Lessons Learned from North Carolina's MCPAR Reports

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States must submit Medicaid Managed Care Program Annual Reports (MCPARs) annually for each contracted managed care program in the state.[1] These reports are helpful tools for data-driven managed care oversight. Examining the MCPARs for one state, North Carolina, reveals how the role and structure of MCPARs as oversight tools are helpful, but there are also ways to make them more useful to advocates. This evaluation of North Carolina's MCPARs also looks at the connection between the reports and the types of sanctions that can be, and were, imposed on the state's Medicaid managed care organizations (MCOs). It also examines how those sanctions are reported in the MCPAR and offers actionable recommendations to strengthen oversight and accountability where the MCPARs fall short.

Importance of MCPAR Reports

The MCPAR is a standardized, federally mandated reporting tool.[2] All states operating Medicaid managed care programs must submit a MCPAR to the Centers for Medicare & Medicaid Services (CMS) within 180 days of each contract year's end and post the report publicly within 30 days of submission.[3] MCPARs are structured to collect and report data across a comprehensive set of domains, including:

- Program characteristics and enrollment
- Financial performance
- Encounter data reporting

[1] States are required to produce MCPARs for all the managed care programs administered by the state. North Carolina posted reports for five managed care programs in 2025. N.C. Medicaid Div. of Health Benefits, MCPAR By Performance Year, https://medicaid.ncdhhs.gov/reports/managed-care-program-annual-report-mcpar#PerformanceYear2025MCPARs-6059 (visited Jan 5, 2026).

[2] 42 C.F.R. § 438.66(e).

[3] *Id.* § 438.66(e)(1).

- Grievance, appeals, and state fair hearings
- Availability, accessibility, and network adequacy
- Quality and performance measures
- Sanctions and corrective action plans
- Beneficiary support systems
- Program integrity
- In-lieu-of-services and settings
- Mental health and substance use disorder parity; and
- Prior authorization and patient access API usage (beginning in June 2026).

MCPARs are not merely compliance documents; they are tools for data-driven Medicaid managed care oversight that is meant to drive program improvement. MCPARs are critical for several reasons, including standardization, transparency, accountability, and as a public compliance mechanism to improve quality and performance.

MCPARs establish standardization and a basis for comparability. MCPARs report on a uniform set of indicators, enabling apples-to-apples comparisons between MCOs within a state and across states. Some examples of comparable information and data states report in the MCPAR include:

- Statewide enrollment numbers
- Plan level share of Medicaid and managed care
- Data on number of appeals resolved and denied by each plan
- Number of fair hearings requests and those that were resolved with favorable decisions for enrollees
- Number of active and resolved grievances
- Quality and performance measures and the results on those measures
- Number of sanctions and corrective action plans
- Dollar amount of imposed sanctions; and
- Types of beneficiary support systems operating in the state.

This standardization is essential for identifying high performance, best practices, outliers, and systemic issues. However, within the standardized reporting form, there are numerous areas where states have open-ended discretion on how to report on certain activities. One example is the state is instructed to describe service-specific program integrity activities. The state is also instructed to describe the standard for timely encounter data submissions used in the managed care program. Another example is reporting a reason for sanction. The instructions simply direct the state to "add a description." Depending on how generic or thorough a description states use to report information in these sections can lead to questions on the part

of advocates as to why the state takes certain actions.

MCPARs also increase transparency and public accountability. Because they must be publicly posted, MCPARs make information about MCO performance, sanctions, and corrective actions accessible to policymakers, providers, advocates, beneficiaries, and other stakeholders, albeit with a data lag. MCPARs are also a public source of broad performance assessment, like External Quality Reviews. MCPARs aggregate data on access, quality, network adequacy, grievances, appeals, financial performance, and program integrity. This information can be tracked year-to-year allowing for monitoring of improvement or the lack thereof.

