North Carolina's Medicaid Managed Care Quality Strategy

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[Version as of 10/10/22]

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Contents

I. Introduction and Overview

North Carolina's Medicaid and NC Health Choice[1] programs are multifaceted and far-reaching, encompassing more than two million diverse beneficiaries and the many programs that serve them. Medicaid and NC Health Choice provide coverage for more than one in two North Carolina birth events, and insure three in seven of North Carolina's children. Medicaid also funds necessary services for individuals with severe behavioral health needs and supports children and adults with developmental disabilities through innovative community-based services.[2]

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 structure, called NC Medicaid Direct, to a capitated managed care structure. The Department remains committed to transitioning North Carolina 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. In July 2021, the North Carolina Department of Health and Human Services (DHHS) (the Department) completed the first phase of managed care implementation with the launch of Standard Plans and the Eastern Band of Cherokee Indians (EBCI) Tribal Option. Further managed care implementation over the next three years will include the launch of 1) Tailored Plans for individuals with significant behavioral health needs and intellectual/developmental disabilities (I/DDs); 2) a Children and Families Specialty Plan for children and youth currently or formerly served by the child welfare system; and 3) a plan for individuals dually eligible for Medicaid and Medicare (discussed further below).

In implementing managed care, North Carolina is building upon its successes to achieve even greater results – innovating and evolving to improve the health of North Carolinians. This Quality Strategy is built with the desire to shape an innovative, whole-person, well-coordinated system of care that addresses both medical and non-medical drivers of health and an enhanced focus on promoting health equity.

(A) History of Medicaid Health Care Delivery in North Carolina

North Carolina has historically had separate payment and delivery systems: one for physical health services and one for behavioral health and intellectual/developmental disabilities (I/DD) services.

- **Physical health services**: Have historically been delivered by NC Medicaid Direct and managed through a Primary Care Case Management (PCCM) program named Community Care of North Carolina (CCNC). The program is administered by the Department. While the majority of behavioral health services have been provided separately through Local Management Entities – Managed Care Organizations (LME-MCOs) described below, some medical homes integrate basic behavioral services in their practices.
- **Behavioral health and I/DD services**: Have historically been delivered by local, limited benefit managed care plans. In 2005, the Department implemented a concurrent 1915(b)/(c) Medicaid waiver to establish managed behavioral health and I/DD care through LME-MCOs. The LME-MCO

[1] North Carolina's combination Children's Health Insurance Program (CHIP) program for children ages 6-18. More information is available at: https://www.ncdhhs.gov/health-choice-children-health-insurance-low-income-children. Throughout this document, references to Medicaid are inclusive of NC Health Choice unless otherwise noted.

[2] Kaiser Family Foundation. Medicaid State Fact Sheets. North Carolina. Available at: http://files.kff.org/attachment/fact-sheet-medicaid-state-NC

concept was initially designed as a pilot project to serve Medicaid beneficiaries with mental health, developmental disabilities and substance use needs in a limited geographical catchment area. The pilot LME-MCO also delivered home- and community-based services and supports authorized by the Innovations Waiver, a 1915(c) home and community-based services waiver for individuals with I/DD. In 2009, the Department elected to expand the 1915 (b)/(c) Medicaid waiver statewide and initiated a collaborative effort between the North Carolina Medicaid and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). The goal was to restructure the delivery system for Medicaid and state-funded mental health, substance use and intellectual/developmental disabilities services. Currently, the Department contracts with six regional LME-MCOs, which act as capitated prepaid inpatient health plans (PIHPs), to operate Medicaid-funded and state-funded services for enrollees who are delayed, excluded, or exempt from integrated Medicaid managed care. The LME-MCO quality strategy is aligned with the quality strategy outlined in this document.

(B) North Carolina's Transition to Managed Care

Table 1 lists the entities that will deliver services to Medicaid and NC Health Choice enrollees after managed care launch and that will be involved in quality measurement and improvement efforts. These entities are described further below:

Table 1. Summary of Managed Care Entities in North Carolina

Plan Name	Entity Type	Managed Care Authority	Populations Served	Launch Date
Standard Plans	MCO	1115	Majority of Medicaid and NC Health Choice population	July 1, 2021
EBCI Tribal Option	PCCM	State Plan Amendment	Federally recognized Tribal members and other individuals eligible to receive Indian Health Services	July 1, 2021
Community Care of North Carolina (CCNC)	PCCM	State Plan Amendment	Individuals delayed or excluded from integrated managed care	Exists today
Behavioral Health and I/DD Services for Medicaid Direct	PIHP	1915(b) Waiver	Individuals delayed, excluded, or exempt from integrated managed care (behavioral health, I/DD services)	Exists today
Tailored Plans	MCO	1115	Individuals with significant behavioral health conditions (serious mental illness, severe emotional disturbance, or severe substance	April 1, 2023

			use disorder), I/DD, or traumatic brain injury (TBI)	
Children and Families Specialty Plan (CFSP)	MCO	1115	Children, youth, and families served by the child welfare system	Awaiting Legislation to Authorize the CFSP

Integrated Managed Care Plans

Standard Plans

On July 1, 2021, the Department, as mandated by NC Session Law 2015-245, Session Law 2018-48, and Session Law 2020-88 transitioned most Medicaid (and NC Health Choice) beneficiaries to fully capitated and integrated plans called Standard Plans.[3] The majority of enrollees, including adults and children with low to moderate intensity behavioral health needs, will receive integrated physical health, behavioral health, long-term services and supports and pharmacy services through Standard Plans.

Tailored Plans

Managed care eligible Medicaid and NC Health Choice beneficiaries with I/DD, TBI, and/or more serious behavioral health disorders, who meet the criteria specified by NC Session Law 2018-48, will be enrolled into Tailored Plans, which are regional, specialized managed care products focused on the needs of these populations. Tailored Plans will offer the same services as Standard Plans in addition to 1915(c) Innovations and TBI waiver services as well as several specialized behavioral health and I/DD services. In addition to managing Medicaid services, Tailored Plans will be responsible for managing State-funded behavioral health, I/DD, and TBI services as LME-MCOs currently do for uninsured and underinsured individuals.[4] Tailored Plans are anticipated to launch on April 1, 2023.

Prior to Tailored Plan launch, beneficiaries identified through regular reviews of encounter and claims data as eligible for the future Tailored Plans will default to the current system (NC Medicaid Direct for physical health and pharmacy services and LME-MCOs for behavioral health and I/DD services), but will have the option to enroll in a Standard Plan.

Children and Families Specialty Plan (CFSP)

In addition to Standard Plans and Tailored Plans, the Department intends to launch a single statewide Children and Families Specialty Plan (CFSP) to mitigate disruptions in care and coverage for children in foster care, children receiving adoption assistance, former foster youth under age 26, minor children of these populations, their eligible family members, and families receiving Child Protective Services (CPS) In-Home Services (collectively referred to as "children, youth, and families served by the child welfare

[3] Full text of SL 2015-245 is available at: https://www.ncleg.gov/EnactedLegislation/SessionLaws/HTML/2015-2016/SL2015-245.html
Full text of SL 2018-48 is available at: https://www.ncleg.net/EnactedLegislation/SessionLaws/HTML/2017-2018/SL2018-48.html
Full text of SL 2020-88 is available at: https://www.ncleg.gov/Sessions/2019/Bills/Senate/PDF/S808v8.pdf

[4] State-funded services are not Medicaid services and are not considered entitlements—this means that funding is limited and services are not available for everyone who may qualify.

system").[5] Designed to meet the unique health care needs of this population, the CFSP will enable children, youth, and families served by the child welfare system across the state to access a broad range of physical health, behavioral health, pharmacy, long-term services and supports (LTSS), Intellectual/Developmental Disability (I/DD) services, and resources to address unmet health-related needs, and maintain treatment plans even if placement changes occur. The CFSP will serve as the central entity accountable for the care of these beneficiaries and ensure that they receive the care they need when and where they need it, regardless of geographical location. All plans awarded a contract through the State for the provision of Medicaid managed care services and able to operate statewide will be able to bid on the CFSP.

Primary Care Case Management Programs

Eastern Band of Cherokee Indians (EBCI) Tribal Option

The Cherokee Indian Hospital Authority (CIHA) has entered into a contract with the Department to address the health needs of the state's EBCI beneficiaries.[6] The EBCI Tribal Option is the first Indian managed care entity in the nation and establishes a new delivery system for enrolled populations.

The EBCI Tribal Option is a non-risk bearing managed care option for federally recognized tribal members and other individuals eligible to receive Indian Health Service, under 42 CFR 438.14(a). The EBCI Tribal Option launched in July 2021, along with Standard Plans. The EBCI Tribal Option is available to beneficiaries in the following counties: Buncombe, Clay, Cherokee, Graham, Haywood, Henderson, Jackson, Macon, Madison, Swain and Transylvania. The program has a strong focus on primary care, preventive health, chronic disease management and provides care management for all members and care management service plans for high-need members. The EBCI Tribal Option coordinates all medical, behavioral health and pharmacy services in the North Carolina Medicaid and NC Health Choice State Plans, including monitoring the quality of services offered.

As a non-risk bearing primary care case management entity, the EBCI Tribal Option is not subject to all federal managed care requirements. However, they will play a strong role in delivering high quality care in a manner that is consistent with the State's overall Quality Strategy. Where the EBCI Tribal Option interacts specifically with the Quality Strategy it is noted throughout.

Community Care of North Carolina

For most Medicaid and NC Health Choice enrollees delayed, excluded, or exempt from integrated managed care, physical health services will continue to be delivered by providers under NC Medicaid Direct and managed by the CCNC PCCM program.[7] The CCNC PCCM Program provides enhanced and coordinated care for patients through multiple activities, including preventive services, data analysis, community-based care coordination and care management.

[5] For additional details on the CFSP, please refer to the CFSP policy paper 'Update on North Carolina's Children and Families Specialty Plan' available here: https://medicaid.ncdhhs.gov/beneficiaries/children-and-families-specialty-plan#:~:text=About%20the%20Children%20and%20Families,treatment%20plans%20when%20placements%20change.

[6] The EBCI Tribal Option Fact Sheet is available here: https://medicaid.ncdhhs.gov/ebci-tribal-option-overview/open

[7] After Tailored Plans launch, individuals remaining in NC Medicaid Direct who have significant behavioral health conditions, and I/DD, or TBI will generally be eligible to obtain Tailored Care Management—a specialized care management program targeted towards individuals with these needs—instead of the CCNC PCCM program.

Other:

Behavioral Health and I/DD Services for Medicaid Direct PIHP

Members who remain enrolled in NC Medicaid Direct will have access to physical health services, LTSS, and pharmacy through Medicaid fee-for-service, and behavioral health and I/DD services through a capitated prepaid inpatient health plan (PIHP), called "Behavioral Health and I/DD Services for Medicaid Direct."

(C) Population Included in Integrated Managed Care

As mentioned previously, on July 1, 2021, NC Medicaid transitioned most Medicaid and NC Health Choice beneficiaries to Medicaid managed care. For remaining populations, enrollment into managed care is described below.

There are limited exceptions to mandatory enrollment in Medicaid managed care for some populations that may be better served outside of managed care. These populations are either *exempt* (meaning they may choose, but are not required, to enroll in NC Medicaid Managed Care) or are *excluded* (meaning they must remain enrolled in NC Medicaid Direct and may not enroll in NC Medicaid Managed Care). In addition, certain populations, including those eligible for Tailored Plans and the CFSP, are delayed in their enrollment, allowing for additional time to conduct thoughtful planning and a seamless transition to managed care.

Figure 1. Populations Exempt, Excluded and Delayed from Integrated Managed Care

Exempt Populations	
• Beneficiaries eligible to receive services from the Indian Health Service (IHS), including members of the EBCI. ○ As noted above, these individuals will have the opportunity to enroll in the EBCI Tribal Option.	
Excluded Populations[8]	
• Medically needy beneficiaries (also known as "Spend Down"), except for those enrolled in the Innovations and TBI waivers • Health Insurance Premium Payment (HIPP) beneficiaries, except for those enrolled in the Innovations and TBI waivers; • Beneficiaries being served through the Community Alternatives Program for Children (CAP/C) • Beneficiaries being served through the Community Alternative Program for Disabled Adults (CAP/DA), including beneficiaries receiving services under CAP/Choice, the consumer-directed care option under the CAP/DA program • Program of All-Inclusive Care for the Elderly (PACE) participants Limited Benefits (i.e. do not receive the full Medicaid benefit package): • Beneficiaries who are enrolled in both Medicare and Medicaid for whom North Carolina Medicaid coverage is limited to the coverage of Medicare premiums and cost sharing • Qualified aliens subject to the five-year bar for means-tested public assistance under 8 U.S.C. § 1613 and who qualify for emergency services under 8 U.S.C. § 1611 • Undocumented aliens who qualify for emergency services under 8 U.S.C. § 1611 • Presumptively eligible beneficiaries, during the period of presumptive eligibility • Beneficiaries enrolled under the Medicaid family planning program[9] • Beneficiaries who are inmates of prisons • Beneficiaries enrolled in the COVID-19 testing benefit	
Delayed Populations	
Special Populations	**Expected Phase-in Timeline**

[8] NC Session Law 2015-245 as amended by Session Law 2016-121 and NC Session Law 2018-49.

[9] As of April 1, 2022, pregnant people have coverage for full Medicaid benefits for one year postpartum beyond the maternity-focused benefits previously included in the Medicaid for Pregnant Women (MPW) program. The extended coverage is currently authorized for birth events that occur through March 2027. More information is available in Section III(C)4.

	(no earlier than)
Tailored Plan-eligible Populations[10,11]	**April 2023**
• Beneficiaries with a serious emotional disturbance (SED) or a diagnosis of severe substance use disorder (SUD) or TBI	
• Beneficiaries with a developmental disability as defined in G.S. 122C 3(12a)	
• Beneficiaries with a mental illness diagnosis who also meet any of the following criteria: o Beneficiaries with serious mental illness (SMI) or serious and persistent mental illness, as those terms are defined in the 2012 settlement agreement between the Department and the United States Department of Justice, including individuals enrolled in and served under the Transitions to Community Living (TCL) settlement agreement o Beneficiaries with two or more psychiatric hospitalizations or readmissions within the prior 18 months o Beneficiaries who have had two or more visits to the emergency department for a psychiatric problem within the prior 18 months and are assessed by the Department as eligible for the Tailored Plan o Individuals known to the Department or an LME-MCO to have had one or more involuntary treatment episodes within the prior 18 months	
• Beneficiaries who, regardless of diagnosis, meet any of the following criteria: o Beneficiaries who have had two or more episodes using behavioral health crisis services within the prior 18 months and are assessed by the Department as eligible for the Tailored Plan o Beneficiaries receiving any of the behavioral health, I/DD, or TBI services that are covered by LME-MCOs and that shall not be covered through any NC Medicaid Managed Care contract other than Tailored Plan o Beneficiaries who are receiving or need to be receiving behavioral health, I/DD, or TBI services funded with State, local, federal or other non-Medicaid funds, or any combination of non-Medicaid funds, in addition to the services covered by Medicaid o Children with complex needs, as that term is defined in the 2016 settlement agreement between the Department and Disability Rights of North Carolina o Children aged 0 to 3 years old with, or at risk for, developmental delay or disability • Children and youth involved with the Division of Juvenile Justice of the Department of Public Safety and Delinquency Prevention Programs who meet criteria established by the Department	
Other Delayed Populations[12]	
• Children in foster care, receiving Title IV-E adoption assistance, under the age of 26 and formerly were in the foster care system	No Earlier Than December 2023
• Medicaid-only beneficiaries receiving long-stay nursing home services	No Later than 5 Years After Standard Plan Launch
• Individuals who are dual-eligible for Medicare and Medicaid	No Later than 5 Years After Standard Plan Launch

Within this document, the term "plans" refers to Standard Plans and/or Tailored Plans. The document explicitly references the CFSP, EBCI Tribal Option, CCNC and the PIHP respectively, when provisions also apply to them.

(D) Linking Quality Strategies for Special Populations During the Transition Period

This Quality Strategy focuses on measuring quality performance and outcomes in the early years of managed care, affecting the populations that will transition immediately to managed care (outlined above); it will expand to capture additional populations as they are brought into managed care over time.

As mentioned previously, during the transition to Standard Plans and the EBCI Tribal Option, North Carolina will continue to operate NC Medicaid Direct and the CCNC PCCM program and contract with LME-MCOs. LME-MCOs will continue to administer the Innovations and TBI waivers as well as manage State-

[10] Section 4.(5) of Session Law 2015-245, as amended by Session Law 2018-48.

[11] For more information on Tailored Plan Eligibility and Enrollment, please refer to final policy guidance published at: https://www.ncdhhs.gov/assistance/medicaid-transformation/proposed-program-design/policy-papers and subsequent updates at: https://files.nc.gov/ncdhhs/BH-IDD-TP-Eligibility-Enrollment-Update-02.02.2021.pdf and https://files.nc.gov/ncdhhs/BH-IDD-TP-EligibilityUpdate-AppendixB-0020221-Updates.pdf.

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

funded services. NC Medicaid Direct will continue to operate the CAP/C and CAP/DA waivers, whose quality requirements are available online at CAP/C Waiver and CAP/DA Waiver. The CCNC PCCM program will continue to manage the physical health care needs of NC Medicaid Direct beneficiaries, unless enrolled in the EBCI Tribal Option. During this time of transition, the quality measures and requirements for each of these special programs and for LME-MCOs will remain in place, and all State Medicaid programs will be focused on the unifying Aims outlined in the section that follows.

When Tailored Plans launch in April 2023, delayed populations described in Figure 1 will become eligible for enrollment. Beneficiaries that are eligible for Tailored Plans will receive a notice informing them they will be auto-enrolled into the Tailored Plan in their region upon Tailored Plan launch and can elect to transfer to a Standard Plan at any point during the coverage year (more information is provided in Section IV(B)(4)).

II. Quality Strategy Aims, Goals, Objectives and Measures

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

Better Care Delivery;
Healthier People, Healthier Communities; and
Smarter Spending.

Included within each of these three Aims is a series of Goals and Objectives, intended to highlight key areas of expected progress and quality focus. Together, as shown in Figure 2 below, these Aims, Goals and Objectives create a framework through which North Carolina defines and drives the overall vision for advancing the quality of care provided to Medicaid beneficiaries in the state. These Aims and Goals were designed to closely align with the Centers for Medicare and Medicaid Services (CMS) Quality Strategy, adapted to address local priorities, challenges, and opportunities for North Carolina's Medicaid program.

Figure 2. North Carolina's Quality Strategy Aims, Goals and Objectives

Aims	Goals	Objectives
Aim 1: Better Care Delivery. *Make health care more person-centered, coordinated, and accessible.*	**Goal 1: Ensure appropriate access to care**	Objective 1.1: Ensure equitable, timely access to care
		Objective 1.2: Maintain Medicaid provider engagement
	Goal 2: Drive equitable, patient-centered, whole-person care	Objective 2.1: Promote patient engagement in care
		Objective 2.2: Link patients to appropriate care management and care coordination services
		Objective 2.3: Address behavioral and physical health comorbidities
Aim 2: Healthier People, Healthier Communities. *Improve the health of North Carolinians through*	**Goal 3: Promote wellness and prevention**	Objective 3.1: Promote child health, development, and wellness
		Objective 3.2: Promote women's health; including maternal morbidity and mortality

Aims	Goals	Objectives
prevention, better treatment of chronic conditions, and better behavioral health care, working collaboratively with community partners.		Objective 3.3: Maximize long-term services and supports (LTSS) populations' quality of life and community inclusion
	Goal 4: Improve chronic condition management	Objective 4.1: Improve behavioral health care
		Objective 4.2: Improve diabetes management
		Objective 4.3: Improve asthma management
		Objective 4.4: Improve hypertension management
	Goal 5: Work with communities to improve population health	Objective 5.1: Address unmet health-related resource needs
		Objective 5.2: Address the opioid crisis
		Objective 5.3: Address tobacco use
		Objective 5.4: Promote health equity
		Objective 5.5: Address obesity
Aim 3: Smarter Spending. *Pay for value rather than volume, incentivize innovation, and ensure appropriate care.*	**Goal 6: Pay for value**	Objective 6.1: Ensure high-value, appropriate care

(A) Development of the Quality Strategy Aims, Goals, and Objectives

These Goals and Objectives reflect significant community and stakeholder input as well as thoughtful consideration of the quality issues that are most significant to North Carolina. The Department contracted with the North Carolina Institute of Medicine (NCIOM) Task Force on Health Care Analytics (NCIOM Task Force) to convene stakeholders across the state to issue recommendations on the specific quality metrics North Carolina Medicaid should focus on throughout the transition to managed care. The NCIOM Task Force brought together a statewide group of providers, beneficiaries, quality experts and plan representatives who recommended a set of Medicaid quality measures to be used to drive improvement in the health of Medicaid beneficiaries.[13] In recognition of the significant deliberative process of the NCIOM Task Force, this Quality Strategy and its Objectives align closely with the NCIOM recommendations.

