Prepaid Health Plan Performance Metrics

Session Law 2023-134, Section 9E.20

Report to

Joint Legislative Oversight Committee on Medicaid

By

North Carolina Department of Health and Human Services

January 26, 2024

Contents

Background:

As required in Section 9E.20 of Session 2023-134 (see Section 1 of the Appendix), the Department of Health and Human Services Division of Health Benefits (DHB or NC Medicaid) shall report to the Joint Legislative Oversight Committee on Medicaid and to the Fiscal Research Division on Prepaid Health Plan (PHP) performance standards, including claims payment metrics, as they apply to each PHP.

The following report outlines key performance metrics of the PHPs through SFY2023, unless otherwise noted. The metrics included (Claims Payment and Timeliness, Medical Loss Ratio, CAHPS, Network Adequacy, Customer Service and Member Engagement) represent a cross section of contract standards and performance metrics that together represent an overall picture of standards that NC Medicaid monitors to ensure the PHPs are complying with federal and state regulation as well as performance standards aligned with NC Medicaid's goals for Medicaid Managed Care.

NOTE: Select terms whose meaning is not apparent in the body of the report are defined in Section 3 of the Appendix; reference links to reports or dashboards are also included in the Appendix.

Prepaid Health Plan Performance Metrics

Claims Payment and Timeliness Metrics

As required in the PHP Contract, the PHP shall pay in accordance with the following requirements:

Prompt Payment Standards

i. The PHP shall promptly pay Clean Claims, regardless of provider contracting status. The PHP shall reimburse medical and pharmacy providers in a timely and accurate manner when a clean medical or pharmacy claim is received.

a) Medical Claims

1. *The PHP shall, within eighteen (18) calendar days of receiving a Medical Claim, notify the provider whether the claim is Clean, or Pend the claim and request from the provider all additional information needed to timely process the claim.*
2. *The PHP shall pay or deny a Clean Medical Claim at lesser of thirty (30) calendar days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.*
3. *A Medical Pended Claim shall be paid or denied within thirty (30) calendar days of receipt of the requested additional information.*

b) Pharmacy Claims

1. *The PHP shall within fourteen (14) calendar days of receiving a Pharmacy Claim pay or deny a Clean Pharmacy Claim or pend the claim and request from the provider all additional information needed to timely process the claim.*
2. *A Pharmacy Pended Claim shall be paid or denied within fourteen (14) calendar days of receipt of the requested additional information.*

c) If the requested additional information on a Medical or Pharmacy Pended Claim is not submitted within ninety (90) calendar days of the notice requesting the required additional information, the PHP may deny the claim in accordance with N.C. Gen. Stat. § 58-3-225(d).

The information below represents the PHP claims payment and timeliness metrics for SFY2023. As Medicaid Managed Care continues to mature in North Carolina, NC Medicaid and the PHPs continue to work to support providers to increase claims compliance and reduce administrative burden. Included in Section 2 of the

Appendix is a description of initiatives the PHPs have undertaken to help support providers with historical claims issues.

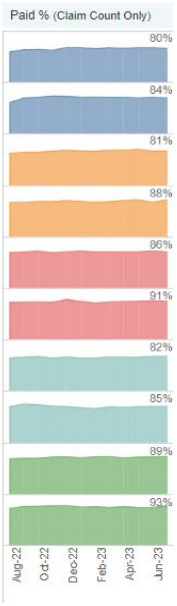
Claims Payment and Timeliness Metrics

The claim status summary metrics within the NC Medicaid PHP Claims Monitoring Dashboard on the DHHS website shows the trends on how claims are paid and denied per claim type. The dashboard compares the current fiscal year paid amounts for the most recent months to historical fiscal year total paid amounts. It includes clean paid or denied claims that are in active status. The figures in the table below display the clean claims summary dashboard for SFY2023. Additional details on claims payment metrics are available on the NC Medicaid PHP Claims Monitoring Dashboard

While a national standard on Medicaid Managed Care claims payment rates does not exist, a 2021 study by the Kaiser Family Foundation noted that across HealthCare.gov insurers, nearly 17% of in-network claims were denied in 2021. Additional details on the study are available at Claims Denials and Appeals in ACA Marketplace Plans in 2021. Denial rates for medical claims in Medicaid are expected to be generally higher than commercial plans and Medicare rates due to state-based policy requirements and benefit design. The Medical Claims Payment Metrics table below, taken from NC Medicaid PHP Claims Monitoring Dashboard, shows the monthly dollars paid for clean (or processed) medical claims in fiscal year 2023, along with charts showing the paid amounts and the percentage of claims paid.

Medical Claims Payment Metrics

PHP	Claim Types		Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023
AmeriHealth	Professional	Paid	21,102,063	29,370,782	30,613,584	21,368,080	27,294,054	25,765,149	30,631,618	28,421,298	32,617,386	29,519,329	34,150,621	27,653,789
		Denied	0	0	0	0	0	0	0	0	0	0	0	0
	Institutional	Paid	33,192,764	58,256,617	52,098,591	32,746,951	29,652,656	45,389,815	66,149,817	57,331,981	48,789,951	46,219,512	60,297,378	50,842,321
		Denied	0	0	0	0	0	0	0	0	0	0	0	0
Carolina Complete	Professional	Paid	15,043,038	20,370,880	16,546,045	18,372,137	22,236,179	24,799,733	19,576,616	15,955,271	28,871,027	19,431,013	25,577,019	21,200,091
		Denied	0	0	0	0	0	0	0	0	0	0	0	0
	Institutional	Paid	22,575,090	42,254,819	38,987,085	25,930,313	28,805,876	37,448,371	29,986,968	26,446,197	44,261,389	32,693,526	37,875,979	41,123,537
		Denied	0	0	0	0	0	0	0	0	0	0	0	0
Healthy Blue	Professional	Paid	34,908,370	37,680,603	41,003,786	44,039,129	46,245,312	65,602,913	47,600,922	43,322,065	50,363,661	53,265,735	59,330,112	52,549,676
		Denied	0	0	0	0	0	0	0	0	0	0	0	0
	Institutional	Paid	41,526,459	53,007,428	55,382,928	68,571,998	144,931,722	84,851,078	76,659,270	70,008,481	82,908,618	71,628,286	82,445,582	103,755,487
		Denied	0	0	0	0	0	0	0	0	0	0	0	0
United	Professional	Paid	26,038,149	30,313,287	30,601,171	32,476,941	35,411,543	34,605,370	27,738,537	33,623,758	41,189,855	34,083,709	37,223,646	34,438,003
		Denied	0	0	0	0	0	0	0	0	0	0	0	0
	Institutional	Paid	59,857,043	53,757,932	72,982,995	61,887,277	62,669,227	65,987,105	48,523,541	55,870,877	62,567,647	61,976,952	62,990,664	60,299,423
		Denied	0	0	0	0	0	0	0	0	0	0	0	0
WellCare	Professional	Paid	26,690,155	27,736,555	29,668,552	37,167,795	36,072,080	36,208,383	36,642,151	34,275,064	44,072,286	43,027,125	38,435,181	41,332,300
		Denied	0	0	0	0	0	0	0	0	0	0	0	0
	Institutional	Paid	41,953,054	35,533,672	54,217,793	97,011,896	44,132,577	51,794,353	64,112,454	59,921,329	86,859,190	71,873,261	76,742,767	68,082,802
		Denied	0	0	0	0	0	0	0	0	0	0	0	0



