customization, programing, reporting, and build efficiencies. Inovalon's QSI-XL include the NCQA HEDIS Measure Certification as well as State and Custom Measure catalog to meet NC State Requirement. Prior to transition, our data and rates were validated within both systems, R&S and QSI-XL to ensure data/process completeness. After all the validation completed and approved through appropriate stakeholders, the transition to QSI-XL was completed Q2, 2022. Inovalon's HEDIS engine was utilized in MY22 for reporting and will continue to function in this capacity until further notice. This should also meet the COB and OMP (Core set measure) requirements per CMS and State guidelines. No risks or issues were identified in 2022 PMV audit and henceforth.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • A new vendor (Inovalon) was selected beginning with HEDIS measurement year 2022 (MY22) to provide HEDIS performance and reporting capabilities. Both Interpreta and Inovalon results were tested congruently using CCH's data to ensure a seamless transition.
d. Identify any barriers to implementing initiatives: • No barriers currently are present as CCH changed HEDIS vendors.
e. Identify strategy for continued improvement or overcoming identified barriers: • No barriers currently are present as CCH changed HEDIS vendors.
HSAG Response

2. Prior Year Recommendations from the EQR Technical Report for Program Integrity (PI) Review:
PI Review
HSAG identified the following opportunity: The PI review identified some omissions in the health plan’s policies and committee documents.
HSAG recommended the following:

• The health plan should correct its documentation to ensure compliance with PHP contract requirements.
PHP Response
a. Describe why this weakness exists: • Policies did not sufficiently document the required elements within the PHP Medicaid Contract. Processes were in place but the policies did not address those processes sufficiently.
b. Describe initiatives implemented based on recommendations: • The following edits were made to the Fraud Prevention Plan to address language gaps: (1) the definitions of fraud and abuse were revised to be consistent with 42 C.F.R. § 455.2; (2) the name of the staff person solely responsible for oversight of the NC PHP compliance functions was included; (3) the system used by CCH to provide education to its Compliance Officer, Senior Management, Board of Directors, employees, subcontractors, and network providers regarding compliance and FWA federal and state requirements was included as required by the PHP Medicaid Contract, Section J.1.b.iv.; (4) language was added to advise that individuals reporting violations will be protected, and not retaliation will be taken against them, as required by the PHP Medicaid Contract, Section J.3.c.; (5) the process was included for conducting criminal background checks and exclusion screenings for owners, agents, delegated entities, employees, network providers, and subcontractors, as required by the PHP Medicaid Contract, Section J.3.c.; and (6) all policies that comprise the Fraud Prevention Plan were referenced within.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The inclusion of all items in the Fraud Prevention Plan necessary under the PHP Medicaid Contract are reviewed annually and submitted to the State for review by July 1 of each year.
d. Identify any barriers to implementing initiatives: • CCH has identified no barriers to ensuring its Fraud Prevention Plan contains all mandatory provisions and procedures.
e. Identify strategy for continued improvement or overcoming identified barriers: • CCH utilizes a system, Archer, to monitor that all policies, including the Fraud Prevention Plan, are updated at least annually. As part of CCH's review, it will compare the language against the current PHP Medicaid Contract language to ensure all necessary provisions and procedures are included.
HSAG Response

PI Review
HSAG identified the following opportunity: Carolina Complete's Compliance Plan requires the health plan to "perform oversight activities to prevent the sharing of confidential, proprietary or competitive in nature information with WellCare NC" but does not describe the processes behind this oversight and prevention.
HSAG recommended the following: • The health plan should revise its Compliance Plan to describe the process by which Carolina Complete safeguards against the sharing of protected health information and proprietary information.

PHP Response
a. Describe why this weakness exists: • CCH's Compliance Plan did not outline our firewall processes.
b. Describe initiatives implemented based on recommendations: • CCH's Compliance Plan has been revised to include how our structure is set up to ensure compliance with the firewall between CCH and other North Carolina PHPs and various protections in place to ensure compliance with the firewall.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Consistent firewall training - both annual and ad hoc - has been effective in ensuring both CCH and Centene staff supporting CCH is aware of the firewall between CCH and Wellcare of NC. CCH Compliance Staff fields frequent requests for clarification and guidance around firewall compliance, demonstrating that it is at the forefront of staff minds and we are often able to prevent firewall incidents before the sharing of Sensitive Business Information due to proactive notification.
d. Identify any barriers to implementing initiatives: • No barriers have been identified in implementing these initiatives.
e. Identify strategy for continued improvement or overcoming identified barriers: • No barriers have been identified in implementing these initiatives.
HSAG Response

