STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

JOSH STEIN
GOVERNOR

DEVDUTTA SANGVAI
SECRETARY

April 6, 2026

SENT VIA ELECTRONIC MAIL

Mr. Brian Matteson, Director
Fiscal Research Division
Suite 619, Legislative Office Building
Raleigh, NC 27603-5925

Dear Director Matteson:

Session Law 2023-134, Section 9E.20, requires the Department of Health and Human Services, NC Medicaid, to 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 and to report annually until the expiration of the initial prepaid health plan contract, 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. Pursuant to the provisions of law, the Department is pleased to submit the attached report.

Should you have any questions regarding this report, please contact Karen Wade, Director of Policy, at Karen.Wade@dhhs.nc.gov.

Sincerely,

DocuSigned by:
Melanie Bush on behalf of Devdutta Sangvai
B8DC650BEB454DA...

Devdutta Sangvai
Secretary

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

JOSH STEIN
GOVERNOR

DEVDUTTA SANGVAI
SECRETARY

April 6, 2026

SENT VIA ELECTRONIC MAIL

The Honorable Benton Sawrey, Chair
Joint Legislative Oversight
Committee on Medicaid
North Carolina General Assembly
Room 521, Legislative Office Building
Raleigh, NC 27603

The Honorable Donny Lambeth, Chair
Joint Legislative Oversight
Committee on Medicaid
North Carolina General Assembly
Room 303, Legislative Office Building
Raleigh, NC 27603

The Honorable Larry Potts, Chair
Joint Legislative Oversight
Committee on Medicaid
North Carolina General Assembly
Room 307B1, Legislative Office Building
Raleigh, NC 27603

The Honorable Donna White, Chair
Joint Legislative Oversight
Committee on Medicaid
North Carolina General Assembly
Room 307B, Legislative Office Building
Raleigh, NC 27603

Dear Chairmen:

Session Law 2023-134, Section 9E.20, requires the Department of Health and Human Services, NC Medicaid, to 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 and to report annually until the expiration of the initial prepaid health plan contract, 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. Pursuant to the provisions of law, the Department is pleased to submit the attached report.

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on behalf of Devdutta Sangvai

Devdutta Sangvai
Secretary

Prepaid Health Plan Performance Metrics

Session Law 2023-134, Section 9E.20

Report to

Joint Legislative Oversight Committee on Medicaid
and

Fiscal Research Division

By

North Carolina Department of Health and Human Services

April 6, 2026

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 SFY2025, 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.*
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 SFY2025. 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.

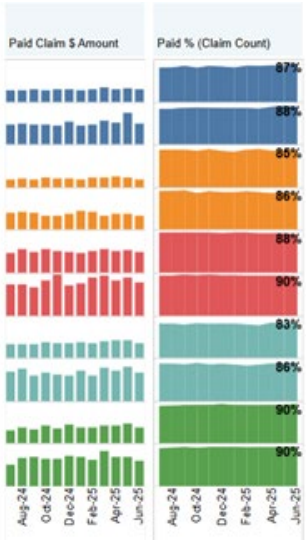
NC Medicaid PHP Claims Monitoring Claims Dashboard Metrics