The Department additionally considered the quality areas of greatest significance specifically to the North Carolina Medicaid population and where current performance showed an opportunity for targeted improvement. The Objectives set forth are similarly aligned to ensure beneficiary access to services, particularly in the State's transition to managed care and including access to historically underfunded services and secondary and tertiary providers. For example:

[13] More information is available at: http://nciom.org/metrics-to-drive-improvements-in-health-a-report-of-the-task-force-on-health-care-analytics/

- Objective 1.2 (maintain Medicaid provider engagement) under **Goal 1** (ensure equitable, appropriate access to care) recognizes the need to maintain North Carolina's historically high rate of provider participation in Medicaid to fully meet beneficiaries' needs, including convenient access to the appropriate range of providers in a timely manner.
- Objectives related to **Goal 2** (drive equitable, patient-centered, whole-person care) seek to ensure that beneficiaries are engaged in their health care and are satisfied with their managed care plan (assessed as part of the Consumer Assessment Health Plan Survey), in addition to ensuring that they are linked to an Advanced Medical Home (AMH), or, for Tailored Plan beneficiaries, an entity that provides Tailored Care Management (e.g., an AMH+ or Care Management Agency (CMA) provider, as described further in Section III(C)).
- Objectives aligned to **Goal 3** (promote wellness and prevention) reflect a continued emphasis on improving the health of children and women.
- Objectives related to **Goal 4** (improve chronic condition management) focus on conditions that heavily affect the North Carolina Medicaid population, including asthma, diabetes, behavioral health disorders and hypertension. While other chronic conditions were additionally considered for inclusion, the Department sought to focus on select, targeted priorities that allow for demonstrable progress, reinforced by the NCIOM Task Force's recommendations and of relevance to existing and newly covered populations in managed care.
- Multiple Objectives tie to **Goal 5** (work with communities to improve population health), which emphasize areas where community engagement remains critical to advancing a high-quality, equitable health system, such as meeting unmet resource needs, combating the opioid epidemic and addressing health disparities. These Objectives recognize and build upon the progress that has been made at a local level throughout the State.
- **Behavioral health** is elevated in multiple areas throughout these Objectives, in recognition of the complexity of delivering high-quality care for populations with behavioral health needs and the prevalence and cost of coexisting behavioral and physical health disorders.
- **Health equity** is also elevated in multiple areas throughout these Objectives, to highlight the Department's commitment to addressing health disparities and inequities, particularly for the state's historically marginalized populations.
- Similarly, the Quality Strategy highlights a key Objective related to populations with **long-term services and supports (LTSS) needs**; most quality Objectives and measures in this Quality Strategy are relevant to populations with LTSS needs.

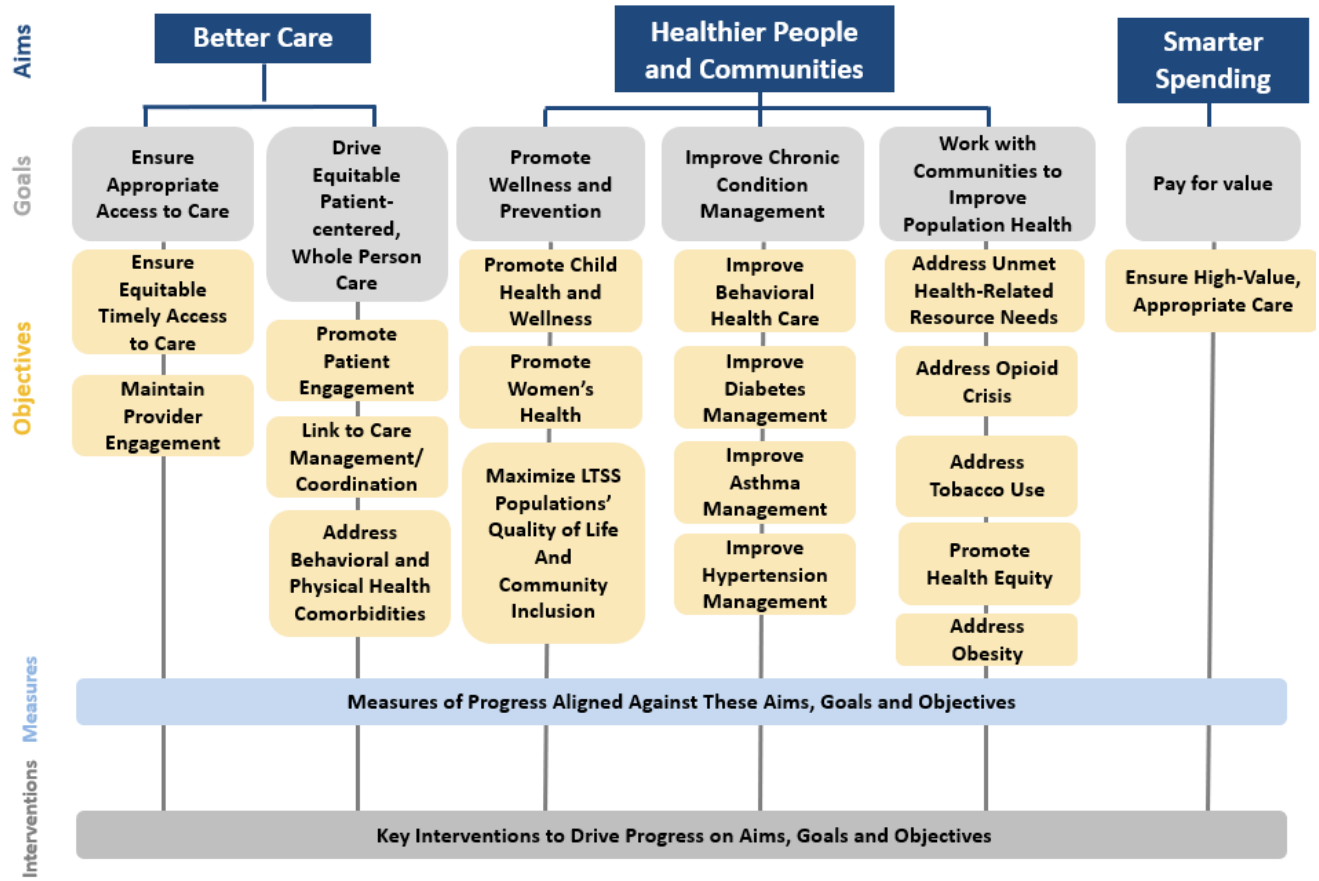
Each of the 18 Objectives are tied to a series of focused interventions (described in detail in Section III(C)) used to drive improvements within, and in many cases across, the Goals and Objectives set forth in this Quality Strategy. To assess the effect of these interventions and continue to identify opportunities for improving the quality of care delivered under Medicaid managed care, in compliance with the requirements set forth in 42 CFR 438.340(b)(2), these interventions are tied to a set of metrics to assess progress (see Appendix B).

As baseline data for plan performance becomes available, the Department intends to further refine these Objectives to target specific improvement goals, including additional metrics that address health disparities. Standard Plans and Tailored Plans are required to maintain systems that collect, analyze, integrate and report encounter data in a timely, accurate and complete manner. These data are used for

several purposes and will be key to the quality of the NC Medicaid Managed Care program, directly related to quality performance and otherwise. The External Quality Review Organization (EQRO), further discussed in Section V(A) and Appendix D of this Quality Strategy will play a critical role in ensuring the validity of plans' reported encounter data, and in the validation and calculation of quality measures. The Department is committed to using these reports to assess opportunities for continued improvement, including how priorities evolve, as additional populations are enrolled in managed care.

Together, this framework represents a comprehensive plan for delivering high-quality, accessible, timely care to NC Medicaid Managed Care beneficiaries (Figure 3).

Figure 3. Overview of the Quality Strategy Framework



(B) Overview of Quality Measures

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

The Department and Standard Plans and Tailored Plans will be accountable for performance on the following:

- A select set of measures that align with the Aims, Goals and Objectives of the Quality Strategy, as identified in Appendix B;
- All **Healthcare Effectiveness Data and Information Set (HEDIS)** measures required for NCQA health plan accreditation, regardless of whether the plan has achieved accreditation to date (Standard Plans and Tailored Plans are required to achieve accreditation by Year 3 of operations, as further discussed in Section III(C)(10); and
- A select set of **CMS Adult and Child Core** measures.[14]

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

The Department will set a benchmark for each measure (with the exception of measures of contraceptive care[15]) to assess at least a 5% improvement year over year in measure performance. More information on the benchmarking methodology can be found in the Technical Specifications.[16]

Additionally, the Department will use tools such as the 5.0 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Adult and Child surveys, Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Survey, North Carolina Treatment Outcomes & Program Performance System (NC-TOPPS), National Core Indicators (NCI) and other surveys to assess patient experience in receiving care and quality of life.

In future years, the Department may develop other surveys to capture additional outcomes of interest or may adapt existing surveys to support more in-depth tracking of patient-reported outcomes.

The Department uses patient-reported surveys as part of its evaluation of plan performance and to consider areas that may require additional focus and prioritization as NC Medicaid Managed Care programs and its beneficiaries' needs evolve.[17] As other special plans and programs are included in managed care, the Department will assess the incorporation of special population-targeted quality measures.

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

Behavioral Health Measures — Focusing on Screening and Timely Treatment

As described above, the State has selected multiple Objectives focused specifically on behavioral health, each of which is tied to quality measures described in Appendix B. These Objectives and the related

[14] For more information on the Child and Adult Core Set, refer to: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html

[15] For measures of contraceptive care, the Department will not apply an external performance benchmark, reflecting the preference-sensitive nature of contraception care. The Department will, however, monitor measure results to assess where contraceptive access may be problematic.

[16] Available here: https://medicaid.ncdhhs.gov/quality-management-and-improvement

[17] The National Quality Forum defines patient-reported outcomes as: a performance measure that is based on patient-reported outcome data aggregated for an accountable healthcare entity (e.g., percentage of patients in an accountable care organization whose depression score as measured by the PHQ-9 improved). More information is available at: https://www.qualityforum.org/Projects/n-r/Patient-Reported_Outcomes/Patient-Reported_Outcomes.aspx

measures were selected based on alignment with previous State reporting on behavioral health measures (both through LME-MCOs and CMS Adult and Child Core measures). The Objectives reflect emerging best practices from leaders on behavioral health measurement, including the National Quality Forum, the Institute for Healthcare Improvement (IHI), the Agency for Healthcare Research and Quality (AHRQ) and the Substance Abuse and Mental Health Services Administration (SAMHSA), among others.

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

As described, the State has set forth an Objective focused on LTSS populations. The LTSS Objective was selected because the Department will review all quality measures in Appendix A and stratify outcomes by LTSS needs status. The Department requires plans submit the measures separately for only individuals that have been identified as having an LTSS need, as defined by the Comprehensive Assessment. Through analyzing these data, the Department will ensure that LTSS individuals have access to care and that plans are promoting equity in health outcomes. In future years, the Department will seek to identify an appropriate quality of life metric.

Opioid Measures — Focusing on Drug Monitoring and Substance Use Treatment

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

Public Health Measures—Focusing on Tobacco and Diet/Exercise

The State has identified multiple Objectives to advance Goal 5 (work with communities to improve population health). To advance this goal, the State will monitor progress on Healthy NC 2030 measures for tobacco use, diet and exercise, which address Objectives 5.3 and 5.5, respectively. The State selected tobacco, diet and exercise as public health measure focus areas due to their significant impact on health in North Carolina and their potential to be affected by required plan activities, such as tobacco cessation assistance and body mass index (BMI) screening.

CFSP Measures

The Department will establish a common set of quality measures as a key mechanism to ensure CFSP accountability. The CFSP will be held accountable for robust and dedicated adult and pediatric measures that emphasize outcomes for beneficiaries over process measures and prioritize the medical needs and experiences that are significant in the CFSP population. *EBCI Tribal Option Measures*

The EBCI Tribal Option will adhere to a separate EBCI Tribal Option Quality Measure Set (see Appendix A, Table 11), which aligns with the overall Medicaid Quality Strategy Framework. The EBCI Tribal Option

measures are aligned to a range of specific Goals and Objectives used to drive quality improvement and operational excellence for the beneficiaries they serve.

The EBCI Tribal Option measures have the following performance targets:

Clinical Measures	Performance Target
Poor Glycemic Control	Achieve the target rate of <20% for the proportion of the patients with diagnosed diabetes who have poor glycemic control.
Controlling High Blood Pressure – Million Hearts	Achieve the target rate of 65.8% for the proportion of patients with a blood pressure <140/90.
Childhood Immunizations	Achieve the target rate of 80.1% for the proportion of IHS eligible children ages 19 through 35 months at the end of the reporting period.

CCNC Primary Care Case Management Measures

CCNC will work with the Department to review performance measures and other metrics and compare performance with quality, access, cost and utilization benchmarks. CCNC will produce an annual Program Performance Metrics report, including outcomes for a separate measure set (see Appendix A, Table 12). Performance targets will be set according to the methodology described above (page 15).

Behavioral Health and I/DD Services for Medicaid Direct PIHP Measures

The Behavioral Health and I/DD Services for Medicaid Direct PIHP covers a specific subset of behavioral health services for individuals who are not otherwise Medicaid-eligible. Because these plans only cover a limited subset of services, the Department and administering plans do not have the encounter data required to calculate most Medicaid Core and HEDIS quality measures. The Behavioral Health and I/DD Services for Medicaid Direct PIHP is only required to report measures for which it collects all required data elements.

(C) Development and Review of the Quality Strategy

1. Development of the Initial Quality Strategy

A critical element of transitioning North Carolina's Medicaid program from fee-for-service to managed care has involved extensive stakeholder feedback. The initial Quality Strategy was published in March 2018 with a 30-day public comment period. Public comments received on the draft are incorporated into this version. Stakeholder feedback was also requested through the publication of several white papers and Requests for Information (RFIs), including North Carolina's Proposed Program Design for Medicaid Managed Care; North Carolina's Care Management Strategy under Managed Care; Provider Health Plan Quality Performance and Accountability; Behavioral Health and Intellectual Disability Tailored Plans

Eligibility and Enrollment; and the Tailored Plan Request for Applications Pre-Release Policy Paper.[18] The Department also released an RFI to solicit feedback from potential plans and other interested stakeholders on options and considerations related to plan design and implementation, including several interventions (e.g., value-based payment) addressed by the Quality Strategy.[19] Each of these program design documents laid the groundwork for how the Department aims to drive quality, value, care improvement, beneficiary protections and plan accountability in a new managed care environment.

Public comments on the initial Quality Strategy focused primarily on quality measures included in this Strategy, as well as the Department's proposed approach to withhold scoring. Of note, the Department has delayed the quality withhold to the third contract year and will defer finalizing the quality withhold scoring approach to learn from first year performance data and stakeholder feedback.[20] In response to comments about measures, the Department will monitor measure performance and maintain a list of candidate measures that can be added as other measures are phased out due to changes in program requirements (such as requirements for health plan accreditation), topped-out status, or other needs. In addition, the launch of Tailored Plans will incorporate additional measures of particular relevance to the specific populations covered. Commenters noted concerns regarding small sample sizes and confidence intervals in measure reporting. The Department is mindful of these concerns, and in consultation with state statisticians and public health experts, the Department expects to combine subsamples as appropriate for individual analyses. A number of commenters expressed interest in using a hybrid quality reporting methodology where appropriate; the Department has emphasized measures that can be reported using only administrative data, but will accept a hybrid reporting approach for measures for which hybrid reporting is appropriate as well.[21] However, the Department reserves the right to suspend hybrid reporting as necessary, such as in the case of a disaster or state of emergency. The Department encourages Standard Plans and Tailored Plans pursuing hybrid reporting to develop consistent reporting approaches that minimize burden on providers.

As outlined in Section II(B), quality priorities and interventions were derived from review of performance against existing quality measures and outcomes in North Carolina, and built upon the work of the NCIOM Task Force on Health Care Analytics. In addition to the stakeholder engagement activities critical to Medicaid transformation, including work on this Quality Strategy, the following steps were taken to receive input on the Quality Strategy, consistent with the standards set forth in 42 CFR 438.340(c):

- Consultation with the Medical Care Advisory Committee; and
- Consultation with the Eastern Band of Cherokee Indians (EBCI) Tribe in accordance with the State's Tribal consultation policy.

The Department incorporated comments from all groups as noted and made its final Quality Strategy available on its website upon CMS approval.

[18] Policy papers are available at: https://www.ncdhhs.gov/assistance/medicaid-transformation/proposed-program-design/policy-papers

[19] For additional information on the November 2017 RFIs, refer to: https://www.ncdhhs.gov/news/press-releases/dhhs-releases-request-information-medicaid-managed-care-program

[20] As per S.L. 2018-49 (available here: https://www.ncleg.gov/enactedlegislation/sessionlaws/html/2017-2018/sl2018-49.html). A methodology to determine the quality score required to receive a withhold target allocation will be released prior to that year.

[21] A hybrid measure is a quality measure that uses more than one source of data for measure calculation.

2. Updates to the Quality Strategy

In 2019, the Department updated the Quality Strategy to remove interventions that were not approved as part of the waiver, such as the Workforce initiative.

In the 2021 update, the Department:

- Integrated Tailored Plan design components into the Quality Strategy;
- Reframed references to the quality measure set to align with recent Standard Plan and Tailored Plan managed care contract/RFA changes; to include addition of all relevant measure sets (e.g., Standard Plan, Tailored Plan, Advanced Medical Home, EBCI Tribal Option and the CCNC PCCM);
- Updated the list of interventions that align with the objectives, aims and goals of the Quality Strategy; and
- Incorporated the CFSP, EBCI Tribal Option and CCNC PCCM into the Quality Strategy.

In this 2022 update, the Department:

- Updated the managed care implementation timeline and associated included, exempt, excluded and delayed populations;
- Incorporated additional CFSP design elements into the Quality Strategy;
- Updated relevant quality measure sets; and
- Included new appendix with Standard Plan performance improvement project examples.

As in previous updates, the 2022 update to the Quality Strategy will incorporate feedback received during the 30-day public comment period.

In 2021, the public comment period began on April 5, 2021 and concluded on May 6, 2021. Public comments focused primarily on quality measures included in this Strategy, managed care plan accreditation and the Department's proposed approach to withhold scoring. Commenters also expressed a desire for more stakeholder representation on the Department's Quality public-facing quality meetings. In response, the Department has added clarification on the technical specifications for the plan and Department-reported quality measures as well as clarified how stakeholders can engage in NC Medicaid Managed Care quality work. The Department also conferred with the Quality Subcommittee of the Medical Care Advisory Committee (MCAC).

In 2022, the public comment period…[Placeholder following the 2022 comment period]

During the 2022 update and similar to prior updates, the EBCI Tribe was consulted in accordance with the State's Tribal consultation policy.

Future Updates

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

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

- Significant new program changes (e.g. launch of new managed care plan products);

- A pervasive pattern of quality deficiencies identified through analysis of the quality performance data submitted by the Standard Plans and Tailored Plans that results in a change to the Goals or Objectives of the Quality Strategy;
- Overarching changes to quality standards resulting from regulatory authorities or legislation at the state or federal level; or
- A change in membership demographics or the provider network of 50% or greater within one year.[22]

The process for reviewing the Quality Strategy includes an evaluation of its effectiveness in the previous three years (or, if updated sooner, since the Quality Strategy's implementation), the results of which will be made publicly available on the Department website. The Department is working with the EQRO to develop the evaluation, which will be available as part of a future update.