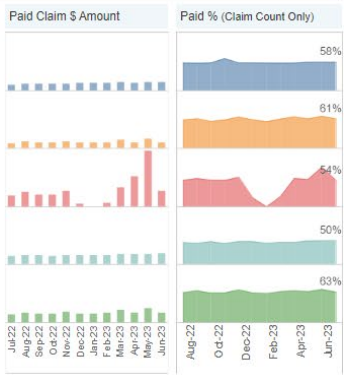
Pharmacy Claims Payment Metrics

Pharmacy claims across Medicaid Direct and Medicaid Managed Care tend to be consistent with the Managed Care paid rate being about 4% higher. Pharmacy claims are adjudicated at point of sale, in real-time, which leads to denials being generally resolved within 1-day. Many claims may have drug utilization edits (such as early refills, therapeutic duplications, drug/drug interactions) that initially deny the claim for patient safety until the pharmacy reviews the denial message and overrides the edit to receive a paid claim. In addition, if inappropriate codes or codes in required fields are not entered, then the claim denies until the pharmacy updates the claim with the proper codes. All these real-time edits can sometimes cause a claim to initially deny multiple times before the correct information is entered on the claim and the claim ultimately pays. Additional details on Medicaid Direct and Medicaid Managed Care payment metrics are included in Section 4 of the Appendix. The

Pharmacy Claims Payment Metrics table below, taken from NC Medicaid PHP Claims Monitoring Dashboard, shows the monthly dollars paid for clean (or processed) pharmacy claims in fiscal year 2023, along with charts showing the paid amounts and the percentage of claims paid.

Pharmacy Claims Payment Metrics

PHP	Claim Types		Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023
AmeriHealth	Pharmacy	Paid	19,067,224	21,844,673	20,152,291	21,338,016	21,432,477	22,283,020	23,650,829	23,854,141	26,873,694	23,717,801	26,508,031	25,260,215
		Denied	0	0	0	0	0	0	0	0	0	0	0	0
Carolina Complete	Pharmacy	Paid	15,254,507	19,975,963	16,913,376	17,101,278	21,433,379	18,876,602	17,073,046	19,262,064	28,297,971	18,776,312	29,910,837	18,783,099
		Denied	0	0	0	0	0	0	0	0	0	0	0	0
Healthy Blue	Pharmacy	Paid	36,092,396	46,606,281	39,762,870	38,099,582	48,959,956	9,261,310	50,626	12,237,251	62,757,871	98,213,996	179,914,542	50,292,045
		Denied	0	0	0	0	0	0	0	0	0	0	0	0
United	Pharmacy	Paid	27,622,580	29,930,962	31,256,052	26,749,414	30,057,957	30,809,027	29,354,173	31,456,487	34,036,488	32,056,879	33,022,885	35,395,483
		Denied	0	0	0	0	0	0	0	0	0	0	0	0
WellCare	Pharmacy	Paid	26,394,931	33,309,503	30,688,791	28,998,881	35,668,460	29,762,358	29,470,600	33,874,531	41,737,746	32,827,942	48,429,399	32,655,972
		Denied	0	0	0	0	0	0	0	0	0	0	0	0