PI Review
HSAG identified the following opportunity: The Carolina Complete Comprehensive Compliance Program does not include a provider self-audit process and procedure.
HSAG recommended the following: • The health plan should develop a provider self-audit process that will support network providers in self-disclosing billing system errors or issues that result in overpayments.
PHP Response
a. Describe why this weakness exists: • CCH's Compliance Program did not sufficiently outline CCH's process for provider self-audits.
b. Describe initiatives implemented based on recommendations: • CCH's provider self-audit process was added to the Compliance Program and Provider Manual.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The provider self-audit process is working as intended. Provider notifications of self-audit have been received and routed to CCH's provider relations and claims teams to coordinate resolution with the provider and adjustment of claims. Providers receive education on this process.
d. Identify any barriers to implementing initiatives: • CCH has identified no barriers to these initiatives and the process appears to be working as intended. Providers are submitting these notices to the correct inbox and they are being routed appropriately. CCH ensures provider self-audit requests are routed to the appropriate points of contact no matter what manner of notification they utilize.

e. Identify strategy for continued improvement or overcoming identified barriers:
- CCH will ensure proper information on points of contact on self-audits is available to providers via training located on our web site and via the Provider Manual.

HSAG Response



PI Review

HSAG identified the following opportunity:

The PI review identified that the CCH Fraud Prevention Plan had not been updated since 2020.

HSAG recommended the following:

- The health plan should ensure that the Fraud Prevention Plan is annually reviewed, updated, and submitted to the State.

PHP Response

a. Describe why this weakness exists:
- Due to delay in Medicaid go-live, the original Fraud Prevention Plan was drafted in 2020 but annual updates did not begin until 2022, one year after Managed Care program launch. At the time of CCH's first Program Integrity review for 2021, CCH was still operating under the 2020 Fraud Prevention Plan and an updated version for 2022 was pending review and approval by the Department.

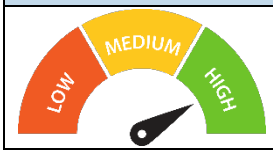
b. Describe initiatives implemented based on recommendations:
- Carolina Complete Health went live on July 1, 2021, under the Fraud Prevention Plan dated 2020 (which has been approved by NC DHHS DHB). The Fraud Prevention Plan was updated and submitted to DHB for review and approval on June 30, 2022. This submission is still pending approval by DHB. The Fraud Prevention Plan was again updated and submitted to DHB for review and approval on April 3, 2023. This submission is also pending review and approval by DHB. Carolina Complete Health continues to review and update its Fraud Prevention Plan annually but the last version that DHB has approved was the 2020 submission. CCH utilizes a system, Archer, to monitor that all policies are updated at least annually.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- CCH's Fraud Prevention Plan has been timely reviewed and updated each year since 2022, ensuring timely submission to the Department for review and approval by July 1 of every year.

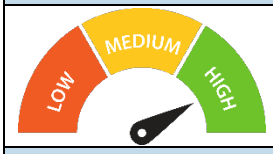
d. Identify any barriers to implementing initiatives:
- CCH has identified no barrier to this review process.

e. Identify strategy for continued improvement or overcoming identified barriers:
- CCH will continue to timely review and submit its Fraud Prevention Plan annually by the Department's July 1 deadline.

HSAG Response



Healthy Blue

1. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation (PMV):
PMV
HSAG identified the following opportunity: During the PMV virtual review, Healthy Blue confirmed a small percentage of capitation for professional claims. Strong oversight of capitated arrangement is critical to ensure the timely reporting of services is captured in Healthy Blue's quality measure reporting, including the monitoring of rejected and denied claims for resolution and resubmission.
HSAG recommended the following: • HSAG recommends ensuring that strong processes are in place to oversee the timeliness of billing by capitated entity, as well as ensuring that rejected and/or denied claims are corrected and resubmitted. These activities will support ensuring that services rendered which are not tied to an FFS payment arrangement are reported in a timely manner and captured in Healthy Blue's PM calculations.
PHP Response
a. Describe why this weakness exists: • The change in the transition to managed care has impacted providers' billing habits. Healthy Blue has incorporated over 800 DHHS encounters edits into our system, which has directly impacted claims reject and denial volumes.
b. Describe initiatives implemented based on recommendations: • Healthy Blue monitors our claims reject and denial dashboard weekly. We review the top 10 reject and denial reasons as well as the 10 top providers. Healthy Blue provides detailed information to health care networks, enabling the networks to meet with providers and provide targeted education. Healthy Blue also encourages claims resubmission of any affected claims. If the claims are outside of timely filing, we will override the timely filing denial to get the claims paid.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • We have improved our reject and denial rate from 19% to ~13%.
d. Identify any barriers to implementing initiatives: • No barriers have been identified at this time.
e. Identify strategy for continued improvement or overcoming identified barriers: • Healthy Blue continues to monitor our dashboard on a weekly basis, allowing us to address any spikes or trending issues.
HSAG Response

