

North Carolina's Medicaid Managed Care Quality Strategy

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I. Introduction and Overview

North Carolina's Medicaid and NC Health Choice 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 births, 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.¹

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. Since that time, the Department has collaborated with the General Assembly and stakeholders to plan the implementation of this directive. The Department is committed to transitioning 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 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 build an innovative, whole-person, well-coordinated system of care that addresses both medical and non-medical drivers of health and an enhanced focus on promoting health equity.

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

North Carolina currently has 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** are delivered by NC Medicaid Direct and managed through the Primary Care Case Management (PCCM) program, named Community Care of North Carolina (CCNC). The program is administered by the North Carolina Department of Health and Human Services (the Department). While the majority of behavioral health services are provided separately through Local Management Entities – Managed Care Organizations (LME-MCOs) described below, there are some medical homes that integrate basic behavioral services in their practices.
- **Behavioral health and I/DD services** are delivered by local managed care organizations. 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 concept was initially designed as a pilot project to serve Medicaid beneficiaries with mental health, developmental disabilities and substance abuse needs in a limited geographical catchment area. The pilot LME-MCO also delivered home- and community-based services and supports through the Innovations Waiver, a 1915(c) home and community-based services waiver for individuals with intellectual/developmental disabilities. 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

¹ Kaiser Family Foundation. Medicaid State Fact Sheets. North Carolina. Available at: files.kff.org/attachment/fact-sheet-medicaid-state-NC

the delivery system for Medicaid and state-funded mental health, substance use and intellectual/developmental disabilities services. Currently, the Department contracts with seven regional LME-MCOs, which act as capitated prepaid inpatient health plans (PIHPs), to operate Medicaid-funded services in different regions of the State. The LME-MCOs quality strategy is aligned with the quality strategy outlined in this document.

(B) North Carolina's Transition to Managed Care

Entities that will deliver services to Medicaid and NC Health Choice enrollees after managed care launch, and who will be involved in quality measurement and improvement efforts, are described below:

Managed Care Plans

Standard Plans

On July 1, 2021, the Department is mandated under NC Session Law 2015-245, Session Law 2018-48, and Session Law 2020-88 to transition most Medicaid and NC Health Choice beneficiaries to fully capitated and integrated plans called Standard Plans.² The majority of Medicaid and NC Health Choice enrollees, including adults and children with low to moderate intensity behavioral health needs, will receive integrated physical health, behavioral health and pharmacy services through Standard Plans.

Behavioral Health I/DD Tailored Plans

Managed care eligible Medicaid and NC Health Choice beneficiaries with intellectual and developmental disabilities (I/DD), traumatic brain injuries (TBIs), and/or more serious behavioral health disorders, who meet the criteria specified by NC Session Law 2018-48, will be enrolled into Behavioral Health and Intellectual and Developmental Disability Tailored Plans (hereafter referred to as BH I/DD Tailored Plans), which are regional, specialized managed care products targeting the needs of these populations. BH I/DD 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, BH I/DD Tailored Plans will be responsible for managing State-funded BH, I/DD, and TBI services as LME-MCOs currently do for uninsured and underinsured individuals. BH I/DD Tailored Plans are anticipated to launch on July 1, 2022.

Prior to BH/IDD Tailored Plan launch in 2022, beneficiaries identified through regular reviews of encounter and claims data as eligible for the future BH I/DD 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.

Specialized Foster Care Plan

In addition to Standard Plans and BH I/DD Tailored Plans, the Department intends to launch a single Specialized Foster Care Plan that covers all regions and mitigates disruptions in care and coverage for children in foster care, children receiving adoption assistance and former foster youth under age 26 (collectively

² Full text of SL 2015-245 is available at ncleg.gov/EnactedLegislation/SessionLaws/HTML/2015-2016/SL2015-245.html
Full text of SL 2018-48 is available at ncleg.net/EnactedLegislation/SessionLaws/HTML/2017-2018/SL2018-48.html
Full text of SL 2020-88 is available at ncleg.gov/Sessions/2019/Bills/Senate/PDF/S808v8.pdf

referred to as “children in foster care”). Designed to meet the unique health care needs of this population, the Specialized Foster Care Plan will enable children in foster care across the state to access a full range of physical health and behavioral health services, including a number of specialized behavioral health services, and maintain treatment plans even if their placement changes. The Specialized Foster Care Plan will serve as the central entity accountable for the care of these beneficiaries and ensure that children in foster care 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 will be able to bid on the Specialized Foster Care Plan, on the condition that the plan can operate statewide. The transition of children in foster care into Medicaid managed care will occur one year after the launch of BH I/DD Tailored Plans and is scheduled for July 1, 2023.

Since the Specialized Foster Care Plan will also hold a contract for either a Standard Plan or a BH I/DD Tailored Plan, this document primarily focuses on requirements for Standard Plans and BH I/DD Tailored Plans. As Specialized Foster Care Plan design is still underway, the Department will revisit this document in the future to update for its inclusion.

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 North Carolina Department of Health and Human Services to support the Eastern Band of Cherokee Indians (EBCI) in addressing the health needs of American Indian/Alaskan Native Medicaid beneficiaries.³ This Indian Managed Care Entity is the first of its kind in the nation and will establish a new delivery system called the EBCI Tribal Option.

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 is set to launch in July 2021, along with Standard Plans. The EBCI Tribal Option will manage health care for approximately 4,000 Tribal Medicaid beneficiaries residing primarily in Cherokee, Graham, Haywood, Jackson and Swain counties. The program will have a strong focus on primary care, preventive health, chronic disease management and provide care management for all members and care management service plans for high-need members.⁴ The EBCI Tribal Option will coordinate 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 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

During the managed care implementation period, physical health services will continue to be delivered by

³ The EBCI Tribal Option Fact Sheet is available here files.nc.gov/ncdhhs/medicaid/TribalOption-FactSheet-FINAL-20190917.pdf

⁴ Cherokee One Feather, NCHHS and CIHA launching EBCI Tribal Option program for Medicaid beneficiaries. November 3, 2020.

Available at theonefeather.com/2020/11/nchhs-and-ciha-launching-ebc-tribal-option-program-for-medicaid-beneficiaries/#:~:text=The%20EBCI%20Tribal%20Option%20is,to%20receive%20Indian%20Health%20Services.&text=The%20EBCI%20Tribal%20Option%20is%20part%20of%20North%20Carolina's%20transition,launch%20on%20July%201%2C%202021

providers under NC Medicaid Direct and managed by the PCCM program for enrollees not enrolled in a fully capitated and integrated managed care plan or in the EBCI Tribal Option.⁵ The PCCM Program provides enhanced and coordinated care for patients through multiple activities, including preventive services, data analysis, community-based care coordination and care management.

Within this document, the term “plans” refers to Standard Plans and/or Behavioral Health I/DD Tailored Plans. The document explicitly references the Specialized Foster Care Plan, the EBCI Tribal Option and CCNC, respectively, when provisions also apply to them.

(C) Populations Included in Managed Care

As noted, starting in July 2021, most Medicaid and NC Health Choice populations will be mandatorily enrolled in managed care Standard Plans or BH I/DD Tailored Plans, with several exceptions described below.

Populations Not Initially Included in Managed Care Enrollment

There are limited exceptions to mandatory enrollment for some populations who 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 BH I/DD Tailored Plans, will be delayed in their enrollment, allowing for additional time to conduct thoughtful planning and a seamless transition to managed care. Excluded, exempt and delayed populations are described in Figure 1 below.

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

Exempt Populations	
<ul style="list-style-type: none"> • Beneficiaries eligible to receive services from the Indian Health Service (IHS), including members of the EBCI. <ul style="list-style-type: none"> ○ As noted above, some of these individuals will have the opportunity to enroll in the EBCI Tribal Option. 	
Excluded Populations ⁶	
<ul style="list-style-type: none"> • 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; • Medically needy beneficiaries (also known as “Spend Down”), except for those enrolled in the Innovations and TBI waivers; • Presumptively eligible beneficiaries, during the period of presumptive eligibility; • Health Insurance Premium Payment (HIPP) beneficiaries, except for those enrolled in the Innovations and TBI waivers; • Beneficiaries enrolled under the Medicaid family planning program; • Beneficiaries who are inmates of prisons; • 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; and • Beneficiaries enrolled in the COVID-19 testing benefit. 	
Delayed Populations	
Special Populations	Expected Phase-in Timeline (no earlier than)

⁵ Individuals who are members of a federally recognized tribe and foster care enrollees can opt in to receiving services by the PCCM, but are not required to enroll.

⁶ NC Session Law 2015-245 as amended by Session Law 2016-121 and NC Session Law 2018-49.

