Managed Care Program Annual Report (MCPAR) for North Carolina: PIHP

Due date	Last edited	Edited by	Status
12/27/2024	12/27/2024	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

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.	12/27/2024

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	04/01/2023
A5b	**Reporting period end date** Auto-populated from report dashboard.	06/30/2024
A6	**Program name** Auto-populated from report dashboard.	PIHP

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 Eastpointe Sandhills 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	North Carolina Medicaid Ombudsman Program NC Medicaid Enrollment Broker 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	

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.	2,991,392
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.	2,587,516

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, reviewing 3 months historic data each from July 2023 - June 2024: 1. Drug Testing Referring Providers cross-plan provider risk analysis identified the provider with the most outlier behavior in their peer group and performed a comparison to whole referring provider peer group. Included a deep dive comparison against top 28 providers via risk factors reviewed in peer group. 2. Psychotherapy, Speech Occupational and Physical Therapy peer group comparison identifying 620 long days across 50 providers. Identified 191 days and 15 providers with impossible billing of > 24 hours per day within those groups. 3. Drug Testing Kickback Scheme Segmentation Analysis: Identified 19 billing providers and 10 rendering providers with similar billing behaviors as a provider recently convicted and sentenced for fraud. Above results were presented to all of the Managed Care Organizations during quarterly SIU oversight. OCPI Compliance Analytics conducted cross-payer payment reviews of the following service areas: 1. Incontinence Suppliers peer group review: Reviewed 8 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 6 were referred for investigation. 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 - 2 Providers 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 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).	See Section 4.J.1.E, page 244
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	i. The PIHP, or Subcontractor to the extent that the Subcontractor is delegated responsibility by the PIHP for coverage of services and payment of claims under the Contract, shall implement and maintain arrangements or procedures for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State. 42 C.F.R. § 438.608(a)(2). ii. In meeting the requirement of 42 C.F.R. § 438.608(a)(2), the PIHP may recover overpayments made to the health care provider or health care facility by making demands for refunds and by offsetting future payments. Any such recoveries may also include related interest payments that were made under the requirements of this Section. Not less than thirty (30) Calendar Days before the PIHP seeks overpayment recovery or offsets future payments, the PIHP shall give written notice to the health care provider or health care facility, which notice shall be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery. The recovery of overpayments or offsetting of future payments shall be made within the two years after the date of the original claim payment unless the PIHP has reasonable belief of fraud or other intentional misconduct by the health care provider or health care facility or its agents. The health care provider or health care facility may recover underpayments or non-payments by the PIHP by making demands for refunds. Any such recoveries by the health care provider or health care facility of underpayments or nonpayment by the PIHP may include applicable interest under this section. The recovery of underpayments or non-payments shall be made within the two years after the date of the original claim adjudication, unless the claim involves a health provider or health care facility receiving payment for the same

		service from a government payor. iii. The PIHP shall coordinate with the Department to ensure overpayment and underpayment recovery is accurately reflected in MLR calculations and capitation rate setting.
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 asking the state how it monitors that reporting.	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 SMA receive, review and analyze the Annual Overpayment Recoveries Report via the Compliance Review Process conducted by the EQRO and The Office of Compliance and Program Integrity. 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.
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.	No
BX.8a	**Federal database checks: Excluded person or entities** During the state’s federal	No

	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.	
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.	Encounter data validation process is completed with an external quality review organization HSAG (Human Services Advisory Group). DHHS internal audit has also reviewed the encounter data validation reports.External Quality Review Reports posted by plan on state website: https://medicaid.ncdhhs.gov/providers/programs-and-services/behavioral-health-idd/lmemco-contracts-and-reports#AllianceBehavioralHealthcare-2864

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.	04/01/2023
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	557,790

	managed care program per 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.	Medicaid Expansion was implemented mid-year 2024 resulting in increased enrollment for all programs

