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

Due date	Last edited	Edited by	Status
12/27/2024	12/27/2024	Dawn Johnson	Submitted

	Indicator	Response
	Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	North Carolina
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Cassandra McFadden
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	cassandra.mcfadden@dhhs.nc.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Dawn Johnson
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	dawn.johnson@dhhs.nc.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	12/27/2024

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	07/01/2023
A5b	**Reporting period end date** Auto-populated from report dashboard.	06/30/2024
A6	**Program name** Auto-populated from report dashboard.	Standard Plan

Add plans (A.7)

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

	Indicator	Response
	Plan name	Blue Cross and Blue Shield Amerihealth Caritas Carolina Complete Health WellCare UnitedHealthcare

Add BSS entities (A.8)

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

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

	Indicator	Response
	BSS entity name	Maximus (Enrollment Broker) North Carolina Medicaid Ombudsman

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

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

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

	Indicator	Response
	ILOS name	

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	2,991,392
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	2,587,516

Topic III. Encounter Data Report

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

Topic X: Program Integrity

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/ overutilization, and other activities. If no PI activities were performed, enter 'No PI activities were performed during the reporting period' as your response. 'N/A' is not an acceptable response.	OCPI Compliance Analytics conducted cross-payer Payment Integrity analyses with a focus on cross payer over-billing and persistent high risk behaviors, reviewing 3 months historic data each from July 2023 - June 2024: 1. Drug Testing Referring Providers cross-plan provider risk analysis identified the provider with the most outlier behavior in their peer group and performed a comparison to whole referring provider peer group. Included a deep dive comparison against top 28 providers via risk factors reviewed in peer group. 2. Psychotherapy, Speech Occupational and Physical Therapy peer group comparison identifying 620 long days across 50 providers. Identified 191 days and 15 providers with impossible billing of > 24 hours per day within those groups. 3. Drug Testing Kickback Scheme Segmentation Analysis: Identified 19 billing providers and 10 rendering providers with similar billing behaviors as a provider recently convicted and sentenced for fraud. Above results were presented to all of the Managed Care Organizations during quarterly SIU oversight. OCPI Compliance Analytics conducted cross-payer payment reviews of the following service areas: 1. Incontinence Suppliers peer group review: Reviewed 8 providers with at least one risk identified and 6 were referred for investigation. 2. E&M peer group review focused on Telehealth: Reviewed 38 providers with at least one risk identified and 6 were referred for investigation. OCPI Compliance Analytics conducted cross-payer payment reviews of individual high risk providers in tandem with the MFCU on the following service areas: 1. Home Health - 1 provider 2. Personal Care Services - 1 provider 3. Behavioral Health - 2 Providers 4. Drug Testing Labs - 1 provider
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	Allow plans to retain overpayments

BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Section 4.J.1.E, page 244
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	The PIHP, or Subcontractor to the extent that the Subcontractor is delegated responsibility by the PIHP for coverage of services and payment of claims under the Contract, shall implement and maintain arrangements or procedures for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State. 42 C.F.R. § 438.608(a)(2). ii. In meeting the requirement of 42 C.F.R. § 438.608(a)(2), the PIHP may recover overpayments made to the health care provider or health care facility by making demands for refunds and by offsetting future payments. Any such recoveries may also include related interest payments that were made under the requirements of this Section. Not less than thirty (30) Calendar Days before the PIHP seeks overpayment recovery or offsets future payments, the PIHP shall give written notice to the health care provider or health care facility, which notice shall be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery. The recovery of overpayments or offsetting of future payments shall be made within the two years after the date of the original claim payment unless the PIHP has reasonable belief of fraud or other intentional misconduct by the health care provider or health care facility or its agents. The health care provider or health care facility may recover underpayments or non-payments by the PIHP by making demands for refunds. Any such recoveries by the health care provider or health care facility of underpayments or nonpayment by the PIHP may include applicable interest under this section. The recovery of underpayments or non-payments shall be made within the two years after the date of the original claim adjudication, unless the claim involves a health provider or health care facility receiving payment for the same

		service from a government payor. iii. The PIHP shall coordinate with the Department to ensure overpayment and underpayment recovery is accurately reflected in MLR calculations and capitation rate setting.
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	The State Medicaid Agency have the Plans report their overpayments and recoveries on an Annual Overpayment Recoveries Report and the Quarterly FWA Provider Report. The SMA receive, review and analyze the Annual Overpayment Recoveries Report via the Compliance Review Process conducted by the EQRO and The Office of Compliance and Program Integrity. The Plans share overpayment and recoveries during their monthly Oversight and Monitoring meeting with the State and on their Quarterly FWA Provider Report of all provider audits and Investigations to include disposition of overpayments and recoveries.
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	" Daily 834 files with member changes. - Monthly 834 Files with all members - A monthly reconciliation process that compares member enrollment data across systems, such as health plans, the Enrollment Broker, and state eligibility systems. "
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	No
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal	No

	database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	No
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter 'No such audits were conducted during the reporting year' as your response. 'N/A' is not an acceptable response.	Encounter data validation process is completed with an external quality review organization HSAG (Human Services Advisory Group). We have the Information Systems Capability Assessment that was completed by the external quality review organization HSAG. DHHS internal audit has also reviewed the encounter data validation reports.

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	Prepaid Health Plan Services #30-190029-DHB – PHP
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	07/01/2023
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://medicaid.ncdhhs.gov/health-plans#HealthPlanContracts%EF%BF%BD-1622
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Long-term services and supports (LTSS) Transportation
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	N/A
C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this	2,022,680

	managed care program per month during the reporting year (i.e., average member months).	
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter 'There were no major changes to the population or benefits during the reporting year' as your response. 'N/A' is not an acceptable response.	Medicaid Expansion was implemented mid-year 2024 resulting in increased enrollment for all programs

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support Other, specify – TMSIS reporting to CMS State and Federal Audit Request
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Timeliness of data certifications Use of correct file formats Provider ID field complete Overall data accuracy (as determined through data validation)
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Section V.H.2
C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of	VI.A. Table 2 LD #22, 23,24,25,26,30

	failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	N/A
C1III.6	**Barriers to collecting/ validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter 'The state did not experience any barriers to collecting or validating encounter data during the reporting year' as your response. 'N/A' is not an acceptable response.	Because this is within the first 18 months of collecting encounter data as part of a new 1115 waiver, the State has had to provide an additional level of technical assistance to the plans to meet the SLAs and to have the plans adjust their systems to adhere to the State's reporting requirements. For the EPS system, the business rules drive the validation of the data being submitted. In order to ensure the business rules align with the policies of DHB, processes have been established to have a clinical review of any changes to those rules. Sometimes this process is lengthy. However, through the External Quality Review Vendor, HSAG, NC has completed the Encounter Data Validation process. Most plans are in full compliance with the CMS Encounter Data Validation protocol.

