NC Medicaid Annual Health Disparities Report

2023

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES
Division of Health Benefits

APRIL 2026

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Acronym List

ADHD — Attention-Deficit/Hyperactivity Disorder

AHRQ — Agency for Healthcare Research and Quality

AMH — Advanced Medical Home

CAHPS — Consumer Assessment of Healthcare Providers and Systems Plan Survey

CCNC — Community Care of North Carolina CDC — Centers for Disease Control and Prevention CHIP — Children's Health Insurance Program

CMHRP — Care Management for High-Risk Pregnancies

CMS — Centers for Medicare & Medicaid Services COPD — Chronic Obstructive Pulmonary Disease CY — Calendar Year

DHB — Division of Health Benefits

DQA — Dental Quality Alliance

ED — Emergency Department

HEDIS — Healthcare Effectiveness Data and Information Set

HMO — Health Maintenance Organization

I/DD — Intellectual/Developmental Disabilities

LME/MCO — Local Management Entity-Managed Care Organization

LTSS — Long Term Services and Supports

NC — North Carolina

NCDHHS — North Carolina Department of Health and Human Services

NCQA — National Committee for Quality Assurance

NQF — National Quality Forum

OB/GYN — Obstetrician Gynecologist

OSUAP — Opioid and Substance Use Action Plan

PAU — Potentially Avoidable Utilization

PCCM — Primary Care Case Management PCP — Primary Care Provider

PDI — Pediatric Quality Indicators

PHP — Prepaid Health Plan

PIP — Performance Improvement Projects PIHP — Prepaid Inpatient Health Plan PMH — Pregnancy Medical Home

PMP — Pregnancy Management Program

PQA — Pharmacy Quality Alliance

PQCNC — Perinatal Quality Collaborative of North Carolina

PQI — Prevention Quality Indicator

QRS — Quality Rating System

HHS — United States Department of Health and Human Services

MESSAGE FROM
Deputy Secretary

February 2026

The Division of Health Benefits (NC Medicaid) and the North Carolina Department of Health and Human Services (NCDHHS) remain committed to ensuring access to quality care and improving health outcomes for all North Carolinians. As part of this commitment, we are pleased to present the 2023 NC Medicaid Health Disparities Report, a resource designed to provide data-driven insights that strengthen program efficiency and support better health for our communities.

This report examines over 50 quality measures across seven domains: beneficiary experience, child and adolescent health, women's health, mental health, substance use, health care utilization, and chronic health. Each measure is stratified by up to eight demographic factors to identify differences in outcomes across populations. Transitioning to a biennial report format allows us to monitor trends more effectively and evaluate progress toward improving care delivery and reducing avoidable gaps in health outcomes.

NC Medicaid and NCDHHS are focused on practical solutions that ensure taxpayer dollars are used effectively to deliver high-quality care. This report serves as a tool for health plans, providers, policymakers, and community partners to identify areas for improvement, guide resource allocation, and support strategies that strengthen health outcomes statewide.

We prioritize a whole-person approach to care that addresses both medical needs and factors that influence health, such as access to services and community supports. This report complements ongoing NC Medicaid initiatives and aligns with broader NCDHHS efforts to improve health outcomes and keep communities safe, healthy, and connected to essential resources.

We hope this report provides valuable information to support informed decision-making and collaborative efforts that benefit all North Carolinians. Thank you for your partnership as we work together to ensure efficient, effective, and high-quality care.

Sincerely,

Jay Ludlam
Deputy Secretary, NC Medicaid
NC Department of Health and Human Services

MESSAGE FROM
Chief Medical Officer

February 2026

North Carolina Medicaid strengthens North Carolina through providing an innovative, whole person centered, and well-coordinated system of care that addresses both the medical and non-medical drivers of health for over 3 million North Carolina residents. Our goal is to provide a system of care that improves the health and well-being of all NC Medicaid beneficiaries. However, health disparities, defined as preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health, exist. We are dedicated to reducing these health disparities and in order to make impactful and sustainable progress in eliminating health disparities among the 3 million North Carolina Medicaid beneficiaries, we need transparent, reliable, and accessible data.

On behalf of NC Medicaid and NCDHHS, I am pleased to share the NC Medicaid Health Disparities Report. The report examines the scope and impact of health disparities across populations and across over 50 combined quality and survey measures. The report aims to inform, equip, and empower healthcare providers and systems with data to promote the delivery of high-quality and equitable care to our beneficiaries. The 2023 report is built upon the previous NC Medicaid Health Disparities report and has been updated to reflect the evolving needs of our Medicaid beneficiaries while continuing to highlight and prioritize the long-standing needs.

While progress has been made, there is still work to be done. Our hope is that sharing this report will encourage a range of health equity interventions including provider education, identification of risk factors that result in negative health outcomes, and improved access to care. I am hopeful that this report will support NC Medicaid's health care partners across the state in developing targeted interventions to reduce care gaps and improve the delivery of equitable and high-quality care to all.

Sincerely,

Dr . Janelle White
Chief Medical Officer, NC Medicaid
NC Department of Health and Human Services

MESSAGE FROM
Chief Quality Officer

February 2026

North Carolina Medicaid has a fundamental responsibility not only to expand access to care, but to ensure that the care our beneficiaries receive is high-quality, safe, equitable, and continuously improving. As Chief Quality Officer, I am honored to support this mission alongside our partners across the health care system who share a commitment to better outcomes for the more than three million North Carolinians served by NC Medicaid.

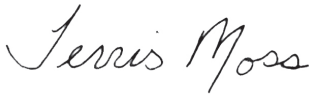
The NC Medicaid Health Disparities Report is a critical component of our quality strategy. It reflects NC Medicaid's commitment to transparency, accountability, and data-driven improvement. By systematically examining performance across more than 50 quality and survey measures, this report allows us to see clearly where our systems are working well — and where they are not. Importantly, it moves beyond averages to illuminate how different populations experience care, helping us identify inequities that might otherwise remain hidden.

From a quality perspective, measurement is not an end in itself — it is a tool for action. The findings in this report inform how NC Medicaid designs programs, sets expectations for managed care plans, and partners with providers, community organizations, and local governments to close gaps in care. They guide our Performance Improvement Projects, quality withholds, and targeted initiatives aimed at reducing preventable hospitalizations, improving chronic disease management, and strengthening preventive care across the lifespan.

This year's report is particularly meaningful in the context of Medicaid expansion. As we welcome hundreds of thousands of newly eligible adults into coverage, we have an opportunity — and an obligation — to build systems that support better health from the start. That includes strengthening primary care, integrating behavioral health and physical health, addressing health-related social needs, and ensuring that quality improvement efforts reach rural communities and historically underserved populations.

While the data show areas of progress, they also remind us that persistent disparities remain. These disparities are not the result of individual choices alone, but of longstanding structural barriers that require sustained, system-level solutions. NC Medicaid is committed to working with our health plans, providers, Tribal partners, and community stakeholders to translate these findings into measurable improvement for our beneficiaries.

I encourage all who use this report to view it not simply as a summary of past performance, but as a roadmap for collective action. By aligning around shared data, shared goals, and shared accountability, we can advance a more equitable, high-quality health care system for every North Carolinian covered by Medicaid.



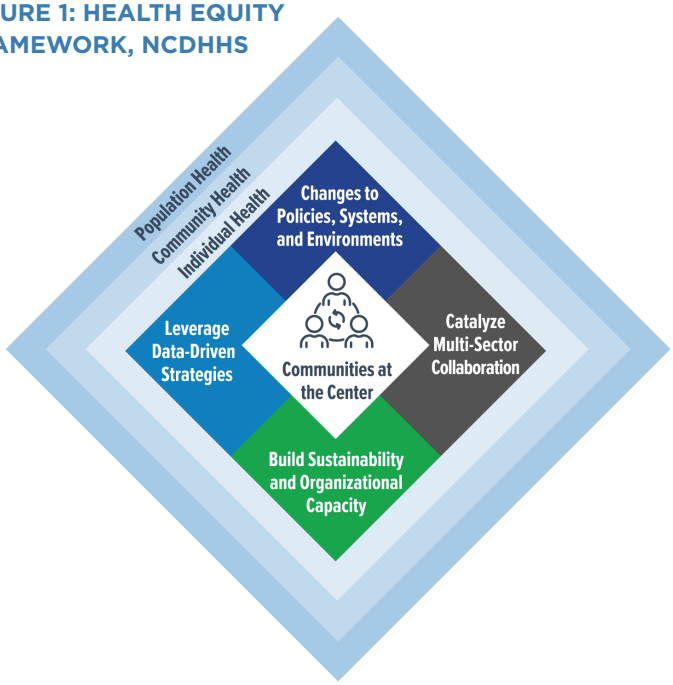
Dr. Terris Moss
Chief Quality Officer, NC Medicaid
NC Department of Health and Human Services

Guiding Principles for the Annual Health Disparities Report

> Health Equity is the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health.
>
> *— The Centers for Medicare & Medicaid Services*

Differences in health and health outcomes across communities have long existed within the American health care system. The COVID-19 pandemic highlighted and exacerbated these longstanding disparities.[1] Members of populations that have been systemically discriminated against experience disparities across many measures of health, reflecting inequities within the health care system and across broader social and economic conditions that influence health.[2, 3] The federal government and many states have identified addressing health disparities as a key priority in advancing health care quality.[4]

FIGURE 1: HEALTH EQUITY FRAMEWORK, NCDHHS



Delivering consistent and high-quality health care outcomes for all individuals requires sustained, data-informed efforts to identify and reduce differences in care and outcomes that can be prevented. NC Medicaid is uniquely positioned to monitor variations in health care delivery and results, as it serves approximately three million North Carolinians. With access to extensive demographic data, NC Medicaid can conduct detailed analysis to monitor health trends and variations in care experiences and outcomes across different groups over time.

The North Carolina Department of Health and Human Services (NCDHHS) has introduced a framework that emphasizes the use of data-driven strategies to improve access to and quality of care (see Figure 1)[5]. Through this approach, NC Medicaid aims to better understand where gaps in care exist and to support informed, evidence-based decision-making. The NC Medicaid Health Disparities Report is one of the key tools developed to support this mission.

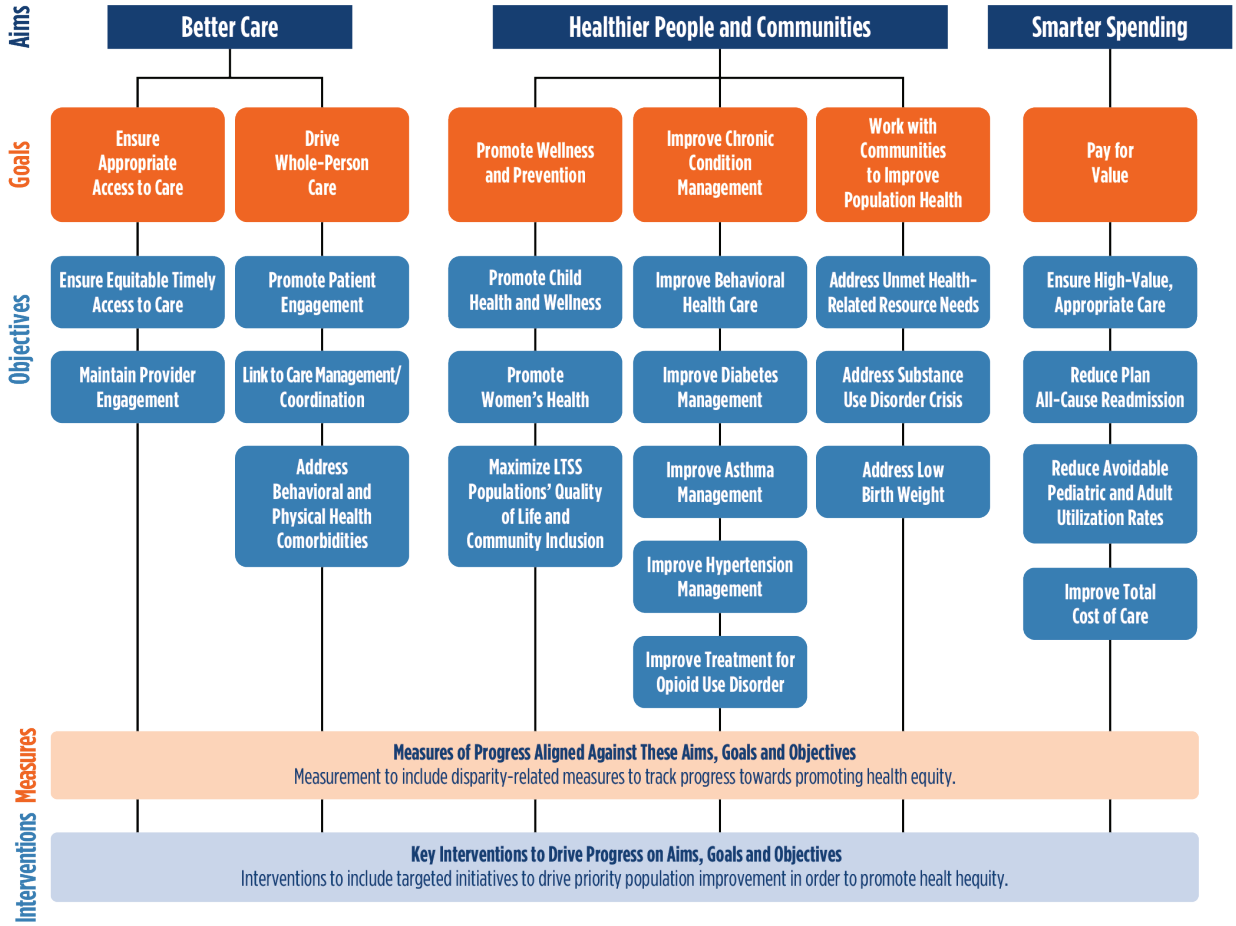
[1] Yearby, R., Clark, B., & Figueroa, J. F. (2022). Structural racism in historical and modern US health care policy. Health Affairs, 41(2), 187–194. https://doi.org/10.1377/hlthaff.2021.01466. Accessed on 9/10/2025.
[2] Ndugga, N., Artiga, S., & Hill, L. (2024, June 11). Key data on health and health care by race and ethnicity. KFF. https://www.kff.org/racial-equity-and-health-policy/report/key-data-on-health-and-health-care-by-race-and-ethnicity. Accessed on 9/10/2025.
[3] Haldar, S., Guth, M., Rudowitz, R., & Artiga, S. (2024, July 1). Medicaid and Racial Health Equity. KFF. https://www.kff.org/medicaid/issue-brief/medicaid-and-racial-health-equity/. Accessed on 9/10/2025.
[4] Healthy People 2030. Framework. U.S Department of Health and Human Services. Accessed on 9/10/2025. https://odphp.health.gov/healthypeople/about/healthy-people-2030-framework
[5] NCDHHS Community and Partner Engagement Guide. (2024). https://www.ncdhhs.gov/health-equity-community-and-partner-engagement-guide/download?attachment=

NC Medicaid Health Disparities Report Mission: To promote, strengthen and evaluate NC Medicaid's efforts to improve the health and wellbeing of all its beneficiaries. This mission guides all data selection, stakeholder engagement and performance interpretation throughout this report.

Overarching Goals of the Report:

1. Present and analyze NC Medicaid's progress toward reducing the health disparities experienced by historically underserved or marginalized populations.
2. Provide current data that may aid prepaid health plans (PHPs), primary care case management entities, community-based organizations, tribal governments, local health departments, state agencies, legislators, local businesses and communities in devising tailored services and outreach plans; and
3. Inform key decision makers about existing health disparities that can be addressed through policy reform and system-level change.

FIGURE 2: NC MEDICAID QUALITY STRATEGY FRAMEWORK[6]

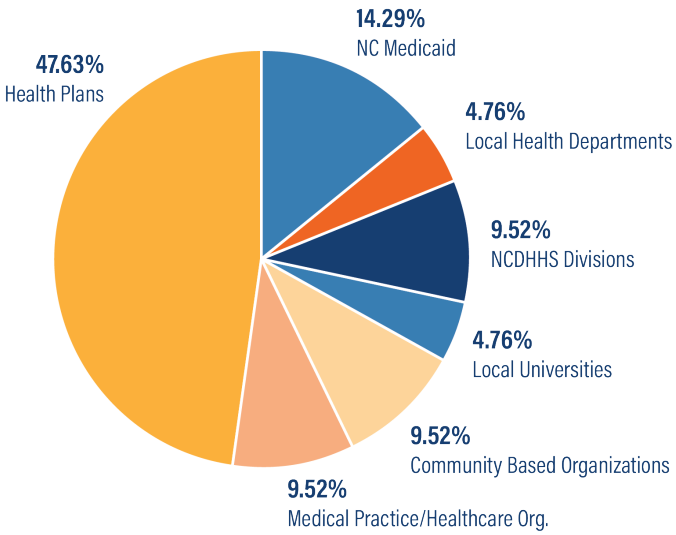


[6] NC Medicaid Managed Care Quality Strategy. Published on 6/18/2025. Accessed on 9/10/2025. https://medicaid.ncdhhs.gov/2025-nc-medicaid-managed-care-quality-strategy/download?attachment

Stakeholder Feedback

NC Medicaid is committed to championing equitable health outcomes for the three million North Carolinians it serves and acknowledges that progress requires active community and partner involvement. A growing body of evidence has found that engaging stakeholders in research promotes inclusion and partnership with groups that can guide the development of work that directly impacts them.[7] After the release of the first NC Medicaid Health Disparities Report (2022), NC Medicaid shared a feedback survey with partners across the state to learn what they thought of the report. The survey assessed the report's readability, aesthetics and usefulness. The survey results were used to inform the development of this iteration of the report, in an effort to make it a more responsive, partner-engaged, useful and relevant tool.

FIGURE 3: STAKEHOLDER FEEDBACK SURVEY RESPONSE BREAKDOWN (N=21)



A majority of the respondents found the report useful, easy to understand/follow and aesthetically appealing. Respondents expressed that the report is a helpful tool that allows them to overlay NC Medicaid data with data about the populations they serve and identify areas where they can have the biggest impact. Others said the report helped them better understand the gaps in care within their respective populations and pushed them to be more mission focused in their work with Medicaid beneficiaries.

Respondents called for more timely data and increased focus on geographic stratifications. In response, this report includes county-level heat maps to show performance distribution across NC counties for select measures.

Respondents also asked for more line-of-business stratifications. This report includes an appendix (Appendix E) to compare overall NC Medicaid rates with Managed Care performance.

The Department will disseminate a similar feedback survey after each iteration of the Health Disparities Report, so it can continue to be responsive to statewide partner needs.

Program Update: NC Medicaid Expansion

North Carolina expanded Medicaid eligibility on Dec. 1, 2023, under the Affordable Care Act (ACA). This expansion extended coverage to nearly all non-elderly adults who earn up to 138% of the Federal Poverty Level (FPL). Since the launch of expansion, more than 600,000 North Carolinians have gained coverage via NC Medicaid for an array of services including emergency care, dental care, vision and hearing services, prescription drugs, maternity and postpartum care, hospital services, behavioral health, preventive and wellness services and check-ups, medically necessary devices and more. This is a huge step towards increased access to affordable health care and improved health outcomes.

Learn more about NC Medicaid expansion here.

[7] Maurer M, Mangrum R, Hilliard-Boone T, Amolegbe A, Carman KL, Forsythe L, Mosbacher R, Lesch JK, Woodward K. Understanding the Influence and Impact of Stakeholder Engagement in Patient-centered Outcomes Research: a Qualitative Study. J Gen Intern Med. 2022 Apr;37(Suppl 1):6-13. doi: 10.1007/s11606-021-07104-w. Epub 2022 Mar 29. PMID: 35349017; PMCID: PMC8993962. Accessed on 9/10/2025.

Shared Term Definitions

Shared definitions are crucial for enabling people from different disciplines, roles and groups to work together toward shared goals.[9] Having a deeper understanding of language can help ensure that our organizations are indeed centering care around the lived experience of patients and communities without reinforcing labels, objectification, stigmatization and marginalization.[10] Below you can find definitions from the NCDHHS Office of Minority Health and Health Disparities.[11]

Health equity is the intentional effort to ensure that everyone experiences a fair opportunity to achieve the highest level of health without barriers to access and care. Health equity can be achieved through ongoing focused societal efforts to address and eliminate inequities and injustices that lead to health disparities.

Note: NC Medicaid operationalizes this definition through data stratification, program design and system accountability.

Health inequities are disparities in health that stem from unjust, systemic policies and practices which limit opportunities for good health.

Health disparities are preventable differences in the burden of disease, injury, violence or opportunities to achieve optimal health that are experienced by populations who have been socially, economically, geographically and environmentally disadvantaged.

This report recognizes the importance of health literacy as a foundation for equitable communication. Efforts were made to ensure that information is clear, accessible and actionable for a broad range of audiences, including those with limited health literacy. By integrating health literacy principles, the report aims to foster understanding and engagement across diverse communities.

What Does it Mean to Apply a Health Equity Lens to Communications?[8]

Applying a health equity lens means intentionally looking at the potential impacts, positive and negative, of proposed communications and messaging. NC Medicaid has applied a health equity lens, to the best of its ability, to all aspects of this report, making concerted effort to avoid bias and stigmatization and reflect on systemic social and health inequities. This report was written with the CDC's health equity guiding principles for inclusive communication and used their preferred terms for select population groups and communities. However, we acknowledge terms that might be appropriate in some circumstances, or that some people prefer, might not be appropriate for others.

[8] Health Equity Guiding Principles to Promote an Equity-Centered Approach to Public Health Communication. Centers for Disease Control and Prevention (CDC). (July 2023). Accessed on 9/10/2025. https://www.cdc.gov/pcd/issues/2023/23_0061.htm

[9] Peek CJ, Westfall JM, Stange KC, Liaw W, Ewigman B, DeVoe JE, Green LA, Polverento ME, Bora N, deGruy FV, Harper PG, Baker NJ. Shared Language for Shared Work in Population Health. Ann Fam Med. 2021 Sep-Oct;19(5):450-457. doi: 10.1370/afm.2708. PMID: 34546952; PMCID: PMC8437558.

[10] American Medical Association (AMA). Advancing Health Equity: A Guide to Language, Narrative, and Concepts. https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf

[11] NCDHHS. Office of Minority Health and Health Disparities. Health Equity Resources, Common Definitions. Accessed 4/30/2024. Available here: https://www.ncdhhs.gov/divisions/office-health-equity/health-equity-resources

How to Best Use this Report

By developing this report and tracking progress systematically, NC Medicaid hopes to build a measurement framework to help groups across the state align on priorities. This report will build a shared and consistent way to measure disparities that inform internal and external work promoting programs and policies that improve health care delivery and health outcomes for all. Below is a table outlining different stakeholders and potential ways they could engage with this report:

TABLE 2: Ideas for Report Use by Stakeholder Type

Stakeholders	Ideas for Using the Report
Community-Based Organizations	Identify and highlight areas of need for populations across the state that have been underserved due to social or economic factors, using this information to design targeted resources and support programs.
Providers and Others Serving NC Medicaid Beneficiaries	Assist with risk assessment, encourage patient engagement and enhance understanding of care gaps or service needs to support more informed care delivery.
Health Disparity & Patient Advocates	Identify areas of focus for preventive health efforts and policy development, supported by data that reflects the experiences of Medicaid beneficiaries. Emphasize the role of NC Medicaid in supporting the health of three million North Carolinians.
NC Medicaid Beneficiaries	Learn about key health topics, access challenges and preventive care opportunities to stay informed and actively participate in discussions with health care providers.
Health Plans and Care Management Entities	Identify areas of need within the larger NC Medicaid beneficiary population and inform care management strategies for populations with identified disparities.
Legislators & Policy Makers	Identify legislative opportunities to reduce disparities, inform policy proposals and allocate resources equitably across communities.

Look for these boxes throughout the report!

CALL OUT: These Contain Helpful Information

Boxes that look like this are scattered throughout the report to provide information on North Carolina Medicaid's efforts related to the improving health care across populations. They call out innovative programs that support improved access or better-quality care or refer to additional data sources that give a deeper look into health disparities for priority populations.

Words or phrases that look like this throughout the report contain links. Click on them to explore more related content.

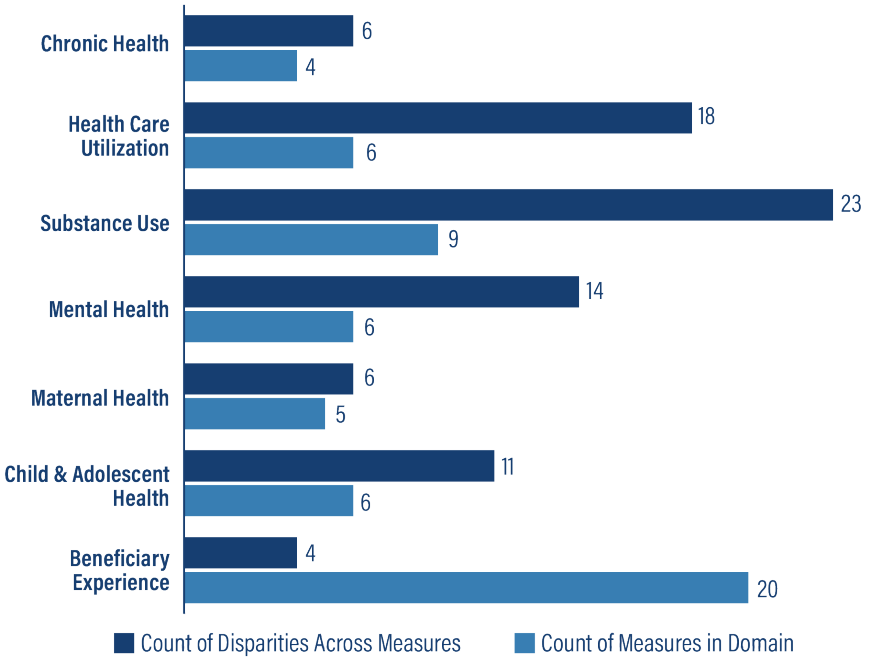
Executive Summary

Summary of Key Findings

The 2023 NC Medicaid Health Disparities Report reviewed **36** quality measures and **20** survey measures across eight stratification elements, identifying areas where groups of interest fared worse than reference groups. For the calendar year (CY) 2023 Health Disparities Report, NC Medicaid identified key findings across the following demographic factors: disability status, gender, primary language, ethnicity, Black or African American binary race,[12] American Indian or Alaskan Native binary race[13] and geography.[14] A health disparity was identified if the relative difference in a quality measure rate between the group of interest and the reference group was greater than or equal to 10%, a threshold selected for its practicality in identifying meaningful gaps.

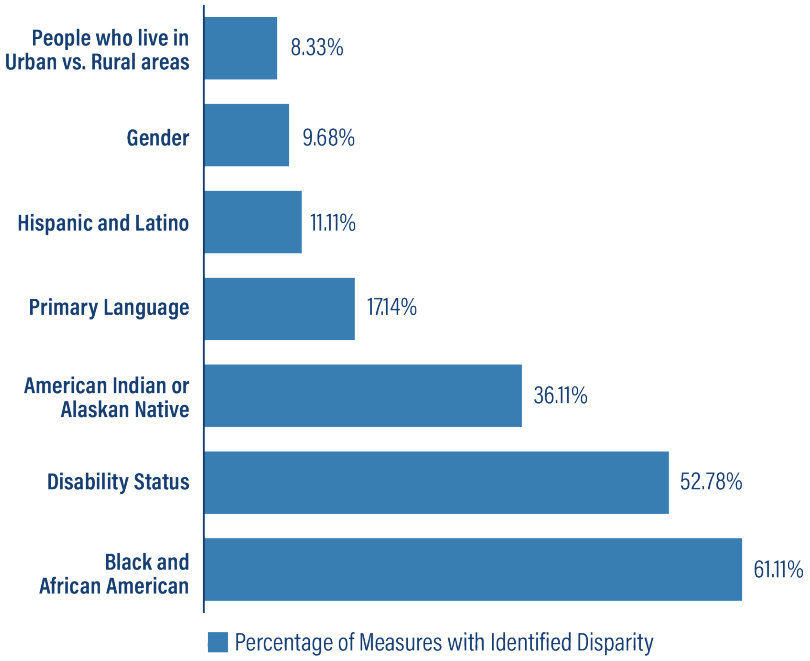
This section summarizes key findings for each of the domains and demographic groups. To learn more about the programs and policies NC Medicaid is implementing to address these disparities, visit the *Addressing Health Inequities* section. Figure 4 presents the count of measures in each domain and the count of identified disparities within that domain.[15] Figure 5 presents the percentage of measures with identified disparities by demographic groups.

FIGURE 4: Disparity Breakdown by Domain in the 2023 NC Medicaid Health Disparities Report



[12] Black or African American Binary Race: A descriptive category that divides a population into two sub-parts: those who identify as Black or African American and those who do not.
[13] American Indian or Alaska Native Binary Race: A descriptive category that divides a population into two sub-parts: those who identify as American Indian or Alaska Native and those who do not. See methodology section for more details.
[14] See the Statistical Analysis Section of the Methodology for detailed descriptions of each demographic stratification.
[15] A disparity is identified as a relative difference greater than 10% between the group of interest and the reference group. See the Methodology section for more information on this approach.

FIGURE 5: Percentage of Quality Measures with Identified Disparities by Demographic Group* in the 2023 NC Medicaid Health Disparities Report



Note: This figure only considers quality measures, not survey measures.
*It was not possible to stratify all measures by all demographic factors, so denominators vary slightly across demographic factors. For example, not all measures could be stratified by age group.

Key Findings for the Black and African American Population

In 2023, individuals who identify as Black and African American made up around 22.1% of North Carolina's population and 37.9% of the total NC Medicaid population.[16] Nationally, Black and African American populations experience persistent disparities in health and health care access across many different indicators. These disparities often reflect longstanding historical and structural barriers to care.[17] Of the 20 survey measures analyzed, zero had an identified disparity for the Black and African American population. Of the 36 quality measures analyzed, 22 had an identified disparity for the Black and African American population. NC Medicaid identified disparities among the Black and African American population across child and adolescent immunizations, initiation and engagement of substance use disorder (SUD) treatment, and admissions for pediatric and young adult asthma; however, the Black and African American populations fared better for measures related to women's preventive health screenings (breast cancer, cervical cancer and chlamydia screening). See Appendix D for a list of all findings for Black and African American population.

[16] NC Medicaid Enrollment Dashboard. Enrollment data taken from December 2023. Accessed on 9/10/2025. https://medicaid.ncdhhs.gov/reports/dashboards/enrollment-dashboard
[17] Ndugga, N., Artiga, S., & Hill, L. (2023, June 2024). Key data on health and health care by race and ethnicity. KFF. https://www.kff.org/racial-equity-and-health-policy/report/key-data-on-health-and-health-care-by-race-and-ethnicity/

Key Findings for the Disability Population

In 2023, individuals who identify as having a disability made up around 10.5% of North Carolina Medicaid's enrollees and 9.3% of North Carolina's population under the age of 65. Living with a disability can lead to significant health disparities due to societal barriers and systemic inequities, rather than the disability itself, resulting in increased risks for chronic conditions, poorer health outcomes and premature death. The Department was unable to stratify the survey measures by disability status for this analysis. Of the 36 quality measures analyzed, 19 had an identified disparity for the population who identified as having a disability. NC Medicaid identified disparities among those who identified as having a disability across all the domains, but specifically within the healthcare utilization and substance use domains. However, those who identified as having a disability fared better than those who did not for measures related to child and adolescent well-care visits and breast cancer screenings. See Appendix D for a list of all findings for this population.

Key Findings for American Indian/Alaskan Native Populations

Structural racism in US health policy has resulted in a legacy of health disparities for those who identify as American Indian and Alaskan Native; these populations experience lower life expectancy and disproportionate disease burden.[18, 19] These outcomes are due in part to disproportionate rates of poverty and discrimination in the delivery of health services and cultural differences in care. In 2023, the American Indian/Alaskan Native population made up roughly 1.6% of all NC Medicaid beneficiaries.[20] Around five thousand NC Medicaid beneficiaries, who are federally recognized tribal members, are covered by the Eastern Band of Cherokee Indians (EBCI) Tribal Option, a primary care case management entity (PCCMe) created by the Cherokee Indian Hospital Authority (CIHA). Outside of the EBCI Tribal Option there are around 42,000 NC Medicaid beneficiaries who identify as American Indian or Alaskan Native, enrolled in NC Medicaid Direct or a managed care plan. The EBCI Tribal Option is the first of its kind in the United States. Of the 20 survey measures analyzed, one had an identified disparity for the American Indian and Alaskan Native population. Of the 36 quality measures analyzed, 13 had an identified disparity for the American Indian and Alaskan Native population. In this analysis, the American Indian/Alaskan Native population had identified disparities in areas related to childhood immunization status, prenatal and postpartum care and appropriate follow up for mental health issues. However, those who identified as American Indian/Alaskan Native fared better for measures related to appropriate follow up for substance use issues, and breast and cervical cancer screenings. See Appendix D for a list of all findings for American Indian/Alaskan Native population.

Key Findings by Geography

As people who live in rural areas face various health disparities not experienced by their urban counterparts, it is important to stratify and evaluate health disparity data by geography. Research has found that people who live in rural areas have higher rates of poverty, less access to health care and are less likely to have health insurance.[21] According to the National Center for Health Statistics, 54 out of North Carolina's 100 counties are classified as rural. Please refer to Figure 5 in the Methodology section for a county-level map of North Carolina. In 2023, North Carolina was the second most rural state in the U.S., with 33% of the population living in rural areas.[22] Of the 20 survey measures analyzed, zero had an

[18] Disparities. Indian Health Service (IHS). Accessed on 1.9.2024. https://www.ihs.gov/newsroom/factsheets/disparities/

[19] Department of Health and Human Services, Office of Minority Health. Profile: American Indian/Alaska Native [Internet]. Rockville (MD): HHS; 2021 Nov 23 [cited 2024 March 18]. Available from: https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62 Google Scholar

[20] NC Medicaid Enrollment Dashboard. Enrollment data taken from December 2023. Accessed on 9/10/2025. https://medicaid.ncdhhs.gov/reports/dashboards/enrollment-dashboard

[21] About Rural Health. 2023. Centers for Disease Control and Prevention (CDC). www.cdc.gov/ruralhealth/about.html#:~:text=Rural%20residents%20report%20less%20leisure,lead%20to%20poor%20health%20outcomes.

[22] Office of state budget and management (OSBM). 2020 Census results. https://www.osbm.nc.gov/blog/2023/05/25/15-things-we-learned-new-2020-census-data

identified disparity for the population living in rural counties. Of the 36 quality measures analyzed, three had an identified disparity for the population living in rural counties. Beneficiaries living in rural counties fared better in breast and colorectal cancer screenings but fared worse in childhood immunizations and diabetes short term complications. See Appendix D for a list of all findings for the rural population.

Key Findings for the Hispanic and Latino Population

Since the 1990s, the Hispanic/Latino population has been the fastest growing demographic group in North Carolina and is now composed of well over one million people.[23] In 2023, Hispanic/Latino beneficiaries made up roughly 15.6% of the total NC Medicaid population.[24] Research shows this population often experiences health disparities in diabetes and obesity rates, work-related injuries, human immunodeficiency virus (HIV) and liver disease.[25] These disparities are often tied to factors such as language or cultural barriers, discrimination, lack of access to preventive care and lack of health insurance.[26] Of the 20 survey measures analyzed, three had an identified disparity for the Hispanic and Latino population. Of the 36 quality measures analyzed, four had an identified disparity for the Hispanic and Latino population. In this report, members of the Hispanic/Latino population fared worse in measures relating to follow up after emergency department (ED) visits for substance use and initiation and engagement of substance use disorder (SUD) treatment. This population fared better across all child and adolescent health measures, and prenatal and postpartum care. See Appendix D for a list of all findings for the Hispanic and Latino population.

Key Findings for Those Whose Primary Language is Not English

In NC, 88% of the population 5 years and older, native and foreign born, speak only English at home.[27] Spanish is the second most spoken language in North Carolina. During the 2018-2022 period, 8% of the population 5 years and older spoke Spanish at home. Other languages can be heard in North Carolina, as well, owing to the many different immigrant groups who have come to North Carolina. Besides English and Spanish, there are roughly 30,000 Chinese, French and Arabic speakers. Research has found that adults with limited English proficiency report worse health status and increased barriers in accessing health care compared to English proficient adults.[28] This is driven by the way the U.S. health system is built around the English language with many providers being unprepared or unable to provide sufficient translation services. Language barriers may lead to miscommunication between provider and patient, decreasing quality-of-care delivery and patient safety.[29] The Department was unable to stratify the survey measures by primary language for this analysis. Of the 36 quality measures analyzed, six had an identified disparity for the population who spoke a non-English primary language. For individuals whose primary language is not English, this report's analysis identified disparities in measures relating to appropriate follow up after ED visit for substance use and initiation and engagement of SUD treatment. However, this population fared better on all measures related to adolescent health, prenatal and postpartum care and appropriate follow up after ED visit and hospitalization for mental illness. See Appendix D for a list of all findings for the population whose primary language is not English.

[23] North Carolina, United States Census Bureau. Population Estimates July 1, 2022.
[24] NC Medicaid Enrollment Dashboard. Enrollment data taken from December 2023. Accessed on 9/10/2025. https://medicaid.ncdhhs.gov/reports/dashboards/enrollment-dashboard
[25] Vega WA, Rodriguez MA, Gruskin E. Health disparities in the Latino population. Epidemiol Rev. 2009;31:99-112. doi: 10.1093/epirev/mxp008. Epub 2009 Aug 27. PMID: 19713270; PMCID: PMC5044865.
[26] Hispanic/Latino Health. U.S Department of Health and Human Services. Office of Minority Health. (2022). Retrieved from: https://minorityhealth.hhs.gov/hispaniclatino-health
[27] North Carolina Office of State Budget and Management. Language Characteristics of North Carolina's Population. Accessed on 5/14/2025. https://www.osbm.nc.gov/blog/2024/03/04/language-characteristics-north-carolinas-population
[28] Gonzalez-Barrera e. al.(2024). Language Barriers in Health Care: Findings from the KFF Survey on Racism, Discrimination, and Health.KFF Survey on Racism, Discrimination, and Health (June 6- August 14, 2023). Accessed on 5/14/2025. Retrieved from: https://www.kff.org/racial-equity-and-health-policy/poll-finding/language-barriers-in-health-care-findings-from-the-kff-survey-on-racism-discrimination-and-health/#:~:text=Adults%20with%20LEP%20report%20worse,compared%20to%20English%20proficient%20adults.&text=Adults%20who%20have%20LEP%20are,19%25.
[29] Al Shamsi H, Almutairi AG, Al Mashrafi S, Al Kalbani T. Implications of Language Barriers for Healthcare: A Systematic Review. Oman Med J. 2020 Apr 30;35(2):e122. doi: 10.5001/omj.2020.40. PMID: 32411417; PMCID: PMC7201401.

Key Findings for Those Who Identified as Female

Most medical concepts of diseases are based on male physiology, leading to gendered norms in research and clinical practice.[30] Gender biases in the health care system have serious implications. Studies have found that hospital staff take women's pain less seriously, spend less time treating them and are more likely to wrongly diagnose pain as "emotional."[31] For example, individuals who identify as female are significantly more likely than men to be misdiagnosed and discharged in the middle of having a heart attack.[32] In 2023, individuals who identified as female made up around 57% of the total NC Medicaid beneficiary population.[33] The Department was unable to stratify the survey measures by gender for this analysis. Of the 36 quality measures analyzed, three had an identified disparity for the female population. For individuals who identify as female, this analysis only found disparities in admissions related to asthma in younger adults and admissions relating to pediatric diabetes short-term complications. Those identifying as female fared better than those who identified as male on the majority of mental health-related measures. See Appendix D for a list of all findings for the female identifying population.

[30] Samulowitz A, Gremyr I, Eriksson E, Hensing G. "Brave Men" and "Emotional Women": A Theory-Guided Literature Review on Gender Bias in Health Care and Gendered Norms towards Patients with Chronic Pain. Pain Res Manag. 2018 Feb 25;2018:6358624. doi: 10.1155/2018/6358624. PMID: 29682130; PMCID: PMC5845507.

[31] Women and pain: disparities in experience and treatment. (2017). Harvard Medical School. Harvard Health Publishing. Retrieved from: https://www.health.harvard.edu/blog/women-and-pain-disparities-in-experience-and-treatment-2017100912562

[32] Nabel EG. Coronary heart disease in women--an ounce of prevention. N Engl J Med. 2000 Aug 24;343(8):572-4. doi: 10.1056/NEJM200008243430809. PMID: 10954767

[33] NC Medicaid Enrollment Dashboard. Enrollment data taken from December 2023. Accessed on 9/10/2025. https://medicaid.ncdhhs.gov/reports/dashboards/enrollment-dashboard

Methodology

Demographic Factors

This section will go through the demographic factors used in this analysis, the disparity calculation and the measures used in this report. For a list of utilized data sources and their descriptions see Appendix B. This report focuses on disparities identified within data from 2023. In addition, within measure's section there is a table included that shows the change in performance for the priority populations between 2022 and 2023. These tables allow you to track performance trends over time even if there is no identified disparity in 2023's data.

Note: There is a significant lag in accessing quality measurement data, due to validation processes and data submission timelines. Validated rates are usually not available until fall of the following year.

NC Medicaid analyzed disparities based on beneficiary's identified ethnicity, race, age, gender, primary language, disability status and geography, where applicable. Tables 3 through 7 display the race and ethnicity categories that NC Medicaid uses, along with the individual racial and ethnic groups that comprise each category. Please note race and ethnicity stratifications for each measure are dependent on the availability of data. For this report, NC Medicaid prioritized binary race comparisons (i.e., the group of interest compared to all other populations combined) to identify health disparities for the populations who identify as Black or African American and American Indian or Alaska Native, where available.

TABLE 3: Race Categories and Groups*

Race Category	Groups Included
Black and African American	Black and African American
White	White, Caucasian
American Indian and Alaskan Native	American Indian, American Indian and Alaska Native
Asian	Asian
Native Hawaiian or Other Pacific Islander	Native Hawaiian or Other Pacific Islander, Hawaiian or Pacific Islander
Multiracial	Multiracial^^
Unknown	Unknown, Unreported
Other	Other

**All racial group descriptions come directly from NC Medicaid application*

^^ Indicates that Multiracial includes individuals who selected two or more races.

TABLE 4: Black and African American Binary Comparison

Race Category	Groups Included
Black and African American	Black, Black and African American+
Not Black or African American*	White, Caucasian, Asian, Native Hawaiian or Other Pacific Islander, Hawaiian or Pacific Islander, Asian or Hawaiian/Pacific Islander, Multiracial^, Unknown/Missing, Unknown, Unreported, Other

** Indicates reference group for the identification of racial disparities.*

+ Includes beneficiaries who select Black or African American and one or more additional race values.

^ Multiracial is only included in the Not Black or African American group if beneficiaries did not select Black or African American as one of their races

TABLE 5: American Indian/Alaskan Native Binary Comparison

Race Category	Groups Included
American Indian and Alaskan Native	American Indian or Alaska Native, American Indian or Alaska Native+
Not American Indian/Alaskan Native*	White, Caucasian, Black, Black or African American, Asian, Native Hawaiian or Other Pacific Islander, Hawaiian or Pacific Islander, Asian or Hawaiian/Pacific Islander, Multiracial^, Unknown/Missing, Unknown, Un-reported, Other

** Indicates reference group for the identification of racial disparities.*

+ Includes beneficiaries who select American Indian/Alaskan Native and one or more additional race values.

^ Multiracial is only included in the Not American Indian/Alaskan Native group if beneficiaries did not select American Indian or Alaska Native as one of their races.

TABLE 6: Ethnicity Categories and Groups

Ethnicity Category	Groups Included
Hispanic/Latino	Hispanic Cuban, Hispanic Mexican American, Hispanic Puerto Rican, Hispanic Other, and Hispanic
Non-Hispanic/Latino*	Not Hispanic/Latino, Non-Hispanic

**Indicates reference group for the identification of ethnic disparities.*

Table 7 displays the remaining demographic stratification groups and their respective reference groups. Please note, the demographic category stratifications presented for each measure are dependent on the availability of data. Where possible, data for the demographic categories represented in Table 7 is sourced from the beneficiary reported information on the NC Medicaid application.

For the 2023 NC Medicaid Health Disparities Report, NC Medicaid made two changes to stratification groups.

1. One previously included stratification element, long-term services and support (LTSS) needs status, was removed. This stratification element was removed because it did not accurately capture the population utilizing LTSS, just those who were eligible due to their needs. The stratification element also closely mirrored the disability status strata as the LTSS needs status strata identified those who identified as aged, blind or disabled. NC Medicaid is actively working to create a more accurate way to identify the LTSS population in quality measurement.
2. For the primary language stratification, the priority population was changed from "Spanish" to "any non-English language." This change makes the priority population more inclusive, as anyone who speaks a non-English language as their primary language may face barriers to care in a system that is primarily centered on the English language.

TABLE 7: Additional Demographic Stratification Groups

Stratification	Groups
Age	Age group determined by each measure's specifications, where applicable.
Gender	Male*, Female
Primary Language	English*, Non-English
Disability Status	No Disability*, Disability
Geography	Urban*, Rural[34] (see Figure 4)

**Indicates reference group for the identification of disparities.*

[34] NCHS Urban-Rural Classification Scheme for Counties. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/data-analysis-tools/urban-rural.html?CDC_AAref_Val=https://www.cdc.gov/nchs/data_access/urban_rural.htm Accessed on 9/10/2025.

FIGURE 6: NC Medicaid Counties, Rural vs. Urban

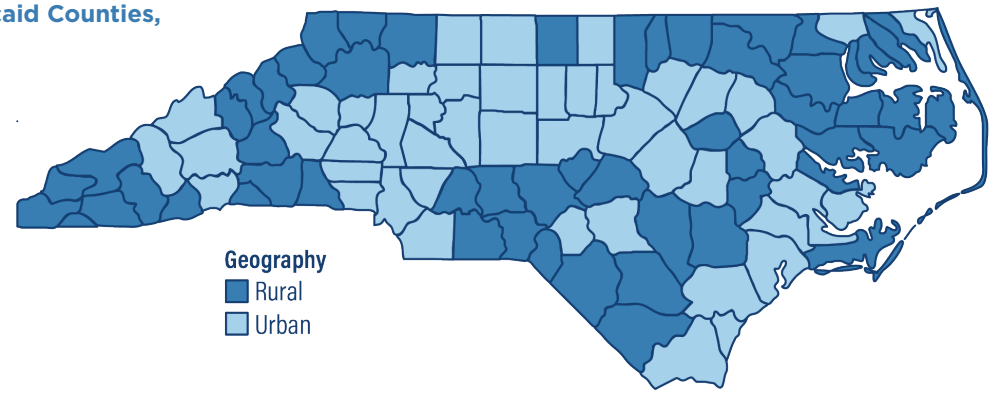


Figure 6 shows how each county in North Carolina is designated either rural or urban. This designation is derived from the National Center for Health Statistics (NCHS) Urban-Rural Classification Scheme for Counties, within the Centers for Disease Control and Prevention (CDC).

As shown in Tables 3, 4 and 5, the Department uses three methods for stratifying race in an attempt to adequately capture all aspects of a beneficiary's racial identity. As part of the enrollment process, members have the option to select up to six distinct race values (White or Caucasian, Black or African American, Asian, Native Hawaiian, Other Pacific Islander, American Indian or Alaskan Native) and an open-ended "Other" category (see Figure 7). The enrollment process also captures additional demographic information, such as primary language and county of residence (see Figure 8).

FIGURE 7: Segments of Application for Health Coverage, NCDHHS[35]

11. Race (OPTIONAL – Check all that apply)
    - ☐ White or Caucasian ☐ Black or African-American ☐ Asian ☐ Native Hawaiian
    - ☐ Other Pacific Islander
    - ☐ American Indian or Alaska Native (If you, complete Appendix B)

    Other: _____

FIGURE 8: Segments of Application for Health Coverage, NCDHHS[35]

1. First name, Middle name, Last name & Suffix			
2. Home address (Leave blank if you don't have one)			3. Apartment or Suite Number
4. City	5. State	6. Zip Code	7. County
8. Mailing Address (if different from home address)			9. Apartment of Suite Number
10. City	11. State	12. Zip Code	13. County
14. Phone Number		15. Other Phone Number	
16. What is your preferred spoken or written language (if not English)?			

[35] For more information, visit the How to Apply for NC Medicaid website. Spanish translation available

Assigning all beneficiaries to a single-race category, including a derived multiracial field for those beneficiaries who select more than one race, leads to a relative underreporting of certain racial groups. This single-race reporting approach risks obscuring important intra-group variation, which is particularly relevant in increasingly diverse, multi-racial populations. On its own, this approach can mask valuable information about beneficiaries' race and identity that should be considered in analysis. Using the three methods outlined below provides the Department with a more holistic picture for monitoring and evaluating racial disparities.

Approaches for stratifying race:

1. **Method 1:** Beneficiaries who select more than one race are only included in a "multiracial" stratum. Members who select a single race are included in their reported race strata (see Table 3).
2. **Method 2:** Beneficiaries who select "Black or African American" as their race are included in the "Black or African American" stratum. This includes beneficiaries who select "Black or African American" and one or more other race values. Any remaining beneficiaries are included in the "Not Black or African American" stratum (see Table 4).
3. **Method 3:** Beneficiaries who select "American Indian or Alaska Native" as their race are included in the "American Indian or Alaska Native" stratum. This includes beneficiaries who select "American Indian or Alaska Native" and one or more other race values. Any remaining beneficiaries are included in the "Not American Indian or Alaska Native" stratum (see Table 5).