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	Attachment K. STATISTICAL REPORTING MEASURES AND LATE SUBMISSION SANCTIONS

	failures to meet encounter data submission and quality 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.	Because this is within the first 18 months of collecting encounter data as part of a new 1115 waiver, the State has had to provide an additional level of technical assistance to the plans to meet the SLAs and to have the plans adjust their systems to adhere to the State's reporting requirements. 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. The state EQR has started the process for reviewing the encounter data quality. A report will be available within 18 months to validate encounters. The CLM01 issue impacted encounter SLAs due to its relation to voids and non-duplicate voids that Plans were required to process. The issue stemmed from incorrect data entered in the CLM01 field, necessitating a data cleanup before addressing the non-duplicate voids. The resolution process involved voiding all previously submitted encounters and resubmitting them with the corrected CLM01 value. This process commenced on 9/19/2023, was initially scheduled for completion by 6/28/2024, but was successfully concluded ahead of schedule on 8/20/2024

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) The consistency and reliability of provider data as reported by providers to the State, as reported by the State to the prepaid health plans, and as ingested and reported back to the State by the Standard Plan Prepaid Health Plans is a challenge for Network Adequacy. While this has greatly improved, there are still areas for improvement. Providers are traditionally poor at updating demographic information and stressing its importance to member choice and claims payment. The state is also providing assistance and information to the prepaid health plans relating to the updated systems and how the new information may impact the information provided to the prepaid health plans. 2) In many areas of the state, Standard Plan PHPs struggle with contracting with providers in general due to a limited supply of providers. This is especially true in the more rural areas of the state and is particularly acute for pediatric specialist. 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.1 General category: General quantitative availability and accessibility standard 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.3 Standard type

Maximum time or distance

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.1 General category: General quantitative availability and accessibility standard 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.3 Standard type

Maximum time or distance

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.1 General category: General quantitative availability and accessibility standard

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.3 Standard type

Maximum time or distance

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.1 General category: General quantitative availability and accessibility standard

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.3 Standard type

Maximum time or distance

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.1 General category: General quantitative availability and accessibility standard

5 / 24

Complete

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.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan reporting

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Crisis Services	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan reporting

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

7 / 24

C2.V.2 Measure standard

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

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Inpatient Behavioral Health Services (Inpatient Hospital)	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan reporting

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: LTSS-related standard: enrollee travels to the provider

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.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Location Based Behavioral Health	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Location Based Services (BH)	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Partial Hospitalization (BH)	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

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

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Partial Hospitalization (BH)	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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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.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Community/Mobile Services	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan reporting

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

Access to ≥ 1 licensed provider per PIHP Region

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Residential treatment facility services	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan reporting

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Access to ≥ 1 licensed provider per PIHP Region

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Residential Treatment: Medically monitored intensive inpatient services (substance abuse medically monitored community residential treatment)	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

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

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Residential Treatment: Clinically managed residential services (substance abuse non-medical community residential treatment)	statewide	Adult

C2.V.7 Monitoring Methods

Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

Contract with all designated CASPs statewide

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Residential Treatment: Clinically managed residential services (substance abuse non-medical community residential treatment)	Statewide	Adolescent, Women & Children

treatment)

C2.V.7 Monitoring Methods

Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

17 / 24

C2.V.2 Measure standard

Contract with all designated CASPs statewide

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Residential Treatment: Clinically managed population-specific high-intensity residential program	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

18 / 24

C2.V.2 Measure standard

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

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Residential Treatment: Clinically managed low	statewide	Adult

managed low-

intensity residential treatment services (substance abuse halfway house)

C2.V.7 Monitoring Methods

Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

19 / 24

C2.V.2 Measure standard

Access to ≥1 program per PIHP Region

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Residential Treatment: Clinically managed low-intensity residential treatment services (substance abuse halfway house)	Adolescent	Statewide

C2.V.7 Monitoring Methods

Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Employment and Housing Services	Statewide	Adult