Topic IV. Appeals, State Fair Hearings & Grievances

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

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

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter 'No challenges were encountered' as your response. 'N/A' is not an acceptable response.	1) The consistency and reliability of provider data as reported by providers to the State, as reported by the State to the prepaid health plans, and as ingested and reported back to the State by the Standard Plan Prepaid Health Plans is a challenge for Network Adequacy. While this has greatly improved, there are still areas for improvement. Providers are traditionally poor at updating demographic information and stressing its importance to member choice and claims payment. The state is also providing assistance and information to the prepaid health plans relating to the updated systems and how the new information may impact the information provided to the prepaid health plans. 2) In many areas of the state, Standard Plan PHPs struggle with contracting with providers in general due to a limited supply of providers. This is especially true in the more rural areas of the state and is particularly acute for pediatric specialist. This lack of providers is evident in the network adequacy geomapping results relating to the MCPs networks but also evident in the geomapping results of the network of all enrolled Medicaid providers.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	The state works with all health plans to confirm that for the gaps identified by analysis an appropriate network adequacy exception request is submitted for the state's review and approval. As part of the request for an exception the MCPS must indicate how the plan will make sure that members have access to the services on a timely basis and their plan to mitigate the provider gap. Additionally, the state engages the MCPS around provider supply issues and discusses ways in which improvements can be made to encourage more provider participation in Medicaid.

Access Measures

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

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

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

Access measure total count: 46

Complete

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

1 / 46

C2.V.2 Measure standard

≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

2 / 46

C2.V.2 Measure standard

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

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

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

3 / 46

Complete

accessibility standard

C2.V.2 Measure standard

≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Urban	Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

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

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Rural	Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

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

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

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

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

C2.V.2 Measure standard

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

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

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

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

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

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of Members

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialist	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of Members

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialist	Urban	Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of Members

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialist	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of Members

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialist	Rural	Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

≥ 1 hospitals within 30 minutes or 15 miles for at least 95% of Members

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Urban	Adult and Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

≥ 1 hospitals within 30 minutes or 30 miles for at least 95% of Members

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

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C2.V.2 Measure standard

≥ 2 pharmacies within 30 minutes or 10 miles for at least 95% of Members

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pharmacy	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

C2.V.2 Measure standard

≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of Members

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pharmacy	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

C2.V.2 Measure standard

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

C2.V.3 Standard type

Minimum number of network providers

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

C2.V.7 Monitoring Methods

Plan reporting

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

20 / 46

C2.V.2 Measure standard

1 nursing facility accepting new patients in every county

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-SNF	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan reporting

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

21 / 46

C2.V.2 Measure standard

≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of Members

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Occupational Therapy	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

22 / 46

Complete

C2.V.2 Measure standard

≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of Members

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Occupational Therapy	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

C2.V.2 Measure standard

≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of Members

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physical Therapy	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

C2.V.2 Measure standard

≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at

least 95% of Members

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physical Therapy	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

25 / 46

C2.V.2 Measure standard

≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of Members

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Speech Language Pathology	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

26 / 46

C2.V.2 Measure standard

≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of Members

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Speech Language Pathology	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

27 / 46

C2.V.2 Measure standard

≥ 1 provider of each crisis service within each PHP Region

C2.V.3 Standard type

Minimum number of network providers

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

C2.V.7 Monitoring Methods

Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

28 / 46

C2.V.2 Measure standard

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

C2.V.3 Standard type

Minimum number of network providers

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

C2.V.7 Monitoring Methods

Plan Reporting

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

29 / 46

C2.V.2 Measure standard

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

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

30 / 46

C2.V.2 Measure standard

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

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

C2.V.2 Measure standard

≥ 1 hospitals within 30 minutes or 30 miles for at least 95% of Members

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Partial Hospitalization - Behavioral Health	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

C2.V.2 Measure standard

≥ 1 hospitals within 60 minutes or 60 miles for at least 95% of Members

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Partial Hospitalization- Behavioral Health	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

C2.V.2 Measure standard

Within 30 Calendar days

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary Care-preventive care services	statewide	6 months of age and older

C2.V.7 Monitoring Methods

plan reporting

C2.V.8 Frequency of oversight methods

Annually

Complete

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

34 / 46

C2.V.2 Measure standard

Within 14 calendar days

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary Care- preventive care services	statewide	Less than 6 months of age

C2.V.7 Monitoring Methods

Plan reporting

C2.V.8 Frequency of oversight methods

Annually

Complete

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

35 / 46

C2.V.2 Measure standard

Within 24 hours

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary Care Service- Urgent Care Services	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

plan reporting

C2.V.8 Frequency of oversight methods

Annually

Complete

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

C2.V.2 Measure standard

Within 30 calendar days

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary Care - Routine/Check up without symptoms	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

plan reporting

C2.V.8 Frequency of oversight methods

Annually

Complete

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

C2.V.2 Measure standard

Immediately (Available 24 hours a day, 365 days a year)

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary Care - After Hours Access (Emergent and Urgent)	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

plan reporting

C2.V.8 Frequency of oversight methods

Annually

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

Complete

accessibility standard

C2.V.2 Measure standard

Within 14 calendar days

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Prenatal Care - Initial Appointment (1st or 2nd Trimester)	statewide	Adult

C2.V.7 Monitoring Methods

plan reporting

C2.V.8 Frequency of oversight methods

Annually

Complete

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

39 / 46

C2.V.2 Measure standard

Within 5 calendar days

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Prenatal Care - Initial Appointment (High risk pregnancy or 3rd Trimester)	statewide	Adult

C2.V.7 Monitoring Methods

plan reporting

C2.V.8 Frequency of oversight methods

Annually

Complete

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

40 / 46

C2.V.2 Measure standard

Within 24 hours

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialty Care - Urgent Care Services	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan reporting

C2.V.8 Frequency of oversight methods

Annually

Complete

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

41 / 46

C2.V.2 Measure standard

Within 30 calendar days

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialty Care - Routine/Check up without symptoms	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan reporting

C2.V.8 Frequency of oversight methods

Annually

Complete

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

42 / 46

C2.V.2 Measure standard

Immediately (Available 24 hours a day, 365 days a year)

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialty Care - After Hours Access (Emergent and Urgent)	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

plan reporting

C2.V.8 Frequency of oversight methods

Annually

Complete

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

43 / 46

C2.V.2 Measure standard

Within 2 hours

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral Health - Mobile Crisis Management Services	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

plan reporting

C2.V.8 Frequency of oversight methods

Annually

Complete

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

44 / 46

C2.V.2 Measure standard

Within 24 hours

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral Health - Urgent Care Services	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

plan reporting

C2.V.8 Frequency of oversight methods

Annually

Complete

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

45 / 46

C2.V.2 Measure standard

Within 14 days

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral Health - Routine Services	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

plan reporting

C2.V.8 Frequency of oversight methods

Annually

Complete

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

46 / 46

C2.V.2 Measure standard

Immediately (Available 24 hours a day, 365 days a year)

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral Health - Emergency Services	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

plan reporting

C2.V.8 Frequency of oversight methods

Annually

Topic IX: Beneficiary Support System (BSS)

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

Topic X: Program Integrity

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

Topic XII. Mental Health and Substance Use Disorder Parity

Beginning December 2024, this section must be completed for programs that include MCOs