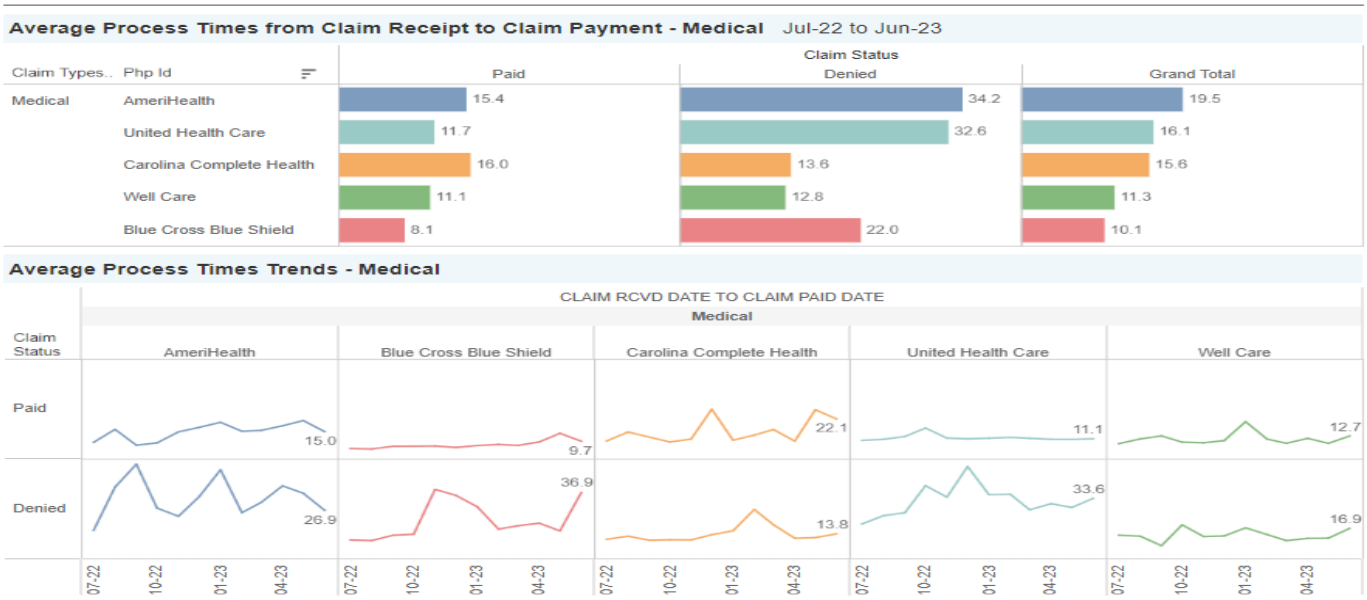


Claim Processing Timeliness Metrics

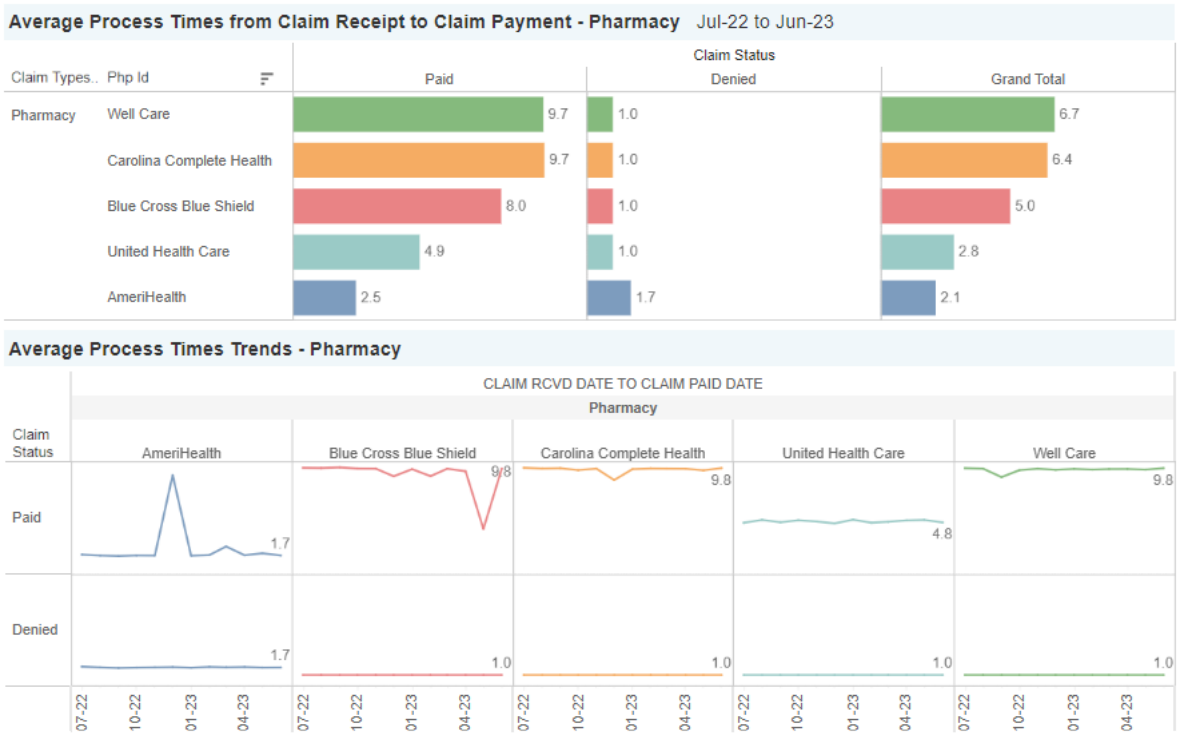
The PHP Claim Processing Timeliness metrics within the NC Medicaid PHP Claims Monitoring dashboard shows the average number of days from when the PHP receives the claim from the provider, to when the PHP pays the claims. The dashboard calculates the average number of days to adjudicate and pay or deny claims from the date the PHP received all information necessary to process a claim which drives prompt payment and interest and penalty requirements.

Medical Claim Processing Timeliness Metrics

The following Medical Claim Processing Timeliness Metric tables are a fiscal year 2023 view of the medical and pharmacy claim data available in the NC Medicaid PHP Claims Monitoring Dashboard – PHP Claims Processing Timeliness view on the DHHS website.



Pharmacy Claim Processing Timeliness Metrics



Medical Claims Metric Considerations

1) Clean Claim Date: The Average Process Times for medical claims could be inflated because the timeliness is calculated based on claim received date rather than the clean claim date. In the future, DHHS plans to revise the metrics to consider the clean claim date which will more accurately depict how long the plans take to adjudicate a claim once all information is available.
2) Medical Claim Duplicate Encounters: PHPs internally re-adjudicate medical claims when fee schedules change retroactively, there is a retroactive member enrollment change or they make a system correction that impacts previously processed claims. The encounters they submit for these medical claims are not linked to the original claim, so the original encounters are not inactivated in EPS (Enrollment Processing System) and are included in data analysis causing possible inflation of denial rates and timeliness trends published on the public site, which do not reflect the true Average Processing Time.

Medical Loss Ratio

As required in NCGA 108D-65, the minimum medical loss ratio for each PHP shall be eighty-eight percent (88%) for health care services. As required by the PHP Contract, they submit their interim Medical Loss Ratio (MLR) report, which can be found below for SFY 2022. Based on NC Medicaid analysis, all PHPs exceed this threshold, meaning they have spent the expected amount on direct care services and healthcare quality initiatives.

SFY2022 MEDICAL LOSS RATIO					
	AmeriHealth	**Healthy Blue**	**Carolina Complete Health**	**United HealthCare**	**WellCare**
Federal					
MLR Numerator	$1,205,020,730	$1,919,113,296	$848,396,670	$1,419,637,160	$1,444,010,219
MLR Denominator	$1,311,705,731	$1,989,473,086	$926,082,675	$1,562,473,269	$1,530,536,329
Calculated MLR	91.87%	96.46%	91.61%	90.86%	94.35%
Department					
MLR Numerator	$1,156,703,106	$1,922,509,120	$840,817,798	$1,405,669,861	$1,427,981,265
MLR Denominator	$1,263,388,107	$1,989,473,086	$926,082,675	$1,548,505,969	$1,530,536,329
Calculated MLR	91.56%	96.63%	90.79%	90.78%	93.30%
Note 1 Department defined Numerator (a) includes voluntary contributions to health-related resources that advance public health and Health and Equity that align with the Department's Quality Strategy and (b) excludes additional directed payments to providers as required in the Contract and allowed under 42 CFR §438.6(c)(1)(iii)(B)					
Note 2 Department defined Denominator similarly excludes payments made from the Department for required additional directed payments along with any associated taxes and fees.					

CAHPS - Member Experience Survey

NC Medicaid contracts with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to administer and report the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Surveys annually. The CAHPS questionnaires are used as a national standard for assessing members' health care experience. The goals of the CAHPS surveys are to provide performance feedback that is actionable and will aid in improving overall care. In 2022, the NC CAHPS survey was administered to adult beneficiaries, the parents/caretakers of child beneficiaries, and the parents/caretakers of child beneficiaries with chronic conditions (CCC). Children with chronic conditions are children whose parents/caretakers report their child needs or uses specific services (e.g., specialty therapy, mental health counseling, prescription medicines) or have limitations in the ability to do what other children of the same age do.