C2.V.7 Monitoring Methods

Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
1915(c) HCBS Waiver Services: NC Innovations	statewide	Adult

C2.V.7 Monitoring Methods

Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
1915(c) HCBS Waiver Services: NC Innovations	statewide	Adult and Pediatrics

C2.V.7 Monitoring Methods

Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
1915(i) Services	Statewide	Adult and Pedatric

C2.V.7 Monitoring Methods

Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

24 / 24

C2.V.2 Measure standard

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

residence

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider

1915(i) Services

C2.V.5 Region

Statewide

C2.V.6 Population

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 – other
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)	No
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 should report the most recent date any MCO sent the state its parity analysis (the state may have multiple reports, one for each MCO).	01/20/2024
C1XII.9	**When was the last parity analysis(es) for this program**	04/01/2025

	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).	
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.	No
C1XII.12c	**When will the state post the current parity analysis(es) on its State Medicaid website in accordance with 42 CFR § 438.920(b)(1)?**	04/01/2025

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** 135,234 **Eastpointe** 51,488 **Sandhills** 74,618 **Partners** 104,406 **Trillium** 128,820 **Vaya** 105,262
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** 4.5% **Eastpointe** 1.7% **Sandhills** 2.5% **Partners** 3.5% **Trillium** 4.3% **Vaya** 3.5%

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** 5.2% **Eastpointe** 2% **Sandhills** 2.9% **Partners** 4% **Trillium** 5% **Vaya** 4.1%

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** 88% **Eastpointe** 95% **Sandhills** 102% **Partners** 98% **Trillium** 100% **Vaya** 91%
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) **Eastpointe** Other, specify – Regional All Behavioral Health Programs and Medicaid Direct under the waiver(s) **Sandhills** 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 or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable.
See glossary for the regulatory definition of MLR.

Alliance

N/A

Eastpointe

N/A

Sandhills

N/A

Partners

N/A

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

Eastpointe

No

Sandhills

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. **Eastpointe** 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. Eastpointe merged with Trillium prior to go live date. Merger date 2/1/24 **Sandhills** 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. Sandhills merged with Partners and Vaya Health prior to go live date Merger date 2/1/24 **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 state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.	**Alliance** 122.1% **Eastpointe** N/A **Sandhills** N/A **Partners** 59.32% **Trillium** 131.98% **Vaya** 95.37%
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	**Alliance** 100% **Eastpointe** 100% **Sandhills** 100%

data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.	**Partners** 100% **Trillium** 100% **Vaya** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

> ⚠ **Beginning June 2025, Indicators D1.IV.1a-c must be completed. Submission of this data before June 2025 is optional; if you choose not to respond prior to June 2025, enter "N/A".**

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** 149 **Eastpointe** 15 **Sandhills** 12 **Partners** 154 **Trillium** 25 **Vaya** 189
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. If you choose not to respond prior to June 2025, enter “N/A”.	**Alliance** N/A **Eastpointe** N/A **Sandhills** N/A **Partners** N/A **Trillium** N/A **Vaya** N/A

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. If you choose not to respond prior to June 2025, enter “N/A”.	**Alliance** N/A **Eastpointe** N/A **Sandhills** N/A **Partners** N/A **Trillium** N/A **Vaya** N/A
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. If you choose not to respond prior to June 2025, enter “N/A”.	**Alliance** N/A **Eastpointe** N/A **Sandhills** N/A **Partners** N/A **Trillium** N/A **Vaya** N/A
D1IV.2	**Active appeals** Enter the total number of	**Alliance** 8

	Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	8 **Eastpointe** 0 **Sandhills** 0 **Partners** 0 **Trillium** 0 **Vaya** 12
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** 102 **Eastpointe** N/A **Sandhills** 0 **Partners** 129 **Trillium** N/A **Vaya** 128
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	**Alliance** 5 **Eastpointe** N/A