BH I/DD Tailored Plan-eligible Populations ^{7, 8}	July 2022
<ul style="list-style-type: none"> • Beneficiaries with a serious emotional disturbance (SED) or a diagnosis of severe substance use disorder (SUD) or TBI 	
<ul style="list-style-type: none"> • Beneficiaries with a developmental disability as defined in G.S. 122C 3(12a) 	
<ul style="list-style-type: none"> • Beneficiaries with a mental illness diagnosis who also meet any of the following criteria: <ul style="list-style-type: none"> ○ 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 Initiative (TCLI) settlement agreement ○ Beneficiaries with two or more psychiatric hospitalizations or readmissions within the prior 18 months ○ 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 BH I/DD Tailored Plan ○ Individuals known to the Department or an LME-MCO to have had one or more involuntary treatment episodes within the prior 18 months 	
<ul style="list-style-type: none"> • Beneficiaries who, regardless of diagnosis, meet any of the following criteria: <ul style="list-style-type: none"> ○ 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 BH I/DD Tailored Plan ○ 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 a BH I/DD Tailored Plan ○ 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 ○ Children with complex needs, as that term is defined in the 2016 settlement agreement between the Department and Disability Rights of North Carolina ○ 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 Populations⁹	
<ul style="list-style-type: none"> • Children in foster care, receiving Title IV-E adoption assistance, under the age of 26 and formerly were in the foster care system 	Two years after managed care implementation
<ul style="list-style-type: none"> • Medicaid-only beneficiaries receiving long-stay nursing home services 	Within five years of managed care implementation
<ul style="list-style-type: none"> • Individuals who are dual-eligible for Medicare and Medicaid 	Within five years of managed care implementation

(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 provide behavioral health and I/DD services to populations excluded or delayed from mandatory enrollment in NC Medicaid Managed Care at launch and will continue to administer the Innovations and TBI waivers as well as manage State-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 care 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.

⁷ Section 4.(5) of Session Law 2015-245, as amended by Session Law 2018-48.

⁸ For more information on BH I/DD Tailored Plan Eligibility and Enrollment, please refer to final policy guidance published at ncdhhs.gov/assistance/medicaid-transformation/proposed-program-design/policy-papers and subsequent updates that can be found at 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>.

⁹ Section 4.(5) of Session Law 2015-245, as amended by Section 5.(b) of Session Law 2018-49.

When BH I/DD Tailored Plans launch in July 2022, delayed populations described in Figure 1 will become eligible for BH I/DD Tailored Plans. Beneficiaries that are eligible for BH I/DD Tailored Plans will receive a notice informing them they will be auto-enrolled into the BH I/DD Tailored Plan in their region upon BH I/DD 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; 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. <i>Make health care more person-centered, coordinated, and accessible.</i>	Goal 1: Ensure appropriate access to care	Objective 1.1: Ensure timely access to care
		Objective 1.2: Maintain Medicaid provider engagement
	Goal 2: Drive 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. <i>Improve the health of North Carolinians through prevention, better treatment of chronic conditions and better behavioral health care, working collaboratively with community partners.</i>	Goal 3: Promote wellness and prevention	Objective 3.1: Promote child health, development and wellness
		Objective 3.2: Promote women’s health
		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

Aims	Goals	Objectives
	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. <i>Pay for value rather than volume, incentivize innovation, and ensure appropriate care.</i>	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 during and 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.¹⁰ 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:

- Objective 1.2 (maintain Medicaid provider engagement) under **Goal 1** (ensure 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 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 BH/IDD 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)).

¹⁰ More information is available at: nciom.org/metrics-to-drive-improvements-in-health-a-report-of-the-task-force-on-health-care-analytics/

- Objectives aligned to **Goal 3** (promote wellness and prevention) reflect a continued emphasis on improving the health of children and women. More than half of all Medicaid beneficiaries in the State as of 2019 are children (56%).¹¹
- Objectives related to **Goal 4** (improve chronic condition management) focus on conditions that heavily impact 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 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.
- 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 enrolled in Standard Plans or BH I/DD Tailored Plans.

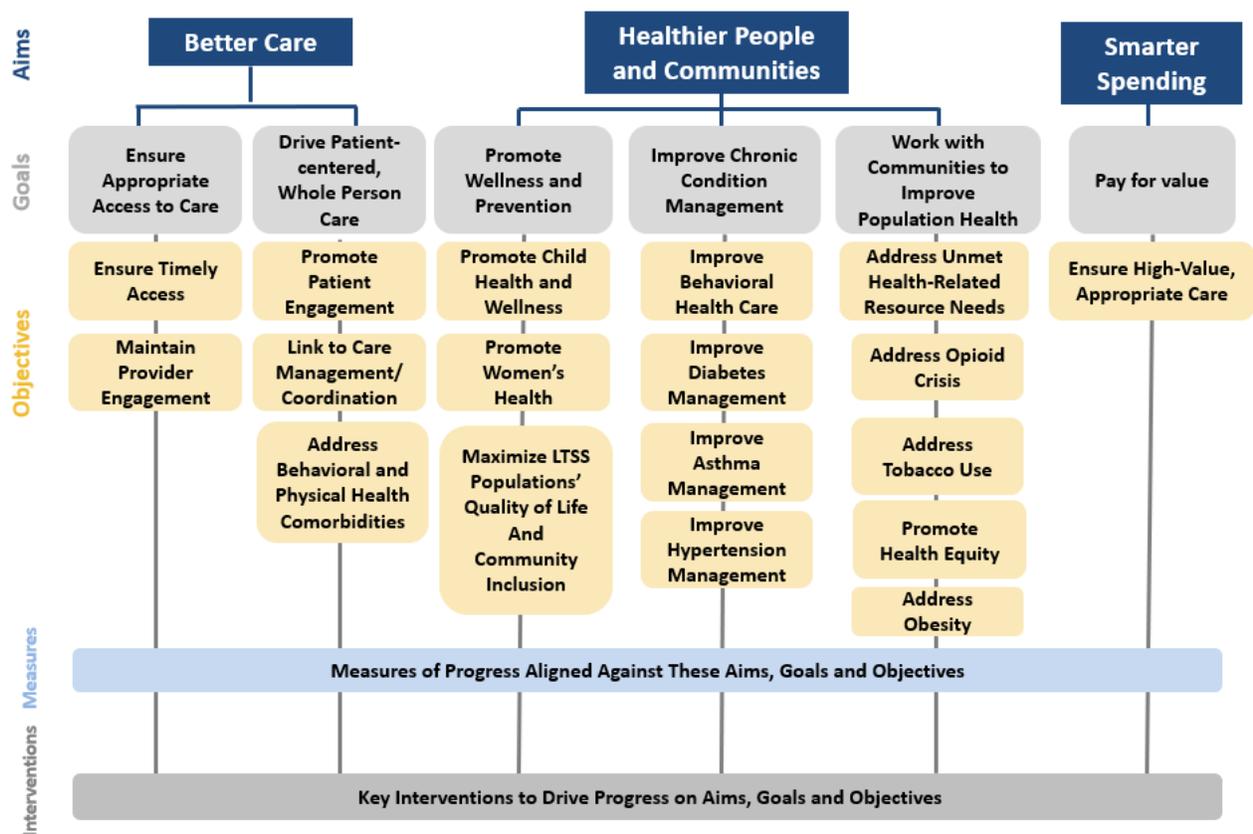
Each of the 18 Objectives are tied to a series of focused interventions (described in detail in Section III(C)) used to drive improvements within, and in many cases across, the Goals and Objectives set forth in this Quality Strategy. To assess the impact of these interventions and continue to identify 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.

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 BH I/DD 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 C 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 MC Medicaid Managed Care beneficiaries (Figure 3).

¹¹ Medicaid and NC Health Choice Annual Report for State Fiscal Year 2019. Available at files.nc.gov/ncdma/SFY2019-MedicaidAnnualReport-FINAL-20191220.pdf

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 BH I/DD 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 BH I/DD 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 BH I/DD 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.¹²

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

¹² For more information on the Child and Adult Core Set, refer to [medicaid.gov/federal-policy-guidance/downloads/cib111417.pdf](https://www.medicaid.gov/federal-policy-guidance/downloads/cib111417.pdf)

For the first two years of managed care implementation, the Department will set a benchmark for each measure (with the exception of measures of contraceptive care) of 105% of the prior year's North Carolina Medicaid overall performance for that measure. Standard Plans, BH I/DD Tailored Plans and the PCCM program (CCNC) will each be compared against their respective program's historical performance. For the third plan year and beyond, the Department will monitor performance and may adjust the benchmarking methodology.

Additionally, and as is further described in Section V(A), the EQRO provides the results of the **Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey**, which asks beneficiaries to report on their experiences accessing care. The Department requires reporting on beneficiary responses including the Adult 5.0 and Children 4.0 surveys. 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.¹³

The Department uses these patient-reported measures 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.¹⁴ As other special plans and programs are included in managed care, the Department will assess the incorporation of special population-targeted quality measures.

In addition to quality measures set forth in this Quality Strategy, the Department requires that Standard Plans and BH I/DD Tailored Plans report several additional areas, including access and compliance with state standards (as noted in Section IV). The Department will review these reports for quality assurance and improvement purposes.

Behavioral Health Measures for Standard Plans and BH I/DD Tailored Plans

As described above, the State has selected multiple Objectives focused specifically on behavioral health, each of which is tied to select quality measures described in Appendix B. These Objectives and the related 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, 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, Tables 8-10 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.

¹³ For more information on the CAHPS Health Plan Survey, refer to qualityforum.org/QPS/MeasureDetails.aspx?standardID=903&print=0&entityTypeID=1.

¹⁴ 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 qualityforum.org/Projects/n-r/Patient-Reported_Outcomes/Patient-Reported_Outcomes.aspx

Opioid Measures—Focusing on Drug Monitoring and Substance Abuse 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, Table 9). 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, DHHS 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 impacted by required plan activities, such as tobacco cessation assistance and BMI screening.

