Managed Care Program Annual Report (MCPAR) for North Carolina: Behavioral Health Prepaid Inpatient Health Plan (PIHP) Waiver Program

Due date	Last edited	Edited by	Status
12/27/2025	12/24/2025	Dawn Johnson	Submitted

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

Indicator	Response
each plan.	

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	North Carolina
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Kelsi Knick
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	kelsi.knick@dhhs.nc.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Dawn Johnson
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	dawn.johnson@dhhs.nc.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	12/24/2025

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	07/01/2024
A5b	**Reporting period end date** Auto-populated from report dashboard.	06/30/2025
A6	**Program name** Auto-populated from report dashboard.	Behavioral Health Prepaid Inpatient Health Plan (PIHP) Waiver Program

Add plans (A.7)

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

	Indicator	Response
	Plan name	Alliance Partners Trillium Vaya

Add BSS entities (A.8)

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

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

Indicator	Response
BSS entity name	Medicaid Contact Center

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

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

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

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

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

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

Topic III. Encounter Data Report

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

Topic X: Program Integrity

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

	overpayment standard Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard selected in indicator B.X.2.	The PIHP's Compliance Program shall comply with 42 C.F.R. § 438.608, and must include: i. Written policies, procedures, and standards of conduct that articulate the PIHP's commitment to comply with all applicable requirements and standards under the Contract, and all applicable federal and State requirements, including: i. Implementation and maintenance arrangements or procedures for notification to the Department when it receives information about a change in a Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the PIHP, including termination of the provider agreement with the PIHP. 42 C.F.R. § 438.608(a)(4). ii. Retention policies for the treatment of recoveries of all overpayments from the PIHP to a Provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse. 42 C.F.R. § 438.608(d)(1)(i). iii. Processes, timeframes, and documentation required for payment of recoveries of overpayments to the Department in situations where the PIHP is not permitted to retain some or all of the recoveries of overpayments. 42 C.F.R. § 438.608(d)(1)(iii). iv. Reporting to the Department within sixty (60) Calendar Days when it has identified the capitation payments or other payments in excess of amounts specified in the Contract. 42 C.F.R. § 438.608(c)(3).
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is	The State Medicaid Agency have the Plans report their overpayments and recoveries on an Annual Overpayment Recoveries Report and the Quarterly FWA Provider Report. The Plans share overpayment and recoveries during their monthly Oversight and Monitoring meeting with the State and on their Quarterly FWA Provider Report of all provider audits and Investigations to include disposition of overpayments and recoveries.

	asking the state how it monitors that reporting.	
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	Daily 834 files with member changes. - Monthly 834 Files with all members - A monthly reconciliation process that compares member enrollment data across systems, such as health plans, the Enrollment Broker, and state eligibility systems.
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider “for cause” terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	Yes
BX.7c	**Changes in provider circumstances: Describe metric** Describe the metric or indicator that the state uses.	Yes (started post Oct 2024, as applicable) - Provider removed from network - Provider removed from claims payment system

BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	No
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to 42 CFR 438.602(g)(3) and 455.104.	No
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter "No such audits were conducted during the reporting year" as your response. "N/A" is not an acceptable response.	Report Name: August 2025 Legislative Reports | NCDHHS Report Desc: A summary report of the findings for fiscal solvency, clean claims payment, and HIPAA compliance for the Local Management Entities/Managed Care Organizations. Report Link: https://www.ncdhhs.gov/about/administrative-offices/office-government-affairs/legislative-reports/2025-legislative-reports/august-2025-legislative-reports Report Name: 2024–2025 Encounter Data Validation Report Report Desc: Encounter data validation process is completed with an external quality review organization HSAG (Human Services Advisory Group). We have the Information Systems Capability Assessment that was completed by the external quality review organization HSAG. DHHS internal audit has also reviewed the encounter data validation reports. Report Link: https://medicaid.ncdhhs.gov/2024-2025-encounter-data-validation-information-systems-review-aggregate-report/download?attachment