Number	Indicator	Response
C1XII.4	**Does this program include MCOs?** If "Yes", please complete the following questions.	Yes
C1XII.5	**Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system?** (i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)	Yes
C1XII.6	**Did the State or MCOs complete the analysis(es)?**	Other, specify – The state completed analysis of the Clinical Coverage Policies for BH/SUD Mental Health Parity for non-compliant limits to meet Parity. The MCOs were instructed to cease using some of the quantitative limits and all quantitative limits from their policies by 12/31/24
C1XII.7a	**Have there been any events in the reporting period that necessitated an update to the parity analysis(es)?** (e.g. changes in benefits, quantitative treatment limits (QTLs), non-quantitative treatment limits (NQTLs), or financial requirements; the addition of a new managed care plan (MCP) providing services to MCO enrollees; and/or deficiencies corrected)	Yes
C1XII.7b	**Describe the event(s) that necessitated an update to the parity analysis(es).** Select all that apply.	Other, specify – To address non-compliant findings from the Department's Clinical Coverage Policy (CCP) parity analysis the Department made updates to utilization management (UM) limits across several MH/SUD policies that are effective 1/1/25. As a result, the Standard Plans have been asked to complete an updated UM parity analysis.
C1XII.8	**When was the last parity analysis(es) for this program completed?**	01/20/2024

	States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state completed its most recent summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date any MCO sent the state its parity analysis (the state may have multiple reports, one for each MCO).	
C1XII.9	**When was the last parity analysis(es) for this program submitted to CMS?** States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).	01/20/2024
C1XII.10a	**In the last analysis(es) conducted, were any deficiencies identified?**	Yes
C1XII.10b	**In the last analysis(es) conducted, describe all deficiencies identified.**	One or more Standard Plans pointed to the Department's Clinical Coverage Policies (CCPs) as the basis for their UM limits. Therefore, CMS requested the Department complete a parity analysis on the Department's CCPs.
C1XII.11a	**As of the end of this reporting period, have these deficiencies been resolved for all plans?**	No
C1XII.11b	**If deficiencies have not been resolved, select all that apply.**	Non-compliance is related to updated parity documentation not yet submitted to CMS.
C1XII.12a	**Has the state posted the current parity analysis(es)**	No

	covering this program on its website? The current parity analysis/ analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO enrollees by an entity other than MCO should have a single state summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than the MCO may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A "Yes" response means that the parity analysis for either the state or for ALL MCOs has been posted.	
C1XII.12c	**When will the state post the current parity analysis(es) on its State Medicaid website in accordance with 42 CFR § 438.920(b)(1)?**	04/01/2025

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**Blue Cross and Blue Shield** 546,320 **Amerihealth Caritas** 358,646 **Carolina Complete Health** 255,388 **WellCare** 441,504 **UnitedHealthcare** 420,822
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**Blue Cross and Blue Shield** 18.3% **Amerihealth Caritas** 12% **Carolina Complete Health** 8.5% **WellCare** 14.8% **UnitedHealthcare** 14.1%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment	**Blue Cross and Blue Shield** 21.1% **Amerihealth Caritas** 13.9%

- Numerator: Plan enrollment (D1.I.1)
- Denominator: Statewide Medicaid managed care enrollment (B.I.2)

Carolina Complete Health

9.9%

WellCare

17.1%

UnitedHealthcare

16.3%

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.	**Blue Cross and Blue Shield** 94.37% **Amerihealth Caritas** 92.8% **Carolina Complete Health** 92.3% **WellCare** 91.6% **UnitedHealthcare** 93.5%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Blue Cross and Blue Shield** Statewide all programs & populations **Amerihealth Caritas** Statewide all programs & populations **Carolina Complete Health** Statewide all programs & populations **WellCare** Statewide all programs & populations **UnitedHealthcare** Statewide all programs & populations
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the	**Blue Cross and Blue Shield** N/A **Amerihealth Caritas** N/A

	populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	**Carolina Complete Health** N/A **WellCare** N/A **UnitedHealthcare** N/A
D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**Blue Cross and Blue Shield** No **Amerihealth Caritas** No **Carolina Complete Health** No **WellCare** No **UnitedHealthcare** No

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Blue Cross and Blue Shield** Medical encounters must be submitted within 30 days of claims payment. Pharmacy encounters must be submitted within 7 days of claims payment. For the purposes of this standard, medical is any 837-P transaction with no lines that contain an NDC OR any 837-I transaction with bill type other than 13x OR any 837-I transaction with bill type of 13x and no lines that contain an NDC. Pharmacy is any NCPDP transaction OR any 837-P transaction where at least one line contains an NDC OR any 837-I transaction with bill type 13x and at least one line that contains an NDC. **Amerihealth Caritas** Medical encounters must be submitted within 30 days of claims payment. Pharmacy encounters must be submitted within 7 days of claims payment. For the purposes of this standard, medical is any 837-P transaction with no lines that contain an NDC OR any 837-I transaction with bill type other than 13x OR any 837-I transaction with bill type of 13x and no lines that contain an NDC. Pharmacy is any NCPDP transaction OR any 837-P transaction where at least one line contains an NDC OR any 837-I transaction with bill type 13x and at least one line that contains an NDC. **Carolina Complete Health** Medical encounters must be submitted within 30 days of claims payment. Pharmacy encounters must be submitted within 7 days of claims payment. For the purposes of this standard, medical is any 837-P transaction with no lines that contain an NDC OR any 837-I transaction with bill type other than 13x OR any 837-I transaction with bill type of 13x and no lines that contain an NDC. Pharmacy is any NCPDP transaction OR any 837-P transaction where at least one line contains an NDC OR any 837-I transaction with bill type 13x and at least one line that contains an NDC. **WellCare**

Medical encounters must be submitted within 30 days of claims payment. Pharmacy encounters must be submitted within 7 days of claims payment. For the purposes of this standard, medical is any 837-P transaction with no lines that contain an NDC OR any 837-I transaction with bill type other than 13x OR any 837-I transaction with bill type of 13x and no lines that contain an NDC. Pharmacy is any NCPDP transaction OR any 837-P transaction where at least one line contains an NDC OR any 837-I transaction with bill type 13x and at least one line that contains an NDC.

UnitedHealthcare

Medical encounters must be submitted within 30 days of claims payment. Pharmacy encounters must be submitted within 7 days of claims payment. For the purposes of this standard, medical is any 837-P transaction with no lines that contain an NDC OR any 837-I transaction with bill type other than 13x OR any 837-I transaction with bill type of 13x and no lines that contain an NDC. Pharmacy is any NCPDP transaction OR any 837-P transaction where at least one line contains an NDC OR any 837-I transaction with bill type 13x and at least one line that contains an NDC.

D1III.2

Share of encounter data submissions that met state's timely submission requirements

What percent of the plan's encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.