Specialized Foster Care Plan Measures

The Department will establish a set of quality measures as a key mechanism to ensure Specialized Foster Care Plan accountability. The Specialized Foster Care Plan will be held accountable for robust and dedicated measures that prioritize person-centeredness and personalization of goals, as well as management of a wide range of comorbidities. Although the Department aims to align with BH I/DD Tailored Plan quality measures when possible, it also recognizes the need to differentiate and prioritize alternative measures for the Specialized Foster Care Plan that reflect the needs and experiences of beneficiaries.

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. These EBCI Tribal Option measures will be 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 ages 19 through 35 months at the end of the reporting period.

Primary Care Case Management (Community Care of North Carolina)

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).

(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 current 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 BH I/DD Tailored Plan Request for Applications Pre-Release Policy Paper.¹⁵ DHHS also released an Request for Information (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.¹⁶ Each of these program design documents laid the groundwork for how DHHS will drive quality, value, care improvement, beneficiary protections and plan accountability in a new managed care environment.

Public comments related to Quality 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. 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 events. In addition, the launch of BH I/DD Tailored Plans will present an opportunity to incorporate additional measures of particular relevance to the specific populations covered. Commenters also 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

¹⁵ Policy papers are available at ncdhhs.gov/assistance/medicaid-transformation/proposed-program-design/policy-papers

¹⁶ For additional information on the November 2017 RFIs, refer to ncdhhs.gov/news/press-releases/dhhs-releases-request-information-medicare-managed-care-program

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.¹⁷ 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 BH I/DD 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 North Carolina Institute of Medicine (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):

- Input was obtained from the Medical Care Advisory Committee; and
- The Eastern Band of Cherokee Indians (EBCI) Tribe was consulted in accordance with the State's Tribal consultation policy.

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

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 this 2021 update, the Department is:

- Integrating BH I/DD Tailored Plan design components (to include State-funded Services) into the Quality Strategy;
- Reframing references to the quality measure set to align with recent Standard Plan and BH I/DD Tailored Plan managed care contract/RFA changes; to include addition of all relevant measure sets (e.g., Standard Plan, BH I/DD Tailored Plan, Advanced Medical Home, EBCI Tribal Option and PCCM [CCNC]);
- Updating the list of interventions that align with the objectives, aims and goals of the Quality Strategy; and
- Incorporating the Specialized Foster Care Plan, EBCI Tribal Option and CCNC into the Quality Strategy.

The 2021 update to the Quality Strategy incorporates feedback received during the 30-day public comment period, which 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).

¹⁷ A hybrid measure is a quality measure that uses more than one source of data for measure calculation.

During the 2021 update and similar to prior updates, the EBCI Tribe was consulted in accordance with the State’s Tribal consultation policy.

The Department will review and update the Quality Strategy as needed or upon a significant change, and no less than once every three years.¹⁸

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

- A pervasive pattern of quality deficiencies identified through analysis of the quality performance data submitted by the Standard Plans and BH I/DD 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.¹⁹

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 and, 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 C of this Quality Strategy.

III. Improvements and Interventions

(A) Quality Assessment and Performance Improvement Programs

The Department requires that Standard Plans and BH I/DD 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;

¹⁸ This Quality Strategy will start at the launch of managed care, currently planned for July 1, 2021, with an update on or before June 30, 2024, or upon significant change.

¹⁹ 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 the quality and appropriateness of care for beneficiaries with special health care needs (defined in Section IV(A)(5));
- 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 survey.

In order for the Department to monitor and ensure the accuracy of managed care plan reporting and assess performance against quality measures on a plan-specific and program-wide basis (as described in Section V(A)), Standard Plans and BH I/DD 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 C.²⁰

The Department and the EQRO will conduct assessments to oversee Standard Plans and BH I/DD Tailored Plans’ performance against the quality Aims, Goals, and Objectives, and measures further described in Section II(B). In addition, Standard Plans and BH I/DD 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 BH I/DD 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(A)) serves as a key Department interface with plans, and is driven by the data collected throughout the assessment processes (described in Section V).

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

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

1. Performance Improvement Projects (PIPs)²¹

²⁰ CMS protocols for EQRO-related activities are available at [medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html](https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html).

²¹ CMS has not specified standard, nationally required PIPs to date.

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. Examples of mandatory clinical PIPs include:

- Diabetes prevention
- Immunizations
- Prenatal care

BH I/DD Tailored Plans must conduct at least three PIPs, which must be approved by the Department and include:²²

- One or more clinical PIP(s), for which the Department may direct BH I/DD Tailored Plans to focus on a specific topic, or where BH I/DD 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.

In addition to the required PIPs, if a Standard Plan or BH I/DD 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 BH I/DD 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). PIPs will be validated by the EQRO and reviewed by the Department. As part of required PIP reporting, Standard Plans and BH I/DD Tailored Plan must describe the details of interventions used to address the issues PIPs focus on, including a description of how health equity will be addressed through improvement strategies/interventions.

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

²² 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.

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 error.

(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.²³ The State plans to use its Quality and Population Health Department and as well as an internal Quality Committee and the Quality Subcommittee of the MCAC to effectively monitor and review plan performance across quality efforts to support key decision-making and ongoing assessment of plan performance against the Aims, Goals and Objectives previously noted. The MCAC will be developed to include 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, BH I/DD 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 closely interact 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

²³ 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; 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 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.

be assessed using measures defined in Appendix A and Appendix B.

Each intervention is briefly described below. In addition, many of these interventions are described in further detail in North Carolina's Proposed Program Design for Medicaid Managed Care,²⁴ and are described in a series of concept papers related to North Carolina's Medicaid transformation.²⁵

1. Opioid and SUD Strategy

As in many states, North Carolina's opioid epidemic continues to evolve into a more deadly and complicated polypharmacy and illicit drug overdose epidemic.²⁶ 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 Action Plan 2.0](#) to reduce opioid addiction and overdose deaths from 2017 to 2021. The state's 1115 SUD demonstration expands access to the full American Society of Addiction Medicine (ASAM) continuum of care, including residential treatment.

To align with the state's Medicaid strategy, Standard Plans and BH I/DD Tailored Plans are required to implement an Opioid Misuse Prevention and Treatment Program that contains interventions that work 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 BH I/DD 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 BH I/DD 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, BH I/DD Tailored Plans are required to ensure they have sufficient network capacity across SUD treatment and pain management services, and include plans to expand network capacity, as needed, in their network access plans. 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

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 impact health outcomes and cost and promoting "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

²⁴ North Carolina's Proposed Program Design for Medicaid Managed Care. August 2017. Available at: files.nc.gov/ncdhhs/MedicaidManagedCare_ProposedProgramDesign_FINAL_20170808.pdf

²⁵ Concept papers related to North Carolina's Medicaid transformation are available at ncdhhs.gov/nc-medicaid-transformation.

²⁶ NC Opioid Action Plan 2.0 is available at files.nc.gov/ncdhhs/OAP-2.0-8.7.2019_final.pdf.

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The Department is addressing the conditions in which people live that directly impact health, known as the social determinants of health (SDOH) – “the structural determinants and conditions in which people are born, grow, live, work and age”.²⁹ 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, increase the risk that patients will develop chronic conditions and drive cost.

To effectively address these challenges, the Department is embedding strategies to promote Healthy Opportunities into its Medicaid program in several ways, including but not limited to:³⁰

- Deploying a standardized set of screening questions related to food insecurity, housing instability, transportation needs and interpersonal violence, which Standard Plans and BH I/DD 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 BH I/DD Tailored Plans’ screening rates constitute a quality measure noted in Section II(B) and Appendix A.³¹ The EBCI Tribal Option will also use the state’s standard screening questions within the EBCI Tribal Option’s respective comprehensive assessment.
- Embedding strategies to address the identified unmet health-related resource needs of beneficiaries by ensuring Standard Plans and BH I/DD Tailored Plans provide assistance that secures 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 social determinants of health (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 Medicaid enrollees. Standard Plans and BH I/DD 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 BH I/DD Tailored Plans are responsible for promoting Healthy Opportunities outside of the

²⁷ 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.

²⁸ 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.

²⁹ 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.

³⁰ Certain SDOH initiatives are pending waiver authority; for more information, see ncdhhs.gov/news/press-releases/dhhs-submits-amendment-medicaid-waiver-application.

³¹ 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 SDOH-related goal in their care plan.

initiatives listed above. Standard Plans and BH I/DD 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.

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 development of a new 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 choices and roles providers will have regarding certain data/analytic, care coordination and care management functions on behalf of Medicaid Managed Care members.

- AMH Tier 1 and Tier 2: Standard Plans will have primary responsibility for care management functions. Tier 1 and Tier 2 practices will be required to closely coordinate with their contracted Standard Plan(s) in the delivery of care management functions.
- Tier 3: AMH Tier 3 practices will lead in organizing and delivering care management services for their Standard Plan Medicaid managed care members. Care management oversight and support will be provided by the Standard Plans with whom they contract. BH I/DD 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 – will directly involve the AMH care team.

AMH Tier 3 practices are potentially 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 option, 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 BH I/DD Tailored Plans.

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 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 is initially based on the Carolina ACCESS program, with placement into three tiers based on the ability of practices 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. Standard Plans are required to contract with AMHs. They will also be required to include incentive payments linked to quality measures and outcomes that are aligned with this Quality Strategy in their contracts with AMHs in Tier 3.