Topic XIII. Prior Authorization

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

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

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	Medicaid Direct Prepaid Inpatient Health Plan Contract #30-2022-007-DHB
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	07/01/2024
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://medicaid.ncdhhs.gov/health-plans#health-plan-contracts
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Long-term services and supports (LTSS) Transportation
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter “N/A” if not applicable.	N/A
C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this managed care program per	361,534

	month during the reporting year (i.e., average member months).	
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter “There were no major changes to the population or benefits during the reporting year” as your response. “N/A” is not an acceptable response.	Tailored Plan launched in July 2024 moving a large number of PIHP enrollees to the new program

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support Other, specify – TMSIS reporting to CMS State and Federal Audit Requests
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Timeliness of data certifications Use of correct file formats Provider ID field complete Overall data accuracy (as determined through data validation)
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Attachment B. Section 9.3. Encounter Data
C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality	Attachment K. STATISTICAL REPORTING MEASURES AND LATE SUBMISSION SANCTIONS

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

Topic IV. Appeals, State Fair Hearings & Grievances

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

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

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter "No challenges were encountered" as your response. "N/A" is not an acceptable response.	1) In many areas of the state, PIHPs struggle with contracting with providers in general due to a limited supply of providers. This is especially true in the more rural areas of the state particularly for Behavioral Health providers and MH/SUD facilities. This lack of providers is evident in the network adequacy geomapping results relating to the MCPs networks but also evident in the geomapping results of the network of all enrolled Medicaid providers.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	The state works with all health plans to confirm that for the gaps identified by analysis an appropriate network adequacy exception request is submitted for the state's review and approval. As part of the request for an exception the MCPS must indicate how the plan will make sure that members have access to the services on a timely basis and their plan to mitigate the provider gap. Additionally, the state engages the MCPS around provider supply issues and discusses ways in which improvements can be made to encourage more provider participation in Medicaid.

Access Measures

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

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

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

Access measure total count: 24

Complete

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

1 / 24

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

2 / 24

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

3 / 24

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Urban	Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

4 / 24

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Rural	Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

5 / 24

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Not answered	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Other, specify

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

6 / 24

C2.V.2 Measure standard

Professional treatment services in facility-based crisis program: The greater of 2+ facilities within each PIHP Region, OR 1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates). Facility-based crisis services for children and adolescents: ≥ 1 provider within each PIHP Region Medically Monitored Inpatient Withdrawal Services (non-hospital medical detoxification: ≥ 2 provider within each PIHP Region Ambulatory withdrawal management without extended on-site monitoring (ambulatory detoxification), Ambulatory withdrawal management with extended onsite monitoring, Clinically managed residential withdrawal (social setting detoxification): ≥ 1 provider of each crisis service within each PIHP Region

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Not answered	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Other, specify

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

7 / 24

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Not answered	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Other, specify

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

8 / 24

C2.V.2 Measure standard

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

C2.V.1 General category

LTSS-related standard: enrollee travels to the provider

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Not answered	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

9 / 24

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Not answered	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

10 / 24

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Not answered	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

11 / 24

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Not answered	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

12 / 24

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Not answered	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Other, specify

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

13 / 24

C2.V.2 Measure standard

Access to ≥ 1 licensed provider per PIHP Region

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Not answered	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Other, specify

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

14 / 24

C2.V.2 Measure standard

Access to ≥ 1 licensed provider per PIHP Region

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Not answered	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Other, specify

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

15 / 24

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Not answered	statewide	Adult

C2.V.7 Monitoring Methods

Other, specify

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

16 / 24

C2.V.2 Measure standard

Contract with all designated CASPs statewide

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Not answered	Statewide	Adolescent, Women & Children

C2.V.7 Monitoring Methods

Other, specify

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

17 / 24

C2.V.2 Measure standard

Contract with all designated CASPs statewide

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Not answered	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Other, specify

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

18 / 24

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Not answered	statewide	Adult

C2.V.7 Monitoring Methods

Other, specify

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

19 / 24

C2.V.2 Measure standard

Access to ≥1 program per PIHP Region

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Not answered	Adolescent	Statewide

C2.V.7 Monitoring Methods

Other, specify

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

20 / 24

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Not answered	Statewide	Adult