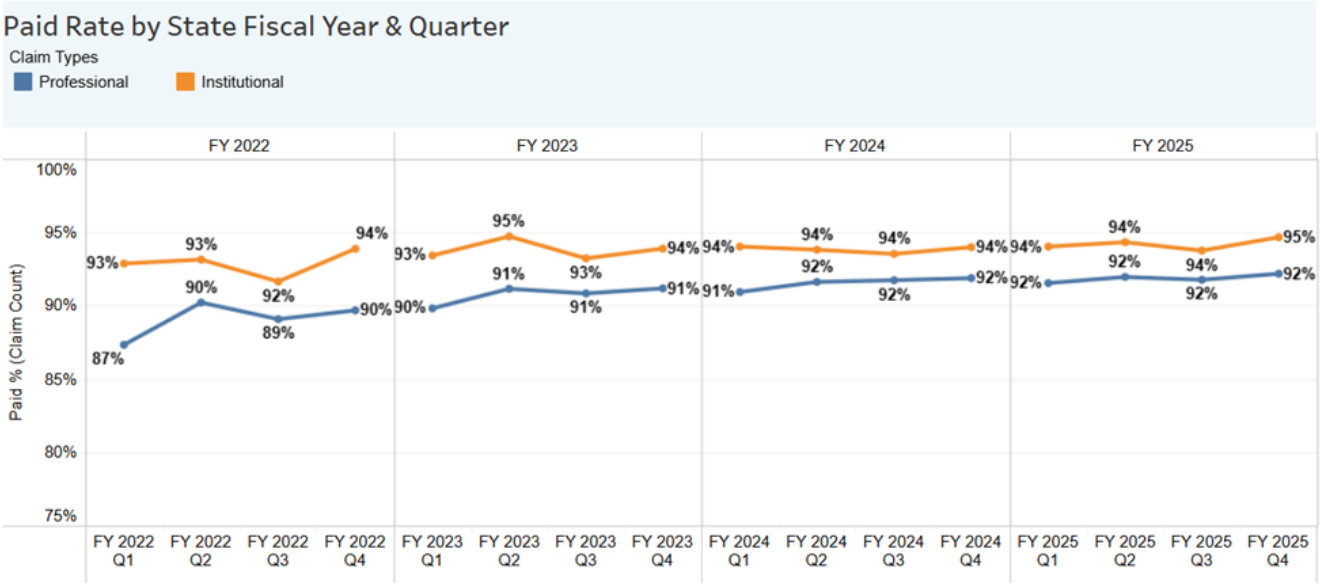
The claim status summary metrics within the NC Medicaid PHP Claims Monitoring Dashboard on the DHHS website shows the trends on how claims are paid and denied per claim type. The dashboard compares the current fiscal year paid amounts for the most recent months to historical fiscal year total paid amounts. 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 SFY2025. 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 2025, along with charts showing the paid amounts and the percentage of claims paid.

Medical Claims Payment Metrics

			FY 2025											
Plan Name	Claim Types		July 2024	August 2024	September 2024	October 2024	November 2024	December 2024	January 2025	February 2025	March 2025	April 2025	May 2025	June 2025
AmeriHealth	Professional	Paid	36,516,661	36,464,272	40,977,693	36,142,952	40,076,253	41,535,013	38,084,866	39,823,354	45,215,720	41,389,116	42,334,202	41,555,352
		Denied												
	Institutional	Paid	63,084,202	65,495,088	62,373,762	62,881,559	60,870,211	74,486,130	60,959,105	63,174,848	76,028,547	70,036,113	102,333,752	66,877,779
		Denied												
Carolina Complete	Professional	Paid	26,101,671	27,986,448	24,111,454	30,598,909	27,649,813	28,311,468	26,042,323	30,222,906	29,484,927	33,732,101	29,497,669	25,810,195
		Denied												
	Institutional	Paid	54,285,247	56,290,634	54,774,094	44,657,441	43,490,441	49,520,515	60,662,221	57,166,755	43,565,157	51,657,811	50,624,915	44,903,707
		Denied												
Healthy Blue	Professional	Paid	60,884,304	73,328,575	63,904,826	73,049,878	67,461,092	64,097,624	61,693,644	67,399,324	75,497,311	69,463,287	71,641,644	66,397,223
		Denied												
	Institutional	Paid	99,867,109	99,649,349	90,726,638	110,208,600	129,951,158	94,792,656	102,480,574	122,492,464	126,487,943	112,842,888	120,140,742	106,185,111
		Denied												
United	Professional	Paid	45,410,681	45,838,828	44,108,957	51,429,706	46,599,760	47,978,739	51,205,136	48,039,881	52,524,246	57,734,936	57,466,990	47,676,619
		Denied												
	Institutional	Paid	93,955,029	101,445,036	81,570,754	89,143,032	82,352,598	79,412,421	95,708,525	81,021,320	105,632,141	96,754,634	108,018,598	89,630,900
		Denied												
WellCare	Professional	Paid	39,711,284	49,760,032	43,940,421	56,580,981	47,521,493	60,629,461	50,777,112	52,098,610	56,497,139	57,408,120	62,276,016	51,667,604
		Denied												
	Institutional	Paid	69,094,111	89,281,487	91,639,255	86,370,309	87,443,470	95,803,666	94,572,130	82,394,324	112,368,923	93,872,623	94,567,940	80,087,557
		Denied												





** Enhancements to the Payment Outcome data pull, implemented in SFY 2025, and resubmission of encounters may impact the Paid Rate performance trend in SFY 2022 compared to the data that was pulled for last year's report.*

Pharmacy Claims Payment Metrics

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 are entered, 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 the NC Medicaid PHP Claims Monitoring Dashboard, shows the monthly dollars paid for clean (or processed) pharmacy claims in fiscal year 2025, along with charts showing the paid amounts and the percentage of claims paid.