BH I/DD Tailored Care Management Model

The Department expects Behavioral Health I/DD 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.³² Goals for BH I/DD Tailored Plan care management—called the Tailored Care Management model—include working with the BH I/DD Tailored Plan population to improve functional status, maximize community inclusion, and improving quality of life. To meet the care management needs of the BH I/DD Tailored Plan population, the AMH program's design has been modified to include two designations called "AMH+" and "Care Management Agency" (CMA), which will act as the community-based sites for care management. AMH+s are Tier 3 AMHs with demonstrable experience serving the BH I/DD Tailored Plan population and which successfully apply for and are approved to provide Tailored Care Management.³³ CMAs are largely behavioral health or I/DD providers with demonstrable experience serving the BH I/DD Tailored Plan population that successfully apply for and are approved to provide Tailored Care Management.

AMH+s and CMAs may choose to contract with a clinically integrated network (CIN) or another partner. CINs are entities with which practices choose to partner to share responsibility for specific functions and capabilities required to operate as an AMH+ or CMA.

4. Managing High-risk Pregnancies

North Carolina is nationally known for its approach to high-risk pregnancy management, its high participation rate of perinatal providers in the Medicaid program and its success in reducing maternal and child health disparities. The State care for high-risk pregnant women through two related initiatives: The Pregnancy Management Program (PMP) and Care Management for High-Risk Pregnancies (CMHRP). The PMP initiative to manage high-risk pregnancies builds on the State's current approach and 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 BH I/DD Tailored Plans. At the practice level, the initiative consists of financial incentives tied to use of a standardized screening tool and postpartum follow-up,³⁴ standard contracting requirements (e.g., no elective delivery prior to 39 weeks), quality measures, quality improvement activities and provider engagement activities. Standard Plans and BH I/DD Tailored Plans are required to follow the parameters of the program when contracting with and reimbursing perinatal providers.

A hallmark of the initiative is the provision of locally-based care management services through CMHRP. Pregnant women at high risk of adverse maternal and/or infant outcomes 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 BH I/DD Tailored Plans

³² More information on the BH I/DD Tailored Plan Care Management model is available at files.nc.gov/ncdhhs/TailoredPlan-CareManagement-PolicyPaper-FINAL-20180529.pdf

³³ The Provider Manual for BH I/DD Tailored Care Management and application is available at medicaid.ncdhhs.gov/providers/programs-and-services/behavioral-health-idd/behavioral-health-idd-tailored-plan

³⁴ At the start of managed care, Standard Plans and BH I/DD 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 BH I/DD Tailored Plans must provide an increased rate for vaginal deliveries.

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 at the launch of each managed care plan.

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 BH I/DD 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 addressing risk factors in children exposed to toxic stress in early childhood, are in foster care 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 of this Quality Strategy, the program aims to improve health outcomes and reduce costs for enrolled children.

In managed care, Standard Plans and BH I/DD Tailored 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 and BH I/DD Tailored Plans are required to contract with LHDs for the provision of CMARC services at each respective managed care plan type's launch.

As a key component of the broader SDOH strategy (described under *2. Healthy Opportunities Strategy* in this section of the Quality Strategy), Standard Plans, BH I/DD Tailored Plans, and the ECBI Tribal Option, when applicable, are expected to screen for any need and provide assistance securing health-related services and resource navigation to all beneficiaries, including at-risk children.

Where the EBCI tribal members are concerned, it is important to note that the Tribe 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 and BH I/DD Tailored 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) Initiative

The [InCK Model](#) is a child-centered local service delivery and state payment model. The program is administered by 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). Services include prevention, early identification, and treatment of behavioral and physical health needs.

The [North Carolina Integrated Care for Kids \(NC InCK\)](#) model is designed to build and support the infrastructure

needed to integrate health and human services for Medicaid- and CHIP-enrolled beneficiaries, from birth to age 20, in a five-county model service area. NC InCK will operate during a seven-year model period that began in January 2020, with a two-year planning period (2020-2022) and a five-year implementation period (2023-2028).

NC InCK will support whole-person care by identifying and addressing core child health care and unmet-health related resource needs. NC InCK will include 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. An analysis of the model service area population's utilization data shows that unmet needs and disconnected service sectors are significant root causes for out-of-home placements, inpatient admissions and emergency department visits. To address these issues, the NC InCK lead organizations will collaborate with a variety of data partners. It will further identify the unmet health care and social service needs of InCK-attributed children and deploy Service Integration Consultants across these sectors. NC InCK will collaborate with children's existing care coordinators and care managers. In addition, NC InCK will support more holistic, integrated care by sharing information among caregivers, providers, care managers and case managers, in accordance with federal and state rules.

Once NC transitions to managed care, Medicaid-eligible children will be enrolled into Standard Plans and BH I/DD Tailored Plans or NC Medicaid Direct (for managed care-excluded populations). The NC InCK team will build on the care needs screening, risk stratification and care management approaches NC Medicaid has developed. NC Medicaid payers and delegated care management organizations will develop a standardized assessment for children in the model service area. Data and results from these multigenerational and cross-sector data sources will help determine a child's level of risk. Data will also 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 stability). The model will also work to reduce the costs of care for children by developing child-specific alternative payment models.

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 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 BH I/DD 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 BH I/DD Tailored Plans shall 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, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements. Services provided via telehealth, virtual patient communications and remote patient monitoring shall be provided in an amount, duration and scope no less than the amount, duration and scope for the same services furnished to beneficiaries under the NC Medicaid Direct program.³⁵

The Standard Plan or BH I/DD Tailored Plan may offer services or modalities in addition to those specified in NC Clinical Coverage Policy 1H: Telehealth, Virtual Patient Communications and Remote Patient Monitoring and can develop and submit their approach as part of the plan's Utilization Management Program Policy for Department approval.

Additionally, when an enrollee requires a medically necessary service that may not be available within the plan's network, the managed care plan may provide access to the service via telehealth. Accordingly, Standard Plans and BH I/DD Tailored Plans are permitted in targeted circumstances to leverage telehealth in their request for an exception to the Department's network adequacy standards.³⁶

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 value-based payment (VBP) arrangements between plans and providers.

Standard Plans and BH I/DD 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 4.³⁷

³⁸ For BH I/DD Tailored Plans, the Department will set VBP contracting targets starting in Contract Year 2.

³⁵ The 1-H Telehealth, Virtual Patient Communications and Remote Patient Monitoring Policy can be found at:

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

³⁶ Standard Plans and BH I/DD Tailored Plans are permitted to leverage telemedicine in their request for exceptions to the State's network adequacy standards. When an enrollee requires a medically necessary service that is not available within the Department's network adequacy standards, the plan may offer the service, if applicable and medically appropriate, through telemedicine, in addition to providing access to an out-of-network provider of the needed service. In these instances, the enrollee must have a choice between an out-of-network provider and telemedicine, and cannot be required to receive services through telemedicine.

³⁷ For more information on the HCP-LAN APM framework, refer to: hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

³⁸ North Carolina will require Standard Plans and BH I/DD Tailored Plans to conduct an annual assessment using the HCP-LAN assessment form, available online at hcp-lan.org/workproducts/National-Data-Collection-Metrics.pdf

After the launch of NC Medicaid Managed Care, the Department will develop a longer-term VBP Roadmap. The Department will work 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 Roadmap with specific goals for value-based payment initiatives in future years.

10. Accreditation

As a key component of ensuring that Standard Plans and BH I/DD Tailored Plans are held to consistent, current standards for quality, access and timeliness of care, Standard Plans and BH I/DD 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.

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. 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 Standard Plans and BH I/DD Tailored Plans to ensure improvements in quality performance are equitably distributed, including across race and ethnicity. In support of this goal, the Department will require Standard Plans and BH I/DD 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 BH I/DD 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) 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 for each plan's respective enrolled population compared against their Standard Plan or BH I/DD Tailored Plan peers. Specifically, the Department will expect a 10% relative improvement in the performance for the group of interest as compared to the performance of the overall population for at least two years **and** until the gap between a group of interest and the overall population is less than a relative 10%.³⁹

³⁹ The Department's disparities definition and incremental targeting approach are still being finalized.

Through a unique partnership, the Department and the Eastern Band of Cherokee Indians (EBCI), North Carolina's only federally recognized Tribe, 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. 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. The 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 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 NC HealthConnex, North Carolina's state-designated Health Information Exchange Authority (HIEA). NC HealthConnex works with the Department to 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. HealthConnex seeks to use this data to produce an initial set of prioritized Electronic Clinical Quality Measures:

- Controlling High Blood Pressure⁴⁰
- Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)⁴¹
- Preventive Care and Screening: Screening for Depression and Follow-up Plan⁴²
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents⁴³

The Department, Standard Plans, BH I/DD Tailored Plans and the EBCI Tribal Option will access clinical data

⁴⁰ More information on the eQCM: Controlling High Blood Pressure is available at ecqi.healthit.gov/ecqm/ep/2018/cms165v6

⁴¹ More information on the eQCM: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) is available at ecqi.healthit.gov/ecqm/ep/2018/cms122v6

⁴² More information on the eQCM: Preventive Care and Screening: Screening for Depression and Follow-up Plan is available at ecqi.healthit.gov/ecqm/ep/2020/cms002v9

⁴³ More information on the eQCM: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents is available at ecqi.healthit.gov/ecqm/ep/2019/cms155v7

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 may participate in NCQAs Data Aggregator Validation program.⁴⁴

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

North Carolina's managed care contracts include robust requirements to ensure that Standard Plans and BH I/DD 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 BH I/DD 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 BH I/DD 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 4.0), which assesses beneficiaries' perceptions of care;
- A standard provider survey tool, which measures provider satisfaction.