Following the approach outlined above allows the Department to parse out those groups that Departmental analyses have confirmed are under- or misrepresented via the "multiracial" reporting group outlined in Method one. These binary comparisons allow for clearer identification of disparities in priority populations, though they may oversimplify complex racial identities.

By combining approaches, the Department can see a full picture of each subgroup's performance that is necessary for measuring disparity reduction and quality performance. *This report focuses on methods two and three.*

Identifying Disparities

For the 2023 NC Medicaid Health Disparities Report, NC Medicaid identified health disparities in select measures based on demographic strata (see demographics factors section above). **A health disparity was identified if the relative difference in a quality measure rate between the group of interest and the reference group was equal to or greater than 10%**, a threshold selected for its practicality in identifying meaningful gaps.

For measures where a higher rate indicates better performance (e.g., Well-Child Visits), the following formula was used:

$$\text{Relative Difference} = \frac{\text{(Reference Group Performance Rate - Group of Interest Performance Rate)}}{\text{Reference Group Performance Rate}}$$

$$\text{Disparity Identified if Relative Difference} > 10\%$$

For example, if the rate of eligible beneficiaries receiving well-child visits for the not Black or African American group was 65% and the rate for the Black or African American group was 45%, the rate for the Black or African American group (the group of interest) was below the rate for the not Black or African American group (the reference group) by a 30.8% relative difference (≥10%), indicating a racial disparity. This is shown in the equation below:

$$30.8\% = \frac{(65.0\%-45.0\%)}{65.0\%}$$

For measures where a lower rate indicates better performance (e.g.,Use of Opioids at High Dosage in Persons Without Cancer), the following formula was used:

$$\text{Relative Difference} = \frac{(\text{Group of Interest Performance Rate} - \text{Reference Group Performance Rate})}{\text{Reference Group Performance Rate}}$$

$$\text{Disparity Identified if Relative Difference} > 10\%$$

For example, if the rate of eligible beneficiaries without a cancer diagnosis using opioids at a high dosage for the Black or African American group was 65% and the rate for the not Black or African American group was 45%, the rate for the Black or African American group (the group of interest) was above the rate for the not Black or African American group (the reference group) by a 44.4% relative difference (≥10%), indicating a racial disparity. This is shown in the equation below:

$$44.4\% = \frac{(65.0\%-45.0\%)}{45.0\%}$$

Findings in this report are calculated from the NC Medicaid beneficiary population, with limited benefit beneficiaries excluded. Limited benefit beneficiaries often have alternative sources of health insurance coverage and receive only partial coverage from NC Medicaid, making it difficult to accurately ascertain their quality measurement performance.[36] When a disparity was identified for a measure, figures were developed to display the different performances and highlight areas of growth. Additionally, the Department provided background information on several of its programs to contextualize the efforts it is making toward eliminating the identified health disparities. For a full table of measure's relative difference calculations, see Appendix D.

For some measures in this report the group of interest, those who identify as Hispanic or Latino for example, have performed much better than the reference group, like those who do not identify as Hispanic or Latino. The report does not consider these instances disparities even if it meets the health disparity standard (10% relative difference) in the negative direction as it does not reflect the definition of a health disparity as being experienced by populations who have been socially, economically, geographically and environmentally disadvantaged.

Relative Change vs. Absolute Change

Relative Change: By what percentage did performance for the group of interest change when compared to the reference group?

Absolute Change: What is the simple difference between performance for the group of interest and the reference group?

[36] Limited benefit members were identified using managed care status codes which were excluded from the analysis. Managed care status codes 018, 020,021, 023 ,024 and 043 were excluded from this analysis. See appendix for more detailed information on these limited benefit groups.

Measures

To identify the list of measures that would be included in the 2023 NC Medicaid Health Disparities Report, NC Medicaid considered multiple factors, including data availability, completeness and accuracy. The National Quality Forum (NQF) developed a protocol for identifying disparity-sensitive quality measures.[37] To select measures for this report, NC Medicaid drew on this protocol and prioritized prevalence, quality gap and impact:

- **Prevalence:** How common is the condition among populations that have been systemically discriminated against?
- **Quality Gap:** How large is the gap in quality of care between the comparison population and the group of interest?
- **Impact:** How influential is the condition or topic financially, publicly and within the community at large?

Table 8 displays the 36 quality measures and the 20 survey measures and their stewards included in the 2023 NC Medicaid Health Disparities Report. For more information on the data sources used for these measures, see Appendix B. Each measure was placed into one of the following domains based on the type of care or health status being measured:

1. Beneficiary Experience,
2. Child and Adolescent Health,
3. Women's Health,
4. Mental Health,
5. Substance Use,
6. Health Care Utilization, and
7. Chronic Health.

What is a Quality Measure?

Quality measures are tools that help quantify health care processes, outcomes, patient perceptions, and systems that are associated with the ability to provide high-quality health care. Quality measures help identify successes and opportunities for growth, so NC Medicaid and its partners can prioritize efforts to achieve better outcomes for beneficiaries.

Please note that measures in Table 8 are organized under the domains in which they appear in the report.

Changes to the 2023 NC Medicaid Health Disparities Report:

When deciding on the measure set for the 2023 iteration of this report, the Department considered the results of the 2022 NC Medicaid Health Disparities Report. The 2022 results revealed that the highest count of identified disparities was within the Substance Use domain. As a result, three new measures were added to the Substance Use domain to expand the analysis of this critical topic, two of these new measures replaced SUD measures from the previous report as to align with widely used measure stewards.

[37] National Quality Forum (NQF). Healthcare Disparities Measurement. https://cms.qualityforum.org/Publications/2012/02/Commissioned_Paper__Healthcare_Disparities_Measurement.aspx Accessed on 9/10/2025.

Two measures were removed from the Health Care Utilization Domain, one related to pediatric gastroenteritis and the other about pediatric urinary tract infections. NC Medicaid decided to remove these measures from the report's measure set due to their small eligible population size, stakeholder feedback and the challenges that come with avoidable utilization measures, such as accurately defining and identifying "avoidable" admissions.

The 2023 Health Disparities Report also features a new domain: Chronic Health. This domain is responsive to the shifting demographic population of NC Medicaid as a result of Medicaid Expansion. On Dec. 1, 2023, NC Medicaid expanded coverage to people ages 19 through 64, up to 138% of the federal poverty level. This resulted in a large increase in Medicaid beneficiaries who are middle aged, highlighting the importance of monitoring the health of those with chronic conditions. Future iterations of this report may include social drivers of health (e.g., housing instability, food insecurity) as data sources and methodology evolve.

TABLE 8: Measures Organized by Domain and Data Sources

Measure		Measure Set (Steward)
Beneficiary Experience (n=20 measures)	Rating of Health Plan — Adult and Child	CAHPS Measure (AHRQ)
	Rating of All Health Care — Adult and Child	CAHPS Measure (AHRQ)
	Customer Service — Adult and Child	CAHPS Measure (AHRQ)
	How Well Doctors Communicate — Adult and Child	CAHPS Measure (AHRQ)
	Rating of Personal Doctor — Adult and Child	CAHPS Measure (AHRQ)
	Rating of Specialist Seen Most Often — Adult and Child	CAHPS Measure (AHRQ)
	Getting Needed Care — Adult and Child	CAHPS Measure (AHRQ)
	Getting Care Quickly — Adult and Child	CAHPS Measure (AHRQ)
	Flu Vaccinations for Adults (FVA)	CAHPS Measure (AHRQ)
	Medical Assistance with Smoking and Tobacco Use Cessation (MSC) Advising Smoker and Tobacco Users to Quit, Discussing Cessation Medication, and Discussing Cessation Strategies	CAHPS Measure (AHRQ)
Child and Adolescent Health (n=6 measures)	Child and Adolescent Well-Care Visits (WCV)	HEDIS Measure (NCQA)
	Childhood Immunization Status — Combination 10 (CIS-10)	HEDIS Measure (NCQA)
	Immunizations for Adolescents — Combination 2 (IMA-2)	HEDIS Measure (NCQA)
	Well-Child Visits in the First 30 Months of Life — Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6+)	HEDIS Measure (NCQA)
	Well-Child Visits in the First 30 Months of Life — Well-Child Visits for Age 15 Months to 30 Months — Two or More Well-Child Visits (W30-2+)	HEDIS Measure (NCQA)
	Oral Evaluation, Dental Services (OEV)	Non-HEDIS Measure (DQA)
Women's Health (n=5 measures)	Cervical Cancer Screening (CCS)	HEDIS Measure (NCQA)
	Chlamydia Screening in Women (CHL)	HEDIS Measure (NCQA)
	Prenatal and Postpartum Care (PPC) — Timeliness of Prenatal Care	HEDIS Measure (NCQA)
	Prenatal and Postpartum Care (PPC) — Postpartum Care	HEDIS Measure (NCQA)
	Breast Cancer Screening (BCS)	HEDIS Measure (NCQA)

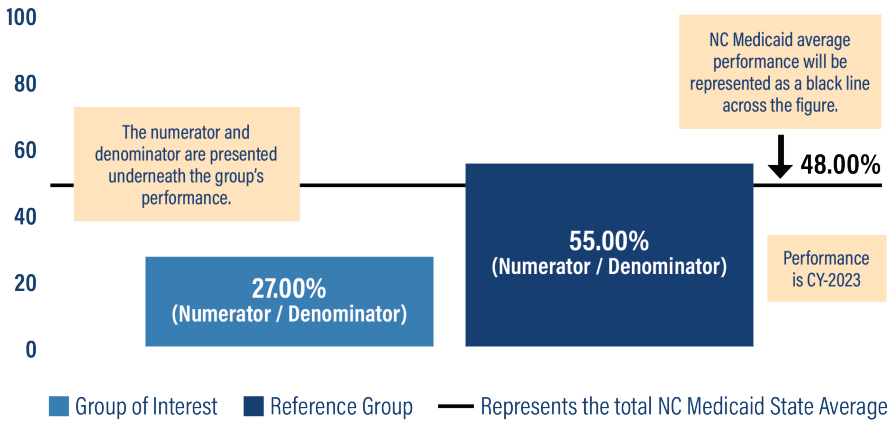
Measure		Measure Set (Steward)
Mental Health (n=6 measures)	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	HEDIS Measure (NCQA)
	Follow-Up After Hospitalization for Mental Illness — 7-Day Follow-Up (FUH)	HEDIS Measure (NCQA)
	Follow-Up After Hospitalization for Mental Illness — 30-Day Follow-Up (FUH)	HEDIS Measure (NCQA)
	Follow-Up After ED Visit for Mental Illness — 7-Day Follow-Up (FUM)	HEDIS Measure (NCQA)
	Follow-Up After ED Visit for Mental Illness — 30-Day Follow-Up (FUM)	HEDIS Measure (NCQA)
	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	HEDIS Measure (NCQA)
Substance Use (n=7 measures)	Follow-Up After ED Visit for Substance Use — 7-Day Follow-Up (FUA)	HEDIS Measure (NCQA)
	Follow-Up After ED Visit for Substance Use — 30-Day Follow-Up (FUA)	HEDIS Measure (NCQA)
	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	Non-HEDIS Measure (PQA)
	Use of Pharmacotherapy for Opioid Use Disorder (OUD)	Non-HEDIS Measure (CMS)
	ED Utilization for SUD per 1,000 Medicaid Beneficiaries	SUD Metric
	Use of Opioids From Multiple Providers (UOP) - Multiple Prescribers and Multiple Pharmacies	HEDIS Measure (NCQA)
	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	PQA
	Initiation and Engagement in SUD treatment (IET) - Initiation	HEDIS Measure (NCQA)
	Initiation and Engagement in SUD treatment (IET) - Engagement	HEDIS Measure (NCQA)
Health Care Utilization (n=8 measures)	PQI 01: Diabetes Short-Term Complications Admission Rate Per 100,000 Member Months	Utilization Metric (AHRQ)
	PQI 15: Asthma in Younger Adults Admission Rate Per 100,000 Member Months	Utilization Metric (AHRQ)
	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate Per 100,000 Member Months	Utilization Metric (AHRQ)
	PQI 08: Heart Failure Admission Rate Per 100,000 Member Months	Utilization Metric (AHRQ)
	PDI 14: Pediatric Asthma Admission Rate Per 100,000 Member Months	Utilization Metric (AHRQ)
	PDI 15: Pediatric Diabetes Short-Term Complications Admission Rate Per 100,000 Member Months	Utilization Metric (AHRQ)
Chronic Health (n=4 measures)	Controlling High Blood Pressure (CBP)	HEDIS Measure (NCQA)
	Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD) - HbA1c Control (<8.0%)	HEDIS Measure (NCQA)
	Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD) - HbA1c Poor Control (>9.0%)	HEDIS Measure (NCQA)
	Colorectal Cancer Screening (COL)	HEDIS Measure (NCQA)

Note: Measure counts include sub measures as distinct measures

How to Read this Report

This report contains figures depicting NC Medicaid's performance on select measures in 2023, with national and historical context when relevant. Each measure was analyzed with all available demographic stratifications listed in Tables 3-7. A figure was only developed when a disparity was identified, which is defined as a relative difference of ≥10%. All relative difference results for each measure are in Appendix D. Each figure will contain the performance of the group of interest, the reference group and the NC Medicaid state average.[38] The Example Figure below shows the figure elements and how they can be used to interpret performance.

Example Figure



Note: Not all measures follow a traditional rate structure (numerator/denominator); some measures are per 1,000 beneficiaries or per 100,000 member months.

Additionally, each measure is accompanied by a table showing measure performance across all eight strata, when possible (see Table 9). The CY2023 column also includes colored arrows, indicating improvement or decreases in performance from CY2022 to CY2023.

TABLE 9: Additional Demographic Stratification Groups

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	44.00%	42.00% ↓
Living in a rural county	41.30%	39.10% ↓
Female	41.00%	43.00% ↑
Hispanic/Latino	33.50%	34.30% ↑
Speaking a non-English primary language	24.80%	30.00% ↑
Black and African American	40.00%	37.00% ↓
American Indian and Alaskan Native	37.90%	36.20% ↓

The ↓ & ↑ icons indicate any improvement or decrease in rate over the years, but do not indicate a statistically significant change in performance.

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

[38] The NC Medicaid state average is the performance of all NC Medicaid beneficiaries except those with limited benefits. See appendix section "Partial Benefit Group Exclusions" for more details.

Caveats & Limitations

Disparity Identification Variations

Due to the availability of data for each data source, there are differences in which demographic strata could be assessed for each measure. For age-specific measures, disparities are only assessed for age groups that fall within the measure specifications. Disparities between age groups were not assessed if the measure specifications only include one age group. For example, the *Childhood Immunization Status (CIS)* measure is limited to beneficiaries who turn two years of age during the measurement year; therefore, disparities between age groups are not relevant. Similarly, for gender-specific measures (e.g., *Cervical Cancer Screening*), gender disparities are not assessed.

Health-Related Resource Needs

Quality measurement data, often consisting of claims and encounters data, only tells a piece of the story about an individual's health. The conditions in which people are born, grow, work, live and age, along with the systems shaping the experiences of their daily life, significantly influence health outcomes.[39] Access to healthy food, stable housing and reliable transportation contribute to overall health. NC Medicaid is currently working to determine how best to measure and address these factors, referred to as health-related resource needs. A new quality measure, developed by the Department in 2023, tracks health plans' ability to screen their members for these needs. This measure only includes data for beneficiaries enrolled in one of NC Medicaid's Managed Care plans, not for the entire NC Medicaid beneficiary population. More information on this measure and its results can be found in the Addressing Health Disparities section of the report.

Disparity Methodology

This report only displays results that met NC Medicaid's health disparity standard, a 10% relative difference between the reference group and the group of interest. Data for certain measures did not meet this standard and therefore are not presented in this report; however, inequities or health disparities may still exist for that health topic. While NC Medicaid uses a 10% relative difference as the health disparity benchmark, this is not shared across all NC organizations or across other state Medicaid programs. Multiple data sources should be leveraged when seeking to fully understand health disparities across these populations and measures.

Process & Utilization vs. Outcome Measures

Most of the measures in this report are health care utilization or process measures. These measures assess the frequency with which the population accessed specific health care services. As health is a multidimensional construct, it is important to note that utilization data does not give the entire picture of an individual's experience with health care or their health outcomes. While NC Medicaid collects information on beneficiary experience via patient-reported measures, due to a lack of reliable and complete clinical data, measures on beneficiary health outcomes are currently incomplete. Even with clinical data, health outcomes are difficult to ascribe to any one activity or intervention. Given this report's focus on utilization metrics, it is important to keep in mind that a population with a higher rate for certain utilization measures indicates increased encounters with the health care system, but not necessarily better health outcomes or experience.

[39] U.S. Department Of Health and Human Services. (n.d.). Social Determinants of Health. Social Determinants of Health - Healthy People 2030. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health Office of Disease Prevention and Health Promotion

Race-based Clinical Algorithms

Clinical algorithms are used across medical specialties to assist in decisions such as diagnosis, medical management and risk stratification. Historically, race has been a component of a variety of algorithms, leading to clinical decisions that are based off a social, not genetic or scientific classification.[40] While some organizations have updated their algorithms, many problematic algorithms remain. These race-based clinical algorithms have the potential to impact clinical decisions within the NC Medicaid population, influencing the performance of certain populations for utilization quality measures. Moving forward, NC Medicaid will use its position within the state to raise awareness of these algorithms and engage in mindful review of clinical policies to ensure we avoid language that supports race-based medicine.

Intersectionality

Intersectionality refers to the idea that multiple social identities like race, gender, class and sexuality intersect and interact to create unique experiences of privilege and discrimination. It's a framework for understanding how different aspects of a person's identity can combine to create unique challenges and opportunities. This report only assesses one element of identity at a time, stratifying by ethnicity or gender instead of combining different demographic elements together, and therefore limits the scope of this analysis.

NC Medicaid Expansion

North Carolina expanded Medicaid eligibility on Dec. 1, 2023, under the Affordable Care Act (ACA). This expansion extended coverage to nearly all non-elderly adults who earn up to 138% of the Federal Poverty Level. Since the launch of expansion, more than 600,000 North Carolinians have gained coverage under NC Medicaid. This rapid increase in enrolled beneficiaries may have an impact on some of the quality measurement rates for 2023, as many new enrollees became eligible for services but may not have received them in time to be counted in the numerator of the measure.

Health Literacy

Personal health literacy is the degree to which individuals can find, understand and use information and services to inform health-related decisions and actions for themselves and others.[41] Employing best practices in health literacy can build trust in people, promoting healthy behaviors. Organizations like NC Medicaid have an important role to play in fostering health literacy. Key recommendations include using plain language, using your audience's preferred language and communication channels, and using culturally and linguistically appropriate language. NC Medicaid tried its best to account for differing levels of health literacy in this report but acknowledges the array of complex topics makes it difficult to ensure all content is understandable and usable for all audiences.

[40] Cerdeña JP, Plaisime MV, Borrell LN. Race as a Risk Marker, Not a Risk Factor: Revising Race-Based Algorithms to Protect Racially Oppressed Patients. J Gen Intern Med. 2024 Oct;39(13):2565-2570. doi: 10.1007/s11606-024-08919-z. Epub 2024 Jul 9. PMID: 38980468; PMCID: PMC11436499.

[41] CDC. Health Literacy. https://www.cdc.gov/health-literacy/php/about/index.html Accessed on 9/10/2025

Results

The Results section is organized by the following domains:

1. Beneficiary Experience
2. Child and Adolescent Health
3. Women's Health
4. Mental Health
5. Substance Use
6. Health Care Utilization
7. Chronic Health

At the beginning of each domain, there is a table that displays the statewide aggregate rate for each measure, a narrative description of the measures included in the domain and national and historical context for the disparities that exist relating to the measures. After the introduction, a high-level overview of the domain's findings follows, including whether there were any measures that did not have identified disparities.

Context for Result Interpretation

It is important to understand that the disparities discussed in this report are not in any way caused by demographic elements (e.g., race, gender, ethnicity), but by social conditions that are more likely to affect populations that have been marginalized. NC Medicaid wants to focus on population level disparities to uncover social and economic conditions which could be generating poor health outcomes for people who identify with certain demographic groups. Factors such as poverty, discrimination, large wealth gaps, access to care and stigma can make it more difficult for people to stay healthy.

To see how total NC Medicaid's performance compares to other state Medicaid health maintenance organizations (HMOs), visit Appendix C.

Small cell suppression note:

For any stratification that resulted in denominators smaller than 30, the data was suppressed and will not be shown in this report. Results with denominators only slightly larger than 30 should be interpreted with caution given the small size of the eligible population.

Beneficiary Experience Domain Findings

The Beneficiary Experience domain includes 20 measures that assess adult and child NC Medicaid beneficiary experiences with health plans, providers and services based on CAHPS survey responses. CAHPS surveys enable NC Medicaid to systemically ask beneficiaries about their experiences with health care. Patient experience encompasses a wide range of interactions and experiences a patient may have with the health care system, including health plans and providers. Research has found disparities between patient experience for some Medicaid beneficiaries who identify as Black or African American and Hispanic/Latino, compared to White enrollees.[42] CAHPS is an important tool that can boost scientific understanding of patient experience within healthcare as part of a larger effort to advance the delivery of safe, patient-centered care.[43]

Note: MY2023 CAHPS data were collected between June through October 2024. To learn more about the CAHPS survey you can read the entire 2024 Adult and Child Medicaid CAHPS Aggregate Report linked here.

Table 10 displays the statewide aggregates for the measures included in the Beneficiary Experience domain.

TABLE 10: Beneficiary Experience Measure Domain NC Medicaid Aggregates

Beneficiary Experience Measure NC Medicaid	CY2023 Aggregate	CY2024 Aggregate
RATING OF HEALTH PLAN		
Adult	73.96%	79.36% ↑
Child	83.50%	86.16% ↑
RATING OF ALL HEALTH CARE		
Adult	78.16%	76.54% ↓
Child	87.30%	86.57% ↓
CUSTOMER SERVICE		
Adult	91.90%	91.35% ↓
Child	88.80%	87.64% ↓
HOW WELL DOCTORS COMMUNICATE		
Adult	93.83%	94.38% ↑
Child	96.50%	96.08% ↓
RATING OF PERSONAL DOCTOR		
Adult	86.63%	87.39% ↑
Child	90.90%	90.40% ↓

Beneficiary Experience Measure NC Medicaid	CY2023 Aggregate	CY2024 Aggregate
RATING OF SPECIALIST SEEN MOST OFTEN		
Adult	86.37%	84.76% ↓
Child	86.50%	87.64% ↑
GETTING NEEDED CARE		
Adult	85.95%	86.13% ↑
Child	86.70%	86.74% ↑
GETTING CARE QUICKLY		
Adult	85.19%	84.64% ↓
Child	89.60%	89.18% ↓
Flu Vaccinations for Adults (FVA)	42.51%	38.66% ↓
EFFECTIVENESS OF CARE- MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION		
Advised to Quit Smoking by Provider	78.87%	79.96% ↑
Discussing Cessation Medication	54.14%	57.53% ↑
Discussing Cessation Strategies	47.15%	48.00% ↑

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

[42] Nguyen, Kevin. Wilson, Ira. Wallack, Anya. Trivedi, Amal. (2022) Racial and Ethnic Disparities in Patient Experience of Care Among Nonelderly Medicaid Managed Care Enrollees. Health Affairs. Wol. 41 No. 2: Racism and Health. Retrieved from https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01331. Accessed on 9/10/2025.

[43] Agency for Healthcare Research and Quality (AHRQ). About the CAHPS Program and Surveys Webpage. Accessed 3/19/2025. Retrieved from https://www.ahrq.gov/cahps/about-cahps/index.html

Some demographic stratifications are based on numerators and/or denominators less than 100. While no rates with less than 11 responses in the numerator are shared, caution should be exercised when interpreting disparities findings for the CAHPS measures with smaller denominators. As a note, CAHPS results could not be stratified by disability status or gender.

Using the Adult CAHPS data from calendar year 2024 no disparities were identified for any of the identified measures, except the *Rating of Specialist Seen Most Often (American Indian and Alaskan Native binary race)* and *Medicaid Assistance with Smoking and Tobacco Use Cessation (Hispanic and Latino binary ethnicity)* sub measures. Using the Child CAHPS data from measurement year 2023, no disparities were identified for any of the selected measures.

See Appendix D for stratified results for all these measures.

Patient Experience Report

The Press Ganey Patient Experience Report gathered and analyzed data from 6.5 million patient encounters across the U.S. The Report found that patient experience improved in 2023, with ambulatory surgery and medical practices hitting five-year highs. While hospitals and emergency departments are improving, they haven't fully recovered to pre-pandemic levels. In hospitals and medical practices, underrepresented populations report lower scores in empathy, care personalization, and addressing concerns. The full report can be found here.

Rating of Specialist Seen Most Often — Adult

The *Rating of Specialist Seen Most Often — Adult* measure assesses how respondents rate the specialist they have talked to the most often in the last six months, using any number from zero to 10, where zero is the worst specialist possible and 10 is the best specialist possible. Ratings of eight, nine, or 10 are considered positive ratings. Health disparities were assessed based on the proportion of respondents who gave a positive rating.

For *Rating of Specialist Seen Most Often*, the gate question, or initial screening question, asks respondents if they made any appointments with a specialist in the last six months. If respondents answer "No" to this question, they are directed to skip the question that comprises the *Rating of Specialist Seen Most Often* measure.

The American Indian and Alaska Native people have long experienced lower health status when compared with other Americans. Lower life expectancy and the disproportionate disease burden exist perhaps because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity and poor social conditions.[47]

Access to the full range of medical specialties is a key piece of high-quality medical care. However, many patients, especially members of groups that have been systematically marginalized, face barriers to such care. Research has found that individuals who identify as Black and African American had lower rates of visits to most specialties, including dermatology, urology, general surgery and orthopedics, when compared to White patients.[44] These disparities persisted even after accounting for several social determinants of access to care, leading researchers to believe that there are several factors leading to these differences in access to specialist care. Due to a long history of structural racism, certain racial and ethnic groups are more likely to reside in areas with a shortage of physicians and are less likely to receive specialty referrals from primary care physicians.[45, 46]

Note: CAHPS measures were not stratified by gender, disability status or primary language due to data limitations.

TABLE 11: Trends in Priority Population Performance for Rating of Specialist Seen Most Often — Adult Measure, by Stratification Element

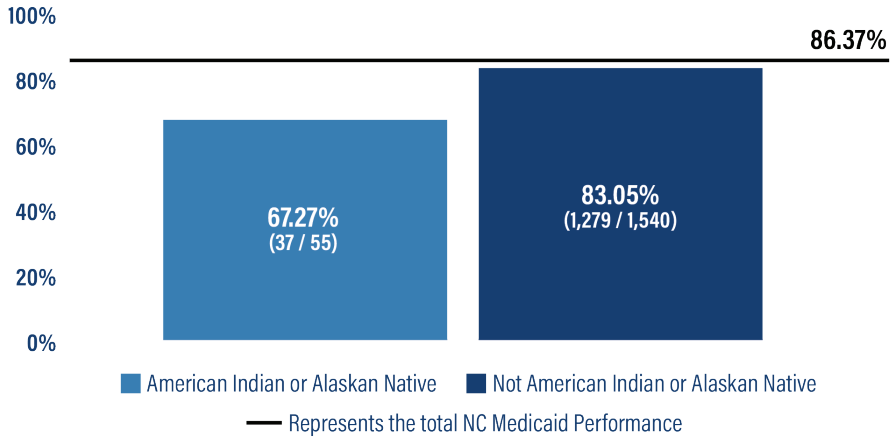
Those Who Identify As...	CY2022 Performance	CY2023 Performance
Living in a rural county	84.6%	82.05% ↓
Hispanic/Latino	85.3%	88.72% ↑
Black and African American	86.7%	82.40% ↓
American Indian and Alaskan Native	77.8%	67.27% ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

Among adult respondents in NC Medicaid, no disparities were identified based on Black Binary race, or ethnicity for the Rating of Specialist Seen Most Often — Adult measure. However, disparities were identified based on American Indian and Alaskan Native binary race.

- Beneficiaries who identified as American Indian and Alaskan Native rated their specialists worse than those who did not, with a relative difference of 19.00% (See Figure 9).

FIGURE 9: *Rating of Specialist Seen Most Often (Adult)*, 2023 NC Medicaid Performance by American Indian and Alaskan Native Binary Race



[44] Cai C, Gaffney A, McGregor A, et al. Racial and Ethnic Disparities in Outpatient Visit Rates Across 29 Specialties. JAMA Intern Med. 2021;181(11):1525–1527. doi:10.1001/jamainternmed.2021.3771

[45] Doescher M, Fordyce M, Skillman S, Jackson E, Rosenblatt R. Persistent primary care health professional shortage areas (HPSAs) and health care access in rural America. Accessed November 16, 2020. http://depts.washington.edu/uwrhrc/uploads/Persistent_HPSAs_PB.pdf

[46] Landon BE, Onnela J-P, Meneades L, O'Malley AJ, Keating NL. Assessment of racial disparities in primary care physician specialty referrals. JAMA Netw Open. 2021;4(1):e2029238. doi:10.1001/jamanetworkopen.2020.29238

[47] Indian Health Services (IHS). Disparities Fact Sheet. Website Accessed on 4/28/2025. Retrieved from https://www.ihs.gov/newsroom/factsheets/disparities/

NC Medicaid Ombudsman

The Ombudsman program offers help to NC Medicaid beneficiaries who have trouble getting access to health care, and connects people to resources like legal aid, social services, housing resources, food assistance and other programs. The Ombudsman provides free, confidential support and education about the rights and responsibilities people have under NC Medicaid.

In 2023, the Ombudsman program answered 17,631 calls from beneficiaries and completed 99% of their 14,024 cases opened. Learn more on the NC Medicaid Ombudsman website.

Medical Assistance with Smoking and Tobacco Use Cessation

The *Medical Assistance with Smoking and Tobacco Use Cessation (MSC)* measure assesses the percentage of current smokers or tobacco users who discussed or were recommended cessation medications (e.g., nicotine gum, patch, nasal spray, inhaler, prescription medication) to assist them with quitting smoking or using tobacco in the last six months. Three rates are reported for this measure, those who were:

1. Advised to quit smoking or using tobacco
2. Discussing cessation medications
3. Discussing cessation strategies.

According to the American Lung Association, Hispanics or Latinos are less likely than non-Hispanic Whites to have access to healthcare, to receive advice to stop tobacco use, to have knowledge of existing smoking cessation resources, to participate in tobacco cessation programs or to utilize pharmacotherapy to stop smoking.[52, 53, 54]

Disparities in smoking cessation assistance receipt exist in safety-net settings, in particular within populations with no health insurance coverage and across racial/ethnic groups, even after controlling for other socioeconomic and demographic factors.[48] Studies have found that receiving advice from a doctor can help a patient stop smoking; Even doctors providing brief, simple advice about smoking cessation increases the likelihood that someone who smokes will successfully quit and remain a nonsmoker for at least 12 months.[49]

To assist in quitting smoking, health care providers can prescribe medications like bupropion and varenicline. The United States Preventive Services Task Force (USPSTF) recommends that clinicians direct patients who use tobacco to tobacco cessation interventions with proven effectiveness and established safety. Cessation counseling and strategies have been shown to increase the rate of six-month smoking cessation from 4.8% for those who received no advice to 8.0% for those who received advice. These USPSTF recommends providers offer behavioral interventions and Food and Drug Administration (FDA)-approved pharmacotherapy for cessation for the best results in cessation efforts.[50, 51]

Note: CAHPS measures were not stratified by gender, disability status or primary language due to data limitations.

[48] Bailey SR, Heintzman J, Jacob RL, Puro J, Marino M. Disparities in Smoking Cessation Assistance in US Primary Care Clinics. Am J Public Health. 2018 Aug;108(8):1082-1090. doi: 10.2105/AJPH.2018.304492. Epub 2018 Jun 21. PMID: 29927641; PMCID: PMC6050829.
[49] Stead LF, Buitrago D, Preciad N, et al. Physician Advice for Smoking Cessation. Cochrane Database of Systematic Reviews. 2022. Issue 4. Art. No.: CD000165. DOI: 10.1002/14651858.CD000165.pub4. Accessed on: July 24, 2025
[50] Centers for Disease Control and Prevention. How Quit Smoking Medicines Work. Nov 28, 2022. Available at: https://www.cdc.gov/tobacco/campaign/tips/quit-smoking/quit-smoking-medications/how-quit-smoking- medicines-work. Accessed on: July 24, 2025.
[51] US Preventive Services Task Force. Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Persons. Jan 19, 2021. Available at: https://jamanetwork.com/journals/jama/fullarticle/2775287. Accessed on: July 24, 2025.
[52] Blanco L, Garcia R, Perez-Stable E, et al. National trends in smoking behaviors among Mexican, Puerto Rican and Cuban men and women in the United States. American Journal of Public Health. 2014;104(5):896-903
[53] Trinidad D, Pérez-Stable E, White M, Emery S, Messer K. A nationwide analysis of US racial/ethnic disparities in smoking behaviors, smoking cessation and cessation-related factors. American Journal of Public Health. 2011;101(4):699-706
[54] CDC. Cigarette smoking among adults and trends in smoking cessation - United States, 2008. Morbidity and Mortality Weekly Report (MMWR) 2009;58(44):1227-1232.

TABLE 12: Trends in Priority Population Performance for the MSC Measure, by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
ADVISED TO QUIT SMOKING OR USING TOBACCO		
Living in a rural county	N/A	78.82%
Hispanic/Latino	N/A	68.06%
Black and African American	76.2%	79.10% ↑
American Indian and Alaskan Native	81.3%	80.70% ↓
DISCUSSING CESSATION MEDICATIONS		
Living in a rural county	N/A	56.81%
Hispanic/Latino	N/A	43.66%
Black and African American	51.7%	60.16% ↑
American Indian and Alaskan Native	57.3%	59.65% ↑
DISCUSSING CESSATION STRATEGIES		
Living in a rural county	N/A	47.65%
Hispanic/Latino	N/A	37.14%
Black and African American	42.7%	50.53% ↑
American Indian and Alaskan Native	42.7%	47.37% ↑

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

Among respondents in NC Medicaid, no disparities were identified based on binary race or geography for all three of the *Medical Assistance with Smoking and Tobacco Use Cessation* (MSC) sub-measures. However, disparities were identified based on ethnicity for all three sub-measures.

- When it came to being advised to quit smoking by a provider, beneficiaries who identified as Hispanic or Latino fared worse than those who did not, with a relative difference of 14.50% (see Figure 10).
- When it came to discussing cessation medications, beneficiaries who identified as Hispanic or Latino fared worse than those who did not, with a relative difference of 23.74% (see Figure 11).
- When it came to discussing cessation strategies, beneficiaries who identified as Hispanic or Latino fared worse than those who did not, with a relative difference of 25.17% (see Figure 12).

FIGURE 10: ***MSC, Advised to Quit Smoking or Using Tobacco*****, 2023 NC Medicaid Performance by Ethnicity Status**

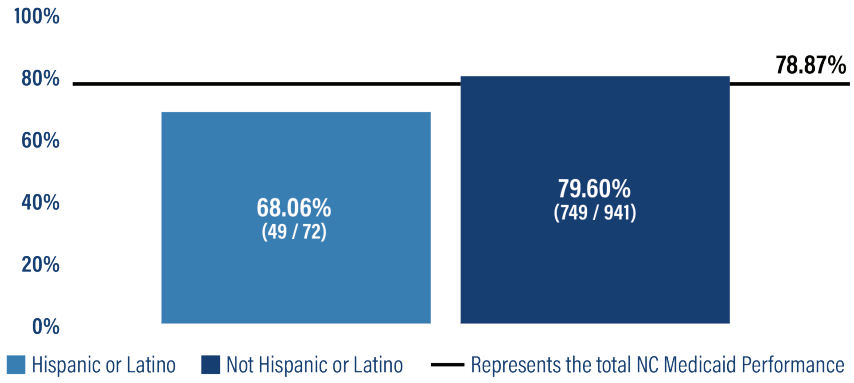


FIGURE 11: ***MSC, Discussing Cessation Medications*****, 2023 NC Medicaid Performance by Ethnicity Status**

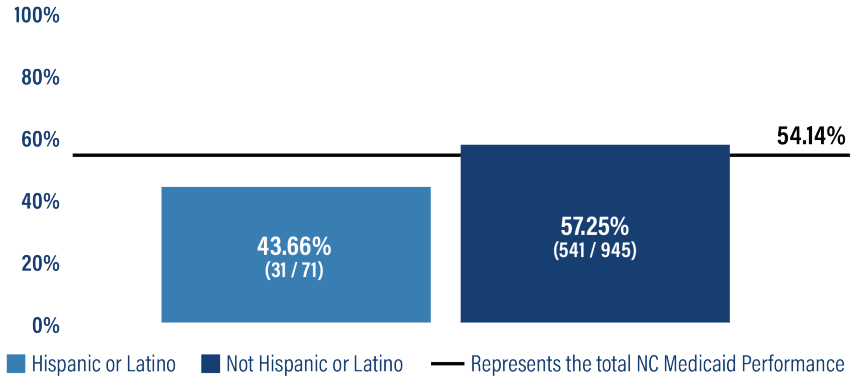
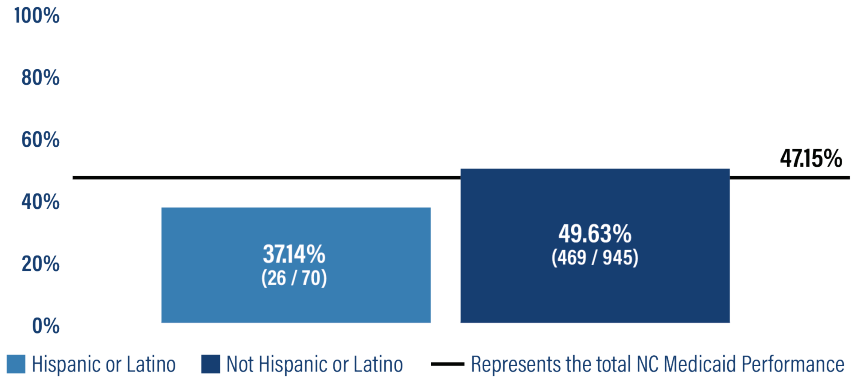


FIGURE 12: ***MSC, Discussing Cessation Strategies*****, 2023 NC Medicaid Performance by Ethnicity Status**



Patient Experience Co-Illustrations

CMS worked with a customer focused research group to develop co-creation illustrations to visualize barriers in accessing prevention, treatment, and recovery services for individuals with substance use disorders (SUD). CMS used Human-Centered Design (HCD) to develop these illustrations and to better understand the people for which government agencies are writing policies and creating programs and services.

Beacon of Hope & Pathways to Recovery & The Story of Sam

Child and Adolescent Health Domain Findings

The Child and Adolescent Health domain includes six measures that assess whether children and adolescents received oral health services, had regular well-child or well-care visits and received immunizations in alignment with the Bright Futures/American Academy of Pediatrics (AAP) recommendations. A recent systematic review underscored the importance of integrating prevention, such as immunization, developmental screenings, and oral health, into pediatric primary care to enhance child health outcomes.[55] The HHS Office of Population Affairs (OASH) advocates for routine health care visits for children and adolescents as they help prevent unhealthy behaviors, promote healthy decision-making, and reduce the likelihood of developing major health issues now and in the future.[56] NC Medicaid covers over half of the births in the state each year and insures three in seven of North Carolina's children.[57] Around 45% of NC Medicaid enrollees are younger than 19 years old, so child and adolescent health is a central priority for NC Medicaid.

Table 13 displays the statewide aggregates for the measures included in the Child and Adolescent Health domain.

TABLE 13: Child and Adolescent Health Domain NC Medicaid Aggregates

Child and Adolescent Health Domain Findings	MY2022	MY2023
Childhood Immunization Status, Combination 10 (CIS-10)	28.65%	24.54% ↓
Immunizations for Adolescents, Combination 2 (IMA-2)	29.69%	29.73% ↑
Well-Child Visits in the First 15 Months — Six or More Well-Child Visits (W30-6+)	61.72%	63.54% ↑
Well-Child Visits for Age 15 Months to 30 Months — Two or More Well-Child Visits (W30-2+)	66.90%	68.98% ↑
Child and Adolescent Well-Care Visits (WCV)	49.47%	51.51% ↑
Oral Evaluation, Dental Services (OEV)	48.49%	49.08% ↑

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

**CY 2023 NC Medicaid Aggregate rate represents the performance of NC Medicaid beneficiaries but excludes limited benefit members and dual eligibles. Please see appendix A "Partial Benefit Group Exclusions" section for more information*

See Appendix D for stratified results for all these measures.

[55] Bohaligah KM, Bohaligah MM, Bohaligah SM. Preventive Strategies for Pediatric Health in Primary Healthcare: A Systematic Review. Cureus. 2025 Feb 7;17(2):e78719. doi: 10.7759/cureus.78719. PMID: 40065858; PMCID: PMC11891502.
[56] Clinical Preventive Services. HHS Office of Population Affairs. (n.d.). https://opa.hhs.gov/adolescent-health/physical-health-developing-adolescents/clinical-preventive-services. Accessed on: March 13, 2026.
[57] Medicaid Delivery Reform and Value-Based Payment Update. (2022) North Carolina Department of Health and Human Services. Available here: https://medicaid.ncdhhs.gov/medicaid-delivery-reform-and-value-based-payment-update/download?attachment#:~:text=Maternal%20and%20Infant%20Health%20Reform,Carolina%2C%20most%20notably%20across%20race. Accessed on July 24, 2025.
[58] Childhood Immunization Status (CIS) Combination 10. National Committee for Quality Assurance (NCQA). (2023). Retrieved from https://www.ncqa.org/hedis/measures/childhood-immunization-status/

Childhood Immunization Status — Combination 10 (CIS–10)

The *Childhood Immunization Status — Combination 10* (CIS–10) measure assesses the percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.[58]

Estimated coverage for most childhood vaccines are lower among children born during 2020 and 2021, during the COVID-19 pandemic, compared to those born during 2018-2019. Research has identified financial barriers, access issues, vaccine hesitancy, and vaccine related misinformation as barriers to increasing coverage and reducing disparities.[62]

Childhood vaccines are crucial in protecting children from several serious and potentially life-threatening diseases, like measles, meningitis, polio, tetanus and whooping cough. These immunizations are given at a time when children are most vulnerable to disease and play a critical role in ensuring children receive necessary preventive care.[59] According to the CDC, coverage with most childhood vaccines was lower among children born during 2020–2021, compared with those born during 2018–2019. Disparities by race and ethnicity, health insurance status, poverty status and urbanicity persist.[60] These disparities have been linked to inadequate access to health care, lack of reliable transportation and childcare, knowledge around vaccines, language and cultural barriers.[61]

TABLE 14: Trends in Priority Population Performance for Childhood Immunization Status, Combination 10 (CIS–10) by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	21.72%	18.39% ↓
Living in a rural county	25.32%	21.41% ↓
Female	28.35%	24.53% ↓
Hispanic/Latino	41.66%	35.68% ↓
Speaking a non-English primary language	47.73%	42.38% ↓
Black and African American	20.13%	18.41% ↓
American Indian and Alaskan Native	27.25%	20.65% ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

[59] Centers for Disease Control and Prevention. Why Vaccinate. Available at: https://www.cdc.gov/vaccines/parents/why-vaccinate/index.html. Accessed on: Jun 28, 2023

[60] Hill HA, Yankey D, Elam-Evans LD, et al. Decline in Vaccination Coverage by Age 24 Months and Vaccination Inequities Among Children Born in 2020 and 2021 — National Immunization Survey-Child, United States, 2021–2023. MMWR Morb Mortal Wkly Rep 2024;73:844–853. DOI: http://dx.doi.org/10.15585/mmwr.mm7338a3.

[61] Kulkarni, A., Desai, R., Alcalá, H., & Balkrishnan, R. (2021). Persistent Disparities in Immunization Rates for the Seven-Vaccine Series Among Infants 19–35 Months in the United States. Health Equity, 5(1), 135-139. doi: 10.1089/heq.2020.0127. Retrieved from https://www.liebertpub.com/doi/pdf/10.1089/heq.2020.0127

[62] Hill HA, Yankey D, Elam-Evans LD, et al. Decline in Vaccination Coverage by Age 24 Months and Vaccination Inequities Among Children Born in 2020 and 2021 — National Immunization Survey-Child, United States, 2021–2023. MMWR Morb Mortal Wkly Rep 2024;73:844–853. DOI: Retrieved from http://dx.doi.org/10.15585/mmwr.mm7338a3.

For 2023, among children in NC Medicaid, no disparities were identified based on primary language, ethnicity or gender for the *Childhood Immunization Status — Combination 10* (CIS-10) measure. However, disparities were identified based on disability status, geography, Black and African American binary race and American Indian and Alaskan Native binary race. Please note, this measure was not assessed for age disparities.

- Beneficiaries who identified as having a disability fared worse than those who did not, with a relative difference of 25.33% (See Figure 13).
- Beneficiaries who live in rural counties fared worse than those who live in urban counties, with a relative difference of 16.40% (See Figure 14).
- Beneficiaries who identified as Black and African American fared worse than those who did not, with a relative difference of 35.34% (See Figure 15).
- Beneficiaries who identified as American Indian or Alaskan Native fared worse than those who did not, with a relative difference of 16.13% (See Figure 16).

FIGURE 13: CIS-10, 2023 NC Medicaid Performance by Disability Status

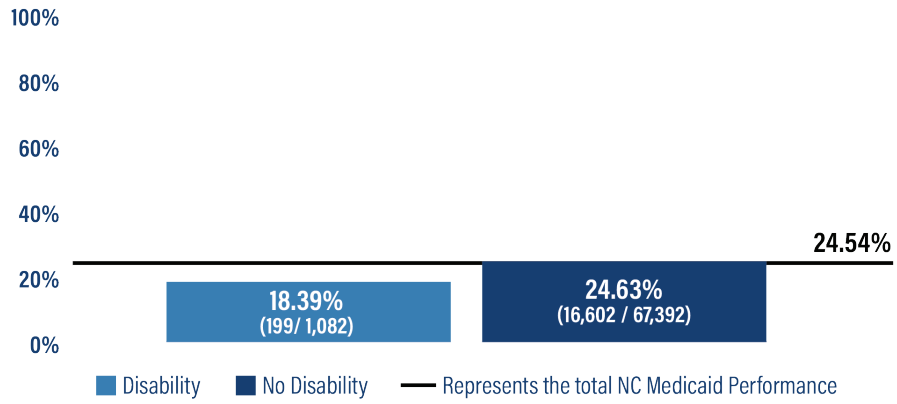


FIGURE 14: CIS-10, 2023 NC Medicaid Performance by Geography

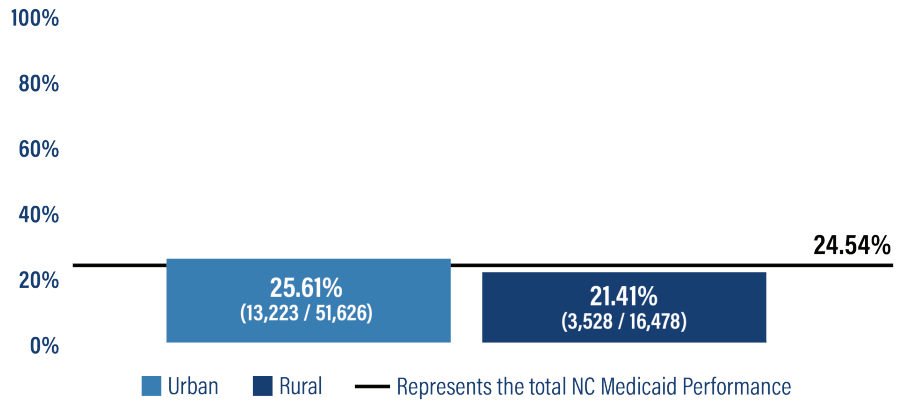


FIGURE 15: CIS-10, 2023 NC Medicaid Performance by Black and African American Binary

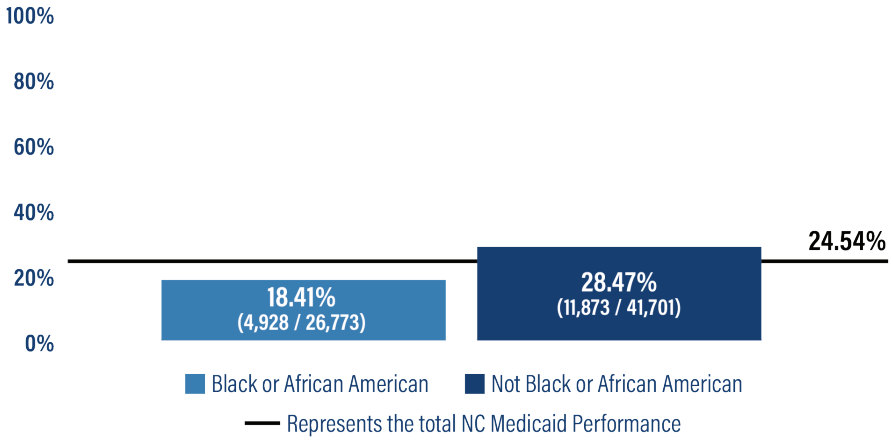
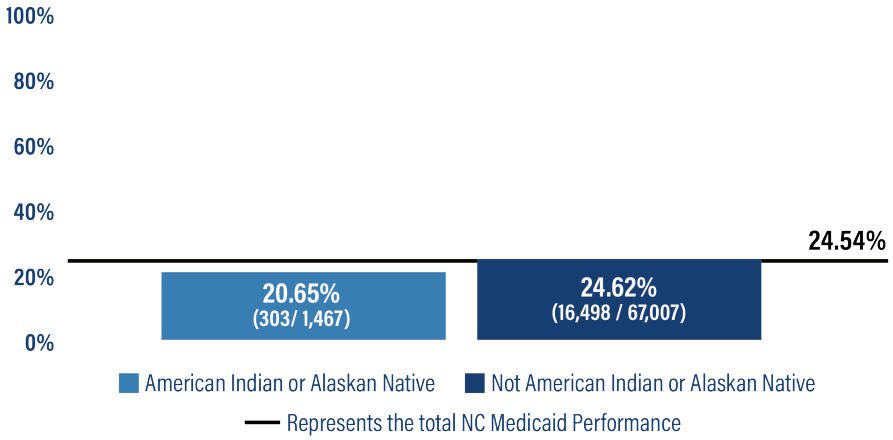


FIGURE 16: CIS-10, 2023 NC Medicaid Performance by American Indian and Alaskan Native Binary



NC Medicaid Standard Plan Withhold Program

The Department will be withholding a percentage of capitation payments from Standard Plans in 2024 to incentivize increasing measure performance and promoting health equity. To earn back these withheld dollars, plans must meet quality performance targets. CIS, Combination 10 is one of the three selected withhold measures. Standard Plans will be held accountable for overall CIS Combination 10 performance improvement, but also for priority population improvement. The priority population for this measure is Black or African American beneficiaries. This is a critical opportunity to address known disparities in CIS performance. To learn more you can review the Withhold Program Guidance Document.