Blue Cross and Blue Shield

99.52%

Amerihealth Caritas

100%

Carolina Complete Health

99.7%

WellCare

99.06%

UnitedHealthcare

99.66%

D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.	**Blue Cross and Blue Shield** 100% **Amerihealth Caritas** 100% **Carolina Complete Health** 100% **WellCare** 100% **UnitedHealthcare** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

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

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Blue Cross and Blue Shield** 2,080 **Amerihealth Caritas** 1,795 **Carolina Complete Health** 1,074 **WellCare** 2,927 **UnitedHealthcare** 1,726
D1IV.1a	**Appeals denied** Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee. If you choose not to respond prior to June 2025, enter "N/A".	**Blue Cross and Blue Shield** N/A **Amerihealth Caritas** N/A **Carolina Complete Health** N/A **WellCare** N/A **UnitedHealthcare** N/A
D1IV.1b	**Appeals resolved in partial favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee. If you choose not to respond prior to June 2025, enter "N/A".	**Blue Cross and Blue Shield** N/A **Amerihealth Caritas** N/A

		Carolina Complete Health N/A **WellCare** N/A **UnitedHealthcare** N/A
D1IV.1c	**Appeals resolved in favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee. If you choose not to respond prior to June 2025, enter "N/A".	**Blue Cross and Blue Shield** N/A **Amerihealth Caritas** N/A **Carolina Complete Health** N/A **WellCare** N/A **UnitedHealthcare** N/A
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	**Blue Cross and Blue Shield** 129 **Amerihealth Caritas** 301 **Carolina Complete Health** 40 **WellCare** 0 **UnitedHealthcare** 67

D1IV.3

Appeals filed on behalf of LTSS users

Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter "N/A" if not applicable.
An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).

Blue Cross and Blue Shield

7

Amerihealth Caritas

178

Carolina Complete Health

59

WellCare

94

UnitedHealthcare

21

D1IV.4

Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal

For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A".
Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A".
The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS —

Blue Cross and Blue Shield

0

Amerihealth Caritas

1

Carolina Complete Health

0

WellCare

0

UnitedHealthcare

0

	they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	
D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Blue Cross and Blue Shield** 1,635 **Amerihealth Caritas** 850 **Carolina Complete Health** 540 **WellCare** 975 **UnitedHealthcare** 647
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Blue Cross and Blue Shield** 438 **Amerihealth Caritas** 941 **Carolina Complete Health** 533 **WellCare** 1,940 **UnitedHealthcare** 1,001

D1IV.6a

Resolved appeals related to denial of authorization or limited authorization of a service

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service.
(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).

Blue Cross and Blue Shield

2,016

Amerihealth Caritas

1,574

Carolina Complete Health

950

WellCare

2,921

UnitedHealthcare

1,716

D1IV.6b

Resolved appeals related to reduction, suspension, or termination of a previously authorized service

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.

Blue Cross and Blue Shield

41

Amerihealth Caritas

0

Carolina Complete Health

115

WellCare

6

UnitedHealthcare

0

D1IV.6c

Resolved appeals related to payment denial

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.

Blue Cross and Blue Shield

4

Amerihealth Caritas

175

Carolina Complete Health

9

WellCare

0

UnitedHealthcare

0

D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**Blue Cross and Blue Shield** 1 **Amerihealth Caritas** 0 **Carolina Complete Health** 0 **WellCare** 0 **UnitedHealthcare** 0
D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**Blue Cross and Blue Shield** 3 **Amerihealth Caritas** 0 **Carolina Complete Health** 0 **WellCare** 0 **UnitedHealthcare** 0
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's**	**Blue Cross and Blue Shield** 15

	right to request out-of-network care Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	**Amerihealth Caritas** 0 **Carolina Complete Health** 0 **WellCare** 0 **UnitedHealthcare** 0
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**Blue Cross and Blue Shield** 0 **Amerihealth Caritas** 46 **Carolina Complete Health** 0 **WellCare** 0 **UnitedHealthcare** 10

Appeals by Service

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

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**Blue Cross and Blue Shield** 131 **Amerihealth Caritas** 25 **Carolina Complete Health** 22 **WellCare** 59 **UnitedHealthcare** 55
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Blue Cross and Blue Shield** 1,016 **Amerihealth Caritas** 404 **Carolina Complete Health** 337 **WellCare** 1,076 **UnitedHealthcare** 457
D1IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or	**Blue Cross and Blue Shield** 20 **Amerihealth Caritas** 8

	managed care plan does not cover inpatient behavioral health services, enter "N/A".	**Carolina Complete Health** 9 **WellCare** 16 **UnitedHealthcare** 0
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	**Blue Cross and Blue Shield** 84 **Amerihealth Caritas** 57 **Carolina Complete Health** 20 **WellCare** 35 **UnitedHealthcare** 9
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	**Blue Cross and Blue Shield** 817 **Amerihealth Caritas** 1,217 **Carolina Complete Health** 667 **WellCare** 1,619 **UnitedHealthcare** 1,139

D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	**Blue Cross and Blue Shield** 4 **Amerihealth Caritas** 0 **Carolina Complete Health** 1 **WellCare** 4 **UnitedHealthcare** 0
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	**Blue Cross and Blue Shield** 7 **Amerihealth Caritas** 35 **Carolina Complete Health** 9 **WellCare** N/A **UnitedHealthcare** 20
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	**Blue Cross and Blue Shield** N/A **Amerihealth Caritas** N/A **Carolina Complete Health** N/A

N/A

WellCare

N/A

UnitedHealthcare

N/A

D1IV.7i

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

Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".

Blue Cross and Blue Shield

1

Amerihealth Caritas

0

Carolina Complete Health

0

WellCare

10

UnitedHealthcare

0

D1IV.7j

Resolved appeals related to other service types

Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i paid primarily by Medicaid, enter "N/A".

Blue Cross and Blue Shield

0

Amerihealth Caritas

49

Carolina Complete Health

9

WellCare

108

UnitedHealthcare

46

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.	**Blue Cross and Blue Shield** 86 **Amerihealth Caritas** 17 **Carolina Complete Health** 14 **WellCare** 21 **UnitedHealthcare** 31
D1IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Blue Cross and Blue Shield** 71 **Amerihealth Caritas** 15 **Carolina Complete Health** 10 **WellCare** 17 **UnitedHealthcare** 25
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Blue Cross and Blue Shield** 1 **Amerihealth Caritas** 0

Carolina Complete Health

0

WellCare

0

UnitedHealthcare

0

D1IV.8d

State Fair Hearings retracted prior to reaching a decision

Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.

Blue Cross and Blue Shield

12

Amerihealth Caritas

2

Carolina Complete Health

2

WellCare

4

UnitedHealthcare

4

D1IV.9a

External Medical Reviews resulting in a favorable decision for the enrollee

If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).

Blue Cross and Blue Shield

0

Amerihealth Caritas

0

Carolina Complete Health

0

WellCare

0

UnitedHealthcare

0

D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Blue Cross and Blue Shield** 0 **Amerihealth Caritas** 0 **Carolina Complete Health** 0 **WellCare** 0 **UnitedHealthcare** 0

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Blue Cross and Blue Shield** 1,324 **Amerihealth Caritas** 820 **Carolina Complete Health** 491 **WellCare** 2,626 **UnitedHealthcare** 1,042
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**Blue Cross and Blue Shield** 39 **Amerihealth Caritas** 3 **Carolina Complete Health** 15 **WellCare** 0 **UnitedHealthcare** 62
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who	**Blue Cross and Blue Shield** 0 **Amerihealth Caritas** 0

	received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**Carolina Complete Health** 84 **WellCare** 8 **UnitedHealthcare** 4
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state	**Blue Cross and Blue Shield** 0 **Amerihealth Caritas** 1 **Carolina Complete Health** 7 **WellCare** 0 **UnitedHealthcare** 0

	can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Blue Cross and Blue Shield** 1,320 **Amerihealth Caritas** 817 **Carolina Complete Health** 491 **WellCare** 2,611 **UnitedHealthcare** 1,037

Grievances by Service

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

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**Blue Cross and Blue Shield** 50 **Amerihealth Caritas** 0 **Carolina Complete Health** 9 **WellCare** 1 **UnitedHealthcare** 43
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Blue Cross and Blue Shield** 481 **Amerihealth Caritas** 679 **Carolina Complete Health** 118 **WellCare** 588 **UnitedHealthcare** 518
D1IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or	**Blue Cross and Blue Shield** 1 **Amerihealth Caritas** 0

managed care plan does not cover this type of service, enter "N/A".