(A) State Access Standards

1. Network Adequacy Standards

Standard Plans and BH I/DD 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

⁴⁴ More information on NCQA's Data Aggregator Validation program is available at [ncqa.org/programs/data-and-information-technology/hit-and-data-certification/hedis-compliance-audit-certification/data-aggregator-validation/](https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/hedis-compliance-audit-certification/data-aggregator-validation/)

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 1 below, and **appointment wait-time standards**, as described in Tables 1-5.

Table 1. Network Adequacy Standards: Time and Distance Standards for Adults and Children

Time/Distance Standards for Medicaid

Service Type	Standard Plan		BH I/DD Tailored Plan	
	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 hospital within 30 minutes or 15 miles for at least 95% of members	≥ 1 hospital 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
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 ⁴⁵	≥ 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

⁴⁵ Measured on members who are female and age 14 or older. Certified nurse midwives may be included to satisfy OB/GYN access requirements.

Service Type	Standard Plan		BH I/DD Tailored Plan	
	Urban Standard	Rural Standard	Urban Standard	Rural Standard
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	<ul style="list-style-type: none"> • ≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of members • Research-based BH treatment for Autism Spectrum Disorder (ASD): Not subject to standard • Office-based Opioid Treatment (OBOT): N/A 	<ul style="list-style-type: none"> • ≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of members • Research-based BH treatment for Autism Spectrum Disorder (ASD): Not subject to standard • Office-based Opioid Treatment (OBOT): N/A
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	<ul style="list-style-type: none"> • Psychosocial rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP): ≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members • Child and Adolescent Day Treatment Services: Not subject to standard 	<ul style="list-style-type: none"> • Psychosocial rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid 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 (BH)	≥ 1 provider of each crisis service within each Standard Plan region		<ul style="list-style-type: none"> • Professional treatment services in facility-based crisis program: The greater of: <ul style="list-style-type: none"> ○ 2+ facilities within each BH I/DD Tailored Plan Region, OR ○ 1 facility within each BH I/DD Tailored Plan Region per 450,000 total regional population (total regional population as estimated by combining NC Office of 	

	Standard Plan		BH I/DD Tailored Plan	
Service Type	Urban Standard	Rural Standard	Urban Standard	Rural Standard
			State Budget and Management county estimates) <ul style="list-style-type: none"> • Facility-based crisis services for children and adolescents: ≥ 1 provider within each BH I/DD Tailored Plan Region • Non-hospital medical detoxification: ≥ 2 providers within each BH I/DD 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 BH I/DD 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 BH service within each BH I/DD Tailored Plan region	
Partial Hospitalization	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of members	≥ 1 provider of partial hospitalization within 60 minutes or 60 miles for at least 95% of members	Partial Hospitalization	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of members
Community/Mobile Services	N/A		≥ 2 providers of community/mobile services within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients.	
All State Plan LTSS (except nursing facilities)	Standard Plans must have at least 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	Standard Plans must have at least 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.	

Service Type	Standard Plan		BH I/DD Tailored Plan	
	Urban Standard	Rural Standard	Urban Standard	Rural Standard
	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		<ul style="list-style-type: none"> • Residential Treatment Facility Services: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region, • Substance Abuse Medically Monitored Residential Treatment: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (refer to 10A NCAC 27G.3400) • Substance Abuse Non-Medical Community Residential Treatment: <ul style="list-style-type: none"> ○ Adult: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (refer to licensure requirements to be determined by the Department) ○ Adolescent: Contract with all designated CASPs within the BH I/DD Tailored Plan's Region ○ Women & Children: Contract with all designated CASPs within the BH I/DD Tailored Plan's Region • Substance Abuse Halfway House: <ul style="list-style-type: none"> ○ Adult: Access to ≥1 male and ≥1 female program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)46 ○ Adolescent: Access to ≥1 program per BH I/DD 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		<ul style="list-style-type: none"> • Community Living & Support, Community Navigator, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living: ≥ 2 providers of each Innovations waiver service within each BH I/DD Tailored Plan Region. 	

⁴⁶ BH I/DD Tailored Plans must also ensure that gender non-conforming recipients have access to substance abuse halfway house services.

Service Type	Standard Plan		BH I/DD Tailored Plan	
	Urban Standard	Rural Standard	Urban Standard	Rural Standard
			<ul style="list-style-type: none"> Crisis Intervention & Stabilization Supports, Day Supports, Financial Support Services: ≥ 1 provider of each Innovations waiver service within each BH I/DD 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		<ul style="list-style-type: none"> Community Networking, Life Skills Training, Residential Supports, Resource Facilitation, In-Home Respite, Supported Employment: ≥ 2 providers of each TBI waiver service within each BH I/DD Tailored Plan Region. Day Supports, Cognitive Rehabilitation, Crisis Intervention & Stabilization Supports: ≥ 1 provider of each TBI waiver service within each BH I/DD Tailored Plan Region. Adult Day Health, Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Natural Supports Education, Occupational Therapy, 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 2. Standard Plan an BH I/DD 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		<ul style="list-style-type: none"> 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 3. 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 4. Standard Plan an BH I/DD 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 BH I/DD Tailored Plans cover certain behavioral health care services for individuals with mild to moderate behavioral health care needs.⁴⁷

⁴⁷ Pending legislative authority.

Table 5. Access Standards for Behavioral Health Care

Table 5a. 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 adequately care for self without supervision due to the effects of chronic substance use; includes crisis intervention.	Immediately (available 24 hours a day, 365 days a year)
Urgent Care Services for Mental Health	<ul style="list-style-type: none"> • 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

Visit Type	Definition	Standard
Urgent Care Services for SUDs	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. • Services to treat a person who describes signs and symptoms resulting in impaired mental functioning which has impacted person's ability to participate in daily living or markedly decreased person's quality of life. • Services to treat a person who describes signs and symptoms resulting in impaired emotional 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 impairment which can likely be diagnosed as a SUD according to the current version of the <i>Diagnostic and Statistical Manual</i> .	Within 14 calendar days

Table 5b. BH I/DD 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)

Visit Type	Description	Standard
Emergency Services for Mental Health	Services to treat a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention.	Immediately (available 24 hours a day, 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	<ul style="list-style-type: none"> • 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 and intervention, could 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	<ul style="list-style-type: none"> • 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

Visit Type	Description	Standard
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 <i>Diagnostic and Statistical Manual</i> .	Within 48 hours

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

- Allergy/Immunology
- Anesthesiology
- Cardiology
- Dermatology
- Endocrinology
- ENT/Otolaryngology
- Gastroenterology
- General Surgery
- Gynecology
- 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 BH I/DD 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. North Carolina statute⁴⁸ requires Standard Plans and BH I/DD 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. Essential providers include FQHCs, free/charitable clinics, State veterans’ homes, and LHDs.

Regardless of network status, Standard Plans and BH I/DD Tailored Plans must allow 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 BH I/DD 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 BH I/DD 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.

Exceptions to Network Adequacy Standards

Standard Plans and BH I/DD 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 BH I/DD 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 BH I/DD 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

⁴⁸ NC S.L. Session Law 2015-245, as amended by Session NC Law 2016-121.

have a choice between an out-of-network provider and telehealth, and cannot be forced to receive services through telehealth. While Standard Plans and BH I/DD 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 BH I/DD 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. BH I/DD 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 BH, I/DD and TBI services. As described previously, Standard Plans and BH I/DD 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 BH I/DD 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 subsection 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 a, 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, BH I/DD 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, BH I/DD 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 BH I/DD Tailored Plan (from either NC Medicaid Direct or another plan or coverage type):

- 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 BH I/DD Tailored Plans.⁴⁹
- 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 BH I/DD Tailored Plan's network:

- In cases when a provider is terminated or leaves the Standard Plan or BH I/DD 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 60 days after delivery.
- In cases where a provider is terminated or leaves the Standard Plan's or BH I/DD 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 BH I/DD 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 BH I/DD Tailored Plans to submit an access plan and regular documentation (including provider network data and report(s) that summarize findings from Standard Plans and BH I/DD Tailored Plans' own network data analysis) to demonstrate network

⁴⁹ 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.

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

As outlined in Appendix C, the Department's contracted EQRO will perform an annual external quality review (EQR) of each Standard Plan and BH I/DD 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 BH I/DD 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 BH I/DD 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 BH I/DD 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 BH I/DD Tailored Plans or NC Medicaid Direct (for example, once a beneficiary exceeds 90 days in a nursing home), Standard Plans and BH I/DD Tailored Plans are required to coordinate with other source(s) of coverage to ensure continuity and non-duplication of services.

Standard Plans and BH I/DD 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 BH I/DD 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 BH I/DD 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 BH I/DD 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 BH I/DD Tailored Plan enrollees. Standard Plans and BH I/DD 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 BH I/DD Tailored Plans), Standard Plans and BH I/DD 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 BH I/DD 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 BH I/DD 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 BH I/DD 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 BH I/DD 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.⁵⁰ The behavioral health and I/DD benefits covered under Standard Plans and BH I/DD Tailored Plans differ in accordance with statute.⁵¹ Standard Plans are required to cover many behavioral health services included in the Medicaid State Plan, and BH I/DD 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 TBI.⁵² Consistent with the requirements set forth in 42 CFR 438.210, North Carolina has developed an approach to Standard Plan and BH I/DD Tailored Plan clinical coverage policies and utilization management (UM) that safeguards beneficiary access to services while encouraging plan innovation. Standard Plans and BH I/DD 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 BH I/DD 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 BH I/DD 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 BH I/DD 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 BH I/DD 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 BH I/DD Tailored Plans follow specific clinical coverage policies developed by the Department.