	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 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.	**Sandhills** 0 **Partners** 3 **Trillium** N/A **Vaya** 0
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** 128 **Eastpointe** 15 **Sandhills** 9 **Partners** 152

		Trillium 21 **Vaya** 186
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** 21 **Eastpointe** N/A **Sandhills** 3 **Partners** 2 **Trillium** 4 **Vaya** 3
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** 146 **Eastpointe** 15 **Sandhills** 12 **Partners** 152 **Trillium** 19

Vaya

186

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

3

Eastpointe

0

Sandhills

0

Partners

2

Trillium

6

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

0

Eastpointe

0

Sandhills

0

Partners

0

Trillium

0

Vaya

3

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 **Eastpointe** 0 **Sandhills** 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 **Eastpointe** 0 **Sandhills** 0 **Partners** 0 **Trillium** 0 **Vaya** 0
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's**	**Alliance** 0

	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).	0 **Eastpointe** 0 **Sandhills** 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 **Eastpointe** 0 **Sandhills** 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** 0 **Eastpointe** N/A **Sandhills** N/A **Partners** 0 **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, including diagnostic and laboratory services. 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** 0 **Eastpointe** N/A **Sandhills** N/A **Partners** 0 **Trillium** N/A **Vaya** 183

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** 4 **Eastpointe** 3 **Sandhills** 6 **Partners** 0 **Trillium** 7 **Vaya** 3
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 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”.	**Alliance** 41 **Eastpointe** 12 **Sandhills** 6 **Partners** 2 **Trillium** 18 **Vaya** 3
D1IV.7e	**Resolved appeals related to covered outpatient**	**Alliance**

	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”.	0 **Eastpointe** N/A **Sandhills** N/A **Partners** 0 **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** 0 **Eastpointe** N/A **Sandhills** N/A **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	**Alliance** 102 **Eastpointe** N/A

	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”.	**Sandhills** 0 **Partners** 137 **Trillium** N/A **Vaya** 128
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 **Eastpointe** N/A **Sandhills** 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 **Eastpointe** N/A **Sandhills** N/A

		Partners 0 **Trillium** N/A **Vaya** 0
D1IV.7j	**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-i paid primarily by Medicaid, enter “N/A”.	**Alliance** 2 **Eastpointe** N/A **Sandhills** N/A **Partners** 0 **Trillium** N/A **Vaya** 0

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.	**Alliance** 3 **Eastpointe** 0 **Sandhills** 1 **Partners** 6 **Trillium** 0 **Vaya** 12
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 **Eastpointe** 0 **Sandhills** 0 **Partners** 0 **Trillium** 0 **Vaya** 1

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 **Eastpointe** 0 **Sandhills** 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** 3 **Eastpointe** 0 **Sandhills** 1 **Partners** 6 **Trillium** 0 **Vaya** 10
D1IV.9a	**External Medical Reviews resulting in a favorable**	**Alliance**

	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).	0 **Eastpointe** 0 **Sandhills** N/A **Partners** 0 **Trillium** 0 **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 **Eastpointe** 0 **Sandhills** N/A **Partners** 0 **Trillium** 0 **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. A grievance is “resolved” when it has reached completion and been closed by the plan.	**Alliance** 748 **Eastpointe** 177 **Sandhills** 159 **Partners** 220 **Trillium** 261 **Vaya** 474
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** 51 **Eastpointe** 0 **Sandhills** 0 **Partners** 0 **Trillium** 0 **Vaya** 47

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

84

Eastpointe

N/A

Sandhills

0

Partners

111

Trillium

N/A

Vaya

5

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 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

Alliance

12

Eastpointe

N/A

Sandhills

0

Partners

13

Trillium

N/A

Vaya

1

	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.	
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** 748 **Eastpointe** 174 **Sandhills** 159 **Partners** 220 **Trillium** 261 **Vaya** 474

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** 0 **Eastpointe** N/A **Sandhills** N/A **Partners** N/A **Trillium** N/A **Vaya** 11
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, including diagnostic and laboratory services. 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** 0 **Eastpointe** N/A **Sandhills** N/A **Partners** N/A **Trillium** N/A **Vaya** 16

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

125

Eastpointe

1

Sandhills

18

Partners

6

Trillium

14

Vaya

44

D1IV.15d

Resolved grievances related to outpatient behavioral health services

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".