Carolina Complete Health

1

WellCare

0

UnitedHealthcare

0

D1IV.15d

Resolved grievances related to outpatient behavioral health services

Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".

Blue Cross and Blue Shield

18

Amerihealth Caritas

0

Carolina Complete Health

3

WellCare

0

UnitedHealthcare

10

D1IV.15e

Resolved grievances related to coverage of outpatient prescription drugs

Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".

Blue Cross and Blue Shield

172

Amerihealth Caritas

0

Carolina Complete Health

9

WellCare

3

UnitedHealthcare

26

D1IV.15f

Resolved grievances related to skilled nursing facility (SNF) services

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

Blue Cross and Blue Shield

2

Amerihealth Caritas

0

Carolina Complete Health

0

WellCare

0

UnitedHealthcare

4

D1IV.15g

Resolved grievances related to long-term services and supports (LTSS)

Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".

Blue Cross and Blue Shield

0

Amerihealth Caritas

0

Carolina Complete Health

3

WellCare

0

UnitedHealthcare

4

D1IV.15h

Resolved grievances related to dental services

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

Blue Cross and Blue Shield

N/A

Amerihealth Caritas

N/A

Carolina Complete Health

N/A

WellCare

N/A

UnitedHealthcare

N/A

D1IV.15i

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

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

Blue Cross and Blue Shield

491

Amerihealth Caritas

141

Carolina Complete Health

303

WellCare

1,527

UnitedHealthcare

429

D1IV.15j

Resolved grievances related to other service types

Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i paid primarily by Medicaid, enter "N/A".

Blue Cross and Blue Shield

109

Amerihealth Caritas

N/A

Carolina Complete Health

45

WellCare

527

UnitedHealthcare

0

Grievances by Reason

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

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Blue Cross and Blue Shield** 113 **Amerihealth Caritas** 130 **Carolina Complete Health** 97 **WellCare** 1,309 **UnitedHealthcare** 107
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/ case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**Blue Cross and Blue Shield** 74 **Amerihealth Caritas** 11 **Carolina Complete Health** 4 **WellCare** 29 **UnitedHealthcare** 0
D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances	**Blue Cross and Blue Shield** 661 **Amerihealth Caritas** 225

include complaints about

difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.

Carolina Complete Health

223

WellCare

1,053

UnitedHealthcare

286

D1IV.16d

Resolved grievances related to quality of care

Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.

Blue Cross and Blue Shield

117

Amerihealth Caritas

41

Carolina Complete Health

21

WellCare

87

UnitedHealthcare

263

D1IV.16e

Resolved grievances related to plan communications

Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications.
Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.

Blue Cross and Blue Shield

37

Amerihealth Caritas

303

Carolina Complete Health

43

WellCare

16

UnitedHealthcare

135

D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	**Blue Cross and Blue Shield** 269 **Amerihealth Caritas** 203 **Carolina Complete Health** 93 **WellCare** 173 **UnitedHealthcare** 227
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**Blue Cross and Blue Shield** 6 **Amerihealth Caritas** 0 **Carolina Complete Health** 1 **WellCare** 22 **UnitedHealthcare** 3
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation	**Blue Cross and Blue Shield** 0 **Amerihealth Caritas** 0 **Carolina Complete Health**

	grievances include cases involving potential or actual patient harm.	0 **WellCare** 0 **UnitedHealthcare** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**Blue Cross and Blue Shield** 30 **Amerihealth Caritas** 0 **Carolina Complete Health** 4 **WellCare** 9 **UnitedHealthcare** 0
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to	**Blue Cross and Blue Shield** 1 **Amerihealth Caritas** 0 **Carolina Complete Health** 0 **WellCare** 0 **UnitedHealthcare** 0

file a grievance.

D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	**Blue Cross and Blue Shield** 16 **Amerihealth Caritas** 0 **Carolina Complete Health** 5 **WellCare** 19 **UnitedHealthcare** 21

Topic VII: Quality & Performance Measures

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

Quality & performance measure total count: 18

Complete

D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits (WCV)

1 / 18

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

1516

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

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

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross and Blue Shield

55.43

Amerihealth Caritas

53.61

Carolina Complete Health

54.03

WellCare

53.76

UnitedHealthcare

52.15

Complete

D2.VII.1 Measure Name: Childhood Immunization Status (CIS) - Combination 10

2 / 18

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0038

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

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

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross and Blue Shield

25.30

Amerihealth Caritas

23.45

Carolina Complete Health

25.04

WellCare

26.44

UnitedHealthcare

24.67

Complete

D2.VII.1 Measure Name: Immunizations for Adolescents (IMA) - Combination 2

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1407

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

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

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

n/a

Measure results

Blue Cross and Blue Shield

30.13

Amerihealth Caritas

28.13

Carolina Complete Health

32.28

WellCare

31.55

UnitedHealthcare

28.01

Complete

D2.VII.1 Measure Name: Chlamydia Screening in Women (CHL)

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0033

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

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

D2.VII.6 Measure Set
Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description
n/a

Measure results

Blue Cross and Blue Shield
60.21

Amerihealth Caritas
61.46

Carolina Complete Health
64.39

WellCare
62.73

UnitedHealthcare
60.50

Complete

D2.VII.1 Measure Name: Cervical Cancer Screening (CCS)

D2.VII.2 Measure Domain
Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number
0032

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Cross-program rate: NC Medicaid Standard Plan Measure Set, NC Medicaid Tailored Plan Measure Set, NC Medicaid CCNC Measure Set

D2.VII.6 Measure Set
Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description
N/A

N/A

Measure results

Blue Cross and Blue Shield

52.50

Amerihealth Caritas

54.14

Carolina Complete Health

54.14

WellCare

55.34

UnitedHealthcare

53.22

Complete

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

6 / 18

D2.VII.2 Measure Domain

Maternal and perinatal health

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

1517

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

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

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

n/a

Measure results

Blue Cross and Blue Shield

Timeliness of Prenatal Care: 53.43% Postpartum Care: 64.80%

Amerihealth Caritas

Timeliness of Prenatal Care: 58.21% Postpartum Care: 67.37%

Carolina Complete Health

Timeliness of Prenatal Care: 55.13% Postpartum Care: 65.58%

WellCare

Timeliness of Prenatal Care: 50.62% Postpartum Care: 67.99%

UnitedHealthcare

Timeliness of Prenatal Care: 49.82% Postpartum Care: 66.13%

Complete

D2.VII.1 Measure Name: PQI 01: Diabetes Short-term Complications Admission Rate

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0272

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

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

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

n/a

Measure results

Blue Cross and Blue Shield

115.71 per 100,000 members

Amerihealth Caritas

153.14 per 100,000 members

Carolina Complete Health

135.09 per 100,000 members

WellCare

130.59 per 100,000 members

UnitedHealthcare

140.17 per 100,000 members

Complete

D2.VII.1 Measure Name: PDI 14: Asthma Admission Rate

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

N/A

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

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

D2.VII.6 Measure Set

AHRQ Quality Indicators (AHRQ QI) - Pediatric Quality Indicators (PDI)

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

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

D2.VII.8 Measure Description

Admissions with a principal diagnosis of asthma per 100,000 population, ages 2 through 17 years. Excludes cases with a diagnosis code for cystic fibrosis and anomalies of the respiratory system, obstetric admissions, and transfers from other institutions.