NC Medicaid Program (the combined results of all five PHPs, the EBCI Tribal Option, and Medicaid Direct) and NC PHP Aggregate (the combined results of all five PHPs only) positive rating results for 2022 were compared to the National Commission for Quality Assurance (NCQA) Quality Compass Benchmarks and Compare Quality Data to determine which NCQA national percentile range the scores fall within. Depending on how North Carolina's scores compared to the NCQA national percentiles, a star rating was assigned from one (★) to five stars (★★★★★), where one star is below the national 25th percentile and five stars is greater than or equal to the 90th percentile. Positive ratings represent the percentage of respondents with positive survey

responses (i.e., rate their experience of care higher). The table below summarizes star ratings for each measure for the NC Medicaid and NC PHP Aggregate compared to NCQA national percentiles. These data for 2022 are considered baseline data as this is the first year the CAHPS survey was administered since the launch of managed care – as such, these data offer limited insight on PHP performance at this point in time.

Additional details on these comparisons and methodology as well as results of the 2022 CAHPS Survey are available in the 2022 Adult and Child Medicaid CAHPS Aggregate Report.

NC Medicaid Program and NC PHP Aggregate Star Ratings
When Positive Ratings Results Were Compared to NCQA National Percentiles (2022)

	NC Medicaid Program Compared to NCQA National Percentiles			NC PHP Aggregate Compared to NCQA National Percentiles		
Measures	**Adult**	**General Child**	**CCC**	**Adult**	**General Child**	**CCC**
Global Ratings						
Rating of Health Plan	★★ 76.3%	★ 83.5%	★ 80.3%	★ 73.2%	★★ 84.1%	★★ 82.6%
Rating of All Health Care	★★ 74.3%	★★★ 89.0%	★★★★ 88.2%	★★★ 77.0%	★★★ 88.8%	★★★★ 88.8%
Rating of Personal Doctor	★★★★ 87.2%	★★ 89.4%	★★★ 90.1%	★★★ 84.5%	★★ 89.2%	★★★ 90.7%
Rating of Specialist Seen Most Often	★★★★ 86.4%	★★★★ 88.9%	★★★ 88.1%	★★★ 83.8%	★★★★ 88.9%	★★★ 87.1%
Composite Measures						
Getting Needed Care	★★★ 83.9%	★★ 83.6%	★★ 86.5%	★★ 81.2%	★★ 82.8%	★★ 86.4%
Getting Care Quickly	★★★★ 85.0%	★★ 85.6%	★★ 90.7%	★★★ 82.7%	★★ 85.1%	★★ 88.9%
How Well Doctors Communicate	★★★ 93.5%	★ 92.2%	★★★ 95.4%	★★★ 93.5%	★ 91.7%	★★ 94.2%
Customer Service	★★★ 90.3%	★ 82.5%	NA 86.7%	★★ 87.3%	★ 82.0%	NA 86.2%
Individual Item Measures						
Coordination of Care	★★★★ 88.2%	★★ 83.0%	★ 81.5%	★★★ 85.5%	★★ 82.2%	★ 80.6%
Flu Vaccination Received	★★★★ 50.1%	NA	NA	★★ 36.5%	NA	NA
Effectiveness of Care Measures						
Advising Smokers and Tobacco Users to Quit	★★★★★ 82.1%	NA	NA	★★★★★ 82.5%	NA	NA
Discussing Cessation Medications	★★★★ 56.1%	NA	NA	★★★ 54.9%	NA	NA

Measures	NC Medicaid Program Compared to NCQA National Percentiles			NC PHP Aggregate Compared to NCQA National Percentiles		
	Adult	General Child	CCC	Adult	General Child	CCC
Discussion Cessation Strategies	★★★★ 52.5%	NA	NA	★★★ 46.9%	NA	NA
CCC Composite Measures and Items						
Access to Specialized Services	NA	NA	★ 69.6%	NA	NA	★★★★ 73.1%
Family-Centered Care (FCC): Personal Doctor Who Knows Child	NA	NA	★ 90.8%	NA	NA	★ 90.1%
Coordination of Care for Children with Chronic Conditions	NA	NA	★ 74.7%	NA	NA	★ 74.3%
FCC: Getting Needed Information	NA	NA	★★★ 93.1%	NA	NA	★★★ 92.8%
Access to Prescription Medicines	NA	NA	★★★ 91.5%	NA	NA	★★★★ 93.0%

Star Assignments Based on Positive Ratings Compared to NCQA National Percentiles: ★★★★★ 90th Percentile or Above ★★★★ 75th-89th Percentiles ★★★ 50th-74th Percentiles ★★ 25th-49th Percentiles ★ Below 25th Percentile
NA indicates the measure is not applicable for the population or the NCQA National Percentiles are not available.
Positive rating is equivalent to the top-box score used by other states that contribute to national data.

Network Adequacy

Network adequacy measures the ability of each PHP to deliver benefits by providing adequate access for members to all covered health care services through a network of contracted health care providers. Federal regulations require NC Medicaid to verify PHPs maintain a network of appropriate providers that is "sufficient to provide adequate access" to all services covered under the contract for all members. Network adequacy and accessibility standards help verify members have access to providers and offer an important tool for NC Medicaid to monitor and measure that access.

In the PHP Contract, the network adequacy standards are established as either:

- A maximum travel time or distance from a member's residence to one or more providers of a certain type, or
- A minimum number of providers of a certain type within a geographic boundary (county or region)

Network accessibility standards are different than network adequacy standards and establish the maximum amount of time a member should have to wait to obtain an appointment with a participating provider based on the type and urgency of the service requested. Additional details on the analysis are available in Section 5 of the Appendix.

A statewide health plan has approximately 5,800 different county/provider/service group/member-age geo-mapping results metrics. NC Medicaid summarizes geo-mapping analysis results to facilitate review and consumption of the information.

NC Medicaid focuses on priority provider/service groups and summarizes network adequacy analysis results on a regional and county-by-county basis for those categories of services.