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

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

III. Improvements and Interventions

(A) Quality Assessment and Performance Improvement Programs

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

- Completion of Department-specified performance improvement projects (further described under *Performance Improvement Projects* below);
- Collection and submission of all designated quality performance measurement data (outlined in Section II(B) and Appendix A);
- Mechanisms to detect both underutilization and overutilization of services;
- Mechanisms to assess the quality and appropriateness of care for beneficiaries with special health care needs (defined in Section IV(A)(5));

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

- Mechanisms to assess and address health disparities, including findings from the EQRO-developed annual health equity report (further discussed in Section V(A)(1));
- Mechanisms to incorporate population health programs targeted to improve outcome measures;
- Mechanisms to assess the quality and appropriateness of care provided to beneficiaries needing LTSS, including assessment of care between settings and a comparison of services and supports received with those set forth in the beneficiary's treatment/service plan;
- Participation in efforts by the State to prevent, detect and remediate critical incidents, including in LTSS services and programs; and
- Contributions to health-related resources that can support or align with broader improvement in particular health outcomes such as through engagement with the Department around understanding state performance on the Behavioral Risk Factor Surveillance System (BRFSS) survey.

In order for the Department to monitor and ensure the accuracy of integrated managed care plan reporting and assess performance against quality measures on a plan-specific and program-wide basis (as described in Section V(A)), Standard Plans and Tailored Plans must:

- Provide all quality data designated for plan reporting at least annually to the Department and the EQRO, or more frequently if specified;
- Provide all accreditation reports; and
- Provide all information required by the EQRO, in compliance with the protocols set forth by CMS for the EQRO activities outlined in Appendix D.[23]

The Department and the EQRO will conduct assessments to oversee Standard Plans and Tailored Plans' performance against the quality Aims, Goals, and Objectives, and measures further described in Section II(B). In addition, Standard Plans and Tailored Plans are required to develop a process to evaluate the impact and effectiveness of their own QAPIs. A description of this process must be submitted to and approved by the Department with submission of the QAPI and be closely aligned to this Quality Strategy.

Further, Standard Plans and Tailored Plans are required to participate in ongoing cross-industry meetings with the Department and Quality Directors designed to exchange and build upon identified best practices. Participants in the meetings will discuss emerging issues and plans for upcoming projects. Plans are also required to participate in an annual Quality Improvement Collaborative. The Quality Subcommittee (described in Section III(B)) serves as a key Department interface with plans, and is driven by the data collected throughout the assessment processes (described in Section V).

The CFSP is required to submit an annual QAPI plan, delineating the CFSP's plans for performance improvement programs and other quality improvement efforts. The CFSP shall address any Department concerns regarding performance against quality measures directly through the QAPI Plan, and, as applicable, build specific programs to improve quality performance into the QAPI Plan.[24]

The EBCI Tribal Option also has distinct quality elements. The EBCI Tribal Option will establish a Quality Committee to oversee quality of care for members and has a designated Quality Director who is

[23] CMS protocols for EQRO-related activities are available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html.

[24] More information is forthcoming on CFSP QAPI requirements.

responsible for all PCCM quality management and quality improvement activities. The EBCI Tribal Option will also submit an annual Quality Improvement Plan to the Department for review and approval.

The EQRO shall also provide oversight to CCNC (PCCM).

1. Performance Improvement Projects (PIPs)[25]

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

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

Standard Plans are required to conduct at least two PIPs annually, which must be approved by the Department. The State may also mandate PIPs to support statewide priorities. Mandatory clinical PIPs in Years 1 and 2 include:

- Diabetes prevention (i.e. Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%))
- Immunizations (i.e. Childhood Immunization Status (Combo 10))
- *New in Year 2:* Prenatal care (i.e. Timeliness of Prenatal Care: Prenatal and Postpartum)

Tailored Plans must conduct at least three PIPs, which must be approved by the Department and include:[26]

- One or more clinical PIP(s), for which the Department may direct Tailored Plans to focus on a specific topic, or where Tailored Plans may be able to select a topic of their choice from the following areas:
    - Maternal health
    - Tobacco cessation
    - Diabetes prevention
    - Birth outcomes
    - Early childhood health and development
    - Hypertension
    - Behavioral-physical health integration
- One or more clinical PIP(s) on the topic of diversion, in-reach, and/or transition for populations in or at risk of entrance into institutional or Adult Care Home (ACH) settings.
- One or more non-clinical PIP(s), which must be aligned to the Aims, Goals, Objectives and interventions outlined within this Quality Strategy.

For Year 1, Tailored Plans are required to develop PIPs related to:

[25] CMS has not specified standard, nationally required PIPs to date.
[26] Form CMS-416 is a required annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) evaluation and participation performance report for state Medicaid agencies to assess the effectiveness of EPSDT services.

- Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
- Follow-up After Hospitalization for Mental Illness: 7 and 30-day
- Clinical PIP, which must be related to diversion, in-reach and/or transition for populations in or at risk of entrance into institutional settings or ACH settings.

See Appendix C for Standard Plan PIP topics, aims and interventions from Calendar Year 2021.

In addition to the required PIPs, if a Standard Plan or Tailored Plan performs below 75% for overall EPSDT screening rates, the plan will be required to submit an additional PIP on EPSDT screening and community outreach plans.

Standard Plans and Tailored Plans will be required to report the status and results of each PIP conducted no less than once annually, as specified; these results, as noted in this section and Section V(A), will be validated by the EQRO and reviewed by the Department. As part of required PIP reporting, Standard Plans and Tailored Plan must describe the details of interventions used to address the issues PIPs focus on, including a description of how improvement strategies/interventions will promote health equity.

The CFSP will be required to complete at least five performance improvement projects (PIPs) each coverage year, with a minimum of one PIP in the non-clinical category, two PIPs in the clinical category, and two PIPs in the transitions and continuity of care category. For its clinical PIP(s), the CFSP must consider how innovative use of care management can contribute to clinical performance improvement. The Department will conduct oversight and monitoring of the CFSP and will convene monthly meetings with the Plan quality director to discuss opportunities for performance improvement.

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

The CCNC PCCM establishes PIPs in the event that any performance measure (see Appendix A, Table 12) fails to achieve its designated benchmark value due to preventable gaps in care. Behavioral Health and I/DD Services for Medicaid Direct PIPs will be restricted to measures for which the plan collects all required data elements.

(B) The Department's Quality Management and Improvement Structure

The Department's Quality Management approach is designed to measure and monitor plan performance against plan requirements through Quality Assurance, Quality Improvement and Innovation activities for all enrollees, including those with Special Health Care Needs.[27] Through the Quality and Population Health

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

- Children with special health care needs are those who have or are at increased risk of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child's age. This includes, but is not limited to, children or infants in foster care; requiring care in the Neonatal Intensive Care Units (NICU); with neonatal abstinence syndrome; in high stress social environments/toxic stress; receiving Early Intervention; with an SED, I/DD, or SUD diagnosis; and/or receiving 1915i, Innovations, or TBI waiver services.
- Adults with special health care needs are those who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for individuals of similar age. This includes, but is not limited to, individuals

Department, the Department monitors and reviews plan performance across quality efforts. The Department will leverage internal Quality Committee, Quality Subcommittee of the MCAC, and the Statewide Consumer and Family Advisory Committee (SCFAC) to support key decision-making and ongoing assessment of plan performance against the Aims, Goals and Objectives previously noted. The MCAC includes plan representatives, providers, and other stakeholders, such as beneficiaries. All MCAC meetings, including all MCAC Quality Subcommittee meetings, are open to the public. The Department invites all organizations and stakeholders to attend the meetings, including those representing the interests of different population groups such as children and North Carolina's aging network (e.g., Area Agencies on Aging, human services organizations and community-based organizations). The MCAC Quality Subcommittee is charged with the following responsibilities:

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

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

(C) Interventions

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

1. Opioid and SUD Strategy

As in many states, North Carolina's opioid epidemic continues to evolve into a more deadly and complicated epidemic of polypharmacy and illicit drug overdose. The Quality Strategy, in recognition of this crisis, includes a specific Objective (Objective 5.2) related to addressing the opioid crisis, as well as broader Objectives tied to behavioral health, including SUD. North Carolina's Medicaid opioid and SUD strategy builds on the NC Opioid and Substance Use Action Plan, which was first released in 2017 and updated in June 2019 and May 2021. North Carolina's Opioid and Substance Use Action Plan (OSUAP) 3.0 updates the 2019 plan to include a broadened focus on polysubstance use as well as centering equity and lived experiences to ensure that strategies addressing the overdose epidemic are led by those closest to

with HIV/AIDS; with an SMI, SED, I/DD, or SUD diagnosis (including opioid addiction); suffering chronic pain; or receiving 1915(b)(3), Innovations, or TBI waiver services.

the issue.[28] Further, the state's 1115 SUD demonstration, approved in April 2019, expands access to the full American Society of Addiction Medicine (ASAM) continuum of care, including residential treatment.[29]

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

- Prevention strategies include establishing quantity limits; supporting and promoting safer prescribing of opioids; increasing access to Screening, Brief Intervention, and Referral to Treatment (SBIRT); and management of acute and chronic pain with opioid-sparing pharmacologic, non-narcotic pharmacologic, and non-pharmacologic modalities.
- Standard Plans and Tailored Plans will also be required to increase access to SUD treatment, including medication-assisted treatment, and support programs focused on treatment and transport to alternative sites of care for individuals with SUD.

To ensure that enrollees with SUD are linked to care that meets their needs, Standard Plans and Tailored Plans will conduct care needs screenings to identify enrollees with SUD and coordinate SUD treatment across all levels of care, as well as recovery and other supports. Care managers will also be required to ensure that enrollees with SUD understand how they can access naloxone and other harm-reduction supports. The EBCI Tribal Option also screens to identify individuals with SUD needs and coordinates SUD treatment.

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

2. Healthy Opportunities Strategy[30]

Central to the State's effort to improve access, quality and timeliness of care is a commitment to address the social and environmental factors that directly affect health outcomes and cost and promote "Healthy Opportunities" for North Carolinians. While access to high-quality medical care is critical, research shows that 80% of a person's health is determined by social and environmental factors and the behaviors that emerge as a result.[31,32]

[28] More information is available here: https://www.ncdhhs.gov/about/department-initiatives/overdose-epidemic/north-carolinas-opioid-and-substance-use-action-plan

[29] In January 2022, the state submitted a request to amend the 1115 waiver to extend the demonstration to 2026 and make additional changes to the program. More detail is available here: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nc-medicaid-reform-demonstration-amendment-pa.pdf

[30] More information about the Healthy Opportunities Pilots is available here: https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots

[31] Linkins KW, Brya JJ, Chandler DW. Frequent users of health services initiative: final evaluation report. 2008; Institute of Medicine. 2015. Capturing Social and Behavioral Domains and Measures in Electronic Health Records: Phase 2. Washington, DC: National Academies Press.

[32] McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. Health Aff (Millwood) 2002;21:78–93; Galea S, Tracy M, Hoggatt KJ, Dimaggio C, Karpati A. Estimated deaths attributable to social factors in the United States. Am J Public Health. 2011;101:1456–65.

The Department is addressing the social drivers of health (SDOH) – "the conditions in which people are born, grow, live, work and age."[33] Stakeholder feedback has consistently cited food insecurity, housing instability and transportation challenges as critical barriers to health, as well as other risks important to underlying health status, such as interpersonal violence and trauma. These and other social factors disproportionately impact Medicaid beneficiaries, increasing the risk that patients will develop chronic conditions and drive cost.

To address these challenges, the Department is embedding strategies to promote Healthy Opportunities into its Medicaid program in several ways, including but not limited to:[34]

- Deploying a standardized set of screening questions related to food insecurity, housing instability, transportation needs, interpersonal violence and toxic stress, which Standard Plans and Tailored Plans will be required to use when screening Medicaid beneficiaries upon enrollment in the plan. Responses to the screening questions will support the plan's efforts to identify and assist members with unmet health-related resource needs. Standard Plans and Tailored Plans' screening rates constitute a quality measure noted in Section II(B) and Appendix A.[35] The EBCI Tribal Option will also use the state's standard screening questions within the EBCI Tribal Option's comprehensive assessment.
- Embedding strategies to address the identified unmet health-related resource needs of beneficiaries by ensuring Standard Plans and Tailored Plans assist in securing health-related services and supports resource navigation.
- Building a statewide coordinated care network (NCCARE360) to electronically refer beneficiaries with identified needs to community resources – and allow for a feedback loop on the outcome of that connection.
- Creating an interactive statewide map of SDOH indicators that can guide community investment and prioritize resources.
- Designing and launching Healthy Opportunities Pilots to test and evaluate the impact of providing select evidence-based, non-medical interventions related to housing, food, transportation, and interpersonal safety to a subset of high-needs enrollees. Standard Plans and Tailored Plans will play a key role in administering the pilots, including identifying beneficiaries who may benefit from pilot services and authorizing those services in pilots that are operational in the region(s) they serve.

Standard Plans and Tailored Plans are responsible for promoting Healthy Opportunities outside of the initiatives listed above. Standard Plans and Tailored Plans also are responsible for reporting on unmet health-related resource needs among beneficiaries and efforts to address identified unmet needs. In subsequent years, additional measures will be developed that assess rates of successful resource linkage and, eventually, improvements tied to addressing unmet resource needs.

[33] Michael Marmot et al., "Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health," The Lancet 372, no. 9650 (Nov. 8, 2008):1661–1669.

[34] Certain SDOH initiatives are pending waiver authority; for more information, see https://www.ncdhhs.gov/news/press-releases/dhhs-submits-amendment-medicaid-waiver-application.

[35] Over time, other measures related to this screening may be added, such as the percent of enrollees screened who are high risk and are referred for unmet social needs and/or the percentage of enrollees screened who are high risk and have at least one goal related to SDOH in their care plan.

The CFSP will also be responsible for implementing the Healthy Opportunities Pilot program for its Pilot-eligible members, in accordance with Department requirements. Integrating with the Healthy Opportunities initiative will be especially critical to former foster youth under age 26 navigating the challenges of young adulthood; parents, guardians and custodians whose children are in the custody of Department of Social Services (DSS) or EBCI Family Safety Program; and families who are receiving CPS In-Home services.

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

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

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

- AMH Tier 1 and Tier 2: Standard Plans have primary responsibility for care management functions. Tier 1 and Tier 2 practices are required to closely coordinate with their contracted Standard Plan(s) in the delivery of care management functions.
- Tier 3: AMH Tier 3 practices lead in organizing and delivering care management services for their Standard Plan members. Care management oversight and support is provided by the Standard Plans with which they contract. Tailored Plans will provide care management oversight and support for AMH Tier 3 practices who become certified to provide Tailored Care Management (described further below). It is expected that Tier 3 practices will perform these functions in partnership with third-party partners they will select.

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

AMH Tier 3 practices are eligible to earn negotiated Performance Incentive Payments based on the set of measures in Appendix A, Table 8a, which were selected for their relevance to primary care and care coordination. Standard Plans are required to offer opportunities for such payments to Tier 3 AMHs, and may, at their discretion, offer them to AMH Tier 1 and 2 practices. For more information on practice-level quality measurement, please refer to the North Carolina Medicaid Quality Measurement Technical Specifications Manual for Standard Plans and Tailored Plans.[36]

Standard Plan Care Management Model

Standard Plans play a crucial role in monitoring care management activities. They take responsibility for managing the care of any beneficiary not enrolled in an AMH, for whom the AMH is not able to meet their

[36] Available here: https://medicaid.ncdhhs.gov/quality-management-and-improvement

needs, or for whom a local care manager is not available. Standard Plans are further required to assume care management functions that augment what AMHs can provide directly, and are incentivized to achieve Department-determined thresholds for the provision of care management at the local level.

AMH certification for practices contracting with Standard Plans was initially based on the Carolina ACCESS program, with placement into three tiers based on practices' ability to assume care management functions at the practice or local levels. Over time, standards for select tiers may evolve to encompass other advanced primary care functions, such as integration of behavioral health services.

Tailored Care Management Model

The Department expects Tailored Plans to meet additional, more intensive standards related to the unique aspects of their population, such as federal health home requirements and requirements related to North Carolina's 1915(c) waiver, while maintaining all standards relevant to the Standard Plans. Goals for Tailored Plan care management—called the Tailored Care Management model—include working with the Tailored Plan population to improve functional status, maximize community inclusion, and improve quality of life. To meet the care management needs of the Tailored Plan population, the AMH program's design has been modified to include two designations called "Advanced Medical Home Plus" (AMH+) and "Care Management Agency" (CMA), which will act as the provider-based sites for care management. AMH+ practices are Tier 3 AMHs with demonstrable experience serving the Tailored Plan population and which successfully apply for and are certified to provide Tailored Care Management.[37] CMAs are largely behavioral health, I/DD, or TBI providers with demonstrable experience serving the Tailored Plan population that successfully apply for and are certified to provide Tailored Care Management.

> More information on the model is available on the Tailored Care Management homepage.

CFSP Care Management Model

Following CFSP launch, members will have access to robust care management directed by the CFSP. Under the CFSP care management model, the CFSP will serve as the central point of accountability for managing the health of members and ensuring access to needed physical and behavioral health services, as well as health-related services, regardless of geographic location or type of transition the member is experiencing.[38]

4. Maternal and Infant Health

North Carolina is nationally known for its 1) high participation rate of perinatal providers in the Medicaid program; 2) approach to high-risk pregnancy management; and 3) its success in reducing maternal and child health disparities.

In November 2021, North Carolina's biennial budget, approved by the NC General Assembly and signed into law by Governor Cooper, included a new benefit providing 12 months of continuous postpartum

[37] The Provider Manual for Tailored Care Management is available at: https://medicaid.ncdhhs.gov/media/11306/download?attachment

[38] More information on the CFSP care management approach is available at: https://medicaid.ncdhhs.gov/beneficiaries/children-and-families-specialty-plan#:~:text=About%20the%20Children%20and%20Families,treatment%20plans%20when%20placements%20change

coverage to eligible Medicaid beneficiaries at or below 196% FPL. Starting April 1, pregnant people will have coverage for full Medicaid benefits beyond the maternity-focused benefits previously included in the Medicaid for Pregnant Women (MPW) program. The extended coverage is currently authorized for birth events that occur through March 2027.[39]

The Pregnancy Management Program (PMP) seeks to improve maternal health and birth outcomes via alignment of practice requirements, incentives, and quality reporting for perinatal providers and across Standard Plans and Tailored Plans. At the practice level, the initiative consists of financial incentives tied to use of a standardized screening tool and postpartum follow-up,[40] standard contracting requirements (e.g., commit to maintaining or lowering the rate of elective delivery prior to 39 weeks), quality measures, quality improvement activities and provider engagement activities.

The State provides care for high-risk pregnant women through the Care Management for High-Risk Pregnancies (CMHRP) program, which is the primary vehicle for delivering care management to pregnant women who may be at risk for adverse birth outcomes. Pregnant women may be referred into the program by maternity or other providers through use of the standardized screening tool or identified through claims analysis. While retaining oversight and accountability for outcomes, Standard Plans and Tailored Plans are required to contract with Local Health Departments (LHDs) or other local care management entities to provide care/case management services to identified high-risk pregnant women.[41]

Managed care plans are also permitted to develop their own maternity programs, to complement the required programs noted above.

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

Managed care plan performance is linked to the Quality Strategy through the quality measures noted in Section II(B) and Appendix A, Tables 8-10, which target specific maternal health outcomes. Standard Plans and Tailored Plans will also be accountable for performance on select process and quality improvement measures.