MCPARs allow for the identification of performance deficiencies. The reports require states to document not only the existence of deficiencies but also the actions states take to remedy problems, including imposition of sanctions and corrective action plans (CAPs). However, more clarification is needed from CMS on what actions should be reported in the MCPAR, as some states have different interpretations of what falls under the umbrella of sanctions. Although there could be improvements, MCPARs document the use of enforcement and deterrence tools and thus provide a record of state activities holding MCOs accountable for contractual and regulatory violations. MCPAR data can inform future policy development, contract negotiations and procurement decisions, and the development of new performance standards. States can use historical sanction data to screen for poor-performing plans during re-procurement. MCPARs also align state oversight with federal expectations, facilitating CMS's ability to monitor state compliance and target technical assistance or enforcement where needed.

Note on Terminology

In the MCPAR, CMS uses the term sanction as a catch-all for enforcement actions and compliance activities the states impose on managed care plans. They intend states to report all activities, formal and informal, monetary penalties and non-monetary as sanctions.[4] They also include liquidated damages under the umbrella of sanctions even though many states, but not all, define liquidated damages in their managed care contracts as a type compliance action distinct from intermediate sanctions, which are non-monetary compliance actions.[5] This memo also uses sanction as a catch-all term for enforcement and compliance activities, including liquidated damages.

[4] E-mail from Daniel Young to CMS Managed Care Technical Assistance (June 27, 2025) (on file with author)

[5] Liquidated damages are a type of monetary penalty negotiated into the managed care contract for violations of or noncompliance with various aspects of contract requirements.

Using MCPAR as an Advocacy Tool in North Carolina

Understanding Sanctions in North Carolina Medicaid Managed Care

As stated above, MCPARs are a publicly available account of sanctions activity. This is important in states like North Carolina, that do not have a public-facing dashboard for managed care enforcement activities. However, to fully understand what is being reported in the MCPAR about sanctions, it is first helpful to know what types of managed care enforcement tools North Carolina has at its disposal.

North Carolina's Prepaid Health Plan contract details how contract violations or noncompliance on the part of the managed care plans trigger the enforcement activities, including remedial actions, intermediate sanctions, liquidated damages, and/or contract termination.[6] The process begins with a risk assessment that determines the severity of the violation.[7]

Table 1: North Carolina Contract Violation and Noncompliance Risk Levels	
Risk Level 1	Contract violations that jeopardize the health, safety, and welfare of members, reduce member's access to services, and/or jeopardize the integrity of Medicaid managed care
Risk Level 2	Contract violations that jeopardize the integrity of Medicaid managed care but not necessarily the health, safety, and wellbeing of members, or access to services
Risk Level 3	Contract violations that diminish the effective oversight and administration of Medicaid managed care
Risk Level 4	Actions or inactions that inhibit the efficient operation of Medicaid managed care

The risk level is one of several criteria that the state uses to determine the type of remedial action, intermediate sanction, liquidated damages it will impose on a plan. In addition to the risk level assessment, the decision to impose remedial actions, sanctions, and/ or liquidated damages is determined by also considering these factors:[8]

[6] N.C. Medicaid Div. of Health Benefits, Revised and Restated Request for Proposal (RFP), Section VI.A. Contract Violations and Noncompliance, https://medicaid.ncdhhs.gov/about-nc-medicaid/health-plans#HealthPlanContracts-1622 (visited Mar 2, 2026) [hereinafter NC MCO Contract].

[7] *Id.* § VI.A.c.i.

[8] *Id.* § VI.A.c.ii.

- The nature, severity, and duration of the violation
- The type of harm suffered due to the violation (e.g., impact on the quality of care, access to care, and program integrity)
- Whether the violation (or one that is substantially similar) has previously occurred
- The timeliness in which the plan self-reports a violation
- The plan's history of compliance
- The good faith exercised by the plan in attempting to stay in compliance (including self-reporting by the plan); and
- Any other factor the State deems relevant based on the nature of the violation.