Measure results

Blue Cross and Blue Shield

32.39 per 100,000 members

Amerihealth Caritas

47.47 per 100,000 members

Carolina Complete Health

76.29 per 100,000 members

WellCare

60.99 per 100,000 members

UnitedHealthcare

52.03 per 100,000 members

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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

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

D2.VII.6 Measure Set

Medicaid Child and Adult Core Set

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

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

D2.VII.8 Measure Description

n/a

Measure results

Blue Cross and Blue Shield

7-Day Follow-Up: 34.06% 30-Day Follow-Up: 54.28%

Amerihealth Caritas

7-Day Follow-Up: 28.45% 30-Day Follow-Up: 47.98%

Carolina Complete Health

7-Day Follow-Up: 32.82% 30-Day Follow-Up: 52.50%

WellCare

7-Day Follow-Up: 31.75% 30-Day Follow-Up: 53.35%

UnitedHealthcare

7-Day Follow-Up: 33.37% 30-Day Follow-Up: 54.94%

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

2801

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

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

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

n/a

Measure results

Blue Cross and Blue Shield

46.88

Amerihealth Caritas

41.57

Carolina Complete Health

42.91

WellCare

46.23

UnitedHealthcare

47.00

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

3389

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

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

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

n/a

Measure results

Blue Cross and Blue Shield

13.48

Amerihealth Caritas

10.71

Carolina Complete Health

8.83

WellCare

12.81

UnitedHealthcare

12.64

Complete

D2.VII.1 Measure Name: Antidepressant Medication Management (AMM)

D2.VII.2 Measure Domain

Behavioral health care

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

0105

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

Cross-program rate: NC Medicaid Tailored Plan Measure Set

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

n/a

Measure results

Blue Cross and Blue Shield

Acute: 64.71% Continuation: 42.75%

Amerihealth Caritas

Acute: 61.29% Continuation: 36.67%

Carolina Complete Health

Acute: 61.30% Continuation: 36.48%

WellCare

Acute: 58.99% Continuation: 34.30%

UnitedHealthcare

Acute: 65.39% Continuation: 41.89%

Complete

D2.VII.1 Measure Name: Getting Needed Care

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Cross-program rate: CAHPS survey used for Standard Plans, EBCI Tribal Option, CCNC (NC Medicaid Direct), and Tailored Plan population

D2.VII.6 Measure Set

AHRQ CAHPS Health Plan Survey

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

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

D2.VII.8 Measure Description

Percentage responding “Always” or “Usually”

Measure results

Blue Cross and Blue Shield

83.3

Amerihealth Caritas

81.79

Carolina Complete Health

82.78

WellCare

83.55

UnitedHealthcare

83.03

Complete

D2.VII.1 Measure Name: Getting Care Quickly

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Cross-program rate: CAHPS survey used for Standard Plans, EBCI Tribal Option, CCNC (NC Medicaid Direct), and Tailored Plan population

D2.VII.6 Measure Set

AHRQ CAHPS Health Plan Survey

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

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

D2.VII.8 Measure Description

Percentage responding “Always” or “Usually”

Measure results

Blue Cross and Blue Shield

86.93

Amerihealth Caritas

80.53

Carolina Complete Health

87.71

WellCare

79.99

UnitedHealthcare

83.65

Complete

D2.VII.1 Measure Name: How Well Doctors Communicate

15 / 18

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Cross-program rate: CAHPS survey used for Standard Plans, EBCI Tribal Option, CCNC (NC Medicaid Direct), and Tailored Plan population

D2.VII.6 Measure Set

AHRQ CAHPS Health Plan Survey

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

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

D2.VII.8 Measure Description

Percentage responding “Always” or “Usually”

Measure results

Blue Cross and Blue Shield

93.93

Amerihealth Caritas

94.22

Carolina Complete Health

93.23

WellCare

91.76

UnitedHealthcare

94.69

Complete

D2.VII.1 Measure Name: Health Plan Customer Service

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Cross-program rate: CAHPS survey used for Standard Plans, EBCI Tribal Option, CCNC (NC Medicaid Direct), and Tailored Plan population

D2.VII.6 Measure Set

AHRQ CAHPS Health Plan Survey

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

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

D2.VII.8 Measure Description

Percentage responding “Always” or “Usually”

Measure results

Blue Cross and Blue Shield

85.77

Amerihealth Caritas

84.82

Carolina Complete Health

88.22

WellCare

91.88

UnitedHealthcare

90.43

Complete

D2.VII.1 Measure Name: Enrollees' Rating of Their Health Care

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Cross-program rate: CAHPS survey used for Standard Plans, EBCI Tribal Option, CCNC (NC Medicaid Direct), and Tailored Plan population

D2.VII.6 Measure Set

AHRQ CAHPS Health Plan Survey

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

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

D2.VII.8 Measure Description

Percentage selecting “8”, “9”, or “10”

Measure results

Blue Cross and Blue Shield

79.61

Amerihealth Caritas

76.47

Carolina Complete Health

73.68

WellCare

82.31

UnitedHealthcare

78.13

Complete

D2.VII.1 Measure Name: Oral Evaluation, Dental Service (OEV)

18 / 18

D2.VII.2 Measure Domain

Dental and oral health services

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

2517

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

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

D2.VII.6 Measure Set

Medicaid Child and Adult Core Sets

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

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

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross and Blue Shield

50.98

Amerihealth Caritas

47.15

Carolina Complete Health

49.00

WellCare

48.42

UnitedHealthcare

47.59

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. Include any pending or unresolved actions.

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

Sanction total count: 24

Complete

D3.VIII.1 Intervention type: Other (Corrective action plan and liquidated damages)

1 / 24

D3.VIII.2 Plan performance issue

Other (Privacy and Security)

D3.VIII.3 Plan name

Amerihealth Caritas

D3.VIII.4 Reason for intervention

Contractor's failure to comply with the terms and conditions of the confidentiality, privacy, and security protections of the Contract during the December 2022 performance period.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$500

D3.VIII.7 Date assessed

09/05/2023

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

Yes, remediated 10/19/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Other (Corrective action plan and liquidated damages)

2 / 24

D3.VIII.2 Plan performance issue

Other (Call Center)

D3.VIII.3 Plan name

Amerihealth Caritas

D3.VIII.4 Reason for intervention

Contractor's failure to meet various call center-related service level agreements (SLAs) during the performance period of January 2023 and June 2023.