5. Care Management for At-risk Children

North Carolina has long been committed to supporting children who were exposed to toxic stress in early childhood or otherwise have complex social or health needs. The Care Coordination for At-Risk Children (CMARC) program serves children from birth to age 5 who meet specific risk criteria, providing them with a comprehensive health assessment and dedicated case management services. Consistent with the goals

[39] More information is available here.
[40] At the start of managed care, Standard Plans and Tailored Plans are required to pay practices $50 for every risk screening tool completed at the initial visit, and $150 for every postpartum visit. Additionally, Standard Plans and Tailored Plans must provide an increased rate for vaginal deliveries.
[41] More information about the program is available here: https://medicaid.ncdhhs.gov/care-management/care-management-high-risk-pregnancies-cmhrp

of this Quality Strategy, the program aims to improve health outcomes and reduce costs for enrolled children.[42]

In managed care, Standard Plans are responsible for care management for high-risk young children and are required to preserve the strengths of the current model, which integrates social supports and provides local care/case management services. While retaining oversight and accountability for outcomes, Standard Plans are required to contract with LHDs for the provision of CMARC services.[43]

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

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

6. Integrated Care for Kids (InCK) Model

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

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

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

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

[42] More information on the program is available here: https://medicaid.ncdhhs.gov/care-management/care-management-risk-children-cmarc

[43] For a three-year transitional period (November 2019–July 2022), Standard Plans will be required to extend to LHDs the "right of first refusal" as contracted providers of CMHRP and CMARC. Tailored Plan-eligible children ages 0–5 who are already enrolled in CMARC at the time of the Tailored Plan launch will continue to receive CMARC through the CMARC transition period. However, children who meet eligibility criteria for CMARC after the Tailored Plan launch will receive similar care management through the new Tailored Care Management model.

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

Within NC InCK, quality of care is measured and improved using both standard health care measures (e.g., proportion of children receiving well-child checks) and novel cross-sector well-being measures (e.g., kindergarten readiness, food insecurity, housing instability).[44] To link incentive payments to meaningful measures of child well-being, InCK will include an alternative payment model (APM), InCK Foundation. The initial quality measurement period will begin in January 2023 and run through December 2023.

7. Provider Supports

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

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

8. Telehealth, Virtual Patient Communications and Remote Patient Monitoring

As the Medicaid program transitions to managed care, telehealth, virtual patient communications and remote patient monitoring will play a crucial role in increasing beneficiary access to care, improving outcomes and decreasing costs. Standard Plans and Tailored Plans may provide services via telehealth, virtual patient communications and remote patient monitoring to Medicaid and NC Health Choice Members as an alternative service delivery model when clinically appropriate and in compliance with all state and federal laws.[45]

[44] See Appendix A, Table 13. The novel Primary Care Kindergarten Readiness Promotion Bundle encourages providers to promote kindergarten readiness by implementing at least five of twelve designated interventions within a primary care visit. Examples of activities promoted through the bundle include office-based literacy promotion, developmental screening, and referral to Pre-K. In addition, a new set of three measures aims to promote screening for food- and housing-related needs and track rates of food insecurity and housing instability. Providers will begin implementing these activities and billing practices in late 2022.

[45] The 1-H Telehealth, Virtual Patient Communications and Remote Patient Monitoring Policy can be found at:

The EBCI Tribal Option also delivers services via telehealth.

9. Value-based Payment (VBP)

To ensure payments to providers are increasingly focused on population health outcomes, appropriateness of care and other measures of value, rather than on a fee-for-service basis, the Department encourages accelerated adoption of VBP arrangements between plans and providers.

Standard Plans and Tailored Plans are required and incentivized to develop and lead innovative strategies to increase the use of VBP arrangements over time – including arrangements that appropriately incentivize providers – and are required to submit their VBP strategies to the Department and report on their use of VBP contracting arrangements each year. In addition, by the end of Year 2 of operations, the portion of each Standard Plan's medical expenditures governed under VBP arrangements must either increase by 20 percentage points or represent at least 50% of total medical expenditures. The Department has defined VBP – for the first two years of plan operations – as payment arrangements that meet the criteria of the Health Care Payment (HCP) Learning and Action Network (LAN) Advanced Payment Model (APM) Categories 2 through 4.[46,47] The Department may set VBP contracting targets for Tailored Plans in the future.

The Department continues to develop a longer-term VBP roadmap and vision, and is working with stakeholders to assess plans' advancements to date and opportunities to align VBP arrangements across payers and in accordance with statewide priorities. Providers, payers, policy experts and patient advocates will all play an instrumental role in developing an achievable but ambitious VBP vision in North Carolina, with specific goals for value-based payment initiatives in future years.

10. Accreditation

As a key component of ensuring that Standard Plans and Tailored Plans are held to consistent, current standards for quality access and timeliness of care, Standard Plans and Tailored Plans are required to attain Health Plan Accreditation with LTSS distinction from the National Committee for Quality Assurance (NCQA) within the first three years of operations (2024 for Standard Plans and 2025 for Tailored Plans).

Although plans are not required to achieve accreditation until the third year of operations, they must meet key accreditation milestones starting in Contract Year One, including:

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

The Department aims to avoid duplication and inconsistency in quality functions completed across the accrediting body, EQRO, and Department-related to plan operations, quality measurement and assessment, and compliance with Department standards. Following Standard Plan and Tailored Plan

https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/telemedicine-and-telepsychiatry-clinical-coverage-policies.

[46] For more information on the HCP-LAN APM framework, refer to: https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

[47] North Carolina will require Standard Plans and Tailored Plans to conduct an annual assessment using the HCP-LAN assessment form, available online at https://hcp-lan.org/workproducts/National-Data-Collection-Metrics.pdf

accreditation, the Department will streamline these activities and, where appropriate, exercise the option to use information provided by the accreditation reports to avoid duplication of mandatory activities as permitted by 42 CFR 438.360.

11. Promoting Health Equity

The Department expects all entities delivering health care services to Medicaid beneficiaries to ensure improvements in quality performance are equitably distributed, including across racial and ethnic groups. The Department requires Standard Plans and Tailored Plans to participate in activities around disparities reduction, and beginning in the third contract year, will hold them financially accountable for ensuring equity in improvements for selected quality measures.

Standard Plans and Tailored Plans are directed to report across select measures by select strata, including by age, race, ethnicity, sex, primary language, and disability status, as well as by key population groups (e.g., LTSS, Transitions to Community Living (TCL)) and by geography (county), where feasible (discussed further in Section V(A)(1)). In evaluating plan performance on these measures, the Department will assess whether the disparities have narrowed through improving performance specifically for the subpopulation experiencing the disparity, in addition to considering overall performance improvement. The Department's approach to analyzing performance improvement for quality measures overall and with respect to disparities is described in detail in the Technical Specifications.[48]

Through a unique partnership, the Department and the EBCI are working together to assist the Tribe in addressing the health needs of American Indian/Alaskan Native beneficiaries and to raise their health status to the highest possible level through creation of a first-in-the nation Indian Managed Care Entity, the EBCI Tribal Option.

Annually, the EQRO will prepare a health equity report documenting progress toward the goal of reducing disparities and sharing the health plans stratified quality performance. The EQRO will identify disparities most closely associated with disparate health outcomes, and will incorporate rewards for reducing or eliminating these disparities into the withhold measure set as soon as feasible.

(D) Health Information Technology

North Carolina's Health Information Technology (HIT) system and initiatives support the overall Quality Strategy. The State's HIT strategy spans all stakeholders and takes into consideration current and future plans, policies, processes and technical capabilities.[49] The Department is responsible for ensuring its information technology vendors are communicating and coordinating with the Department and with each other to create a successful and well-integrated system.

Data will play a crucial role in North Carolina's Medicaid transformation, including driving a continuous quality improvement process. In support of the overall strategy to improve the quality of care, the Department is leveraging existing technology tools and considering new capabilities. These tools and new capabilities will help clinicians and care managers access a range of information, including patient-level data, alerts on hospital admissions/discharges, patient assessments, risk stratification, care plans, and

[48] Available here: https://medicaid.ncdhhs.gov/quality-management-and-improvement
[49] More information is available at: https://medicaid.ncdhhs.gov/media/4892/open; and https://www.ncdhhs.gov/media/8657/download

social determinants. The Department is consulting with stakeholders to establish communication between parties involved in encounter data exchange and to plan other types of information exchange and required reporting.

Another crucial component of the state's HIT initiative is ongoing work with North Carolina's Health Information Exchange Authority's (HIEA) and continued development of NC HealthConnex, North Carolina's statewide health information exchange. Through NC HealthConnex, the Department envisions that plans will access clinical data needed for quality measurement instead of collecting data directly from providers. This will significantly reduce providers' workload as they will only be required to submit clinical data to NC HealthConnex as opposed to reporting clinical data to multiple PHPs and to the Department. NC HealthConnex data will be used to improve the Department's understanding of specific care needs such as maternal care pathways and to identify risk factors for poor maternal and birth outcomes like maternal mortality, low birth weight, and infant mortality. Additionally, HealthConnex will serve as a central point for providers to access and make decisions based on beneficiaries' clinical records, particularly during transition between plans or managed care/NC Medicaid Direct, to ensure that beneficiaries do not have interruptions in essential services during these transitions.

The Department is currently working with NC HealthConnex to:

1. Provide an extract that contains clinical data elements needed to run hybrid quality measures on an annual basis. The extract will be transferred to DHB's analytic environment so it can be joined with claims and pushed to CareAnalyzer, the NCQA certified vendor that produces NC Medicaid's annual HEDIS measures.
2. Develop and enhance dashboards utilizing aggregated clinical and non-claims data (e.g. provider-specific, multi-payor (managed care, NC Medicaid) dashboard to track quality, outpatient, inpatient and ED utilization, COVID-19 dashboard).
3. Foster a hub for exchange of essential population health data for care management including care plans, clinical assessments, patient risk lists, patient registries and patient attribution lists.
4. Ensure that all Medicaid providers with the capacity to do so, including labs, registries and long-term care facilities are submitting complete, accurate data to the HIEA.
5. Produce an initial set of prioritized Electronic Clinical Quality Measures:
    - Controlling High Blood Pressure[50]
    - Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)[51]
    - Preventive Care and Screening: Screening for Depression and Follow-Up Plan[52]
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents[53]

NC HealthConnex works with DHB to ensure that clinical data elements critical to the proposed Admission, Discharge and Transfer (ADT) monitoring system are clearly defined and that there is a plan to

[50] More information on the eCQM: Controlling High Blood Pressure is available at: https://ecqi.healthit.gov/ecqm/ec/2021/cms165v9
[51] More information on the eCQM: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) is available at: https://ecqi.healthit.gov/ecqm/ec/2021/cms122v9
[52] More information on the eCQM: Preventive Care and Screening: Screening for Depression and Follow-Up Plan is available at: https://ecqi.healthit.gov/ecqm/ec/2021/cms002v10
[53] More information on the eCQM: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents is available at: https://ecqi.healthit.gov/ecqm/ec/2022/cms155v10

systematically incentivize providers to use feedback to continuously improve the accuracy and completeness of these fields.

The Department, Standard Plans, Tailored Plans and the EBCI Tribal Option will access clinical data needed for quality measurement through NC HealthConnex, reducing providers' workload. Plans, the EBCI Tribal Option and AMHs can share clinical information on patients enrolled in a variety of care management and population health programs improving coordination of care for patients and reducing administration burden for providers and plans.

Last, as part of quality reporting efforts, NC HealthConnex participates in NCQA's Data Aggregator Validation program, which validates NC HealthConnex as an independent source of truth for all the quality measures that plans are required to produce, acting as an independent assessor in instances when measures are under dispute.[54]

IV. State Standards for Access, Structure, and Operations for Standard Plans and Tailored Plans

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

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

- The CAHPS Plan Survey (Adult 5.0, Children 5.0), which assesses beneficiaries' perceptions of care;
- A standard provider survey tool, which measures provider satisfaction.

[54] More information on NCQA's Data Aggregator Validation program is available at: https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/hedis-compliance-audit-certification/data-aggregator-validation/

(A) State Access Standards

1. Network Adequacy Standards[55,56]

Standard Plans and Tailored Plans are expected to maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to all services covered under the Medicaid and NC Health Choice programs for all beneficiaries, including those with limited English proficiency or with physical or mental disabilities, based on standards developed by the Department. Parameters include time and distance requirements and cannot be provided exclusively through telehealth or remote services. To recognize the special needs of accessibility to behavioral health services, the standards include specific measurements for those services. Per federal regulations at 42 CFR 438.68, plan networks must meet network adequacy standards developed by the State and published online. Network adequacy standards are important tools for ensuring that beneficiaries have access to providers and care. North Carolina's network adequacy standards vary by geographic area and include **time and distance standards**, for providers who serve adult and pediatric beneficiary needs, as described in Table 2 below, and **appointment wait-time standards**, as described in Tables 2-6.

Table 2. Network Adequacy Standards: Time and Distance Standards for Adults and Children

Time/Distance Standards for Medicaid

	Standard Plan		Tailored Plan	
Service Type	**Urban Standard**	**Rural Standard**	**Urban Standard**	**Rural Standard**
Primary Care	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members
Specialty Care	≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members	≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members	≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members	≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members
Hospitals	≥ 1 hospitals within 30 minutes or 15	≥ 1 hospitals within 30 minutes or 30 miles for at least 95% of members	≥ 1 hospitals within 30 minutes or 15 miles for at least 95% of members	≥ 1 hospitals within 30 minutes or 30 miles for at least 95% of members

[55] CFSP network adequacy standards generally align with the Standard Plan and Tailored Plan time and distance requirements, amended in certain instances to meet minimum statewide contracting standards in place of regional standards set forth in the Standard Plan and Tailored Plan contracts for certain provider types. The CFSP will have an "any willing provider" network for all services except intensive in-home services, multisystemic therapy, residential treatment services and PRTFs (subject to legislative authority). For more information, please see the policy paper here: https://medicaid.ncdhhs.gov/media/10893/download?attachment

[56] The Behavioral Health and I/DD Services for Medicaid Direct PIHP will be subject to the same network adequacy requirements for covered services as Tailored Plans. The Department is in the process of developing network adequacy requirements for the 1915(i) benefits which will apply to both Tailored Plans and PIHP contracts.

	Standard Plan		Tailored Plan	
Service Type	**Urban Standard**	**Rural Standard**	**Urban Standard**	**Rural Standard**
	miles for at least 95% of members			
Pharmacies	≥ 2 pharmacies within 30 minutes or 10 miles for at least 95% of members	≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of members	≥ 2 pharmacies within 30 minutes or 10 miles for at least 95% of members	≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of members
Obstetrics[57]	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members
Occupational, Physical, or Speech Therapists	≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of members	≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of members
Outpatient Behavioral Health Services	≥ 2 providers of each outpatient behavioral health service within 30 minutes or 30 miles of residence for at least 95% of Members	≥ 2 providers of each outpatient behavioral health service within 45 minutes or 45 miles of residence for at least 95% of members	• ≥ 2 providers of each outpatient behavioral health service within 30 minutes or 30 miles of residence for at least 95% of members • Research-based behavioral health treatment for Autism Spectrum Disorder (ASD): Not subject to standard •	• ≥ 2 providers of each outpatient behavioral health service within 45 minutes or 45 miles of residence for at least 95% of members • Research-based behavioral health treatment for Autism Spectrum Disorder (ASD): Not subject to standard •
Location-Based Services	≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of Members	≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of Members	• Psychosocial rehabilitation, Substance Use Comprehensive Outpatient Treatment, Substance Use Intensive Outpatient	• Psychosocial rehabilitation, Substance Use Comprehensive Outpatient, Substance Use Intensive Outpatient Program, and Outpatient Opioid

[57] Measured on members who are female and age 14 or older. Certified nurse midwives may be included to satisfy OB/GYN access requirements.

	Standard Plan		Tailored Plan	
Service Type	**Urban Standard**	**Rural Standard**	**Urban Standard**	**Rural Standard**
			Program, and Outpatient Opioid Treatment (OTP): ≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members • Child and Adolescent Day Treatment Services: Not subject to standard	Treatment (OTP): ≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of members • Child and Adolescent Day Treatment Services: Not subject to standard
Crisis Services	≥ 1 provider of each crisis service within each Standard Plan region		• Professional treatment services in facility-based crisis program: The greater of: o 2+ facilities within each Tailored Plan Region, OR o 1 facility within each Tailored Plan Region per 450,000 total regional population (total regional population as estimated by combining NC Office of State Budget and Management county estimates) • Facility-based crisis services for children and adolescents: ≥ 1 provider within each Tailored Plan Region • Non-hospital medical detoxification: ≥ 2 providers within each Tailored Plan Region • Ambulatory detoxification, ambulatory withdrawal management with extended on-site monitoring, clinically managed residential withdrawal: ≥ 1 provider of each crisis service within each Tailored Plan Region • Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization: Not subject to standard	
Inpatient Behavioral Health Services	≥ 1 provider of each inpatient behavioral health service within each Standard Plan region		≥ 1 provider of each inpatient behavioral health service within each Tailored Plan region	
Partial Hospitalization	≥ 1 provider of partial hospitalization	≥ 1 provider of partial hospitalization	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles	≥ 1 provider of partial hospitalization within 60

	Standard Plan		Tailored Plan	
Service Type	**Urban Standard**	**Rural Standard**	**Urban Standard**	**Rural Standard**
	within 30 minutes or 30 miles for at least 95% of members	within 60 minutes or 60 miles for at least 95% of members	for at least 95% of members	minutes or 60miles for at least 95% of members
Community/ Mobile Services	N/A		≥ 2 providers of community/mobile services within each Tailored Plan Region. Each county in Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients.	
All State Plan LTSS (except nursing facilities)	≥2 LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services, and hospice services), identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.	≥2 providers accepting new patients available to deliver each State Plan LTSS in every county; providers are not required to live in the same county in which they provide services.	≥ 2 LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services, and hospice services), identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.	
Nursing Facilities	≥ 1 nursing facility accepting new patients in every county		≥ 1 nursing facility accepting new patients in every county.	

Residential Treatment Services	N/A		• Residential Treatment Facility Services: Access to ≥ 1 licensed provider per Tailored Plan Region,
			• Substance Use Medically Monitored Residential Treatment: Access to ≥ 1 licensed provider per Tailored Plan Region (refer to 10A NCAC 27G.3400)
			• Substance Use Non-Medical Community Residential Treatment:
			  ○ Adult: Access to ≥ 1 licensed provider per Tailored Plan Region (refer to licensure requirements to be determined by the Department)
			  ○ Adolescent: Contract with all designated CASPs within the Tailored Plan's Region	

	Standard Plan		Tailored Plan	
Service Type	**Urban Standard**	**Rural Standard**	**Urban Standard**	**Rural Standard**
			○ Women & Children: Contract with all designated CASPs within the Tailored Plan's Region • Substance Use Halfway House: ○ Adult: Access to ≥1 male and ≥1 female program per Tailored Plan Region (Refer to 10A NCAC 27G.5600E)[58] ○ Adolescent: Access to ≥1 program per Tailored Plan Region (Refer to 10A NCAC 27G.5600E) • Psychiatric Residential Treatment Facilities (PRTFs) & Intermediate Care Facilities for individuals with intellectual disabilities ICF-IID: Not subject to standard	
1915(c) Health and Community Based Services (HCBS) Waiver Services: NC Innovations	N/A		• Community Living & Support, Community Navigator, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living: ≥ 2 providers of each Innovations waiver service within each Tailored Plan Region. • Crisis Intervention & Stabilization Supports, Day Supports, Financial Support Services: ≥ 1 provider of each Innovations waiver service within each Tailored Plan Region. • Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Individual Directed Goods and Services, Natural Supports Education, Specialized Consultation, Vehicle Modification: Not subject to standard	
1915(c) HCBS Waiver Services: NC TBI Waiver (applicable to TBI Waiver participating counties only)	N/A		• Community Networking, Life Skills Training, Residential Supports, Resource Facilitation, In-Home Respite, Supported Employment: ≥ 2 providers of each TBI waiver service within each Tailored Plan Region. • Day Supports, Cognitive Rehabilitation, Crisis Intervention & Stabilization Supports: ≥ 1 provider of each TBI waiver service within each Tailored Plan Region. • Adult Day Health, Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Natural Supports Education, Occupational Therapy,	

[58] Tailored Plans must also ensure that gender non-conforming recipients have access to substance use halfway house services.

	Standard Plan		Tailored Plan	
Service Type	**Urban Standard**	**Rural Standard**	**Urban Standard**	**Rural Standard**
			Physical Therapy, Speech and Language Therapy, Vehicle Modification: N/A	

Standard Plan Access Standards for Medicaid

Primary Care Access Standards: "Primary care" means basic or general health care provided by a medical professional (such as a general practitioner, pediatrician, or nurse) with whom a patient has initial contact and by whom the patient may be referred to a specialist.