The State then sends the plan a Notice of Deficiency detailing the violation or noncompliance, the risk level assessment of the violation, the State's intended actions in response to the infraction, and how and by when the plan can dispute the violation and imposed actions.[9] The State will then, prior to or in conjunction with issuing intermediate sanctions or liquidated damages, require the plan to immediately stop the noncompliant behavior or actions, submit and implement a CAP, or participate in additional education and training.[10]

If the State determines that the plan's actions or noncompliance violate the contract or any other applicable law, the State may impose the following intermediate sanctions:[11]

- Civil monetary penalties in accordance with 42 C.F.R. § 438.704
- Appointment of temporary management of the plan in accordance with 42 C.F.R. § 438.706(a)
- Notification to members of their right to terminate their enrollment with the plan without cause
- Suspension of all or part of new enrollment, including default enrollment, after the effective date of the sanction
- Suspension, recoupment, or withholding of payment
- Suspension of all or part of marketing activities

[9] *Id.* § VI.A.d.

[10] A CAP is a step-by-step plan of action that the state requires plans to develop to achieve targeted outcomes for resolution of identified errors. *See,* CMS, Corrective Action Plan (CAP) Process, https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/perm/downloads/2013correctiveactionpowerpoint.pdf#:~:text=%E2%80%A2%20A%20corrective%20action%20plan,achieve%20targeted%20outcomes%20for%20resolution (visited Feb 10, 2026).

[11] N.C. MCO Contract, *supra* note 6, at § VI.A.e.iv.

- Suspension of part of the contract
- Exclusion from participation in Medicaid Managed Care; and
- Any other additional sanctions allowed under North Carolina or federal law or regulation.

The State may impose liquidated damages if the plan has violated the terms, conditions, requirements, and/or performance standards of the contract. Liquidated damages are pre-determined reasonable estimates of what specific violations would cost the state due to the plan not meeting its contractual obligations. The plan then compensates the state for its financial losses.[12] The amounts of the liquidated damages that the State can impose are agreed to in the contract and cover ten different aspects of the managed care program:[13]

- Administration and management
- Members
- Benefits and care management
- Providers
- Quality and value
- Claims and encounter management
- Financial requirements
- Compliance
- Technical specifications; and
- Directives and deliverables.

Depending on the infraction, liquidated damages are mainly imposed per occurrence, per day, per occurrence per member, per day per member, or per month. Despite the number of enforcement action options available to the state to impose on the MCOs, the MCPARs show that in North Carolina, the State has only utilized CAPs and liquidated damages.

North Carolina MCPAR-Documented Sanctions: 2023 through 2025

The 2023-2025 North Carolina MCPARs detail the sanctions imposed on MCOs within the state for various deficiencies.[14] Table 2 below summarizes the number and types of enforcement actions and the total amount of monetary penalties for the years covered in the three reports.

[12] *Id.* at § VI.A.e.v.
[13] *Id.* at § VI.A, tbl. 1: PHP Liquidated Damages.
[14] N.C. Medicaid Div. of Health Benefits, Managed Care Program Annual Report, https://medicaid.ncdhhs.gov/reports/managed-care-program-annual-report-mcpar (visited Jan 5, 2026).

Types of Sanctions Documented in the North Carolina MCPARs:

- **Monetary Penalties**
  - Liquidated damages ranging from $500 to $1,000,000. Repeat violations appear to occasionally be given higher penalties.[15]
- **Corrective Action Plans (CAPs)**
  - The state imposes CAPs for both initial and repeat violations, often in conjunction with liquidated damages.
  - In these MCPAR, the stated reasons that plans had stand-alone CAPs imposed on them were primarily for failing to meet mailing timelines for member and provider packets and failing to comply with non-emergency medical transportation (NEMT) and non-emergency ambulance transportation (NEAT).