Pharmacy Claims Payment Metrics

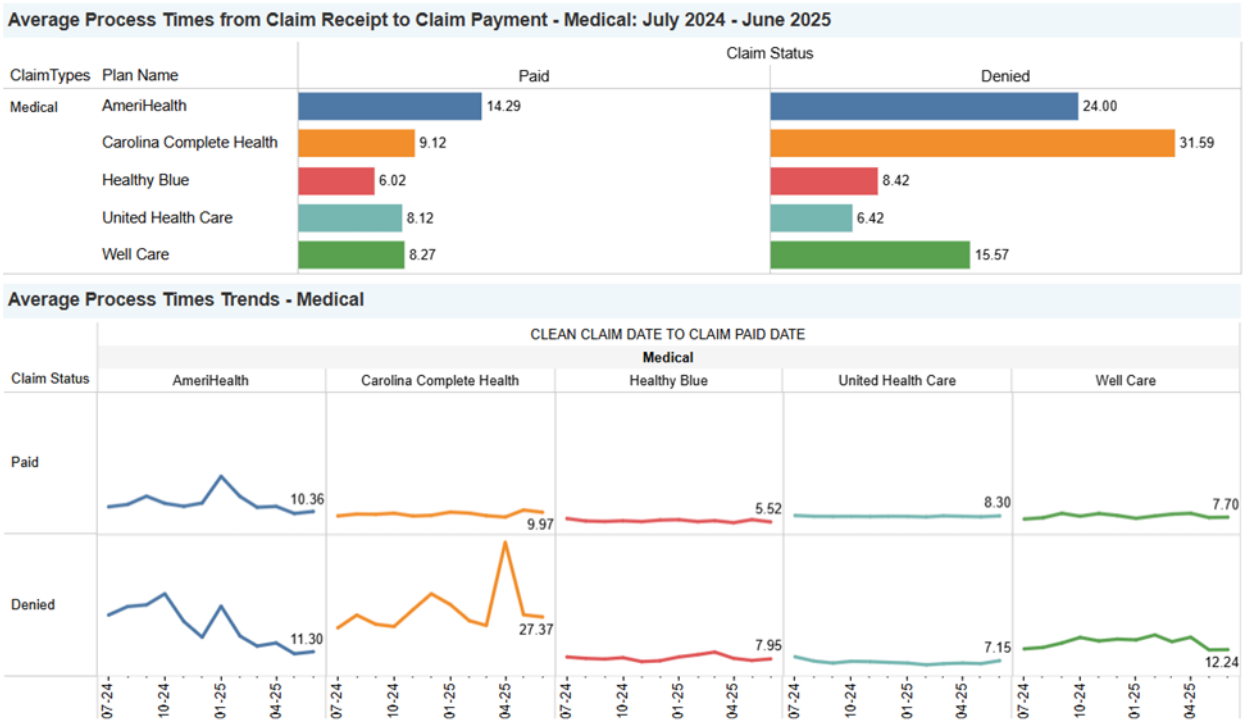
			FY 2025													
Plan Name	Claim Types		July 2024	August 2024	September 2024	October 2024	November 2024	December 2024	January 2025	February 2025	March 2025	April 2025	May 2025	June 2025	Paid Claim $ Amount	Paid % (Claim Count)
AmeriHealth	Pharmacy	Paid	31,461,817	31,744,238	30,014,214	35,569,207	31,420,431	34,721,488	37,099,594	36,194,584	39,829,466	42,704,766	41,399,618	42,073,242		52%
		Denied														
Carolina Complete	Pharmacy	Paid	21,576,421	23,218,391	22,977,794	25,275,427	26,372,968	23,836,308	24,438,066	25,797,624	29,242,112	33,310,735	40,265,844	33,175,290		62%
		Denied														
Healthy Blue	Pharmacy	Paid	71,201,610	61,788,735	62,921,319	80,679,255	68,352,373	71,148,426	78,391,795	77,422,222	80,238,791	98,888,047	82,941,510	83,307,436		55%
		Denied														
United	Pharmacy	Paid	41,672,014	44,666,195	43,102,921	46,575,278	46,879,426	49,099,813	47,311,038	51,567,064	50,549,220	58,484,409	58,163,531	56,676,026		58%
		Denied														
WellCare	Pharmacy	Paid	39,639,461	42,009,627	41,761,966	46,949,844	46,470,189	47,533,773	47,290,351	46,573,317	52,815,285	56,858,925	61,805,590	58,627,880		62%
		Denied														