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

$15,000

1

D3.VIII.7 Date assessed
09/20/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 10/16/2023

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Other (Corrective action plan and liquidated damages)

3 / 24

D3.VIII.2 Plan performance issue
Other (Annual Network Adequacy)

D3.VIII.3 Plan name
Amerihealth Caritas

D3.VIII.4 Reason for intervention

Contractor's failure to meet the network standards specified in CCHS CY2 NA Final Notice Attachment as of the date of the annual submission (without an approved exception or alternative arrangement).

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$245,000

D3.VIII.7 Date assessed
11/28/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 01/08/2024

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

4 / 24

D3.VIII.2 Plan performance issue
Other (Automated Claims Processing)

D3.VIII.3 Plan name
Amerihealth Caritas

D3.VIII.4 Reason for intervention

Contractor's failure to comply with the automated claims processing Contract requirements related to nonemergency medical transportation (NEMT) services, particularly as it relates to the impact on nonemergency ambulance transportation (NEAT) providers.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

01/31/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Other (Corrective action plan and liquidated damages)

5 / 24

D3.VIII.2 Plan performance issue

Privacy and Security

D3.VIII.3 Plan name

Amerihealth Caritas

D3.VIII.4 Reason for intervention

Contractor's failure to comply with the terms and conditions of the confidentiality, privacy, and security protections of the Contract during the January 2023 to September 2023 performance period.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$4,500

D3.VIII.7 Date assessed

02/09/2024

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

Yes, remediated 05/14/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Other (Corrective action plan and liquidated damages)

D3.VIII.2 Plan performance issue

Other (Privacy and Security)

D3.VIII.3 Plan name

Blue Cross and Blue Shield

D3.VIII.4 Reason for intervention

Contractor's failure to comply with the terms and conditions of the confidentiality, privacy, and security protections of the Contract during the performance period of April 2022.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$101,000

D3.VIII.7 Date assessed

09/08/2023

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

Yes, remediated 11/14/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Other (Corrective action plan and liquidated damages)

D3.VIII.2 Plan performance issue

Call Center

D3.VIII.3 Plan name

Blue Cross and Blue Shield

D3.VIII.4 Reason for intervention

Contractor's failure to meet various call center-related service level agreements (SLAs) during the performance period of January 2023 and June 2023.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$50,000

D3.VIII.7 Date assessed

D3.VIII.8 Remediation date non-

D3.VIII.7 Date assessed

09/20/2023

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

Yes, remediated 11/08/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

8 / 24

D3.VIII.2 Plan performance issue

Other (Annual Network Adequacy)

D3.VIII.3 Plan name

Blue Cross and Blue Shield

D3.VIII.4 Reason for intervention

Contractor's failure to meet the network standards specified in CCHS CY2 NA Final Notice Attachment as of the date of the annual submission (without an approved exception or alternative arrangement).

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

11/28/2023

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

Yes, remediated 07/26/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Other (Automated Claims Processing)

9 / 24

D3.VIII.2 Plan performance issue

Other (Automated Claims Processing)

D3.VIII.3 Plan name

Blue Cross and Blue Shield

D3.VIII.4 Reason for intervention

Contractor’s failure to comply with the automated claims processing Contract requirements related to nonemergency medical transportation (NEMT) services, particularly as it relates to the impact on nonemergency

ambulance transportation (NEAT) providers.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
N/A

D3.VIII.7 Date assessed
01/31/2024

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

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Other (Corrective action plan and liquidated damages)

D3.VIII.2 Plan performance issue
Privacy and Security

D3.VIII.3 Plan name
Blue Cross and Blue Shield

D3.VIII.4 Reason for intervention

Contractor's failure to comply with the terms and conditions of the confidentiality, privacy, and security protections of the Contract during certain months of the January 2023 to September 2023 performance period.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$1,500

D3.VIII.7 Date assessed
02/20/2024

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 04/11/2024

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Other (Corrective action plan and liquidated damages)

D3.VIII.2 Plan performance issue

Call Center

D3.VIII.3 Plan name

Carolina Complete Health

D3.VIII.4 Reason for intervention

Contractor’s failure to meet various call center-related service level agreements (SLAs) during the performance period of January 2023 and June 2023.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$15,000

D3.VIII.7 Date assessed

09/20/2023

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

Yes, remediated 12/21/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Other (Corrective action plan and liquidated damages)

12 / 24

D3.VIII.2 Plan performance issue

Other (Annual Network Adequacy)

D3.VIII.3 Plan name

Carolina Complete Health

D3.VIII.4 Reason for intervention

Contractor's failure to meet the network standards specified in CCHS CY2 NA Final Notice Attachment as of the date of the annual submission (without an approved exception or alternative arrangement).

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

11/28/2023

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

Yes, remediated 01/08/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

13 / 24

D3.VIII.2 Plan performance issue

Other (Automated Claims Processing)

D3.VIII.3 Plan name

Carolina Complete Health

D3.VIII.4 Reason for intervention

Contractor's failure to comply with the automated claims processing Contract requirements related to nonemergency medical transportation (NEMT) services, particularly as it relates to the impact on nonemergency ambulance transportation (NEAT) providers.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

01/31/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Other (Corrective action plan and liquidated damages)

14 / 24

D3.VIII.2 Plan performance issue

(Privacy and Security)

D3.VIII.3 Plan name

Carolina Complete Health

D3.VIII.4 Reason for intervention

Contractor's failure to comply with the terms and conditions of the confidentiality, privacy, and security protections of the Contract during the January 2023 to September 2023 performance period.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$500

D3.VIII.7 Date assessed

02/09/2024

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

Yes, remediated 03/22/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

15 / 24

D3.VIII.2 Plan performance issue

Other (Provider Welcome Packets)

D3.VIII.3 Plan name

Carolina Complete Health

D3.VIII.4 Reason for intervention

Contractor's failure to meet the mailing timeframes specified in the Contract for sending provider welcome packets during the July 2023 to September 2023 quarterly performance period.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

03/04/2024

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

Yes, remediated 03/26/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Other (Corrective action plan and liquidated damages)

16 / 24

D3.VIII.2 Plan performance issue

Other (Annual Network Adequacy)

D3.VIII.3 Plan name

UnitedHealthcare

D3.VIII.4 Reason for intervention

Contractor's failure to meet the network standards specified in CCHS CY2 NA Final Notice Attachment as of the date of the annual submission (without an approved exception or alternative arrangement).