PMV
HSAG identified the following opportunity: Healthy Blue indicated that a large volume of lab data from multiple lab sources appeared to include a high volume of duplicate claims that are being rejected through the Inovalon software.

HSAG recommended the following:

- HSAG recommends that Healthy Blue further investigate the root cause and source of the duplicate claims to resolve prior to integrating into the Inovalon HEDIS engine. This will reduce the processing time of duplicate data and eliminate any risk of duplicates being counted within a PM impacted by lab services.

PHP Response

a. Describe why this weakness exists:
   - When a laboratory provider sent an update to a previously submitted laboratory result, Healthy Blue was not identifying it as an update to a result currently in our data warehouse. This caused loading of a new record, resulting in a duplicate. (There was no impact to having duplicate laboratory data in the HEDIS environment as the HEDIS software only loaded one record.).

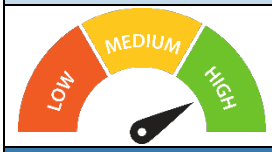
b. Describe initiatives implemented based on recommendations:
   - On September 1, 2023, Healthy Blue modified its logic to populate the RQST_ID field in our data warehouse with the laboratory specimen number, instead of an auto-generated number. This now allows Healthy Blue to track if an update was received for the specimen, and ensure only the latest version of the update is maintained.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - The issue was resolved.

d. Identify any barriers to implementing initiatives:
   - No barriers have been identified at this time.

e. Identify strategy for continued improvement or overcoming identified barriers:
   - Healthy Blue continues to populate the RQST_ID field with the laboratory specimen number, rather than an auto-generated number.

HSAG Response



2. Prior Year Recommendation from the EQR Technical Report for Program Integrity (PI) Review:

PI Review

HSAG identified the following opportunity:

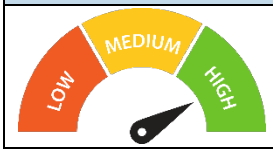
The PI review identified some omissions of references to supporting documents in the health plan's Compliance Plan and Program Integrity Plan, as well as contextual information in its SIU Antifraud Plan.

HSAG recommended the following:

- The health plan should revise its documents to ensure references to all supporting documents have been included and provide additional context to describe alignment and required activities and processes completed to support the PI program.

PHP Response

a. Describe why this weakness exists:
   - Multiple departments within Healthy Blue maintain oversight of the processes which satisfy the Program Integrity requirements within the NC Medicaid PHP Contract.

b. Describe initiatives implemented based on recommendations: • The departments with oversight of the Program Integrity requirements collaborated to provide a single NC Fraud Prevention Plan, addressing all applicable requirements.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
d. Identify any barriers to implementing initiatives: • Maintaining one document requires consistent collaboration between the multiple departments responsible for oversight.
e. Identify strategy for continued improvement or overcoming identified barriers: • The departments responsible for the various Program Integrity requirements are now collaborating to comply with applicable guidance for this deliverable.
HSAG Response


UnitedHealthcare of North Carolina, Inc.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation (PMV):
PMV
HSAG identified the following opportunity: UnitedHealthcare reported initial challenges related to obtaining clinical data from providers in support of PM reporting.
HSAG recommended the following: • While UnitedHealthcare reported these initial challenges, the PHP had outlined appropriate mitigation strategies to obtain additional clinical data. HSAG recommends that UnitedHealthcare continue using its described process for onboarding providers to receive select clinical data in support of PM reporting. For MY 2021, UnitedHealthcare may maximize its efforts by initiating the clinical data exchange with providers attributed to serving the highest proportion of the PHP's members, based on utilization reports. Demonstrating its progress as of December 2021, the PHP indicated it had established 17 bidirectional data connections with 1,296 providers through its AMH delegation arrangements.
PHP Response
a. Describe why this weakness exists: • The timeframe of the audit reflects the mid-year go-live of the program, commencing in July 2021. As such, UnitedHealthcare (UHC) was in various stages of implementing appropriate procedures to facilitate clinical data exchange with contracted providers throughout 2021.
b. Describe initiatives implemented based on recommendations: • Throughout 2022, UHC continued to implement procedures to on-board practices, with emphasis placed on clinical data sharing. Advanced Medical Home (AMH) providers received education and resources to access the UHC Patient Care Opportunities Report (PCOR). The PCOR provides insight into the status of member health care delivery, assessed to defined performance measures. This report containing member-level detail is accessible via secure log-in through UHC Provider Portal. It