Claim Processing Timeliness Metrics

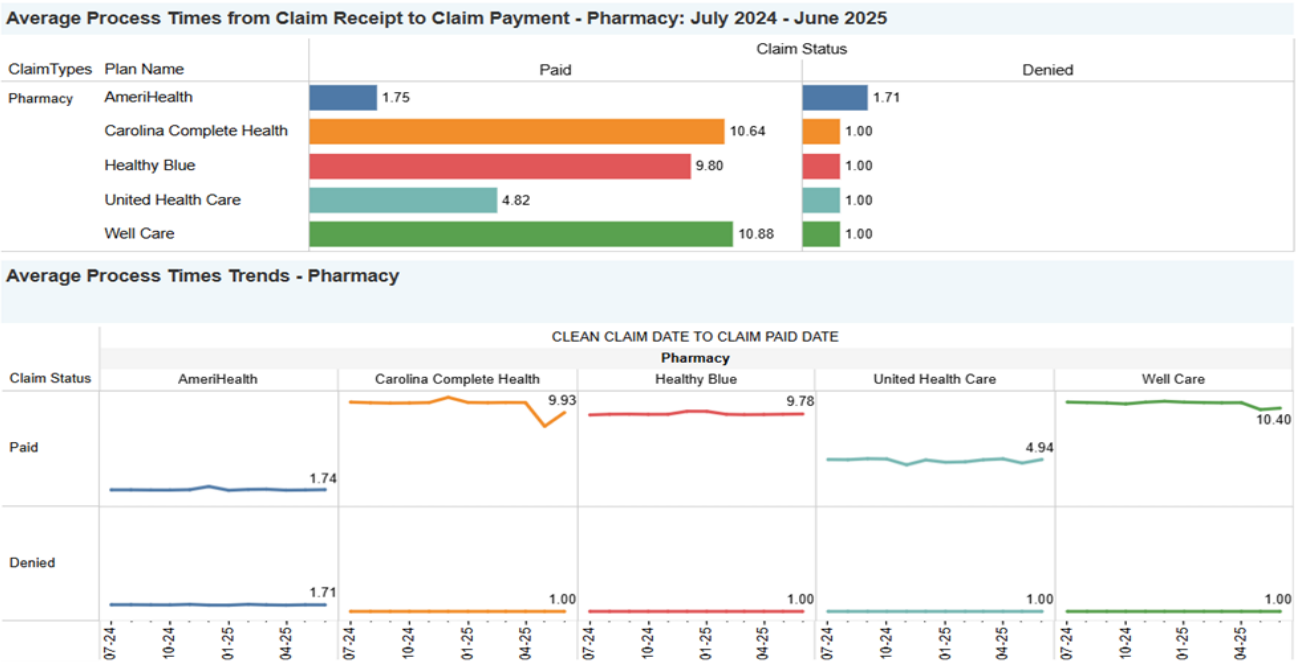
The PHP Claim Processing Timeliness metrics within the NC Medicaid PHP Claims Monitoring dashboard shows the average number of days from when the PHP receives the clean claim from the provider, to when the PHP pays the claims. The dashboard calculates the average number of days to adjudicate and pay 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 2025 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

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 NCGS 108D-65, the minimum medical loss ratio (MLR) for each PHP shall be eighty-eight percent (88%) for health care services. As required by the PHP Contract, PHPs calculate and report aggregate MLR on an annual basis aligned to the rating year. MLR numerators and denominators for SFY 2024 are summarized in the table below. Based on NC Medicaid analysis, for CMS-defined MLR, all PHPs exceed the minimum MLR threshold, meaning they have spent the expected amount on direct care services and healthcare quality initiatives. For Department-defined MLR, all PHPs exceed the minimum MLR threshold for Non-Expansion Medicaid populations. For Department-defined MLR, one PHP exceeds the minimum MLR threshold for Medicaid Expansion populations. For four PHPs, the Department-defined MLR for the Medicaid Expansion population are less than the minimum MLR threshold.

SFY2024 MEDICAL LOSS RATIO					
	AmeriHealth	**Healthy Blue**	**Carolina Complete Health**	**United HealthCare****	**WellCare**
Federal – Combined Expansion and Non-Expansion					
MLR Numerator	$2,188,302,022	$3,657,105,645	$1,611,867,224	$2,724,856,936	$2,858,388,329
MLR Denominator	$2,351,392,831	$3,866,035,343	$1,730,079,843	$2,907,587,983	$3,073,980,395
Credibility-Adjusted MLR	93.06%	94.60%	93.17%	93.72%	92.99%
Department - Expansion					
MLR Numerator	$170,288,421	$286,849,968	$106,113,776	$220,996,907	$220,351,196
MLR Denominator	$220,889,025	$317,524,696	$134,806,367	$260,939,475	$266,151,476
Credibility-Adjusted MLR	77.09%	90.34%	80.02%	84.69%	82.79%
Department – Non-Expansion					
MLR Numerator	$1,252,858,092	$2,199,916,374	$955,775,265	$1,577,772,365	$1,662,429,372
MLR Denominator	$1,365,348,296	$2,372,119,085	$1,045,295,294	$1,720,706,577	$1,832,221.159
Credibility-Adjusted MLR	91.76%	92.74%	91.44%	91.69%	90.73%
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.					