(B) Structure and Operations Standards

1. Provider Selection

Standard Plans and BH I/DD 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

⁵⁰ 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.

⁵¹ NC Session Law 2015-245, as amended by Session Law 2018-48.

⁵² NC Session Law, as amended by Session Law 2018-48, specifies that Standard Plans and BH I/DD 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 BH I/DD Tailored Plans.

networks except for refusal to accept network rates. BH I/DD Tailored Plans may not exclude physical health and pharmacy providers from their networks except for refusal to accept network rates.^{53, 54}

- **Credentialing and re-credentialing:** Standard Plans and BH I/DD 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.
- **Enrolled providers:** Standard Plans and BH I/DD 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 BH I/DD 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 BH I/DD 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 BH I/DD 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 BH I/DD 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

⁵³ NC Session Law 2015-245, as amended by Session Law 2016-121. Note that this state statute also requires Standard Plans and BH I/DD 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.

⁵⁴ NC Session Law 2018-48 Section 4.(10)(a)(1)(IV) permits BH I/DD Tailored Plans to maintain a closed network for BH, I/DD, and TBI services and, pending legislative change, the BH I/DD Tailored Plan must include all essential providers for BH, I/DD, and TBI services located in the BH I/DD Tailored Plan’s Region in its Network regardless of closed network requirements.

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
- 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 BH I/DD 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 BH I/DD 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 abuse services for medical necessity reviews for all populations except children ages 0 through 6. Plans must also use 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 BH I/DD Tailored Plans are required to disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. Standard Plans and BH I/DD 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 BH I/DD 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 BH I/DD 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, plan's 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 BH I/DD 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 service 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 BH I/DD Tailored Plans must 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.⁵⁵

- 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;
- Website URL(s);
- Provider specialty;
- Whether provider is accepting new beneficiaries;

⁵⁵ Per federal regulations, Standard Plans and BH I/DD 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.

- 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 BH I/DD Tailored Plan receives updated provider information. Provider directories must be posted on the Standard Plan’s or BH I/DD 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 BH I/DD 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 BH I/DD Tailored Plans in accordance with statute.⁵⁶

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.

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

⁵⁶ NC Session Law 2015-245, as amended by Session Law 2018-48.

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.⁵⁷ 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.

BH I/DD Tailored Plans Enrollment

Upon Standard Plan implementation in July 2021, beneficiaries determined eligible for BH I/DD 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.

Prior to BH I/DD Tailored Plan launch in July 2022, the Department will conduct data reviews to identify beneficiaries enrolled in Standard Plans, new Medicaid beneficiaries, and NC Medicaid Direct beneficiaries who meet BH I/DD Tailored Plan data-based eligibility criteria. Beneficiaries determined eligible for BH I/DD Tailored Plans will receive a notice informing them they will be auto-enrolled into the BH I/DD Tailored Plan in their region upon BH I/DD Tailored Plan launch and can elect to transfer to a Standard Plan at any point during the coverage year.

Following BH I/DD Tailored Plan implementation, the Department will regularly review encounter, claims and

⁵⁷ 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.

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

Beneficiaries, including Standard Plan enrollees, who are not identified as eligible for BH I/DD Tailored Plans by the Department will be able to request to enroll in a BH I/DD Tailored Plan in the period before and after BH I/DD 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 BH I/DD 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 BH I/DD Tailored Plan in their region (or NC Medicaid Direct/LME-MCO prior to BH I/DD Tailored Plan launch) and will notify them of the transfer.

BH I/DD Tailored Plan Disenrollment

BH I/DD Tailored Plan enrollees may request disenrollment from a BH I/DD Tailored Plan and transfer to a Standard Plan or the EBCI Tribal Option (if eligible) at any time during the coverage year. Because there is only one plan per region, a BH I/DD 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, BH I/DD Tailored Plans (when eligible) and the EBCI Tribal Option.

Children in Foster Care Enrollment and Disenrollment

With limited exceptions⁵⁸, individuals eligible for the Specialized Foster Care Plan will be automatically enrolled in the plan that is designed to best meet this unique population's needs upon launch. Enrollees will have the option to change their plan at any time during the coverage year for any reason. The State will ensure that individuals eligible for the Specialized Foster Care Plan are educated about their options.

5. Confidentiality

To ensure compliance with 42 CFR 438.224, Standard Plan, the EBCI Tribal Option and BH I/DD 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 BH I/DD Tailored Plans to meet the standards set forth in 42

⁵⁸ Tribal members are exempt from auto-enrollment in the Specialized Foster Care Plan.

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 BH I/DD 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 DHHS on grievances only.

Beneficiary Grievances

Beneficiaries may file a grievance with a plan at any time, either orally or in writing. Standard Plans, BH I/DD 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 BH I/DD 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 BH I/DD 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 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 BH I/DD 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 BH I/DD 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 BH I/DD 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 less 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 BH I/DD 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 denial requests;
- 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 BH I/DD 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 BH I/DD 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 BH I/DD 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 BH I/DD 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 BH I/DD 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 QAPs Standard Plans and BH I/DD 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 BH I/DD 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 BH I/DD 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 BH I/DD 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 BH I/DD Tailored Plans and within the program broadly, EQRO activities will not be deemed met by accreditation until all Standard Plans and BH I/DD 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*⁵⁹

- Validate Standard Plans' and BH I/DD 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 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, BH I/DD 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*.^{60, 61} This information is provided to Standard Plans and BH I/DD Tailored Plans upon beneficiary enrollment, and is used by the Department to better understand disparities in care within and across Standard Plans and BH I/DD 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

⁵⁹ 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 C.

⁶⁰ 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.

⁶¹ This demographic information is collected via the Medicaid application and transmitted to Standard Plans and BH I/DD Tailored Plans at the time of enrollment.

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. The Department is committed to developing measure targets that not only address overall continuous quality improvement but also target opportunities to reduce health disparities.

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 BH I/DD 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 Department contract provisions. Failure to achieve these minimum performance thresholds may result in sanctions. Additionally, there are a number of priority areas where the Department will encourage plans to perform beyond compliance thresholds through a uniquely designed withhold program, in which a portion of each plan's capitation rate is withheld and paid when the plan meets reasonably achievable performance targets. The Department is planning to launch a withhold program in Contract Year 3.

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 withhold payment opportunities outlined in Figures 4 and 5 below are included in the first year of the plan withhold program. (Per S.L. 2018-49, the withhold program cannot be initiated until at least 18 months after managed care launch.) 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 Figures 4 and 5. These figures show the timing of withhold programs for both Standard Plans and BH I/DD Tailored Plans.

Figure 4. Standard Plan Withhold Timeline

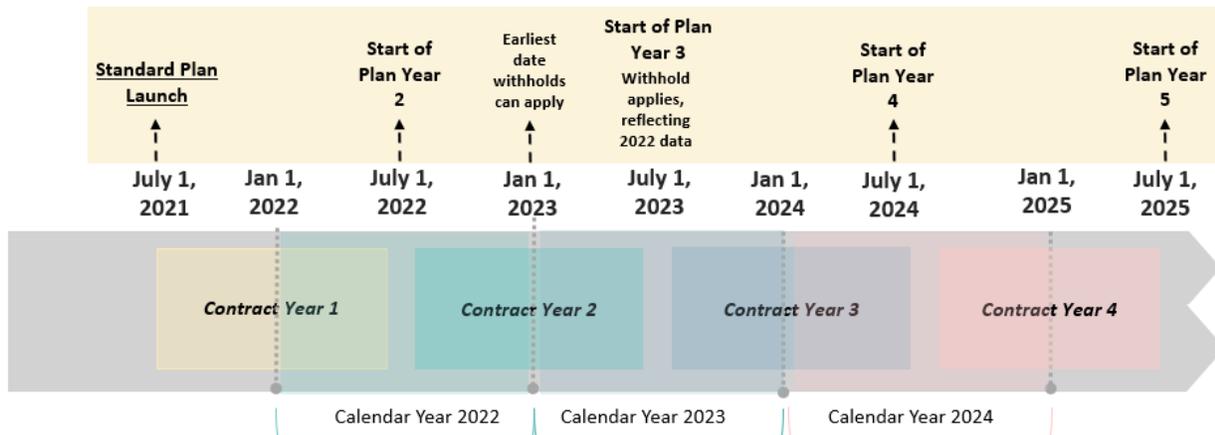


Figure 5. BH I/DD Tailored Plan Withhold Timeline



Each year, the Department will assess Standard Plans and BH I/DD Tailored Plans’ performance across withhold payment 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. Anticipated Withhold Program Year 3 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 BH I/DD Tailored Plans are contractually required to collect and submit timely encounter, quality and performance data to the Department. Standard Plans and BH I/DD 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 BH I/DD 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 BH I/DD 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 BH I/DD 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 C). The Department ensures Standard Plans, BH I/DD 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 BH I/DD Tailored Plans to submit a monthly report on beneficiary grievances and appeals to ensure timeliness of those required processes;
- Auditing Standard Plans and BH I/DD 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 BH I/DD Tailored Plans' Compliance Plans, and any other policy and procedure governing how Standard Plans and BH I/DD Tailored Plans monitor compliance and quality of services provided by their networks, at any time; and⁶²
- Annually reviewing the Standard Plans' and BH I/DD Tailored Plans' required Fraud Prevention Plans and requiring modifications, and 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 BH I/DD Tailored Plans will also 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 D.