incorporates data feeds from the North Carolina Immunization Registry and many of the leading national Electronic Medical Record (eMR) vendors. Best practices in closing open care gaps and provider incentive program metrics/practice performance were discussed during ongoing AMH meetings.

- In October 2022, AMH providers were provided overall education, resources, and a self-paced course around use of Practice Assist. As this UHC platform for submission of performance measure data is used by other lines of business, some providers were already familiar with the platform functionality. Providers were educated about the upcoming reporting capabilities in 2023, including the fact that the PCOR would be made available in Practice Assist for providers to view and download via secure log-in through UHC Provider Portal.
- In October 2022, UHC conducted outreach to high membership practices based upon data indicating the greatest opportunity to close care gaps prior to year-end. Practice-specific issues with data exchange were addressed/mitigated, such as education regarding use of correct coding to indicate measure numerator compliance to the HEDIS® specifications.
- During 2022, UHC established flat file connections:
  - Atrium Health Wake Forest Baptist Health already had a flat file in place for the UHC Medicare line of business. The addition of the North Carolina (NC) Medicaid line of business was moved to production in August of 2022.
  - A flat file connection for Community Care Physicians Network (CCPN) was successfully tested during the fall of 2022 for NC Medicaid. The file was moved to production in January 2023 accounting for >140 (Tax ID Numbers) TINs.
- UHC realized the following gains in eMR connections in 2022:

Connected TAX IDS

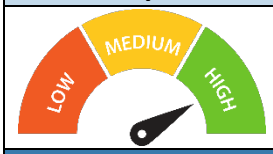
Vendor	Jan-22	Dec-22
ECW	115	136
Athena	320	334
Veradigm	144	147
EPIC	0	24
Direct	16	18
Totals	595	659
	% change	10.8%

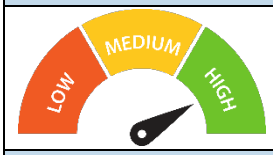
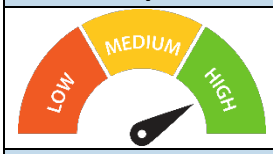
c.

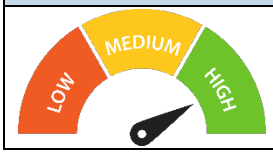
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Reflecting measures where Measure Year (MY) 2021 data were available, UHC notes that improvement was seen in seven of nine measures when comparing year over year. Given that MY2022 initiated seven months after program launch, the ability to ingest pertinent data is supported.

Measure	2021 Rate %	2022 Rate %	% Improvement
CIS C10	29.63	26.03	-12.15%
IMA CO2	23.07	29.93	29.74%
W30 (0-15 MTH)	6.64	58.37	779.07%
W30 (15-30 MTH)	5.12	66.34	1195.70%
WCV	28.44	46.7	64.21%
CCS	40.94	54.99	34.32%
CHL	62.71	57.65	-8.07%
PPC (TOPC)	37.12	77.86	109.75%
PPC (PPC)	60.33	78.83	30.66%

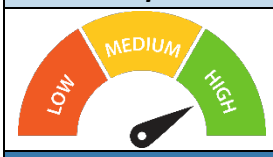
d. Identify any barriers to implementing initiatives: • Implementation of data sharing initiatives requires consideration of multiple stakeholders, with each one having the potential to present unique dependencies. For example, the provider can present barriers if there are unforeseen technical and/or bandwidth issues, such as securing a new flat file connection such as with CCPN.
e. Identify strategy for continued improvement or overcoming identified barriers: • Ongoing communication between both provider and UHC data teams to review status, agree on mitigation timelines, etc., was helpful to not only overcome data sharing barriers, but also set the stage for effective partnership going forward.
HSAG Response