Table 3. Standard Plan and Tailored Plan Access Standards for Primary Care

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

Table 4. Access Standards for Prenatal Care

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

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

Table 5. Standard Plan and Tailored Plan Access Standards for Specialty Care

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

Behavioral Health Care Access Standards: "Behavioral health care" means health care services and treatment provided in the community for behavioral disorders and/or SUDs. Standard Plans and Tailored Plans cover certain behavioral health care services for individuals with mild to moderate behavioral health care needs.[59]

Table 6. Access Standards for Behavioral Health Care

Table 6a. Standard Plan Access Standards

Visit Type	Definition	Standard
Mobile Crisis Management Services	Mobile crisis services, for adults and children, that are direct and periodic services available at all times, 24 hours a day, 7 days a week, 365 days a year, and primarily delivered face-to-face with the individual and in locations outside the agency's facility.	Within 2 hours
Emergency Services for Mental Health	Services to treat a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking, or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention.	Immediately (available 24 hours a day, 365 days a year)
Emergency Services for SUDs	Services to treat a life-threatening condition in which the person is – by virtue of their use of alcohol or other drugs – suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to	Immediately (available 24 hours a day, 365 days a year)

[59] Pending legislative authority.

Visit Type	Definition	Standard
	adequately care for self without supervision due to the effects of chronic substance use; includes crisis intervention.	
Urgent Care Services for Mental Health	• Services to treat a condition in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention, shall progress to the need for emergent services/care. • Services to treat a condition in which a person has potential to become actively suicidal or homicidal without immediate intervention.	Within 24 hours
Urgent Care Services for SUDs	• Services to treat a condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the person's substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance. • Services to treat a condition in which a person displays a condition which could, without diversion and intervention, progress to the need for emergent services/care.	Within 24 hours
Routine Services for Mental Health	• Services to treat a person who describes signs and symptoms resulting in impaired behavioral functioning which has impacted person's ability to participate in daily living or markedly decreased person's quality of life.	Within 14 calendar days
Routine Services for SUDs	Services to treat a person who describes signs and symptoms consequent to substance use resulting in a level of	Within 14 calendar days

Visit Type	Definition	Standard
	impairment which can likely be diagnosed as a SUD according to the current version of the *Diagnostic and Statistical Manual*.	

Table 6b. Tailored Plan Access Standards

Visit Type	Description	Standard
Mobile Crisis Management Services	Mobile crisis services, for adults and children, that are direct and periodic services available at all times, 24 hours a day, 7 days a week, 365 days a year, and primarily delivered in-person with the individual and in locations outside the agency's facility.	Within 2 hours
Facility-Based Crisis Management Services (FBC for Child & Adolescent, FBC for Adults, Non-Hospital Medical Detox)	A Medicaid crisis service.	Emergency services available immediately (available 24 hours a day, 7 days a week, 365 days a year)
Emergency Services for Mental Health	Services to treat a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention.	Immediately (available 24 hours a day, 7 days a week, 365 days a year)
Emergency Services for SUDs	Services to treat a life-threatening condition in which the person is – by virtue of their use of alcohol or other drugs – suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance use; includes crisis intervention.	Immediately (available 24 hours a day, 7 days a week, 365 days a year)
Urgent Care Services for Mental Health	• Services to treat a condition in which a person is not actively suicidal or homicidal and denies having a plan, means, or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness, or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition that could rapidly deteriorate without immediate intervention; and/or without diversion	Within 24 hours

Visit Type	Description	Standard
	and intervention, could progress to the need for emergent services/care. •	
Urgent Care Services for SUDs	• Services to treat a condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the person's substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance. • Services to treat a condition in which a person displays a condition which could, without diversion and intervention, progress to the need for emergent services/care.	Within 24 hours
Routine Services for Mental Health	Services to treat a person who describes signs and symptoms resulting in clinically significant distress, or impaired functioning, which has impacted the person's ability to participate in daily living or markedly decreased a person's quality of life.	Within 14 calendar days
Routine Services for SUDs	Services to treat a person who describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a SUD according to the current version of the *Diagnostic and Statistical Manual*.	Within 48 hours

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

- Allergy/Immunology
- Anesthesiology
- Cardiology
- Dermatology
- Endocrinology
- ENT/Otolaryngology
- Gastroenterology
- General Surgery
- Obstetrics
- Hematology
- Infectious Disease
- Nephrology

- Neurology
- Oncology
- Ophthalmology
- Optometry
- Orthopedic Surgery
- Pain Management (Board Certified)
- Psychiatry
- Pulmonology
- Radiology
- Rheumatology
- Urology

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

Mandatory Network Providers

In addition to meeting the State's network adequacy standards, federal and state statutes and regulations require Standard Plans and Tailored Plans to contract with certain types of providers. Federal regulations require plan networks to include at least one federally qualified health center (FQHC), at least one rural health clinic (RHC), and at least one freestanding birth center (FBC), where available, for the plan's contracted service area.[60] North Carolina statute requires Standard Plans and Tailored Plans to contract with all "essential providers" in their geographical coverage area, unless the Department approves an alternative arrangement for securing the types of services offered by the essential providers.[61] Essential providers include FQHCs, free/charitable clinics, rural health centers, State veterans' homes, and LHDs.

Regardless of network status, Standard Plans and Tailored Plans must allow eligible members access to Indian Health Care Providers (IHCPs), including CHIA and family planning providers.

Out-of-Network Services

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

[60] Available here: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/SMD16006.pdf
[61] NC S.L. Session Law 2015-245, as amended by Session Law 2016-121.

Exceptions to Network Adequacy Standards

Standard Plans and Tailored Plans that are unable to meet network adequacy standards may request an exception for a specific provider type in a specific region. Standard Plans and Tailored Plans are required to submit a request for an exception to the Department with corresponding information in support of that request. Criteria for review and acceptance of an exception include but are not limited to:

- Utilization patterns in the specific service area;
- The number of Medicaid providers in the relevant provider type/specialty practicing in the specific service area;
- The history of beneficiary complaints regarding access;
- Specific geographic considerations; and
- The proposed long-term plan by the plan to address the access-to-care gap in its network and the comprehensiveness and appropriateness of the plan for addressing beneficiary needs, including the plan's process for making referrals to out-of-network providers, as relevant, and the plan's use of telehealth, virtual patient communications and remote patient monitoring, as appropriate.

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

Telehealth, Virtual Patient Communications, and Remote Patient Monitoring

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

2. Availability of Services

Standard Plans and Tailored Plans must contract with a sufficient number of providers to ensure that all services covered under the contract are available and accessible to beneficiaries in a timely manner, as required under 42 CFR 438.206. To ensure this, under state law, Standard Plans must include any willing providers in their networks, except when a plan is unable to negotiate rates. Tailored Plans must include any willing providers for physical health and pharmacy services but, as set forth in N.C. Gen. Stat. § 108D-23, have the authority to maintain closed networks for behavioral health, I/DD and TBI services. As described previously, Standard Plans and Tailored Plans must also contract with all "essential providers" in their area unless the Department approves an alternative arrangement. North Carolina also seeks to ensure the availability of services through, among other things, its network adequacy standards, which include both time and distance standards and appointment wait-time standards (see above). Other

requirements on managed care networks and the availability of services covered under the contract include:

- Direct access to a women's health specialist for covered care necessary to provide women's routine and preventive health care services (note that this is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist).
- Direct access to emergency services, children's screening services, primary care services, school-based clinic services and LHD services.
- Direct access to behavioral health services, such that Standard Plans and Tailored Plans will not require beneficiaries to obtain a referral or prior authorization for at least one mental health assessment and at least one substance dependence use disorder assessment from a participating provider in any calendar year.
- Direct access to covered services offered by family planning providers and/or family planning services.
- Direct access to specialists, for beneficiaries with special health care needs (defined under sub-section 5, "Coordination and Continuity of Care"), in a manner that is appropriate for the beneficiaries' health condition and age.
- Access to a second opinion from either an in-network provider or an out-of-network provider (to be arranged by the plan), at no cost to the enrollee.
- Access to necessary covered services from an out-of-network provider for as long as the plan's network is unable to provide such services.
- Access to covered services 24 hours a day, 7 days a week, when medically necessary.
- Access to network providers during hours of operation that are no less than the hours of operation offered to commercial enrollees or, if the provider serves only Medicaid beneficiaries, comparable to NC Medicaid Direct.
- Timely access to contracted services for the tribal population.
- Access to a pharmacy network within time and distance standards.
- Access to telehealth, virtual patient communications and remote patient monitoring as a tool for facilitating timely access to needed services that are not available within the plan's network and in accordance with the 1H: Telehealth, Virtual Patient Communications and Remote Patient Monitoring Policy.

Standard Plans, Tailored Plans and the EBCI Tribal Option must also ensure the availability and delivery of services in a culturally and linguistically competent manner to all beneficiaries, including those with limited English proficiency and literacy, of diverse cultural and ethnic backgrounds or with disabilities, and regardless of gender, sexual orientation or gender identity. Standard Plans, Tailored Plans and the EBCI Tribal Option must also ensure that network providers deliver physical access, reasonable accommodations and accessible equipment for beneficiaries with physical or cognitive disabilities.

3. Access to Care During Transitions of Coverage

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

In instances where a beneficiary transitions into a Standard Plan or Tailored Plan (from either NC Medicaid Direct or another plan or coverage type)[62]:

- When a beneficiary is in an ongoing course of treatment or has an ongoing special condition, the beneficiary may continue receiving services from their provider (even if they are out-of-network) for up to 90 days for Standard Plans and 180 days for Tailored Plans.[63]
- New enrollees who are pregnant may continue receiving services from their behavioral health provider and obstetrician throughout their pregnancy or until loss of Medicaid eligibility during the pregnancy, whichever is later.

When a provider leaves or is terminated from a Standard Plan's or Tailored Plan's network:

- In cases when a provider is terminated or leaves the Standard Plan or Tailored Plan's network for non-renewal of the contract:
    - An enrollee in an ongoing course of treatment or with an ongoing special condition may continue receiving services from that provider for up to 90 days.
    - A pregnant enrollee in their second or third trimester may continue receiving services from the provider throughout their pregnancy and up to 12 months after delivery.
- In cases where a provider is terminated or leaves the Standard Plan's or Tailored Plan's network because of quality of care or program integrity-related concerns, the Standard Plan or BH I/DD Tailored Plan shall notify and assist the enrollee in transitioning to an appropriate in-network provider who can meet their needs.

4. Assurances of Adequate Capacity and Services

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

- Requiring Standard Plans and Tailored Plans to submit an access plan and regular documentation (including provider network data and report(s) that summarize findings from Standard Plans and Tailored Plans' own network data analysis) to demonstrate network adequacy;
- Requiring Standard Plans and Tailored Plans to submit updated machine-readable provider directories in a standardized format;
- Contracting with an EQRO to review and validate plan data and findings;
- Requiring that Standard Plans and Tailored Plans be accredited (by Year 3);
- Monitoring beneficiary complaints related to access to care and provider networks;
- Reviewing quality measurement data to show realized access;
- Reviewing CAHPS survey findings related to beneficiary experience of availability and access to services and taking action as needed; and

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

- When necessary, issuing corrective action plans (CAPs) when Standard Plans and Tailored Plans are identified as noncompliant with network adequacy standards and access requirements.

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

5. Coordination and Continuity of Care

Care and Coordination of Services

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

Standard Plans and Tailored Plans are responsible for assessing risk in their enrolled populations, including risk based on SDOH and other risk factors. As required by 42 CFR 438.208(b)(3), Standard Plans and Tailored Plans are required to make best efforts to conduct a universal screening process for newly enrolled beneficiaries within 90 days of enrollment. The Department requires Standard Plans and Tailored Plans to include within their initial screening tools standardized questions relating to highest-priority SDOH (housing, food, transportation and interpersonal violence). Standard Plans and Tailored Plans are required to implement a care management strategy that takes the results of these screenings into account as well as markers of high cost based on past claims (including pharmacy). In recognition that care management for those with complex health and/or social needs is most effective when delivered in the community, plans are required to meet State requirements to ensure that care management for high-needs beneficiaries is delivered in predominantly community settings at a local level. As required by 42 CFR 438.208(b)(iv), plans are required to coordinate their services with those received from community and social support providers.

Primary care practices, including those that operate as care management entities (AMHs, AMH+s, CMAs), play a critical role in care management and care coordination for Standard Plan and Tailored Plan enrollees. Standard Plans and Tailored Plans are required to deliver care management locally to the maximum extent possible (including by AMHs, AMH+s, CMAs, and other local care managers, such as LHDs), while also accounting for the diversity of North Carolina's delivery system.

Additional Services for Beneficiaries with Special Health Care Needs or Who Need LTSS

For beneficiaries who have special health care needs and beneficiaries who need LTSS (categories that cover all beneficiaries enrolled in Tailored Plans), Standard Plans and Tailored Plans are required, in

compliance with the parameters set forth in 42 CFR 438.208(c), to conduct a comprehensive assessment to identify any ongoing special conditions that require a course of treatment or regular care monitoring.

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

- **Children with Special Health Care Needs** are defined as those who have or are at increased risk of having a serious or chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child's age. This includes, but is not limited to, children or infants in foster care; requiring care in the Neonatal Intensive Care Units; with neonatal abstinence syndrome; in high-stress social environments/toxic stress; receiving Early Intervention; with an SED, I/DD, or SUD diagnosis; and/or receiving 1915(i), Innovations or TBI waiver services.
- **Adults with Special Health Care Needs** are defined as those who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that usually expected for individuals of similar age. This includes, but is not limited to, individuals with HIV/AIDS; an SMI, SED, I/DD or SUD diagnosis (including opioid addiction); chronic pain; or receiving 1915(i), Innovations or TBI waiver services.

Based on the comprehensive assessment, the State requires Standard Plans and Tailored Plans to identify enrollees who require LTSS and to develop a person-centered care plan for such enrollees. The care plan must be developed by a person with expertise in LTSS service coordination and trained in person-centered planning processes. The plan also must ensure that a beneficiary with special health care needs determined through assessment to require a course of treatment or regular care monitoring has direct access to a specialist as appropriate for the enrollee's condition and identified needs.

Standard Plans and Tailored Plans are responsible for identifying individuals with special health care needs and in need of LTSS primarily using a claims data review, predictive modeling and/or care needs screening. Standard Plans and Tailored Plans are required to use this information to ensure the development of an appropriate treatment/service plan as described above.

6. Coverage and Authorization of Services

Standard Plans and Tailored Plans are required to cover the same physical health, LTSS and pharmacy services as required in NC Medicaid Direct, except for a small number of services carved out of Medicaid managed care by statute.[64] The behavioral health and I/DD benefits covered under Standard Plans and Tailored Plans differ in accordance with statute.[65] Standard Plans are required to cover many behavioral health services included in the Medicaid State Plan, and Tailored Plans will be required to cover the same behavioral health services as Standard Plans, as well as additional, higher-intensity behavioral health and I/DD services included in the Medicaid State Plan and 1915(c) waiver services for individuals with I/DD and

[64] NC Session Law 2015-245, as amended, excludes dental services; services provided through PACE; services documented in an individualized education program (IEP) and provided or billed by local education agencies; services provided and billed by a Children's Developmental Services Agency (CDSA) that are included on the child's Individualized Family Service Plan; services for Medicaid program applicants during the period of time prior to eligibility determination; and the fabrication of eyeglasses, including complete eyeglasses, eyeglass lenses, and ophthalmic frames. The Department also recommends that the fitting and the provider visual aid dispensing fee for eyeglasses be carved out of managed care, which would require a statutory change.
[65] NC Session Law 2015-245, as amended by Session Law 2018-48.

TBI.[66] Consistent with the requirements set forth in 42 CFR 438.210, North Carolina has developed an approach to Standard Plan and Tailored Plan clinical coverage policies and utilization management (UM) that safeguards beneficiary access to services while encouraging plan innovation. Standard Plans and Tailored Plans are required to follow NC Medicaid Direct's clinical coverage policies for a limited set of services to maintain services for specific vulnerable populations, maximize federal funding, and comply with State mandates, and are permitted to establish their own clinical coverage policies for all other services within specific guardrails.

Standard Plans and Tailored Plans are required to use the Department definition of medical necessity, defined in 10A NCAC 25A.0201, when making coverage determinations and are prohibited from setting benefit limits that are more stringent than in NC Medicaid Direct. For example, if NC Medicaid Direct covered 10 visits for a specific service, Standard Plans and Tailored Plans could cover 12 visits, but could not limit a beneficiary to a visit amount less than 10.

The Department requires that Standard Plans and Tailored Plans use a common prior authorization request form for all services. The plans collaborated with stakeholders to design a streamlined form to minimize administrative burden. There is a standard request process for "in-lieu of services," designed to encourage Standard Plans and Tailored Plans to cover services or settings that are not otherwise covered under the State Plan but are medically appropriate, cost-effective alternatives to a covered service.

Finally, for a limited number of services, the Department requires that Standard Plans and Tailored Plans follow specific clinical coverage policies developed by the Department.

(B) Structure and Operations Standards

1. Provider Selection

Standard Plans and Tailored Plans are required to implement written policies and procedures for the selection and retention of network providers. These policies and procedures must meet state and federal requirements, including:

- **"Any willing provider" requirement:** Standard Plans may not exclude providers from their networks except for refusal to accept network rates. Tailored Plans may not exclude physical health and pharmacy providers from their networks except for refusal to accept network rates.[67,68]

[66] NC Session Law, as amended by Session Law 2018-48, specifies that Standard Plans and Tailored Plans will cover inpatient behavioral health services, outpatient behavioral health emergency room services, outpatient behavioral health services provided by direct-enrolled providers, mobile crisis management services, facility-based crisis services for children and adolescents, professional treatment services in a facility-based crisis program, outpatient opioid treatment services, ambulatory detoxification services, non-hospital medical detoxification services, partial hospitalization, medically supervised or ADATC detoxification crisis stabilization, research-based intensive behavioral health treatment, diagnostic assessment services, and EPSDT services. Other behavioral health, I/DD, and TBI services currently covered by the LME-MCOs will only be available in Tailored Plans.

[67] NC Session Law 2015-245, as amended by Session Law 2016-121. Note that this state statute also requires Standard Plans and Tailored Plans to contract with all providers in their geographical coverage area that are designated by the Department as "essential providers" (see the "Mandatory Network Providers" section above), unless the Department approves an alternative arrangement for securing the types of services offered by the essential providers.

[68] NC Session Law 2018-48 Section 4.(10)(a)(1)(IV) permits Tailored Plans to maintain a closed network for behavioral health, I/DD, and TBI services and, pending legislative change, the Tailored Plan must include all essential providers for behavioral health, I/DD, and TBI services located in the Tailored Plan's Region in its Network regardless of closed network requirements.

- **Credentialing and re-credentialing:** Standard Plans and Tailored Plans must follow a documented process that is in line with the State's uniform credentialing policy and centralized credentialing verification program for making a determination to move to contracting or re-contracting with network providers.[69]
- **Enrolled providers:** Standard Plans and Tailored Plans may only contract with providers who are enrolled in NC Medicaid Direct.
- **Nondiscrimination:** In selecting and contracting with network providers, Standard Plans and Tailored Plans must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- **Excluded providers:** Standard Plans and Tailored Plans may not employ or contract with providers that are excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

2. Practice Guidelines

Consistent with the requirements of 42 CFR 438.236, Standard Plans and Tailored Plans are required to develop practice guidelines that:

- Are based on valid and reliable clinical evidence or a consensus of providers in the particular field;
- Consider the needs of beneficiaries;
- Are adopted in consultation with contracting health care professionals;
- Are reviewed and updated periodically as appropriate; and
- Starting in Contract Year 1, meet the clinical practice guidelines required for Health Plan Accreditation with LTSS distinction set forth by the NCQA. 42 CFR 438.236(b).

Additionally, the Department requires that Standard Plans and Tailored Plans meet the following standards:

- The plan's Quality Improvement (QI) Committee or other designated committee must approve clinical practice guidelines;
- The plan must adopt guidelines from recognized sources of feedback of board-certified practitioners from appropriate specialties that would use the guidance;
- The plan must adopt guidelines for at least two medical conditions and at least two behavioral health conditions, with at least one behavioral health guideline that addresses children and adolescents;
- The plan must update guidelines based upon clinical evidence at least every two years, or more frequently if the national guidelines change within the two-year period;
- The plan must annually evaluate the consistency with which health care professionals in Utilization Management apply criteria in decision-making;
- The plan must act on opportunities to improve consistency, if applicable;
- The plan must distribute clinical practice guidelines and revisions to all practitioners who are likely to use them; and

[69] Credentialing for the Behavioral Health and I/DD Services for Medicaid Direct PIHP currently aligns with the credentialing process for Tailored Plans.