** United HealthCare notified the department on 1/13/2026 of an adjustment to their FY2024 MLR Reporting that will impact health plan's MLR reporting in this performance report.

CAHPS - Beneficiary 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 beneficiaries' 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 2024, the NC CAHPS survey was administered to adult beneficiaries and the parents/caretakers of child beneficiaries.

NC Medicaid Program (the combined results of all five Standard Plans (or PHPs), the EBCI Tribal Option, and Medicaid Direct) and NC PHP Aggregate (the combined results of all five PHPs only) positive rating results for 2024 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 2024 represent beneficiary experience with the second year of Managed Care.

Additional details on these comparisons and methodology as well as results of the 2024 CAHPS Survey are available in the 2024 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 (2024)

Measures	NC Medicaid Program Compared to National Percentiles		NC PHP Aggregate Compared to National Percentiles	
	Adult	Child	Adult	Child
Global Ratings				
Rating of Health Plan	★★★ 79.36%	★★ 86.16%	★★ 74.94%	★★ 86.54%
Rating of All Health Care	★★★ 76.54%	★★★ 86.57%	★★★ 75.86%	★★★ 86.54%
Rating of Personal Doctor	★★★★★ 87.39%	★★★ 90.40%	★★★ 84.75%	★★★ 90.26%
Rating of Specialist Seen Most Often	★★★★ 84.76%	★★★ 87.64%	★★ 80.83%	★★★ 87.63%
Composite Measures				
Getting Needed Care	★★★★ 86.13%	★★★★ 86.74%	★★★ 81.89%	★★★★ 86.58%
Getting Care Quickly	★★★ 84.64%	★★★ 89.18%	★★★ 82.04%	★★★ 88.77%
How Well Doctors Communicate	★★★★ 94.38%	★★★★ 96.08%	★★★★ 94.10%	★★★★ 95.88%

Measures	NC Medicaid Program Compared to National Percentiles		NC PHP Aggregate Compared to National Percentiles	
	Adult	Child	Adult	Child
Customer Service	★★★★ 91.35%	★★ 87.64%	★ 87.30%	★★ 87.51%
Individual Item Measures				
Coordination of Care	★★★★ 87.56%	★★★★ 87.98%	★★ 84.38%	★★★★ 88.22%
Medical Assistance With Smoking and Tobacco Use Cessation Items				
Advising Smokers and Tobacco Users to Quit	★★★★ 79.96%	NA	★★★ 76.21%	NA
Discussing Cessation Medications	★★★★ 57.33%	NA	★★★ 51.50%	NA
Discussing Cessation Strategies	★★★ 48.00%	NA	★★ 43.79%	NA
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. Positive rating is equivalent to the top-box score used by other states that contribute to national data. For further details, please refer to the Methodology Section within the Reader's Guide beginning on page 38.*				

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	≥ 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 April 2025.

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%	86%
Physical Therapy	100%	100%	100%	100%	100%	100%
Speech Therapy	100%	100%	100%	100%	100%	92%
Allergy/Immunology (Adult)	100%	100%	94%	100%	97%	86%
Allergy/Immunology (Child)	99%	57%	75%	97%	73%	33%
Cardiology (Adult)	100%	100%	100%	100%	100%	100%
Cardiology (Child)	40%	99%	99%	100%	96%	100%
Gastroenterology (Adult)	100%	100%	100%	100%	100%	99%
Gastroenterology (Child)	100%	98%	89%	99%	73%	75%
Oncology (Adult)	100%	100%	100%	100%	100%	100%
Oncology (Child)	100%	72%	79%	88%	68%	74%
Psychiatry (Adult)	100%	100%	100%	100%	100%	100%
Psychiatry (Child)	100%	100%	100%	100%	99%	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%	99%
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%	98%
Physical Therapy	100%	100%	100%	100%	100%	99%
Speech Therapy	100%	100%	100%	100%	100%	94%
Allergy/Immunology (Adult)	100%	100%	100%	99%	100%	100%
Allergy/Immunology (Child)	99%	87%	98%	100%	89%	52%
Cardiology (Adult)	100%	100%	100%	100%	100%	100%
Cardiology (Child)	100%	100%	100%	100%	100%	99%
Gastroenterology (Adult)	100%	100%	100%	100%	100%	100%
Gastroenterology (Child)	100%	100%	99%	99%	100%	93%
Oncology (Adult)	100%	100%	100%	100%	100%	100%
Oncology (Child)	100%	91%	98%	87%	97%	94%
Psychiatry (Adult)	100%	100%	100%	100%	100%	100%
Psychiatry (Child)	100%	100%	100%	100%	100%	100%