C2.V.7 Monitoring Methods

Other, specify

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

21 / 24

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Not answered	statewide	Adult

C2.V.7 Monitoring Methods

Other, specify

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

22 / 24

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Not answered	statewide	Adult and Pediatrics

C2.V.7 Monitoring Methods

Other, specify

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

23 / 24

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Not answered	Statewide	Adult and Pedatric

C2.V.7 Monitoring Methods

Other, specify

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

24 / 24

C2.V.2 Measure standard

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

C2.V.1 General category

General quantitative availability and accessibility standard

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Not answered	Statewide	Adult and Pediatrics

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Topic IX: Beneficiary Support System (BSS)

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

C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	NC Medicaid Enrollment Broker: - Call Center Service Level Agreement Requirements and Monitoring - Quality Monitoring: Call Listening sessions using calibration template for % of calls - Customer surveys - Enrollments completed - Staffing NC Medicaid Ombudsman - Call Center Service Level Agreement Requirements and Monitoring - Customer surveys - Staffing Medicaid Contact Center: - Call Center Service Level Agreement Requirements and Monitoring - Quality Monitoring: Call Listening sessions using calibration template for % of calls - Customer surveys - Staffing

Topic X: Program Integrity

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

Topic XII. Mental Health and Substance Use Disorder Parity

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

	should report the most recent date any MCO sent the state its parity analysis (the state may have multiple reports, one for each MCO).	
C1XII.9	**When was the last parity analysis(es) for this program submitted to CMS?** States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).	04/01/2025
C1XII.10a	**In the last analysis(es) conducted, were any deficiencies identified?**	No
C1XII.12a	**Has the state posted the current parity analysis(es) covering this program on its website?** The current parity analysis/analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO enrollees by an entity other than MCO should have a single state summary parity analysis report.States with NO services provided to MCO enrollees by an entity other than the MCO may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A "Yes" response means that the parity analysis for either the state or for ALL MCOs has been posted.	Yes
C1XII.12b	**Provide the URL link(s).** Response must be a valid hyperlink/URL beginning with "http://" or "https://". Separate links with commas.	https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies/mental-health-parity

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**Alliance** 89,916 **Partners** 69,433 **Trillium** 127,948 **Vaya** 74,237
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? Numerator: Plan enrollment (D1.I.1)Denominator: Statewide Medicaid enrollment (B.I.1)	**Alliance** 2.9% **Partners** 2.2% **Trillium** 4.1% **Vaya** 2.4%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care?Numerator: Plan enrollment (D1.I.1)Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**Alliance** 3.1% **Partners** 2.4% **Trillium** 4.5% **Vaya** 2.6%
D1I.4: Parent	**Organization: The name of the parent entity that controls the Medicaid Managed Care Plan.** If the managed care plan is owned or controlled by a separate entity (parent), report the name of that entity. If the managed care plan is not	**Alliance** Alliance Health **Partners** Partners Health Management **Trillium**

controlled by a separate entity, please report the managed care plan name in this field.	Trillium Health Resources **Vaya** Vaya Health

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.	**Alliance** 106.42% **Partners** 99.88% **Trillium** 112.72% **Vaya** 97.62%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Alliance** Other, specify – Regional All Behavioral Health Programs and Medicaid Direct under the waiver(s) **Partners** Other, specify – Regional All Behavioral Health Programs and Medicaid Direct under the waiver(s) **Trillium** Other, specify – Regional All Behavioral Health Programs and Medicaid Direct under the waiver(s) **Vaya** Other, specify – Regional All Behavioral Health Programs and Medicaid Direct under the waiver(s)
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS	**Alliance** N/A **Partners** N/A

	or Group VIII expansion enrollees? If so, describe the populations here. Enter “N/A” if not applicable. See glossary for the regulatory definition of MLR.	**Trillium** N/A **Vaya** N/A
D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**Alliance** No **Partners** No **Trillium** No **Vaya** No