- As requested by the Department, the plan must submit to the Department a copy of any required clinical practice guidelines and make the plan's Chief Medical Office (or designee) available to discuss the coordination of clinical practice guidelines and clinical coverage policies.

As mentioned above in Section III(C)(10), starting in Contract Year 1, Standard Plans and Tailored Plans must, respectively, meet the clinical practice guidelines required for Health Plan Accreditation and Health Plan Accreditation with LTSS distinction set forth by NCQA.

Additionally, for behavioral health services, Standard Plans and Tailored Plans are required to use the following behavioral health guidelines and tools at part of the plan's Utilization Management (UM) Program:

- American Society for Addiction Medicine (ASAM) criteria for substance use services for medical necessity reviews for all populations except children ages 0 through 6.
- EPSDT criteria when evaluating requests for service for children; Plans must use either the Early Childhood Services Intensity Instrument (ECSII) or Children and Adolescents Needs and Strengths (CANS) for Infants, Toddlers and Pre-Schoolers to determine medical necessity for children ages 0 through 5 or another validated assessment tool with prior approval by the Department.

Standard Plans and Tailored Plans are required to disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. Standard Plans and Tailored Plans will make decisions related to UM, beneficiary education and coverage of services consistent with these guidelines.

3. Enrollee Information

To ensure the capacity for NC Medicaid Managed Care education and plan/primary care provider (PCP) selection support at NC Medicaid Managed Care launch, the Department has procured an enrollment broker to facilitate outreach, education and consumer assistance to enrollees and potential enrollees.

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

Recognizing the importance of beneficiaries' receiving consistent and accurate information about how to effectively use NC Medicaid Managed Care, the Department will develop a model member handbook that Standard Plans, the EBCI Tribal Option and Tailored Plans must customize and use. The member handbook will include the following information:

- Benefits provided by the plans, including the amount, duration and scope of those benefits, and guidance on how and where to access benefits, including carved out services, non-emergency transportation, EPSDT, family planning services and supplies from out-of-network providers;
- Enrollee enrollment and disenrollment policy;
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the beneficiary's AMH/primary care provider;

- Overview of the continuation of benefits policy, including when, why and how a member or member's authorized representative may file for a continuation of benefits;
- How and where to access any benefits provided by the Department, including carved-out services;
- The extent to which, and how, both after-hours and emergency coverage are provided;
- Any restrictions on the beneficiary's freedom of choice among in-network and out-of-network providers;
- Cost sharing imposed on North Carolina Medicaid or NC Health Choice beneficiaries;
- Member enrollment and disenrollment policy and the process of selecting and changing the beneficiary's AMH/PCP;
- Grievance, appeal and State Fair Hearing procedures and timeframes;
- How to exercise an advance directive, as set forth in federal requirements;
- The toll-free telephone number for the Member Services Line, Behavioral Health Crisis Line, Nurse Line, Provider Service Line, and Prescriber Service Line and how to access auxiliary aids and services, including additional information in alternative formats or languages;
- Information on how to report suspected fraud, waste or abuse;
- Information on the Opioid Misuse Prevention Program, plans' prevention and population health programs and Transition of Care Policy;
- Contact information for beneficiary support systems, including the Ombudsman Program and the enrollment broker;
- Information on the plan's Transition of Care policy; and
- Information about the plan's prevention and population health programs.

Standard Plans, the EBCI Tribal Option and Tailored Plans are permitted to provide this information by mail or email (only if beneficiary has expressed consent to email), in addition to posting online.

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

Provider Directories

Standard Plans, the EBCI Tribal Option and Tailored Plans must each compile the following information about all its network providers in a format specified by the Department and make available to enrollees and potential enrollees. The plan provider directory must be made available in both paper and electronic formats, be easy to understand and meet language and format requirements in accordance with 42 CFR 438.10, the Contract, and as specified by Department.[70]

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

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

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

Per 42 CFR 438.10, information included in a paper provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 10 business days after the Standard Plan or Tailored Plan receives updated provider information. Provider directories must be posted on the Standard Plan's or Tailored Plan's website, in a machine-readable file and format, as specified by the State.

4. Enrollment and Disenrollment

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

County Departments of Social Services (DSS) offices will continue to conduct Medicaid eligibility determinations and will assess whether beneficiaries are required to enroll in a plan. The DSS offices will then share that information with the enrollment broker, who will be tasked with supporting beneficiaries with plan and PCP selection. The Department will conduct regular data reviews to identify beneficiaries who are eligible for Tailored Plans. The Public Health and Human Services for the Cherokee Communities (PHHS) helps conduct eligibility determinations for EBCI members and verification of Tribal status. As detailed below, the Department has established different plan enrollment and disenrollment processes for Standard Plans, the EBCI Tribal Option and Tailored Plans in accordance with statute.[71]

Standard Plan Enrollment

As part of the transition to NC Medicaid Managed Care and prior to the launch of Standard Plans in July 2021, the Department will establish a 60-day choice period for current Medicaid beneficiaries. Beneficiaries will be sent notices from the Department about their Standard Plan options, the time period during which they must select a Standard Plan and contact information for in-person, by telephone and online consumer enrollment broker support for selecting a Standard Plan and PCP.

[71] NC Session Law 2015-245, as amended by Session Law 2018-48.

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

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

Standard Plan Disenrollment

All NC Medicaid Managed Care beneficiaries – whether they select or are assigned to a Standard Plan – have a 90-day period following the effective coverage date to change plans "without cause". After the completion of the 90-day period, most beneficiaries must remain enrolled in their Standard Plan for the remainder of their eligibility period unless they can demonstrate a "with cause" reason for switching.[72] Certain special populations may change Standard Plans without cause at any time, including children in foster care, members of a federally recognized Tribe and IHS eligible and beneficiaries receiving LTSS in institutional and community-based settings. All beneficiaries will have the option to change plans annually at the time of eligibility redetermination.

In rare cases, Standard Plans will be permitted to request of the Department beneficiary disenrollment, but only if the enrollee's behavior seriously hinders the Standard Plan's ability to care for the beneficiary or other members and the plan has documented efforts to resolve the enrollee's issues. Consistent with 42 CFR 438.56, Standard Plans will be prohibited from requesting beneficiary disenrollment because of an adverse change in the enrollee's health status, or enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the enrollee's special needs.

Tailored Plan Enrollment

Upon Standard Plan implementation in July 2021, beneficiaries determined eligible for Tailored Plans will not transition to Standard Plans and will remain in their current Medicaid delivery system. These beneficiaries will receive a notice informing them of their eligibility status and will have the option to enroll in Standard Plans.

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

Prior to Tailored Plan launch, the Department will conduct data reviews to identify beneficiaries enrolled in Standard Plans, new Medicaid beneficiaries, and NC Medicaid Direct beneficiaries who meet Tailored Plan data-based eligibility criteria. Beneficiaries determined eligible for Tailored Plans will receive a notice informing them they will be auto-enrolled into the Tailored Plan in their region upon Tailored Plan launch and can elect to transfer to a Standard Plan at any point during the coverage year.

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

Beneficiaries, including Standard Plan enrollees, who are not identified as eligible for Tailored Plans by the Department will able to request to enroll in a Tailored Plan in the period before and after Tailored Plan launch. The enrollment broker will provide information to beneficiaries by phone, online chat, website and mail on how to request to enroll in a Tailored Plan. Upon approval, the Department, working with the enrollment broker, will process the transfer and transition the beneficiary from the Standard Plan to the Tailored Plan in their region (or NC Medicaid Direct/LME-MCO prior to Tailored Plan launch) and will notify them of the transfer.

Tailored Plan Disenrollment

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

The Tribal Option Enrollment and Disenrollment

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

CFSP Enrollment and Disenrollment

With limited exceptions[73], children in foster care, children receiving adoption assistance, former foster youth under age 26, and minor children of these populations will be automatically enrolled in the Children and Families Specialty Plan at its launch. All other CFSP-eligible populations will have the option to enroll in the CFSP.[74] Enrollees will have the option to change their plan at any time during the coverage year for

[73] Tribal members are exempt from auto-enrollment into the Children and Families Specialty Plan but will have the option to opt-into the CFSP at launch; individuals eligible for Medicare or are in other managed care excluded groups are not eligible to enroll in the CFSP; individuals otherwise eligible for the CFSP who are Innovations or TBI waiver enrollees, beneficiaries residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID), or eligible for the Transition to Community Living (TCL) must enroll in a BH I/DD Tailored Plan to access those services; they may opt-in to the CFSP when they no longer require those services.

[74] Populations that may opt-in to the CFSP are Medicaid and NC Health Choice-enrolled parents, guardians, custodians, and minor

any reason. The State will ensure that individuals eligible for the Children and Families Specialty Plan are educated about their options.

5. Confidentiality

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

6. Grievance and Appeals Systems

The Department is committed to ensuring that beneficiaries can address their problems quickly and with minimal burden and requires Standard Plans and Tailored Plans to meet the standards set forth in 42 CFR 438.228. North Carolina is committed to honoring and supporting the right of beneficiaries to pursue a formal appeal of an adverse benefit determination through their plan, or upon exhaustion of the plan appeal process, through timely access to a State fair hearing. (42 CFR 438.228, 438.400, 438.402.) Additionally, beneficiaries will also be able to appeal enrollment and disenrollment determinations by the enrollment broker under a similar process.

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

Beneficiary Grievances

Beneficiaries may file a grievance with a plan at any time, either orally or in writing. Standard Plans, Tailored Plans and the EBCI Tribal Option are required to acknowledge receipt of each grievance in writing within five calendar days and must resolve the grievance within 30 calendar days from the date the plan receives the grievance. In instances in which the grievance relates to the denial of an expedited appeal request, Standard Plans and Tailored Plans are required to resolve the grievance and provide notice to all affected parties within five calendar days from the date the plan receives the grievance, and include within the notice Department-specified content. These standards comply with federal requirements for beneficiary grievances. (42 CFR 438.402 and 438.406.)

Beneficiary Appeals

Federal law sets forth the specific standards for beneficiary rights for appeals which all Standard Plans and Tailored Plans are expected to follow. (42 CFR 438.402; 438.406; 438.408; and 438.420.) Specifically, in North Carolina, beneficiaries in NC Medicaid Managed Care must first seek to resolve appeals with their

siblings of children/youth in foster care and families receiving CPS In-Home Services.

plan and will have 60 days from the date of the notice of an adverse benefit determination to file a request for an appeal with the plan. Standard Plans and Tailored Plans are required to send written acknowledgement of the request within five calendar days for a standard appeal and within 24 hours for an expedited appeal request. To ensure access to services, beneficiaries may request their benefits be continued or reinstated while the appeal is pending.

Standard Plans and Tailored Plans must provide written notice of resolution as expeditiously as the appellant's health condition requires and within 30 calendar days of receipt of a standard appeal request. For an expedited appeal request, Standard Plans and Tailored Plans must provide written notice of resolution, and make a "reasonable effort" to provide oral notice, within 72 hours of receipt of an appeal.

If the plan upholds the adverse benefit determination, the beneficiary may request a State fair hearing through the Office of Administrative Hearings; based on federal regulations, the enrollee must have no fewer than 90 days and no more than 120 calendar days from the date of the notice to request a fair hearing (the state is determining the exact timeframe that will be used). Beneficiaries will have the right to request a continuation of benefits while the appeal is pending.

Ombudsman Program

North Carolina is committed to providing beneficiaries with support and active preparation for the appeals, grievance and State fair hearing process, as well as to facilitating real-time issue resolution. The Department will establish an ombudsman program external to the Department focused on providing advocacy, assistance and education to beneficiaries as they navigate NC Medicaid Managed Care and the appeals, grievance and fair hearing process.

The ombudsman program will also serve an oversight function, monitoring trends in plan performance or beneficiary concerns and proactively provide feedback to the Department regarding any issues that arise.

In order to ensure plan compliance with the appeals and grievances requirements set forth by the Department, Standard Plans and Tailored Plans are required to report:

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

7. Sub-Contractual Relationships and Delegation

All Standard Plan, EBCI Tribal Option and Tailored Plan sub-contractual relationships and delegations of services or functions on behalf of the plan under the plan contracts are required to comply with 42 CFR 438.230. Standard Plans and Tailored Plans will remain accountable for all contract terms which are performed by subcontractors and delegation. Plans will be required to complete pre-delegation assessments or reviews prior to the effective delegation date to assess readiness, as applicable. As part of

the readiness review, the Department confirms that plans have the necessary policies, procedures and documents to evidence such compliance and periodically audit Standard Plans and Tailored Plans' compliance with this requirement during the term of the contract.

8. Health Information Technology

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

V. Assessment

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

(A) Assessment of Quality and Appropriateness of Care

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

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

- Reviews annual performance against measure benchmarks;
- Requires, reviews, and approves each Standard Plan, the EBCI Tribal Option and Tailored Plan QAPI, including how the managed care plan will assess and improve upon its own performance against its QAPI on an annual basis;
- Sets parameters for the PIPs described in Section III(A)(1), including changes to such programs based on Department-identified quality priorities and opportunities for targeted improvement;
- Conducts monthly and as otherwise needed Quality Director meetings to engage with Standard Plan, the EBCI Tribal Option and Tailored Plan and address issues as they arise;
- Reviews all accreditation and EQRO compliance reports to determine areas of deficiency and, as needed, sets forth and monitors corrective action plans;

- Works closely with the EQRO to develop the requirements for and understand opportunities for improvement as a result of the health equity report discussed within this section of the Quality Strategy;
- Publishes the quality data described in Section III(A) to promote transparency regarding plan performance and engage stakeholders on opportunities for improvement;
- Designs and administers the quality withhold program, further discussed below; and
- Uses the EQRO quality performance reports, outlined below, to drive improvement and performance against the Quality Strategy.

The Department will identify the EQR-related activities for which it has exercised the non-duplication option before NCQA accreditation is required in Contract Year 3, and communicate which activities, if any, will be deemed met by accreditation. NCQA accreditation is anticipated to be comparable to EQR-related activities given the high-standards plans must meet to become NCQA accredited. To ensure that information can be accurately and readily compared across Standard Plans and Tailored Plans and within the program broadly, EQRO activities will not be deemed met by accreditation until all Standard Plans and Tailored Plans are required to have met consistent accreditation standards. Any requirements deemed met by completion of accreditation requirements will be implemented in compliance with the standards set forth in 42 CFR 438.360 related to the non-duplication of mandatory activities with accreditation review.

EQRO Functions Related to Quality Assessment and Performance Improvement[75]

- Validate Standard Plans' and Tailored Plans' performance improvement projects outlined in Section III(A)(1) of this Quality Strategy;
- Validate all plan-submitted quality performance measures outlined in Appendix A, Tables 8 and 9, and aggregate measures for collective review by the Department;
- Calculate performance measures in addition to those reported by the plans and validated by the EQRO, as requested by the Department;
- Conduct the CAHPS Plan Survey;
- Validate the encounter data reported by the plans, as requested by the Department;
- Produce an annual technical report that summarizes findings on access and quality of care, including:
    - A description of the manner in which the data from all activities conducted were aggregated and analyzed, and conclusions were drawn as to the quality of care provided by each plan;
    - An assessment of each plan's strengths and weaknesses for the quality of care provided;
    - Recommendations for improving the quality of health care services provided by each plan;
    - Comparative information about all plans; and
    - Starting in year 2 of Standard Plan operations, an assessment of the degree to which each plan has effectively addressed the recommendations for quality improvement

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

made by the EQRO during the previous year's external quality review.

- Produce an annual health equity analysis, assessing plan and program-wide performance on select measures indicated in Appendix A based on select strata including age, race, ethnicity, sex, primary language, disability status and a breakdown of measures for key population groups (e.g., LTSS, based on aged/blind/disabled status); and
- Provide technical assistance, as directed by the Department, to plans for conducting PIPs, quality reporting and accreditation preparedness.

1. Improving Equity in Care and Outcomes

In compliance with the requirements set forth in 42 CFR 438.340(b)(6) and discussed in Section II(B), Standard Plans, Tailored Plans and CCNC must report select measures outlined in Appendix A based on select strata including age, race, ethnicity, sex, primary language, geography (county) and disability status, *where feasible (*see the Technical Specifications for the full list of stratification requirements).[76,77] This information is provided to Standard Plans and Tailored Plans upon beneficiary enrollment, and is used by the Department to better understand disparities in care within and across Standard Plans and Tailored Plans and by the EQRO. The information will be used to develop an annual health equity report that identifies trends and variations in use of health services and outcomes based on the factors noted above. This analysis will support the State's development of an action plan for measuring and evaluating efforts to address disparities in the Medicaid program. The Department will consider the analysis, and develop focused interventions where practical. As appropriate, these interventions will include:

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

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

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

2. Withhold Program

Standard Plans and Tailored Plans are required to meet several performance and reporting thresholds (which may be met through hybrid reporting where appropriate) to remain in compliance with

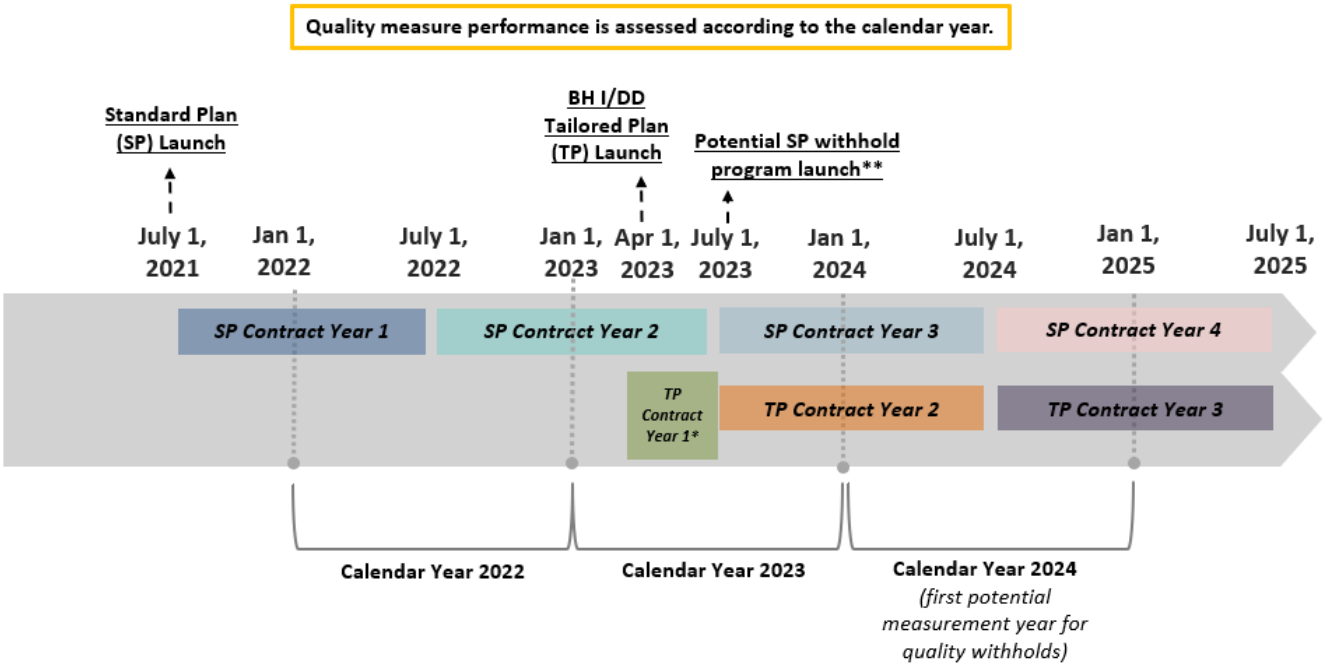
[76] Consistent with the requirements set forth in 42 CFR 438.340(b)(6), "disability status" indicates whether the individual qualified for Medicaid on the basis of a disability.

[77] This demographic information is collected via the Medicaid application and transmitted to Standard Plans and Tailored Plans at the time of enrollment.