Immunizations for Adolescents — Combination 2 (IMA–2)

The *Immunizations for Adolescents — Combination 2 (IMA–2)* measure assesses the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine; one Tdap vaccine; and have completed the HPV series by their 13th birthday.[63] Please note, this measure was not assessed for age disparities.

Vaccines are a safe and effective way to protect adolescents against potentially deadly diseases. The best defense against vaccine-preventable disease, including meningococcal meningitis, tetanus, diphtheria, pertussis (whooping cough), and HPV, is by receiving the recommended vaccinations.[64] These are serious diseases that can lead to breathing difficulties, heart problems, nerve damage, pneumonia, seizures, cancer and even death.[64] Nationally, adolescents have high rates of Tdap and meningococcal vaccination; however, rates for the HPV vaccination are much lower.[65] Despite overall progress in increasing vaccination coverage among adolescents, coverage disparities remain, particularly in areas with relatively high population density, also known as metropolitan statistical areas (MSAs). Receipt of the HPV vaccine was lower among adolescents living in non-MSAs than among adolescents living in MSAs.[66] Research on why children are unvaccinated has focused on vaccine hesitancy, the hesitancy to vaccinate despite availability, and under-vaccination, the lack of vaccination due to unavailability or inaccessibility of vaccines, often caused by resource deficits or structural disadvantage.[67, 68] A survey done in 2018, found that parental concerns around HPV vaccinations focused on safety worries, lack of necessity, knowledge about HPV and absence of physician recommendation.[69]

TABLE 15: IMA–2 by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	29.01%	28.83% ↓
Living in a rural county	32.11%	31.24% ↓
Female	31.23%	31.19% ↓
Hispanic/Latino	40.81%	40.69% ↓
Speaking a non-English primary language	44.20%	45.40% ↑
Black and African American	26.95%	27.45% ↑
American Indian and Alaskan Native	45.76%	40.13% ↓

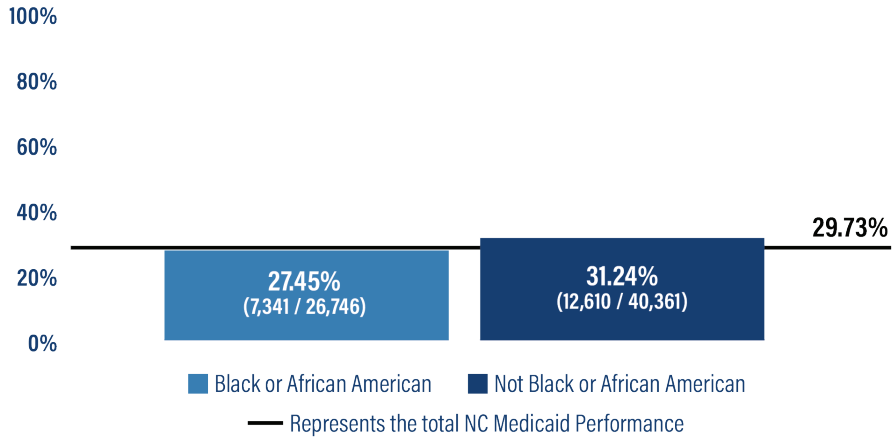
**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

[63] Immunizations for Adolescents (IMA) Combination 2. National Committee for Quality Assurance (NCQA). (2023). Retrieved from https://www.ncqa.org/hedis/measures/immunizations-for-adolescents/
[64] American Academy of Pediatrics. (2026, February 5). AAP immunization schedule. Red Book Online. Retrieved April 7, 2026, from https://publications.aap.org/redbook/resources/15585/AAP-Immunization-Schedule
[65] Immunizations for Adolescents (IMA) Combination 2. National Committee for Quality Assurance (NCQA). See National Average Tables on IMA webpage. (2023). https://www.ncqa.org/hedis/measures/immunizations-for-adolescents/
[66] Pingali C, Yankey D, Elam-Evans LD, et al. National Vaccination Coverage Among Adolescents Aged 13–17 Years — National Immunization Survey-Teen, United States, 2021. MMWR Morbidity Mortality Weekly Rep 2022; 71:1101–1108. DOI: Retrieved from http://dx.doi.org/10.15585/mmwr.mm7135a1
[67] MacDonald NE. Vaccine hesitancy: Definition, scope, and determinants. Vaccine. 2015. Aug 14;33(34):4161–4. doi: 10.1016/j.vaccine.2015.04.036
[68] Smith PJ, Chu SY, Barker LE. Children who have received no vaccines: Who are they and where do they live? Pediatrics. 2004. Jul 1;114(1):187–95. doi: 10.1542/peds.114.1.187
[69] Brewer, Sarah E., et al. "'but then that's another barrier': A qualitative study of parent and provider perspectives on rural versus urban disparities in adolescent vaccination." Vaccine, vol. 42, no. 26, Dec. 2024, p. 126456, https://doi.org/10.1016/j.vaccine.2024.126456.

Among adolescents enrolled in NC Medicaid in MY2023, no disparities were identified based on gender, geography, disability status, primary language, American Indian/Alaskan Native binary race or ethnicity for the IMA–2 measure. However, disparities were identified based on Black or African American binary race. Please note, this measure was not assessed for age disparities.

- Adolescent beneficiaries who identified as Black and African American fared worse than those who did not, with a relative difference of 12.13% (See Figure 17).

FIGURE 17: IMA-2, 2023 NC Medicaid Performance by Black or African American Binary Race



Well-Child Visits in the First 30 Months of Life

The Well-Child Visits in the First 30 Months of Life measure has two sub measures:

1. *Well-Child Visits in the First 15 Months — Six or More Well-Child Visits* (W30) measure assesses the percentage of beneficiaries who turned 15 months old during the measurement period and had six or more well-child visits with a PCP during the last 15 months.[70]
2. *Well-Child Visits in the First 30 Months of Life — Well-Child Visits for Age 15 Months to 30 Months — Two or More Well-Child Visits* (W30) measure assesses the percentage of children who turned 30 months old during the measurement period and had two or more well-child visits.

Well-child visits are essential for helping children stay healthy as these visits are used to track growth and developmental milestones, administer vaccinations to prevent illnesses and serve as an opportunity for parents/caretakers to discuss any concerns about their child's health.[71] Routine well-child visits ensure a collaborative partnership is formed between the pediatrician, parent and child.[72] Research has found that while well-child visit adherence has increased over the years, large racial and ethnic disparities remain.[73, 74] These disparities can, in part, be attributed to cultural barriers in seeking preventive care, the limitations that come with low socioeconomic status and limited access to care.[75] One study conducted in 2024 found that providers noted that provider trust and parent or guardian support were key interpersonal factors that support adolescents' access to health care services.[76]

[70] Well-Child Visits in the First 30 Months of Life (W30). National Committee for Quality Assurance (NCQA) (2023). Retrieved from https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/
[71] Centers for Disease Control and Prevention. Vaccines for Your Children: Catch up on Well-Child Visits and Recommended Vaccinations. Available at: https://www.cdc.gov/vaccines/parents/visit/vaccination-during-COVID-19.html. Accessed on: Jun 28, 2023.
[72] American Academy of Pediatrics. Family Life: AAP Schedule of Well-Childcare Visits; 2022. Available at: https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx. Accessed on: Jun 28, 2023.
[73] Garg A, Wilkie T, LeBlanc A, Lyu R, Scornavacca T, Fowler J, Rhein L, Alper E. Prioritizing Child Health: Promoting Adherence to Well- Child Visits in an Urban, Safety-Net Health System During the COVID-19 Pandemic. Jt Comm J Qual Patient Saf. 2022 Apr;48(4):189-195. doi: 10.1016/j.jcjq.2022.01.008. Epub 2022 Jan 26. PMID: 35216919; PMCID: PMC8789396.
[74] Abdus S, Selden TM. Adherence with recommended well-child visits has grown, but large gaps persist among various socioeconomic groups. Health Aff (Millwood). 2013 Mar;32(3):508-15. doi: 10.1377/hlthaff.2012.0691. PMID: 23459729.
[75] Ronsaville DS, Hakim RB. Well childcare in the United States: racial differences in compliance with guidelines. Am J Public Health. 2000 Sep;90(9):1436-43. doi: 10.2105/ajph.90.9.1436. PMID: 10983203; PMCID: PMC1447611
[76] Garney WR, Flores SA, Garcia KM, Panjwani S, Wilson KL. Adolescent Healthcare Access: A Qualitative Study of Provider Perspectives. Journal of Primary Care & Community Health. 2024;15. doi:10.1177/21501319241234586

TABLE 16: Trends in Priority Population Performance for Well-Child Visits in the *First 30 Months of Life, first 15 Months* by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	20.84%	25.58% ↑
Living in a rural county	64.22%	64.67% ↑
Female	61.82%	64.03% ↑
Hispanic/Latino	66.69%	68.35% ↑
Speaking a non-English primary language	66.08%	67.37% ↑
Black and African American	56.94%	58.53% ↑
American Indian and Alaskan Native	62.47%	62.64% ↑

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

Among children in NC Medicaid, no disparities were identified based on gender, primary language, ethnicity, American Indian/Alaskan Native binary race or geography for the *Well-Child Visits in the First 30 Months of Life — first 15 months of life* measure. However, disparities were identified based on disability status and Black or African American binary race. Please note, this measure was not assessed for age disparities.

- Child beneficiaries who identified as having a disability fared worse than those who did not, with a relative difference of 60.04% (See Figure 18).
- Child beneficiaries who identified as Black and African American fared worse than those who did not, with a relative difference of 12.29% (See Figure 19).

FIGURE 18: W30, First 15 Months, 2023 NC Medicaid Performance by Disability Status

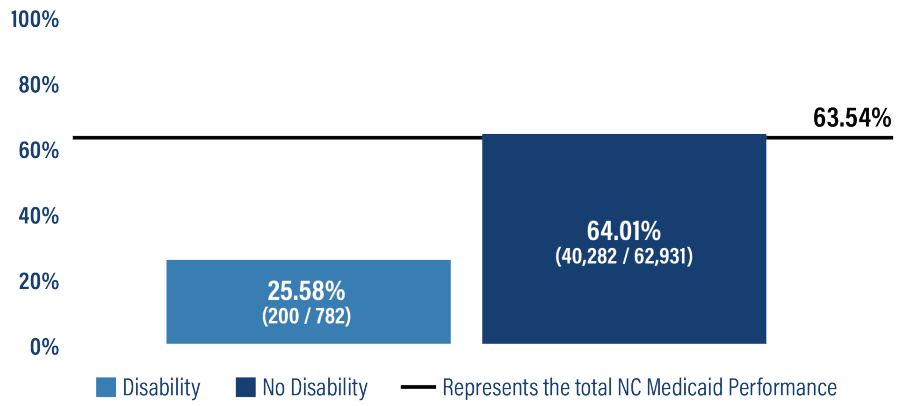


FIGURE 19: W30, First 15 Months, 2023 NC Medicaid Performance by Black and African American Binary

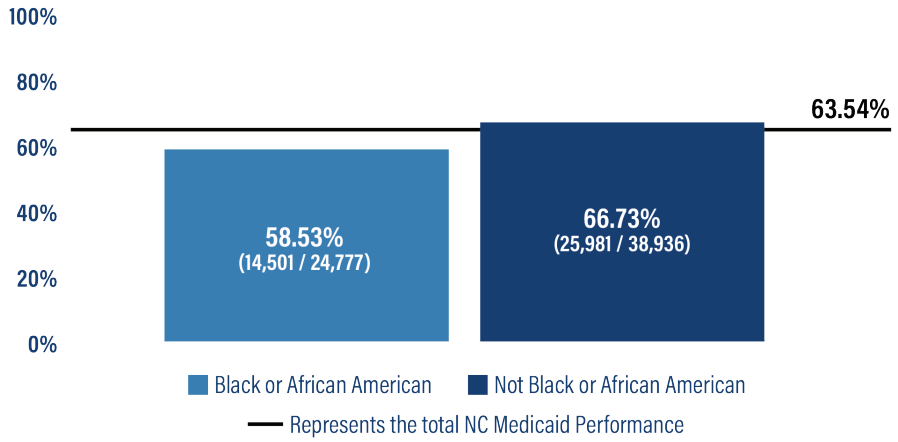


TABLE 17: Trends in Priority Population Performance for *Well-Child Visits in the First 30 Months of Life — Well-Child Visits for Age 15 Months to 30 Months* measure by Stratification Element

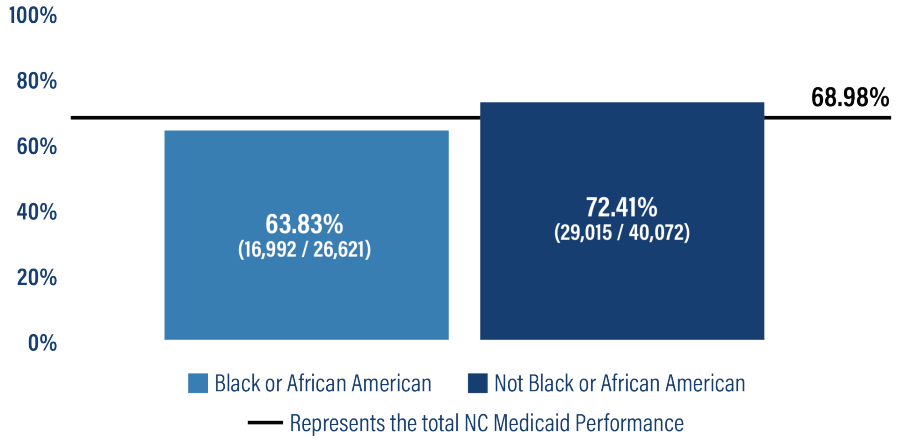
Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	69.03%	67.46% ↓
Living in a rural county	67.36%	69.85% ↑
Female	66.64%	68.67% ↑
Hispanic/Latino	75.08%	76.59% ↑
Speaking a non-English primary language	77.03%	77.68% ↑
Black and African American	61.26%	63.83% ↑
American Indian and Alaskan Native	66.80%	64.13% ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

For the second sub measure, Well-Child Visits in the First 30 Months of Life — Age 15 Months to 30 Months, no disparities were identified based on gender, disability status, geography, ethnicity, primary language or American Indian/Alaskan Native binary race. However, disparities were identified based on Black or African American binary race:

- Child beneficiaries who identified as Black and African American fared worse than those who did not, with a relative difference of 11.85% (See Figure 20).

FIGURE 20: W30, 15-30 Months, 2022 NC Medicaid Performance by Black or African American Binary Race



CMS Child Health Fact Sheets

CMS Autism Fact Sheet: Approximately five percent of children ages three to 17 with public insurance have autism or autism spectrum disorder (ASD), as reported by parents. This fact sheet, developed by the Centers for Medicare & Medicaid Services (CMS), provides more information on this population.

CMS ADHD Fact Sheet: Approximately 13 percent of children ages three to 17 with public insurance have attention-deficit/hyperactivity disorder (ADHD), as reported by parents. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit requires that all eligible children enrolled in Medicaid, and the Children's Health Insurance Program (CHIP), receive screenings designed to identify health and developmental issues, including ADHD, as early as possible. This fact sheet, developed by CMS, provides more information on this population.

Child and Adolescent Well-Care Visits (WCV)

The Child and Adolescent Well-Care Visits (WCV) measure assesses the percentage of beneficiaries three to 21 years of age who had at least one comprehensive well-care visit with a PCP or obstetrician/gynecologist (OB/GYN) during the measurement period.[77]

According to the AAP and Bright Futures, it is important for children and adolescents to receive timely comprehensive assessments in order to monitor development, identify health problems early and support parents and caretakers in making informed decisions about their child's health and well-being.[78] According to a 2022 study, the national rate of children receiving the recommended number of well-child visits has increased since 2007, but large gaps remain across race, ethnicity, poverty level, insurance and geography.[79] These disparities can, in part, be attributed to cultural barriers in seeking preventive care, limited maternal education and geographic access to care.[80]

[77] Child and Adolescent Well-Care Visits (WCV). National Committee for Quality Assurance (NCQA) (2023). Retrieved from https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/

[78] AAP and Bright Futures. Recommendations for Preventive Pediatric Health Care. 2022. Available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.154115824.997896208.1674250263-622056754.1553100444. Accessed on: Jun 28, 2023.

[79] Abdus S, Selden TM. Well-Child Visit Adherence. JAMA Pediatr. 2022;176(11):1143–1145. doi:10.1001/jamapediatrics.2022.2954

[80] Van Eck K, Thakkar M, Matson PA, Hao L, Marcell AV. Adolescents' Patterns of Well-Care Use Over Time: Who Stays Connected. Am J Prev Med. 2021 May;60(5):e221-e229. doi: 10.1016/j.amepre.2020.12.008. Epub 2021 Feb 27. PMID: 33648787; PMCID: PMC8068632.

TABLE 18: Trends in Priority Population Performance for WCV measure by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	51.27%	53.83% ↑
Living in a rural county	48.34%	50.90% ↑
Female	50.43%	52.32% ↑
Hispanic/Latino	57.60%	59.36% ↑
Speaking a non-English primary language	59.38%	60.54% ↑
Black and African American	47.24%	49.05% ↑
American Indian and Alaskan Native	48.40%	49.99% ↑

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

Among children and adolescents enrolled in NC Medicaid, no disparities were identified based on binary race, ethnicity, gender, primary language, disability status, LTSS needs status, or geography for the WCV measure. However, disparities were identified based on age:

- Adolescents aged 18 through 21 fared worse than children aged 3 through 11, with relative difference of 55.94% (See Figure 21).
- Adolescents aged 18 through 21 fared worse than adolescents aged 12 through 17, with relative difference of 49.36% (See Figure 22).

FIGURE 21: WCV, 2023 NC Medicaid Performance by Age Group, (3 through 11 versus 18 through 21)

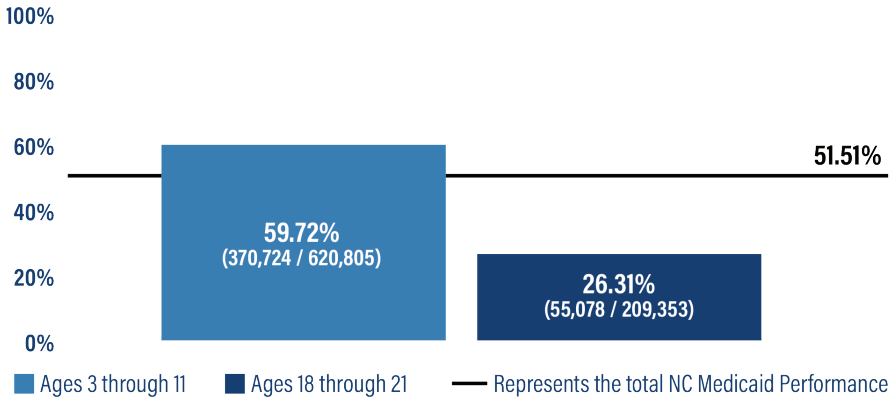
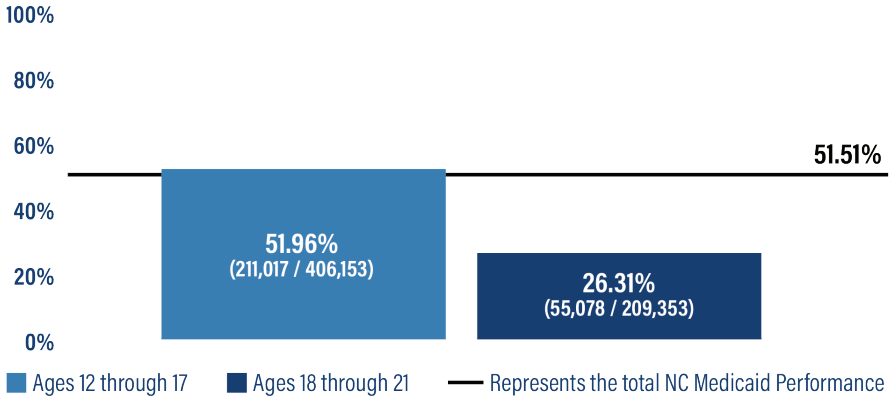


FIGURE 22: WCV, 2023 NC Medicaid Performance by Age Group, (12 through 17 versus 18 through 21)



The NC Integrated Care for Kids Model (InCK)

The NC Integrated Care for Kids Model (InCK) is a health equity-driven, child-centered local service delivery and state payment model aimed at improving quality of care and reducing expenditures for children insured by NC Medicaid in select North Carolina counties. NC InCK is working to integrate care for children across core child service areas to improve their well-being. In designing its care management services, the NC InCK team strived to design a family-led, strengths-based model that provides necessary, convenient care to children and families. To learn more, visit the InCK website. Three years after NC InCK's launch, the program has engaged over 2,650 children in care management services, outreached to over 6,300 families, and engaged families in qualitative interviews about their experiences with InCK care management services.

Oral Evaluation, Dental Services (OEV-CH)

The Oral Evaluation, Dental Services (OEV) measure assesses the percentage of children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year.[81]

Dental health is an important part of overall health and wellbeing. CMS suggests that a child's first dental visit should take place within six months of when a baby's first tooth appears, with continued preventive dental care visits twice a year. States are required to provide dental benefits to children covered by Medicaid, however, availability of and access to dental services can be a barrier. The CDC notes that disparities in oral health are preventable, and has reported disparities in oral health outcomes for certain populations, primarily due to social determinants of health, such as living in communities where they don't have access to fluoridated water, school sealant programs or healthy food.[82]

The United States' oral health has greatly improved since the 1960s, but not all communities have equal opportunities to experience these improvements.[83] As of 2024, around 57 million Americans live in dental health professional shortage areas and around 67% of those shortage areas are rural communities.[84] While this specific quality measure, OEV, is focusing on children, disparities in oral health exist among all age groups. These disparities exist by sex, poverty status, race and ethnicity, education level, and smoking status.[85]

TABLE 19: Trends in Priority Population Performance for OEV measure by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	46.03%	47.68% ↑
Living in a rural county	45.53%	47.05% ↑
Female	49.71%	50.24% ↑
Hispanic/Latino	61.28%	60.78% ↓
Speaking a non-English primary language	63.52%	62.05% ↓
Black and African American	44.62%	45.46% ↑
American Indian and Alaskan Native	45.33%	45.58% ↑

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

[81] Oral Evaluation, Dental Services (OEV-CH) Measure Summary (2024). Centers for Medicare and Medicaid Services (CMS). Available here: www.medicaid.gov/medicaid/quality-of-care/downloads/dentaloralhealth-ta-resource.pdf

[82] National Institute of Dental and Craniofacial Research. Oral Health in America: A Report of the Surgeon General. National Institutes of Health, US Department of Health, and Human Services; 2021. https://www.nidcr.nih.gov/research/oralhealthinamerica Accessed 9/10/2025.

[83] National Institutes of Health. *Oral Health in America: Advances and Challenges.* US Dept of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research; 2021. Accessed January 18, 2024. Retrieved from https://www.nidcr.nih.gov/sites/default/files/2021-12/Oral-Health-in-America-Advances-and-Challenges.pdf

[84] Health Workforce Shortage Areas: Explore HPSAs. Health Resources & Services Administration. Accessed January 18, 2024. Retrieved from https://data.hrsa.gov/topics/health-workforce/shortage-areas

[85] Centers for Disease Control and Prevention. *Oral Health Surveillance Report: Dental Caries, Tooth Retention, and Edentulism, United States, 2017-March 2020.* U.S. Dept of Health and Human Services; 2024. Accessed October 17, 2024. Retrieved from https://www.cdc.gov/oral-health/php/2024-oral-health-surveillance-report/index.html

Among children and adolescents in NC Medicaid, no disparities were identified based on ethnicity, gender, primary language, disability status, American Indian/ Alaskan Native binary race or geography for the OEV measure. However, disparities were identified based on Black or African American binary race and age:

- Child beneficiaries who identified as Black and African American fared worse than those who did not, with a relative difference of 11.54% (See Figure 23).
- Child beneficiaries who are 15 through 18 years old fared worse than those who are 12 through 14 years old, with a relative difference of 16.96% (See Figure 24).

FIGURE 23: OEV, Total Rate, 2023 NC Medicaid Performance by Black or African American Binary Race

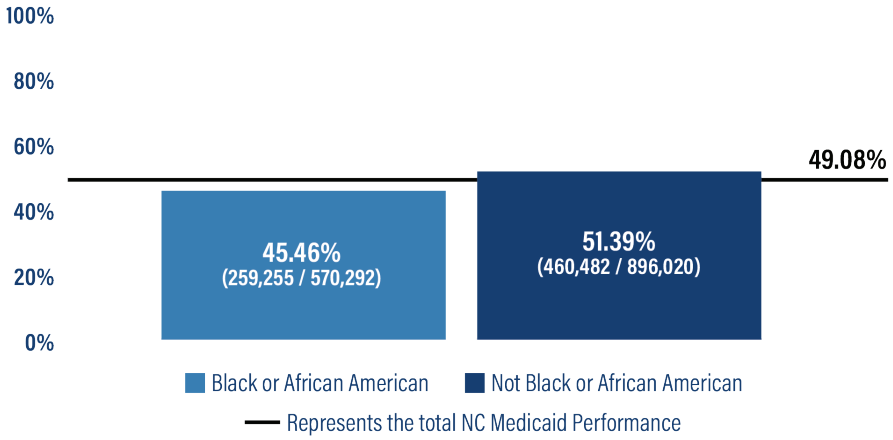
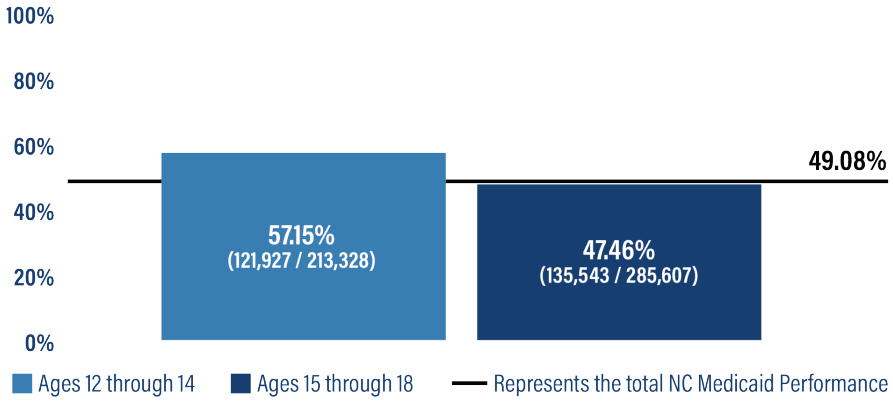


FIGURE 24: OEV, Total Rate, 2023 NC Medicaid Performance by Age Group



Oral Health Tips & Education

State public health dental hygienists provide oral health education and training programs that include videos, interactive demonstrations, and printed educational materials. Instruction covers dental disease prevention, oral hygiene practices, dental injury prevention and professional dental care practices. Programs are targeted toward all age groups with a focus on vulnerable populations, such as young children, the elderly and those with intellectual and developmental disabilities. Find these education materials here.

Women's Health Domain Findings

The Women's Health domain includes three measures related to important female screenings, and two measures related to prenatal and postpartum care. Individuals who identified as female make up roughly 56% of the total NC Medicaid enrolled population, and NC Medicaid focuses on this important population through a variety of programs and policies, some of which are described in this section.

Table 20 displays the statewide aggregates for the measures included in the Women's Health domain.

TABLE 20: Women's Health Domain NC Medicaid Aggregates

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Cervical Cancer Screening (CCS)	50.80%	42.67% ↓
Chlamydia Screening in Women (CHL) (total)	57.07%	59.17% ↑
Prenatal and Postpartum Care (PPC) — Timeliness of Prenatal Care	41.91%	43.92% ↑
Prenatal and Postpartum Care (PPC) — Postpartum Care	60.86%	60.71% ↓
Breast Cancer Screening (BCS)	46.36%	32.81% ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

**CY 2023 NC Medicaid Aggregate rate represents the performance of NC Medicaid beneficiaries but excludes limited benefit members and dual eligibles. Please see appendix A "Partial Benefit Group Exclusions" section for more information*

See Appendix D for stratified results for all these measures.

CMS Maternal Health Factsheet

More than one out of every four Medicaid and Children's Health Insurance Program (CHIP) beneficiaries are females in their reproductive years (ages 15 through 49), and Medicaid finances about 41% of all births in the United States.

This CMS infographic provides an overview of the demographics, access to care, health status, health outcomes, risk factors, and health care utilization among beneficiaries seeking pregnancy-related care and those with a recent live birth.

Cervical Cancer Screening

The Cervical Cancer Screening (CCS) measure assesses the percentage of beneficiaries ages 21 through 64 who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria:

- Beneficiaries ages 21 through 64 who were recommended for routine cervical cancer screening and had cervical cytology performed within the last three years.
- Beneficiaries 30 to 64 years of age, who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing within the last five years.
- Beneficiaries 30 to 64 years of age, who were recommended for routine cervical cancer screening and had cervical cytology/hrHPV co-testing within the last five years.[86]

[86] Cervical Cancer Screening (CCS). National Committee on Quality Assurance (NCQA). (2023). Retrieved from https://www.ncqa.org/hedis/measures/cervical-cancer-screening/

Although preventable, cervical cancer is one of the most common cancers among individuals who identify as female worldwide. Human papillomavirus (HPV) is a sexually transmitted virus that is believed to be responsible for most cases of cervical cancer.[87] Despite encouraging clinical advances in cervical cancer prevention and detection, disparities persist between racial and ethnic groups throughout the cervical cancer continuum.[88]

The USPSTF recommends screening for chlamydia in sexually active women 24 years and younger or 25 years or older and at increased risk of infection.[89] Under-screened women are more likely to be diagnosed with invasive cervical cancer at later stages and have worse survival outcomes. Under- or un-insured women, low-income women and minoritized groups face barriers to screening, including lack of insurance and cost.[90] Access to reliable transportation, knowledge of affordable clinics, adequate health literacy and trust in a patient's health care provider can all impact whether someone is screened for cervical cancer.[91]

American Association for Cancer Research (AACR)

The goal of cancer screenings is to find precancer or cancer at the earliest possible time in development. Screening tests have been widely used across the U.S. to detect breast, cervical, colorectal, and prostate cancers. Despite clinical guidelines, many people do not get screened, including a disproportionate number of individuals who identify with populations that have been systemically marginalized. Review AACR's Cancer Disparities Progress Report here.

TABLE 21: Trends in Priority Population Performance for Cervical Cancer Screening (CCS) measure by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	45.16%	42.62% ↓
Living in a rural county	51.91%	44.34% ↓
Female	50.80%	42.68% ↓
Hispanic/Latino	53.86%	47.06% ↓
Speaking a non-English primary language	50.55%	41.47% ↓
Black and African American	54.14%	46.42% ↓
American Indian and Alaskan Native	53.61%	46.15% ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

Although performance declined across all demographic groups from 2022 to 2023, the relative differences between groups did not meet NC Medicaid's ≥10% disparity threshold. Among those who identify as women in NC Medicaid, no disparities were identified in any of the demographic strata in 2023.

87 World Health Organization. Cervical Cancer Webpage. Accessed on 3/27/2025. Retrieved from https://www.who.int/news-room/fact-sheets/detail/cervical-cancer#:~:text=Persistent%20HPV%20infection%20of%20the,causes%2095%25%20of%20cervical%20cancers.

88 Perkins, R., & Mitchell, E. (2023). Cervical cancer disparities. Journal of the National Medical Association, 115(2), S19–S25. https://doi.org/10.1016/j.jnma.2023.02.006

89 United States Preventive Services Task Force. Chlamydia and Gonorrhea: Screening. Available at: https://www.uspreventiveservicestaskforce.org/uspstf/document/final-evidence-summary/chlamydia-and-gonorrhea-screening. Accessed on: July 24, 2025

90 Zeno EE, Brewer NT, Spees LP, Des Marais AC, Sanusi BO, Hudgens MG, Jackson S, Barclay L, Wheeler SB, Smith JS. Racial and ethnic differences in cervical cancer screening barriers and intentions: The My Body My Test-3 HPV self-collection trial among under-screened, low-income women. PLoS One. 2022 Oct 13;17(10):e0274974. doi: 10.1371/journal.pone.0274974. PMID: 36227948; PMCID: PMC9562154.

91 Dr. Cardenas-Trowers. The Link Between Racial Disparities and Cervical Cancer. (2022). The Mayo Clinic. Q&A Podcast. Retrieved from https://newsnetwork.mayoclinic.org/discussion/mayo-clinic-qa-podcast-the-link-between-racial- disparities-and-cervical-cancer/

Chlamydia Screening in Women (CHL)

The Chlamydia Screening in Women (CHL) measure assesses the percentage of women ages 16 through 24 who were identified as sexually active and had at least one test for chlamydia during the measurement year.[92]

Chlamydia is the most frequently reported bacterial sexually transmitted infection (STI) in the United States.[93] In 2023, there were more than 2.4 million STIs reported in the United States, with 1.6 million of those being chlamydia.[94] Chlamydia is most prevalent among adolescent and young females, with almost two-thirds of all reported infections occurring among people ages 15 through 24. If left untreated, chlamydia can lead to severe and permanent complications including pelvic inflammatory disease and infertility.[95] Chlamydia screening remains an underused preventive health service for young women of all racial and ethnic groups. Black or African American women tend to have higher rates of chlamydia testing than people in other racial/ethnic groups.[96] Research has found that racial bias may play a part in screening practices.[97] These screenings should be informed by people's risk for contracting STIs, rather than demographic characteristics.

TABLE 22: Trends in Priority Population Performance for Chlamydia Screening in Women measure by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	39.55%	40.41% ↑
Living in a rural county	54.66%	56.70% ↑
Hispanic/Latino	59.55%	62.77% ↑
Speaking a non-English primary language	59.58%	63.75% ↑
Black and African American	64.58%	66.73% ↑
American Indian and Alaskan Native	58.71%	62.46% ↑

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

Among those who identify as women in NC Medicaid, no disparities were identified based on ethnicity, primary language, American Indian/Alaskan Native or Black and African American binary race, or geography for the CHL measure. However, disparities were identified based on disability status and age

- Beneficiaries who identified as having a disability fared worse than those who did not, with a relative difference of 32.68% (See Figure 25).
- Beneficiaries ages 16 through 20 fared worse than those ages 21 through 24, with a relative difference of 12.27% (See Figure 26).

[92] Chlamydia Screening in Women (CHL). National Committee for Quality Assurance (NCQA). (2023). Retrieved from https://www.ncqa.org/hedis/measures/chlamydia-screening-in-women/
[93] CDC. Sexually Transmitted Disease Surveillance, 2021. Atlanta, GA: Department of Health and Human Services; April 2023.
[94] Centers for Disease Control and Prevention (CDC). National Overview of STIs in 2023 Retrieved from. https://www.cdc.gov/sti-statistics/annual/summary.html
[95] United States Preventive Services Task Force. Chlamydia and Gonorrhea: Screening. Available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/chlamydia-and-gonorrhea-screening#bootstrap-panel--4. Accessed on: Jun 28, 2023.
[96] Patel CG, Chesson HW, Tao G. Racial Differences in Receipt of Chlamydia Testing Among Medicaid-Insured Women in 2013. Sex Transm Dis. 2016 Mar;43(3):147-51. doi: 10.1097/OLQ.0000000000000405. PMID: 26859801; PMCID: PMC6784822.
[97] Wood S, Min J, Tam V, Pickel J, Petsis D, Campbell K. Inequities in Chlamydia trachomatis Screening Between Black and White Adolescents in a Large Pediatric Primary Care Network, 2015-2019. Am J Public Health. 2022 Jan;112(1):135-143. doi: 10.2105/AJPH.2021.306498. PMID: 34936422; PMCID: PMC8713640.

FIGURE 25: CHL, 2023 NC MEDICAID PERFORMANCE BY DISABILITY STATUS

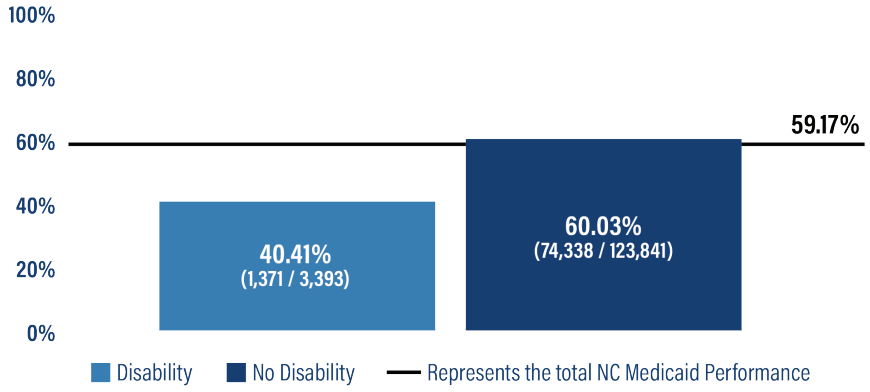


FIGURE 26: CHL, 2023 NC Medicaid Performance by Age Group

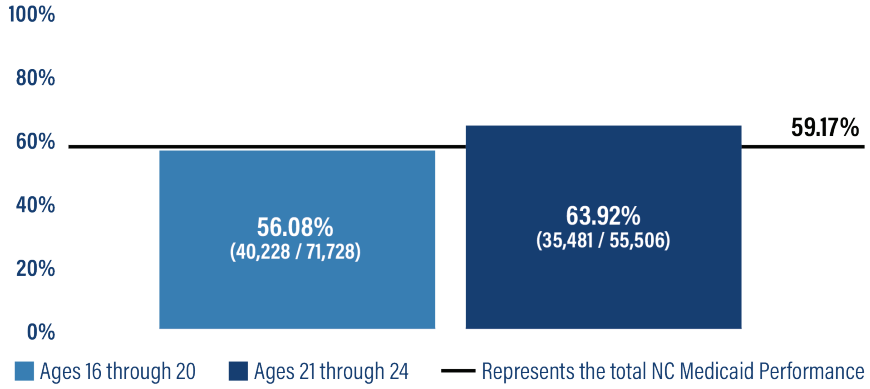
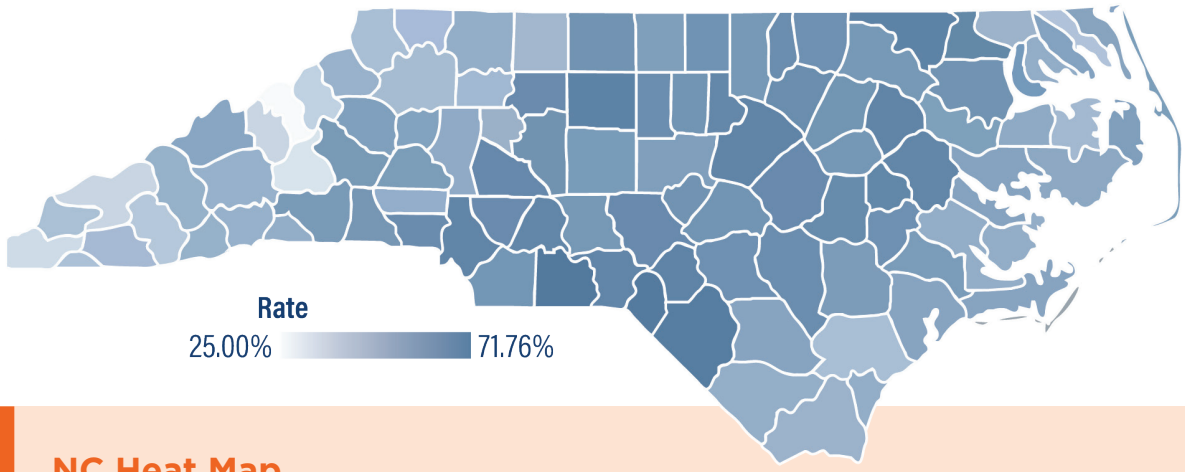


FIGURE 27: CHL, 2023 NC Medicaid, Map of Performance by Residential County



NC Heat Map

When looking at chlamydia screening rates at the county level you can see that counties in the Charlotte metro, Triangle and Triad regions have the highest rates (see Figure 27). Counties in the northeastern and far western regions are faring worse for this measure, and this aligns with trends in health care shortage areas in NC. In counties designated as health professional shortage areas, it would be more difficult for women to access chlamydia screenings.

NCDHHS STD/STI Information

NC local health departments provide free and confidential STD screening and clinical services as well as information on organizations, programs and services available in your community. Find your local health department here.

- National HIV/STD Hotline: 1-800-CDC-INFO (1-800-232-4636)
- American Sexual Health Association (ASHA) Sexually Transmitted Infections Resource Center Hotline: 1-919-361-8488 (8 a.m. to 6 p.m. Eastern Time, M-F) provides information, materials and referrals to anyone concerned about sexually transmitted infections (STI). Or visit ASHA online

Prenatal and Postpartum Care

The Prenatal and Postpartum Care (PPC) measure has two submeasures, which assess:

- Timeliness of Prenatal Care: The percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before enrollment start date or within 42 days of enrollment in the organization.
- Postpartum Care: The percentage of deliveries in which women had a postpartum visit on or between seven and 84 days after delivery.[98]

The United States continues to have the highest rate of maternal mortality of any high-income nation, despite a decline since the COVID-19 pandemic. The maternal mortality rate for 2023 decreased to 18.6 deaths per 100,000 live births, compared to 22.3 in 2022.[99] These outcomes are not evenly distributed; American Indian, Alaskan Native and Black women are two to three times more likely to die of pregnancy-related causes than White women.[100] Structural racism and implicit bias can play a role in these disparities, as well as access to care and economic inequities.[101, 102] Studies indicate that around 80% of all pregnancy-related deaths could be prevented if birthing people had better access to health care and education, received better quality of care and made changes in their health and lifestyle habits.[103]

[98] Prenatal and Postpartum Care (PCC). National Committee for Quality Assurance (NCQA). (2023). Retrieved from: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/
[99] Hoyert, Donna Ph.D. Health E-Stat 100: Maternal Mortality Rates in the United States, 2023. (Feb 2025). National Center for Health Statistics. Accessed 5/22/2025. Retrieved from https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2023/Estat-maternal-mortality.pdf
[100] Pregnancy Related Deaths in the United States. (2022). Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/hearher/pregnancy-related-deaths/index.html
[101] Barfield,Wanda MD, MPH. Addressing Health Inequities Among Pregnant People. (2022). Hear Her Campaign. CDC. Retrieved from https://www.cdc.gov/hearher/news-media/article-health-inequities.html#:~:text=CDC%20launched%20the%20Hear%20Her,and%2C%20unfortunately%2C%20some%20die. Accessed July 24, 2025
[102] Hill, Latoya. Artiga, Samantha. Ranji, Usha. Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them. (2022). KFF. Retrieved from https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial- disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/#:~:text=Maternal%20and%20infant%20health%20disparities,outcomes%20for%20people%20of%20color. Accessed July 24, 2025
[103] Preventing Pregnancy Related Deaths. (2024) CDC. Maternal Mortality Prevention. Retrieved from https://www.cdc.gov/maternal-mortality/preventing-pregnancy-related-deaths/index.html Accessed on July 24, 2025

TABLE 23: Trends in Priority Population Performance for PPC, Timeliness of Prenatal Care measure by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	49.47%	48.89% ↓
Living in a rural county	43.86%	44.31% ↑
Hispanic/Latino	45.07%	45.76% ↑
Speaking a non-English primary language	44.75%	44.15% ↓
Black and African American	40.75%	42.86% ↑
American Indian and Alaskan Native	34.65%	32.96% ↓

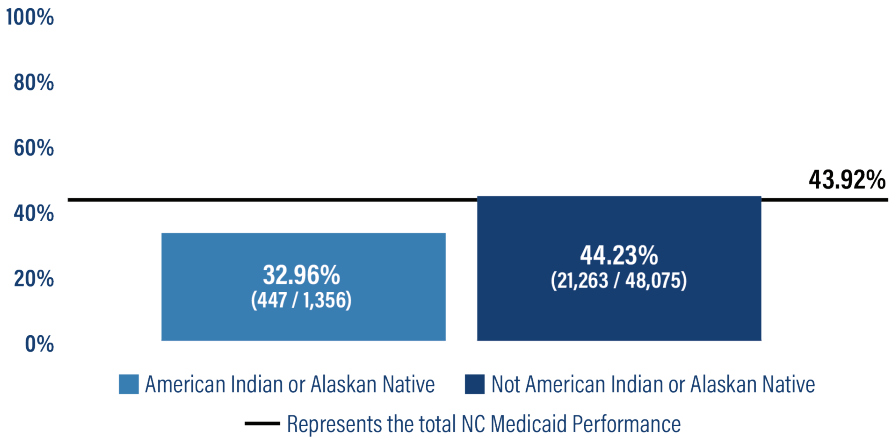
**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

Despite continued advancements in medical care, stark disparities in maternal and infant health persist in the United States. Pregnancy-related mortality rates among American Indian and Alaskan Native and Black and African American women are over three times higher than the rate for White women.[104] These disparities reflect broader underlying social and economic inequities that are rooted in differential access and discrimination.

Among birthing NC Medicaid beneficiaries, no disparities were identified based on primary language, ethnicity, geography, Black or African American binary race or age for either sub measures of the PPC measure. However, disparities were identified based on American Indian/ Alaskan Native binary race for the prenatal sub measure and American Indian/Alaskan Native binary race and disability status for the postpartum sub measure.

- Beneficiaries who identified as American Indian and Alaskan Native fared worse in prenatal care than those who did not, with a relative difference of 25.48% (See Figure 28).
- Beneficiaries who identified as American Indian and Alaskan Native fared worse in postpartum care than those who did not, with a relative difference of 10.12% (See Figure 29).
- Beneficiaries who identified as having a disability fared worse in postpartum care than those who did not, with a relative difference of 17.49% (See Figure 30).

FIGURE 28: PPC, Timeliness of Prenatal Care, 2023 NC Medicaid Performance by American Indian and Alaskan Native Binary Race



[104] Hill, L., Rao, A., Artiga, S., & Ranji, U. (2025, March 11). Racial Disparities in maternal and Infant health: Current status and efforts to address them | KFF. KFF. Retrieved from https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/

FIGURE 29: PPC, Postpartum Care, 2023 NC Medicaid Performance by American Indian and Alaskan Native Binary Race

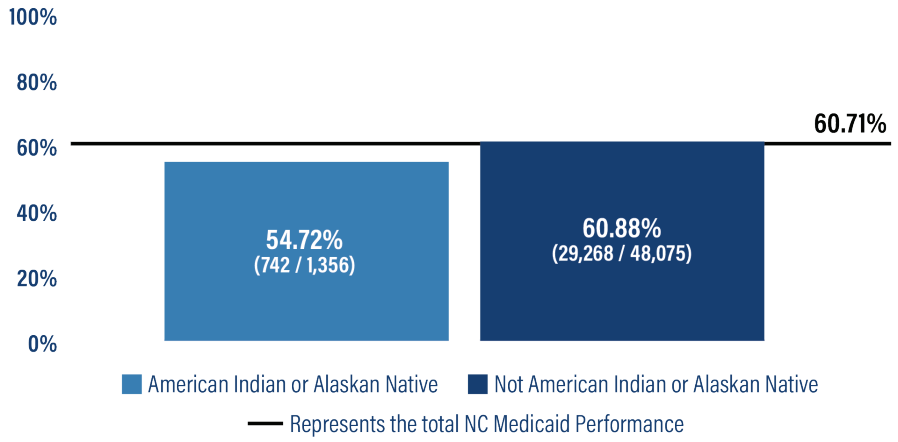


FIGURE 30: PPC, Postpartum Care, 2023 NC Medicaid Performance by Disability Status

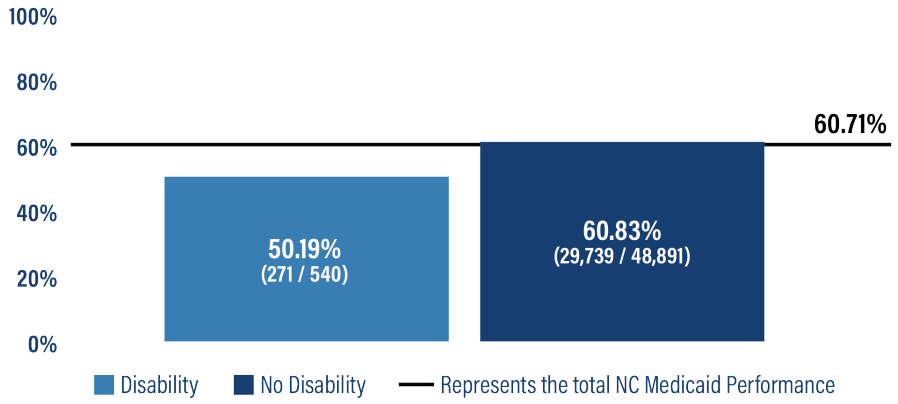


TABLE 24: Trends in Priority Population Performance for Prenatal and Postpartum Care (PPC), Postpartum measure by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	53.71%	50.19% ↓
Living in a rural county	57.33%	58.12% ↑
Hispanic/Latino	69.12%	67.46% ↓
Speaking a non-English primary language	73.27%	72.88% ↓
Black and African American	58.75%	58.00% ↓
American Indian and Alaskan Native	53.54%	54.72% ↑

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

PPC F Codes

Timely and adequate prenatal and postpartum care is important for ensuring the long-term health and well-being of pregnant people and their infants. Currently, NC Medicaid is performing below the national average on the Prenatal and Postpartum Care (PPC) quality measure. NC Medicaid believes that data quality is the main driver of this low performance. Prenatal and postpartum related services are often documented using global billing codes, which can obscure any instance of prenatal care. To improve data collection and ensure a complete and more accurate picture of prenatal and postpartum care delivery, two new, non-paid, F codes have been added to NC Medicaid's clinical policy. Both codes are meant to support more accurate and complete data collection around prenatal and postpartum care delivery in North Carolina and is required for providers (requirement began on July 1st, 2025). To learn more about the F codes visit this fact sheet linked here.