Alliance

336

Eastpointe

176

Sandhills

50

Partners

59

Trillium

229

Vaya

186

D1IV.15e

Resolved grievances related to coverage of outpatient

Alliance

	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”.	0 **Eastpointe** N/A **Sandhills** N/A **Partners** N/A **Trillium** N/A **Vaya** 2
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 **Eastpointe** N/A **Sandhills** N/A **Partners** N/A **Trillium** N/A **Vaya** 3
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	**Alliance** 84 **Eastpointe** N/A

	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”.	**Sandhills** N/A **Partners** 115 **Trillium** N/A **Vaya** 220
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 **Eastpointe** N/A **Sandhills** 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** 0 **Eastpointe** N/A **Sandhills** N/A

		Partners 1 **Trillium** N/A **Vaya** 3
D1IV.15j	**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-i paid primarily by Medicaid, enter “N/A”.	**Alliance** 203 **Eastpointe** N/A **Sandhills** 90 **Partners** 40 **Trillium** 18 **Vaya** 36

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** 29 **Eastpointe** 14 **Sandhills** 0 **Partners** 47 **Trillium** 14 **Vaya** 80
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** 33 **Eastpointe** 9 **Sandhills** 3 **Partners** 17 **Trillium** 43 **Vaya** 28

D1IV.16c

Resolved grievances related to 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

73

Eastpointe

20

Sandhills

16

Partners

41

Trillium

41

Vaya

99

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 acceptability of care provided by a provider or the plan.

Alliance

192

Eastpointe

90

Sandhills

89

Partners

112

Trillium

45

Vaya

156

D1IV.16e

Resolved grievances related to plan communications

Alliance

		14
	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.	**Eastpointe** 11 **Sandhills** 0 **Partners** 0 **Trillium** 2 **Vaya** 3
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** 43 **Eastpointe** 29 **Sandhills** 9 **Partners** 31 **Trillium** 12 **Vaya** 100
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	**Alliance** 75 **Eastpointe** 6

	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.	**Sandhills** 0 **Partners** 12 **Trillium** 9 **Vaya** 3
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 exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Alliance** 76 **Eastpointe** 8 **Sandhills** 19 **Partners** 13 **Trillium** 24 **Vaya** 37
D1IV.16i	**Resolved grievances related to lack of timely plan response to a 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	**Alliance** 0 **Eastpointe** 2 **Sandhills** 0

service authorization or appeal request (including requests to expedite or extend appeals).

Partners

0

Trillium

0

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

Eastpointe

0

Sandhills

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

213

Eastpointe

0

Sandhills

23

Partners

0

Trillium

71

Vaya

15

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)

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, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Alliance

7 day follow-up: 12.50% 30-day follow-up: 27.29%

Eastpointe

7 day follow-up: 11.30% 30-day follow-up: 21.58%

Sandhills

7 day follow-up: 7.46% 30-day follow-up: 19.08%

Partners

7 day follow-up: 13.35% 30-day follow-up: 27.36%

Trillium

7 day follow-up: 13.49% 30-day follow-up:30.82%

Vaya

7 day follow-up: 17.57% 30-day follow-up: 31.23%

Complete

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

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, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Alliance

49.76%

Eastpointe

42.37%

Sandhills

28.35%

Partners

41.85%

Trillium

55.12%

Vaya

54.64%

Complete

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

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, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Alliance

7.42

Eastpointe

6.16

Sandhills

14.53

Partners

15.05

Trillium

11.86

Vaya

13.72

Complete

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

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, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Alliance