Carolina Complete Health

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%	92%	97%
Allergy/Immunology (Child)	76%	92%	46%
Cardiology (Adult)	100%	100%	100%
Cardiology (Child)	100%	100%	100%
Gastroenterology (Adult)	100%	100%	100%
Gastroenterology (Child)	100%	98%	100%
Oncology (Adult)	100%	100%	100%
Oncology (Child)	99%	85%	95%
Psychiatry (Adult)	100%	100%	100%
Psychiatry (Child)	100%	100%	100%

United Healthcare

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%	99%
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%	97%
Physical Therapy	100%	100%	100%	100%	100%	100%
Speech Therapy	100%	100%	100%	100%	100%	94%
Allergy/Immunology (Adult)	100%	100%	100%	99%	98%	100%
Allergy/Immunology (Child)	100%	87%	81%	92%	59%	50%
Cardiology (Adult)	100%	100%	100%	100%	100%	100%
Cardiology (Child)	100%	100%	100%	100%	100%	100%
Gastroenterology (Adult)	100%	100%	100%	100%	100%	100%
Gastroenterology (Child)	100%	100%	99%	98%	100%	95%
Oncology (Adult)	100%	100%	100%	100%	100%	100%
Oncology (Child)	100%	89%	87%	87%	100%	99%
Psychiatry (Adult)	100%	100%	100%	100%	100%	100%
Psychiatry (Child)	100%	100%	100%	100%	99%	100%

WellCare of NC

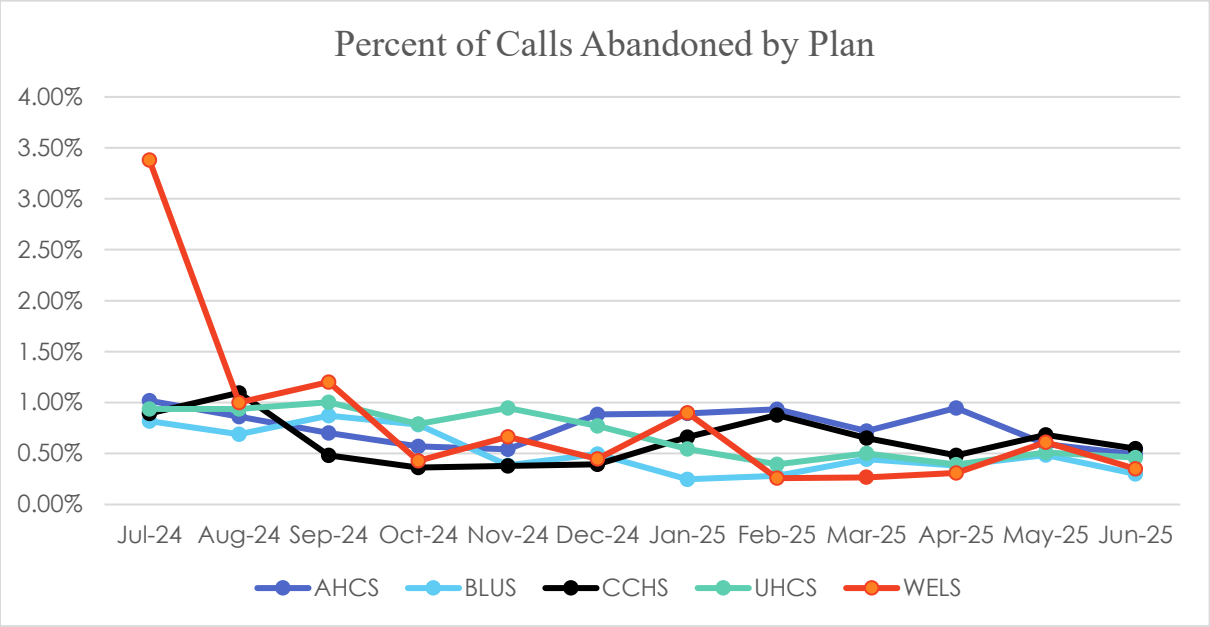
Category/Specialty	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
	% members	% members	% members	% members	% members	% members
Hospitals	100%	100%	100%	100%	100%	99%
OB/GYN	100%	100%	100%	100%	100%	100%
Primary Care (Adult)	100%	100%	100%	100%	100%	98%
Primary Care (Child)	100%	100%	100%	100%	100%	97%
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%	100%	100%
Speech Therapy	100%	100%	100%	100%	100%	96%
Allergy/Immunology (Adult)	100%	100%	100%	99%	100%	100%
Allergy/Immunology (Child)	100%	99%	99%	100%	100%	54%
Cardiology (Adult)	100%	100%	100%	100%	100%	100%
Cardiology (Child)	100%	100%	100%	100%	100%	100%
Gastroenterology (Adult)	100%	100%	100%	100%	100%	100%
Gastroenterology (Child)	100%	100%	100%	98%	100%	94%
Oncology (Adult)	100%	100%	100%	100%	100%	100%
Oncology (Child)	100%	93%	93%	89%	94%	96%
Psychiatry (Adult)	100%	100%	100%	100%	100%	100%
Psychiatry (Child)	100%	100%	100%	100%	100%	100%