Department contract provisions. Failure to achieve these minimum performance thresholds may result in sanctions. Additionally, the Department may encourage plans to perform beyond compliance thresholds through a withhold program, in which a portion of each plan's capitation rate is withheld and paid when the plan meets reasonably achievable performance targets on priority measures. The Department may launch a withhold program for Standard Plans as soon as Contract Year 3, which begins July 2023. (Per S.L. 2018-49, the withhold program cannot be initiated until at least 18 months after managed care launch.) Potential timing for Tailored Plan withholds is under development.

In accordance with the requirements set forth in 42 CFR 438.6 and the Department's goal to advance the withhold program to focus on key performance improvement areas over time, the areas outlined in Table 7 may be included in the withhold program. Because managed care contracting occurs in the state fiscal year and quality measure reporting occurs in the calendar year, quality measure performance will be attributed to contract years on an offset basis, shown in Figure 4. The earliest quality measurement year that could be subject to withholds is 2024. Pending feasibility, withholds may apply for operational or other non-quality measures starting in July 2023, because these measures do not need to be assessed according to a calendar measurement year. This figure shows the timing of potential withhold programs for Standard Plans.

Figure 4. Potential Withhold Program Timeline



**Tailored Care Management will launch in December 2022.*
***Per S.L. 2018-49, the withhold program cannot be initiated until at least 18 months after managed care launch.*

Each year, the Department will assess performance across withhold areas to modify the program to continually advance its goals, focus on new targets that foster continuous quality improvement, and assess opportunities to tie the withhold program to evolving priorities.

Table 7. Potential Withhold Measurement Areas

Year 3 Measurement Area	Overview
Enhanced Operational Performance	Dedicated measures related to critical initiatives, such as reporting of accurate encounter data and establishment of select program priorities/interventions
Quality Measure Performance	Managed care plan performance aligned to set targets on a subset of required measures
Accreditation	Early achievement of health plan accreditation milestones, designed to ensure early operational effectiveness
Social Determinants of Health	Performance standards related to addressing beneficiaries' unmet social needs, such as completing care needs screenings and referring identified beneficiaries with unmet resource needs to social services

(B) Monitoring and Compliance of Access, Structure, and Operations

Standard Plans and Tailored Plans are contractually required to collect and submit timely encounter, quality and performance data to the Department. Standard Plans and Tailored Plans are also required to submit reports on a range of other metrics, as discussed throughout this Quality Strategy, including demonstration of network adequacy; value-based contracting arrangements; and volume, nature and outcomes of grievances and appeals. These reports are essential to the Department's ability to evaluate the program and hold Standard Plans and Tailored Plans accountable for meeting goals, performance measurement priorities and expectations. In addition to the Department's monitoring, the North Carolina Department of Insurance (DOI) licenses Standard Plans and will ensure they meet solvency standards through processes similar to those used for existing commercial plans. DOI intends to license Tailored Plans as well in the future, pending legislative action granting this authority.

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

- Reviewing the plan's governing policies and procedures during readiness and EQRs, and as necessary to ensure compliance with the plan contract;
- Requiring the reports set forth throughout this Strategy and within plan contracts. The Department reviews each report to ensure continued compliance with the relevant contractual requirement and tracks and trends any potential noncompliance to engage the managed care plan in corrective action prior to the determination that the plan is being noncompliant. For example, the Department requires Standard Plans and Tailored Plans to submit a monthly report on beneficiary grievances and appeals to ensure timeliness of those required processes;
- Auditing Standard Plans and Tailored Plans at any time, for any reason, if there is a suspicion of noncompliance or deficiency. In such instances, the Department may require the managed care plan to submit a CAP or take other corrective action, including imposing liquidated damages and/or intermediate sanctions;

- Reviewing, as determined by the Department, Standard Plans and Tailored Plans' Compliance Plans, and any other policy and procedure governing how Standard Plans and Tailored Plans monitor compliance and quality of services provided by their networks, at any time; and[78]
- Annually reviewing the Standard Plans' and Tailored Plans' required Fraud Prevention Plans and requiring modifications; the State may also require a plan to perform specific and/or targeted monitoring or auditing activities in addition to those outlined in the Fraud Prevention Plan. Standard Plans and Tailored Plans will also each submit an annual Fraud Prevention Report outlining the outcome and scope of the activities set forth in its Fraud Prevention Plan, including, at a minimum, the items listed in Appendix E.

Based on the EQRO's review of Standard Plans and Tailored Plans' compliance with contractual requirements and/or any deficiencies identified with requirements that result in a Notice of Deficiency (NOD) issued by the Department to the managed care plan, the plan, at a minimum, is required to submit a Corrective Action Plan (CAP). The CAP must address each deficiency specifically and provide a timeline for the corrective action to be completed. Follow-up reviews may be conducted as appropriate to assess the managed care plan's progress in implementing and/or validation of its implementation of the CAP. This issuance of a NOD will not preclude the State from imposing intermediate sanctions, for instance, if that potential member harm, or fraud or abuse, or substantial noncompliance with contractual requirements is identified.

1. Provider Screening

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

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

Additionally, all providers are subject to criminal background checks by the Department. Providers must be enrolled in North Carolina Medicaid and have gone through North Carolina's centralized credentialing verification program to participate in the managed care program.

Standard Plans, the EBCI Tribal Option and Tailored Plans are also required to perform precontracting and monthly screenings of all network providers against the Exclusion Lists. Standard Plans and Tailored Plans and the Department shall report to one another if they identify any provider as appearing on the Exclusion Lists to ensure that no payments are paid to a provider appearing on such Exclusion Lists.

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

2. Program Integrity

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

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

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

(C) Use of Sanctions

The State may impose any or all sanctions, including requiring a Standard Plan or Tailored Plan to take remedial action, imposing intermediate sanctions, and/or assessing liquidated damages, due to noncompliance with contract requirements or applicable federal or state law which includes, but is not limited to, a finding by the Department that a Standard Plan or Tailored Plan acts or fails to act as follows:

- Fails substantially to provide medically necessary services that the plan is required to provide, under law or under the contract with the State, to an enrollee covered under the contract.
- Imposes premiums or charges on enrollees that are in excess of the premiums or charges permitted under the Medicaid program.
- Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to re-enroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.
- Misrepresents or falsifies information that it furnishes to CMS or to the Department.
- Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 422.210.

- Distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information.
- Violates any of the other applicable requirements of Sections 1903(m), 1905(t), or 1932 of the Social Security Act and any implementing regulations.

Upon the discovery of noncompliance or a deficiency, the Department will assign the noncompliance or deficiency into one of four risk levels. The risk level assignment and the imposition of specific sanctions against a Standard Plan or Tailored Plan will be commensurate with the noncompliance or deficiency, taking into consideration some or all of the following factors:

- The nature, severity, and duration of the violation;
- The type of harm suffered due to the violation (e.g., impact on the quality of care, access to care or program integrity);
- Whether the violation (or one that is substantially similar) has previously occurred;
- The timeliness with which the plan self-reports a violation;
- The plan's history of compliance;
- The good faith exercised by the plan in attempting to stay in compliance (including self-reporting by the plan); and
- Any other factor that the Department deems relevant based on the nature of the violation.

VI. Conclusion and Opportunities

1. Opportunities for Improvement in Data Collection and Measurement

Continuous assessment of progress against this Quality Strategy is not without challenges. As North Carolina Medicaid continues its transition from a predominantly fee-for-service model to a system of managed care, new roles and responsibilities will continue to create new processes and potential barriers to data collection. Historically, the Department's Medicaid data infrastructure has leveraged a combination of NC Medicaid Direct claims and encounter data from LME-MCOs. A significant amount of the analysis and reporting of data to providers is managed through the Department's contract with its PCCM vendor. To manage utilization and improve outcomes through NC Medicaid Managed Care, the Department will be required to collect and process encounter data from Standard Plans and Tailored Plans and integrate these data with NC Medicaid Direct claims for carved-out populations and services.

To address potential challenges with the State's collection of encounter data, Standard Plans and Tailored Plans will be regularly held accountable for submitting timely and accurate encounter data. Managed care contracts provide guidance specifying the format, frequency, quality review and other standards for encounter data submission. The contracts also specify incentives for plans to submit timely and accurate encounter data and impose financial penalties for failure to do so. The Department's systems track the current portfolio of statewide quality measures. As additional measures are identified, including metrics that require the collection of data beyond those captured in claims and encounter data or described in this Quality Strategy, the Department will continue to work with stakeholders to enhance existing capabilities. The Department will further develop new data collection processes and systems to

accommodate the need for accurate, focused and quality data to guide the work in best serving the needs of beneficiaries and the Medicaid population.

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

2. Opportunities for Advancing the Quality of Care

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

- Refining the Quality Objectives outlined within this Quality Strategy, based on identification of opportunities for improvement based on managed care plan and program-wide performance results from managed care implementation, and to address health disparities;
- Continuing to integrate SDOH and address unmet resource needs in treatment planning, provision of services and improvements in overall health outcomes;
- Developing the State's VBP strategy, designed to build upon advancements made in the first two years of managed care; and
- Building upon the integration of behavioral health and physical health services, a key element of driving whole-person centered care forward.

Further, described throughout this Quality Strategy are requirements, standards and protocols built to ensure the State, Standard Plans and Tailored Plans, the EQRO, and other key entities and stakeholders remain engaged in ongoing, active quality improvement efforts. For example: Standard Plans and Tailored Plans are required to report several Department-defined quality measures, as shown in Appendix A, Tables 8 and 9; these measures will be assessed and validated by the EQRO, and the Department will work together with the EQRO, Standard Plans and Tailored Plans and other key experts and stakeholders to continually review progress on these measures, identify opportunities for improvement and maintain the Quality Strategy as a living documentation of these efforts.

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

context of the populations that will be included in that transition in the near-term and will continue to evolve as part of the continuous quality improvement process.

Engagement and feedback are critical to the success of this Quality Strategy, to the Department's future quality efforts, and to Medicaid's transformation efforts. The Department welcomes and encourages stakeholder comments on this Quality Strategy prior to its finalization and ongoing comments and updates to the Quality Strategy. The Department also appreciates comments as it conducts its continuous quality improvement processes. The Department will continue to engage with the MCAC and with beneficiaries, providers, plans, elected officials, local agencies, communities, partners, constituents and other stakeholders throughout the health care and social services systems to shape, address, implement and monitor Medicaid program changes. These efforts will include changes to quality, the transition to managed care and other related topics.

Appendices

Appendix A. Quality Measure Sets[79,80]

Table 8. Standard Plan Medicaid Measure Set[81]

The following table lists quality measures that will be the priority focus for Standard Plan accountability. An asterisk (*) indicates that the measure is calculated by the Department. More information on the measures can be found in the North Carolina's Medicaid Quality Measurement Technical Specifications Manual for Standard Plans and Behavioral Health Intellectual/Developmental Disability Tailored Plans, available here.

NQF#	Measure	Steward
Pediatric Measures		
1516	Child and Adolescent Well-are Visits (WCV)	NCQA
0038	Childhood Immunization Status (Combination 10) (CIS)	NCQA
1407	Immunization for Adolescents (Combo 2) (IMA)	NCQA
NA	Total Eligibles Receiving at least One Initial or Periodic Screen (Federal Fiscal Year)	DHHS
2801	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	NCQA
1392	Well-child Visits in the First 30 Months of Life (W30)	NCQA
Adult Measures		
0032	Cervical Cancer Screening (CCS)	NCQA
0033	Chlamydia Screening in Women (CHL)	NCQA
0059	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC)	NCQA
3389	Concurrent use of Prescription Opioids and Benzodiazepines (COB)	PQA
0018	Controlling High Blood Pressure (CBP)	NCQA
0039	Flu Vaccinations for Adults (FVA, FVO)*	NCQA
0576	Follow-up After Hospitalization for Mental Illness (FUH)	NCQA
0027	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)*	NCQA
1768	Plan All-cause Readmissions (PCR) [Observed versus expected ratio]	NCQA
NA	Rate of Screening for Unmet Resource Needs	DHHS
0418 / 0418e	Screening for Depression and Follow-Up Plan (CDF)	CMS
NA	Total Cost of Care*	To Be Determined

[79] The Department is in the process of reviewing the quality measure sets and may make changes.

[80] For information on quality performance, please refer to the Annual Quality Report, located at: https://medicaid.ncdhhs.gov/quality-management-and-improvement

[81] Measures are grouped into either Adult or Pediatric subsets to confirm adequate coverage of measures by population. As indicated in the North Carolina's Medicaid Quality Measurement Technical Specifications Manual for Standard Plans and Behavioral Health Intellectual/Developmental Disability Tailored Plans, all measures will be calculated for the full age range indicated regardless of where they are listed.

NQF#	Measure	Steward
2940	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	PQA
2950	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	PQA
Maternal Measures		
NA	Low Birth Weight[82]	DHHS
1517	Prenatal and Postpartum Care (PPC) • Timeliness of Prenatal Care • Postpartum Care	NCQA
NA	Rate of Screening for Pregnancy Risk	DHHS

Table 8a. AMH Measure Set[83]

The following table lists the quality measures that AMHs are required to report to the Department.

NQF#	Measure Name	Steward	Frequency[84]
Pediatric Measures			
1516	Child and Adolescent Well-are Visits (WCV)	NCQA	Annually
0038	Childhood Immunization Status (Combo 10) (CIS)	NCQA	Annually
1407	Immunizations for Adolescents (Combo 2) (IMA)	NCQA	Annually
1392	Well-child Visits in the First 30 Months of Life (W30)	NCQA	Annually
Adult Measures			
0032	Cervical Cancer Screening (CCS)	NCQA	Annually
0033	Chlamydia Screening in Women (CHL)	NCQA	Annually
0018	Controlling High Blood Pressure (CBP)	NCQA	Annually
0059	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC)	NCQA	Annually
1768	Plan All-cause Readmissions (PCR) [Observed versus expected ratio]	NCQA	Annually
0418/ 0418e	Screening for Depression and Follow-up Plan (CDF)	CMS	Annually
NA	Total Cost of Care	To Be Determined	Annually

[82] The Department will work jointly with plans to calculate and report this measure.

[83] Measures are grouped into either Adult or Pediatric subsets to confirm adequate coverage of measures by population. As indicated in the North Carolina's Medicaid Quality Measurement Technical Specifications Manual for Standard Plans and Tailored Plans, all measures will be calculated for the full age range indicated regardless of where they are listed.

[84] Monthly gap measure reports are also required.

Table 9. Tailored Plan Medicaid Measure Set[85]

The following table lists quality measures that will be the priority focus for Tailored Plan accountability. An asterisk (*) indicates that the measure is calculated by the Department. More information on the measures can be found in the North Carolina's Medicaid Quality Measurement Technical Specifications Manual for Standard Plans and Behavioral Health Intellectual/Developmental Disability Tailored Plans, available here.

NQF#	Measure Name	Steward
Pediatric Measures		
1516	Child and Adolescent Well-care Visits (WCV)	NCQA
0038	Childhood Immunization Status (CIS)	NCQA
0108	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)	NCQA
1407	Immunization for Adolescents (Combo 2) (IMA)	NCQA
2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	NCQA
NA	Total Eligibles Receiving at Least One Initial or Periodic Screen (Federal Fiscal Year)	DHHS
2801	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	NCQA
1392	Well-child Visits in the First 30 Months of Life (W30)	NCQA
Adult Measures		
0105	Antidepressant Medication Management (AMM)$^{\alpha}$	NCQA
0032	Cervical Cancer Screening (CCS)	NCQA
0033	Chlamydia Screening in Women (CHL)	NCQA
0059	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC)[86]	NCQA
3389	Concurrent Use of Prescription Opioids and Benzodiazepines (COB)	PQA
3175	Continuation of Pharmacotherapy for Opioid Use Disorder (OUD)$^{\alpha}$	CMS
0018	Controlling High Blood Pressure (CBP)	NCQA
1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NCQA
0039	Flu Vaccinations for Adults (FVA, FVO)*	NCQA
0576	Follow-up After Hospitalization for Mental Illness (FUH)$^{\alpha}$	NCQA
0027	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)*	NCQA
1768	Plan All-cause Readmissions (PCR) [Observed versus expected ratio]	NCQA
NA	Rate of Screening for Unmet Resource Needs$^{\alpha}$	DHHS
0418 /	Screening for Depression and Follow-Up Plan (CDF)[87]	CMS

[85] Measures are grouped into either Adult or Pediatric subsets to confirm adequate coverage of measures by population. As indicated in the North Carolina's Medicaid Quality Measurement Technical Specifications Manual for Standard Plans and Behavioral Health Intellectual/Developmental Disability Tailored Plans, all measures will be calculated for the full age range indicated regardless of where they are listed.

[86] Pending additional information regarding the collection of clinical data.

[87] Pending additional feedback regarding the collection of clinical data. This measure will be accompanied by future guidance to limit screening in patients where it's not appropriate.

NQF#	Measure Name	Steward
0418e		
NA	Total Cost of Care*	To Be Determined
2940	Use of Opioids at High Dosage in Persons Without Cancer (OHD)[α]	PQA
2950	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)[α]	PQA
Maternal Measures		
NA	Low Birthweight[88]	DHHS
1517	Prenatal and Postpartum Care • Timeliness of Prenatal Care • Postpartum Care	NCQA
NA	Rate of Screening for Pregnancy Risk	DHHS

Table 10. Department-Calculated Medicaid Measure Set[89]

The Department will calculate and monitor the following quality measures in the Medicaid program and reserves the right to report these measures at the plan-level. This list is subject to change. More information on the measures can be found in the North Carolina's Medicaid Quality Measurement Technical Specifications Manual for Standard Plans and Behavioral Health Intellectual/Developmental Disability Tailored Plans, available here.

NQF#	Measure Name	Steward
Pediatric Measures		
N/A	Avoidable Pediatric Utilization PDI 14: Asthma Admission Rate PDI 15: Diabetes Short-term Complications Admission Rate PDI 16: Gastroenteritis Admission Rate PDI 18: Urinary Tract Infection Admission Rate	Agency for Healthcare Research and Quality (AHRQ)
NA	Percentage of Eligibles Who Received Preventive Dental Services (PDENT)[90]	CMS
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (the total of all ages for each of the three rates)	NCQA
Adult Measures		

[88] The Department will work jointly with plans to calculate and report this measure.

[89] Measures are grouped into either Adult or Pediatric subsets to confirm adequate coverage of measures by population. As indicated in the North Carolina's Medicaid Quality Measurement Technical Specifications Manual for Standard Plans and Behavioral Health Intellectual/Developmental Disability Tailored Plans, all measures will be calculated for the full age range indicated regardless of where they are listed.

[90] Note: The Oral Evaluation, Dental Services and Topical Fluoride for Children measures will replace the PDENT measure in 2022 to align with the Adult Core Set.

NQF#	Measure Name	Steward
1879	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)[α]	NCQA
N/A	Admission to an Institution from the Community (AIF)	CMS
0023	Adult BMI Assessment (ABA)[91]	City of New York Department of Health and Mental Hygiene
N/A	Ambulatory Care: Emergency Department (ED) Visits (AMB)	NCQA
1800	Asthma Medication Ratio (AMR)	NCQA
N/A	Avoidable Adult Utilization: PQI 01: Diabetes Short-term Complication Admission Rate PQI 15: Asthma in Younger Adults Admission Rate PQI 05: COPD or Asthma in Older Adults Admission Rate PQI 08: Heart Failure Admission Rate PQI 15: Asthma in Younger Adults Admission Rate	AHRQ
2372	Breast Cancer Screening (BCS)	NCQA
0061	Comprehensive Diabetes Care (CDC): Blood Pressure Control (<140/90 mm Hg)	NCQA
0575	Comprehensive Diabetes Care (CDC): Hemoglobin A1c (HbA1c) Control (<8.0%)	NCQA
0547	Diabetes and Medication Possession Ratio for Statin Therapy	CMS
2607	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI)	NCQA
3489	Follow-Up After Emergency Department Visit for Mental Illness	NCQA
3488	Follow-up After Emergency Department Visit for Substance Use (FUA)[α]	NCQA
2082/ 3210e	HIV Viral Load Suppression (HVL)	HRSA
N/A	Inpatient Utilization (IU)	CMS
2856	Pharmacotherapy Management of COPD Exacerbation (PCE)	NCQA
N/A	Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI 92)	AHRQ
N/A	Statin Therapy for Patients With Cardiovascular Disease (SPC)	NCQA
2597	Substance Use Screening and Intervention Composite	American Society of Addiction Medicine
3400	Use of Pharmacotherapy for Opioid Use Disorder (OUD)	CMS
Maternal Measures		

[91] This measure has been retired by NCQA, but the Department shall continue to calculate it monitoring reasons.