- Primary Care
- Hospitals
- Pharmacy
- OB/GYN
- Outpatient Behavioral Health
- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Specialty Care
    - Allergy/Immunology
    - Cardiology
    - Gastroenterology
    - Oncology
    - Psychiatry

Network Adequacy Standards

Service Type	Urban Standard	Rural Standard
Hospitals	≥ 1 hospitals within 30 minutes OR 15 miles for at least 95% of members	≥ 1 hospitals within 30 minutes OR 30 miles for at least 95% of members
Primary Care (*Adult & Child*)	≥ 2 providers within 30 minutes OR 10 miles for at least 95% of members	≥ 2 providers within 30 minutes OR 30 miles for at least 95% of members
Pharmacies	≥ 2 pharmacies within 30 minutes OR 10 miles for at least 95% of members	≥ 2 pharmacies within 30 minutes OR 30 miles for at least 95% of members
OB/GYN [1]	≥ 2 providers within 30 minutes OR 10 miles for at least 95% of members	≥ 2 providers within 30 minutes OR 30 miles for at least 95% of members
Outpatient Behavioral Health Services	≥ 2 providers of each outpatient behavioral health service within 30 minutes OR 30 miles of residence for at least 95% of members	≥ 2 providers of each outpatient behavioral health service within 45 minutes OR 45 miles of residence for at least 95% of members
Occupational, Physical and Speech Therapy	≥ 2 providers (of each provider type) within 30 minutes OR 10 miles for at least 95% of members	≥ 2 providers (of each provider type) within 30 minutes OR 30 miles for at least 95% of members
Specialty Care	≥ 2 providers (per specialty type) within 30 minutes OR 15 miles for at least 95% of members	≥ 2 providers (per specialty) within 60 minutes OR 60 miles for at least 95% of members

Network Adequacy Results

The following tables provide the results of the Departments Network Adequacy Analysis for January 2023.

AmeriHealth Caritas

Category/Specialty	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
	% members	% members	% members	% members	% members	% members
Hospitals	100%	100%	100%	100%	100%	99%
OB/GYN	100%	100%	100%	100%	100%	100%
Primary Care (Adult)	100%	100%	100%	100%	100%	100%
Primary Care (Child)	100%	100%	100%	100%	100%	100%
Pharmacy	100%	100%	100%	100%	100%	100%
Outpatient Behavioral Health (Adult)	100%	100%	100%	100%	100%	100%
Outpatient Behavioral Health Services (Child)	100%	100%	100%	100%	100%	100%
Occupational Therapy	100%	100%	100%	100%	100%	95%
Physical Therapy	100%	100%	100%	100%	100%	99%
Speech Therapy	100%	100%	100%	100%	100%	99%
Allergy/Immunology (Adult)	100%	100%	99%	100%	100%	96%
Allergy/Immunology (Child)	89%	85%	79%	100%	78%	33%
Cardiology (Adult)	100%	100%	100%	100%	100%	100%
Cardiology (Child)	100%	100%	100%	100%	100%	99%
Gastroenterology (Adult)	100%	100%	100%	100%	100%	99%
Gastroenterology (Child)	100%	97%	99%	99%	100%	99%
Oncology (Adult)	100%	100%	100%	100%	100%	100%
Oncology (Child)	100%	87%	96%	93%	78%	81%
Psychiatry (Adult)	100%	100%	100%	100%	100%	100%
Psychiatry (Child)	100%	100%	100%	100%	100%	100%

Healthy Blue

Category/Specialty	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
	% members	% members	% members	% members	% members	% members
Hospitals	100%	100%	100%	100%	100%	99%
OB/GYN	100%	100%	100%	100%	100%	100%
Primary Care (Adult)	100%	100%	100%	100%	100%	100%
Primary Care (Child)	100%	100%	100%	100%	100%	99%
Pharmacy	100%	100%	100%	100%	100%	100%
Outpatient Behavioral Health (Adult)	100%	100%	100%	100%	100%	100%
Outpatient Behavioral Health Services (Child)	100%	100%	100%	100%	100%	100%
Occupational Therapy	100%	100%	100%	100%	100%	96%
Physical Therapy	100%	100%	100%	100%	100%	99%
Speech Therapy	100%	100%	100%	100%	100%	99%
Allergy/Immunology (Adult)	100%	100%	100%	100%	100%	100%
Allergy/Immunology (Child)	89%	97%	99%	100%	100%	49%
Cardiology (Adult)	100%	100%	100%	100%	100%	100%
Cardiology (Child)	100%	100%	100%	100%	100%	99%
Gastroenterology (Adult)	100%	100%	100%	100%	100%	99%
Gastroenterology (Child)	99%	99%	94%	99%	100%	93%
Oncology (Adult)	100%	100%	100%	100%	100%	100%
Oncology (Child)	100%	97%	99%	99%	100%	85%
Psychiatry (Adult)	100%	100%	100%	100%	100%	100%
Psychiatry (Child)	100%	100%	100%	100%	100%	100%

Category/Specialty	Region 3	Region 4	Region 5
	% members	% members	% members
Hospitals	100%	100%	100%
OB/GYN	100%	100%	100%
Primary Care (Adult)	100%	100%	100%
Primary Care (Child)	100%	100%	100%
Pharmacy	100%	100%	100%
Outpatient Behavioral Health (Adult)	100%	100%	100%
Outpatient Behavioral Health Services (Child)	100%	100%	100%
Occupational Therapy	100%	100%	100%
Physical Therapy	100%	100%	100%
Speech Therapy	100%	100%	100%
Allergy/Immunology (Adult)	100%	100%	100%
Allergy/Immunology (Child)	100%	100%	100%
Cardiology (Adult)	100%	100%	100%
Cardiology (Child)	100%	100%	100%
Gastroenterology (Adult)	100%	100%	100%
Gastroenterology (Child)	100%	97%	100%
Oncology (Adult)	100%	100%	100%
Oncology (Child)	100%	97%	100%
Psychiatry (Adult)	100%	100%	100%
Psychiatry (Child)	100%	100%	100%

Category/Specialty	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
	% members	% members	% members	% members	% members	% members
Hospitals	100%	100%	100%	100%	100%	100%
OB/GYN	100%	100%	100%	100%	100%	100%
Primary Care (Adult)	100%	100%	100%	100%	100%	100%
Primary Care (Child)	100%	100%	100%	100%	100%	100%
Pharmacy	100%	100%	100%	100%	100%	100%
Outpatient Behavioral Health (Adult)	100%	100%	100%	100%	100%	100%
Outpatient Behavioral Health Services (Child)	100%	100%	100%	100%	100%	100%
Occupational Therapy	100%	100%	100%	100%	100%	100%
Physical Therapy	100%	100%	100%	100%	98%	100%
Speech Therapy	99%	100%	100%	100%	100%	100%
Allergy/Immunology (Adult)	100%	100%	100%	100%	100%	100%
Allergy/Immunology (Child)	82%	92%	76%	99%	40%	22%
Cardiology (Adult)	100%	100%	100%	100%	100%	100%
Cardiology (Child)	100%	100%	100%	99%	100%	100%
Gastroenterology (Adult)	100%	100%	100%	100%	100%	100%
Gastroenterology (Child)	95%	98%	98%	97%	65%	95%
Oncology (Adult)	100%	100%	100%	100%	100%	100%
Oncology (Child)	100%	70%	98%	93%	100%	94%
Psychiatry (Adult)	100%	100%	100%	100%	100%	100%
Psychiatry (Child)	100%	100%	100%	100%	100%	100%