Table 2: Total Sanctions by MCPAR Report Year

Year	MCOs Sanctioned	Total Sanctions	CAPs[16]	Monetary Sanctions	Total $ Amount
2023	5	30	14	16	$2,233,550
2024	5	24	6	18	$882,120
2025	5	20	2	18	$572,250

Key categories of violations and deficiencies leading to sanctions in North Carolina include:[17]

- **Access to Care and Network Adequacy**
  - Failure to meet network adequacy standards (Level 1 violation)
- **Quality of Services**

[15] The State imposed the largest liquidated damages on AmeriHealth, reported in the 2023 MCPAR. The State imposed separate fines on the plan for $1 million, $227,000, and two fines totaling $400,000. *See* App. A, tbl. 3.

[16] Corrective Action Plans without an accompanying monetary sanction. All the liquidated damages imposed on the plans had an accompanying CAP.

[17] N.C. MCO Contract, *supra* note 6, at § VII., att. K. Risk Level Matrix.

  - Call center noncompliance for failing to meet contractual service level agreements (Level 2 violation)
  - Noncompliance with preferred drug list performance standards. (Level 1 violation)
  - Failure to mail Welcome Packets to members and providers within contractually obligated timeframes (Level 4 violation)
- **Reporting Failures**
  - Network file discrepancies, such as failure to load accurate provider information into state Medicaid data systems (Level 1 violation)
  - Privacy and security violations for failing to comply with the terms and conditions of the confidentiality, privacy, and security protections of the contract (Level 2 violation)
- **Claims Processing Errors**
  - Deficiencies in automated claims processing for NEMT and NEAT (Level 1 violation)

Notably, the types of violations and the number of imposed sanctions shifted across the three reporting years, potentially suggesting some areas of improvement or the State determined some of the issues were resolved, while others persisted. For example, network file discrepancies and preferred drug list noncompliance were cited multiple times across the plans in the 2023 report, but were not cited in 2024.[18] However, call center and network adequacy issues persisted, sometimes with increased penalty amounts. Call center and privacy and security sanctions continued to be noted in 2025, mirroring those in the 2024 report. While four of the five plans had CAPs imposed on them for NEMT and NEAT claims processing in the 2024 report – that were noted as in progress for remediation – the State sanctioned only BCBS for that issue in the 2025 report.[19] There were no sanctions for network adequacy issues in the 2025 report.

[18] *See infra* App. A, tbl. 3 & tbl. 4. The Medicaid Section 1115 Monitoring Report, submitted in February 2023, confirms that the preferred drug list sanction was for not achieving the compliance benchmark of 95% for AmeriHealth and BCBS. *See* N.C. Medicaid Reform Demonstration, Medicaid Section 1115 Monitoring Report, Nov. 1, 2021-Oct. 31, 2022 (Feb. 1, 2023), https://medicaid.ncdhhs.gov/dy4q4-annual-managed-care-report-nov-2021-oct-2022/download?attachment, (visited Feb 28, 2026).

[19] *Infra* App. A, tbl. 4 & tbl. 5.

Effectiveness of Sanctions

Similarly to other states, North Carolina utilizes both monetary and non-monetary sanctions, but the size of financial penalties remains relatively small compared to MCO revenues. This raises questions about the deterrent effect of such sanctions. For example, fines of $15,000–$400,000 may be insufficient to compel large MCOs to change business practices, especially when annual payments total $6 billion a year to the five MCOs.[20]

However, the combination of monetary penalties, CAPs, and public reporting have led to the appearance of some changes, such as the reduction of certain types of violations in subsequent years. Persistent deficiencies in areas like call center operations suggest that further escalation of enforcement or alternative accountability mechanisms may be needed.

Deficiencies of the MCPAR Reports

Specificity and Lack of Context

Despite the data the MCPARs collect on sanctions, the way the data is presented limits the depth of analysis that can be drawn from it.[21] Beyond a general reason for imposing each sanction, the report provides little context to help interpret the listed sanctions or track changes in outcomes. There is also little information detailing whether contract violations drawing similar sanctions are new issues or ongoing. For example, one might infer that if a plan is sanctioned for call center noncompliance in one MCPAR and again for call center noncompliance in a subsequent year, that it must be for the same issue. The description of the intervention in the MCPAR only states that the contractor failed to meet "various call center-related service level agreements." More detail is needed to know which parts of the service level agreements the plan failed to meet.