69.10

Eastpointe

77.84

Sandhills

80.56

Partners

79.53

Trillium

75.07

Vaya

74.44

Complete

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

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, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Alliance

Initiation: 60.53% Continuation: 65.83%

Eastpointe

Initiation: 60.49% Continuation: 68.89%

Sandhills

Initiation: 56.94% Continuation: 61.90%

Partners

Initiation: 52.28% Continuation: 55.05%

Trillium

Initiation: 54.55% Continuation: 57.58%

Vaya

Initiation: 58.95% Continuation: 60.00%

Complete

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

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, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Alliance

5.14

Eastpointe

6.05

Sandhills

7.16

Partners

6.82

Trillium

5.57

Vaya

6.16

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

3400

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

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

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Alliance

21.36

Eastpointe

16.64

Sandhills

13.94

Partners

17.14

Trillium

20.37

Vaya

21.82

Complete

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

D2.VII.2 Measure Domain

Maternal and perinatal health

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

1517

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

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

D2.VII.6 Measure Set

Medicaid Adult and Child Core Set

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Alliance

Timeliness of Prenatal Care: 44.19% Postpartum Care: 46.44%

Eastpointe

Timeliness of Prenatal Care: 33.66% Postpartum Care: 45.54%

Sandhills

Timeliness of Prenatal Care: 41.56% Postpartum Care: 46.10%

Partners

Timeliness of Prenatal Care: 50.32% Postpartum Care: 49.68%

Trillium

Timeliness of Prenatal Care: 47.58% Postpartum Care: 42.74%

Vaya

Timeliness of Prenatal Care: 57.04% Postpartum Care: 54.23%

Complete

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

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, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Alliance

Total Metabolic Testing: 43.80%

Eastpointe

Total Metabolic Testing: 49.18%

Sandhills

Total Metabolic Testing: 48.10%

Partners

Total Metabolic Testing: 45.36%

Trillium

Total Metabolic Testing: 42.92%

Vaya

Total Metabolic Testing: 49.24%

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness (FUM) 10 / 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, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Alliance

7 day follow-up: 35.76% 30 day follow-up: 52.55%

Eastpointe

7 day follow-up: 25.00% 30 day follow-up: 49.09%

Sandhills

7 day follow-up: 22.84% 30-day follow-up: 37.05%

Partners

7 day follow-up: 32.39% 30-day follow-up: 50.00%

Trillium

7 day follow-up: 39.50% 30-day follow-up: 57.47%

Vaya

7 day follow-up: 42.59% 30-day follow-up: 60.44%

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. Include any pending or unresolved actions.

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: 4

Complete

D3.VIII.1 Intervention type: Corrective action plan

1 / 4

D3.VIII.2 Plan performance issue

(Privacy and Security)

D3.VIII.3 Plan name

Vaya

D3.VIII.4 Reason for intervention

In the month of June 2023, a VAYA employee incorrectly emailed a form containing PHI of a VAYA member to a private citizen.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

03/11/2024

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

Yes, remediated 04/18/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

2 / 4

D3.VIII.2 Plan performance issue

(Privacy and Security)

D3.VIII.3 Plan name

Alliance

D3.VIII.4 Reason for intervention

In the months of July, August and September 2023, Alliance sent forms via email and US mail, that contained the PHI of 11 members to incorrect covered and non-covered entities.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

04/09/2024

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

04/09/2024

Yes, remediated 05/10/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

D3.VIII.2 Plan performance issue

Other (Failure to Provide Medically Necessary Services)

D3.VIII.3 Plan name

Sandhills

D3.VIII.4 Reason for intervention

Sandhills failed to provide appropriate care coordination, timely access to services, assessments, and support, and failure to timely respond to state inquiries and requests for information for one member.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