Division of Public Health (DPH) Maternal Health Dashboard

The NCDHHS DPH Maternal Health Dashboard was created to provide data showing trends, racial/ethnic inequities, maternal age, maternal education, and geographical differences for a variety of important health indicators describing maternal risk factors and characteristics as well as birth outcomes. The indicators included in the dashboard include low birthweight, preterm births, smoking during pregnancy and gestational diabetes among others. NC Medicaid recently partnered with the Division of Public Health (DPH) to add a Maternal Medicaid Status strata to the dashboard. This new strata permits users to stratify results by the mother's Medicaid status, allowing users to compare rates for births covered by Medicaid, births that were not covered by Medicaid and total births in NC. Additionally, the Maternal Medicaid Status strata can be further stratified by perinatal care region and/or residential county, allowing users to evaluate performance in different parts of the state. Dashboard linked here.

Breast Cancer Screening

The Breast Cancer Screening (BCS) measure assesses the percentage of beneficiaries ages 50 through 74 who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer in the past two years.

With the exception of skin cancer, breast cancer is the most common cancer in women in the United States, with it accounting for roughly 30% (or 1 in 3) of all new female cancers each year.[105] Breast cancer mainly occurs in middle-aged and older women. While breast cancer-related deaths are decreasing in the United States overall, disparities still exist. In 2024, Black women have 5% lower breast cancer incidence than White women, but 38% higher mortality, this is often attributed to later diagnosis and less access to high-quality treatment.[106]

[105] American Cancer Society. Key Statistics for Breast Cancer. Accessed on 5/13/2025. Retrieved from https://www.cancer.org/cancer/types/breast-cancer/about/how-common-is-breast-cancer.html
[106] American Cancer Society. Breast Cancer Facts and Figures. (2024-2025). Accessed 7/24/2025. Retrieved from https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/breast-cancer-facts-and-figures/2024/breast-cancer-facts-and-figures-2024.pdf

Note for data interpretation: BCS is one of the measures impacted by NC Medicaid Expansion. A large portion of the Expansion population was aged 50 through 64, and many of these beneficiaries were limited benefit members prior to Expansion. The eligible population for BCS in 2022 was 34,000 and increased to roughly 54,000 in 2023, possibly indicating that the limited benefit beneficiary population that qualified for full benefits after Expansion were included in the denominator of the measure but were not numerator compliant given that Expansion occurred at the end of the measurement year (December 2023). Given this change, performance trends for this measure should be interpreted with caution,

TABLE 25: Trends in Priority Population Performance for BCS measure by Stratification Element

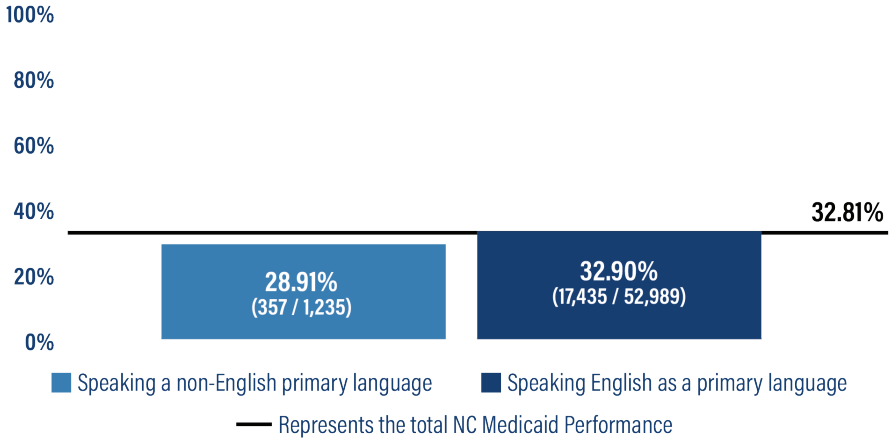
Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	47.33%	47.47% ↑
Living in a rural county	47.32%	35.21% ↓
Female	N/A	N/A
Hispanic/Latino	51.58%	31.08% ↓
Speaking a non-English primary language	54.95%	28.91% ↓
Black and African American	50.24%	35.89% ↓
American Indian and Alaskan Native	46.19%	34.99% ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

Among beneficiaries in NC Medicaid, disparities were not identified based on ethnicity, binary race, disability status, or geography, despite large absolute decreases across multiple groups from 2022 to 2023. However, disparities were identified based on primary language for the BCS measure:

- Beneficiaries who identified as speaking a non-English language as their primary language fared worse in breast cancer screening than those who speak English as their primary language, with a relative difference of 12.13% (See Figure 31).

FIGURE 31: BCS, 2023 NC Medicaid Performance by Primary Language



Mental Health Domain Findings

The Mental Health domain includes two measures related to follow-up visits for mental illness and two measures related to care for beneficiaries using antipsychotics. Ensuring beneficiaries receive timely follow-up care following ED visits or hospitalizations for mental illness allows providers to reassess treatment plans and medications, and connect beneficiaries with additional services, which may help prevent subsequent ED visits or hospitalizations.[107]

In the United States, people from racial, ethnic, gender and sexual minoritized groups often suffer from worse mental health outcomes due to multiple factors including cultural stigma surrounding mental health care, discrimination, access to care and the impacts of low socioeconomic status.[108] In 2024, 23% of adults in the United States and 22% of adults in North Carolina experiences any mental illness.[109] Medicaid enrollees have a higher overall prevalence of moderate to severe mental illness or substance use disorders compared to the general population. As of 2020, nationally, an estimated 29% of Medicaid enrollees have a mental illness, relative to 21% of privately insured and 20% of uninsured people.[110]

Table 26 displays the statewide aggregates for the measures included in the Mental Health domain.

TABLE 26: Mental Health Domain NC Medicaid Aggregates

Mental Health Domain Measures	CY2022 NC Medicaid Aggregate	CY2023 NC Medicaid Aggregate*
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	64.63%	63.64% ↓
Follow-Up After Hospitalization for Mental Illness 7-Day Follow-Up (FUH-7)	24.55%	22.86% ↓
Follow-Up After Hospitalization for Mental Illness 30-Day Follow-Up (FUH-30)	42.65%	41.31% ↓
Follow-Up After ED Visit for Mental Illness 7-Day Follow-Up (FUM-7)	42.64%	39.82% ↓
Follow-Up After ED Visit for Mental Illness 30-Day Follow-Up (FUM-30)	58.80%	55.41% ↓
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	44.23%	43.12% ↓
American Indian and Alaskan Native	46.19%	34.99% ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

**CY 2023 NC Medicaid Aggregate rate represents the performance of NC Medicaid beneficiaries but excludes limited benefit members and dual eligibles. Please see appendix A "Partial Benefit Group Exclusions" section for more information.*

See Appendix D for stratified results for all these measures.

[107] Beadles CA, Ellis AR, Lichstein JC, et al. First Outpatient Follow-Up After Psychiatric Hospitalization: Does One Size Fit All? Psychiatric Services. 2015; 66(4):364-372. Available at: https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201400081. Accessed on: Jun 28, 2023.

[108] Mental health disparities: Diverse Populations. American Psychiatric Association. Retrieved from https://www.psychiatry.org/psychiatrists/diversity/education/mental-health-facts

[109] Adult Prevalence of Mental Illness (AMI). (2024). Mental Health America (MHA). https://mhanational.org/wp-content/uploads/2024/12/2024-State-of-Mental-Health-in-America-Report.pdf Accessed on July 24, 2025.

[110] Saunders, H., & Rudowitz, R. (2022, June 6). Demographics and health insurance coverage of nonelderly adults with mental illness and substance use disorders in 2020. KFF. Retrieved from https://www.kff.org/medicaid/issue-brief/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020

Adherence to Antipsychotic Medications for Individuals with Schizophrenia

The *Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)* measure assesses adults 18 years of age and older who have schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.[110]

Antipsychotic medications have been effective at alleviating symptoms, preventing relapse and improving life expectancy for those with schizophrenia; however, lack of medication adherence can cause many challenges.[111] Schizophrenia is a chronic psychiatric disorder that requires ongoing treatment and monitoring.[112] Antipsychotic medications have been effective at alleviating symptoms, preventing relapse and improving life expectancy for those with schizophrenia.[113] Medication non-adherence is common and a major concern in the treatment of schizophrenia. Disparities in the use of antipsychotic medications for schizophrenia exist, with racial and ethnic groups often receiving different and potentially less optimal treatment compared to their White counterparts.[114]

Projected Cost and Economic Impact of Mental Health Inequities in the United States

This report addresses both the current and projected economic burden of mental health inequities, while underscoring the integral link between mental health and chronic conditions. Report linked here.

TABLE 27: Trends in Priority Population Performance for *Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)* measure by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	68.73%	68.47% ↓
Living in a rural county	65.84%	63.71% ↓
Female	64.41%	63.44% ↓
Hispanic/Latino	66.58%	69.04% ↑
Speaking a non-English primary language	78.00%	66.67% ↓
Black and African American	60.64%	59.49% ↓
American Indian and Alaskan Native	61.84%	57.74% ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

[110] Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA). National Committee for Quality Assurance (NCQA). (2023). Retrieved from https://www.ncqa.org/hedis/measures/adherence-to-antipsychotic-medications- for-individuals-with-schizophrenia/

[111] Guo J, Lv X, Liu Y, et al. Influencing factors of medication adherence in schizophrenic patients: a meta-analysis. Schizophrenia. 2023. 9(31). Available at: https://www.nature.com/articles/s41537-023-00356-x. Accessed on: Jun 28, 2023.

[112] Mayo Clinic. Schizophrenia. Available at: https://www.mayoclinic.org/diseases-conditions/schizophrenia/diagnosis-treatment/drc-20354449. Accessed on: Jun 28, 2023.

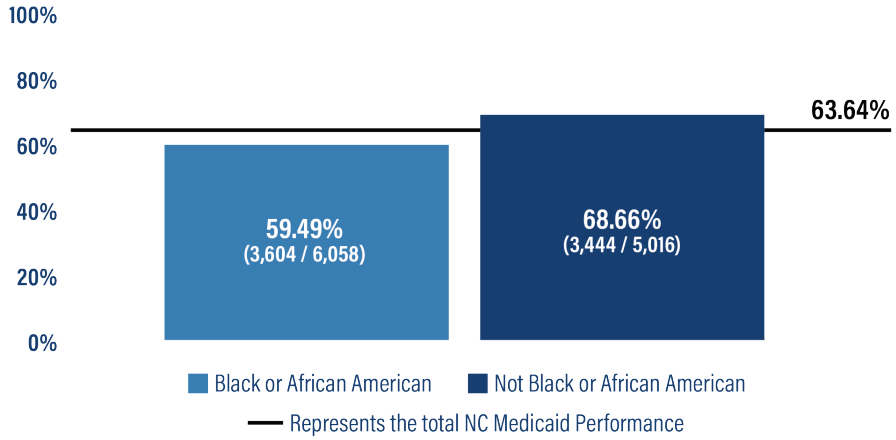
[113] Guo J, Lv X, Liu Y, et al. Influencing factors of medication adherence in schizophrenic patients: a meta-analysis. Schizophrenia. 2023. 9(31). Available at: https://www.nature.com/articles/s41537-023-00356-x. Accessed on: Jun 28, 2023.

[114] Medina, C., Akinkunmi, A., Bland, N. et al. Differences in schizophrenia treatments by race and ethnicity—analysis of electronic health records. Schizophr 10, 48 (2024). Retrieved from https://doi.org/10.1038/s41537-024-00470-4

Among beneficiaries in NC Medicaid, disparities were not identified based on gender, primary language, ethnicity, disability status, American Indian/Alaskan Native binary race, age or geography. However, disparities were identified based on Black or African American binary race for the SAA measure:

- Beneficiaries who identified as Black and African American fared worse than those who do not, with a relative difference of 13.36% (See Figure 32).

FIGURE 32: SAA, 2023 NC Medicaid Performance by Black or African American Binary Race



Follow-Up After Hospitalization for Mental Illness

The *Follow-Up After Hospitalization for Mental Illness* (FUH) has two sub-measures:

1. *7-Day Follow-Up* (FUH–7) assesses the percentage of discharges for beneficiaries six years and older who were hospitalized for treatment of select mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within seven days of discharge.
2. *30-Day Follow-Up* (FUH–30) assesses the percentage of discharges for beneficiaries six years and older who were hospitalized for treatment of select mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 30 days after discharge.[115]

When patients are hospitalized for mental health disorders, they often do not receive sufficient follow-up care. Providing follow-up care after psychiatric hospitalization can result in positive patient outcomes, lessen the likelihood of re-hospitalization and reduce the overall cost of outpatient care.[116] In North Carolina, along with the rest of the country, members of communities that have been historically marginalized by their exclusion from quality care face barriers in access to mental health care due to discrimination, cost and mistrust in the mental health care system.[117] Efforts to increase connection to outpatient mental health follow-up care after psychiatric hospitalization should incorporate cultural and structural competencies to address social conditions and determinants of mental health that underly disparities.[118]

[115] Follow-Up After Hospitalization for Mental Illness (FUH). National Committee for Quality Assurance (NCQA). (2023). Retrieved from https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/
[116] Barekatain M, Maracy MR, Rajabi F, Baratian H. (2014). Aftercare services for patients with severe mental disorder: A randomized controlled trial. J Res Med Sci. 19(3):240-5.
[117] Zabelski, S., Hollander, M. & Alexander, A. Addressing Inequities in Access to Mental Healthcare: A Policy Analysis of Community Mental Health Systems Serving Minoritized Populations in North Carolina. *Adm Policy Ment Health* (2024). Retrieved from https://doi.org/10.1007/s10488-024-01344-8
[118] Smith TE, Corbeil T, Wall MM, Tang F, Essock SM, Frimpong E, Goldman ML, Mascayano F, Radigan M, Wang R, Rodgers I, Dixon LB, Olfson M, Lewis-Fernández R. Community, Hospital, and Patient Factors Contributing to Ethnoracial Disparities in Follow-Up After Psychiatric Hospitalization. Psychiatr Serv. 2023 Jul 1;74(7):684-694. doi: 10.1176/appi.ps.20220110. Epub 2023 Jan 18. PMID: 36651116; PMCID: PMC10329986.

TABLE 28: Trends in Priority Population Performance for *FUH 7-Day follow-up* measure by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	19.46%	16.87% ↓
Living in a rural county	24.79%	22.89% ↓
Female	26.61%	24.87% ↓
Hispanic/Latino	33.59%	31.55% ↓
Speaking a non-English primary language	36.45%	40.29% ↑
Black and African American	21.20%	18.72% ↓
American Indian and Alaskan Native	18.82%	15.60% ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

Among beneficiaries in NC Medicaid, disparities were not identified based on gender, primary language, ethnicity or geography. However, disparities were identified based on Black and American Indian/Alaskan Native binary race, disability status and age for the FUH–7 measure:

- Beneficiaries who identified as having a disability fared worse than those who did not, with a relative difference of 33.57% (See Figure 33).
- Beneficiaries who identified as Black and African American fared worse than those who did not, with a relative difference of 27.02% (See Figure 34).
- Beneficiaries who identified as American Indian and Alaskan Native fared worse than those who did not, with a relative difference of 32.29% (See Figure 35).
- Beneficiaries ages 18 through 64 fared worse than those aged 6 through 17, with a relative difference of 44.94% (See Figure 36).

Appropriate follow-up visits after hospitalization are critical for patients with mental health conditions. In a study that tracked around 140,000 youth with Medicaid insurance aged 10 to 18 years old who experienced psychiatric hospitalization, attendance at a follow-up mental health visit within 7 days of discharge was associated with half the risk for suicide within the subsequent 6 months compared to those who did not have a follow-up visit.[119] This study also found that Black youth, individuals receiving Medicaid because of low income, and individuals with histories of chronic medical illness, self-harm, or substance abuse were less likely to have attended a mental health appointment within 1 week of discharge.

[119] Brent DA, Goldstein TR, Benton TD. Bridging Gaps in Follow-up Appointments After Hospitalization and Youth Suicide: Mental Health Care Disparities Matter. JAMA Netw Open. 2020;3(8):e2013100. doi:10.1001/jamanetworkopen.2020.13100

FIGURE 33: FUH, 7-Day Follow-Up, 2023 NC Medicaid Performance by Disability Status

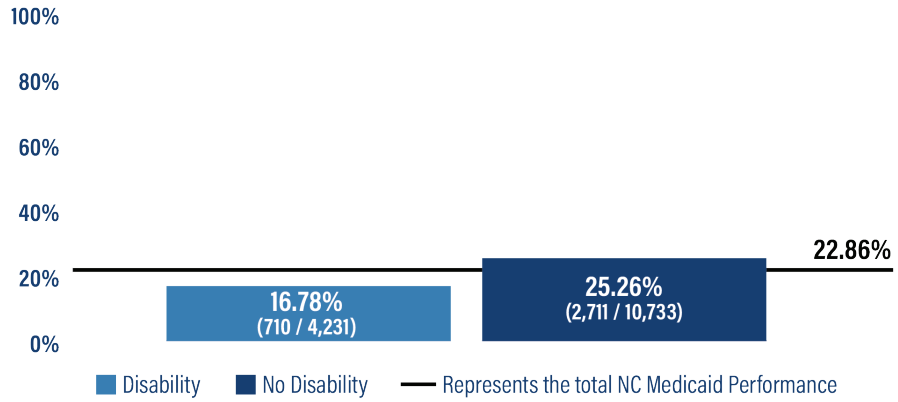


FIGURE 34: FUH, 7-Day Follow-Up, 2023 NC Medicaid Performance by Black or African American Binary Race

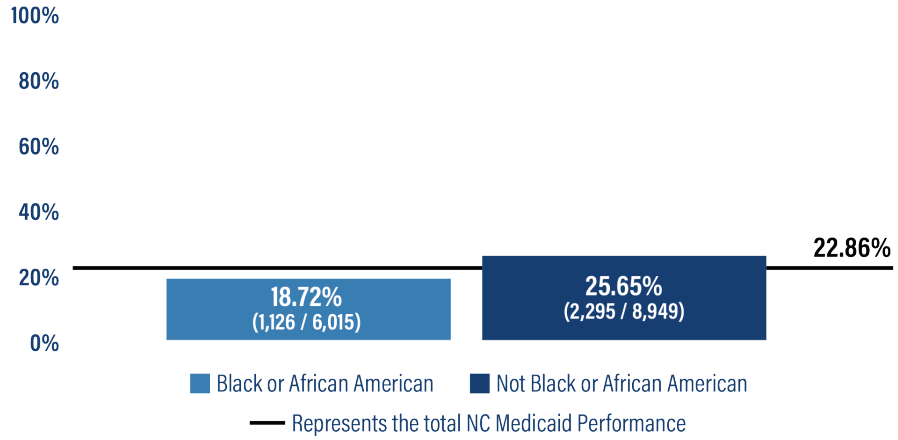


FIGURE 35: FUH, 7-Day Follow-Up, 2023 NC Medicaid Performance by American Indian and Alaskan Native Binary Race

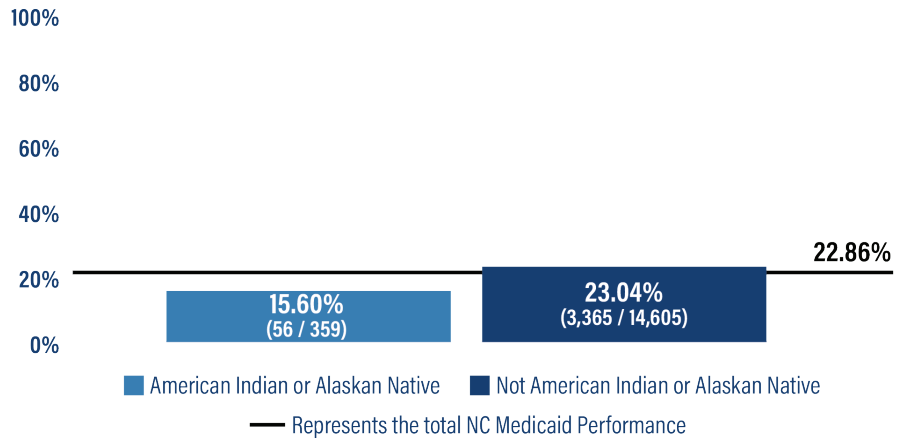
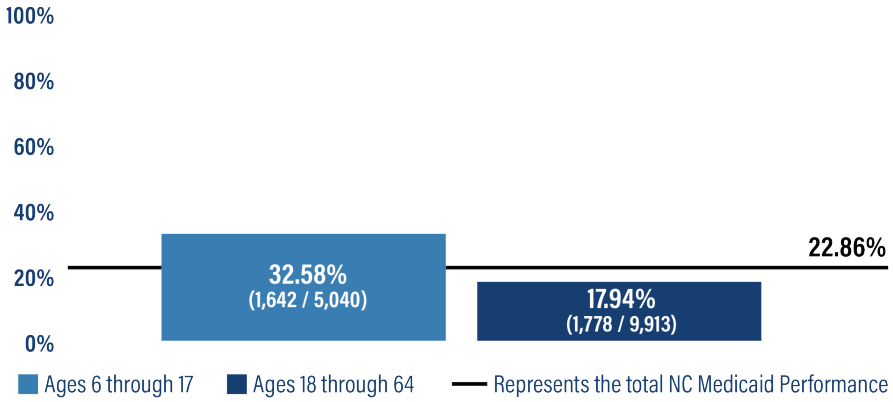


FIGURE 36: FUH, 7-Day Follow-Up, 2023 NC Medicaid Performance by Age Group



The difference seen in Figure 36 could reflect challenges in post-discharge care coordination for adults, including appointment availability, insurance barriers and social determinants of health such as transportation.

TABLE 29: Trends in Priority Population Performance for FUH 30-Day follow-up measure by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	35.33%	33.80% ↓
Living in a rural county	42.64%	40.38% ↓
Female	45.67%	44.33% ↓
Hispanic/Latino	53.21%	52.75% ↓
Speaking a non-English primary language	60.75%	59.71% ↓
Black and African American	38.77%	35.93% ↓
American Indian and Alaskan Native	32.06%	32.59% ↑

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

For the second sub measure, *30-Day Follow-Up* (FUH–30), no disparities were identified based on geography, gender, ethnicity or primary language. However, disparities were identified based on both American Indian/ Alaskan Native and Black or African American binary race, age, and disability status for the FUH–30 measure:

- Beneficiaries who identified as having a disability fared worse than those who did not, with a relative difference of 23.65% (See Figure 37).
- Beneficiaries who identified as Black and African American fared worse than those who did not, with a relative difference of 20.03% (See Figure 38).
- Beneficiaries who identified as American Indian and Alaskan Native fared worse than those who did not, with a relative difference of 21.53% (See Figure 39).
- Beneficiaries ages 18 through 64 years fared worse than those ages 6 through 17, with a relative difference of 38.89% (See Figure 40).

FIGURE 37: FUH, 30-Day Follow-Up, 2023 NC Medicaid Performance by Disability Status

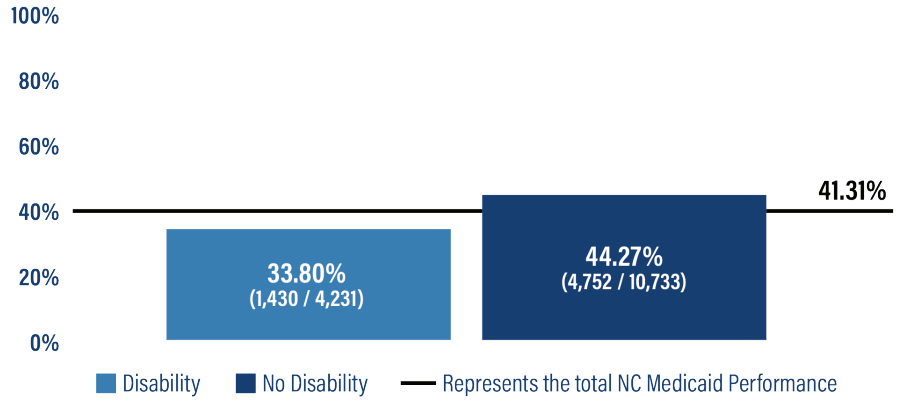


FIGURE 38: FUH, 30-Day Follow-Up, 2023 NC Medicaid Performance by Black or African American Binary Race

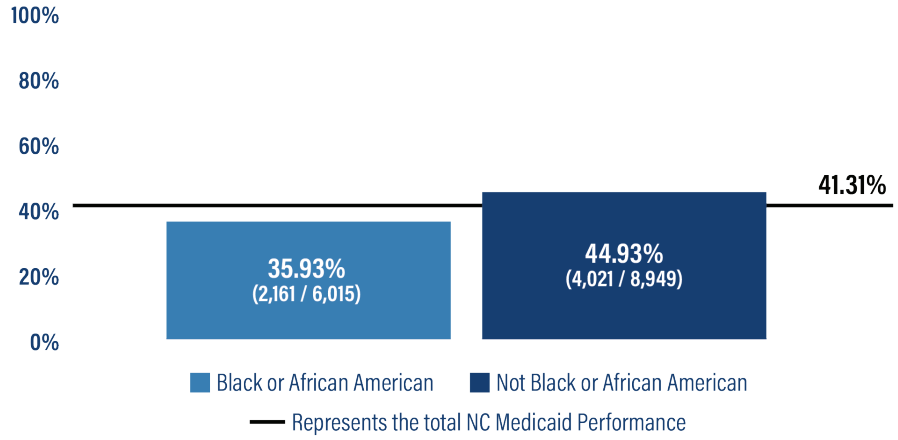


FIGURE 39: FUH, 30-Day Follow-Up, 2023 NC Medicaid Performance by American Indian and Alaskan Native Binary Race

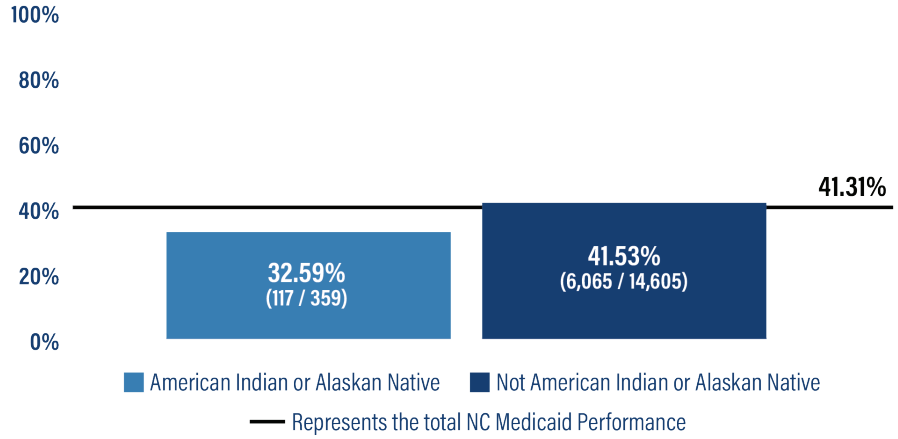
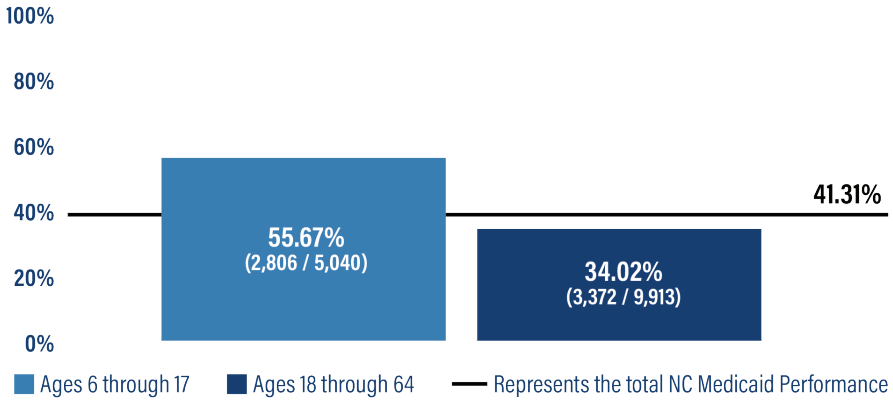


FIGURE 40: FUH, 30-Day Follow-Up, 2023 NC Medicaid Performance by Age Group



Follow-Up After ED Visit for Mental Illness

The Follow-Up After ED Visit for Mental Illness (FUM) has two sub-measures:

1. 7-Day Follow-Up (FUM–7) assesses the percentage of ED visits for beneficiaries six years and older for select mental illness or intentional self-harm diagnoses, who had a follow-up visit for mental illness within seven days of the ED visit.[120]
2. 30-Day Follow-Up (FUM–30) assesses the percentage of ED visits for beneficiaries six years and older for select mental illness or intentional self-harm diagnoses, who had a follow-up visit for mental illness within 30 days of the ED visit.

The CDC estimates that there is an average of approximately 13.2 million ED visits for mental illness each year, representing roughly 12.3% of all adult ED visits.[121] In 2022, there were 54,868 suicidal ideation-related and 122,336 depression-related ED visits in NC.[122] The period immediately after the ED visit is vital for ensuring patients are engaged in treatment and maintaining continuity of care. Receiving timely follow-up care after an ED visit for mental illness or intentional self-harm can help prevent future hospital visits and admissions, and improve health outcomes.[123] Adults with lower socioeconomic status are more likely to visit the ED for mental health, highlighting a need for increased access to affordable outpatient and telemedicine services.[124] A CDC report found that individuals who identified as Black or African American had the highest rates of mental health-related ED visits, longer ED wait times and longer visits than their White counterparts between 2018 and 2020.[125] Systemic issues relating to access to care, cultural stigma around mental health and structural discrimination could contribute to these differences in appropriate follow-up visits and care.

[120] Follow-Up After ED Visit for Mental Illness (FUM). National Committee for Quality Assurance (NCQA). (2023). Retrieved from https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/
[121] Centers for Disease Control and Prevention. Emergency Department Visits Among Adults with Mental Health Disorders: United States 2017–2019. Available at: https://www.cdc.gov/nchs/products/databriefs/db426.htm. Accessed on: Jun 28, 2023.
[122] Statewide Annual ED Trends for Depression. (2022). Mental Health Dashboard. NC DETECT. NCDHHS. Accessed on 6/12/2024. Available here: https://ncdetect.org/mental-health-dashboard/
[123] McCullumsmith, C., B. Clark, C. Blair, K. Cropsey, & R. Shelton. 2015. "Rapid Follow-Up for Patients After Psychiatric Crisis." Community Mental Health Journal 51(2), 139–44. https://doi.org/10.1007/s10597-014-9782-z
[124] Penner F, Rajesh A, Kinney KL, Mabus KL, Barajas KG, McKenna KR, Lim CS. Racial and demographic disparities in emergency department utilization for mental health concerns before and during the COVID-19 pandemic. Psychiatry Res. 2022 Apr;310:114442. doi: 10.1016/j.psychres.2022.114442. Epub 2022 Feb 12. PMID: 35219262; PMCID: PMC8840823.
[125] Peters ZJ, Santo L, Davis D, DeFrances CJ. Emergency Department Visits Related to Mental Health Disorders Among Adults, by Race and Hispanic Ethnicity: United States, 2018-2020. Natl Health Stat Report. 2023 Mar;(181):1-9. PMID: 36939656. National Health Statistics Reports. Accessed 7/25/2025- Retrieved from https://www.cdc.gov/nchs/data/nhsr/nhsr181.pdf

TABLE 30: Trends in Priority Population Performance for FUM 7-Day follow-up measure by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	42.52%	39.36% ↓
Living in a rural county	41.67%	39.99% ↓
Female	42.99%	40.53% ↓
Hispanic/Latino	47.65%	43.19% ↓
Speaking a non-English primary language	48.99%	46.67% ↓
Black and African American	39.78%	37.91% ↓
American Indian and Alaskan Native	40.30%	32.88% ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

Among beneficiaries in NC Medicaid, no disparities were identified based on gender, LTSS needs status, disability status, primary language, ethnicity, American Indian/Alaskan Native binary race, or geography for the *Follow-Up After ED Visit for Mental Illness — 7-Day Follow-Up* (FUM–7) measure. However, disparities were identified based on American Indian and Alaskan Native binary race and age:

- Beneficiaries who identified as American Indian and Alaskan Native fared worse than those who did not, with a relative difference of 17.76% (See Figure 41).
- Beneficiaries aged 18 through 64 fared worse than those aged 6 through 17, with a relative difference of 34.40% (See Figure 42).

Tribal Epidemiology Centers

The Tribal Epidemiology Center (TEC) program enhances epidemiologic and public health support to American Indian and Alaska Native (AI/AN) individuals and communities. The TECs, of which there are 12, have worked for more than 30 years to identify and address health risks, support disease prevention and control, and collaborate on common priorities while tailoring public health services to meet regional and local needs. Together, the TECs offer services to 574 Tribes and 9.7 million AI/AN people nationwide.

FIGURE 41: FUM, 7-Day Follow-Up, 2023 NC Medicaid Performance by American Indian and Alaskan Native Binary Race

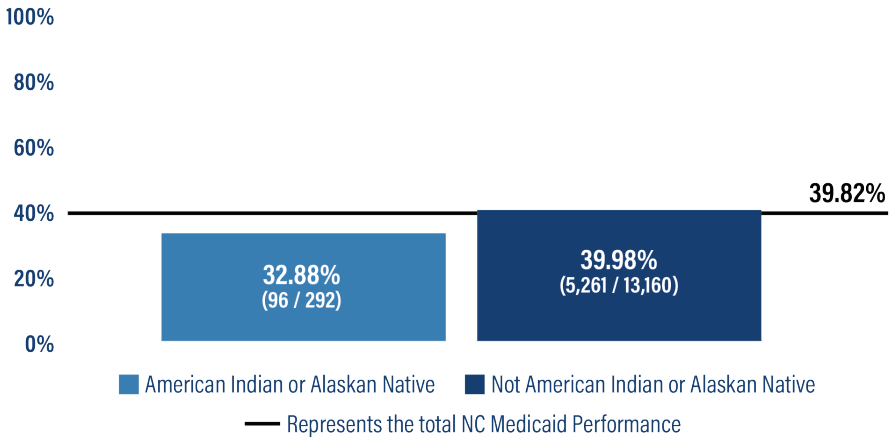


FIGURE 42: FUM, 7-Day Follow-Up, 2023 NC Medicaid Performance by Age Group

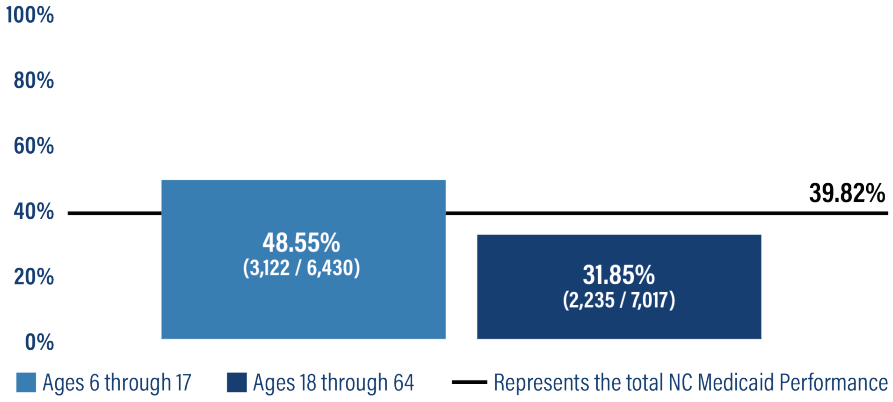


TABLE 31: Trends in Priority Population Performance for FUM 30-Day follow-up measure by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	60.34%	57.11% ↓
Living in a rural county	58.05%	54.77% ↓
Female	58.10%	56.25% ↓
Hispanic/Latino	65.61%	59.21% ↓
Speaking a non-English primary language	67.79%	61.11% ↓
Black and African American	54.98%	52.69% ↓
American Indian and Alaskan Native	51.71%	47.26% ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

For the second sub measure, FUM–30, no disparities were identified based on gender, disability status, primary language, ethnicity, Black or African American binary race or geography for the–30 measure. However, disparities were identified based on American Indian/Alaskan Native binary race and age:

- Beneficiaries who identified as American Indian and Alaskan Native fared worse than those who did not, with a relative difference of 14.98% (See Figure 43).
- Beneficiaries aged 18-64 fared worse than those ages 6 through 17, with a relative difference of 30.40% (See Figure 44).

FIGURE 43: FUM, 30-Day Follow-Up, 2023 NC Medicaid Performance by American Indian and Alaskan Native Binary Race

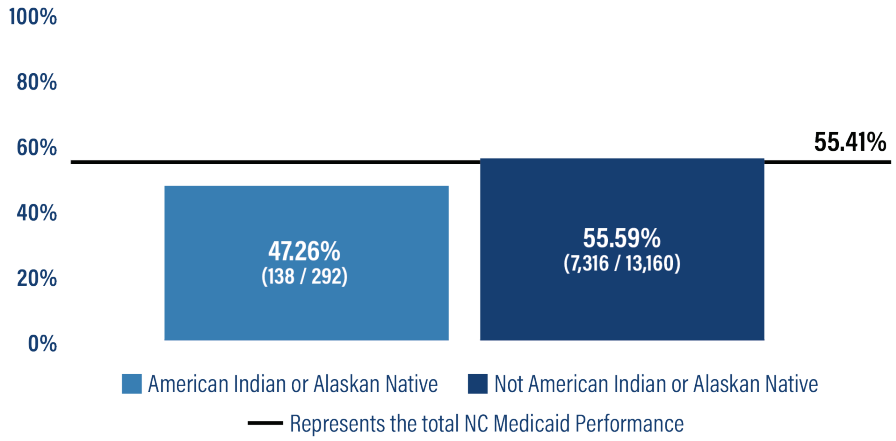
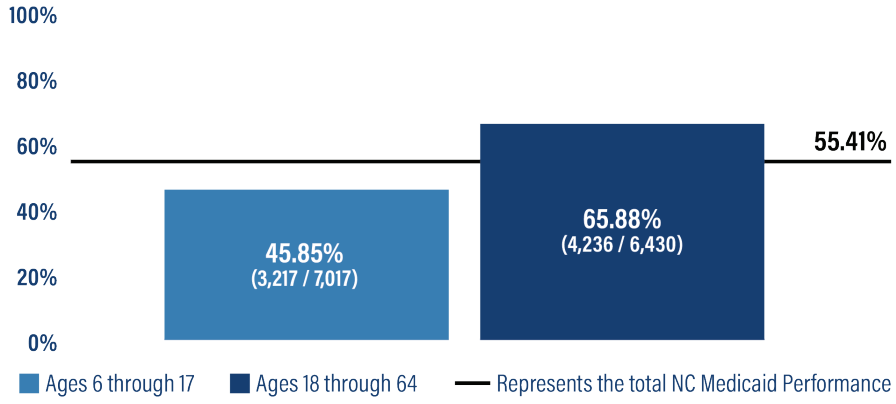


FIGURE 44: FUM, 30-Day Follow-Up, 2023 NC Medicaid Performance by Age Group



Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics

The Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) measure assesses the percentage of children and adolescents 1 to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.[126] This measure excludes children for whom first-line antipsychotics may be appropriate (i.e., children with a diagnosis of schizophrenia, bipolar disorder, other psychotic disorders, autism or other developmental disorders).

In North Carolina, as in many other states, there are a limited number of mental health professionals available to provide needed services. According to the Health Resources and Services Administration (HRSA), in 2025, North Carolina had 18 mental health professional shortage areas (HPSAs).[130] You can access data on HPSAs for others states at the HRSA dashboard linked here.

Given that very few antipsychotics are approved by the FDA for use in children and adolescents and the risk factors (e.g., weight gain, diabetes, developmental effects) associated with the use of antipsychotics, clinical guidelines recommend the use of psychosocial care, such as behavioral interventions and psychological therapies, as first-line treatment.[127] Therefore, it is important that children and adolescents receive psychosocial care prior to being prescribed an antipsychotic. Following rapid growth of pediatric antipsychotic prescribing in the early 2000s, especially in the Medicaid population, there have been concerns regarding safety and appropriateness of prescribing patterns. However, an analysis using Medicaid administrative claims data from 45 states, found a substantial increase in the proportion of children with an antipsychotic prescription who received any diagnosis associated with an FDA-approved pediatric indication from 2008 to 2016.[128] A study on Florida's Medicaid population found that 24% of children did not receive first-line psychosocial care prior to antipsychotic drug initiation, with older children, children who identified as White and those living in rural areas having lower odds of receiving a behavioral intervention prior to antipsychotic drug use.[129]

TABLE 32: Trends in Priority Population Performance for APP measure by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	33.18%	29.77% ↓
Living in a rural county	44.62%	43.51% ↓
Female	48.77%	47.82% ↓
Hispanic/Latino	47.19%	50.23% ↑
Speaking a non-English primary language	49.23%	52.86% ↑
Black and African American	41.55%	58.79% ↑
American Indian and Alaskan Native	43.57%	63.55% ↑

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

[126] Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP). National Committee for Quality Assurance (NCQA). (2023). Retrieved from https://www.ncqa.org/hedis/measures/use-of-first-line-psychosocial-care- for-children-and-adolescents-on-anti-psychotics/

[127] Bushnell GA, Crystal S, Olfson, M. Trends in Antipsychotic Medication Use in Young Privately Insured Children. Journal of the American Academy of Child & Adolescent Psychiatry. 2020. 60(7): 877–886. Available at: https://www.jaacap.org/article/S0890-8567(20)31987-0/fulltext#articleInformation. Accessed on: Jun 28, 2023.

[128] Bushnell G, Lloyd J, Olfson M, Cook S, Das H, Crystal S. Antipsychotic Medication Use In Medicaid-Insured Children Decreased Substantially Between 2008 And 2016. Health Aff (Millwood). 2023 Jul;42(7):973-980. doi: 10.1377/hlthaff.2022.01625. PMID: 37406239; PMCID: PMC10845053.

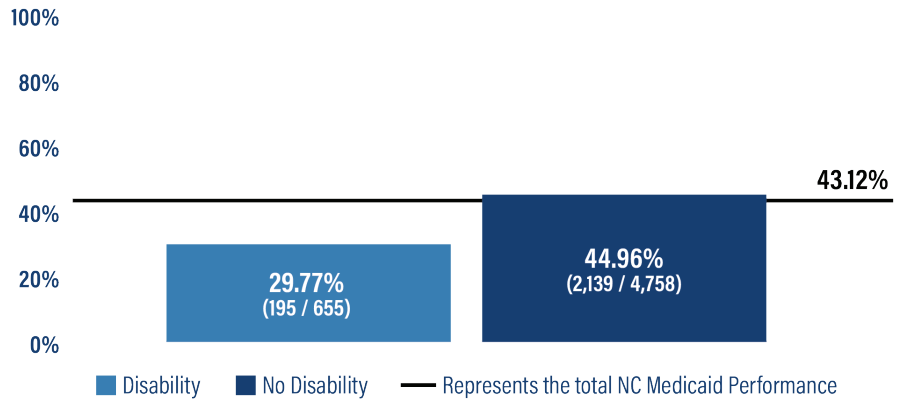
[129] Shenkman EA, Huo T, Li Q, Bussing R, Forrest CB, Xu H, Woodard J, Muller KE. Florida Medicaid Children's Receipt of First-Line Psychosocial Care Prior to Antipsychotic Initiation. Acad Pediatr. 2022 Apr;22(3S):S100-S107. doi: 10.1016/j.acap.2021.11.014. PMID: 35339236.

[130] Lombardi, Brianna. Lanier, Paul. (2023). Responding to North Carolina's Behavioral Health Workforce Crisis. Carolina Across 100. Available here: https://carolinaacross100.unc.edu/responding-to-north-carolinas-behavioral- health-workforce-crisis/

Among children enrolled in NC Medicaid, no disparities were identified based on gender, primary language, ethnicity, American Indian/ Alaskan Native or Black or African American binary race, geography or age for the *Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics* (APP) measure. However, disparities were identified based on disability status:

- Beneficiaries who identified as having a disability fared worse than those who did not, with a relative difference of 33.79% (See Figure 45).

FIGURE 45: APP, 2023 NC Medicaid Performance by Disability Status



Tailored Plans

In 2024, NC Medicaid launched integrated health plans for individuals with behavioral health needs and I/DD, also known as Tailored Plans. Tailored Plans cover doctor visits, prescription drugs and services for serious mental health, severe substance use, I/DD and TBI all in one plan. More information on Tailored Plans is available on the Tailored Plan webpage.

Substance Use Domain Findings

The Substance Use domain includes two measures that assess follow-up care after an ED visit for substance use, four measures related to opioid use and three measures related to utilization for beneficiaries with SUD. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), 46.3 million Americans 12 years of age and older meet the criteria for SUD and 94% of those who met the criteria for SUD did not receive any treatment because they did not think they needed treatment.[131] Ensuring beneficiaries receive the appropriate treatment for SUD is essential for improving all aspects of the patient's life.[132] Multiple studies have revealed that despite uniform rates of substance use among people from racial and ethnic populations in the United States, large treatment gaps persist.[133]

Table 33 displays the NC Medicaid aggregates for the measures included in the Substance Use domain.

TABLE 33: Substance Use Domain NC Medicaid Aggregates

Substance Use Domain Findings	CY2022 NC Medicaid Aggregate	CY 2023 NC Medicaid Aggregate***
Follow-Up After ED Visit for Substance Use — 7-Day Follow-Up (FUA-7)	23.49%	21.04% ↓
Follow-Up After ED Visit for Substance Use 30-Day Follow-Up (FUA-30)	33.49%	30.46% ↓
Use of Opioids at High Dosage in Persons Without Cancer (OHD)**	7.46%	7.33% ↑
Use of Pharmacotherapy for Opioid Use Disorder (OUD) Total Rate	58.44%	58.56% ↑
ED Utilization for SUD per 1,000 Medicaid Beneficiaries**	16.01	10.00 ↑
Use of Opioids from Multiple Providers (UOP)- Multiple Prescribers and Multiple Pharmacies**	0.85%	1.35% ↓
Concurrent Use of Prescription Opioids and Benzodiazepines (COB)**	12.62%	12.36% ↑
Initiation and Engagement of Substance Use Disorder Treatment (IET) Initiation	41.93%	39.62% ↓
Initiation and Engagement of Substance Use Disorder Treatment (IET) Engagement	14.56%	12.79% ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

***A lower rate indicates better performance for this measure.*

****CY 2023 NC Medicaid Aggregate rate represents the performance of NC Medicaid beneficiaries but excludes limited benefit members and dual eligibles. Please see appendix A "Partial Benefit Group Exclusions" section for more information*

See Appendix D for stratified results for all these measures.

[131] U.S. Department of Health and Human Services. SAMHSA Announces National Survey on Drug Use and Health (NSDUH) Results Detailing Mental Illness and Substance Use Levels in 2021. Jan. 4, 2023. Available at: https://www.hhs.gov/about/news/2023/01/04/samhsa-announces-national-survey-drug-use-health-results-detailing-mental-illness-substance-use-levels-2021.html. Accessed on: Jun 28, 2023.

[132] Centers for Disease Control and Prevention. Drug Overdose Recovery Is for Everyone: Understanding Treatment of Substance Use Disorders. Available at: https://www.cdc.gov/drugoverdose/featured-topics/recovery-SUD.html. Accessed on: Jun 28, 2023.

[133] Substance Abuse and Mental Health Service Administration. 2019 National Survey on Drug Use and Health: African Americans. Retrieved from https://www.samhsa.gov/data/sites/default/files/reports/rpt31099/2019NSDUH-AA/AfricanAmerican%202019%20NSDUH.pdf. Published Sept 2020. Accessed April 7,2021.

Follow-Up After ED Visit for Substance Use

The *Follow-Up After ED Visit for Substance Use* has two sub-measures:

1. *7-Day Follow-Up* (FUA–7) measure assesses the percentage of ED visits for beneficiaries 13 years and older with a principal diagnosis of a SUD, or any diagnosis of drug overdose, who had a Follow-Up visit for SUD within seven days of the ED visit.[134]
2. *30-Day Follow-Up* (FUA–30) measure assesses the percentage of ED visits for beneficiaries 13 years and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, who had a Follow-Up visit for SUD within 30 days of the ED visit.