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Alliance** Medical encounters must be submitted within 30 days of claims payment. For the purposes of this standard, medical is any 837-P transaction with no lines that contain an NDC OR any 837-I transaction with bill type other than 13x OR any 837-I transaction with bill type of 13x and no lines that contain an NDC. **Partners** Medical encounters must be submitted within 30 days of claims payment. For the purposes of this standard, medical is any 837-P transaction with no lines that contain an NDC OR any 837-I transaction with bill type other than 13x OR any 837-I transaction with bill type of 13x and no lines that contain an NDC. **Trillium** Medical encounters must be submitted within 30 days of claims payment. For the purposes of this standard, medical is any 837-P transaction with no lines that contain an NDC OR any 837-I transaction with bill type other than 13x OR any 837-I transaction with bill type of 13x and no lines that contain an NDC. **Vaya** Medical encounters must be submitted within 30 days of claims payment. For the purposes of this standard, medical is any 837-P transaction with no lines that contain an NDC OR any 837-I transaction with bill type other than 13x OR any 837-I transaction with bill type of 13x and no lines that contain an NDC.
D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the	**Alliance** 99.92% **Partners** 99.92% **Trillium**

	state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.	99.92% **Vaya** 99.92%
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.	**Alliance** 100% **Partners** 100% **Trillium** 100% **Vaya** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during the reporting year.An appeal is “resolved” at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary’s representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Alliance** 161 **Partners** 864 **Trillium** 9 **Vaya** 16
D1IV.1a	**Appeals denied** Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee.	**Alliance** 85 **Partners** 300 **Trillium** 6 **Vaya** 12
D1IV.1b	**Appeals resolved in partial favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee.	**Alliance** 11 **Partners** 12 **Trillium** 1 **Vaya** 0
D1IV.1c	**Appeals resolved in favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee.	**Alliance** 65 **Partners** 552

		Trillium 2 **Vaya** 4
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	**Alliance** 0 **Partners** 0 **Trillium** 0 **Vaya** 0
D1IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter “N/A” if not applicable.An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	**Alliance** 3 **Partners** 122 **Trillium** 0 **Vaya** 5
D1IV.4	**Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter “N/A”.Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the	**Alliance** 1 **Partners** 0 **Trillium** 0 **Vaya** 0

	reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter “N/A”.The appeal and critical incident do not have to have been “related” to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user.To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	
D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year.See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Alliance** 137 **Partners** 774 **Trillium** 8 **Vaya** 14
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year.See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Alliance** 24 **Partners** 73 **Trillium** 1 **Vaya** 2

D1IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service.(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Alliance** 159 **Partners** 864 **Trillium** 9 **Vaya** 16
D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**Alliance** 0 **Partners** 0 **Trillium** 0 **Vaya** 0
D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**Alliance** 2 **Partners** 0 **Trillium** 0 **Vaya** 0
D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**Alliance** 0 **Partners** 0 **Trillium** 0

		Vaya 0
D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**Alliance** 0 **Partners** 0 **Trillium** 0 **Vaya** 0
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	**Alliance** 0 **Partners** 0 **Trillium** 0 **Vaya** 0
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**Alliance** 0 **Partners** 0 **Trillium** 0 **Vaya** 0

Appeals by Service

Number of appeals resolved during the reporting period related to various services. Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services.Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter “N/A”.	**Alliance** 9 **Partners** 23 **Trillium** N/A **Vaya** 0
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter “N/A”.	**Alliance** 55 **Partners** 199 **Trillium** N/A **Vaya** 0
D1IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter “N/A”.	**Alliance** 29 **Partners** 1 **Trillium** 0 **Vaya** 0
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that	**Alliance** 48 **Partners**

	were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter “N/A”.	171 **Trillium** 9 **Vaya** 4
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter “N/A”.	**Alliance** 13 **Partners** 464 **Trillium** N/A **Vaya** 0
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter “N/A”.	**Alliance** 3 **Partners** 0 **Trillium** N/A **Vaya** 0
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter “N/A”.(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Alliance** 1 **Partners** 141 **Trillium** 0 **Vaya** 5