NQF#	Measure Name	Steward
2903/2904	Contraceptive Care: All Women (CCW)	US Office of Population Affairs
2902	Contraceptive Care: Postpartum (CCP)	US Office of Population Affairs
1382	Live Births Weighing Less Than 2,500 Grams	CDC
NA	Prenatal Depression Screening and Follow-up (PND)	NCQA
Select Public Health Measures		
NA	Diet/Exercise ○ Increase fruit and vegetable consumption among adults ○ Increase percentage of adults who get recommended amount of physical activity Opioid Use ○ Reduce the unintentional poisoning mortality rate Tobacco Use ○ Decrease the percentage of adults who are current smokers ○ Decrease the percentage of high school students using tobacco ○ Decrease the percentage of women who smoke during pregnancy ○ Decrease exposure to secondhand smoke in the workplace	NA
Patient Satisfaction		
0006	CAHPS Survey	AHRQ
Provider Satisfaction		
NA	Provider Survey	DHHS

Table 11. EBCI Tribal Option Measure Set
The following table lists the quality measures that the EBCI Tribal Option proposes calculating reporting.

Measure	Steward
Poor Glycemic Control	GPRA
Controlling High Blood Pressure – Million Hearts	GPRA
Childhood Immunizations	GPRA

Table 12. CCNC PCCM Measure Set

The following table lists the quality measures that the CCNC PCCM is required to calculate and report annually to the Department. An asterisk (*) indicates that the measure is calculated by the Department.

NQF #	Measure	Steward
Pediatric Measures		
1516	Child and Adolescent Well-Care Visits (WCV)	NCQA
0038	Childhood Immunization Status (Combination 10) (CIS)	NCQA
1407	Immunization for Adolescents (Combination 2) (IMA)	NCQA
1492	Well-Child Visits in the First 30 Months of Life (W30)	NCQA
Adult Measures		
0032	Cervical Cancer Screening (CCS)	NCQA
0033	Chlamydia Screening in Women (Total Rate) (CHL)	NCQA
0059	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA
0018	Controlling High Blood Pressure (CBP)	NCQA
1768	Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]	NCQA
N/A	Total Cost of Care*	Health Partners

Table 13. InCK Quality Measures

The following table lists quality measures for the InCK program.

NQF#	Measure Name	Steward	Frequency
N/A	Ambulatory Care: ED visits (AMB)	NCQA	Annually
N/A	Food Insecurity Rate	NC InCK: Children's HealthWatch	Annually
N/A	Housing Instability Rate	NC InCK: National Association of Community Health Centers (NACHC)	Annually
N/A	Kindergarten Readiness Rate	NC Department of Public Instruction	Annually
N/A	Primary Care Kindergarten Readiness Bundle	NC InCK	Annually
0418/0418	Screening for Clinical Depression and Follow-Up Plan (CDF)	CMS	Annually
N/A	Screening for Food Insecurity	NC InCK	Annually
N/A	Screening for Housing Instability	NC InCK	Annually
N/A	Shared Action Plan for Children in SIL-2 and SIL-3	NC InCK	Annually

N/A	Total Cost of Care	To Be Determined	Annually
1392	Well-Child Visits in the First 30 Months of Life (Disparity Measure) (W30)	NCQA	Annually

Appendix B. Standard Plan and Tailored Plan Measures Tracked to Quality Strategy Goals

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

This Appendix does ***not*** depict the full universe of quality measures that Standard Plans and Tailored Plans are required to report or may be required to report in the future; rather, it is intended to outline select quality measures that meet the state's quality goals. All measures below will be publicly reported on the Department's website annually. As the continuous quality improvement process evolves, the Department will refine the measures required from Standard Plans and Tailored Plans, based on plan performance, the evolution of national clinical standards, and North Carolina-specific opportunities for improvement.

Measure Name	Measure Description *(for clinical and CAHPS survey measures)*	Data Source	Measure Steward *(if applicable)*
Goal 1: Ensure Appropriate Access to Care			
Getting Care Quickly **NQF #: 0006**	The survey asks enrollees how often they got care as soon as needed when sick or injured and got non-urgent appointments as soon as needed and allows the following response options: never; sometimes; usually; or always. • Q4: Respondent got care for illness/injury as soon as needed (or, for the Child Version: Child got care for illness/injury as soon as needed). • Q6: Respondent got non-urgent appointment as soon as needed (or, for the Child Version: Child got non-urgent appointment as soon as needed).	EQRO: CAHPS Health Plan Survey 5.0, Adult Version, and CAHPS Health Plan Survey 5.0, Child Version	AHRQ
Getting Needed Care **NQF #: 0006**	The survey asks enrollees how often it was easy for them to get appointments with specialists and get the care, tests, or treatment they needed through their health plan and allows the following response options: never; sometimes; usually; or always.	EQRO: CAHPS Health Plan Survey 5.0, Adult Version	AHRQ
Goal 2: Drive Patient-centered, Whole-Person Care			
Rating of All Health Care **NQF #: 0006**	The survey asks enrollees for several ratings on a scale of 0 to 10, with 0 being the worst and 10 being the best. • Q8: Rating of all health care (or, for the Child Version: Q8: Rating of all health care).	EQRO: CAHPS Health Plan Survey 5.0, Adult Version, and CAHPS Health Plan Survey 5.0, Child Version	AHRQ
Rating of Personal Doctor **NQF #: 0006**	The survey asks enrollees for several ratings on a scale of 0 to 10, with 0 being the worst and 10 being the best. • Q16: Rating of personal doctor (or, for the Child Version: Q19: Rating of personal doctor).	EQRO: CAHPS Health Plan Survey 5.0, Adult Version, and CAHPS Health Plan Survey 5.0, Child Version	AHRQ
Customer Service	The survey asks enrollees how often customer service staff were helpful and treated them with courtesy and respect and allows	EQRO: CAHPS Health Plan Survey 5.0, Adult Version	AHRQ

Measure Name	Measure Description *(for clinical and CAHPS survey measures)*	Data Source	Measure Steward *(if applicable)*
NQF #: 0006	the following response options: never; sometimes; usually; or always. • Q22: Customer service gave necessary information/help (or, for the Child Version: Q25: Customer service gave necessary information/help). • Q23: Customer service was courteous and respectful (or, for the Child Version: Q26: Customer service was courteous and respectful).		
Coordination of Care **NQF #: 0006**	The CAHPS Health Plan Survey is a survey that asks health plan enrollees to report about their care and health plan experiences as well as the quality of care received from physicians.	EQRO: CAHPS Health Plan Survey 5.0, Adult Version	AHRQ
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications **NQF #: 1932**	The percentage of patients 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	Tailored Plans: Claims Data	NCQA
Goal 3: Promote Wellness and Prevention			
Childhood Immunization Status (Combination 10) **NQF #: 0038**	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	Standard Plans and Tailored Plans: Claims Data	NCQA
Well-Child Visits in the First 30 Months of Life **NQF #: 1392**	The percentage of members who had the following number of well-child visits during the last 30 months. Two rates will be reported: • Well-Child Visits in the First 15 Months: Six or more well-child visits • Well-Child Visits for Age 15 Months – 30 Months: Two or more well-child visits	Standard Plans and Tailored Plans: Claims Data	NCQA
Immunizations for Adolescents (Combo 2) **NQF #: 1407**	The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine and one tetanus, diphtheria, toxoids and acellular pertussis (Tdap) vaccine; and have completed the human papillomavirus (HPV) vaccine series by their	Standard Plans and Tailored Plans: Claims Data	NCQA

Measure Name	Measure Description *(for clinical and CAHPS survey measures)*	Data Source	Measure Steward *(if applicable)*
	13th birthday. The measure calculates a rate for each vaccine and two combination rates.		
Cervical Cancer Screening **NQF #: 0032**	The percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: • Women 21-64 years of age who had cervical cytology performed every 3 years. • Women 30-64 years of age who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.	Standard Plans and Tailored Plans: Claims Data	NCQA
Chlamydia Screening in Women **NQF #: 0033**	The percentage of women 16-24 years of age who were identified as sexually active and who had at least 1 test for chlamydia during the measurement year.	Standard Plans and Tailored Plans: Claims Data	NCQA
Prenatal and Postpartum Care (Both Rates) **NQF #: N/A**	The percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care: • Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization. • Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	Standard Plans and Tailored Plans: Claims Data	NCQA
Low Birth Weight **NQF #: N/A**	The percentage of births with birth weight <2,500 grams.	State Vital Records	DHHS
Goal 4: Improve Chronic Condition Management			
Follow-Up After Hospitalization for Mental Illness **NQF #: 0576**	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: • The percentage of discharges for which the member received follow-up within 30 days after discharge. • The percentage of discharges for which the member received follow-up within 7 days after discharge.	Standard Plans and Tailored Plans: Claims Data	NCQA
Antidepressant Medication Management **NQF #: 0105**	Percentage of patients 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported: • Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).	Standard Plans and Tailored Plans: Claims Data	NCQA

Measure Name	Measure Description *(for clinical and CAHPS survey measures)*	Data Source	Measure Steward *(if applicable)*
	• Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).		
Comprehensive Diabetes Care: HbA1c Control (>9%) **NQF #: 0059**	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or for whom an HbA1c test was not done during the measurement year.	Standard Plans and Tailored Plans: Claims Data	NCQA
Asthma Medication Ratio (Total Rate) **NQF #: 1800**	The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	Standard Plans and Tailored Plans: Claims Data	NCQA
Controlling High Blood Pressure **NQF #: 0018**	The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria: • Members 18-59 years of age whose BP was <140/90 mm Hg. • Members 60-85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Members 60-85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg. *Note: A single rate is reported and is the sum of all three groups.*	Standard Plans and Tailored Plans: Claims Data	NCQA
Goal 5: Work with Communities to Improve Population Health			
Rate of Screening for Unmet Health-Related Resource Needs	The percentage of enrollees screened for unmet social needs from the health risk screening by the plan within measurement period.	Standard Plans and Tailored Plans: Standardized Screening Tool	DHHS
Concurrent Use of Prescription Opioids and Benzodiazepines **NQF #: 3389**	The percentage of individuals 18 years of age and older with concurrent use of prescription opioids and benzodiazepines during the measurement year.	Standard Plans and Tailored Plans: Claims Data	PQA
Continuation of Pharmacotherapy for Opioid Use Disorder **NQF #: 3175**	Percentage of adults 18-64 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment.	Tailored Plans: Claims Data	CMS

Measure Name	Measure Description *(for clinical and CAHPS survey measures)*	Data Source	Measure Steward *(if applicable)*
Medical Assistance with Smoking and Tobacco Use Cessation **NQF #: 0027**	The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation: • Advising Smokers and Tobacco Users to Quit. A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year. • Discussing Cessation Medications. A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. • Discussing Cessation Strategies. A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.	EQRO: CAHPS Health Plan Survey 5.0, Adult Version	AHRQ
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (the total of all ages for each of the three rates) **NQF #: 0024**	The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: • BMI percentile documentation. • Counseling for nutrition. • Counseling for physical activity. • Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.	Standard Plans and Tailored Plans: Claims Data	NCQA
Goal 6: Pay for Value			
Total Cost of Care **NQF #: N/A**	TBD	TBD	Health Partners
Plan All-Cause Readmissions **NQF#: 1768**	For patients 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: • Count of Index Hospital Stays* (denominator) • Count of 30-Day Readmissions (numerator)	Standard Plans and Tailored Plans: Claims Data	NCQA

Measure Name	Measure Description *(for clinical and CAHPS survey measures)*	Data Source	Measure Steward *(if applicable)*
	• Average Adjusted Probability of Readmission *An acute inpatient stay with a discharge during the first 11 months of the measurement year (e.g., on or between January 1 and December 1).		
Avoidable Pediatric Utilization	Discharges for patients ages 6 to 17 years, that meet the inclusion and exclusion rules for any of the following PDIs: • PDI 14: Asthma Admission Rate • PDI 15: Diabetes Short-Term Complications Admission Rate • PDI 16: Gastroenteritis Admission Rate • PDI 18: Urinary Tract Infection Admission Rate	Standard Plans and Tailored Plans: Claims Data	AHRQ
Avoidable Adult Utilization	Discharges, for patients ages 18 years and older, that meet the inclusion and exclusion rules for the numerator in any of the following PQIs: • PQI 01: Diabetes Short-term Complication Admission Rate • PQI 05: COPD or Asthma in Older Adults Admission Rate • PQI 08: Heart Failure Admission Rate • PQI 15: Asthma in Younger Adults Admission Rate	Standard Plans and Tailored Plans: Claims Data	AHRQ

Appendix C. 2021 Standard Plan PIP Aims and Interventions[92]

The following are the Standard Plan PIPs for Calendar Year (CY) 2021 as assessed during the EQR for each plan.

Standard Plan	PIP Topic	PIP Aim	Intervention
Carolina Complete Health	Childhood Immunization Status	Increase the Combo-10 immunization rate for Carolina Complete Health's eligible two-year old members from 36% to 41%.	Not Available
	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	Decrease the percentage of Carolina Complete Health's members ages 18 to 75 with diabetes (type 1 and type 2) who have HbA1c poor control (>9.0%) from 40% to 35%.	
	Maternal Health: Timeliness of Prenatal Care	Increase the Timeliness of Prenatal Care rate for Carolina Complete Health's eligible deliveries of live births from 40% to 45%.	
	Improve Provider Satisfaction	Increase by 5% from baseline the percentage of a plan's contracted primary care and OB/GYN providers who responded with "Excellent" or "Good" to Question #19 - How would you describe your overall experience interacting with Carolina Complete Health of the DHB North Carolina Provider Experience Survey.	
Healthy Blue of North Carolina	Impact of Member Incentives on Adherence to Timely Childhood Immunizations	Increase Healthy Blue's Combo-10 immunization rate for Healthy Blue's eligible two year old members.	Not Available

[92] Information on Tailored Plan PIPs will be added once available.

	Impact of Care Coordination Delivered by Tier 3 Advance Medical Homes on Diabetes Management	Decrease the percentage of Healthy Blue's members ages 18 to 75 with diabetes (Type 1 and Type 2) who have who have HbA1c poor control (>9.0%).	• Provider Support Visits by AMH Tier (rolled up to CINs) and Region: The Provider Relation team hosts ongoing "Office Hour Calls" and In-Person visits with network providers to assess overall performance and offer support to include education on proper billing of CPT codes, if needed.
	Method of Member Outreach and Impact on Timely Prenatal Visits	Increase Healthy Blue's Timeliness of Prenatal Care rate.	• Healthy Blue My Advocate Program: This program assists with the identification of high-risk pregnancy for referrals to the local health departments' Case Management High Risk Pregnancy Program (CMHRP). It 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. • Engagement via Live Telephonic Call Campaign: Members identified (per the denominator) receive assistance with making OB appointments. In addition, 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 drivers of health factors. • Text Message Engagement Campaign: Members identified (per the denominator) are reminded to schedule appointments and of upcoming scheduled appointments.
	Method of Counseling and Impact on Sustained Tobacco Cessation	Increase the percentage of Healthy Blue's members ages 13 years and older identified as tobacco users who self-report at least 30 days tobacco cessation.	• Telephonic Counseling with a certified Tobacco Cessation Specialist (Optum Quit for Life), Provider Office visit w/ PCP, or Telehealth Visit.
AmeriHealth Caritas North Carolina	Improving Childhood Immunizations with Combo 10	Increase the percentage of Members in the eligible population who complete immunization requirements.	Not Available
	Comprehensive Diabetes Care for Members with Hemoglobin A1c Control Over 9.0	Decrease the percentage of members with an HbA1c result equal to or greater than 9%.	
	Timeliness of Prenatal Care	Increase the percentage of women in the eligible population who receive a prenatal visit either within the first trimester, on or before the enrollment start date or within 42 days of enrollment with AmeriHealth Caritas North Carolina.	
	Referral Management to NCCare 360 for SDOH	Increase the percentage of Members who have a positive screening for unmet health-related resource needs and are referred to NCCARE360, on or before the enrollment start date.	

UnitedHealthcare of North Carolina	Increasing Childhood Immunizations Combination 10 Rates	Increase the percentage of eligible children that receive the required Combo 10 series of immunizations during the measurement year.	Not Available
	Comprehensive Diabetes Care (CDC)—HbA1c Poor Control	Decrease the percentage of eligible members who have HbA1c of greater than 9% during the measurement year.	
	Timeliness of Prenatal Care	Increase the percentage of deliveries that received a prenatal care visit within the required timeframe during the measurement year.	
	Maximizing Care Needs Screening Completion Rates	Increase the percentage of care needs screening that are completed within 90 days of enrollment during the measurement period.	
WellCare of North Carolina	Childhood Immunizations	Increase the rate of compliance with childhood immunizations combo 10 for WellCare eligible members as measured by the Childhood Immunization Status measure.	• Select a Secondary performance measure 1: This HEDIS measure is an indicator of how many visits an enrolled child had with their primary care provider. It is at these visits where a child would receive their immunizations. Members requiring visits will appear on member specific care gap reporting delivered to providers. • Select a Secondary performance measure 2: The percentage of WellCare Medicaid members enrolled for at least 12 months with a diagnosis of measles on a claim.

	Comprehensive Diabetes Care: HbA1c Poor Control (9.0%)	Reduce the percentage of members with a HbA1c greater than 9%.	• Select a Secondary performance measure 1: The percentage of members 18-75 years of age with diabetes (type 1 and 2) who had Hemoglobin A1c (HbA1c) testing. • Select a Secondary performance measure 2: The percentage of members with diabetes who have not had a visit with a primary care provider in the past 12 months.
	Timeliness of Prenatal Care	Increase the percentage of women who receive timely prenatal care as defined by the percentage of women who received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment.	• Select a Secondary performance measure: Prevalence of low birth weight.
	Access to Preventive/Ambulatory Care	Increase the number of preventive care visits for eligible members (20 years and older as of the measurement year) as measured by the Healthcare Effectiveness Data and Information Set (HEDIS) Adults' Access to Preventive/Ambulatory Health Services (AAP).	• Select a Secondary performance measure: CAHPS Survey Question "In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed? • Select a Secondary performance measure: The percentage of members without a visit within the measurement year.

Appendix D. External Quality Review Organization (EQRO) Activities

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

Mandatory EQRO Activities
• Validation of PIPs conducted by each plan • Validation of each plan's reported performance measures • Review of each plan's compliance with the standards set forth in 42 CFR 438 Subpart D • Validation of plan network adequacy[93] • Annual technical report that summarizes findings on access and quality of care, including the requirements set forth in 42 CFR 438.364
Optional Activities
• Validation of encounter data reported by each plan • Administration of the CAHPS Plan Survey and Provider Survey • Calculation of performance measures in addition to those reported by Standard Plans and Tailored Plans, at the direction of the Department or as required for completion of the technical and/or health equity report • Completion of studies on quality that focus on an aspect of clinical or non-clinical services at a point in time (e.g., specific assessment of the interventions described within this Quality Strategy), at the direction of the Department • Administration of the annual provider survey • Conducting Quality Forums
Additional Activities
• Review, in conjunction with the requirements set forth in 42 CFR 438 Subpart D, of the requirements set forth by the Department in plan contracts • Technical assistance to Standard Plans and Tailored Plans as related to conducting PIPs, quality reporting, and accreditation preparedness, as directed by the Department • Annual healthy equity report, assessing plan and program-wide performance against select measures indicated in/based on select strata, including age, race, ethnicity, sex, and primary language, and a breakdown of measures for key population groups (e.g., LTSS) • Tracer audits of each plan for program integrity

[93] Validation of network adequacy is required by 42 CFR 438.358(b)(iv), pending release of EQRO protocols related to this requirement. In the interim, the Department utilizes the EQRO for this function as an additional activity. Additional information can be found in this June 2016 CMS informational bulletin, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib061016.pdf

Appendix E. Minimum Required Elements of Standard Plans and Tailored Plans' Annual Fraud Prevention Plans and Reports

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

Annual Fraud Prevention Report Minimum Requirements
• The name of the plan
• The name of the person and department responsible for submitting the Fraud Prevention Report

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