Providing timely follow-up care for people with SUD after an ED visit can help reduce substance use, future ED use, hospitalization, and length of hospital stay.[135] Individuals from the Black or African American and Hispanic/Latino communities tend to have more unmet needs for SUD treatment services, and experience worse outcomes when they are able to access those services.[136, 137] These disparities can be tied to structural racism, socioeconomic marginalization, differential access to health care and structural inequities within substance use policies and treatment resource distribution.[138]

TABLE 34: Trends in Priority Population Performance for FUA-7-day follow up measure by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	24.96%	25.22% ↑
Living in a rural county	25.29%	21.08% ↓
Female	22.73%	21.33% ↓
Hispanic/Latino	19.14%	16.46% ↓
Speaking a non-English primary language	17.44%**	19.65% ↑
Black and African American	18.80%	16.13% ↓
American Indian and Alaskan Native	44.55%	30.50% ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

**Small Cell Warning

[134] Follow-Up After ED Visit for AOD Abuse or Dependence (FUA). National Committee for Quality Assurance (NCQA). (2023) Retrieved from. https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-alcohol-and- other-drug-abuse-or-dependence/

[135] BlueCross BlueShield of Montana. Follow-Up After Emergency Department Visit for Substance Use. Available at: https://www.bcbsmt.com/docs/provider/mt/clinical/tipsheets/hedis-fua-tip-sheet.pdf. Accessed on: Jun 28, 2023.

[136] Pinedo M. A current re-examination of racial/ethnic disparities in the use of substance abuse treatment: Do disparities persist? Drug Alcohol Depend. 2019 Sep 1;202:162-167. doi: 10.1016/j.drugalcdep.2019.05.017. Epub 2019 Jul 19. PMID: 31352305; PMCID: PMC10676029.

[137] Guerrero, E.G., Marsh, J.C., Duan, L., Oh, C., Perron, B. and Lee, B. (2013), Disparities in Completion of Substance Abuse Treatment between and within Racial and Ethnic Groups. Health Serv Res, 48: 1450-1467. Retrieved from https://doi. org/10.1111/1475-6773.12031

[138] Farahman, Pantea MD,MA. Arshed, Arslaan MD, MS, MHA. Bradley, Mark MD, MS. Systemic Racism and Substance Use Disorders. (2020). Psychiatric Annals. Vol. 50, no. 11. Retrieved from https://www.marylandmacs.org/media/som/microsites/macs/documents/Systemic-Racism-and-SUDs.pdf

Among beneficiaries in NC Medicaid, no disparities were identified based on disability status, gender, age, primary language, American Indian/Alaskan Native binary race, or geography for the FUA–7 measure. However, disparities were identified based on ethnicity and Black or African American binary race.

- Beneficiaries who identified as Hispanic and Latino fared worse than those who did not, with a relative difference of 22.96% (See Figure 46).
- Beneficiaries who identified as Black and African American fared worse than those who did not, with a relative difference of 32.94% (See Figure 47).

Note: Caution should be exercised when interpreting these findings, given the small size of the eligible population for some demographic stratifications.

FIGURE 46: FUA,7-Day Follow-Up 2023 NC Medicaid Performance by Ethnicity

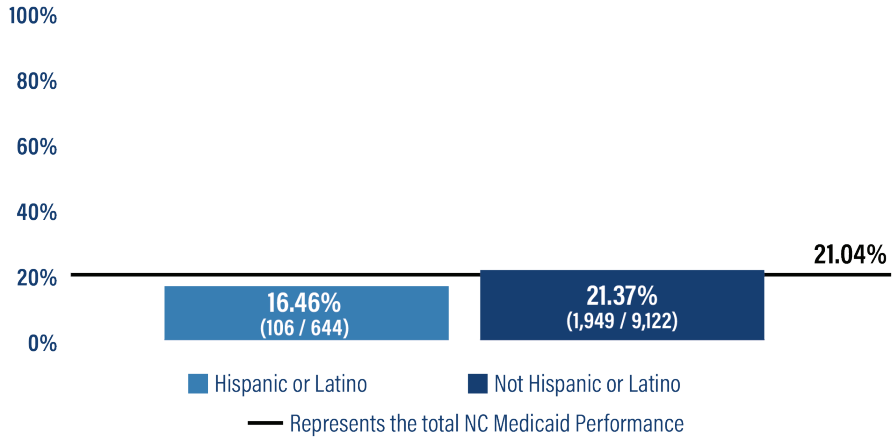


FIGURE 47: FUA,7-Day Follow-Up 2023 NC Medicaid Performance by Black and African American Binary Race

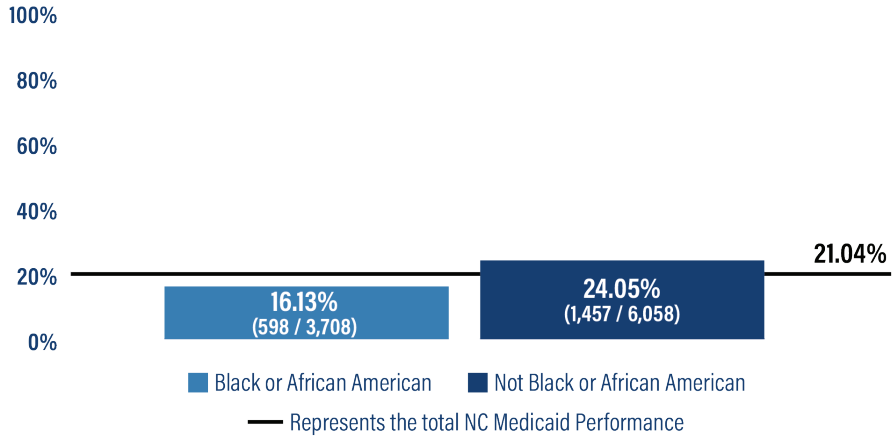


TABLE 35: Trends in Priority Population Performance for FUA-30-day Follow Up measure by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	37.16%	38.15% ↑
Living in a rural county	35.29%	30.59% ↓
Female	33.07%	31.08% ↓
Hispanic/Latino	25.10%	25.47% ↑
Speaking a non-English primary language	23.26%**	23.70% ↑
Black and African American	27.29%	23.98% ↓
American Indian and Alaskan Native	54.70%	41.11% ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

**Small Cell Warning

For the second sub-measure, FUA 30-Day Follow-Up, no disparities were identified based on age, disability status, gender or geography for the FUA–30 measure. However, disparities were identified based on primary language, ethnicity and Black or African American binary race. Please exercise caution when interpreting disparities findings given that some demographic stratifications are based on small numerators and/or denominators.

- Beneficiaries whose primary language is not English fared worse than those whose primary language is English, with a relative difference of 22.51% (See Figure 48).
- Beneficiaries who identified as Hispanic and Latino fared worse than those who did not, with a relative difference of 17.36% (See Figure 49).
- Beneficiaries who identified as Black and African American fared worse than those who did not, with a relative difference of 30.37% (See Figure 50).

FIGURE 48: FUA,30-Day Follow-Up 2023 NC Medicaid Performance by Primary Language

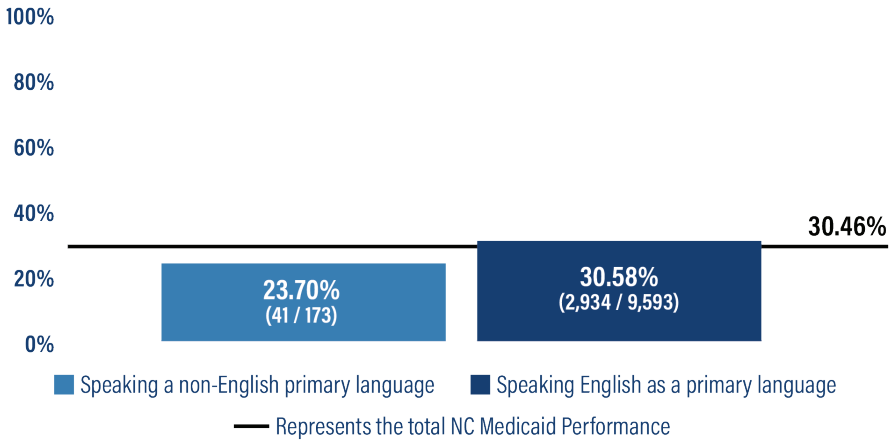


FIGURE 49: FUA,30-Day Follow-Up 2023 NC Medicaid Performance by Ethnicity

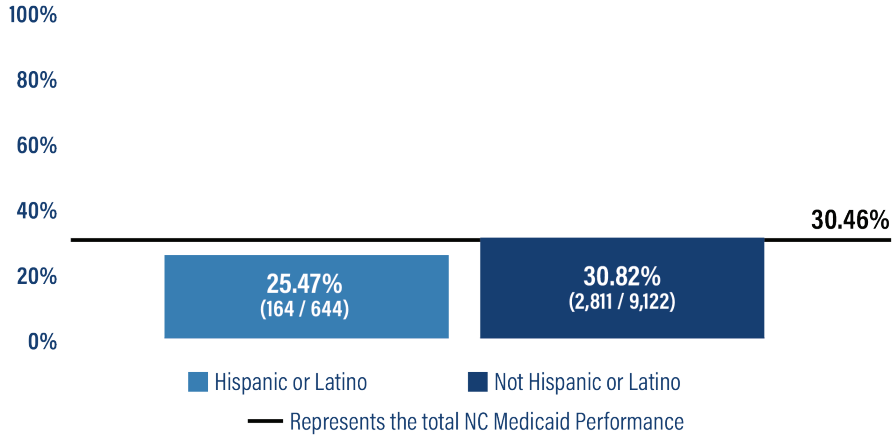
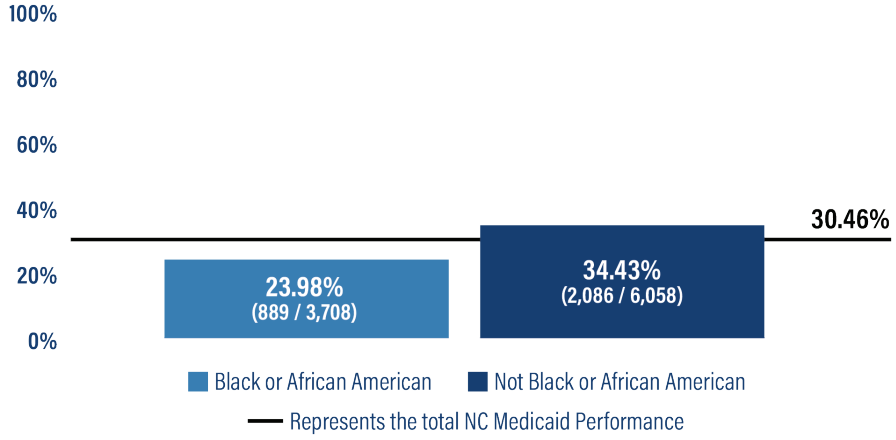


FIGURE 50: FUA,30-Day Follow-Up 2023 NC Medicaid Performance by Black and African American Binary Race



Use of Opioids at High Dosage in Persons Without Cancer

The *Use of Opioids at High Dosage in Persons Without Cancer* (OHD) measure assesses the percentage of beneficiaries 18 years and older who received prescriptions of opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. A lower rate indicates better performance for this measure.

In 2023, opioid-related overdoses accounted for approximately 81,083 deaths in the United States; this is the first decrease in the number of annual overdose deaths since 2018.[139] This ongoing opioid epidemic has emphasized the importance of preventing improper prescription of opioids. Excessive use of opioids by individuals without qualifying medical conditions, such as cancer or sickle cell disease, can be a sign of overuse which can result in higher likelihood of serious illness or death.[140] Communities who identify as Black and African American and American Indian and Alaskan Native tend to have higher rates of opioid overdose deaths.[141] In a multivariable analysis looking at opioid overdose deaths, men were more at risk than women, people who had identified disabilities were more at risk than those who did not, and

[139] Centers for Disease Control and Prevention. U.S. Overdose Deaths Decrease in 2023, First Time Since 2018. National Center for Health Statistics. Accessed on 5/22/2025. Retrieved from https://www.cdc.gov/nchs/pressroom/releases/20240515.html

[140] Medicaid.gov. Use of Opioids at High Dosage in Persons Without Cancer: Age 18 and Older. Available at: https://www.medicaid.gov/state-overviews/scorecard/opioid-use-at-high-dosage-without-cancer/index.html. Accessed on: Jun 28, 2023.

[141] Kariisa M, Davis NL, Kumar S, et al. Vital Signs: Drug Overdose Deaths, by Selected Sociodemographic and Social Determinants of Health Characteristics — 25 States and the District of Columbia, 2019–2020. MMWR Morb Mortal Wkly Rep 2022;71:940–947. DOI: Retrieved from http://dx.doi.org/10.15585/mmwr.mm7129e2.

people who were unemployed were more at risk those who were employed.[142] These disparities are likely driven by social determinants of health such as work and housing instability, food insecurity, racism, class discrimination, immigration status and stigma and it's important to understand their role in shaping risks and treatment outcomes for addiction related conditions.[143]

TABLE 36: Trends in Priority Population Performance for OHD measure by Stratification Element (lower rate indicates better performance)

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	9.64%	9.49% ↑
Living in a rural county	6.99%	6.91% ↑
Female	6.86%	6.75% ↑
Hispanic/Latino	4.97%	5.71% ↓
Speaking a non-English primary language	3.23%**	2.41% ↑
Black and African American	4.99%	5.13% ↓
American Indian and Alaskan Native	3.82%	4.87% ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

**Small Cell Warning

Among adults in NC Medicaid, no disparities were identified based on gender, primary language, ethnicity, American Indian/Alaskan Native or Black and African American binary race, geography or age for the OHD measure. However, disparities were identified based on disability status.

- Beneficiaries who identified as having a disability fared worse than those who did not, with a relative difference of 84.30% (See Figure 51).

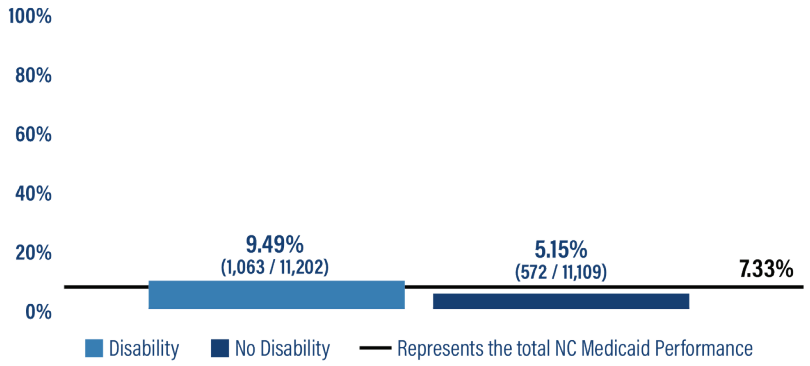
Note: Please exercise caution when interpreting disparities findings given that some demographic stratifications are based on small numerators and/or denominators.

A Lower Rate Indicates Better Performance for This Measure

[142] Altekruse SF, Cosgrove CM, Altekruse WC, Jenkins RA, Blanco C. Socioeconomic risk factors for fatal opioid overdoses in the United States: Findings from the Mortality Disparities in American Communities Study (MDAC). PLoS One. 2020 Jan 17;15(1):e0227966. doi: 10.1371/journal.pone.0227966. PMID: 31951640; PMCID: PMC6968850.

[143] NIDA. 2023, April 27. Social Determinants of Health Can't Be Extricated from Addiction Science. Retrieved from https://nida.nih.gov/about-nida/noras-blog/2023/04/social-determinants-health-cant-be-extricated-addiction-science on 2024, March

FIGURE 51: OHD, 2023 NC Medicaid Performance by Disability Status



Use of Pharmacotherapy for Opioid Use Disorder Total Rate

The OUD measure assesses the percentage of Medicaid beneficiaries ages 18 through 64 with an OUD who filled a prescription for or were administered or dispensed any FDA-approved medication for the disorder during the measurement year. This report focuses on the overall rate for this measure.

Based on the 2023 National Survey on Drug Use and Health, among people ages 12 or older, an estimated 5.7 million people had an OUD in that past year.[144] Pharmacotherapy, which is the treatment of health conditions by using drugs as medications, has been identified as a critical component of treating OUD. Patients who use pharmacotherapy are less likely to exhibit withdrawal or craving symptoms and use illicit opioids and are more likely to continue their treatment and participate in mental health therapy.[145] After an opioid related event, White patients received medication for OUD up to 80% more frequently than Black patients and up to 25% more frequently than Hispanic patients.[146] Factors such as stigma, health care access, socioeconomic status, discrimination and access to social supports act as meaningful barriers to successful OUD treatment.[147]

TABLE 37: Trends in Priority Population Performance for OUD measure by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	43.65%	44.90% ↑
Living in a rural county	61.07%	60.93% ↓
Female	60.76%	61.16% ↑
Hispanic/Latino	48.57%	54.21% ↑
Speaking a non-English primary language	18.75%**	41.46% ↑
Black and African American	31.89%	34.19% ↑
American Indian and Alaskan Native	60.75%	59.61% ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

**Small Cell Warning

[144] Results from the 2023 National Survey on Drug Use and Health. (2023). Substance Abuse and Mental Health Services Administration (SAMHSA). Retrieved from https://www.samhsa.gov/data/sites/default/files/reports/rpt47096/2023-nsduh-companion-report.pdf

[145] The National Committee for Quality Assurance. Pharmacotherapy for Opioid Use Disorder (POD). Available at: https://www.ncqa.org/hedis/measures/pharmacotherapy-for-opioid-use-disorder/. Accessed on: Jun 28, 2023

[146] "Racial inequality in receipt of medications for opioid use disorder," Michael L. Barnett, Ellen Meara, Terri Lewinson, Brianna Hardy, Deanna Chyn, Moraa Onsando, Haiden A. Huskamp, Ateev Mehrotra, Nancy E. Morden, New England Journal of Medicine, May 11, 2023, doi: 10.1056/NEJMsa2212412

[147] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Sciences Policy; Committee on Medication-Assisted Treatment for Opioid Use Disorder; Mancher M, Leshner AI, editors. Medications for Opioid Use Disorder Save Lives. Washington (DC): National Academies Press (US); 2019 Mar 30. 5, Barriers to Broader Use of Medications to Treat Opioid Use Disorder. Available from: https://www.ncbi.nlm.nih.gov/books/NBK541389/

Among adults in NC Medicaid, no disparities were identified based on gender, geography, American Indian or Alaska Native binary race, ethnicity or age for the *Use of Pharmacotherapy for Opioid Use Disorder* (OUD) measure. However, disparities were identified based on Black or African American binary race, primary language and disability status:

- Beneficiaries who identified as having a disability fared worse than those who did not, with a relative difference of 29.24% (See Figure 52).
- Beneficiaries whose primary language is not English fared worse than those whose primary language is English, with a relative difference of 29.22%.
  - Even though a disparity was identified for beneficiaries who identify as speaking a language other than English as their primary language, this figure was suppressed due to small population size.
- Beneficiaries who identified as Black and African American fared worse than those who did not, with a relative difference of 46.70% (See Figure 53).

FIGURE 52: OUD, Total Rate, 2023 NC Medicaid Performance by Disability Status

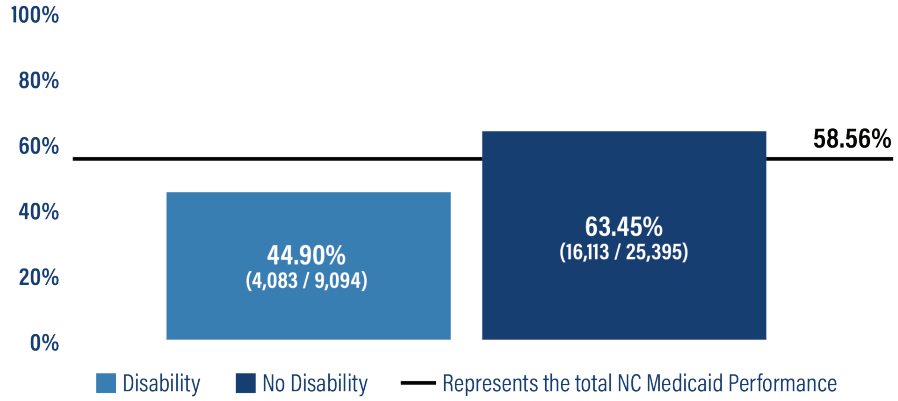
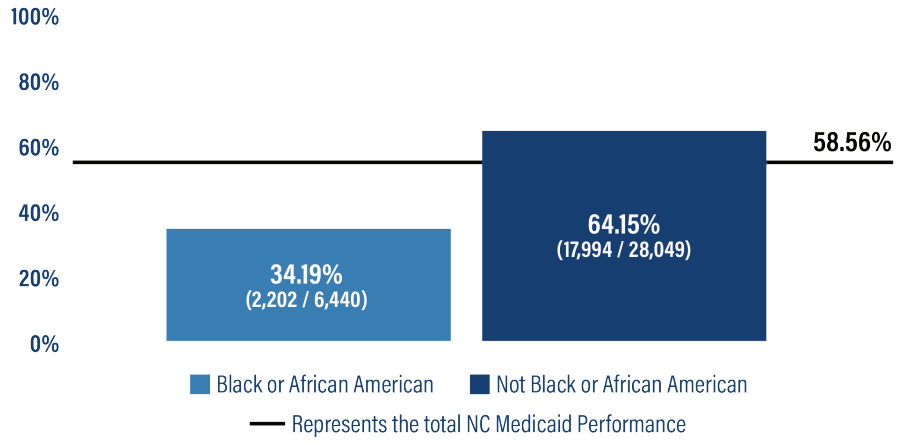


FIGURE 53: OUD, Total Rate, 2023 NC Medicaid Performance by Black and African American Binary Race



ED Utilization for SUD per 1,000 Medicaid Beneficiaries

The *ED Utilization for SUD per 1,000 Medicaid Beneficiaries* measure assesses the total number of ED visits for SUD per 1,000 beneficiaries in the measurement period.[148] A lower rate indicates better performance for this measure. Due to the data source for this measure, NC Medicaid was not able to assess disparities based on primary language.

The negative effects associated with substance use are substantial, ranging from mental health disorders to infectious disease and even death. The rate of emergency department visits with a primary diagnosis of SUD among adults increased from 74.4 per 10,000 population during 2018–2019 to 103.8 during 2020–2021.[149] These types of ED visits have been linked to longer stays, higher costs and increased hospital admissions.[150] Despite a higher prevalence of SUD among White individuals, research has found that the rate for ED visits related to SUD is higher among individuals who identify as Non-Hispanic Black.[151] The same study found that the rate of SUD-related ED visits is also higher among men and those living in the most socially vulnerable communities.[152] These disparities could be linked to barriers in access to and cost of care, stigma surrounding SUD and limited social support.

TABLE 38: Trends in Priority Population Performance for ED Utilization for SUD per 1,000 Medicaid Beneficiaries measure by Stratification Element (lower rate indicates better performance)

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	62.12	39.4 ↑
Living in a rural county	17.97	11.6 ↑
Female	13.71	9.1 ↑
Hispanic/Latino	3.52	2.7 ↑
Speaking a non-English primary language	N/A	N/A
Black and African American	17.10	20.1 ↓
American Indian and Alaskan Native	35.88	10.9 ↑

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

Among adults in NC Medicaid, no disparities were identified based on ethnicity or gender for the *ED Utilization for SUD per 1,000 Medicaid Beneficiaries* measure. However, disparities were identified based on disability status, geography and both binary race strata.

- Beneficiaries who identified as having a disability fared worse than those who did not, with a relative difference of 545.90% (See Figure 54).
- Beneficiaries who lived in rural counties fared worse than those who lived in urban counties, with a relative difference of 22.11% (See Figure 55).

[148] This measure is a Demonstration Year metric (Nov 2022 – Oct 2023), not a calendar year metric.
[149] National Center for Health Statistics, National Hospital Ambulatory Medical Care Survey, 2018–2021. Retrieved from https://www.cdc.gov/nchs/ahcd/index.htm
[150] Beckerleg W, and Hudgins J. Substance Use-related Emergency Department Visits and Resource Utilization. Western Journal of Emergency Medicine, vol. 23, no. 2. Feb 2022; 28;23(2):166–173. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8967472. Accessed on: Jun 28, 2023.
[151] Owens PL, Moore BJ. Racial and Ethnic Differences in Emergency Department Visits Related to Substance Use Disorders, 2019. 2022 Dec 8. In: Healthcare Cost and Utilization Project (HCUP) Statistical Briefs [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2006 Feb-. Statistical Brief #301. Available from: https://www.ncbi.nlm.nih.gov/books/NBK588378/
[152] This study assigned community social vulnerability based on patient county of residence. All rates are based on the U.S. population specific to each racial and ethnic group and social vulnerability group. Patient residence counties were classified as most vulnerable (counties with social vulnerability index values in the fourth quartile) versus less vulnerable (counties with social vulnerability index values in the lower three quartiles).

- Beneficiaries who identified as Black and African American fared worse than those who did not, with a relative difference of 105.10% (See Figure 56).
- Beneficiaries who identified as American Indian and Alaskan Native fared worse than those who did not, with a relative difference of 15.96% (See Figure 57).

A Lower Rate Indicates Better Performance for This Measure

FIGURE 54: ED Utilization for SUD per 1,000 Medicaid Beneficiaries, 2023 NC Medicaid Performance by Disability Status

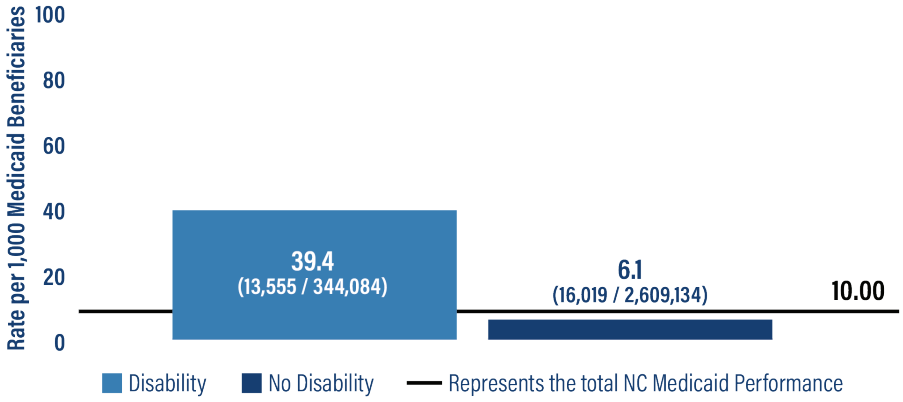


FIGURE 55: ED Utilization for SUD per 1,000 Medicaid Beneficiaries, 2023 NC Medicaid Performance by Geography

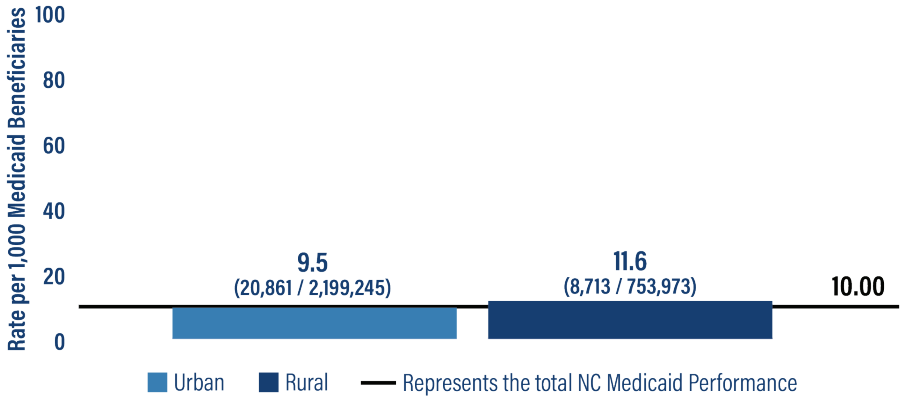


FIGURE 56: ED Utilization for SUD per 1,000 Medicaid Beneficiaries, 2023 NC Medicaid Performance by African American Binary Race

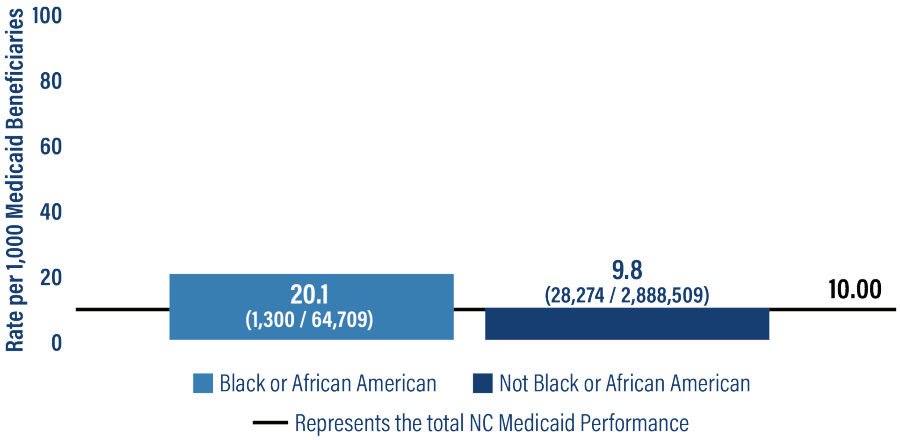
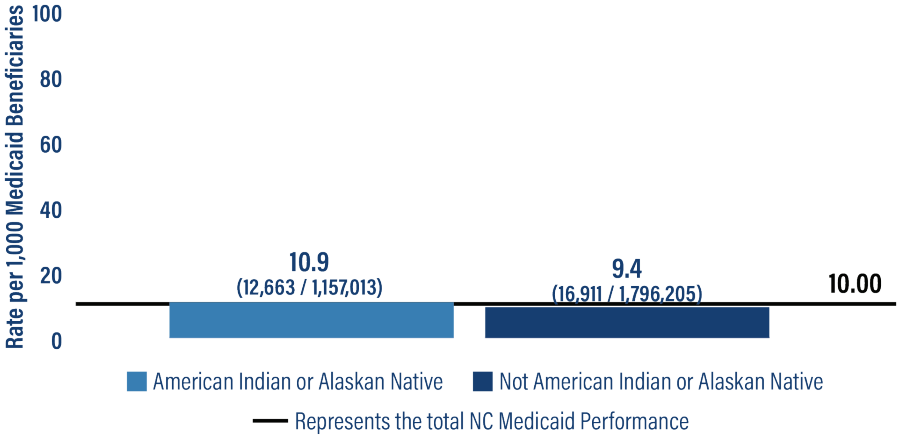


FIGURE 57: ED Utilization for SUD per 1,000 Medicaid Beneficiaries, 2023 NC Medicaid Performance by American Indian and Alaskan Native Binary Race



Note: This measure is not a traditional rate and is presented per 1,000 Medicaid Beneficiaries. This can lead to the relative difference percentages to be much larger than traditional rate comparisons.

Use of Opioids From Multiple Providers

The Use of Opioids from Multiple Providers (UOP) measure assesses potentially high-risk opioid analgesic prescribing practices: The proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year from multiple providers.[153] This report will utilize the multiple prescribers and multiple pharmacies sub measure. A lower rate indicates better performance for this measure.

Studies show that individuals who receive opioids from four or more prescribers or pharmacies have a higher likelihood of opioid-related overdose death than those who receive opioids from one prescriber or one physician.[154] Research has found that counties with a higher degree of rurality have higher opioid prescribing rates and this association can be partially explained by higher percentages of White populations, higher unemployment rates, less nurse practitioners and physician assistants and more specialized opioid prescribers such as surgeons and oncologists.[155]

Higher rates opioids prescribing and of opioid-related deaths have been recorded in nonmetropolitan (rural) areas.[157] While rural and urban counties have similar needs for opioid use treatment, disparities exist. A higher proportion of counties that need treatment but have low to no capacity for treatment are rural.[158]

Research has also found differences in opioid prescribing patterns for those living with disabilities. With one study in 2022, finding that adults with cerebral palsy and spina bifida had a significantly higher oral morphine equivalents prescription pattern as compared to adults without these disabilities.[156] More work needs to be done to better understand the healthcare burden associated with pain and opioid prescription in these populations, as well as to understand the disparities to access appropriate pain management options for individuals living with these and other disabilities.

TABLE 39: Trends in Priority Population Performance for *UOP Multiple Prescribers & Multiple Pharmacies* measure by Stratification Element (lower rate indicates better performance)

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	0.85%	1.24% ↓
Living in a rural county	0.62%	0.94% ↓
Female	0.74%	1.29% ↓
Hispanic/Latino	0.98%	1.06%** ↓
Speaking a non-English primary language	0.00%	0.96%** ↓
Black and African American	1.14%	1.77% ↓
American Indian and Alaskan Native	0.73%	0.58% ↑

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

**Small Cell Warning

[153] NCQA HEDIS Homepage for Use of Opioids from Multiple Providers (UOP). Accessed on 4.30.2025. Retrieved from https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/use-of-opioids-from-multiple-providers-uop/

[154] Gwira Baumblatt, J.A., C. Wiedeman, J.R. Dunn, W. Schaffner, L.J. Paulozzi, T.F. Jones. 2014. High-Risk Use by Patients Prescribed Opioids for Pain and Its Role in Overdose Deaths. JAMA Intern Med 174(5):796–801.

[155] Sun, F. (2022). Rurality and opioid prescribing rates in U.S. counties from 2006 to 2018: A spatiotemporal investigation. Social Science & Medicine, 296, 114788. Retrieved from https://doi.org/10.1016/j.socscimed.2022.114788

[156] Peterson, M. D., Kamdar, N., Haapala, H. J., Brummett, C., & Hurvitz, E. A. (2022). Opioid prescription patterns among adults with cerebral palsy and Spina Bifida. Heliyon, 8(7). https://doi.org/10.1016/j.heliyon.2022.e09918

[157] Mack KA, Jones CM, Ballesteros MF. Illicit drug use, illicit drug use disorders, and drug overdose deaths in metropolitan and nonmetropolitan areas—United States. Am J Transplant 2017;17:3241–52

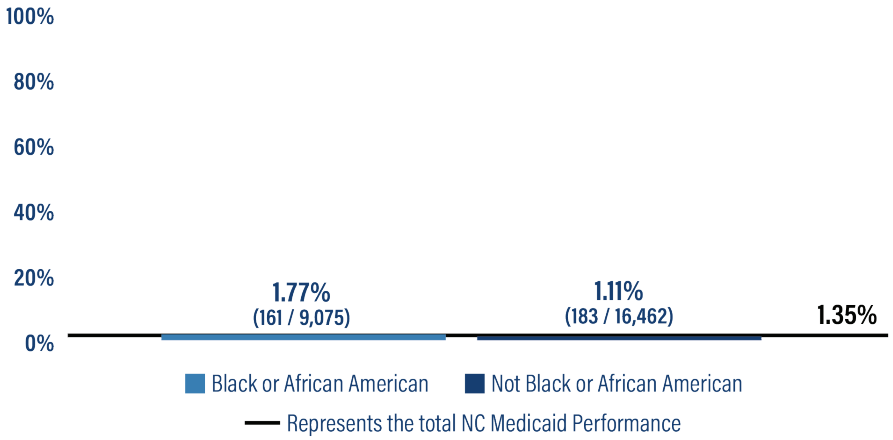
[158] Amanda Latimore, Alberto Ortega Hinojosa, Lauren Kestner, Parakh Patel. (Nov 2021). Exploring Urban-Rural Disparities in Accessing Treatment for Opioid Use Disorder. https://www.air.org/resource/field/exploring-urban-rural-disparities-accessing-treatment-opioid-use-disorder#:~:text=Rural%20and%20Urban%20Differences&text=Overall%2C%2035%20percent%20of%20rural,to%2Dno%20capacity%20for%20buprenorphine

Among adults in NC Medicaid, no disparities were identified based on gender, primary language, ethnicity, geography, American Indian /Alaskan Native binary race, disability status or age for the UOP measure. However, disparities were identified based on Black and African American binary race.

- Beneficiaries who identified as Black and African American fared worse than those who did not, with a relative difference of 59.59% (See Figure 58).

A Lower Rate Indicates Better Performance for This Measure

FIGURE 58: UOP, Multiple Prescribers and Multiple Pharmacies, 2023 NC Medicaid Performance by Black and African American Binary Race



Concurrent Use of Opioids and Benzodiazepines

The *Concurrent Use of Prescription Opioids and Benzodiazepines (COB)* measure assesses percentage of individuals ages 18 and older with concurrent use of prescription opioids and benzodiazepines during the measurement year.[157] A lower rate indicates better performance for this measure.

The concurrent use of opioids and benzodiazepines significantly increases the risk of overdose, respiratory depression, coma and even death. Both drug classes act as central nervous system depressants, and their combined effect can be highly dangerous.[158] The CDC recommends that clinicians should avoid prescribing opioids and benzodiazepines at the same time whenever possible. Improving the way opioids and benzodiazepines are prescribed helps patients to recover better or manage longer-term illnesses in a safe manner while reducing these risks.[159] Studies have found that African American, Multiracial and Asian American patients were less likely than White patients to receive benzodiazepine prescriptions.[160] These differences could be due to a combination of factors including racial bias, clinical perceptions of risk and disparities in access to and continuity of care.

[157] This measure is stewarded by the Pharmacy Quality Alliance (PQA). Opioid Measures Website: Retrieved from https://www.pqaalliance.org/opioid-measures

[158] Benzodiazepines and Opioids. National Institute on Drug Abuse (NIH). Accessed on 5/22/2025. Retrieved from https://nida.nih.gov/research-topics/opioids/benzodiazepines-opioids

[159] Prescription Opioid and Benzodiazepine Medications and Occupational Safety and Health. CDC. Overdose Resource Exchange (ORE). Accessed on 5/22/2025. Retrieved from https://www.cdc.gov/overdose-resources/hcp/files/prescription-opioid-and-benzodiazepine-medications-and-occupational-safety-and-health.html#:~:text=Avoid%20concurrent%20opioid%20or%20benzodiazepine,recommendations%20%5Bsee%20Hegmann%20et%20al.

[160] Samyukta Dore, Jeremy Weleff, Akhil Anand, Nicolas R. Thompson, Brian S. Barnett, Race, economic status, and disparities in the receipt of benzodiazepine prescriptions in a large primary care sample, General Hospital Psychiatry, ISSN 0163-8343, https://doi.org/10.1016/j.genhosppsych.2023.09.002.

TABLE 40: Trends in Priority Population Performance for COB measure by Stratification Element (lower rate indicates better performance)

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	14.74%	14.09% ↑
Living in a rural county	11.42%	11.08% ↑
Female	14.10%	14.01% ↑
Hispanic/Latino	9.82%	9.73% ↑
Speaking a non-English primary language	7.46%**	7.95%** ↓
Black and African American	5.72%	5.72%
American Indian and Alaskan Native	7.30%	6.21% ↑

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

**Small Cell Warning

Among adults in NC Medicaid, no disparities were identified based on primary language, ethnicity, American Indian/Alaskan Native binary race, Black and African American binary race or geography for the *Concurrent Use of Prescription Opioids and Benzodiazepines (COB)* measure. However, disparities were identified based on disability status and gender.

- Beneficiaries who identified as having a disability fared worse than those who did not, with a relative difference of 32.49% (See Figure 59).
- Beneficiaries who identified as female fared worse than those who identified as male, with a relative difference of 58.43% (See Figure 60).

A Lower Rate Indicates Better Performance for This Measure

FIGURE 59: *COB*, 2023 NC Medicaid Performance by Disability Status

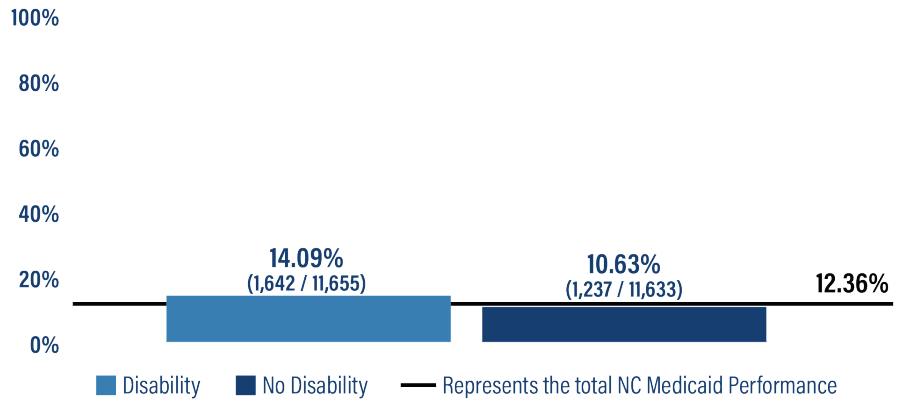
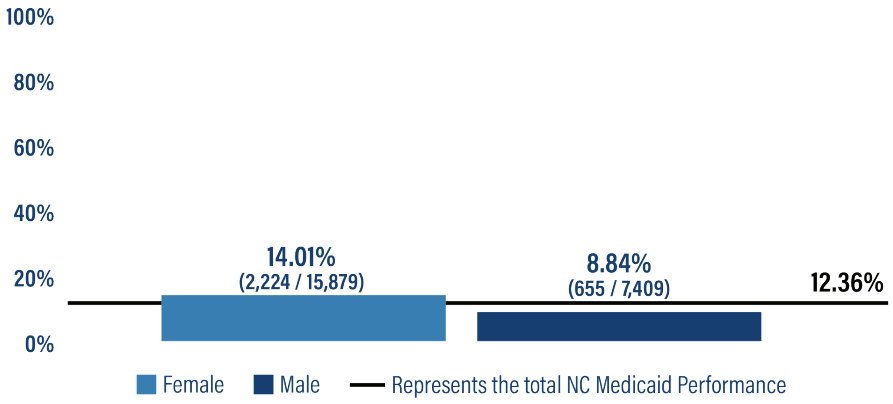


FIGURE 60: *COB*, 2023 NC Medicaid Performance by Gender



Initiation and Engagement of Substance Use Disorder Treatment

The *Initiation and Engagement of Substance Use Disorder Treatment (IET)* measure assesses the percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported:

1. Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days.
2. Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Initiation and engagement in SUD treatment are crucial for improving outcomes and reducing risks for individuals with SUD. Early and regular treatment, including medication-assisted therapy, can significantly reduce morbidity, mortality and other negative consequences associated with SUD.[161] Disparities have been found in outpatient SUD treatment completion rates, including one study that found individuals with substance use disorders in rural areas have lower rates of initial and ongoing treatment, and are more likely to seek care out-of-network.[162] Another study in Delaware, the state with the second highest drug overdose death rate, found that patients who identified as Black or African American were more likely to be lost contact with, administratively discharged or marked as failing to meet treatment requirements than having a completed treatment discharge when compared to White clients.[163] That same study found that women were 30% less likely than men to have "failed to meet treatment requirements" compared to completing treatment. Improvements in access to treatment have sought to decrease these disparities and increase treatment engagement and success.

[161] Kampman, K., K. Freedman. 2020. "American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update." *Journal of Addiction Medicine* 14, no. 2S: 1–91, Retrieved from https://doi.org/10.1097/ADM.0000000000000633.

[162] Raver E, Retchin SM, Li Y, Carlo AD, Xu WY. Rural-urban differences in out-of-network treatment initiation and engagement rates for substance use disorders. Health Serv Res. 2024 Oct;59(5):e14299. doi: 10.1111/1475-6773.14299. Epub 2024 Mar 8. PMID: 38456488; PMCID: PMC11366955.

[163] Borton, D., Streisel, S., Stenger, M., Fraser, K., Sutton, M., & Wang, Y. C. (2022). Disparities in substance use treatment retention: An exploration of reasons for discharge from publicly funded treatment. Journal of Ethnicity in Substance Abuse, 23(4), 857–875. Retrieved from https://doi.org/10.1080/15332640.2022.2143977

TABLE 41: Trends in Priority Population Performance for IET – *Initiation of SUD Treatment* measure by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	44.57%	42.79% ↓
Living in a rural county	41.31%	39.16% ↓
Female	41.33%	39.76% ↓
Hispanic/Latino	33.59%	34.31% ↑
Speaking a non-English primary language	24.79%	30.04% ↑
Black and African American	40.01%	37.04% ↓
American Indian and Alaskan Native	37.94%	36.28% ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

Among adults in NC Medicaid, no disparities were identified based on disability status, American Indian/Alaskan Native binary race, gender or geography for the IET, Initiation sub measure. However, disparities were identified based on primary language, Black and African American binary race and ethnicity.

- Beneficiaries who identified as having a primary language other than English fared worse than those who speak English as their primary language, with a relative difference of 24.36% (See Figure 61).
- Beneficiaries who identified as Black and African American fared worse than those who did not, with a relative difference of 10.30% (See Figure 62).
- Beneficiaries who identified as Hispanic or Latino fared worse than those who did not, with a relative difference of 14.06% (See Figure 63).

FIGURE 61: *IET, Initiation*, 2023 NC Medicaid Performance by Primary Language

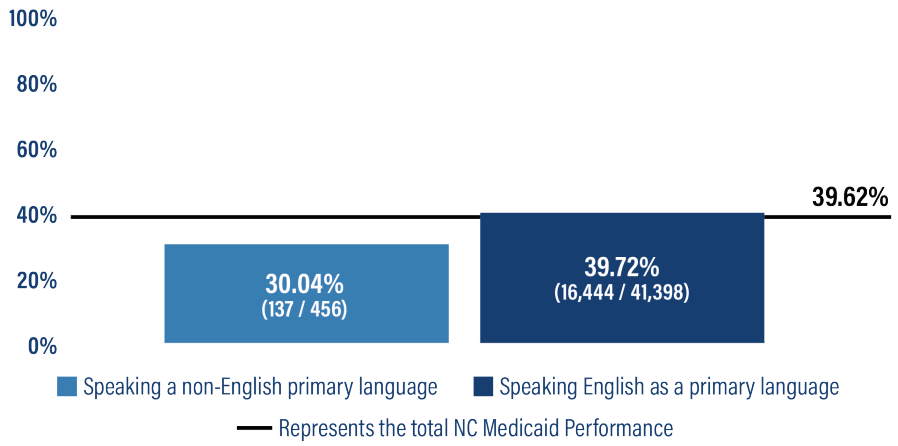


FIGURE 62: *IET, Initiation*, 2023 NC Medicaid Performance by Black and African American Binary Race

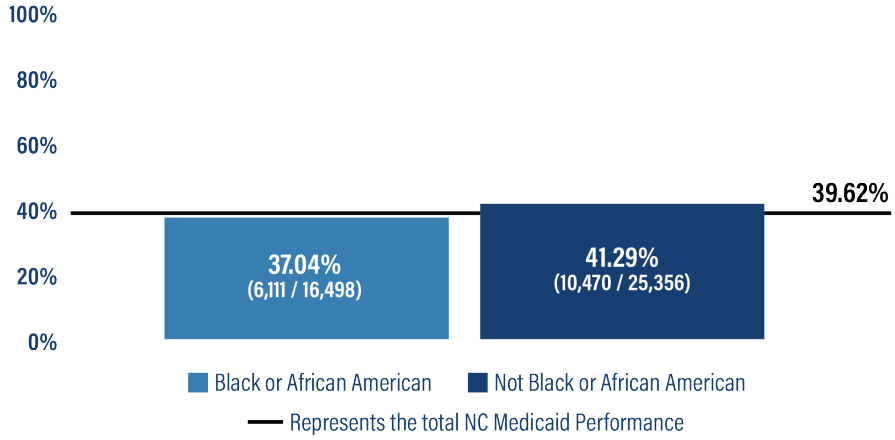


FIGURE 63: *IET, Initiation*, 2023 NC Medicaid Performance by Ethnicity

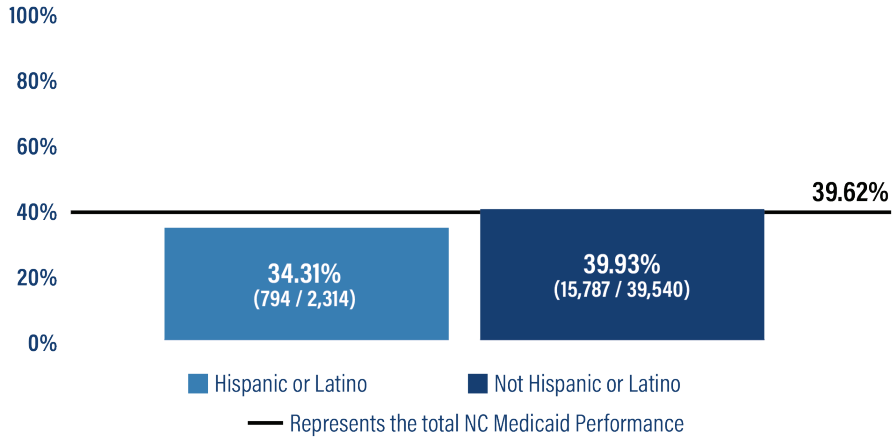


TABLE 42: Trends in Priority Population Performance for IET – Engagement of SUD Treatment measure by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	12.69%	10.33% ↓
Living in a rural county	16.13%	13.63% ↓
Female	15.08%	13.93% ↓
Hispanic/Latino	9.90%	10.33% ↑
Speaking a non-English primary language	7.41%*	8.77% ↑
Black and African American	11.98%	9.63% ↓
American Indian and Alaskan Native	15.26%	13.19% ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

**Small Cell Warning

Among adults in NC Medicaid, no disparities were identified based on American Indian/Alaskan Native binary race, gender, or geography for the *Initiation and Engagement of Substance Use Disorder Treatment (IET)*, Engagement sub measure. However, disparities were identified based on disability status, primary language, Black and African American binary race and ethnicity.