Customer Services and Member Engagement

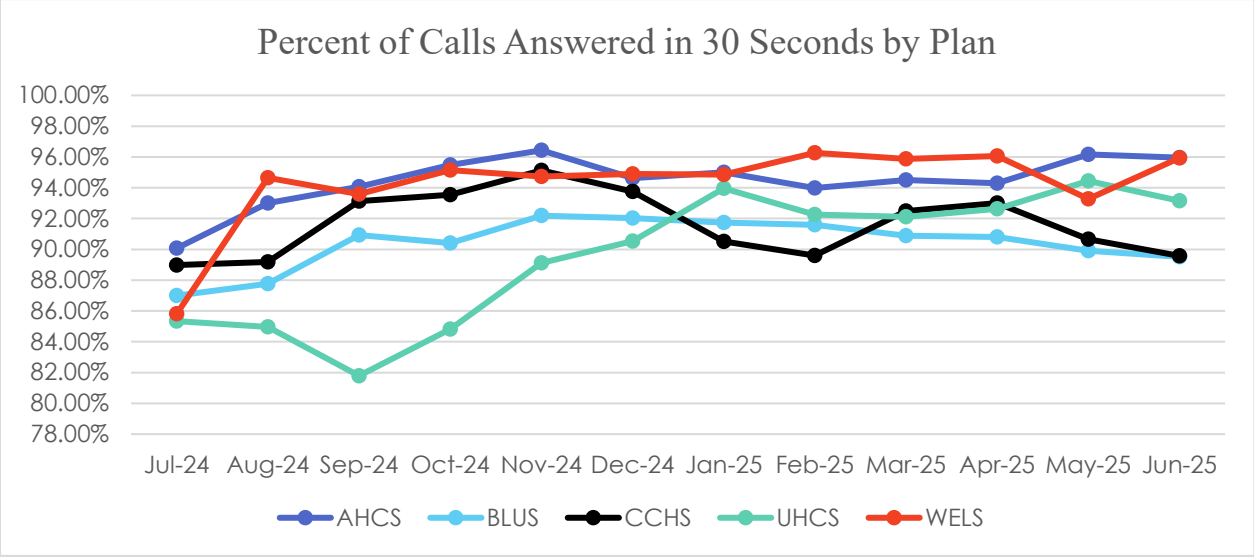
Call Center Performance

NC Medicaid also evaluates PHP customer service based on call center performance, including abandonment rates and service level. 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 SFY2025.