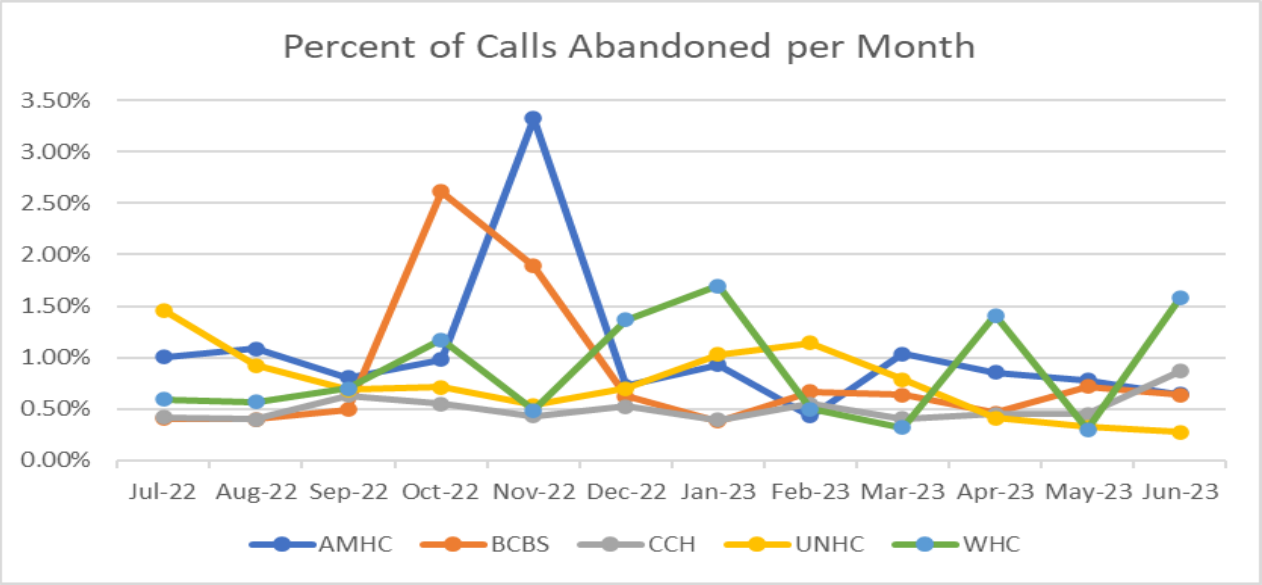
Category/Specialty	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
	% members	% members	% members	% members	% members	% members
Hospitals	100%	100%	100%	100%	100%	99%
OB/GYN	100%	100%	100%	100%	100%	100%
Primary Care (Adult)	100%	100%	100%	100%	100%	100%
Primary Care (Child)	100%	100%	100%	100%	100%	100%
Pharmacy	100%	100%	100%	100%	100%	100%
Outpatient Behavioral Health (Adult)	100%	100%	100%	100%	100%	100%
Outpatient Behavioral Health Services (Child)	100%	100%	100%	100%	100%	100%
Occupational Therapy	100%	100%	100%	100%	100%	99%
Physical Therapy	100%	100%	100%	100%	98%	99%
Speech Therapy	99%	100%	100%	100%	100%	99%
Allergy/Immunology (Adult)	100%	100%	100%	100%	100%	100%
Allergy/Immunology (Child)	24%	84%	91%	99%	73%	48%
Cardiology (Adult)	100%	100%	100%	100%	100%	100%
Cardiology (Child)	99%	98%	100%	100%	100%	99%
Gastroenterology (Adult)	100%	100%	100%	100%	100%	100%
Gastroenterology (Child)	38%	100%	100%	99%	100%	94%
Oncology (Adult)	100%	100%	100%	100%	100%	100%
Oncology (Child)	100%	92%	95%	92%	100%	87%
Psychiatry (Adult)	100%	100%	100%	100%	100%	100%
Psychiatry (Child)	100%	100%	100%	100%	100%	100%

Customer Services and Member Engagement

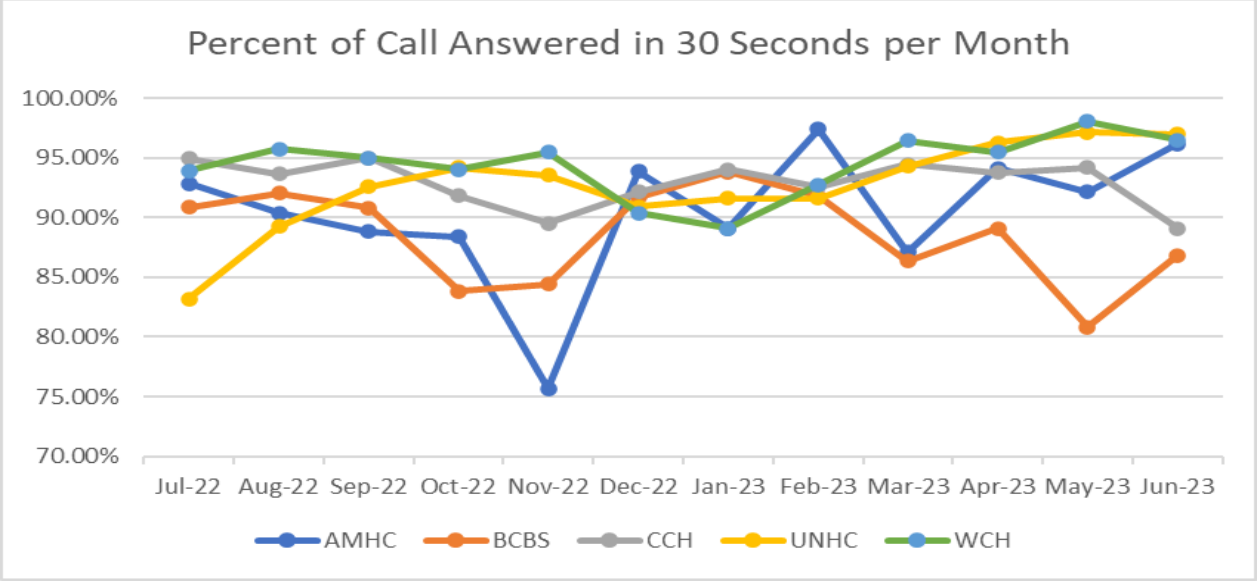
Call Center Performance

NC Medicaid also evaluates PHP customer service based on call center performance, including abandonment rates and average speed to answer. The charts below provide an overview of the key metrics NC Medicaid evaluates to determine if the PHP call centers are meeting critical service level agreement (SLA) thresholds established in the PHP contract for SFY2023.