- Beneficiaries who identified as having a disability fared worse than those who did not, with a relative difference of 23.79% (See Figure 64).
- Beneficiaries who identified as having a primary language other than English fared worse than those who speak English as their primary language, with a relative difference of 31.65% (See Figure 65).
- Beneficiaries who identified as Black and African American fared worse than those who did not, with a relative difference of 35.18% (See Figure 66).
- Beneficiaries who identified as Hispanic or Latino fared worse than those who did not, with a relative difference of 20.14% (See Figure 67).

FIGURE 64: *IET, Engagement*, 2023 NC Medicaid Performance by Disability Status

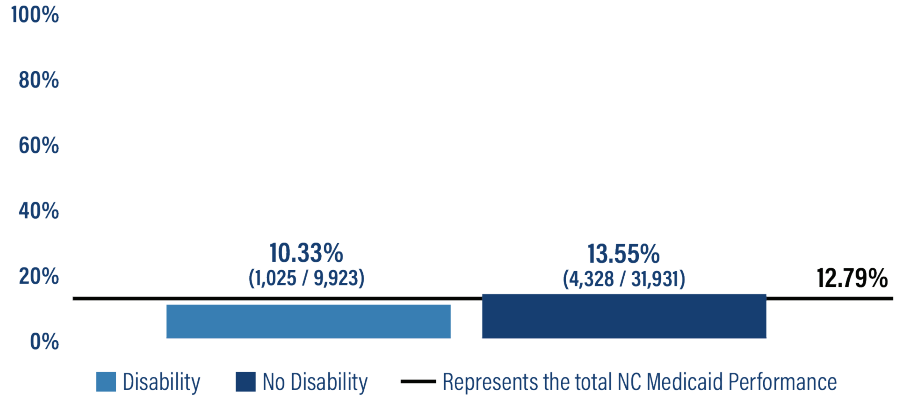


FIGURE 65: *IET, Engagement*, 2023 NC Medicaid Performance by Primary Language

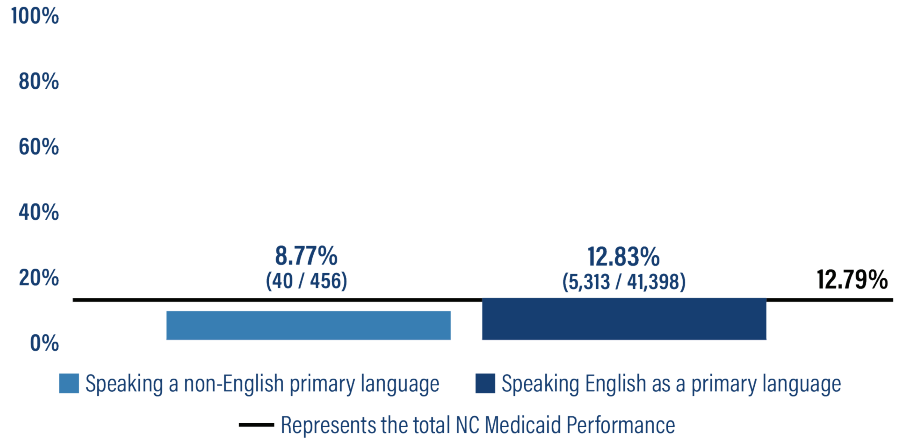


FIGURE 66: *IET, Engagement*, 2023 NC Medicaid Performance by Black and African American Binary Race

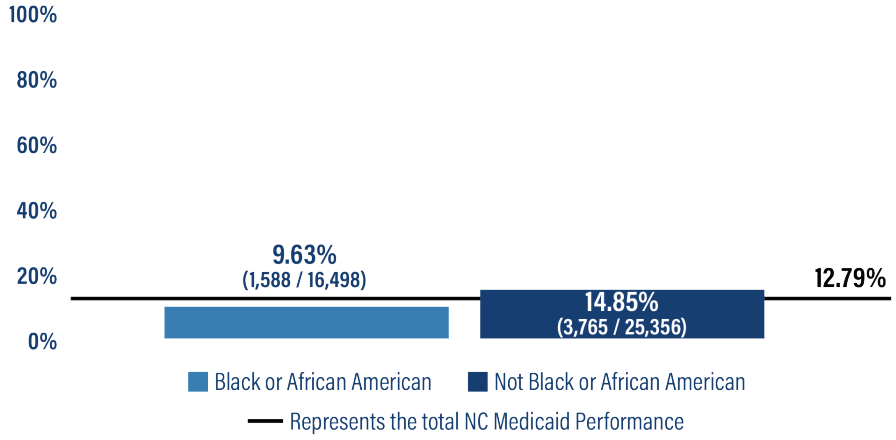
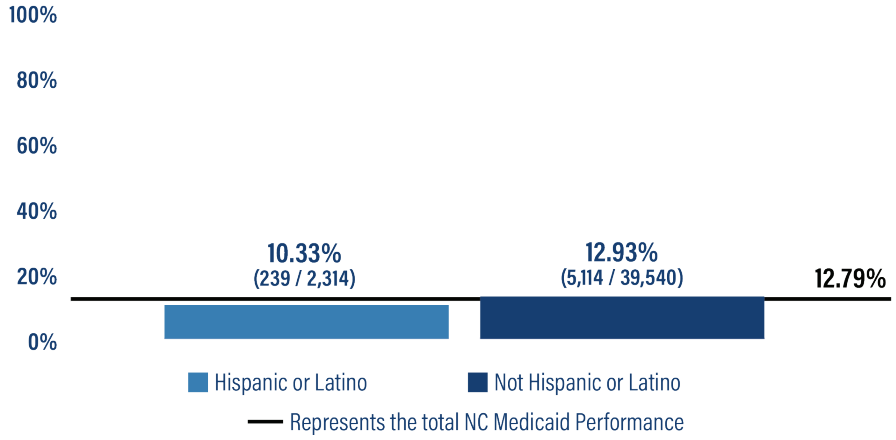


FIGURE 67: *IET, Engagement*, 2023 NC Medicaid Performance by Ethnicity



NC Medicaid's 1115 Waiver

In 2018, North Carolina's 1115 Demonstration Waiver was approved by CMS. The State's overarching goal for the demonstration was to improve health and well-being for all North Carolinians through a whole-person, well-coordinated system of care that addresses medical and non-medical drivers of health and advances health access by reducing disparities for groups that have been economically and socially marginalized. A key piece of this demonstration waiver was securing federal Medicaid matching funds for individuals obtaining SUD treatment in institutions for mental diseases (IMDs). This expansion of coverage aims to reduce SUD, decreasing long-term use of opioids and improving quality and outcomes for patients with SUD. This waiver was renewed in 2024, to learn more visit NC Medicaid's Section 1115 Demonstration Waiver page.

Health Care Utilization Domain Findings

The Health Care Utilization domain includes six measures related to adult and child condition-specific admissions. In 2020, 131.3 million individuals went to the ED in the United States, with 18.6 million ED visits resulting in a hospital admission.[164] ED utilization varies by race and ethnicity; non-Hispanic Black patients are twice as likely to visit an ED than their White or Hispanic counterparts.[165]

In 2018, there were nearly 3.8 million readmissions within 30 days of discharge in the United States with an average cost of $15,200 per readmission; and while some readmissions may be expected, most of them are not. For the 3.8 million readmissions, the top four primary diagnoses for the admissions were septicemia, heart failure, diabetes and COPD.[166] Given the cost associated with these types of visits and to ensure care is being provided to beneficiaries in appropriate settings, it is important to understand the reasons why beneficiaries are showing up in the ED for care, especially when it results in an admission (e.g., lack of access to a PCP, untreated or unmanaged conditions).

Table 43 displays the total NC Medicaid performance for the measures included in the Health Care Utilization domain.

TABLE 43: Health Care Utilization Domain NC Medicaid Aggregates

Those Who Identify As...	CY 2022 NC Medicaid Aggregate	CY 2023 NC Medicaid Aggregate
PQI 01: Diabetes Short-Term Complications Admission Rate Per 100,000 Member Months*	14.64	14.87 ↓
PQI 15: Asthma in Younger Adults Admission Rate Per 100,000 Member Months**	2.26	3.74 ↓
PQI 05: COPD or Asthma in Older Adults Admission Rate Per 100,000 Member Months*	33.71	42.38 ↓
PQI 08: Heart Failure Admission Rate Per 100,000 Member Months**	36.43	37.81 ↓
PDI 14: Pediatric Asthma Admission Rate Per 100,000 Member Months**	5.17	4.86 ↑
PDI 15: Pediatric Diabetes Short-Term Complications Admission Rate Per 100,000 Member Months*	2.61	2.49 ↑

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

**A lower rate indicates better performance for this measure.

See Appendix D for stratified results for all these measures.

[164] Centers for Disease Control and Prevention. National Center for Health Statistics: Emergency Department Visits. Available at: https://www.cdc.gov/nchs/fastats/emergency-department.htm. Accessed on: Jun 28, 2023.
[165] National Hospital Ambulatory Medical Care Survey: 2016 Emergency Department Summary Tables. Retrieved from https://www.cdc.gov/nchs/data/nhamcs/web_tables/2016_ed_web_tables.pdf
[166] Weiss AJ and Jiang HJ. Statistical Brief #278: Overview of Clinical Conditions with Frequent and Costly Hospital Readmissions by Payer, 2018. Available at: https://hcup-us.ahrq.gov/reports/statbriefs/sb278-Conditions-Frequent-Readmissions-By-Payer-2018.jsp. Accessed on: Jun 28, 2023.

PQI 01: Diabetes Short-Term Complications Admission Rate per 100,000 Member Months

The PQI 01: *Diabetes Short-Term Complications Admission Rate per 100,000 Member Months* measure assesses the number of hospitalizations for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 member months for beneficiaries 18 years of age and older. A lower rate indicates better performance for this measure.

If individuals with diabetes do not have access to high-quality outpatient care to properly manage their diabetes, they could become at risk for life-threatening diabetes complications. This can lead to expensive and unnecessary inpatient hospital admissions.[167] These outcomes are not evenly distributed. In 2019, people who identified as non-Hispanic Black were 2.5 times as likely to be hospitalized with diabetes and associated long-term complications than those who identify as non-Hispanic White.[168] These populations are more likely to live in under-resourced neighborhoods and face barriers such as poverty, lack of access to healthy food, restrictions on safe physical activity, inadequate employment and limited health education opportunities.[169] These social determinants of health are deeply rooted in a history of economic, environmental, social, and structural discrimination.

TABLE 44: Trends in Priority Population Performance for PQI *01 Diabetes Short-Term Complications Admission Rate per 100,000 Member Months* measure by Stratification Element (lower rate indicates better performance)

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	38.74	39.25 ↓
Living in a rural county	15.09	16.13 ↓
Female	14.36	14.64 ↓
Hispanic/Latino	5.47	6.40 ↓
Speaking a non-English primary language	3.99	4.47 ↑
Black and African American	19.44	19.08 ↑
American Indian and Alaskan Native	19.40	16.11 ↑

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

Among adults in NC Medicaid, no disparities were identified based on ethnicity, age, gender, or primary language. However, disparities were identified based on Black and American Indian/ Alaskan Native binary race, geography and disability status for the *PQI 01: Diabetes Short-Term Complications Admission Rate per 100,000 Member Months* measure:

- Beneficiaries who identified as having a disability fared worse than those who did not, with a relative difference of 293.49% (See Figure 68).
- Beneficiaries who identified as Black and African American fared worse than those who did not, with a relative difference of 58.32% (See Figure 69).

[167] Medicaid. PQI 01: Diabetes Short-Term Complications Admission Rate: Age 18 and Older. Available at: https://www.medicaid.gov/state-overviews/scorecard/diabetes-short-term-complications-admission-rate/index.html. Accessed on: Jun 28, 2023.

[168] Diabetes and African Americans.(2019). US Department of Health and Human Services. Office of Minority Health. Available at: https://minorityhealth.hhs.gov/diabetes-and-african-americans#:~:text=In%202019%2C%20non%2DHispanic%20blacks%20were%202.5%20times%20likely%20to,compared%20to%20non%2DHispanic%20whites.

[169] Diabetes in Black Communities. Understanding Health Inequity. (July 2022). Northwestern Medicine. Accessed on 6/5/2024. Available here: https://www.nm.org/healthbeat/healthy-tips/nutrition/diabetes-in-the-black-community#:~:text=Why%20Black%20People%20Are%20at,to%20be%20diagnosed%20with%20diabetes.

- Beneficiaries who identified as American Indian and Alaskan Native fared worse than those who do not, with a relative difference of 28.54% (See Figure 70).
- Beneficiaries who live in rural counties fared worse than those who do not, with a relative difference of 11.77% (See Figure 71).

Note: Please exercise caution when interpreting disparities findings given that some demographic stratifications are based on small numerators and/or denominators.

A Lower Rate Indicates Better Performance for This Measure

FIGURE 68: PQI 01, 2023 NC Medicaid Performance by Disability Status (per 100,000 member months)

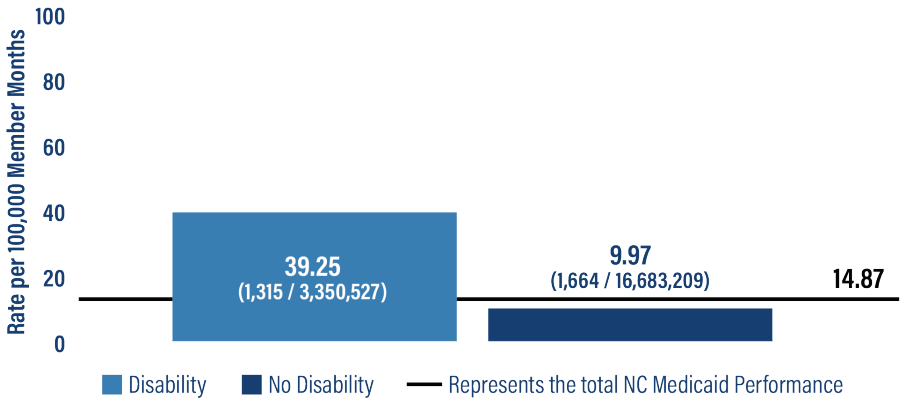


FIGURE 69: PQI 01, 2023 NC Medicaid Performance by Black and African American Binary Race (per 100,000 member months)

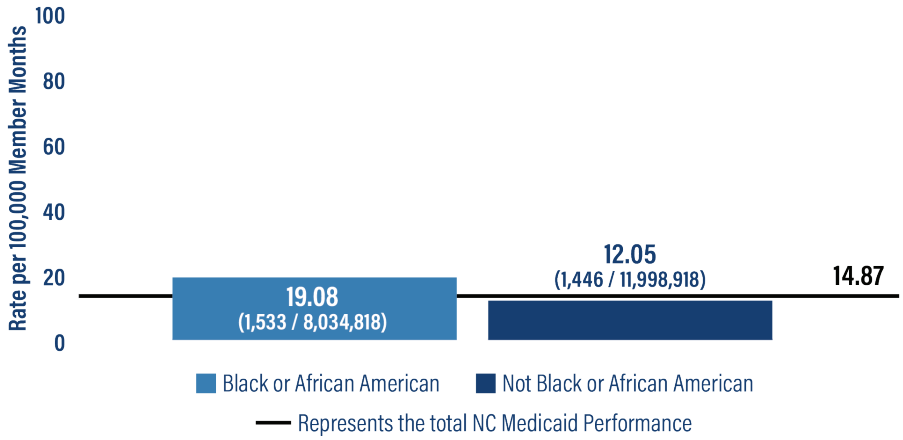


FIGURE 70: PQI 01, 2023 NC Medicaid Performance by American Indian and Alaskan Native Binary Race (per 100,000 member months)

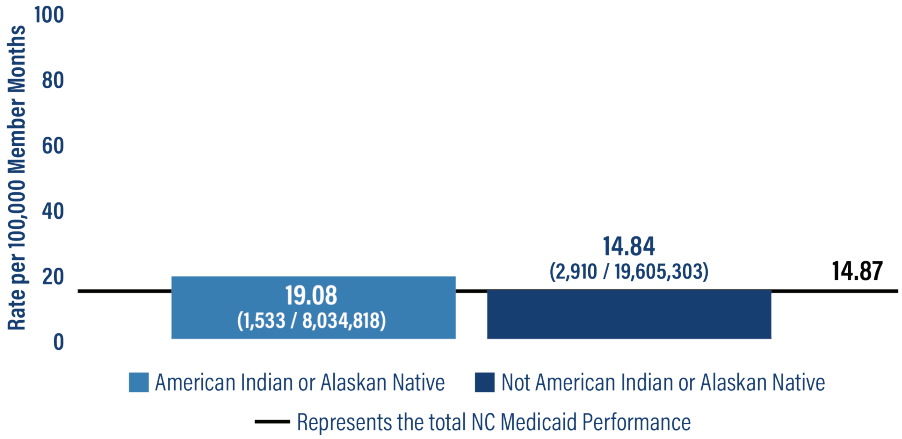
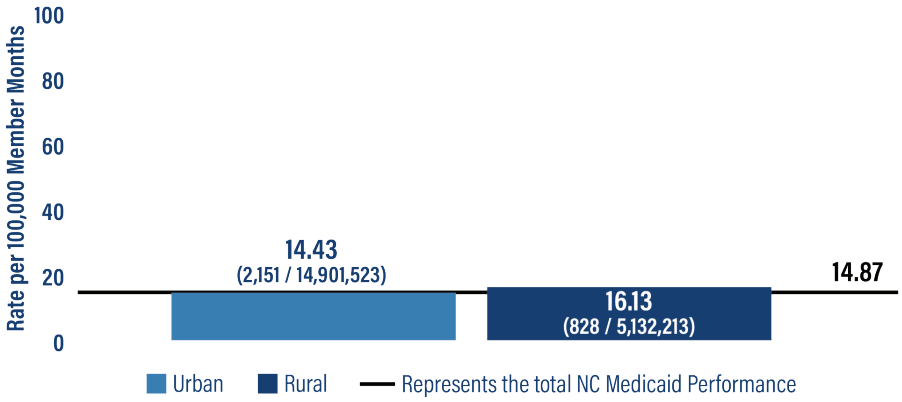


FIGURE 71: PQI01, 2023 NC Medicaid Performance by Geography (per 100,000 member months)



PQI 15: Asthma in Younger Adults Admission Rate per 100,000 Member Months

The *PQI 15: Asthma in Younger Adults Admission Rate per 100,000 Member Months* measure assesses the number of hospitalizations for a principal diagnosis of asthma per 100,000 member months for beneficiaries 18 to 39 years of age. A lower rate indicates better performance for this measure.

Communities that live in poverty and have been systemically discriminated against often reside in areas with increased air pollution. Living in a census tract identified as having disproportionately high environmental burdens, such as pollution exposure, can increase the odds of severe and uncontrolled asthma.[175] This association is influenced by age at onset, disease duration, and potentially by traffic-related air pollution exposure.

Around 25 million people in the United States are affected by asthma, a condition that can often be treated effectively.[170] Asthma affects all ages and genders within the United States, but individuals who identify as Black or African American are disproportionately burdened by this disease.[171] These disparities can partially be explained by these population's increased exposure to asthma triggers, like mold and allergens, which is due to structural issues such as systemic racism, segregation, and discriminatory housing policies.[172] In younger adults, asthma is one of the most common reasons for hospital admissions and emergency room visits; this is considered preventable with proper observation and treatment in outpatient settings.[173] Studies have found that asthma was more common among children who identified as male, Black or African American, whose parents' education level was less than a bachelor's degree and who had public health insurance.[174]

TABLE 44: Trends in Priority Population Performance for PQI *01 Diabetes Short-Term Complications Admission Rate per 100,000 Member Months* measure by Stratification Element (lower rate indicates better performance)

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	6.33	6.10 ↑
Living in a rural county	2.59	1.82 ↑
Female	2.77	2.83 ↓
Hispanic/Latino	0.62	1.05 ↓
Speaking a non-English primary language	0.85	0.34 ↑
Black and African American	3.24	3.33 ↓
American Indian and Alaskan Native	2.67	3.00 ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

[170] Centers for Disease Control and Prevention (CDC). 2021. "Most Recent National Asthma Data" Available here: https://www.cdc.gov/asthma/most_recent_national_asthma_data.htm
[171] Perez MF, Coutinho MT. An Overview of Health Disparities in Asthma. Yale J Biol Med. 2021 Sep 30;94(3):497-507. PMID: 34602887; PMCID: PMC8461584.
[172] Asthma and Allergy Foundation of America, (2020). [Asthma Disparities in America: A Roadmap to Reducing Burden on Racial and Ethnic Minorities]. Retrieved from aafa.org/asthmadisparities
[173] Centers for Medicare & Medicaid Services. Medicaid/CHIP: Health Care Quality Measures. Quality of Care for Adults in Medicaid: Findings from the 2017 Adult Core Set. Dec 2018. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-adult-chart-pack.pdf. Accessed on: Jun 28, 2023.
[174] Pate CA, Qin X, Johnson C, Zahran HS. Asthma disparities among U.S. children and adults. J Asthma. 2023 Dec;60(12):2214-2223. doi: 10.1080/02770903.2023.2228915. Epub 2023 Jul 10. PMID: 37366607; PMCID: PMC10760409.
[175] Byrwa-Hill BM, Morphew TL, Presto AA, Fabisiak JP, Wenzel SE. Living in environmental justice areas worsens asthma severity and control: Differential interactions with disease duration, age at onset, and pollution. J Allergy Clin Immunol. 2023 Nov;152(5):1321-1329.e5. doi: 10.1016/j.jaci.2023.04.015. Epub 2023 May 6. PMID: 37156327; PMCID: PMC10626048.

Among adults in NC Medicaid, no disparities were identified based on age, ethnicity, geography or primary language for the *PQI 15: Asthma in Younger Adults Admission Rate per 100,000 Member Months*. However, disparities were identified based on American Indian/Alaskan Native and Black or African American binary race, gender and disability status:

- Beneficiaries who identified as having a disability fared worse than those who did not, with a relative difference of 213.94% (See Figure 72).
- Beneficiaries who identified as American Indian and Alaskan Native fared worse than those who did not, with a relative difference of 28.95% (See Figure 73).
- Beneficiaries who identified as Black and African American fared worse than those who did not, with a relative difference of 99.52% (See Figure 74).
- Beneficiaries who identified as Female fared worse than those who identified as Male, with a relative difference of 92.79% (See Figure 75).

Note: Please exercise caution when interpreting disparities findings given that some demographic stratifications are based on small numerators and/or denominators.

A Lower Rate Indicates Better Performance for This Measure

FIGURE 72: PQI 15, 2022 NC Medicaid Performance by Disability Status (per 100,000 member months)

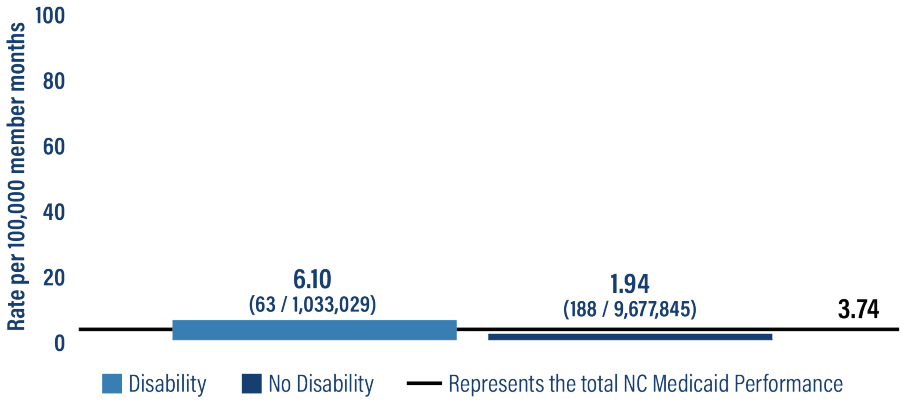


FIGURE 73: PQI 15, 2022 NC Medicaid Performance by Black and African American Binary Race (per 100,000 member months)

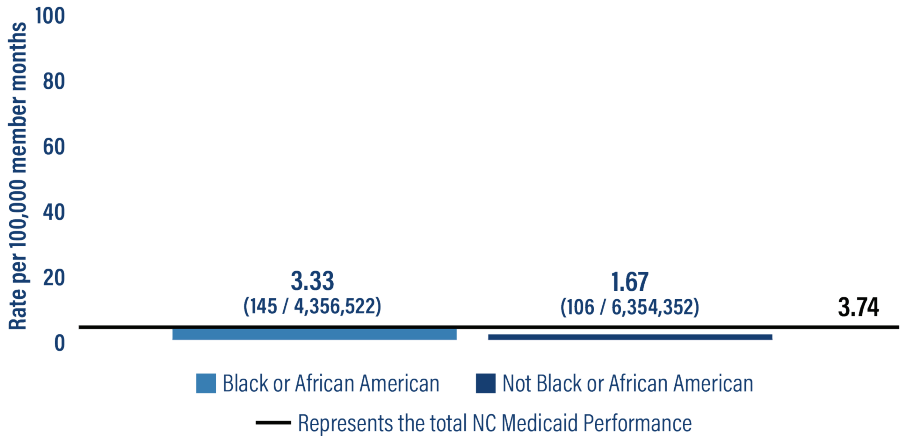


FIGURE 74 PQI 15, 2022 NC Medicaid Performance by American Indian and Alaskan Native Binary Race (per 100,000 member months)

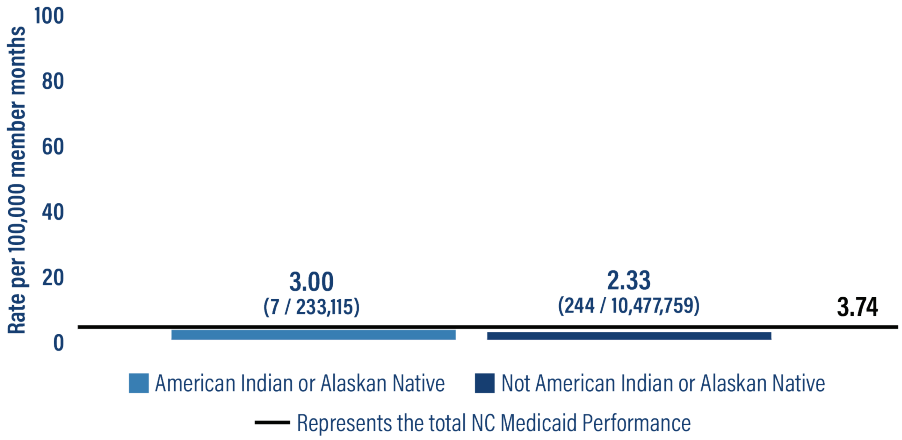
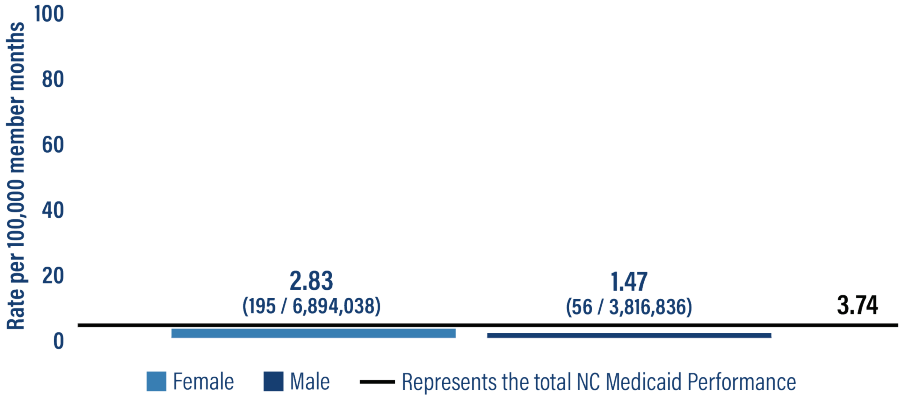


FIGURE 75: PQI 15, 2022 NC Medicaid Performance by Gender (per 100,000 member months)



PQI 05: COPD or Asthma in Older Adults Admission Rate per 100,000 Member Months

The *PQI 05: COPD or Asthma in Older Adults Admission Rate per 100,000 Member Months* measure assesses the number of hospitalizations with a principal diagnosis of COPD or asthma per 100,000 member months for beneficiaries 40 years and older. A lower rate indicates better performance for this measure.

COPD is one of the most prevalent chronic diseases in the United States and ranked as the sixth overall leading cause of death in the United States in 2021.[176] Hospital admissions for COPD and asthma could be prevented with proper management in an outpatient setting.[177] People who identify as Black and African American and American Indian or Alaskan Natives have the highest current asthma rates compared to other races and ethnicities. In 2018, people who identified as Black (10.9%) were 42% more likely than those who identify as White (7.7%) to still have asthma.[178]

[176] COPD Trends Brief: Mortality. (2021) American Lunch Association. Accessed on 12/22/2023. Retrieved from https://www.lung.org/research/trends-in-lung-disease/copd-trends-brief/copd-mortality#:~:text=Age-,Leading%20Causes,19%2C%20accidents%2C%20and%20stroke.

[177] Bindman AB, Grumbach K, Osmond D, et al. Preventable hospitalizations, and access to health care. JAMA 1995;274(4):305–11.

[178] Current Asthma Rates by Race/Ethnicity. CDC. NIHS 2018. Analysis by the American Lung Association. Available here: https://www.lung.org/research/trends-in-lung-disease/asthma-trends-brief/current-demographics#raceEthnicity

TABLE 46: Trends in Priority Population Performance for PQI 05: COPD or Asthma in Older Adults Admission Rate per 100,000 Member Months measure by Stratification Element (lower rate indicates better performance)

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	73.56	89.71 ↓
Living in a rural county	32.56	41.79 ↓
Female	33.79	43.45 ↓
Hispanic/Latino	11.87	10.79 ↑
Speaking a non-English primary language	6.18	6.74 ↓
Black and African American	31.45	37.33 ↓
American Indian and Alaskan Native	75.09	45.67 ↑

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

Among adults in NC Medicaid, no disparities were identified based on primary language, age, gender, Black or African American binary race or geography for the *PQI 05: COPD or Asthma in Older Adults Admission Rate per 100,000 Member Months* measure. However, disparities were identified based on American Indian/Alaskan Native binary race and disability status:

- Beneficiaries who identified as having a disability fared worse than those who did not, with a relative difference of 235.71% (See Figure 76).
- Beneficiaries who identified as American Indian and Alaskan Native fared worse than those who did not, with a relative difference of 46.38% (See Figure 77).

Note: Please exercise caution when interpreting disparities findings given that some demographic stratifications are based on small numerators and/or denominators.

A Lower Rate Indicates Better Performance for This Measure

FIGURE 76: PQI 05, 2023 NC Medicaid Performance by Disability Status (per 100,000 member months)

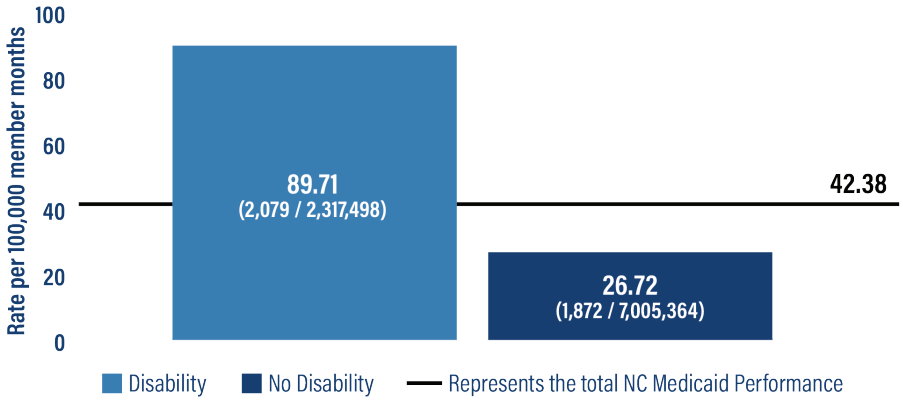
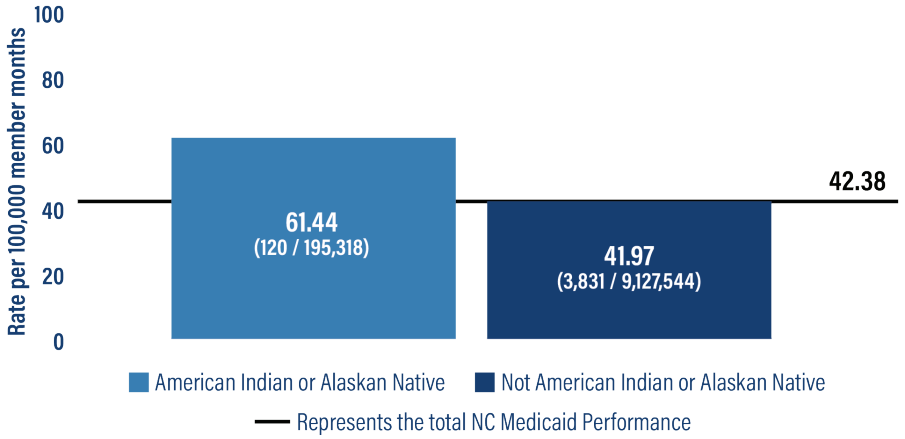


FIGURE 77: PQI 05, 2023 NC Medicaid Performance by American Indian and Alaskan Native Binary Race (per 100,000 member months)



PQI 08: Heart Failure Admission Rate per 100,000 Member Months

The *PQI 08: Heart Failure Admission Rate per 100,000 Member Months* measure assesses the number of hospitalizations with a principal diagnosis of heart failure per 100,000 member months for beneficiaries 18 years of age and older. A lower rate indicates better performance for this measure.

Approximately 6.2 million people in the United States suffer from congestive heart failure (CHF), with coronary artery disease, high blood pressure and diabetes being the most common causes. These underlying conditions can be treated, controlled, and monitored effectively in outpatient settings. In cases where CHF patients are hospitalized, it could be due to the lack of proper prevention and management of these conditions.[179] Racial and ethnic minoritized groups have the highest incidence, prevalence and hospitalization rates from heart failure.[180] Research has found that overall heart failure survival has improved, and some racial and ethnic disparities have narrowed, but some disparities in heart failure outcomes, access to advanced therapies and utilization of therapies had persisted or worsened.

TABLE 47: Trends in Priority Population Performance for PQI 08: Heart Failure Admission Rate per 100,000 Member Months measure by Stratification Element (lower rate indicates better performance)

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	111.00	111.27 ↓
Living in a rural county	38.40	40.18 ↓
Female	28.74	31.61 ↓
Hispanic/Latino	11.87	12.38 ↓
Speaking a non-English primary language	15.36	18.26 ↓
Black and African American	52.57	51.70 ↑
American Indian and Alaskan Native	28.50	29.41 ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

[179] Centers for Disease Control and Prevention. Heart Disease. Available at: https://www.cdc.gov/heartdisease/heart_failure.htm. Accessed on: Jun 28, 2023.
[180] Lewsey SC, Breathett K. Racial and ethnic disparities in heart failure: current state and future directions. Curr Opin Cardiol. 2021 May 1;36(3):320-328. doi: 10.1097/HCO.0000000000000855. PMID: 33741769; PMCID: PMC8130651.

Among adults in NC Medicaid, no disparities were identified based on ethnicity, age, gender, primary language, American Indian/Alaskan Native binary race or geography. However, disparities were identified based on Black or African American binary race and disability status for the *PQI 08: Heart Failure Admission Rate per 100,000 Member Months* measure:

- Beneficiaries who identified as having a disability fared worse than those who did not, with a relative difference of 382.65% (See Figure 78).
- Beneficiaries who identified as Black and African American fared worse than those who did not, with a relative difference of 81.39% (See Figure 79).

Note: Please exercise caution when interpreting disparities findings given that some demographic stratifications are based on small numerators and/or denominators

A Lower Rate Indicates Better Performance for This Measure

FIGURE 78: PQI 08, 2023 NC Medicaid Performance by Disability Status (per 100,000 member months)

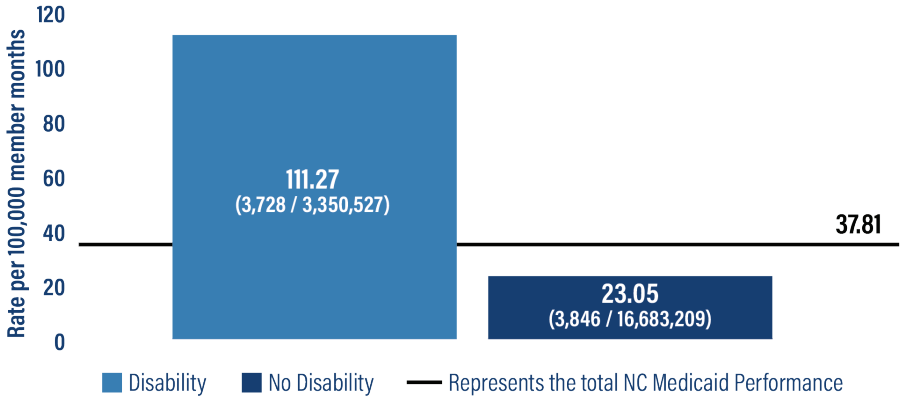
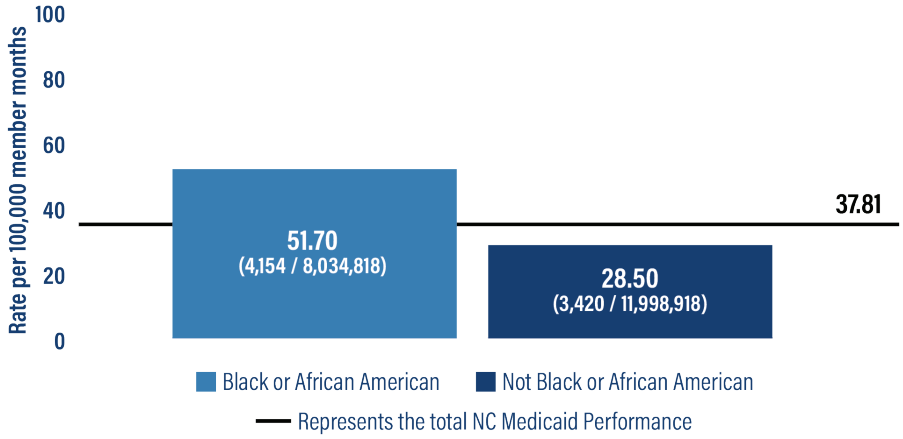


FIGURE 79: PQI 08, 2023 NC Medicaid Performance by Black and African American Binary Race (per 100,000 member months)



PDI 14: Pediatric Asthma Admission Rate per 100,000 Member Months

The *PDI 14: Pediatric Asthma Admission Rate per 100,000 Member Months* measure assesses the number of hospitalizations with a principal diagnosis of asthma per 100,000 member months for beneficiaries two to 17 years of age. A lower rate indicates better performance for this measure.

Asthma is the most prevalent chronic illness among children, currently affecting more than 4.5 million children in the United States.[181] Proper management of asthma is crucial to prevent it from becoming more severe and debilitating. Poorly controlled asthma can increase the risk of ED visits, hospitalization and school absences, causing a significant burden on the patients, families and health care systems.[182] Disparities in asthma outcomes have been documented since the 1980s, showing that children who identify as Black or African American face higher morbidity and mortality due to asthma when compared with children who identify as White.[183] More recent research has found that these disparities in pediatric asthma are lessened after controlling for material hardship, which was defined as parent- reported poor housing quality, housing crowding, lack of amenities and no vehicle access.[184] Poor housing quality in particular is strongly associated with asthma morbidity.

Environmental injustice is the inequitable and disproportionately heavy exposure of poor, systemically marginalized, and disenfranchised populations to toxic chemicals, contaminated air and water, unsafe workplaces and other environmental hazards. The concept of environmental injustice was first developed in the 1980s in studies of hazardous waste sites that found waste sites in the Southeast were located disproportionately in poor counties inhabited largely by African Americans, Native Americans and other marginalized populations.[186]

In addition to indoor air pollution found in poor quality housing, disproportionate exposures to ambient or environmental air pollutants in lower income communities are a clear example of environmental injustice associated with elevated rates of asthma. Among the ambient air pollutants found in especially high concentrations in lower income communities and neighborhoods of color are fine particulates, ozone and oxides of nitrogen.[185]

NC Environmental Justice

NC Department of Environmental Quality's Environmental Justice Program works to ensure the fair treatment and meaningful involvement of all people regardless of race, color, national origin or income with respect to the development, implementation and enforcement of environmental laws, regulations and policies. The North Carolina Department of Environmental Quality (DEQ) strives to conduct the people's business in an open and transparent way. Below are some resources and tools from their website on environmental justice efforts.

- Environmental Justice Reports
- NC Community Mapping System
- Public Participation Plan & Language Access Plan

[181] National Center for Health Statistics. (2022). 2021 NHIS Child Summary Health Statistics. U.S. Department of Health and Human Services. https://data.cdc.gov/d/wxz7-ekz9

[182] Pu C, Tseng YC, Tang GJ, et al. Perception and Willingness to Maintain Continuity of Care by Parents of Children with Asthma in Taiwan. Int J Environ Res Public Health. Mar 30, 2021; 18(7):3600. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8037309. Accessed on: Jun 28, 2023.

[183] Anna Volerman, Marshall H. Chin, Valerie G. Press; Solutions for Asthma Disparities. Pediatrics March 2017; 139 (3): e20162546. 10.1542/peds.2016-2546

[184] Hughes HK, Matsui EC, Tschudy MM, Pollack CE, Keet CA. Pediatric Asthma Health Disparities: Race, Hardship, Housing, and Asthma in a National Survey. Acad Pediatr. 2017 Mar;17(2):127-134. doi: 10.1016/j.acap.2016.11.011. Epub 2016 Nov 19. PMID: 27876585; PMCID: PMC5337434.

[185] Landrigan PJ, Rauh VA, Galvez MP. Environmental justice and the health of children. Mt Sinai J Med. 2010 Mar-Apr;77(2):178-87. doi: 10.1002/msj.20173. PMID: 20309928; PMCID: PMC6042867.

[186] Bullard RD, Wright BH. Environmental justice for all: community perspectives on health and research needs. Toxicol Ind Health. 1993;9:821–841. doi: 10.1177/074823379300900508

TABLE 48: Trends in Priority Population Performance for PDI:14 Pediatric Asthma Admission Rate per 100,000 Member Months measure by Stratification Element (lower rate indicates better performance)

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	8.93	10.04 ↓
Living in a rural county	3.49	2.58 ↑
Female	4.55	3.94 ↑
Hispanic/Latino	3.44	3.83 ↓
Speaking a non-English primary language	3.07	2.92 ↑
Black and African American	8.39	8.05 ↑
American Indian and Alaskan Native	6.05	6.64 ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

Among children in NC Medicaid, no disparities were identified based on ethnicity, age, gender, geography or primary language. However, disparities were identified based on both Black and American Indian/Alaskan Native binary race and disability status for the *PDI 14: Pediatric Asthma Admission Rate per 100,000 Member Months* measure:

- Beneficiaries who identified as having a disability fared worse than those who did not, with a relative difference of 115.34% (See Figure 80).
- Beneficiaries who identified as Black and African American fared worse than those who did not, with a relative difference of 186.27% (See Figure 81).
- Beneficiaries who identified as American Indian and Alaskan Native fared worse than those who do not, with a relative difference of 37.74% (See Figure 82).

Note: Please exercise caution when interpreting disparities findings given that some demographic stratifications are based on small numerators and/or denominators.

A Lower Rate Indicates Better Performance for This Measure

FIGURE 80: PDI 14, 2023 NC Medicaid Performance by Disability Status (per 100,000 member months)

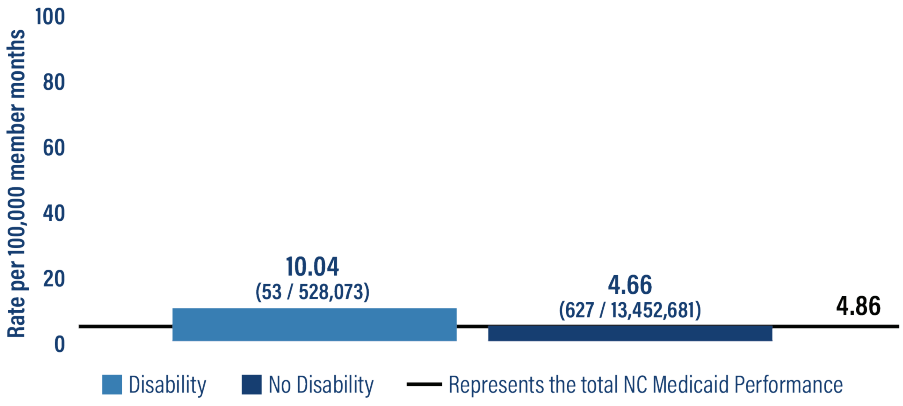


FIGURE 81: PDI 14, 2023 NC Medicaid Performance by Black or African American Binary Race (per 100,000 member months)

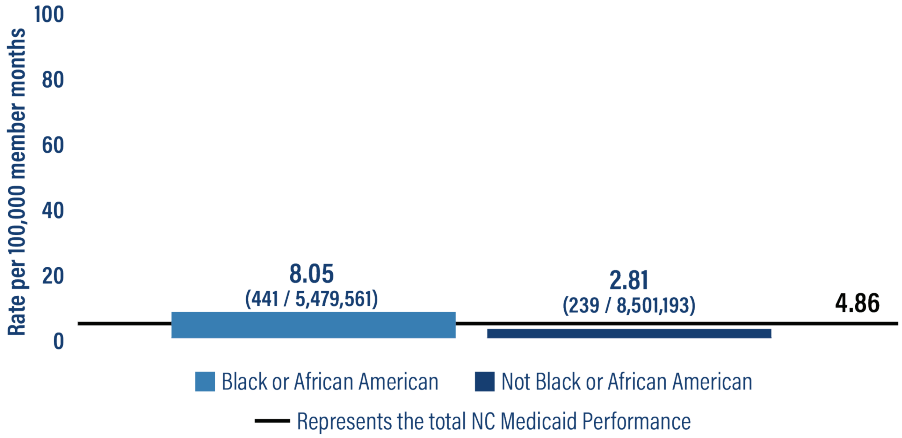
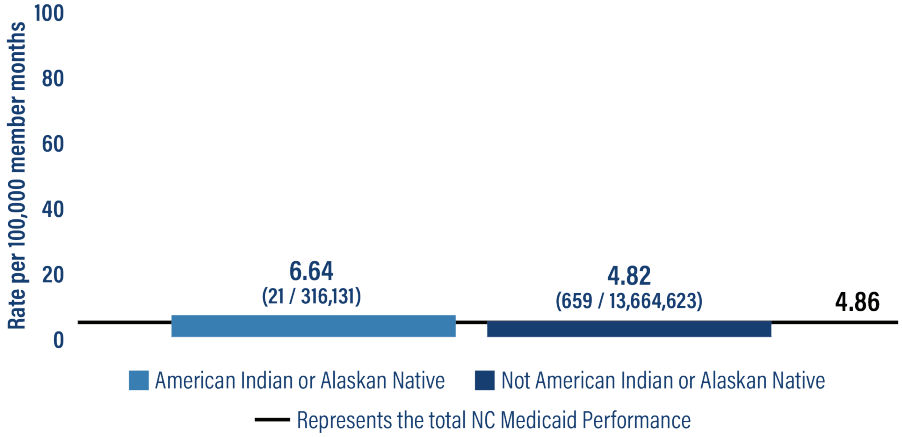


FIGURE 82: PDI 14, 2023 NC Medicaid Performance by American Indian or Alaskan Native Binary Race (per 100,000 member months)



PDI 15: Diabetes Short-Term Complications Admission Rate per 100,000 Member Months

The *PDI 15: Pediatric Diabetes Short-Term Complications Admission Rate per 100,000 Member Months* measure assesses the number of hospitalizations with a primary diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 member months for beneficiaries six to 17 years of age. A lower rate indicates better performance for this measure.

Although the prevalence of type 2 diabetes is on the rise in the pediatric population, type 1 diabetes is still the most prevalent form diagnosed in pediatric populations in the United States.[187] Providers should collaborate with families in an outpatient setting to develop age-appropriate treatment goals focusing on nutrition, physical activity and medication treatment, in order to appropriately manage diabetes and prevent complications.[188] The same risk factors seen in adults, such as family history, obesity and

[187] National Diabetes Statistics Report. (2021). Centers for Disease Control and Prevention (CDC). Available at: https://www.cdc.gov/diabetes/data/statistics-report/index.html. Accessed on March 19,2023.
[188] Beck JK and Cogen FR. Outpatient Management of Pediatric Type 1 Diabetes. Sep–Oct 2015. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4596120. Accessed on: Jun 28, 2023.

lack of physical activity, can also increase the likelihood of a child developing diabetes. Children with any type of diabetes are at a higher risk of complications related to the disease. It is crucial to identify, screen and treat children with type 2 diabetes early to prevent long-term complications from the disease.189 Despite significant advancements in the care of children with diabetes, racial and ethnic disparities in care delivery and health outcomes persist in the United States. A large pediatric cohort study found that even after socio-economic status (SES) adjustment, disparities in insulin treatment method and treatment outcomes existed between Black versus Hispanic and White children. The study recommended that barriers to insulin pump use and optimal glycemic control beyond SES should be explored in all ethnic groups.[190]

TABLE 49: Trends in Priority Population Performance for PDI 15: Pediatric Diabetes Short-Term Complications Admission Rate per 100,000 Member Months measure by Stratification Element (lower rate indicates better performance)

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	7.02	6.65 ↑
Living in a rural county	2.05	1.90 ↑
Female	2.56	2.82 ↓
Hispanic/Latino	1.75	1.24 ↑
Speaking a non-English primary language	1.96	0.66 ↑
Black and African American	3.20	3.28 ↓
American Indian and Alaskan Native	0.42	1.65 ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

Among children in NC Medicaid, no disparities were identified based on ethnicity, age, gender, primary language, American Indian/Alaskan Native binary race or geography. However, disparities were identified based on Black or African American binary race, gender and disability status for the *PDI 15: Pediatric Diabetes Short-Term Complications Admission Rate per 100,000 Member Months* measure:

- Beneficiaries who identified as having a disability fared worse than those who did not, with a relative difference of 187.89% (See Figure 83).
- Beneficiaries who identified as female fared worse than those who identified as male, with a relative difference of 29.32% (See Figure 84).
- Beneficiaries who identified as Black and African American fared worse than those who did not, with a relative difference of 65.37% (See Figure 85).