Based on the EQRO's review of Standard Plans and BH I/DD 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

⁶² Standard Plans and BH I/DD Tailored Plans are required to have in effect a Compliance Plan which complies with 42 CFR 438.608.

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 BH I/DD Tailored Plans are also required to perform precontracting and monthly screenings of all network providers against the Exclusion Lists. Standard Plans and BH I/DD 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.

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 and BH I/DD Tailored Plans' compliance and program integrity activities. The Department conducts operational audits and data reviews of Standard Plans and BH I/DD Tailored Plans and providers and, through these activities, as appropriate, will share any information between Standard Plans and BH I/DD Tailored Plans regarding potential fraud, waste, or abuse by providers or beneficiaries. The Department will require certain monitoring and auditing activities; Standard Plans and BH I/DD 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 BH I/DD 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 C, the Department performs a full review of the Standard Plans' and BH I/DD 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 BH I/DD 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 BH I/DD 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 BH I/DD 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 BH I/DD 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 administered by a PCCM 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 BH I/DD 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 BH I/DD 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', BH I/DD 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 in managed care implementation Year 1, 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 road map, 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 BH I/DD Tailored Plans, the EQRO, and other key entities and stakeholders remain engaged in ongoing, active quality improvement efforts. For example: Standard Plans and BH I/DD

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 BH I/DD 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 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 Medical Care Advisory Committee (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

Table 8. Standard Plan Medicaid Measure Set⁶³

The following table lists quality measures that will be the priority focus for Standard Plan accountability; these measures, which will primarily be calculated by plans, and will comprise the set from which plans can draw measures for required quality improvement activities. 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		
N/A	Child and Adolescent Well-Care Visits (WCV)	NCQA
0038	Childhood Immunization Status (Combination 10) (CIS)	NCQA
1407	Immunization for Adolescents (Combination 2) (IMA)	NCQA
N/A	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
N/A	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
0039	Flu Vaccinations for Adults (FVA, FVO)*	NCQA
0027	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)*	NCQA
0576	Follow-Up After Hospitalization for Mental Illness (FUH)	NCQA
0418/ 0418e	Screening for Depression and Follow-Up Plan (CDF)	CMS
2940	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	PQA

⁶³ 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.

2950	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	PQA
3389	Concurrent use of Prescription Opioids and Benzodiazepines (COB)	PQA
1768	Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]	NCQA
N/A	Total Cost of Care*	IBM Watson Health Cost of Care Model
N/A	Rate of Screening for Unmet Resource Needs	DHHS
Maternal Measures		
N/A	Low Birth Weight ⁶⁴	DHHS
N/A	Prenatal and Postpartum Care (PPC)	NCQA
N/A	Rate of Screening for Pregnancy Risk	DHHS

Table 8a. AMH Measure Set⁶⁵

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

NQF #	Measure	Steward
Pediatric Measures		
N/A	Child and Adolescent Well-Care Visits (WCV)	NCQA
0038	Childhood Immunization Status (Combination 10) (CIS)	NCQA
1407	Immunization for Adolescents (Combination 2) (IMA)	NCQA
N/A	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

⁶⁴ The Department will work jointly with the plans to report this measure.

⁶⁵ 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.

0418/ 0418e	Screening for Depression and Follow-Up Plan (CDF)	CMS
N/A	Total Cost of Care*	IBM Watson Health Cost of Care Model

Table 9. BH I/DD Tailored Plan Medicaid Measure Set⁶⁶

The following table lists quality measures that will be the priority focus for BH I/DD Tailored Plan accountability; these measures, which will primarily be calculated by plans, will comprise the set from which plans can draw measures for required quality improvement activities. 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		
N/A	Child and Adolescent Well-Care Visits (WCV)	NCQA
0038	Childhood Immunization Status (Combination 10) (CIS)	NCQA
0108	Follow-up for Children Prescribed ADHD Medication (ADD)	NCQA
1407	Immunization for Adolescents (Combination 2) (IMA)	NCQA
2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	NCQA
N/A	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
N/A	Well-Child Visits in the First 30 Months of Life (W30)	NCQA
Adult Measures		
0105	Antidepressant Medication Management (AMM)	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%) ⁶⁷	NCQA
0018	Controlling High Blood Pressure (CBP)	NCQA
0039	Flu Vaccinations for Adults (FVA, FVO)*	NCQA
0027	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)*	NCQA
0576	Follow-up After Hospitalization for Mental Illness (FUH)	NCQA
0418/ 0418e	Screening for Depression and Follow-up Plan (CDF) ⁶⁸	CMS
1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	NCQA
2940	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	PQA

⁶⁶ 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.

⁶⁷ Pending additional information regarding the collection of clinical data

⁶⁸ 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
2950	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	PQA
3389	Concurrent use of Prescription Opioids and Benzodiazepines (COB)	PQA
3175	Continuation of Pharmacotherapy for Opioid Use Disorder	USC
1768	Plan All Cause Readmissions (PCR) [Observed versus expected ratio]	NCQA
TBD	Total Cost of Care*	IBM Watson Health Cost of Care Model
N/A	Rate of Screening for Unmet Resource Needs	DHHS
Maternal Measures		
N/A	Low Birth Weight ⁶⁹	DHHS
N/A	Prenatal and Postpartum Care (PPC)	NCQA
N/A	Rate of Screening for Pregnancy Risk	DHHS

Table 10. Department-Calculated Medicaid Measure Set⁷⁰

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 <ul style="list-style-type: none"> • PDI 14: Asthma Admission Rate • PDI 15: Diabetes Short-term Complications Admission Rate • PDI 16: Gastroenteritis Admission Rate • PDI 18: Urinary Tract Infection Admission Rate 	AHRQ
0004	Initiation/Engagement of Alcohol and Other Drug Dependence Treatment	NCQA
N/A	Percentage of Eligibles Who Received Preventive Dental Services (PDENT) ⁷¹	CMS

⁶⁹ The Department will work jointly with the plans to report this measure.

⁷⁰ 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.

⁷¹ This measure will be delivered under NC Medicaid Direct, therefore, the Department will calculate measure rates and share them with plans.

NQF #	Measure Name	Steward
2803	Tobacco Use and Help with Quitting Among Adolescents	NCQA
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (the total of all ages for each of the 3 rates)	NCQA
Adult Measures		
1879	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	CMS
0543	Adherence to Statin Therapy for Individuals with Coronary Artery Disease	CMS
0023	Adult BMI Assessment (ABA)	City of New York Department of Health and Mental Hygiene
1800	Asthma Medication Ratio (AMR)	NCQA
N/A	Avoidable Adult Utilization <ul style="list-style-type: none"> • PQI 01: Diabetes Short-term Complication Admission Rate • PQI 05: COPD or Asthma in Older Adults Admission Rate • PQI 08: Heart Failure Admission Rate • PQI 15: Asthma in Younger Adults Admission Rate 	AHRQ
2372	Breast Cancer Screening (BSC)	NCQA
0061	Comprehensive Diabetes Care (CDC): Blood Pressure Control (<140/90 mm Hg)	NCQA
0575	Comprehensive Diabetes Care (CDC): Hemoglobin A1c (HbA1c) Poor Control (<8.0%)	NCQA
0057	Comprehensive Diabetes Care (CDC): HbA1c Testing	NCQA
0064	Comprehensive Diabetes Care (CDC): LDL-C control (<100 mg/dL)	NCQA
0063	Comprehensive Diabetes Care (CDC): LDL-C screening	NCQA
2607	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA
0547	Diabetes and Medication Possession Ratio for Statin Therapy	NCQA
3488	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	NCQA
2605	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	NCQA

NQF #	Measure Name	Steward
3210/3210e	HIV Viral Load Suppression (HVL)	HRSA
2856	Pharmacotherapy Management of COPD Exacerbation (PCE)	NA
0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	PCPI Foundation
2597	Substance Use Screening and Intervention Composite	ASAM
2600	Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	NCQA
Maternal Measures		
2904	Contraceptive Care: Access to Long-Acting Reversible Contraception (LARC)	US Office of Population Affairs
2903	Contraceptive Care: Most & Moderately Effective Methods	US Office of Population Affairs
2902	Contraceptive Care: Postpartum	US Office of Population Affairs
N/A	Low Birth Weight ⁷²	DHHS
1382	Live Births Weighing Less Than 2500 Grams ⁷³	CDC
NA	Prenatal Depression Screening and Follow-up (PND)	NCQA
Select Public Health Measures		

⁷² Includes DHHS-modified low birth weight measure.

⁷³ Calculated at the state level.