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$151,120

D3.VIII.7 Date assessed

11/28/2023

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

Yes, remediated 09/25/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

D3.VIII.2 Plan performance issue

Other (Automated Claims Processing)

D3.VIII.3 Plan name

UnitedHealthcare

D3.VIII.4 Reason for intervention

Contractor’s failure to comply with the automated claims processing Contract requirements related to nonemergency medical transportation (NEMT) services, particularly as it relates to the impact on nonemergency ambulance transportation (NEAT) providers.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

01/31/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Other (Corrective action plan and liquidated damages)

D3.VIII.2 Plan performance issue

(Privacy and Security)

D3.VIII.3 Plan name

UnitedHealthcare

D3.VIII.4 Reason for intervention

Contractor's failure to meet the mailing timeframes specified in the Contract for sending provider welcome packets during the July 2023 to September 2023 quarterly performance period.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$49,000

D3.VIII.7 Date assessed

02/09/2024

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

Yes, remediated 03/22/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Other (Corrective action plan and liquidated damages)

D3.VIII.2 Plan performance issue

Other (Provider Welcome Packets)

D3.VIII.3 Plan name

UnitedHealthcare

D3.VIII.4 Reason for intervention

Contractor's failure to meet the mailing timeframes specified in the Contract for sending provider welcome packets for during the July 2023 to September 2023 quarterly performance

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$7,500

D3.VIII.7 Date assessed

03/04/2024

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

Yes, remediated 06/12/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Other (Corrective action plan and liquidated damages)

20 / 24

D3.VIII.2 Plan performance issue

Other (Call Center)

D3.VIII.3 Plan name

UnitedHealthcare

D3.VIII.4 Reason for intervention

Contractor's failure to meet various call center-related service level agreements (SLAs) during the performance period of July 2023 to September 2023.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$10,000

D3.VIII.7 Date assessed

05/08/2024

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

Yes, remediated 07/11/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Other (Corrective action plan and liquidated damages)

21 / 24

D3.VIII.2 Plan performance issue

D3.VIII.3 Plan name

WellCare

Other (Call Center)

D3.VIII.4 Reason for intervention

Contractor's failure to meet various call center-related service level agreements (SLAs) during the performance period of January 2023 and June 2023.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$15,000

D3.VIII.7 Date assessed
09/20/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 10/23/2023

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Other (Corrective action plan and liquidated damages)

22 / 24

D3.VIII.2 Plan performance issue
Other (Annual Network Adequacy)

D3.VIII.3 Plan name
WellCare

D3.VIII.4 Reason for intervention

Contractor's failure to meet the network standards specified in CCHS CY2 NA Final Notice Attachment as of the date of the annual submission (without an approved exception or alternative arrangement).

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$190,000

D3.VIII.7 Date assessed
11/28/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 03/05/2024

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Other (Corrective action plan and liquidated damages)

D3.VIII.2 Plan performance issue

Other (Privacy and Security)

D3.VIII.3 Plan name

WellCare

D3.VIII.4 Reason for intervention

Contractor's failure to meet the mailing timeframes specified in the Contract for sending provider welcome packets during the July 2023 to September 2023 quarterly performance period.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$500

D3.VIII.7 Date assessed

02/09/2024

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

Yes, remediated 03/22/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Other (Corrective action plan and liquidated damages)

D3.VIII.2 Plan performance issue

Other (Call Center)

D3.VIII.3 Plan name

WellCare

D3.VIII.4 Reason for intervention

Contractor’s failure to meet various call center-related service level agreements (SLAs) during the performance period of July 2023 to September 2023.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$20,000

D3.VIII.7 Date assessed

03/05/2024

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

Yes, remediated 04/16/2024

D3.VIII.9 Corrective action plan

Yes

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Blue Cross and Blue Shield** 5 **Amerihealth Caritas** 4 **Carolina Complete Health** 1 **WellCare** 32 **UnitedHealthcare** 5
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Blue Cross and Blue Shield** 136 **Amerihealth Caritas** 92 **Carolina Complete Health** 79 **WellCare** 239 **UnitedHealthcare** 141
D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting	**Blue Cross and Blue Shield** 0.25:1,000 **Amerihealth Caritas** 0.26:1,000

	per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Carolina Complete Health** 0.31:1,000 **WellCare** 0.54:1,000 **UnitedHealthcare** 0.34:1,000
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**Blue Cross and Blue Shield** 129 **Amerihealth Caritas** 62 **Carolina Complete Health** 63 **WellCare** 126 **UnitedHealthcare** 98
D1X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Blue Cross and Blue Shield** 0.24:1,000 **Amerihealth Caritas** 0.17:1,000 **Carolina Complete Health** 0.25:1,000 **WellCare** 0.29:1,000 **UnitedHealthcare** 0.28:1,000

D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Blue Cross and Blue Shield** Makes referrals to the State Medicaid Agency (SMA) only **Amerihealth Caritas** Makes referrals to the State Medicaid Agency (SMA) only **Carolina Complete Health** Makes referrals to the State Medicaid Agency (SMA) only **WellCare** Makes referrals to the State Medicaid Agency (SMA) only **UnitedHealthcare** Makes referrals to the State Medicaid Agency (SMA) only
D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of referrals made.	**Blue Cross and Blue Shield** 10 **Amerihealth Caritas** 20 **Carolina Complete Health** 4 **WellCare** 4 **UnitedHealthcare** 8
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referrals listed in indicator D1.X.7 made to the	**Blue Cross and Blue Shield** 0.02:1,000 **Amerihealth Caritas**

	state during the reporting year to the number of enrollees? For number of enrollees, use the average number of individuals enrolled in the plan per month during the reporting year (reported in indicator D1.I.1). Express this as a ratio per 1,000 beneficiaries.	0.06:1,000 **Carolina Complete Health** 0.02:1,000 **WellCare** 0.01:1,000 **UnitedHealthcare** 0.02:1,000
D1X.9a:	**Plan overpayment reporting to the state: Start Date** What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**Blue Cross and Blue Shield** 07/01/2023 **Amerihealth Caritas** 07/01/2023 **Carolina Complete Health** 07/01/2023 **WellCare** 07/01/2023 **UnitedHealthcare** 07/01/2023
D1X.9b:	**Plan overpayment reporting to the state: End Date** What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**Blue Cross and Blue Shield** 06/30/2024 **Amerihealth Caritas** 06/30/2024 **Carolina Complete Health** 06/30/2024 **WellCare** 06/30/2024

		UnitedHealthcare 06/30/2024
D1X.9c:	**Plan overpayment reporting to the state: Dollar amount** From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?	**Blue Cross and Blue Shield** $44,695,525.03 **Amerihealth Caritas** $10,213,551.31 **Carolina Complete Health** $5,627,839.93 **WellCare** $31,118,616.27 **UnitedHealthcare** $123,308.76
D1X.9d:	**Plan overpayment reporting to the state: Corresponding premium revenue** What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))	**Blue Cross and Blue Shield** $3,620,636,772 **Amerihealth Caritas** $2,339,220,875 **Carolina Complete Health** $1,277,111,444 **WellCare** $2,282,346,471 **UnitedHealthcare** $2,736,596,529
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Blue Cross and Blue Shield** Weekly **Amerihealth Caritas** Weekly

Carolina Complete Health

Weekly

WellCare

Weekly

UnitedHealthcare

Weekly

Topic XI: ILOS

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

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

Number	Indicator	Response
D4XI.1	**ILOSs offered by plan** Indicate whether this plan offered any ILOS to their enrollees.	**Blue Cross and Blue Shield** No ILOSs were offered by this plan **Amerihealth Caritas** No ILOSs were offered by this plan **Carolina Complete Health** No ILOSs were offered by this plan **WellCare** No ILOSs were offered by this plan **UnitedHealthcare** No ILOSs were offered by this plan

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Maximus (Enrollment Broker)** Enrollment Broker **North Carolina Medicaid Ombudsman** Ombudsman Program
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Maximus (Enrollment Broker)** Enrollment Broker/Choice Counseling **North Carolina Medicaid Ombudsman** Other, specify – Program Information/Rights & Responsibilities/Referrals