D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter “N/A”.	**Alliance** N/A **Partners** N/A **Trillium** N/A **Vaya** N/A
D1IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter “N/A”.	**Alliance** 0 **Partners** 0 **Trillium** N/A **Vaya** 0
D1IV.7k:	**Resolved appeals related to durable medical equipment (DME) & supplies** Enter the total number of appeals resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter “N/A”.	**Alliance** 33 **Partners** 104 **Trillium** N/A **Vaya** 0
D1IV.7l:	**Resolved appeals related to home health / hospice** Enter the total number of appeals resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter “N/A”.	**Alliance** 0 **Partners** 47 **Trillium** N/A

		Vaya 0
D1IV.7m:	**Resolved appeals related to emergency services / emergency department** Enter the total number of appeals resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include appeals related to emergency outpatient behavioral health – those should be included in indicator D1.IV.7d. If the managed care plan does not cover this type of service, enter “N/A”.	**Alliance** 0 **Partners** 2 **Trillium** N/A **Vaya** 0
D1IV.7n:	**Resolved appeals related to therapies** Enter the total number of appeals resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter “N/A”.	**Alliance** 1 **Partners** 1 **Trillium** N/A **Vaya** 0
D1IV.7o	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-n paid primarily by Medicaid, enter “N/A”.	**Alliance** 19 **Partners** N/A **Trillium** N/A **Vaya** 7

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests resolved during the reporting year with the plan that issued an adverse benefit determination.	**Alliance** 7 **Partners** 2 **Trillium** 0 **Vaya** 14
D1IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Alliance** 0 **Partners** 0 **Trillium** 0 **Vaya** 0
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Alliance** 0 **Partners** 0 **Trillium** 0 **Vaya** 0

D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	**Alliance** 7 **Partners** 2 **Trillium** 0 **Vaya** 14
D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A".External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Alliance** 0 **Partners** 0 **Trillium** N/A **Vaya** 0
D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A".External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Alliance** 0 **Partners** 0 **Trillium** N/A **Vaya** 0

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care.A grievance is “resolved” when it has reached completion and been closed by the plan.	**Alliance** 1,674 **Partners** 605 **Trillium** 1,448 **Vaya** 120
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**Alliance** 0 **Partners** 0 **Trillium** 0 **Vaya** 0
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users.An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**Alliance** 122 **Partners** 523 **Trillium** 5 **Vaya** 102
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on	**Alliance** 9 **Partners** 12 **Trillium**

	behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user.If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field.To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	0 **Vaya** 50
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting year.See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Alliance** 1,674 **Partners** 605 **Trillium** 1,426 **Vaya** 134

Grievances by Service

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

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter “N/A”.	**Alliance** 1 **Partners** 11 **Trillium** 1 **Vaya** 7
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Do not include grievances related to outpatient behavioral health services - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter “N/A”.	**Alliance** 3 **Partners** 592 **Trillium** 36 **Vaya** 44
D1IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter “N/A”.	**Alliance** 103 **Partners** 0 **Trillium** 1 **Vaya** 4
D1IV.15d	**Resolved grievances related to outpatient behavioral health services**	**Alliance** 479

	Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter “N/A”.	**Partners** 2 **Trillium** 120 **Vaya** 1
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter “N/A”.	**Alliance** 7 **Partners** 3 **Trillium** 26 **Vaya** 0
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter “N/A”.	**Alliance** 0 **Partners** 0 **Trillium** 0 **Vaya** 1
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter “N/A”.	**Alliance** 122 **Partners** 523 **Trillium** 5 **Vaya** 22

D1IV.15h

Resolved grievances related to dental services

Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter “N/A”.

Alliance

N/A

Partners

N/A

Trillium

N/A

Vaya

N/A

D1IV.15i

Resolved grievances related to non-emergency medical transportation (NEMT)

Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter “N/A”.

Alliance

555

Partners

417

Trillium

607

Vaya

8

D1IV.15k

Resolved grievances related to durable medical equipment (DME) & supplies

Enter the total number of grievances resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter “N/A”.

Alliance

3

Partners

3

Trillium

8

Vaya

0

D1IV.15l

Resolved grievances related to home health / hospice

Enter the total number of grievances resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter “N/A”.