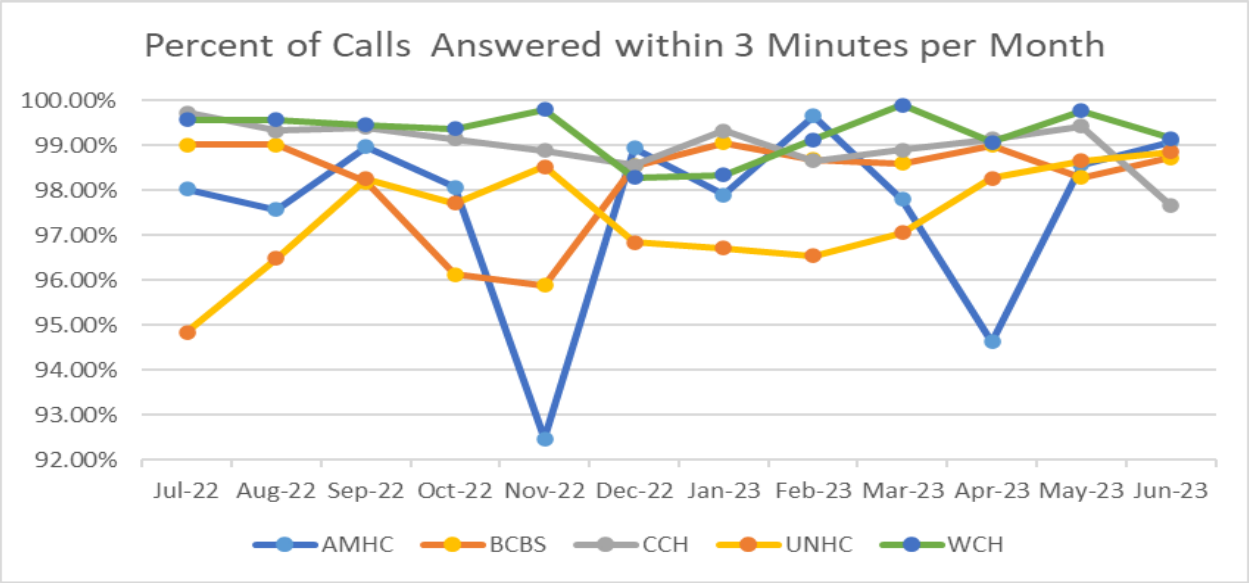
Percent of Calls Abandoned: The percent of calls that are terminated by the system or caller before being answered by a live voice



Percent of Calls Answered Within 30 Seconds: The percent of calls abandoned or answered by a live voice within 30 seconds



Percent of Calls Answered Within 3 Minutes: The percent of calls abandoned or answered by a live voice within 3 minutes



Member Mailings Performance

PHPs are contractually required to send a member Welcome Packet to new beneficiaries within six (6) calendar days following receipt of the member enrollment file from the Department. The six-day member mailing requirement is an SLA included in the PHP contract and ensures new members receive critical information about the new PHP to which the member belongs. In the table below, a "Y" reflects that a PHP has been late sending a member welcome packet during the applicable month in SFY2023.

Late Member Mailings 2023									
Plan	**Jan.***	**Feb.***	**Mar.**	**April**	**May**	**June**	**July**	**Aug.**	**Sept.**
AMHC	N/A	N/A	N	N	N	N	N	N	N
BCBS	N/A	N/A	N	N	N	N	N	N	N
CCH	N/A	N/A	N	N	N	N	N	**Y**	**Y**
UNHC	N/A	N/A	N	N	N	N	N	N	N
WCHP	N/A	N/A	N	N	N	N	N	N	N

*Member mailing SLAs were waived for all PHPs during January and February 2023

Appendix:

1) Session Law 2023-134 Language
    a. SECTION 9E.20. The Department of Health and Human Services, Division of Health Benefits (DHB), shall develop performance standards, including claims payment metrics requiring claims to be paid within a set number of days, applicable to prepaid health plans operating standard benefits plans in accordance with Chapter 108D of the General Statutes. Beginning December 1, 2023, and annually until the expiration of the initial prepaid health plan contract, DHB shall report to the Joint Legislative Oversight Committee on Medicaid and to the Fiscal Research Division on these performance standards as they apply to each individual prepaid health plan.
2) PHP Claims Payment Initiatives
    a. Since the launch of Standard Plans on July 1, 2021, there has been increasingly strong partnerships and engagement between NC DHHS, PHPs, and providers to improve claims processes and operations, optimize overall program performance, and simplify administrative burden for providers. PHPs work closely with providers to address claims processing issues and have seen significant improvements over time. The Department, PHPs and providers have implemented substantial changes to optimize the program, including modernizing standards for claims and payment processes, and promoting additional transparency and accountability to better serve Medicaid beneficiaries.
    b. Engagement with Providers
        i. **Direct Engagement with Providers** – Individually, each PHP has established regular collaborative meetings with provider associations, hospital systems, individual physicians, ancillary providers, and Federally Qualified Health Centers to discuss trends in claims performance, identify claims processing issues and coordinate efforts to resolve problems as they arise.
        ii. **Industrywide Provider/PHP Collaboration** – On behalf of all five PHPs, the North Carolina Association of Health Plans (NHAHP) has established regular working groups and ad hoc meetings between provider organizations and PHPs focused on collaborative solutions to reduce claims denials and rejects and ease administrative burdens on providers.
        iii. These efforts have resulted in improved billing and claims processing practices, and recommendations for modifications to regulatory policies, many of which the Department has implemented, to reduce claim denials.
    c. Provider Outreach and Education
        i. **Training Opportunities** – Each PHP offers regular training opportunities for all providers, some of which include continuing Medical Education Credits. PHP training programs cover a broad range of topics from basic processes, such as how to submit claims, enroll in electronic funds transfers, and obtain prior authorization to more specialized programs on topics such as Early and Periodic Screening Diagnosis and Treatment (EPSDT), Long-Term Care and Supports (LTSS) and Medicaid Expansion.
        ii. **Documentation and Educational Materials** – PHPs are continuously working to identify opportunities to improve documentation and develop provider education materials to clarify billing guidelines, explain systemic changes, and prevent common reasons for denials. For example, the PHPs have standardized the format of their Quick Reference Guides to make it easier for providers to utilize.
    d. Global Tracking of Denial and Reject Reasons

i. **Denial Tracking** - PHPs closely track claim denial and rejections to identify trends and common underlying causes and develop solutions to address them. These ongoing monitoring efforts lead to internal process improvements and enhanced provider outreach efforts.

ii. For example, a key challenge during the initial transition to Managed Care was claims denials related to the taxonomy enrollment and the credentialing file. Both payer and provider issues resulted in claims being denied too frequently. PHPs reconfigured systems to enable better processing of the state file and developed provider education to support submitting correct taxonomy information and updating NCTracks to ensure claims could be processed timely and accurately the first time.

iii. **Data Sharing** – PHPs regularly share operational and claims data performance reporting with providers to ensure transparency and improve payment performance.