NQF #	Measure Name	Steward
N/A	<ul style="list-style-type: none"> • Diet/Exercise <ul style="list-style-type: none"> ○ Increase fruit and vegetable consumption among adults ○ Increase percentage of adults who get recommended amount of physical activity • Opioid Use <ul style="list-style-type: none"> ○ Reduce the unintentional poisoning mortality rate • Tobacco Use <ul style="list-style-type: none"> ○ 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 <p>Decrease exposure to second hand smoke in the workplace</p>	NA
Patient Satisfaction		
0006	CAHPS Survey	AHRQ
Provider Satisfaction		
N/A	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. PCCM (CCNC) Measure Set

The following table lists the quality measures that CCNC 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		
N/A	Child and Adolescent Well-Care Visits (WCV)	NCQA
0038	Childhood Immunization Status (Combination 10) (CIS)	NCQA
1407	Immunization for Adolescents (Combination 2) (IMA)	NCQA
N/A	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*	IBM Watson Health Cost of Care Model

Appendix B. Standard Plan and BH I/DD Tailored Plan Measures Tracked to Quality Strategy Goals

Standard Plans and BH I/DD 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 BH I/DD 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 BH I/DD 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			
<i>Getting Care Quickly</i> 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. <ul style="list-style-type: none"> 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
<i>Getting Needed Care</i> 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			
<i>Rating of All Health Care</i> 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. <ul style="list-style-type: none"> 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
<i>Rating of Personal Doctor</i> 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. <ul style="list-style-type: none"> 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

Measure Name	Measure Description <i>(for clinical and CAHPS survey measures)</i>	Data Source	Measure Steward <i>(if applicable)</i>
<p><i>Customer Service</i></p> <p>NQF #: 0006</p>	<p>The survey asks enrollees how often customer service staff were helpful and treated them with courtesy and respect and allows the following response options: never; sometimes; usually; or always.</p> <ul style="list-style-type: none"> 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). 	<p>EQRO: CAHPS Health Plan Survey 5.0, Adult Version</p>	<p>AHRQ</p>
<p><i>Coordination of Care</i></p> <p>NQF #: 0006</p>	<p>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.</p>	<p>EQRO: CAHPS Health Plan Survey 5.0, Adult Version</p>	<p>AHRQ</p>
<p>Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</p> <p>NQF #: 1932</p>	<p>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.</p>	<p>BH I/DD Tailored Plans: Claims Data</p>	<p>NCQA</p>
Goal 3: Promote Wellness and Prevention			
<p>Childhood Immunization Status (Combination 10)</p> <p>NQF #: 0038</p>	<p>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.</p>	<p>Standard Plans and BH I/DD Tailored Plans: Claims Data</p>	<p>NCQA</p>
<p>Well-Child Visits in the First 30 Months of Life</p> <p>NQF #: N/A</p>	<p>The percentage of members who had the following number of well-child visits during the last 30 months. Two rates will be reported:</p> <ul style="list-style-type: none"> 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 	<p>Standard Plans and BH I/DD Tailored Plans: Claims Data</p>	<p>NCQA</p>

Measure Name	Measure Description <i>(for clinical and CAHPS survey measures)</i>	Data Source	Measure Steward <i>(if applicable)</i>
Immunizations for Adolescents (Combination 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 13 th birthday. The measure calculates a rate for each vaccine and two combination rates.	Standard Plans and BH I/DD Tailored Plans: Claims Data	NCQA
Percent of Eligibles Who Received Preventive Dental Services NQF #: 1334	Percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 continuous days, are eligible for EPSDT services, and received at least 1 preventive dental service during the reporting period.	Standard Plans and BH I/DD Tailored Plans: Claims Data	CMS (collected via the CMS-416 form)
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: <ul style="list-style-type: none"> • 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 BH I/DD 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 BH I/DD 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: <ul style="list-style-type: none"> • 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 BH I/DD Tailored Plans: Claims Data	NCQA
Low Birth Weight NQF #: N/A	The percentage of births with birth weight <2,500 grams.	TBD: State Vital Records	DHHS

Measure Name	Measure Description (for clinical and CAHPS survey measures)	Data Source	Measure Steward (if applicable)
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: <ul style="list-style-type: none"> 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 BH I/DD 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: <ul style="list-style-type: none"> Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months). 	Standard Plans and BH I/DD Tailored Plans: Claims Data	NCQA
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 BH I/DD Tailored Plans: Claims Data	NCQA
<i>Asthma Medication Ratio (Total Rate)</i> 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 BH I/DD 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: <ul style="list-style-type: none"> 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. <i>Note: A single rate is reported and is the sum of all three groups.</i>	Standard Plans and BH I/DD Tailored Plans: Claims Data	NCQA

Measure Name	Measure Description <i>(for clinical and CAHPS survey measures)</i>	Data Source	Measure Steward <i>(if applicable)</i>
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 BH I/DD 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 BH I/DD 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.	BH I/DD Tailored Plans: Claims Data	USC
Medical Assistance with Smoking and Tobacco Use Cessation NQF #: 0027	<p>The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation:</p> <ul style="list-style-type: none"> • 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

Measure Name	Measure Description <i>(for clinical and CAHPS survey measures)</i>	Data Source	Measure Steward <i>(if applicable)</i>
<p><i>Adult Body Mass Index (BMI) Assessment</i></p> <p>NQF #: 0023</p>	<p>The percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.</p>	<p>Standard Plans and BH I/DD Tailored Plans: Claims Data</p>	<p>NCQA</p>
<p><i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (the total of all ages for each of the three rates)</i></p> <p>NQF #: 0024</p>	<p>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:</p> <ul style="list-style-type: none"> • 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. 	<p>Standard Plans and BH I/DD Tailored Plans: Claims Data</p>	<p>NCQA</p>
Goal 6: Pay for Value			
<p>Total Cost of Care</p> <p>NQF #: N/A</p>	<p>TBD</p>	<p>TBD</p>	<p>IBM Watson Health Cost of Care Model</p>
<p>Plan All-Cause Readmissions</p> <p>NQF#: 1768</p>	<p>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:</p> <ul style="list-style-type: none"> • Count of Index Hospital Stays* (denominator) • Count of 30-Day Readmissions (numerator) • Average Adjusted Probability of Readmission <p>*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).</p>	<p>Standard Plans and BH I/DD Tailored Plans: Claims Data</p>	<p>NCQA</p>

Measure Name	Measure Description <i>(for clinical and CAHPS survey measures)</i>	Data Source	Measure Steward <i>(if applicable)</i>
Avoidable Pediatric Utilization	Discharges for patients ages 6 to 17 years, that meet the inclusion and exclusion rules for any of the following PDIs: <ul style="list-style-type: none"> • 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 BH I/DD 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: <ul style="list-style-type: none"> • 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 BH I/DD Tailored Plans: Claims Data	AHRQ

Appendix C. External Quality Review Organization (EQRO) Activities

As noted throughout this Quality Strategy, the EQRO plays a critical role in reporting Standard Plans and BH I/DD 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
<ul style="list-style-type: none"> • 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 adequacy⁷⁴ • Annual technical report that summarizes findings on access and quality of care, including the requirements set forth in 42 CFR 438.364
Optional Activities
<ul style="list-style-type: none"> • 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 BH I/DD 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
<ul style="list-style-type: none"> • 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 BH I/DD 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

⁷⁴ 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 D. Minimum Required Elements of Standard Plans and BH I/DD Tailored Plans' Annual Fraud Prevention Plans and Reports

Fraud Prevention Plan Minimum Requirements
<ul style="list-style-type: none"> • The name of the Compliance Officer
<ul style="list-style-type: none"> • Description of the SIU, the roles within the SIU and staffing by title
<ul style="list-style-type: none"> • Description of the SIU staff qualifications
<ul style="list-style-type: none"> • Plan's internal controls and policies and procedures that are designed to prevent, detect, and report known or suspected fraud and abuse activities
<ul style="list-style-type: none"> • The process and procedures to ensure that all suspected fraud and abuse is reported in compliance with the contract
<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • A description of the managed care plan's specific controls to detect and prevent potential fraud and abuse, including, without limitation: <ul style="list-style-type: none"> ○ 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
<ul style="list-style-type: none"> • Assurance that the identities of individuals reporting violations by the plan are protected and that there is no retaliation against such persons
<ul style="list-style-type: none"> • Describe criminal background exclusion screening process for its owners, agents, employees, network providers, and subcontractors

Annual Fraud Prevention Report Minimum Requirements
<ul style="list-style-type: none"> • The name of the plan
<ul style="list-style-type: none"> • The name of the person and department responsible for submitting the Fraud Prevention Report
<ul style="list-style-type: none"> • The date the report was prepared
<ul style="list-style-type: none"> • The date the report is submitted
<ul style="list-style-type: none"> • Name of persons who have SIU responsibilities, as well as the name of the Compliance Officer

Annual Fraud Prevention Report Minimum Requirements

- 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:
 - The managed care plan case number, if any
 - The NPI(s) of the providers subject to the review or activity and name(s) of the providers
 - The dates when the audit, review, or activity commenced and when it was completed
 - 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
 - A brief statement about the concern, allegation, or complaint
 - Findings or requests associated with the allegation or complaint; refrain from using “substantiated” or “unsubstantiated” as the only finding statement
 - The payback amount/overpayment amount, if any
 - If an appeal was provided and the results, including overpayment amount, if any
 - The amount recouped by the managed care plan, if any
 - The remaining amount owed to the managed care plan, if any
 - The date the allegation or complaint was received (the open date)
 - The date all action on the case was exhausted and/or final determinations were rendered, with the exception of referrals sent to PI for the closed date
 - If the matter was referred to PI for potential fraud
 - Any additional comments related to the case, provider, or additional administrative actions taken; also include if the activity was completed outside the SIU
- Any providers subject to prepayment review, the length of any such review, and the outcome
- A description of any predictive modeling used