04/26/2024

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

Yes, remediated 07/13/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

D3.VIII.2 Plan performance issue

(Privacy and Security)

D3.VIII.3 Plan name

Partners

D3.VIII.4 Reason for intervention

In the months of March and April 2024, Partners sent US mail and emails of documents and forms that contained the PHI of three members to private citizens.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

05/13/2024

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

Yes, remediated 06/04/2024

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** 33 **Eastpointe** 8 **Sandhills** 5 **Partners** 8 **Trillium** 8 **Vaya** 8
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Alliance** 104 **Eastpointe** 93 **Sandhills** 29 **Partners** 143 **Trillium** 145 **Vaya** 112

D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Alliance** 0.77:1,000 **Eastpointe** 1.81:1,000 **Sandhills** 0.39:1,000 **Partners** 1.37:1,000 **Trillium** 1.13:1,000 **Vaya** 1.06:1,000
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**Alliance** 98 **Eastpointe** 93 **Sandhills** 18 **Partners** 122 **Trillium** 127 **Vaya** 84
D1X.5	**Ratio of resolved program integrity investigations to**	**Alliance**

	enrollees What is the ratio of program integrity investigations resolved by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	0.72:1,000 **Eastpointe** 1.81:1,000 **Sandhills** 0.24:1,000 **Partners** 1.17:1,000 **Trillium** 0.99:1,000 **Vaya** 0.8:1,000
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 **Eastpointe** Makes referrals to the State Medicaid Agency (SMA) only **Sandhills** 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** 18 **Eastpointe** 0 **Sandhills** 0 **Partners** 24 **Trillium** 10 **Vaya** 10
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referrals listed in indicator D1.X.7 made to the state during the reporting year to the number of enrollees? For number of enrollees, use the average number of individuals enrolled in the plan per month during the reporting year (reported in indicator D1.I.1). Express this as a ratio per 1,000 beneficiaries.	**Alliance** 0.13:1,000 **Eastpointe** 0:1,000 **Sandhills** 0:1,000 **Partners** 0.23:1,000 **Trillium** 0.08:1,000 **Vaya** 0.1:1,000
D1X.9a:	**Plan overpayment reporting to the state: Start Date**	**Alliance** 04/01/2022

	What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	04/01/2023 **Eastpointe** 04/01/2023 **Sandhills** 04/01/2023 **Partners** 04/01/2023 **Trillium** 04/01/2023 **Vaya** 04/01/2023
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** 06/30/2024 **Eastpointe** 06/30/2024 **Sandhills** 06/30/2024 **Partners** 06/30/2024 **Trillium** 06/30/2024 **Vaya** 06/30/2024
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** $424,356.80 **Eastpointe** $24,735,531.39

		Sandhills $16,970.58 **Partners** $574,175.41 **Trillium** $1,258,574.93 **Vaya** $4,825,261.50
D1X.9d:	**Plan overpayment reporting to the state: Corresponding premium revenue** What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))	**Alliance** $1,336,936,465 **Eastpointe** $275,277,413 **Sandhills** $406,322,429 **Partners** $990,312,691 **Trillium** $1,214,366,319 **Vaya** $945,938,485
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Alliance** Weekly **Eastpointe** Weekly **Sandhills** 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** No ILOSs were offered by this plan **Eastpointe** No ILOSs were offered by this plan **Sandhills** No ILOSs were offered by this plan **Partners** No ILOSs were offered by this plan **Trillium** No ILOSs were offered by this plan **Vaya** No ILOSs were offered by this plan

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).	**North Carolina Medicaid Ombudsman Program** Ombudsman Program **NC Medicaid Enrollment Broker** Enrollment Broker **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).	**North Carolina Medicaid Ombudsman Program** Other, specify – Program Information/Rights & Responsibilities/Referrals **NC Medicaid Enrollment Broker** Enrollment Broker/Choice Counseling **Medicaid Contact Center** Other, specify – PCP Changes/ Benefits Information