Alliance

7

Partners

1

Trillium

3

		Vaya 1
D1IV.15m	**Resolved grievances related to emergency services / emergency department** Enter the total number of grievances resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include grievances related to emergency outpatient behavioral health - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter “N/A”.	**Alliance** 0 **Partners** 0 **Trillium** 2 **Vaya** 2
D1IV.15n	**Resolved grievances related to therapies** Enter the total number of grievances resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter “N/A”.	**Alliance** 9 **Partners** 5 **Trillium** 1 **Vaya** 0
D1IV.15o	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-n paid primarily by Medicaid, enter “N/A”.	**Alliance** 385 **Partners** 1 **Trillium** 638 **Vaya** 44

Grievances by Reason

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

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service.Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Alliance** 201 **Partners** 69 **Trillium** 1,029 **Vaya** 6
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management.Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**Alliance** 153 **Partners** 30 **Trillium** 139 **Vaya** 4
D1IV.16c	**Resolved grievances related to network adequacy or access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care.Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**Alliance** 24 **Partners** 380 **Trillium** 169 **Vaya** 4
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care.Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or	**Alliance** 310 **Partners** 90 **Trillium**

	acceptability of care provided by a provider or the plan.	120 **Vaya** 54
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications.Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**Alliance** 64 **Partners** 9 **Trillium** 28 **Vaya** 26
D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	**Alliance** 200 **Partners** 11 **Trillium** 90 **Vaya** 23
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud.Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**Alliance** 14 **Partners** 8 **Trillium** 29 **Vaya** 2
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or	**Alliance** 102 **Partners**

	exploitation.Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	13 **Trillium** 10 **Vaya** 6
D1IV.16i	**Resolved grievances related to lack of timely plan response to a prior authorization/service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**Alliance** 0 **Partners** 19 **Trillium** 60 **Vaya** 0
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal.Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**Alliance** 0 **Partners** 0 **Trillium** 0 **Vaya** 0
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	**Alliance** 606 **Partners** 0 **Trillium** 72 **Vaya** 0

Topic VII: Quality & Performance Measures

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

Quality & performance measure total count: 10

Complete

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

1 / 10

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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

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

D2.VII.6 Measure Set

Medicaid Child Core Set and Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Alliance

7-Day Follow-Up: 30.65% 30-Day Follow-Up: 51.18%

Partners

7-Day Follow-Up: 33.36% 30-Day Follow-Up: 48.53%

Trillium

7-Day Follow-Up: 4.74% 30-Day Follow-Up: 2.85%

Vaya

7-Day Follow-Up: 23.59% 30-Day Follow-Up: 34.25%

Complete

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

2 / 10

D2.VII.2 Measure Domain

Behavioral health care

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

2801

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

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

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Alliance

43.12

Partners

53.92

Trillium

41.85

Vaya

42.73

Complete

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

3 / 10

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

3389

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

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

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Alliance

10.31

Partners

17.11

Trillium

12.69

Vaya

4.07

Complete

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

4 / 10

D2.VII.2 Measure Domain

Care of acute and chronic conditions / Primary Care Access and Preventive Care

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

1932

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

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

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Alliance

74.87

Partners

77.64

Trillium

39.20

Vaya

60.94

Complete

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

5 / 10

D2.VII.2 Measure Domain

Behavioral health care

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

0108

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

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

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Alliance

Initiation: 4.98% Continuation: 6.61%

Partners

Initiation: 48.05% Continuation: 55.88%

Trillium

Initiation: 24.48% Continuation: 8.11%**

Vaya

Initiation: 15.13% Continuation: Not reported

Complete

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

6 / 10

D2.VII.2 Measure Domain

Behavioral health care

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

2940

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

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

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Alliance

4.69%

Partners

6.40%

Trillium

8.06%

Vaya

4.68%

Complete

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

7 / 10

D2.VII.2 Measure Domain

Primary care access and preventative care

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

2800

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

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

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Alliance

Total Metabolic Testing:32.99%

Partners

Total Metabolic Testing: 44.11%

Trillium

Total Metabolic Testing: 6.27%

Vaya

Total Metabolic Testing: 19.95%

Complete

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

8 / 10

D2.VII.2 Measure Domain

Behavioral health care

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

3489

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

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

D2.VII.6 Measure Set

Medicaid Adult and Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Alliance

7-Day Follow-Up: 35.65% 30-Day Follow-Up: 52.01%

Partners

7-Day Follow-Up: 35.75% 30-Day Follow-Up: 50.27%

Trillium

7-Day Follow-Up: 49.69% 30-Day Follow-Up: 33.61%

Vaya

7-Day Follow-Up: 37.08% 30-Day Follow-Up: 52.69%

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Substance Use Disorder Treatment (IET)