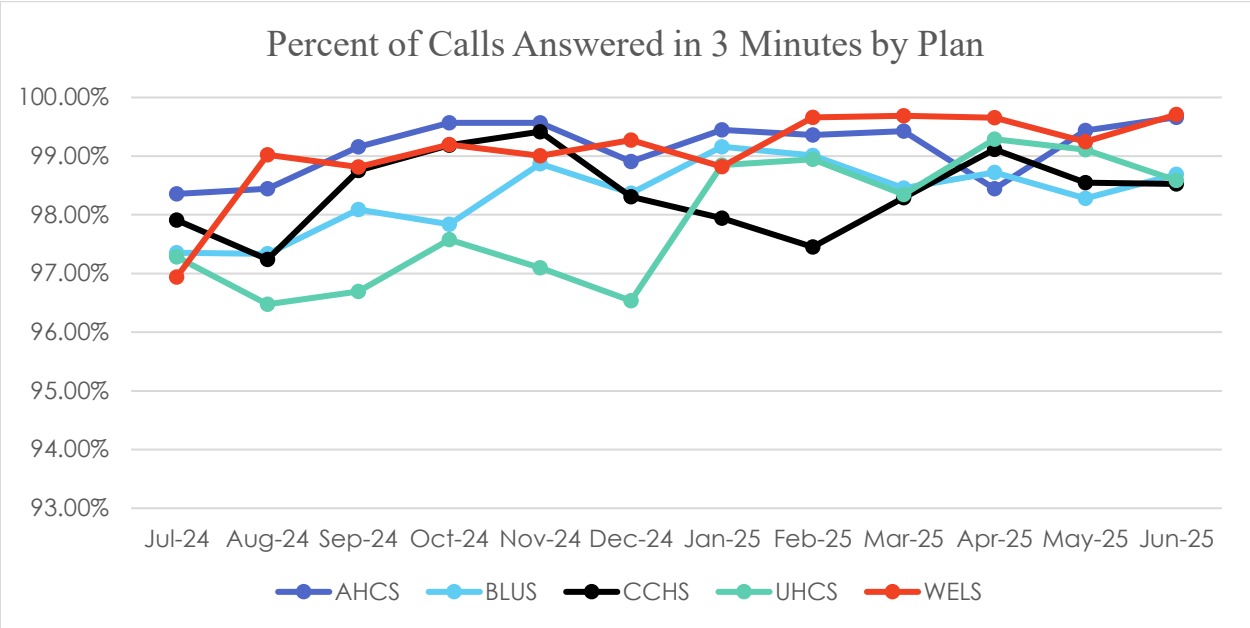
Percent of Calls Abandoned: The percent of calls that are terminated by the system or caller before being answered by a live voice. Plans are expected to be under 5% each month



Percent of Calls Answered Within 30 Seconds: The percent of calls abandoned or answered by a live voice within 30 seconds. Plans are expected to be over 85% each month.



Percent of Calls Answered Within 3 Minutes: The percent of calls abandoned or answered by a live voice within 3 minutes. Plans are expected to be over 95% each month.



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 "N" reflects that a PHP has been timely sending member welcome packets during the applicable month in SFY2025.

Late Member Mailings July 2024 – June 2025												
Plan	**Jul**	**Aug.**	**Sep.**	**Oct.**	**Nov.**	**Dec.**	**Jan.**	**Feb.**	**Mar.**	**Apr.**	**May.**	**Jun.**
AMHC	N	N	N	N	N	N	N	N	N	N	N	N
BCBS	N	N	N	N	N	N	N	N	N	N	N	N
CCH	N	N	N	N	N	N	N	N	N	N	N	N
UNHC	N	N	N	N	N	N	N	N	N	N	N	N
WCHP	N	N	N	N	N	N	N	N	N	N	N	N

Appendix:

1) Session Law 2023-134 Language
    1) 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
    1) 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.
    2) 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.
    3) 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.
    4) Global Tracking of Denial and Reject Reasons
        i. **Denial Tracking** - PHPs closely track claim denials and rejects 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. For example, over the past four years, Managed Care has worked diligently to improve overall claim-denial metrics, particularly those associated with the absence of an Explanation of Benefits (EOB) from other insurance. Both payer-related and provider-related issues contributed to claims being denied at an

excessive rate. In response, the PHPs enhanced their clearinghouse functionality to allow providers to attach required documentation after claim submission, thereby reducing the need for resubmissions and supporting accurate, first-pass claim processing.

ii. **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:

1) **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 rest with the Contractor and must be determined for each claim, provided applied consistently and reasonably. 85 FR 72754, 72819.
2) **Claim Adjudication:** The process of paying claims submitted or denying them after comparing the claim data elements to the benefit or coverage requirements.
3) **Pharmacy Claim:** Includes outpatient pharmacy (point-of-sale claims) as well as physician-administered (professional claims) drug claims.
4) **Medical Claim:** Inpatient hospital, outpatient hospital (institutional claims), and physician-administered services.
5) **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.
6) **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.
7) **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) 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.

5) 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) 2024 Adult and Child Medicaid CAHPS Aggregate Report: https://medicaid.ncdhhs.gov/2024-cahps-survey-three-years-managed-care-full-report/download?attachment