2. Prior Year Recommendation from the EQR Technical Report for Program Integrity (PI) Review:
PI Review
HSAG identified the following opportunity: The PI review identified some omissions in the health plan's policies and committee documents.
HSAG recommended the following: • The health plan should correct its documentation to ensure compliance with Prepaid Health Plan (PHP) contract requirements.
PHP Response
a. Describe why this weakness exists: • Challenges at the time of go-live launch and associated learning curve as structures and functions fell into place implementing a new program.
b. Describe initiatives implemented based on recommendations: • Compliance Committee Charter, which originally stated bi-annual meetings, was updated to reflect quarterly committee meetings and 51% of committee members be present for a quorum. With the cadence of quarterly meetings, the committee members, comprised of North Carolina Community & State Health plan leadership team members with the Chief Executive Officer (CEO) as co-chair with Chief Compliance Officer (CCO) along with shared partners of UHC, assists in the open communication and collaboration within the large umbrella of Compliance.
c. Identify any noted performance improvement because of initiatives implemented (if applicable): • Committee meeting notes are published to committee members along with availability on a shared drive. Committee members vote on the meeting minutes and easily observed that Health plan leadership are engaged in all regulatory activity due to the increase cadence and agenda of committee meetings.
d. Identify any barriers to implementing initiatives: • No barriers in implementing cadence and better process.
e. Identify strategy for continued improvement or overcoming identified barriers: • N/A

HSAG Response

PI Review
HSAG identified the following opportunity: The PI review identified workplan omissions in the health plan's documents.
HSAG recommended the following: • The health plan should update its Annual Comprehensive Compliance Plan to include the workplan and develop and implement workplans for announced and unannounced site visits and field audits of high-risk providers.
PHP Response
a. Describe why this weakness exists: • As above, challenges at the time of go-live launch and associated learning curve as structures and functions fell into place implementing a new program to manage and catalogue the volume of deliverables.
b. Describe initiatives implemented based on recommendations: • Fraud, Waste and Abuse Prevention plan and Annual Comprehensive Compliance Plan were edited to ensure that policies and procedures put in place for conducting both announced and unannounced site visits and field audits for high-risk providers. On-site strategy policy 2.8.1 is utilized by Special Investigations Unit (SIU) team for on-site inspection. In addition, the Annual Comprehensive Compliance Plan was updated to include the workplan.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A as the process was in place and required an edit to the Comprehensive Compliance Plan.
d. Identify any barriers to implementing initiatives: • United aware of provider abrasion that the process itself may cause.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue open communication with providers on the process for the visit and collaborate towards successful outcomes.
HSAG Response

PI Review
HSAG identified the following opportunity: The PI review found that there were a limited number of UHC investigations drawn via tips from North Carolina beneficiaries, employees of network providers, and/or other community stakeholders.
HSAG recommended the following: • The health plan should increase its local data mining efforts to identify potential FWA.

PHP Response
a. Describe why this weakness exists: • With an implementation of the North Carolina Health Plan go-live date of 7/1/2021 along with analytics and detection processes typically taking up to six months or more to identify patterns in claims before tips can be generated, time was required to have data, mine that data, tips to generate, and focus FWA investigation.
b. Describe initiatives implemented based on recommendations: • Most data analytics and processes were in place for Year 1 of Health Plan implementation. UHC continues to refine, evaluate, and enhance processes and analytics as UHC continues to learn the North Carolina landscape. The use of data analytics is a part of the detection tools used to generate tips and forward to investigation as applicable. Some specific data analytics used for program integrity work for NC are administrative prospective claims edits, prospective claims flagging, retrospective data mining for aberrant billing patterns, provider education, and prospective and retrospective auditing of high dollar claims/facility audits. Based on recommendations, modification has been completed to the intake process to ensure that all tips are reviewed in a centralized unit for consistency in triage methodology and best practices put in place to improve tips to investigation opportunities.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Upcoming enchantments projects: UHC continues to strive for continuous improvement and identification of potential FWA leads generation opportunities. UHC is currently seeking opportunities within the home community-based service space to increase identification of FWA activities and to potentially increase tips leading to investigations. UHC is also analyzing its data to address any needs tied to guardrails and checks.
d. Identify any barriers to implementing initiatives: • Identification of nuances specific to the NC Health Plan to streamline algorithms.
e. Identify strategy for continued improvement or overcoming identified barriers: • Engagement of Health Plan (HP) leadership and HP Subject Matter Experts' (SME) to validated data/tips once generated for NC before taking administrative action.
HSAG Response