3) Claims Payment Terms and Definitions:

a. **Clean Claim:** A claim submitted to a PHP by a service provider that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is suspended, under investigation for fraud or abuse, or a claim under review for medical necessity. 42 C.F.R. § 447.45(b). Determination of whether a claim is clean rests with the Contractor and must be determined for each claim, provided applied consistently and reasonably. 85 FR 72754, 72819.

b. **Claim Adjudication:** The process of paying claims submitted or denying them after comparing the claim data elements to the benefit or coverage requirements.

c. **Pharmacy Claim:** Includes outpatient pharmacy (point-of-sale claims) as well as physician-administered (professional claims) drug claims.

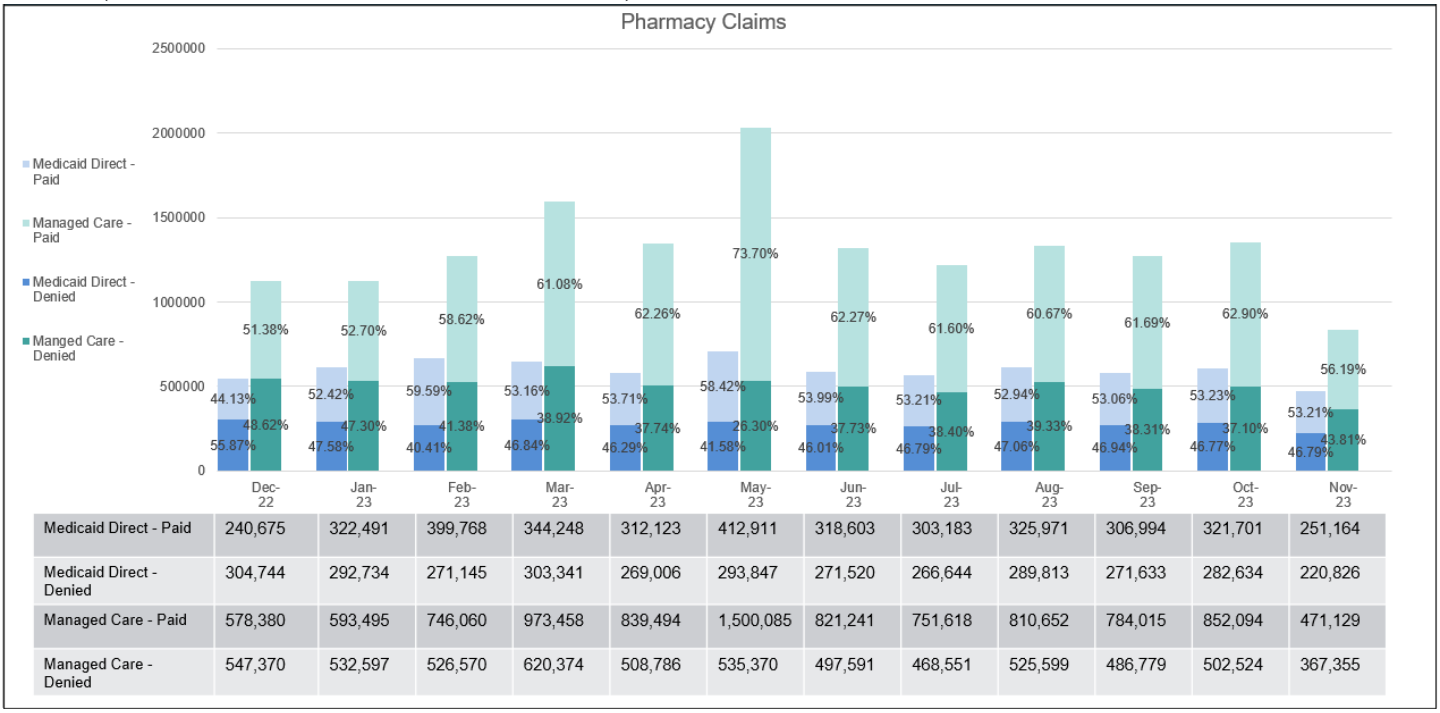
d. **Medical Claim:** Inpatient hospital, outpatient hospital (institutional claims), and physician-administered services.

e. **Denied Claim:** When a PHP or its Subcontractor refuses to reimburse a medical or pharmacy service provider for all or a portion of the services submitted on the claim.

f. **Prompt Payment Standards:** The PHP shall promptly pay Clean Claims, regardless of provider contracting status. The PHP shall reimburse medical and pharmacy providers in a timely and accurate manner when a clean medical or pharmacy claim is received.

g. **Interest:** For the purposes of claim payment or encounter submission, an amount from a PHP that is due to a service provider for holding the provider’s money inappropriately as result of the late reimbursement or underpayment of a clean claim.

4) Pharmacy Claims Payment Comparison of Medicaid Direct and Medicaid Managed Care (December 2022 – November 2023)



	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Medicaid Direct - Paid	240,675	322,491	399,768	344,248	312,123	412,911	318,603	303,183	325,971	306,994	321,701	251,164
Medicaid Direct - Denied	304,744	292,734	271,145	303,341	269,006	293,847	271,520	266,644	289,813	271,633	282,634	220,826
Managed Care - Paid	578,380	593,495	746,060	973,458	839,494	1,500,085	821,241	751,618	810,652	784,015	852,094	471,129
Managed Care - Denied	547,370	532,597	526,570	620,374	508,786	535,370	497,591	468,551	525,599	486,779	502,524	367,355

5) Network adequacy analysis approach

For the time/distance standards, the Department uses "geo-mapping" software to calculate the distance in travel time and travel miles from a member's residence to provider locations. A PHP's network must demonstrate that at least 95% of members in a county live within the adequacy standard (by either the miles OR by the travel time) to be compliant in that county for that standard.

A PHP must request an exception from any network adequacy standard with which they cannot comply. For the standards based on a minimum number of providers within a geographic boundary, PHPs must demonstrate their provider networks have the correct number of providers of the correct type in the specific area to be compliant.

Appointment wait time standards are monitored through secret-shopper analysis, provider surveys and analysis of member complaints following managed care launch.

6) Key Links

1. NC Medicaid PHP Claims Monitoring Dashboard:
   https://medicaid.ncdhhs.gov/reports/dashboards/php-claims-monitoring-dashboard
2. Claims Denials and Appeals in ACA Marketplace Plans in 2021:
   https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/
3. 2022 Adult and Child Medicaid CAHPS Aggregate Report:
   https://medicaid.ncdhhs.gov/nc-cahps-2022-survey-full-report/download?attachment