9 / 10

D2.VII.2 Measure Domain

Behavioral health care

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

0004

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

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

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Alliance

Initiation: 41.66% Engagement: 5.73%

Partners

Initiation: 40.20% Engagement: 5.73%

Trillium

Initiation: 38.80% Engagement: 8.92%

Vaya

Initiation: 38.50% Engagement: 6.27%

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Substance Use (FUA)

10 / 10

D2.VII.2 Measure Domain

Behavioral health care

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

3488

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

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

D2.VII.6 Measure Set

Medicaid Adult and Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Alliance

7-Day Follow-Up: 18.95% 30-Day Follow-Up: 27.92%

Partners

"7-Day Follow-Up: 18.54% 30-Day Follow-Up: 27.80%"

Trillium

"7-Day Follow-Up: 16.78% 30-Day Follow-Up: 29.06%"

Vaya

7-Day Follow-Up: 28.34% 30-Day Follow-Up: 37.00%

Topic VIII. Sanctions

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

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

Sanction total count: 6

Complete

D3.VIII.1 Intervention type: Corrective Action Plan & Liquidated Damages

1 / 6

D3.VIII.2 Plan performance issue

Privacy and Security Incidents (October 2023 to June 2024)

D3.VIII.3 Plan name

Alliance

D3.VIII.4 Reason for intervention

Contractor's failure to comply with the terms and conditions of the confidentiality, privacy, and security protections of the Contract performance period.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$1,250

D3.VIII.7 Date assessed

03/04/2025

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

Yes, remediated 06/03/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

2 / 6

D3.VIII.2 Plan performance issue

CY1 - Notice Regarding Annual Network Adequacy Determination and Deficiencies

D3.VIII.3 Plan name

Alliance

D3.VIII.4 Reason for intervention

Contractor's failure to meet the network standards as of the date of the annual submission (without an approved exception or alternative arrangement).

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

06/20/2025

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

Yes, remediated 10/02/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective Action Plan & Liquidated Damages

3 / 6

D3.VIII.2 Plan performance issue

Privacy and Security Incidents (October 2023 to March 2024)

D3.VIII.3 Plan name

Partners

D3.VIII.4 Reason for intervention

Contractor's failure to comply with the terms and conditions of the confidentiality, privacy, and security protections of the Contract performance period.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$125

D3.VIII.7 Date assessed

10/24/2024

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

Yes, remediated 02/05/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective Action Plan & Liquidated Damages

4 / 6

D3.VIII.2 Plan performance issue

D3.VIII.3 Plan name

Privacy and Security Incidents (April 2024 to December 2024)

Partners

D3.VIII.4 Reason for intervention

Contractor's failure to comply with the terms and conditions of the confidentiality, privacy, and security protections of the Contract performance period.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$375

D3.VIII.7 Date assessed

06/30/2025

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

Yes, remediated 08/18/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

5 / 6

D3.VIII.2 Plan performance issue

Privacy and Security Incident (October 2023 to March 2024)

D3.VIII.3 Plan name

Trillium

D3.VIII.4 Reason for intervention

Contractor's failure to comply with the terms and conditions of the confidentiality, privacy, and security protections of the Contract performance period.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

01/27/2025

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

Yes, remediated 03/31/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective Action Plan & Liquidated Damages

6 / 6

D3.VIII.2 Plan performance issue

Privacy and Security Incidents (October 2023 to September 2024)

D3.VIII.3 Plan name

Vaya

D3.VIII.4 Reason for intervention

Contractor's failure to comply with the terms and conditions of the confidentiality, privacy, and security protections of the Contract performance period.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$8,625