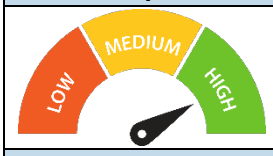
WellCare of North Carolina, Inc.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation (PMV):
PMV
HSAG identified the following opportunity: WellCare indicated that the NC immunization registry had issues returning records to the PHP; therefore, WellCare was in the process of studying the problem with the State's analysts.
HSAG recommended the following: • WellCare should continue working with the State to resolve the ongoing data challenges occurring with the State immunization registry, as these data are critical to support quality reporting across immunization

measures within the scope of PMV: Childhood Immunization Status—Combination 10 and Immunizations for Adolescents—Combination 2.
PHP Response
a. Describe why this weakness exists: • In the past, the NC immunization registry (NCIR) would provide users an incomplete file of vaccinations. This was due to technical limitations within the NCIR data delivery system when processing large panels of members.
b. Describe initiatives implemented based on recommendations: • The NCIR has implemented technical improvements to their system. Specifically, it no longer terminates data delivery that is still processing at midnight each day.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Now data delivery continues to run after midnight and processes data containing information for the complete panel.
d. Identify any barriers to implementing initiatives: • There are no known barriers to implementing initiatives.
e. Identify strategy for continued improvement or overcoming identified barriers: • This issue has been resolved.
HSAG Response

2. Prior Year Recommendation from the EQR Technical Report for Program Integrity (PI) Review:
PI Review
HSAG identified the following opportunity: The PI review identified some omissions in the health plan's policies.
HSAG recommended the following: • The health plan should correct its documentation to ensure compliance with PHP contract requirements.
PHP Response
a. Describe why this weakness exists: • As WellCare continues to refine its Fraud, Waste, and Abuse prepayment review process/policy in accordance with regulatory/contractual requirements, it was an oversight that the SIU prepayment review program was not explicitly outlined in the Provider Manual.
b. Describe initiatives implemented based on recommendations: • A section specific to the SIU prepayment review program was added to the Provider Manual in July 2023 for release.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
d. Identify any barriers to implementing initiatives: • N/A

e. Identify strategy for continued improvement or overcoming identified barriers:
- In the event of regulatory/contractual changes to the prepayment review expectations, the policy manual along with appropriate operating documents will be included in any updates.

HSAG Response



PI Review

HSAG identified the following opportunity:

The PI review identified that the health plan's Fraud Prevention Plan was not submitted or implemented in a timely manner and did not demonstrate final language.

HSAG recommended the following:

- The health plan should ensure that all dates in the NC Fraud Prevention Plan Line of Business: WellCare of NC document correspond with the current Plan year, and that draft language is finalized.

PHP Response

a. Describe why this weakness exists:
- The contract year 1 (one) review related to the Fraud Prevention Plan did not occur due to Plan oversight.

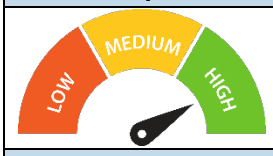
b. Describe initiatives implemented based on recommendations:
- The document language and dates were updated accordingly, and the language policy "supplement to the plan" was included.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- N/A

d. Identify any barriers to implementing initiatives:
- N/A

e. Identify strategy for continued improvement or overcoming identified barriers:
- These documents will continue to be reviewed and updated annually to ensure compliance with the PHP contract requirements.

HSAG Response



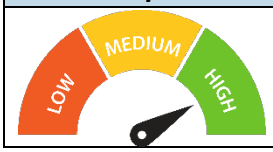
PI Review

HSAG identified the following opportunity:

The PI review identified some omissions in the health plan's Fraud Prevention Plan.

HSAG recommended the following:

- The health plan should correct its documentation to ensure compliance with PHP contract requirements.

PHP Response
a. Describe why this weakness exists: • The Fraud Prevention package, including a report/work plan, was not initially submitted as it was not believed to be a requirement.
b. Describe initiatives implemented based on recommendations: • The Annual Fraud Prevention Report, Policy, and WellCare Workplan were submitted via the HSAG SAFE portal in July 2023.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
d. Identify any barriers to implementing initiatives: • N/A
e. Identify strategy for continued improvement or overcoming identified barriers: • These documents will be reviewed, updated, and submitted annually to ensure compliance with the PHP contract requirements.
HSAG Response


Tailored Plan Follow Up

Tailored Plans did not launch in SFY 2022; therefore, no recommendations were made by HSAG.