Note: Please exercise caution when interpreting disparities findings given that some demographic stratifications are based on small numerators and/or denominators.

A Lower Rate Indicates Better Performance for This Measure

189 Tillotson CV, Bowden SA, Boktor SW. Pediatric Type 2 Diabetes Mellitus. StatPearls. Jul 18, 2022. Available at: https://www.ncbi.nlm.nih.gov/books/NBK431046. Accessed on: Jun 28, 2023.
190 Willi SM, Miller KM, DiMeglio LA, Klingensmith GJ, Simmons JH, Tamborlane WV, Nadeau KJ, Kittelsrud JM, Huckfeldt P, Beck RW, Lipman TH; T1D Exchange Clinic Network. Racial-ethnic disparities in management and outcomes among children with type 1 diabetes. Pediatrics. 2015 Mar;135(3):424-34. doi: 10.1542/peds.2014-1774. PMID: 25687140; PMCID: PMC4533245.

FIGURE 83: PDI 15, 2023 NC Medicaid Performance by Disability Status (per 100,000 member months)

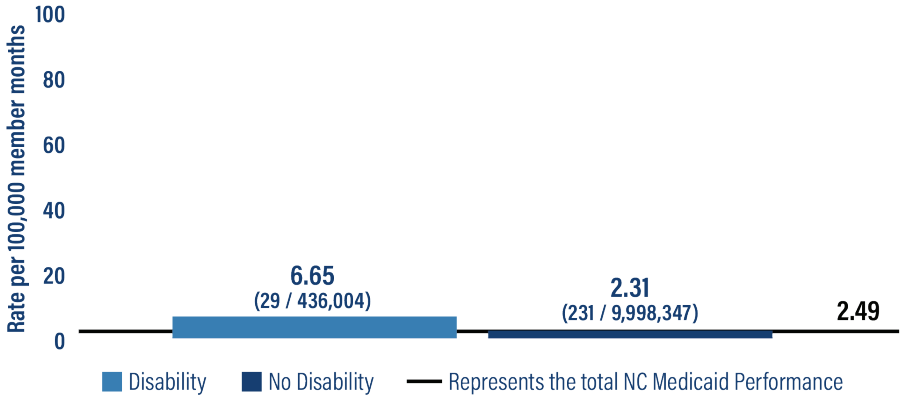


FIGURE 84: PDI 15, 2023 NC Medicaid Performance by Gender (per 100,000 member months)

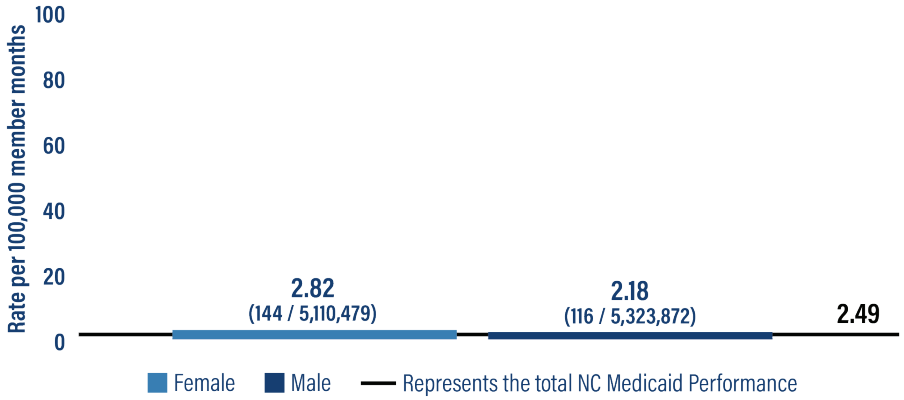
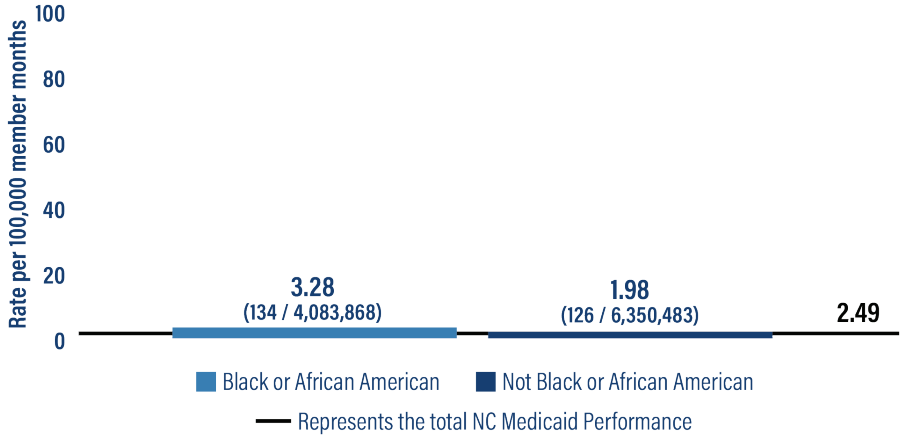


FIGURE 85: PDI 15, 2023 NC Medicaid Performance by Black or African American Binary Race (per 100,000 member months)



Chronic Health Domain Findings

Chronic health conditions are long-term diseases or illnesses that persist for an extended period, typically more than three months. Chronic health conditions are a significant public health concern, as many of them are the leading causes of illness, disability and death, and account for a large portion of healthcare costs. The chronic health domain includes four measures that assess rates of high blood pressure, diabetes care and cancer screening.

North Carolina's Medicaid expansion has been crucial in addressing chronic diseases among North Carolinians by providing access to care, improving outcomes and decreasing mortality rates for many chronic conditions. Although establishing direct causality between health insurance and health outcomes is complex, evidence generally shows Medicaid expansion is associated with improved health outcomes for chronic conditions, including increased early-stage cancer diagnosis, improved disease management and lower mortality rates for many chronic conditions.[191]

Table 50 displays the total NC Medicaid performance for the measures included in the Chronic Health domain.

TABLE 50: Chronic Health Domain NC Medicaid Aggregates

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Controlling High Blood Pressure (CBP)	41.08%	50.41% ↑
Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD) - HbA1c Control (<8.0%)	8.62%	8.48% ↓
Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD) - HbA1c Poor Control (>9.0%)**	90.41%	90.28% ↑
Colorectal Cancer Screening (COL)	31.90%	22.56% ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

**A lower rate indicates better performance for this measure.

*** CY 2023 NC Medicaid Aggregate rate represents the performance of NC Medicaid beneficiaries but excludes limited benefit members and dual eligibles. Please see appendix A "Partial Benefit Group Exclusions" section for more information

Controlling High Blood Pressure

The measure assesses the percentage of members ages 18 through 85 who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.

Hypertension, also known as high blood pressure, is a condition where the force of blood pushing against the walls of your arteries is persistently too high.[192] Roughly one in three adult Medicaid beneficiaries throughout the United States have been told they had hypertension.[193] While it can be managed through diet, exercise and medication, when left untreated, hypertension can cause heart attack or heart failure, increase one's risk of having a stroke and cause damage to the kidneys.[194] Studies have found persistent disparities in rates of hypertension and blood pressure control among Americans from racial or ethnic minority groups. [195] Many

[191] Jessica Mathers, Jennifer Tolbert, Priya Chidambaram, and Sammy Cervantes. 5 Key Facts About Medicaid Expansion. (KFF) April 2025. Retrieved from https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-expansion/#:~:text=Although%20establishing%20direct%20causality%20between,rates%20for%20many%20chronic%20conditions.

[192] What is High Blood Pressure? American Heart Association (AHA). Accessed on 5/12/2025. Retrieved from https://www.heart.org/en/health-topics/high-blood-pressure/the-facts-about-high-blood-pressure

[193] Centers for Medicare and Medicaid Services (CMS). Medicaid Facts and Figures. (Jan 2020). Accessed 5/12/2025. Retrieved from https://www.cms.gov/newsroom/fact-sheets/medicaid-facts-and-figures

[194] National Heart, Lung, and Blood Institute (NIH). High Blood Pressure Website. Accessed on 5/12/2025. Retrieved from https://www.nhlbi.nih.gov/health/high-blood-pressure/treatment

[195] Abrahamowicz AA, Ebinger J, Whelton SP, Commodore-Mensah Y, Yang E. Racial and Ethnic Disparities in Hypertension: Barriers and Opportunities to Improve Blood Pressure Control. Curr Cardiol Rep. 2023 Jan;25(1):17-27. doi: 10.1007/s11886-022-01826-x. Epub 2023 Jan 9. PMID: 36622491; PMCID: PMC9838393.

factors contribute to blood pressure control including key social determinants of health (SDOH) such as health literacy, socioeconomic status and access to healthcare as well as low awareness rates and dietary habits. Interventions such as dietary programs designed to help reduce salt intake, faith-based interventions and community-based programs have found success in achieving better blood pressure control.

TABLE 51: Trends in Priority Population Performance for Controlling High Blood Pressure (CBP) measure by Stratification Element

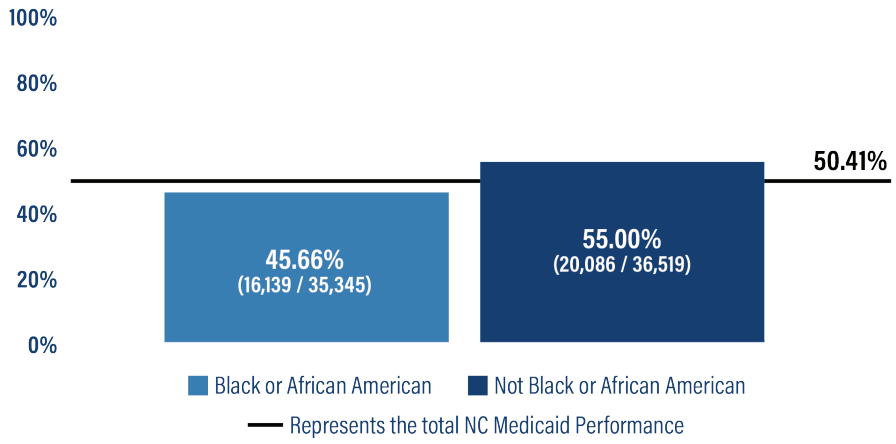
Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	44.08%	52.36% ↑
Living in a rural county	40.69%	49.65% ↑
Female	41.41%	51.41% ↑
Hispanic/Latino	40.01%	52.43% ↑
Speaking a non-English primary language	38.08%	51.91% ↑
Black and African American	38.44%	45.66% ↑
American Indian and Alaskan Native	42.51%	50.25% ↑

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

Among NC Medicaid beneficiaries, no disparities were identified based on disability status, ethnicity, age, gender, primary language, American Indian/Alaskan Native binary race or geography. However, disparities were identified based on Black or African American binary race for the *CBP* measure:

- Those who identified as Black and African American fared worse than those who did not, with a relative difference of 16.98% (See Figure 86).

FIGURE 86: *CBP*, 2023 NC Medicaid Performance by Black or African American Binary Race



Hemoglobin A1c (HbA1c) Control for Patients with Diabetes

The measure assesses the percentage of members ages 18 through 75 with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:

- Controlled (lower than 8.0%)
- Poor Control (above 9.0%)

Diabetes is a disease that affects how the body uses blood sugar (glucose) and can lead to excess sugar in the blood. When left uncontrolled, diabetes can lead to an array of life altering complications including heart disease, nerve damage, blindness and decreased blood flow to the lower extremities, increasing the likelihood of amputation.[196] In 2021, around 1.6% of the U.S. population, or 38.4 million people of all ages, had diabetes.[197] Historically, American Indian or Alaska Native and non-Hispanic Black adult populations have higher rates of diabetes. Additionally, adults with a lower socioeconomic status have had higher rates of illness and death from diabetes. Understanding and mitigating the impact of social determinants of health, such as education, income, neighborhood, food environment and health care access are priorities in addressing diabetes due to disease prevalence, economic costs, and disproportionate population burden.[198]

NC Minority Diabetes Prevention Program

In 2016, the North Carolina General Assembly allocated funding available to the Division of Public Health (DPH) for the Office of Minority Health and Health Disparities to establish and administering evidence-based diabetes prevention programs (DPP) in partnership with local health departments targeting those who identify as Black and African American, Hispanic/Latino and as American Indian (HB 1030, 2015-241, Section 12E.3). Diabetes Prevention Programs are designed to empower people with prediabetes to take charge of their health and well-being. These 12-month, evidence-based programs can help people who have prediabetes or are at high risk for type 2 diabetes make realistic and achievable lifestyle changes that can decrease their risk of developing type 2 diabetes.

TABLE 52: Trends in Priority Population Performance for *Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD), Poor Control (HbA1c >9%)* measure by Stratification Element, a lower rate indicates better performance

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	89.05%	88.93% ↑
Living in a rural county	89.66%	90.66% ↓
Female	90.45%	90.09% ↑
Hispanic/Latino	91.02%	90.70% ↑
Speaking a non-English primary language	92.63%	88.75% ↑
Black and African American	91.04%	90.90% ↑
American Indian and Alaskan Native	93.37%	94.41% ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

[196] Mayo Clinic. Diabetes Website. Overview. Accessed on 5/12/2025. Retrieved from https://www.mayoclinic.org/diseases-conditions/diabetes/symptoms-causes/syc-20371444
[197] National Diabetes Statistics Report. (May 2024). Center for Disease Control and Prevention (CDC). Accessed on 5/12/2025. https://www.cdc.gov/diabetes/php/data-research/
[198] Hill-Briggs, F., Adler, N. E., Berkowitz, S. A., Chin, M. H., Gary-Webb, T. L., Navas-Acien, A., Thornton, P. L., & Haire-Joshu, D. (2020). Social Determinants of Health and Diabetes: A Scientific review. Diabetes Care, 44(1), 258–279. https://doi.org/10.2337/dci20-0053

TABLE 53: Trends in Priority Population Performance for *HBD, Control (HbA1c <8%)* measure by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	10.00%	9.73% ↓
Living in a rural county	9.09%	8.03% ↓
Female	8.63%	8.72% ↑
Hispanic/Latino	7.79%	8.20% ↑
Speaking a non-English primary language	6.58%	9.30% ↑
Black and African American	8.18%	7.98% ↓
American Indian and Alaskan Native	6.21%	4.95% ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

Among NC Medicaid beneficiaries with diabetes, no disparities were identified based on any demographic strata for the *HBD, Poor Control (HbA1c >9%)* measure. However, there were disparities identified for the Control (<8%) sub measure.

Among NC Medicaid beneficiaries with diabetes, no disparities were identified based on disability status, ethnicity, age, gender, primary language or geography. However, disparities were identified based on Black or African American and American Indian and Alaskan Native binary race for the *HBD, Control (HbA1c <8%)* measure:

- Those who identified as Black and African American fared worse than those who did not, with a relative difference of 10.28% (See Figure 87).
- Those who identified as American Indian and Alaskan Native fared worse than those who did not, with a relative difference of 42.30% (See Figure 88).

FIGURE 87: *HBD, Control (HbA1c <8%)*, 2023 NC Medicaid Performance by Black or African American Binary Race

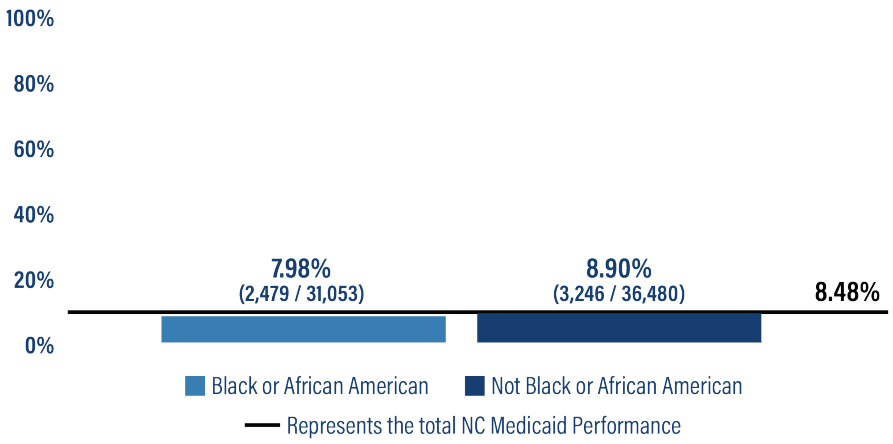
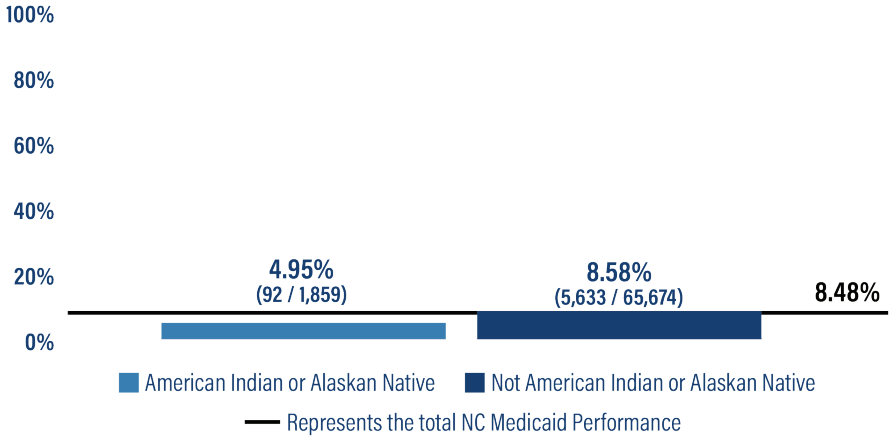


FIGURE 88: *HBD, Control (HbA1c <8%)*, 2023 NC Medicaid Performance by American Indian and Alaskan Native Binary Race



Colorectal Cancer Screening

The measure assesses the percentage of members ages 45 through75 who had appropriate screening for colorectal cancer. This includes any of the following tests: annual fecal occult blood test, flexible sigmoidoscopy every five years, colonoscopy every 10 years, computed tomography colonography every five years, stool DNA test every three years.

Colorectal cancer is the third most diagnosed cancer in the U.S.[199] Colorectal cancer that develops in the tissues of the colon or rectum, parts of the digestive system. Colon cancer typically affects older adults, though it can happen at any age.[200] Colorectal cancer screening saves lives, as the screening can find pre-cancerous polyps that can be removed before they turn into cancer. About seven in ten U.S. adults ages 50 through 75 are up to date with their colorectal cancer screenings.[201] Colorectal cancer has a greater than 90% survival rate with early detection and treatment, but disparities limit access to equitable screening and treatment for many, particularly Black Americans, American Indians/ Alaska Natives and underserved Americans, who are disproportionately affected by the disease. Black Americans experience the highest incidence and mortality from colorectal cancer and research has partially attributed this disparity to structured societal issues such as socioeconomic status, health care access and environmental factors such as access to health food.[202] Other contributing factors may include pervasive stigma, discomfort with screening methods, lack of institutional trustworthiness and bias/racism in the healthcare system.[203]

Note for data interpretation: Colorectal cancer screening (COL) is one of the measures impacted by NC Medicaid Expansion. A large portion of the Expansion population was ages40 through64. The eligible population for COL in 2022 was 99,000 and increased to roughly 155,000 in 2023. This increase may be attributed to the increase in NC Medicaid's fully eligible beneficiary population due to Medicaid expansion. Since Expansion occurred at the end of the year in December 2023, many of these new members would not have had the time to receive a covered colorectal cancer screening in time to be counter in the numerator for this measure, leading to an overall decrease in the rate for 2023.

[199] American Cancer Society. Key Statistics for Colorectal Cancer. Accessed on 5/12/2025. Retrieved from https://www.cancer.org/cancer/types/colon-rectal-cancer/about/key-statistics.html
[200] Mayo Clinic. Colon Cancer. Overview. Accessed on 5/12/2025. Retrieved from https://www.mayoclinic.org/diseases-conditions/colon-cancer/symptoms-causes/syc-20353669
[201] Use of Colorectal Cancer Screening Tests. Centers for Disease Control and Prevention (CDC). Accessed on 5/12/2025. Retrieved from https://www.cdc.gov/colorectal-cancer/use-screening-tests/index.html
[202] Carethers JM. Racial and ethnic disparities in colorectal cancer incidence and mortality. Adv Cancer Res. 2021;151:197-229. doi: 10.1016/bs.acr.2021.02.007. Epub 2021 May 5. PMID: 34148614; PMCID: PMC9069392.
[203] Colorectal Cancer Alliance. Health Equity. Breaking Down Barriers, Increasing Access. Accessed on 5/12/2025. Retrieved from https://colorectalcancer.org/basics/health-equity

TABLE 54: Trends in Priority Population Performance for Colorectal Cancer Screening (COL) measure by Stratification Element

Those Who Identify As...	CY2022 Performance	CY2023 Performance
Having a disability	37.27%	36.71% ↓
Living in a rural county	32.85%	23.93% ↓
Female	33.52%	23.95% ↓
Hispanic/Latino	31.22%	22.35% ↓
Speaking a non-English primary language	28.57%	20.19% ↓
Black and African American	32.36%	23.21% ↓
American Indian and Alaskan Native	29.98%	20.85% ↓

**Note: The ↓ icon signifies a worsening performance for the priory population, while a ↑ icon signifies an improved performance for the priority population.*

Among NC Medicaid beneficiaries, no disparities were identified based on ethnicity, gender, binary race, or geography. However, disparities were identified based on disability status, primary language and age group for the COL measure:

- Those who identified as having a disability fared worse than those who did not, with a relative difference of 56.55% (See Figure 89).
- Those who identified as speaking a non-English language as their primary language fared worse than those who spoke English as a primary language, with a relative difference of 10.69% (See Figure 90).
- Those ages 46 through 50 during 2023 fared worse than those ages 51 through 75 during 2023, with a relative difference of 36.23% (See Figure 91).

FIGURE 89: *COL*, 2023 NC Medicaid Performance by Disability Status

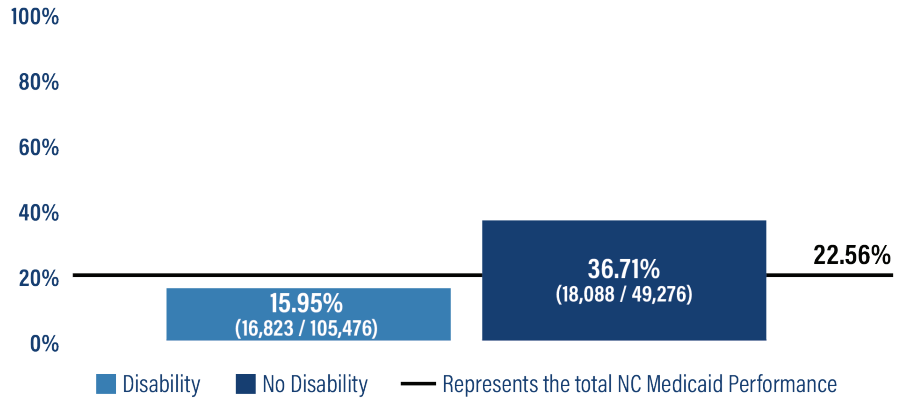


FIGURE 90: *COL*, 2023 NC Medicaid Performance by Primary Language

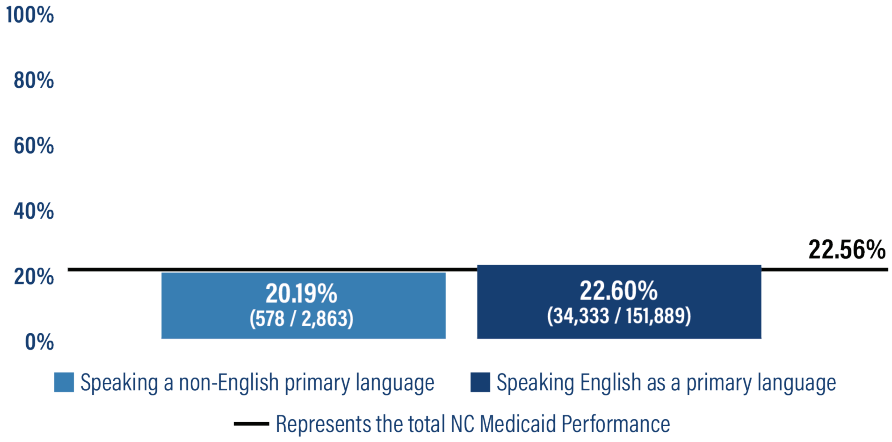
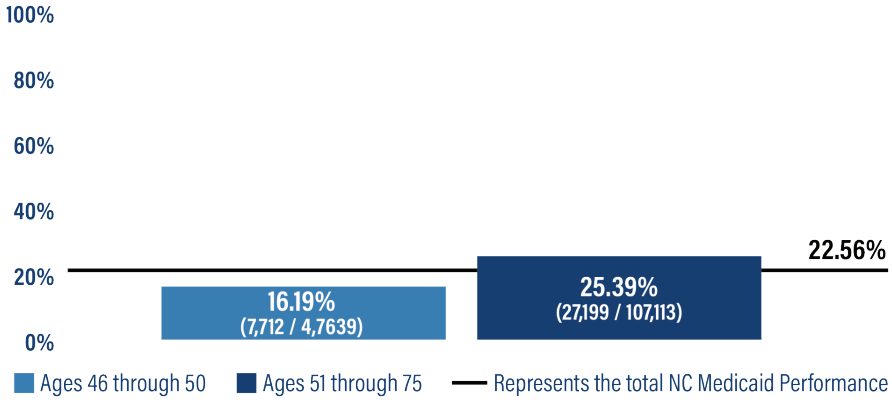


FIGURE 91: *COL*, 2023 NC Medicaid Performance by Age Group



Addressing Health Inequities

How Does NC Medicaid Promote Health Equity?

NC Medicaid is constantly working toward an innovative, whole-person, well-coordinated system of care that addresses both medical and non-medical drivers of health. This report is just one tool that NC Medicaid is using to enhance focus on promoting health equity. After identifying and reflecting on health disparities within its beneficiary population, the next step is to think through ways in which NC Medicaid can have a meaningful impact on reducing or eliminating them.

The Department has implemented various efforts to ensure that beneficiaries are receiving equitable access to quality health care, which can be organized into four key areas:[204]

1. Financial Incentives
2. Quality
3. Access to Care
4. Programmatic Interventions

NCDHHS Health Equity Portfolio FY 2023-2024 Year-in-Review

NCDHHS established a Health Equity Portfolio in 2021, which is comprised of three offices: the office of rural health, the office of diversity, equity and inclusion and the office of Minority Health and Health Disparities. The Health Equity Portfolio developed a Year-in-Review Report that highlights the Health Equity Portfolio's key accomplishments in Fiscal Year (FY) 23-24, discusses lessons learned and provides insight into what's coming next in FY 24-25 to build sustainable equity efforts and for the Portfolio to continue growing its outreach, infrastructure, operations and partnerships to achieve workforce belonging and health equity outcomes in NC. Find the report here.

Financial Incentives

NC Medicaid has implemented a series of financial incentives with PHPs that incentivize focus on health equity and quality improvement. This section will explore two examples of financial incentives.

Standard Plan Quality Withholds

NC Medicaid strongly encourages Standard Plans to improve their performance in priority areas, including those related to addressing health disparities. One tool to foster health equity in collaboration with health plans is the Standard Plan Quality Withhold Program. This program is a key component of North Carolina's overarching Quality Strategy.

Beginning with 2024, the Department has withheld a percentage of each Standard Plan's total risk-adjusted capitation payment. To receive these withheld funds, Standard Plans must meet reasonable and achievable performance targets on quality measures following the defined performance period and quality measurement cycle.

[204] The health equity related initiatives listed in this report are not meant to be comprehensive, but simply a summary snapshot of the programs and projects at NC Medicaid

The withhold program is designed to align with NC Medicaid's Quality Aims, Goals and Objectives, particularly focusing on:

1. Promoting child health, development, and wellness,
2. Enhancing women's health,
3. Addressing unmet health-related resource needs, and
4. Advancing health equity.

In alignment with these objectives, the Standard Plan Quality Withhold Program focuses on areas where quality measure performance is declining, or disparities have been identified among priority populations who are medically underserved. By doing so, it aims to raise awareness and provide incentives for continuous improvement in these vital areas.

NC Medicaid's Standard Plan Withhold Program was based on three measures in 2024:

1. *Childhood Immunization Status (CIS-10),*
2. *Timeliness of Prenatal Care and Postpartum Care (PPC), and*
3. *Rate of Screening for Health-Related Resource Needs (HRRN)*

NC Medicaid continues to perform below NCQA's Quality Compass national Medicaid HMO average (henceforth referred to as "national average") for the childhood immunization *(CIS-10)* measure.[205] This measure assesses the percentage of children age two that received a combination of 10 recommended vaccines by their second birthday. In addition to overall low performance, the Department identified a significant disparity for this measure when comparing performance of the Black or African American population to the Non-Black or -African American population. Therefore, the CIS-10 measure was used for two withhold measures in 2024: an overall performance improvement measure and a priority population improvement measure (focused on performance improvement for the Black or African American population).

NC Medicaid has also performed below the national average in measures of infant and maternal health, specifically when looking at antenatal and postnatal care. The PPC measure has two indicators: (1) *Timeliness of Prenatal Care*, which assesses the percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization; and (2) *Postpartum Care*, which assesses the percentage of deliveries in which women had a postpartum visit on or between seven and 84 days after delivery. In 2023, the Department identified that NC Medicaid rates were much lower than national averages for both *Timeliness of Prenatal Care* and *Postpartum Care* submeasures. Timely access to prenatal and postpartum care is important, as studies have shown that as many as 60% of all pregnancy-related deaths could be prevented if women had better access to or received better quality of care. The Withhold Program does not include a priority population for the PPC measure, but the overall performance improvement will encourage performance across all groups.

HRRN is a homegrown measure specific to NC Medicaid that looks at the percentage of enrollees who received and successfully completed a screening for health-related resource needs.[206] Health plans are contractually required to make at least three attempts to screen their members for health-related resource needs; however, this data is currently being recorded and reported inconsistently. In the first year of the Withhold Program, this measure will be used as a pay for reporting measure, with a focus on screening for health-related resource needs during the calendar year. In future years, the Department aims to transition this to a performance-based measure.

[205] Quality Compass® is a registered trademark of the NCQA. Please refer to the 2022 Quality Compass benchmarks (representing CY 2021 data) for exact benchmark values.
[206] More information on the HRRN measure, and all other measures mentioned in this report, can be found in North Carolina's Quality Measurement Technical Specifications Manual

Using the *CIS-10* and *PPC* measures as a part of the Withhold Program is a tool to address the inequities seen in vaccination rates, and to improve rates of timely prenatal and postpartum care. Using the Rate of Screening for Health-Related Resource Needs measure aligns with state quality aims of healthier people, healthier communities and provides an opportunity to improve screening rates and to improve information collected on screenings performed by plans. In future years, NC Medicaid may consider other withhold measures that focus on improving health equity and reducing disparities. Each year, the Department will assess performance across withhold areas to modify the program to continually advance its goals, focus on new targets that foster continuous quality improvement and assess opportunities to tie the Withhold Program to evolving priorities.

PHP Health Equity Reinvestment Activities

Through the PHP Reinvestment Initiative, Standard Plans have an opportunity to invest in community-based projects that address unmet health-related resource needs, health outcomes and/or access to care. Investments can be credited toward in lieu of remittance or serve as voluntary contributions that are factored into the numerator of a Standard Plan's medical loss ratio (MLR). Additionally, aggregate reinvestment expenditures (only in relation to the numerator of the MLR) from a Standard Plan that account for at least 0.1% of their annual capitation revenue in a Standard Plan Region may be eligible for an auto-enrollment preference incentive.

Standard Plans must submit reinvestment pro`posals for Departmental approval to receive the aforementioned financial credits. Amongst other requirements, proposals must be data-informed, align with the Department's Quality Strategy, include a clear narrative on how the investment will be operationalized and provide an evaluation plan. Approved reinvestment projects have involved healthy food box programs, training for doulas in maternity care deserts, and mobile health clinics. Additional examples of qualifying investments in different domains and health care focus areas are included in Table 55.

TABLE 55: REINVESTMENT DOMAINS AND HEALTH CARE FOCUS AREAS

Domains and Health Care Focus Areas	Examples
Housing	Medical respite, permanent supportive housing projects, rental assistance and housing subsidies
Food	Food pantries, nutrition programs, farmers' markets, delivered meals and food boxes
Transportation	Public or private transportation to assist community members in accessing medical services, grocery stores, local events or activities of daily living
Interpersonal Safety	Early childhood initiatives, parenting programs, activities that address adverse childhood experiences, and programs for survivors of interpersonal violence, elder abuse or child abuse
Employment/Economic Development	Local hiring programs, workforce development efforts and re-entry initiatives
Health Outcomes and Access to Care	Language accessibility services, cultural humility programs, mobile clinics and re-entry programs

Quality

As stated in the NC Medicaid Managed Care Quality Strategy, the Department works with different health plans and product lines to develop a data-driven, outcomes-based continuous quality improvement process that promotes equity through reduction or elimination of health disparities. This section will describe different areas of quality work where NC Medicaid hopes to impact health inequities.

Quality Reporting

To ensure delivery of high-quality care under the managed care delivery system, the Department has developed the NC Medicaid Managed Care Quality Strategy and identified a set of quality metrics that it will use to assess health plans' performance across their populations. Standard Plans and Tailored Plans are directed to report select measures and stratify them by a variety of elements, including age, race, ethnicity, sex, primary language and disability status and by key population groups and geography, where feasible. In evaluating plan performance on these measures, the Department will assess whether identified disparities have narrowed through improving performance specifically for the subpopulation experiencing the disparity, in addition to considering overall performance improvement for each plan's respective enrolled population compared to its Standard Plan or Tailored Plan peers. The Department requires Standard Plans, Tailored Plans and Prepaid Inpatient Health Plans (PIHPs), in compliance with 42 CFR 438.330, to establish and implement an ongoing and comprehensive Quality Assessment and Performance Improvement program (QAPI). The QAPI includes mechanisms to assess and address health disparities based on the results of this NC Medicaid Health Disparities Report. The Department also expects plans to embed continuous quality improvement efforts to improve outcomes and promote health equity.

NC Medicaid Public Facing Quality Measurement Dashboard

To provide greater visibility into North Carolina Medicaid's quality measurement performance, NC Medicaid developed a public-facing Quality Measures Dashboard. The dashboard enables users to visualize quality measurement data, compare performance across managed care plans, and stratify quality measures by race, gender, language, age, and geography.

NC Medicaid is eager to continue improving and adding measures to the dashboard over time, equipping beneficiaries and the public with important quality measurement performance data. Dashboard is linked above..

Health Disparity Targeting Methodology

Through required quality reporting the Department identifies measures with significant disparities, defined as equal to or greater than a 10% relative difference in performance between the group of interest and the reference group. Upon identification, priority population improvement targets are set for the group of interest using our gap-to-goal benchmarking approach. In the evaluation of plan performance on these measures, the Department assesses whether disparities have narrowed through performance improvement, specifically for the subpopulation experiencing the disparity. Additionally, the Department will consider overall performance improvement for each plan's respective enrolled population as compared to its Standard Plan or Tailored Plan peers. Performance in 2024 and the priority population improvement targets for NC Medicaid and Standard Plans can be found in the Quality Measure Performance and Targets for the AMH Measure Set. For more information on the Department's approach to analyzing performance improvement for quality measures, see the NC Medicaid Quality Measurement Technical Specifications Manual.[207]

[207] North Carolina's Medicaid Quality Measurement Technical Specifications Manual for Standard Plans and Behavioral Health Intellectual/Developmental Disability Tailored Plans, Version 2025.5, Accessed 5/23/2025. Available at: https://medicaid.ncdhhs.gov/medicaid-managed-care-quality-measurement-technical-specifications-manual/download?attachment

Performance Improvement Projects

Performance improvement projects (PIPs) are long-term quality improvement projects that aim to improve performance on a specific measure for managed care plans. They can be clinical, related to the treatment or management of conditions, or non-clinical, focused on administrative processes and procedures. Managed Medicaid Plans are required to conduct at least three PIPs that are designed to achieve significant improvement, sustained over time, in different quality performance areas of focus. The Department identifies measures based on opportunities for improvement and priority areas. These measures can be chosen based on year-over-year performance and identified disparities. The PIP's life cycle is three years. During the initial year, the plans establish a process to initiate and roll out the interventions to impact the PIP measures. In the second year, the plans report out on baseline rates and initiate interventions. Year three is focused on identified areas of improvement from the prior year. During this process, the plans stratify their data to understand any disparities within their populations. This stratification can help guide targeted interventions for priority populations. PIPs must measure performance using objective quality indicators, assessment of barriers, implementation of interventions to achieve improvement in access and quality of care and evaluation of effectiveness of the interventions.

HIE Medicaid Services Program: Health-Related Social Needs Screening Use Case

The HIE Medicaid Services (HMS) Program is a joint effort between the North Carolina Health Information Exchange Authority (NC HIEA) and the North Carolina Department of Health and Human Services (NCDHHS) Division of Health Benefits (DHB). The goal of this partnership is to leverage NC HealthConnex, North Carolina's state-designated health information exchange, to support NC Medicaid's quality, population health and care management efforts by improving data exchange. The HIE Medicaid Services Program is working to develop the capabilities to access and integrate Medicaid beneficiaries' HRSN data across health plans, providers and NC Medicaid. This would support Medicaid beneficiaries by minimizing the number of time sensitive questions are asked while gaining a deeper understanding of their HRSN to connect them with the necessary services. Understanding and addressing HRSN is a key focus for NCDHHS and NC Medicaid. Complete and up to date data on a patient's HRSN can help patients get connected to the resources they need to thrive, help providers improve clinical decision-making and help policymakers evaluate the effectiveness of programs and policies focused on HRSN. Learn more about this use case, among others, at the HIE Medicaid Services website.

Rate of Screening for Health Related-Resource Needs

This homegrown quality measure looks at the percentage of NC Medicaid managed care enrollees who received and completed a health-related resource needs screening using the NCDHHS Standardized SDOH Screening Questions. This screening form includes four priority domains: food insecurity, housing/utilities instability, transportation needs and being at risk of, or experiencing, interpersonal violence/toxic stress. The NC Medicaid managed care health plans are contractually required to attempt to screen all their members every year using the NCDHHS standardized SDOH screening questions.[208]

Access To Care

Access to care has many different dimensions, including provider availability, beneficiary utilization and beneficiary perceptions and experiences. This section describes areas of work related to access where NC Medicaid hopes to impact health inequities.

[208] Screening questions are available here.

EBCI Tribal Option

The Department and, North Carolina's only federally recognized Tribe, are working together to address the health needs of Medicaid-eligible Tribal members. The EBCI Tribal Option, a first-in-the nation Indian Managed Care Entity, provides care coordination for approximately 4,500 federally recognized Tribal members and other individuals eligible to receive care through the Indian Health Service. Launched in July 2021, the EBCI Tribal Option is primarily offered in five NC counties: Cherokee, Graham, Haywood, Jackson and Swain.

The EBCI Tribal Option manages primary care needs (e.g., immunizations, well visits, sick visits, holistic health care, integrated care). Members receive care coordination and complex case management, including care coordination for mental health disorders, SUD, I/DD, Traumatic Brain Injury (TBI) or LTSS. The EBCI Tribal Option assists with coordinating services and resources, such as transportation, housing, food and interpersonal violence interventions, as well as specialty care, services and referrals. They also offer added services, such as wellness programs and education vouchers. EBCI Tribal Option members have the opportunity to receive services from any NC Medicaid provider.

This unique partnership aims to eliminate barriers to care and reduce health disparities among the American Indian or Alaskan Native population while promoting tribal sovereignty.[209]

NC Integrated Care for Kids (NC InCK) Model

The NC Integrated Care for Kids Model (NC InCK) is a health equity-driven, child-centered local service delivery and State payment model aimed at improving the quality of care and reducing expenditures for children insured by NC Medicaid in five North Carolina counties: Alamance, Orange, Durham, Granville and Vance. NC InCK aims to integrate services for children, including physical and behavioral health, food, housing, early care and education, Title V (maternal and child health needs assessment), child welfare, mobile crisis response services, juvenile justice and legal aid. Three clinically integrated networks across the participating counties, Duke Connected Care, UNC Health Alliance and Community Care Physician Network coordinate care for pilot-eligible children across the continuum of child core services, including health care, schools, foster care and juvenile justice systems and social services. NC InCK is funded through a grant from CMS and will operate during a seven-year model period that began in January 2020 with a two-year planning period (2020 and 2021) and a five-year implementation period (2022 through 2026).

InCK believes that all children and families deserve opportunities to thrive regardless of their race, color, national origin, disability, age, sex and religion. NC InCK aims to achieve its goal through three sets of activities, all of which are informed by the InCK Family Council and Youth Council, which are made up of NC InCK members and their caregivers, to ensure that program activities are family-centered and promote equity.

- NC InCK more holistically assesses the needs of children using a novel stratification approach that integrates data from NC Medicaid, the Department of Public Instruction and the Department of Public Safety to assign children to one of three service integration levels (SILs
- NC InCK employs integration consultants and family navigators to integrate services across sectors for children who could benefit from additional support.
- NC InCK has developed and implemented a novel alternative payment model (APM) to incentivize provider actions that improve the holistic well-being of children and close crucial disparities. In this APM, quality of care is measured and improved using standard health care measures (e.g., proportion of children receiving well-child checks) and novel cross-sector, well-being measures (e.g., kindergarten readiness, food insecurity and housing stability).

[209] More information on the EBCI Tribal Option available at: https://ebcitribaloption.com/

NC InCK's stratification process evaluates factors outside the traditional health care system. For example, factors that determine a child's SIL include positive screens for housing or transportation needs, Temporary Assistance for Needy Families (TANF) eligibility, a high Social Deprivation Index, risk of out-of-home placement, juvenile justice residential placement, foster care involvement, chronic school absenteeism, frequent short-term suspensions, expulsion from school and guardian challenges like substance use during pregnancy or a recent psychiatric admission. Children with these flags are identified for increasingly intensive care management services. This process facilitates the provision of more intensive services to children and families whom the health care system has historically marginalized, and those whose needs have historically gone unmet by the health care system. NC InCK will continuously evaluate the SIL algorithm to ensure that all children in need of services are being elevated for care management

In designing its care management services, the NC InCK team strived to design a family-led, strengths-based model that provides necessary, convenient care to children and families. NC InCK's integration consultants and family navigators are trained explicitly in how to ensure equitable implementation of the service model including in how to support family navigators in effectively communicating with families and creating family-centered goals. Children, youth and families have the opportunity to co-create Shared Action Plans with their Family Navigator that outline goals and strengths of the child in the family's own words. In encouraging the family to drive its own care goals, this process helps promote more equitable health outcomes by ensuring families are given the opportunities and resources that are most useful to them.

The external workgroup that designed the NC InCK APM named an explicit goal of embedding equity into the model. One of the six performance measures linked to incentive payments is focused on closing the disparity between Black/African American and White patients in the number of well-child visits provided in the first 30 days of life. In addition to this explicitly equity-focused measure, all performance measures shared with plans and providers as part of the APM are stratified by race, ethnicity and county. With access to this data, providers are able to facilitate equity-focused quality improvement processes within their own systems.

Tailored Care Management

The Behavioral Health I/DD Tailored Care Management (TCM) model reflects the goal of whole-person care management in NC Medicaid Managed Care. Provider-based care management promotes integrated care and offers beneficiaries a choice in how they receive care management. Through TCM, beneficiaries have a single designated care manager supported by a multidisciplinary care team to provide whole-person care management that addresses all their needs, including physical health, behavioral health, I/DD, TBI, pharmacy, LTSS and unmet health-related resource needs. As part of its commitment to advancing health equity, the Department has also developed a supplement to the TCM Certification Application that gives organizations the option to identify as a Historically Underutilized Provider (HUP). This information will be used to advance health equity in the TCM program by, for example, informing fund distribution for capacity building services and ensuring the TCM program certification process is conducted equitably.[210]

Telemedicine

During the COVID-19 pandemic, telemedicine was a key tool in providing continued access to care for NC Medicaid beneficiaries. NC Medicaid beneficiaries quickly began utilizing telemedicine services in March 2020 when policies were adopted to support social distancing at the outset of the COVID-19 Public Health Emergency. The proportion of beneficiaries receiving care via telemedicine climbed as high as 16% during the stay-at-home order initiated on March 27, 2020, when in-person claims were at historic lows.

[210] NCDHHS. Behavioral Health and Intellectual/Developmental Disability Tailored Plan. Available at: https://files.nc.gov/ncdma/Updated-Guidance-on-Tailored-Care-Management-vF.pdf. Accessed on: Jun 28, 2023.

COVID-19 policies allowing telemedicine for certain outpatient behavioral health services, such as diagnostic assessments and psychotherapy, have been made permanent. Other clinical coverage policies that were made permanent allow for physician assessments or supervision of staff to be conducted virtually, potentially reducing the impact of provider shortages.

Research has found that telemedicine has the potential to play a significant role in expanding access to health care services; however, if not executed equitably it can contribute to the digital divide and exacerbate existing inequities.[211]

Network Adequacy Activities

NC Medicaid has a variety of tools for tracking and reporting network adequacy. Network adequacy helps ensure that all beneficiaries, whether they live in urban or rural areas, can access covered services in a timely manner. To measure compliance with time/distance standards, the Department uses "geo-mapping" software to calculate the distance in travel time and travel miles from a beneficiary's residence to provider locations. Health plans must demonstrate that at least 95% of their members in a county live within the contractually required time/distance standard. In addition, appointment wait time standards are monitored through secrete-shopper analysis, provider surveys and analysis of member complaints. To learn more about network adequacy and how NC Medicaid tracks it, visit the Health Plan Network Adequacy page.

Programmatic Interventions

NC Medicaid manages a variety of innovative programs, and some provide unique services to priority populations. This section will describe different programmatic interventions focused on addressing health inequities.

Healthy Opportunities Pilots

The Healthy Opportunities Pilots (HOP) is the nation's first comprehensive program to test and evaluate the impact of providing select evidence-based, non-medical interventions to address housing, food, transportation and interpersonal safety/toxic stress on high-needs Medicaid enrollees' health outcomes and health care costs. The federal government authorized the use of Medicaid funding for HOP over five years, beginning 2019.[212] Access to high-quality medical care is critical; however, research shows that health outcomes are largely determined by social and environmental factors and the behaviors that emerge as a result.[213] Launched in March 2022 in three predominantly rural regions of North Carolina, the goals of HOP are to:

- Integrate evidence-based, non-medical services into Medicaid to improve health outcomes for Medicaid beneficiaries, promote health equity and reduce costs in NC Medicaid.
- Leverage rapid-cycle assessments to evaluate which services are of highest value and impact.
- Create an accountable infrastructure, sustainable partnerships and payment vehicles that support integrating the highest value non-medical services into the Medicaid program sustainability at scale.

[211] Kuziemsky C, Hunter I, Udayasankaran JG, Ranatunga P, Kulatunga G, John S, John O, Flórez-Arango JF, Ito M, Ho K, Gogia SB, Araujo K, Rajput VK, Meijer WJ, Basu A. Telehealth as a Means of Enabling Health Equity. Yearb Med Inform. 2022 Aug;31(1):60-66. doi: 10.1055/s-0042-1742500. Epub 2022 Jun 2. PMID: 35654429; PMCID: PMC9719760.

[212] CMS Approved North Carolina DHHS Medicaid Reform 1115 Demonstration Waiver. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-ca.pdf. Accessed on: Feb 1, 2023

[213] Hood CM, Gennuso KP, Swain GR, et al. County Health Rankings: Relationships Between Determinant Factors and Health Outcomes. American Journal of Preventive Medicine 50 (2) (2016): 129–135. Available at https://pubmed.ncbi.nlm.nih.gov/26526164/. Accessed on: Feb 1, 2023

Pilot stakeholders — including health plans, Care Management Entities, Human Service Organizations (HSOs) (i.e., community-based organizations and social service agencies) and Network Leads (i.e., organizations that build and manage a network of HSOs) — all play coordinated but distinct roles to provide whole-person care to HOP enrollees. Through HOP, the Department is dedicated to demonstrating the improvement of health outcomes associated with addressing Social Drivers of Health.

Unfortunately, budget proposals from both chambers of the North Carolina General Assembly do not include funding for Healthy Opportunities Pilots (HOP) services beyond June 30, 2025, for the State Fiscal Years 2026-2027. The Department recognizes the significant impact this change may have on the individuals and communities it serves, and it is continuing conversations with State lawmakers about the importance of HOP and value in continued funding.

Community Health Workers

The American Public Health Association defines a Community Health Worker (CHW) as *"a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural humility of service delivery."* [214] Section 5313 of the Patient Protection and Affordable Care Act authorizes the CDC to provide grants promoting the CHW workforce. This allowed NC to start an NC CHW initiative aimed at identifying CHWs who may participate in statewide training for certification.[215] The Department is working to determine how its CHW infrastructure can be integrated into population health programs, such as HOP, AMH Tier 3 care management, Tailored Care Management and other programs to improve health outcomes by addressing social determinants of health and disparities in access to services.

NC Reach Out and Read Program

As part of the NC Early Childhood Action Plan, the Department partnered with the national early childhood program, Reach Out and Read (ROR), to launch the ROR Carolinas program in February 2019. The Department's partnership with ROR is one of the first in the country among Medicaid programs.