D3.VIII.7 Date assessed

02/25/2025

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

Yes, remediated 05/14/2025

D3.VIII.9 Corrective action plan

Yes

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Alliance** 37 **Partners** 8 **Trillium** 7 **Vaya** 19
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Alliance** 70 **Partners** 90 **Trillium** 229 **Vaya** 39
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**Alliance** 72 **Partners** 95 **Trillium** 225 **Vaya** 41
D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Alliance** Makes referrals to the State Medicaid Agency (SMA) only **Partners**

Makes referrals to the State Medicaid Agency (SMA) only

Trillium

Makes referrals to the State Medicaid Agency (SMA) only

Vaya

Makes referrals to the State Medicaid Agency (SMA) only

D1X.7

Count of program integrity referrals to the state

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

Alliance

9

Partners

8

Trillium

12

Vaya

0

D1X.9a:

Plan overpayment reporting to the state: Start Date

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

Alliance

07/01/2024

Partners

07/01/2024

Trillium

07/01/2024

Vaya

07/01/2024

D1X.9b:

Plan overpayment reporting to the state: End Date

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

Alliance

06/30/2025

Partners

06/30/2025

Trillium

06/30/2025

Vaya

		06/30/2025
D1X.9c:	**Plan overpayment reporting to the state: Dollar amount** From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?	**Alliance** $38,242.25 **Partners** $1,002,702 **Trillium** $37,135.04 **Vaya** $2,982,389.78
D1X.9d:	**Plan overpayment reporting to the state: Corresponding premium revenue** What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))	**Alliance** $291,982,170.12 **Partners** $276,297,500.11 **Trillium** $489,437,998.78 **Vaya** $284,315,494.50
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Alliance** Weekly **Partners** Weekly **Trillium** Weekly **Vaya** Weekly

Topic XI: ILOS

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

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

Number	Indicator	Response
D4XI.1	**ILOSs offered by plan** Indicate whether this plan offered any ILOS to their enrollees.	**Alliance** Yes, at least 1 ILOS is offered by this plan **Partners** Yes, at least 1 ILOS is offered by this plan **Trillium** Yes, at least 1 ILOS is offered by this plan **Vaya** Yes, at least 1 ILOS is offered by this plan
D4XI.2a	**ILOSs utilization by plan** Select all ILOSs offered by this plan during the contract rating period. For each ILOS offered by the plan, enter the deduplicated number of enrollees that utilized this ILOS during the contract rating period. If the plan offered this ILOS during the contract rating period but there was no utilization, enter “0”.	**Alliance** Behavioral Health Crisis Assessment and Intervention: Child ACT: Family Centered Treatment: High Fidelity Wraparound: In-Home Therapy Services: Long Term Community Supports: Residential Services - Complex Needs: Short Term Residential Stabilization: Transitional Youth Services: **Partners** ACT - Step Down: Behavioral Health Urgent Care: Family Centered Treatment: High Fidelity Wraparound: Individual Rehabilitation, Coordination, and Support : Long Term Community Supports: Rapid Care: Rapid Response: Residential Services - Complex Needs: Transitional Youth Services: **Trillium** Behavioral Health Crisis Assessment and Intervention: Child First:

	Community Living Facilities and Support: Family Centered Treatment: Family Navigator: High Fidelity Wraparound: **Vaya** ACT - Step Down: Behavioral Health Crisis Assessment and Intervention: Case Support (Day Treatment Comparison): Child ACT: Critical Time Intervention: Enhanced Crisis Response: Family Centered Treatment: Family Navigator: High Fidelity Wraparound: In-Home Therapy Services: Long Term Community Supports: Outpatient Plus: Rapid Care: Residential Services - Complex Needs: Transitional Youth Services:

Topic XIII. Prior Authorization

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

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

Topic XIV. Patient Access API Usage

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

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

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Medicaid Contact Center** Subcontractor
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Medicaid Contact Center** Other, specify – PCP Changes/ Benefits Information

Section F: Notes

Notes

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

Number	Indicator	Response
F1	**Notes (optional)**	Not answered