ROR partners with pediatric primary care locations to incorporate ROR's evidence-based model into regular pediatric checkups. The three-part model focuses on:

1. Training primary care clinicians to encourage parents to read aloud to their children and understand the importance of early childhood literacy development.
2. Providing pediatric primary care clinicians with developmentally appropriate books to "prescribe" to children to take home and keep, resulting in each child receiving 10 to 15 new books before starting kindergarten.
3. Creating a literacy-rich environment in the waiting room with gently used books and volunteer readers, where possible.[216]

In a 2023 State Plan Amendment, NC Medicaid committed to expanding and improving the ROR program over the next three years, including the addition of 40 new clinic sites, increasing the number of children served and training roughly 120 new pediatric primary care providers.[217] The ROR Carolinas program continues to identify specific opportunities to promote health equity and address systemic racism experienced by populations that have been systemically discriminated against. One example is the Books and Diversity project, which is focused on building the ROR library to include books that reflect cultural diversity and provide affirmation for all children.

[214] American Public Health Association. Community Health Workers. Available at: https://www.apha.org/apha-communities/member-sections/community-health-workers. Accessed on: Jun 28, 2023.
[215] NCDHHS. About the NC Community Health Worker Initiative. Available at: https://www.ncdhhs.gov/divisions/office-rural-health/community-health-workers/about-nc-community-health-worker-initiative. Accessed on: Jun 28, 2023.
[216] Reach Out and Read. Mission, Vision, and Model. Available at: https://www.rorcarolinas.org/about-us/vision-mission-model/. Accessed on: Jun 28, 2023.
[217] State of North Carolina DHHS State Plan Amendment. (2023). https://medicaid.ncdhhs.gov/spa-23-0043-proposed-amendment-cms-chip-optional-fmap-allotment/download?attachment

Transitions to Community Living

Transitions to Community Living (TCL) provides eligible adults living with serious mental illness the opportunity to choose where they live, work and play in North Carolina. This initiative promotes recovery through providing long-term housing, community-based services, supported employment and community integration. The six pillars of TCL are community-based supported housing, community-based mental health services, supported employment, discharge and transition process, pre-admission screening and diversion, and quality assurance and performance improvement. As of October 2023, there were over 3,500 individuals in supportive housing, over 4,800 people had been diverted from institutional care and over 2,500 individuals were receiving supported enrollments services. For more information visit the TCL DHHS homepage.

AMH Tier 3

The Department developed the AMH model as the primary vehicle for care management as the state transitioned to Medicaid Managed Care. High-quality primary care with the capacity to manage population health is foundational to the success of North Carolina's Medicaid Transformation, supporting the delivery of timely care in the appropriate setting to meet each member's needs. The AMH model supports the Department's transformation vision by maintaining the strengths of North Carolina's legacy care management structure and promoting delivery of care management in the community. The AMH program requires PHPs to delegate certain care management functions to AMHs who meet the criteria. AMH Tier 3 practices are expected to provide high-need care management and produce a practice-wide view of risk and patient need, allowing the delivery of person-centered care management. This focus on performing high-quality primary care and localized care management, which defines the AMH program, is important in supporting health outcomes and facilitating reductions in disparities.

The Department has identified a subset of quality measures for health plans to use to monitor and incentivize AMH performance. The AMH measure set is posted annually; it shares PHPs performance across years and sets benchmark targets for performance improvement. The AMH measure set is also stratified using the Black or African American binary, the American Indian or Alaskan Native binary, and ethnicity and performance improvement targets are set when a disparity is identified (greater than a 10% relative difference). This comparison and target setting methodology reinforces NC Medicaid's commitment to working toward improving priority population's quality of care.

To learn more please visit the Advanced Medical Home Manual.

Nutrition Insecurity Cross-Enrollment Pilot

The Nutrition Insecurity Cross-Enrollment (NICE) pilot, which identifies Medicaid beneficiaries likely eligible for but not enrolled in SNAP and WIC and tests the effectiveness of various outreach methods to boost enrollment. The NICE pilot integrates monthly data from Medicaid, SNAP, and WIC across five North Carolina counties. This scalable approach underscores the importance of data sharing, focused outreach, and collaboration to expand access to nutrition programs. Additionally, this program offers a promising framework to inform policies integrating healthcare and nutrition assistance for improved food security and child health outcomes. Scaling such efforts nationally could improve food security, foster health equity, and enhance the overall well-being of children and families.

Conclusion

NC Medicaid is committed to improving health outcomes for all North Carolinians by expanding access to care and addressing gaps where disparities persist. A key step toward this goal is identifying and responding to the health inequities highlighted in this report.

The 2023 NC Medicaid Health Disparities Report analyzed 56 measures across eight stratification elements, revealing areas where certain populations experienced worse outcomes than reference groups. Notably, individuals identifying as Black or African American had the highest percentage of measures with identified disparities (see Table 56). These findings reflect national trends rooted in longstanding social determinants of health and structural barriers, underscoring the need for historically informed strategies. NC Medicaid has implemented targeted initiatives to address these gaps, such as the Standard Plan Withhold Program, which prioritizes performance improvement for this population. Medicaid expansion is also expected to have broad, positive impacts — 37% of newly enrolled expansion beneficiaries as of December 2024 identified as Black or African American.[218] Research has found that expansion of coverage can narrow disparities in health care quality and outcomes.[219]

Disparities were also significant among individuals who identify as having disabilities. Addressing these disparities requires a focus on quality-of-life factors, including accessible transportation, housing, affordable health care, employment opportunities and protection against discrimination. Because of this, NC Medicaid continues to innovate care delivery and services for these populations. For example, NC Medicaid is a part of the CMS Money Follows the Person (MFP) program, which helps eligible North Carolinians living in inpatient facilities move into their own homes and communities with support. This program will help eliminate barriers that prevent Medicaid beneficiaries with physical disabilities from receiving long-term care in settings of their choice.

TABLE 56: Percentage of Disparities Identified by Demographic Strata Using MY2023 Data, Quality Measures Only

Demographic Strata	Percent of Measures with Disparities Identified in 2023 Analysis
Disability Status	52.78%
Black or African American Binary	61.11%
American Indian or Alaskan Native Binary	36.11%
Ethnicity	11.11%
Primary Language	17.14%
Gender	9.68%
People who live in Urban vs. Rural areas	8.33%

[218] NC Medicaid Expansion Enrollment Dashboard. NCDHHS. (accessed on 5/23/2025). Available here: https://medicaid.ncdhhs.gov/reports/medicaid-expansion-dashboard

[219] Cross-Call, Jesse. (2020). Medicaid Expansion Has Helped Narrow Racial Disparities in Health Coverage and Access to Care. (Center of Budget and Policy Priorities). Retrieved From: https://www.cbpp.org/research/health/medicaid-expansion-has-helped-narrow-racial-disparities-in-health-coverage-and

TABLE 57: Count of Disparities Identified by Health Domain using MY2023 Data

Health Domain	Total Number of Measures in Domain	Count of Identified Disparities Across Measures
Beneficiary Experience	20	4
Child & Adolescent Health	6	12
Women's Health	5	6
Mental Health	6	14
Substance Use	9	23
Health Care Utilization	6	18
Chronic Health	4	6

Across domains, the largest count of identified disparities is within the substance use domain, followed by the health care utilization domain. The substance use domain also had the highest count of identified disparities in the 2022 NC Medicaid Health Disparities Report, signifying that this is a reoccurring priority area for NC Medicaid. The U.S. Department of Health and Human Services has recognized disparities in substance use disorder treatment services and outcomes as a major problem across the country.[220] Literature reveals structural racism, poverty, differential access to health care and the inequitable nature of substance use policies and treatment resource distribution as some of the causes of these disparities.[221, 222, 223, 224] NC Medicaid will continue to focus on this service area through existing programs, such as the 14 state-operated treatment centers and available crisis services and new innovative programs like the behavioral health and I/DD Tailored Plans that launched in 2024.

The measures within the health care utilization domain are prevention quality indicators that track potentially avoidable pediatric and adult admissions. These measures help identify issues of access to outpatient care, including appropriate follow-up care after hospital discharge. Seeing disparities in this domain indicates that NC Medicaid should focus on high-quality outpatient care which could potentially prevent avoidable admissions, with a specific focus on preventive asthma and diabetes management.

Tracking trends over time is essential. Measures such as CHL, CBP and WCV saw improvements across every single priority population from 2022 to 2023. Other measures, such as W30, OUD, COB and OEV saw improvements across many of the priority populations from 2022 to 2023. On the flip side, we saw worsening performance for measures such as FUH and FUM, which saw worse performance across almost every priority population from 2022 to 2023. Some of these declines in service utilization quality measures can be attributed to the large increase in eligible population due to NC Medicaid Expansion. NC Medicaid will continue to track these trends and focus on areas with persistent or worsening disparities.

In addition to looking at priority population performance over time, we analyzed changes to relative differences over time. Appendix F shows how the relative difference changed from 2022 to 2023 for every measure across each available demographic stratification. A few measures in the substance use and mental health domains, APP, OHD and IET initiation, had decreases in their relative differences for almost all the demographic stratifications between 2022 and 2023. A few child and adolescent health measures, WCV and W30, and the maternal health measure, PPC Prenatal, saw widening gaps (increased

[220] Bui, Juliet. Waters, Annette. Ghertner, Robin. Allen, Eva. Et al. (Nov. 2022). US DHHS. OMH. ASPE. Addressing Substance Use and Social Needs of People of Color with Substance Use Disorders. Available here: https://aspe.hhs.gov/sites/default/files/documents/0a15be5c88dacf7c8dccc046a3f4025e/Addressing-Substance-Use-and-Social-Needs-of-People-of-Color.pdf

[221] Weinstein, James N., Amy Geller, Yamrot Negussie, and Alina Baciu (eds.). "Communities in Action: Pathways to Health Equity." Washington, DC: The National Academies Press, 2017. https://doi.org/10.17226/24624.

[222] Government Accountability Office. "Nonviolent Drug Convictions: Stakeholders' Views on Potential Actions to Address Collateral Consequences." No. GAO-17-691. Washington, DC: U.S. Government Accountability Office, 2017. https://www.gao.gov/products/gao-17-691.

[223] U.S. Commission on Civil Rights. "Collateral Consequences: The Crossroads of Punishment, Redemption, and the Effects on Communities." Washington, DC: U.S. Commission on Civil Rights, 2019. chromeextension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.usccr.gov/files/pubs/2019/06-13-CollateralConsequences.pdf.

[224] Farahmand, P., A. Arshed, and M.V. Bradley. "Systemic Racism and Substance Use Disorders." Psychiatric Annals, vol. 50, no. 11, 2020, pp. 494–98. https://doi.org/10.3928/00485713-20201008-01

relative differences) for almost all demographic stratifications between 2022 and 2023. The Department will continue to monitor these trends and use them to inform priority areas.

There is a unique opportunity to innovate around how, as a state, North Carolina can translate what is presented in this analysis to create positive change.

Ultimately, reporting disparities is only the first step. Real progress requires collaboration with stakeholders — community organizations, advocacy groups, providers, and others — to translate these findings into meaningful action. Addressing deeply rooted inequities demands initiatives that acknowledge historical context, center community voices, and prioritize sustainability. NC Medicaid recognizes that change cannot happen in isolation; it requires trust, time, resources, and shared commitment across the state.

This report is intended as a tool for advocacy and action. By informing stakeholders and guiding targeted interventions, it can help address health disparities and improve outcomes for all North Carolinians.

Looking Ahead

NC Medicaid emphasizes that the NC Medicaid Health Disparities Report is an iterative and evolving effort. Following the release of the inaugural report, NC Medicaid distributed a feedback survey to a broad network of statewide partners. Insights gathered from this feedback directly informed the development of the 2023 report. NC Medicaid will continue to collect feedback on this report's readability, accessibility and usability across the state, as this allows the report to be more stakeholder- and needs-driven.

To ensure the report remains relevant, accessible and responsive to the communities it serves, NC Medicaid will continue to seek input on its readability, usability and overall effectiveness. This ongoing feedback loop ensures the report remains a dynamic, stakeholder-informed tool that drives equity-centered improvements across North Carolina.

Looking Ahead: Strengthening Future Reports

NC Medicaid is committed to expanding and deepening engagement in future iterations of this report. Key areas of focus include:

1. Convene community organizations across the state who work with NC Medicaid beneficiaries to discuss root causes within identified areas of need.
2. Bring the NC Medicaid Health Disparities Report to the AMH and TCM Technical Advisory Groups to hear from providers gather provider feedback and enhance its utility within clinical settings.
3. Integrate and align these results with other critical reports, such as the Access to Care Report, Quality Report and the Access Monitoring Review Plan to ensure alignment across programs and priorities.
4. Seek collective wisdom/expertise and engage with receptive communities whenever possible, acknowledging the rich diversity, history and perceptions of health present within each community.

Additional Resources

Federal, state and local groups are working to overcome health disparities and have developed many resources. These resources are thorough and provide analysis frameworks, disseminate shared definitions, increase capacity, share vital data and track indicators. NC Medicaid hopes the NC 2023 NC Medicaid Health Disparities Report is a helpful tool; however, it must be paired with other resources to be truly impactful. This section of the report contains just some of these critical resources.

One important local and national resource is the Behavioral Risk Factor Surveillance System (BRFSS). BRFSS is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. BRFSS results are stratified by gender, race, ethnicity, age, education level, veteran status, household income, housing status and more.

- National BRFSS Information
- NC 2022 BRFSS Results

Additional NC Resources

NCDHHS Office of Minority Health and Health Disparities works to eliminate health disparities for all individuals and keeps communities healthy, safe, and connected to needed resources and services.

- Health Equity Resources
- Community and Partner Engagement Guide

NCDHHS Office of Rural Health supports equitable access to health in rural and underserved communities.

- Office of Rural Health Programs
- Community Health Workers

The Office of Minority Health and Health Disparities 2024 Health Disparities Data Report and Guide

NCDHHS Office of Minority Health and Health Disparities recently released an analysis of health disparities across North Carolina. To find out more about the most pressing health needs across the state, not just within NC Medicaid's population, visit their report linked here.

Additional National Resources

There are many nationwide organizations working toward improving the health of populations that have been systemically discriminated against. This section highlights some of these groups and their resources.

CDC Resources

The CDC works to ensure health equity is embedded in an all-of-public health approach to overcoming persistent health disparities and health inequities across a range of population groups that disproportionately experience poor health outcomes. You can find more details on CDC's commitment to health equity on this fact sheet. Provided below are some examples of achievements and advancements as a result of CDC's commitment to embedding health equity into their overall approach:

- In 2023, CDC launched a health equity partnership network in collaboration with the Association of State and Territorial Health Officials (ASTHO) and the National Association of State Offices of Minority Health (NASOMH).
- In 2023, CDC developed an agency-wide health equity Notice of Funding Opportunity (NOFO) template and checklist resources with accompanying guidance that advises CDC Centers, Institutes, and Offices on how to embed health equity into non-research NOFOs.
- In 2023, CDC collaborated with multiple community partners through its Communities in Context program in the Greater Detroit, Michigan area to pilot a public health monitoring framework and track structural drivers of inequities at the local level to identify areas to improve community health.

The American Medical Association (AMA) Resources

The AMA Center for Health Equity works to embed health equity across the organization so that health equity becomes part of the practice, process, action, innovation, and organizational performance and outcomes.

- Advancing Health Equity: A Guide to Language, Narrative and Concepts
  - A tool to provide some guidance on equity-focused, person-first language, narratives and concepts. This tool is meant to give physicians, health care workers and others a valuable foundational toolkit for health equity.
- Embedding Equity in Crisis Preparedness and Response in Health Systems
  - A guide for anyone who has a role within a health system, but especially critical for senior leaders who have the power to make health equity a strategic organizational priority.

Additional National Resources

- CDC Health Equity Resources
- Health Equity Language Guide for State Officials
- Understanding and Mitigating Environment Health Disparities and Risks, EPA
- CMS Framework for Health Equity
- Rural Health Disparities. Rural Health Information Hub
- Urban Institute's Report on Supporting NC's Immigrant Families
- CMS 2024 Quality Measure National Impact Report

The Office of Minority Health (OMH) Resources

OMH at the U.S. Department of Health and Human Services (HHS) develops health policies and programs with the goal of eliminating health disparities.

- Health Literacy and Limited English Proficiency: 2023 reading list
  - This brief bibliography contains a variety of resources focused on health literacy and limited English proficiency (LEP).
- Health Disparities Bibliography
  - The Health Disparities Bibliography provides an overview of pivotal past and present books, documents, journal articles and federal reports that define health disparities issues in the United States.
- Minority Health SVI
  - The CDC and OMH at HHS developed the Minority Health Social Vulnerability Index (SVI) to enhance existing resources to support the identification of racial and ethnic minority communities at greatest risk for disproportionate impact and adverse outcomes.

Appendix

Appendix A: Partial Benefit Group Exclusions

Partial benefit groups receive only select coverage for services due to different eligibility status. This section describes six different partial benefit groups, their covered services, and whether they were excluded from quality measurement calculations in this Plan .

Family Planning

Managed Care Status Code: MCS018

Description: Family planning, reproductive health and contraceptive services are provided to eligible men and women, whose income is at or below 195% of the federal poverty level, with no age restrictions. (Link to More Information)

Partial Dual Eligible

Managed Care Status Code: MCS020

Description: Partial dual eligibles receive Medicare financial support from Medicaid but no Medicaid services such as LTSS . These partial dual aid categories include comprehensive Medicare Aid (MQB-Q), limited Medicare aid (MQB-B), Medicaid working disabled (MWB), and limited Medicare-Aid capped enrollment (MQB-E). (Link to More Information)

Emergency Services Only

Managed Care Status Code: MCS021

Description: Emergency services include labor and delivery, including cesarean section. It can also include any treatment after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's life at jeopardy.

Incarcerated

Managed Care Status Code: MCS023

Description: The only services that are covered while a beneficiary's Medicaid is in suspension for incarceration are medical services received during an inpatient stay. Inpatient stay services include the care of patients whose condition requires admission to a hospital.

Presumptive Eligibility

Managed Care Status Code: MCS024

Description: Presumptive eligibility for pregnant women covers only ambulatory prenatal care, defined as outpatient services related to pregnancy, including prenatal care services and services related to other conditions that may complicate the pregnancy. To receive this eligibility the patient must attest to pregnancy, income level and NC residency. The patient does not have to attest to U .S . citizenship.

COVID-19

Managed Care Status Code: MCS043

Description: NC Medicaid reimbursed COVID-19 testing, treatment, and vaccination costs for individuals without insurance who enroll in the NC Medicaid Optional COVID-19 Testing, Treatment and Vaccination (MCV) program.

Appendix B: Data Sources

NC Medicaid used a combination of Department-calculated and vendor-calculated data sources to identify disparities among the NC Medicaid population . Table 17 displays all data sources used for disparity identification .

TABLE 58: Data Sources for Disparity Identification

Measure Sets	Description	Time Period	Responsible for Data Collection	Data Source
Healthcare Effectiveness Data and Information Set (HEDIS®)[225] Measures	A set of standardized performance measures developed and maintained by the National Committee for Quality Assurance (NCQA)	CY 2023	Department	Administrative (claims/ encounters)
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[226] Measures	A national standard for assessing beneficiary experience for accessing care and the quality of care provided by physicians. The CAHPS questionnaires were developed under cooperative agreements among the Agency for Healthcare Research and Quality (AHRQ), Harvard Medical School, RAND Corporation, and the Research Triangle Institute (RTI).	CY 2023	Health Services Advisory Group (HSAG)	Survey
Non-HEDIS Measures	Quality measures developed and maintained by measure stewards other than NCQA (such as theDQA, the Pharmacy Quality Alliance (PQA), or CMS) or home-grown measures that are specific to the Department. More information on these metrics can be found in NC Medicaid's Quality Measurement Technical Specifications Manual.	CY 2023	Department	Administrative (claims/ encounters)
Utilization Metrics	AHRQ Quality Indicator Measures that focus on potentially preventable hospitalizations for the pediatric and adult populations.	CY 2023	Department	Administrative (claims/ encounters)
Substance Use Disorder (SUD) Metrics	SUD metrics reported as part of NC's 1115 SUD Demonstration Waiver.[227]	CY 2023	Sheps center for health services research	Administrative (claims/ encounters)

[225] HEDIS® is a registered trademark of the NCQA.
[226] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[227] For more information on the 1115 SUD demonstration waiver and its measures visit the SUD Waiver Extension Application. (2023)

Appendix C: NC Medicaid Performance Compared to National Averages

This Appendix presents a table of all the NC Medicaid aggregate performance for all the measures in this analysis and the national Medicaid HMO average, when available. Measures that are non-HEDIS do not have comparable Medicaid HMO national averages.

TABLE 59: NC Medicaid performance compared to national Medicaid HMO average, MY 2023 (2024 CAHPS)

Count	Domain	Measure	Total NC Medicaid Performance	Medicaid HMO National Average[229]
1	Beneficiary Experience	Rating of Health Plan — Adult	79.36%	N/A
2		Rating of Health Plan — Child	86.16%	N/A
3		Rating of All Health Care — Adult	76.54%	N/A
4		Rating of All Health Care — Child	86.57%	N/A
5		Customer Service — Adult	91.35%	N/A
6		Customer Service — Child	87.64%	N/A
7		How Well Doctors Communicate — Adult	94.38%	N/A
8		How Well Doctors Communicate — Child	96.08%	N/A
9		Rating of Personal Doctor — Adult	87.39%	N/A
10		Rating of Personal Doctor — Child	90.40%	N/A
11		Rating of Specialist Seen Most Often — Adult	84.76%	N/A
12		Rating of Specialist Seen Most Often — Child	87.64%	N/A
13		Getting Needed Care — Adult	86.13%	N/A
14		Getting Needed Care — Child	86.74%	N/A
15		Getting Care Quickly — Adult	84.64%	N/A
16		Getting Care Quickly — Child	89.18%	N/A
17		Flu Vaccinations for Adults (FVA)	38.66%	N/A
18		Medical Assistance with Smoking and Tobacco Use Cessation (MSC) — Advised to Quit Smoking by Provider	79.96%	73.5%
19		Medical Assistance with Smoking and Tobacco Use Cessation (MSC) — Discussing Cessation Medication	57.53%	52.8%
20		Medical Assistance with Smoking and Tobacco Use Cessation (MSC) — Discussing Cessation Strategies	48.00%	46.6%

[229] NCQA HEDIS National Medicaid HMO averages for MY2023 can be found here: https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/. We are unable to share CAHPS national average data but you can see the comparisons in the full NC Medicaid Adult and Child CAHPS Aggregate Report. Available here: https://medicaid.ncdhhs.gov/2024-cahps-survey-three-years-managed-care-full-report/download?attachment .

Count	Domain	Measure	Total NC Medicaid Performance	Medicaid HMO National Average[229]
21	Child & Adolescent Health	Childhood Immunization Status — Combination 10 (CIS)	24.54%	29.1%
22		Immunizations for Adolescents — Combination 2 (IMA-2)	29.73%	35.8%
23		Well-Child Visits in the First 30 Months of Life — Well-Child Visits in the First 15 Months — Six or More Well-Child Visits (W30-6+)	63.54%	59.0%
24		Well-Child Visits in the First 30 Months of Life — Well-Child Visits for Age 15 Months to 30 Months — Two or More Well-Child Visits (W30-2+)	68.98%	69.2%
25		Child and Adolescent Well-Care Visits (WCV)	51.51%	52.1%
26		Oral Evaluation (OEV-CH)	49.08%	42.8%[230]
27	Women's Health	Breast Cancer Screening (BCS)	32.81%	53.3%
28		Cervical Cancer Screening (CCS)	42.67%	55.4%
29		Chlamydia Screening in Women (CHL)	59.17%	56.5%
30		Prenatal and Postpartum Care (PPC) — Timeliness of Prenatal Care	43.92%	83.1%
31		Prenatal and Postpartum Care (PPC) — Postpartum Care	60.71%	78.6%
32	Mental Health	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	63.64%	61.1%
33		Follow-Up After Hospitalization for Mental Illness — 7-Day Follow-Up (FUH)	22.86%	38.5%
34		Follow-Up After Hospitalization for Mental Illness — 30-Day Follow-Up (FUH)	41.31%	59.1%
35		Follow-Up After ED Visit for Mental Illness — 7-Day Follow-Up (FUM)	39.82%	39.6%
36		Follow-Up After ED Visit for Mental Illness — 30-Day Follow-Up (FUM)	55.41%	54.1%
37		Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	43.12%	57.9%
38	Substance Use	Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence — 7-Day Follow-Up (FUA)	21.04%	24.1%
39		Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence — 30-Day Follow-Up (FUA)	30.46%	35.5%
40		Use of Opioids at High Dosage in Persons Without Cancer (OHD)	7.33%	N/A
41		Use of Pharmacotherapy for Opioid Use Disorder (OUD) Total Rate	58.56%	N/A
42		Use of Opioids From Multiple Providers (UOP)- Multiple Prescribers and Multiple Pharmacies**-Multiple Prescribers and Multiple Pharmacies	1.35%	2.2%
43		ED Utilization for SUD per 1,000 Medicaid Beneficiaries	10.0	N/A
44		Concurrent Use of Opioids and Benzodiazepines (COB)	12.36%	13.0%[231]
45		Initiation And Engagement in SUD Treatment - Initiation (IET)	39.62%	45.1%
46		Initiation And Engagement in SUD Treatment - Engagement (IET)	12.79%	14.8%

[230] Oral Evaluation, Dental Services (OEV) Measure is stewarded by the Dental Quality Alliance (DQA) and its national Medicaid HMO national average is therefore not available through NCQA's Quality Compass Tool. The rate shown here is the CMS Core Set National Median, available on the CMS Core Set dashboard available here: https://www.medicaid.gov/medicaid/quality-of-care/core-set-data-dashboard/measure/Oral-Evaluation-Dental-Services-Ages-Less-Than-1-through-20-OEV-CH?keywords=%5B%22659%22%5D&measure=HC.104&measureView=state&population=999&methodology=372&dataView=pointInTime&chart=map&timePeriods=%5B%222023%22%5D

[231] Concurrent Use of Opioids and Benzodiazepines (COB) Measure is stewarded by the Pharmacy Quality Alliance (PQA) and its national Medicaid HMO national average is therefore not available through NCQA's Quality Compass Tool. The rate shown here is the CMS Core Set National Median, available on the CMS Core Set dashboard available here: https://www.medicaid.gov/medicaid/quality-of-care/core-set-data-dashboard/measure/Concurrent-Use-of-Opioids-and-Benzodiazepines-Age-18-and-Older-COB-AD?measure=HC.74&measureView=state&population=999&methodology=372&dataView=pointInTime&chart=map&timePeriods=%5B%222023%22%5D

Count	Domain	Measure	Total NC Medicaid Performance	Medicaid HMO National Average[229]
47	Health Care Utilization	PQI 01: Diabetes Short-Term Complications Admission Rate Per 100,000 Member Months	14.87	N/A
48		PQI 15: Asthma in Younger Adults Admission Rate Per 100,000 Member Months	3.74	N/A
49		PQI 05: COPD or Asthma in Older Adults Admission Rate Per 100,000 Member Months	42.38	N/A
50		PQI 08: Heart Failure Admission Rate Per 100,000 Member Months	37.81	N/A
51		PDI 14: Pediatric Asthma Admission Rate Per 100,000 Member Months	4.86	N/A
52		PDI 15: Pediatric Diabetes Short-Term Complications Admission Rate Per 100,000 Member Months	2.49	N/A
53	Chronic Health	Controlling High Blood Pressure (CBP)	50.41%	63.9%
54		Hemoglobin A1c (HbA1c) Control for Patients with Diabetes - HbA1c Poor Control (HBD)	90.28%	35.8%
55		Hemoglobin A1c (HbA1c) Control for Patients with Diabetes - HbA1c Control (HBD)	8.48%	55.4%
56		Colorectal Cancer Screening (COL)	22.56%	38.64%

**PDI/PQI rates are calculated differently, as per 100,000 population, at the Medicaid HMO National level*
***Lower rate indicates better performance*

Appendix D: Summary Disparity Analysis Tables

This Appendix presents a table of all the measures in this analysis and whether a disparity was identified for each stratification element and its relative difference .

$$\text{Relative Difference} = \frac{\text{(Reference Group Performance Rate-Group of Interest Performance Rate)}}{\text{Reference Group Performance Rate}}$$

How to read this table:

- Group of interest marked by an asterisk (*) .
- Negative relative difference signifies group of interest* fared better than reference group .

TABLE 60: Relative difference of reference group vs . group of interest for MY2023, Quality Measures

Domain	Measures	**Disability Status** (Disability* vs. Not)	**Geography** (Rural* vs. Urban)	**Gender** (Female* vs. Male)	**Ethnicity** (Hispanic/Latino* vs. Not)	**Primary Language** (Non-English* vs. English)	**Black Binary** (Black/African American* vs. Not)	**AI/AN Binary** (American Indian/ Alaskan Native* vs. Not)
Child & Adolescent Health	Child and Adolescent Well-Care Visits (WCV)	-4.67%	1.78%	-3.15%	-20.70%	-19.06%	7.66%	3.01%
	Childhood Immunization Status — Combination 10 (CIS)	25.33%	16.40%	0.08%	-70.15%	-85.07%	35.34%	16.13%
	Immunizations for Adolescents — Combination 2 (IMA-2)	3.12%	-6.51%	-10.10%	-54.66%	-60.94%	12.13%	-36.26%
	Well-Child Visits in the First 30 Months of Life — Well-Child Visits in the First 15 Months — Six or More Well-Child Visits (W30)	60.04%	-2.12%	-1.52%	-10.53%	-6.70%	12.29%	2.09%
	Well-Child Visits in the First 30 Months of Life — Well-Child Visits for Age 15 Months to 30 Months — Two or More Well-Child Visits (W30)	2.26%	-1.41%	0.89%	-14.84%	-13.78%	11.85%	7.18%
	Oral Evaluation (OEV-CH)	2.95%	5.84%	-4.73%	-33.49%	-29.03%	11.54%	7.28%
Women's Health	Breast Cancer Screening (BCS)	-102.43%	-10.03%	N/A	5.56%	12.13%	-16.75%	-6.81%
	Cervical Cancer Screening (CCS)	0.14%	-4.97%	N/A	-11.36%	2.86%	-16.49%	-8.36%
	Chlamydia Screening in Women (CHL)	32.68%	6.30%	N/A	-6.82%	-7.52%	-22.60%	-5.10%
	Prenatal and Postpartum Care (PPC) — Timeliness of Prenatal Care	-11.47%	-1.10%	N/A	-4.98%	-0.55%	3.97%	25.48%
	Prenatal and Postpartum Care (PPC) — Postpartum Care	17.49%	5.68%	N/A	-13.34%	-20.76%	7.26%	10.12%
Mental Health	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	-36.42%	-0.03%	0.58%	-8.81%	-4.78%	13.36%	9.46%
	Follow-Up After Hospitalization for Mental Illness — 7-Day Follow-Up (FUH)	33.57%	0.04%	-26.31%	-42.89%	-78.83%	27.02%	32.29%
	Follow-Up After Hospitalization for Mental Illness — 30-Day Follow-Up (FUH)	23.65%	3.12%	-21.32%	-30.96%	-45.78%	20.03%	21.53%
	Follow-Up After ED Visit for Mental Illness — 7-Day Follow-Up (FUM)	1.58%	-0.48%	-3.87%	-9.34%	-17.62%	8.91%	17.76%
	Follow-Up After ED Visit for Mental Illness — 30-Day Follow-Up (FUM)	-4.20%	1.60%	-3.34%	-7.56%	-10.51%	9.11%	14.98%
	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	33.79%	-1.47%	-21.87%	-18.19%	-22.96%	1.52%	-7.31%

Domain	Measures	**Disability Status** (Disability* vs. Not)	**Geography** (Rural* vs. Urban)	**Gender** (Female* vs. Male)	**Ethnicity** (Hispanic/Latino* vs. Not)	**Primary Language** (Non-English* vs. English)	**Black Binary** (Black/African American* vs. Not)	**AI/AN Binary** (American Indian/ Alaskan Native* vs. Not)
Substance Use	Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence — 7-Day Follow-Up (FUA)	-27.13%	-0.26%	-3.02%	22.96%	6.71%	32.94%	-47.63%
	Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence — 30-Day Follow-Up (FUA)	-35.06%	-0.49%	-4.49%	17.36%	22.51%	30.37%	-36.89%
	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	84.30%	-8.52%	-20.98%	-22.46%	-67.20%	-39.83%	-34.55%
	Use of Pharmacotherapy for Opioid Use Disorder (OUD) Total Rate	29.24%	-6.02%	-15.60%	7.56%	29.22%	46.70%	-1.89%
	Use of Opioids From Multiple Providers (UOP)- Multiple Prescribers and Multiple Pharmacies**-Multiple prescribers and Multiple Pharmacies	-15.33%	-39.75%	-12.25%	-21.46%	-28.70%	59.59%	-57.85%
	ED Utilization for SUD per 1,000 Medicaid Beneficiaries	545.90%	22.11%	-18.75%	-76.52%	N/A	105.10%	15.96%
	Concurrent Use of Opioids and Benzodiazepines (COB)	32.49%	-15.5%	58.43%	-21.72%	-35.74%	-64.20%	-50.83%
	Initiation And Engagement in SUD Treatment- Initiation	-10.77%	1.66%	-0.91%	14.06%	24.36%	10.30%	8.78%
	Initiation And Engagement in SUD Treatment- Engagement	23.79%	-9.46%	-24.90%	20.14%	31.65%	35.18%	-3.27%
Health Care Utilization	PQI 01: Diabetes Short-Term Complications Admission Rate Per 100,000 Member Months	293.49%	11.77%	-4.11%	-59.42%	-70.50%	58.32%	28.54%
	PQI 15: Asthma in Younger Adults Admission Rate Per 100,000 Member Months	213.94%	-27.13%	92.79%	-58.79%	-87.65%	99.52%	28.95%
	PQI 05: COPD or Asthma in Older Adults Admission Rate Per 100,000 Member Months	235.71%	1.96%	6.90%	-75.55%	-84.42%	-18.27%	46.38%
	PQI 08: Heart Failure Admission Rate Per 100,000 Member Months	382.65%	8.62%	-34.71%	-69.43%	-52.41%	81.39%	-22.59%
	PDI 14: Pediatric Asthma Admission Rate Per 100,000 Member Months	115.34%	-53.78%	-31.42%	-26.01%	-40.22%	186.27%	37.74%
	PDI 15: Pediatric Diabetes Short-Term Complications Admission Rate Per 100,000 Member Months	187.89%	-29.09%	29.32%	-56.73%	-74.85%	65.37%	-34.46%

Domain	Measures	Disability Status (Disability* vs. Not)	Geography (Rural* vs. Urban)	Gender (Female* vs. Male)	Ethnicity (Hispanic/Latino* vs. Not)	Primary Language (Non-English* vs. English)	Black Binary (Black/African American* vs. Not)	AI/AN Binary (American Indian/ Alaskan Native* vs. Not)
Chronic Health	Controlling High Blood Pressure (CBP)	6.27%	2.28%	-5.94%	-4.25%	-3.12%	16.98%	0.31%
	Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD) - HbA1c Poor Control	2.34%	0.62%	-0.65%	0.49%	-1.74%	1.28%	4.71%
	Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD) - HbA1c Control	-24.83%	7.49%	-9.37%	3.45%	-10.14%	10.28%	42.30%
	Colorectal Cancer Screening (COL)	56.55%	-8.28%	-17.38%	0.99%	10.69%	-4.96%	7.77%

TABLE 61: Relative difference of reference group vs . group of interest for 2023, CAHPS measures

Measure	Ethnicity (Hispanic/Latino* vs. Not)	Black Binary (Black and African American* vs. Not)	American Indian/ Alaskan Native Binary (AI/AN* vs. Not)	Geography (Rural* vs. Urban)
Rating of Health Plan — Adult	-6.19%	-0.82%	0.87%	2.84%
Rating of Health Plan — Child	-6.98%	1.93%	3.17%	-1.00%
Rating of All Health Care — Adult	-7.14%	0.39%	7.27%	4.17%
Rating of All Health Care — Child	-0.17%	-0.11%	-2.70%	0.02%
Customer Service — Adult	1.24%	-4.88%	-4.50%	-1.21%
Customer Service — Child	1.16%	-0.83%	-5.65%	-4.11%
How Well Doctors Communicate — Adult	-0.60%	-1.26%	1.25%	0.38%
How Well Doctors Communicate — Child	3.40%	-0.17%	0.48%	-0.46%
Rating of Personal Doctor — Adult	0.29%	-0.96%	3.41%	0.63%
Rating of Personal Doctor — Child	-1.73%	2.07%	6.32%	2.26%
Rating of Specialist Seen Most Often — Adult	-9.38%	0.20%	19.00%	0.98%
Rating of Specialist Seen Most Often — Child	-2.55%	4.66%	-3.03%	-5.49%
Getting Needed Care — Adult	4.47%	-4.07%	-1.02%	-2.70%
Getting Needed Care — Child	2.92%	-2.14%	1.59%	-2.57%
Getting Care Quickly — Adult	3.30%	-2.65%	-2.55%	-1.44%
Getting Care Quickly — Child	7.53%	-1.06%	-3.31%	-0.59%
Flu Vaccinations for Adults (FVA)	1.46%	-77.02%	-13.22%	3.19%
Medical Assistance with Smoking and Tobacco Use Cessation (MSC) — Advised to Quit Smoking by Provider	14.50%	-0.23%	-2.29%	-0.34%

Measure	Ethnicity (Hispanic/Latino* vs. Not)	Black Binary (Black and African American* vs. Not)	American Indian/ Alaskan Native Binary (AI/AN* vs. Not)	Geography (Rural* vs. Urban)
Medical Assistance with Smoking and Tobacco Use Cessation (MSC) — Discussing Cessation Medication	23.74%	-10.02%	-5.46%	-1.34%
Medical Assistance with Smoking and Tobacco Use Cessation (MSC) — Discussing Cessation Strategies	25.17%	-5.23%	3.43%	3.01%

Note: CAHPS data was not stratified by disability status, gender or primary language.

TABLE 62: Relative difference of reference group vs. group of interest for MY2023 for Age Groups

Measure Acronyms	Age Group	Relative Difference
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Ages 1-11* vs. Ages 12-17	7.71%
Chlamydia Screening in Women (CHL)	Ages 16-20* vs. Ages 21-24	12.27%
Follow-Up After Hospitalization for Mental Illness — 7-Day (FUH)	Ages 6-17 vs. Ages 18-64*	44.94%
Follow-Up After Hospitalization for Mental Illness — 30-Day (FUH)	Ages 6-17 vs. Ages 18-64*	38.89%
Follow-Up After ED Visit for Mental Illness — 7-Day (FUM)	Ages 6-17 vs. Ages 18-64*	34.40%
Follow-Up After ED Visit for Mental Illness — 30-Day (FUM)	Ages 6-17 vs. Ages 18-64*	30.40%
Oral evaluation, dental services (OEV)	Ages 10-11 vs. Ages 19-20*	16.96%
Child and Adolescent Well-Care Visits (WCV)	Ages 12-17 vs. Ages 18-21*	49.36%
	Ages 3-11 vs. Ages 18-21*	55.94%
Colorectal Cancer Screening (COL)	Ages 51-75 vs. Ages 46-50	36.23%

**Group of Interest. Group of interest and group of reference is dependent upon measure specifications.*

Appendix E: MY2023 Total NC Medicaid & NC Medicaid Managed Care Comparison

TABLE 63: MY2023 Total NC Medicaid & NC Medicaid Managed Care Performance Rate Comparison

Count	Domain	Measure	Total NC Medicaid Performance	NC Medicaid Managed Care Performance
1	Beneficiary Experience	Rating of Health Plan — Adult	79.36%	74.94%
2		Rating of Health Plan — Child	86.16%	86.54%
3		Rating of All Health Care — Adult	76.54%	75.86%
4		Rating of All Health Care — Child	86.57%	86.54%
5		Customer Service — Adult	91.35%	87.30%
6		Customer Service — Child	87.64%	87.51%
7		How Well Doctors Communicate — Adult	94.38%	94.10%
8		How Well Doctors Communicate — Child	96.08%	95.88%
9		Rating of Personal Doctor — Adult	87.39%	84.75%
10		Rating of Personal Doctor — Child	90.40%	90.26%
11		Rating of Specialist Seen Most Often — Adult	84.76%	80.83%
12		Rating of Specialist Seen Most Often — Child	87.64%	87.63%
13		Getting Needed Care — Adult	86.13%	81.89%
14		Getting Needed Care — Child	86.74%	86.58%
15		Getting Care Quickly — Adult	84.64%	82.04%
16		Getting Care Quickly — Child	89.18%	88.77%
17		Flu Vaccinations for Adults (FVA)	38.66%	N/A
18		Medical Assistance with Smoking and Tobacco Use Cessation (MSC) — Advised to Quit Smoking by Provider	79.96%	76.21%
19		Medical Assistance with Smoking and Tobacco Use Cessation (MSC) — Discussing Cessation Medication	57.53%	51.50%
20		Medical Assistance with Smoking and Tobacco Use Cessation (MSC) — Discussing Cessation Strategies	48.00%	43.79%
21	Child & Adolescent Health	Childhood Immunization Status — Combination 10 (CIS)	24.54%	24.45%
22		Immunizations for Adolescents — Combination 2 (IMA)	29.73%	29.44%
23		Well-Child Visits in the First 30 Months of Life — First 15 Months (W30)	63.54%	63.73%
24		Well-Child Visits in the First 30 Months of Life — 15 to 30 Months (W30)	68.98%	68.54%
25		Child and Adolescent Well-Care Visits (WCV)	51.51%	51.24%
26		Oral Evaluation (OEV-CH)	49.08%	48.80%

Count	Domain	Measure	Total NC Medicaid Performance	NC Medicaid Managed Care Performance
27	Women's Health	Breast Cancer Screening (BCS)	32.81%	32.03%
28		Cervical Cancer Screening (CCS)	42.67%	42.94%
29		Chlamydia Screening in Women (CHL)	59.17%	59.94%
30		Prenatal and Postpartum Care (PPC) — Timeliness of Prenatal Care	43.92%	43.99%
31		Prenatal and Postpartum Care (PPC) — Postpartum Care	60.71%	61.50%
32	Mental Health	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	63.64%	61.25%
33		Follow-Up After Hospitalization for Mental Illness — 7-Day Follow-Up (FUH)	22.86%	25.30%
34		Follow-Up After Hospitalization for Mental Illness — 30-Day Follow-Up (FUH)	41.31%	42.83%
35		Follow-Up After ED Visit for Mental Illness — 7-Day Follow-Up (FUM)	39.82%	36.60%
36		Follow-Up After ED Visit for Mental Illness — 30-Day Follow-Up (FUM)	55.41%	50.22%
37		Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	43.12%	40.41%
38	Substance Use	Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence — 7-Day Follow-Up (FUA)	21.04%	12.94%
39		Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence — 30-Day Follow-Up (FUA)	30.46%	19.33%
40		Use of Opioids at High Dosage in Persons Without Cancer (OHD)	7.33%	7.75%
41		Use of Pharmacotherapy for Opioid Use Disorder -Total Rate (OUD)	58.56%	63.95%
42		Use of Opioids From Multiple Providers (UOP)- Multiple Prescribers and Multiple Pharmacies**	1.35%	1.36%
43		ED Utilization for SUD per 1,000 Medicaid Beneficiaries	10.0	N/A
44		Concurrent Use of Opioids and Benzodiazepines (COB)	12.36%	12.03%
45		Initiation And Engagement in SUD Treatment - Initiation (IET)	39.62%	33.31%
46		Initiation And Engagement in SUD Treatment - Engagement (IET)	12.79%	8.90%
47	Health Care Utilization	PQI 01: Diabetes Short-Term Complications Admission Rate Per 100,000 Member Months	14.87	16.45
48		PQI 15: Asthma in Younger Adults Admission Rate Per 100,000 Member Months	3.74	2.64
49		PQI 05: COPD or Asthma in Older Adults Admission Rate Per 100,000 Member Months	42.38	47.61
50		PQI 08: Heart Failure Admission Rate Per 100,000 Member Months	37.81	24.57
51		PDI 14: Pediatric Asthma Admission Rate Per 100,000 Member Months	4.86	4.84
52		PDI 15: Pediatric Diabetes Short-Term Complications Admission Rate Per 100,000 Member Months	2.49	2.47

Count	Domain	Measure	Total NC Medicaid Performance	NC Medicaid Managed Care Performance
53	Chronic Health	Controlling High Blood Pressure (CBP)	50.41%	50.63%
54		Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD)-HbA1c Poor Control**	90.28%	89.54%
55		Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD)-HbA1c Control	8.48%	9.10%
56		Colorectal Cancer Screening (COL)	22.56%	21.65%

**CAHPS data for NC Medicaid Managed Care rates are the 2024 CAHPS NC PHP Aggregate Rates*

***For these measures a lower rate indicates better performance*

Note: Rates have limited benefits beneficiaries and dual eligibles excluded

Appendix F: Change in Relative Difference Over Time

This table shows how the relative difference percentages have changed from 2022 to 2023.

■ Relative Difference has been reduced from 2022-2023

♦ Relative Difference has increased from 2022-2023

TABLE 64: CHANGE IN RELATIVE DIFFERENCE OVER TIME, 2022 TO 2023

Domain	Measure	Disability Status	Gender	Primary Language	Ethnicity	Black Binary	AI/AN Binary	Geography
Child & Adolescent Health	Child and Adolescent Well-Care Visits (WCV)	■	♦	♦	♦	♦	♦	■
	Childhood Immunization Status — Combination 10 (CIS)	♦	■	■	■	■	♦	♦
	Immunizations for Adolescents — Combination 2 (IMA)	♦	♦	■	♦	■	♦	♦
	Well-Child Visits in the First 30 Months of Life — First 15 Months (W30)	■	■	♦	♦	♦	♦	♦
	Well-Child Visits in the First 30 Months of Life — 15 to 30 Months (W30)	♦	♦	♦	♦	■	♦	■
	Oral Evaluation (OEV-CH)	■	♦	♦	♦	■	♦	■
Women's Health	Breast Cancer Screening (BCS)	■	N/A	♦	♦	■	■	■
	Cervical Cancer Screening (CCS)	■	N/A	♦	■	■	■	■
	Chlamydia Screening in Women (CHL)	♦	N/A	■	■	♦	■	♦
	Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care	♦	N/A	♦	♦	■	♦	♦
	Prenatal and Postpartum Care (PPC) - Postpartum Care	♦	N/A	■	♦	♦	■	■

Domain	Measure	Disability Status	Gender	Primary Language	Ethnicity	Black Binary	AI/AN Binary	Geography
Mental Health	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	■	■	♦	■	♦	♦	♦
	Follow-Up After Hospitalization for Mental Illness — 7-Day Follow-Up (FUH)	■	■	■	■	♦	♦	♦
	Follow-Up After Hospitalization for Mental Illness — 30-Day Follow-Up (FUH)	♦	■	■	■	♦	■	♦
	Follow-Up After ED Visit for Mental Illness — 7-Day Follow-Up (FUM)	♦	■	■	♦	■	♦	■
	Follow-Up After ED Visit for Mental Illness — 30-Day Follow-Up (FUM)	■	■	♦	♦	■	♦	■
	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	♦	■	■	■	■	■	■
Substance Use	Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence — 7-Day Follow-Up (FUA)	■	■	■	♦	♦	♦	♦
	Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence — 30-Day Follow-Up (FUA)	■	■	■	■	♦	♦	♦
	Use of Opioids at High Dosage in Persons Without Cancer (OHD)**	■	■	♦	■	■	■	■
	Use of Pharmacotherapy for Opioid Use Disorder (OUD) Total Rate	■	■	■	■	■	♦	♦
	Use of Opioids From Multiple Providers (UOP)- Multiple Prescribers and Multiple Pharmacies** -Multiple prescribers and Multiple Pharmacies	■	♦	♦	■	■	■	■
	ED Utilization for SUD per 1,000 Medicaid Beneficiaries	■	■	N/A	■	♦	■	■
	Concurrent Use of Opioids and Benzodiazepines (COB)**	■	♦	♦	♦	♦	■	■
	Initiation And Engagement in SUD Treatment (IET) - Initiation	■	■	■	■	♦	■	■
	Initiation And Engagement in SUD Treatment (IET) - Engagement	♦	■	■	■	♦	♦	♦

Domain	Measure	Disability Status	Gender	Primary Language	Ethnicity	Black Binary	AI/AN Binary	Geography
Health Care Utilization	PQI 01: Diabetes Short-Term Complications Admission Rate Per 100,000 Member Months**	■	♦	N/A	♦	■	■	♦
	PQI 15: Asthma in Younger Adults Admission Rate Per 100,000 Member Months**	■	■	N/A	♦	■	♦	■
	PQI 05: COPD or Asthma in Older Adults Admission Rate Per 100,000 Member Months**	♦	♦	N/A	■	■	■	♦
	PQI 08: Heart Failure Admission Rate Per 100,000 Member Months**	■	♦	N/A	■	■	■	♦
	PDI 14: Pediatric Asthma Admission Rate Per 100,000 Member Months**	♦	■	N/A	♦	♦	♦	■
	PDI 15: Pediatric Diabetes Short-Term Complications Admission Rate Per 100,000 Member Months**	■	♦	N/A	■	♦	♦	■
Chronic Health	Controlling High Blood Pressure (CBP)	♦	■	■	■	♦	♦	♦
	Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD)- HbA1c Poor Control**	♦	■	■	■	■	♦	♦
	Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD)- HbA1c Control	♦	■	■	■	♦	♦	♦
	Colorectal Cancer Screening (COL)	♦	■	■	■	■	♦	■

*** For these measures lower rates indicate better performance*

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