[20] Sarah Ovaska, *Five companies, $30 billion over five years: North Carolina announces its Medicaid managed care selections,* NC HEALTH NEWS (Feb 5, 2019) https://www.northcarolinahealthnews.org/2019/02/05/five-companies-30-billion-over-five-years-north-carolina-announces-its-medicaid-managed-care-selections/.

[21] See Jada Raphael & Elizabeth Hinton, KFF, Medicaid Managed Care Reporting and Transparency: Managed Care Program Annual Reports (Feb. 18, 2026), https://www.kff.org/medicaid/medicaid-managed-care-reporting-and-transparency-managed-care-program-annual-reports/#ad20e0da-d57d-417e-9029-70792e7f5cf9 (discussing the utility and limitations of MCPARs in managed care monitoring and oversight).

Some states have compound sanctions in their contracts that escalate the financial penalty based on the plan failing to achieve compliance within the timeframe established by the state or the plan failing to maintain compliance for a same requirement during a particular time period, six months for example.[22] In North Carolina, the state may impose additional sanctions, liquidated damages, and/or elevate the contract violation to a higher Risk Level if repeat contract violations occur, but the contract does not specify that fines increase for repeat violations.[23] If these types of details were included in the MCPAR, this could let advocates evaluate whether the intensity of the penalty is appropriate, and the extent to which a MCO's response requires more scrutiny.

The 2025 North Carolina MCPAR report includes one example that suggests that repeat sanctions are for a repeated violation. The North Carolina Standard Plan contract details numerous liquidated damages that can be levied on the plans for failing to meet contractual obligations. For the various member services call lines, 16 different liquidated damages can be imposed related to call response times, call hold/wait times, and call abandonment rates. [24] These are assessed monthly based on the plan's performance. The liquidated damages for these contract violations range from $5,000 to $15,000 a month. The report indicates the State sanctioned AmeriHealth $35,000 for failing to meet call center service level agreements for the period of October 2023 to June 2024, that the plan remediated. They sanctioned AmeriHealth again, $55,000, for the same stated reason for the period of July 2024 through September 2024, also noted as remediated. This demonstrates an escalating fine imposed by the state, which seems to indicate a repeated violation very similar in scope. Yet we do not know which aspects of the call center service level agreement the plan failed to meet because the MCPAR does not drill down to the level of detail of which service line(s) failed to meet the monthly performance standards and/or which performance metrics AmeriHealth failed to meet. Thus, the escalation in liquidated damages against AmeriHealth for call center noncompliance in the 2025 MCPAR may not be for an exact repeat violation.

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[22] Ohio Dep't of Medicaid, Ohio Medicaid Provider Agreement for Managed Care Organization. (Feb. 2025) App. N. Compliance Actions, § 3.d. https://medicaid.ohio.gov/resources-for-providers/managed-care/mc-policy/managed-care-agreements/managed-care-agreements.

[23] N.C. MCO Contract, *supra* note 6, at § VI.A.c.ii.i.

[24] N.C. Medicaid Div. of Health Benefits, Revised and Restated Request for Proposal (RFP), Section VI.A. Contract Violations and Noncompliance, e. Remedial Actions, Intermediate Sanctions, and Liquidated Damages v. Liquidated Damages, tbl. 2: PHP Service Level Agreement at Service Lines, https://medicaid.ncdhhs.gov/contract-30-190029-dhb-php-amendment-2-cch-3-model/download (visited Feb 9, 2026).

Incongruencies Between Sanctions, Member Experiences, and Grievances

The North Carolina standard plan contract has four liquidated damages that the State can impose on plans for disruptions in NEMT service.[25] Two are assessed per-member-per-occurrence. One is assessed against the NEMT per-occurrence on the driver and the other per-calendar-day on the transportation vehicle. A member who experiences a ride no-show could potentially trigger liquidated damages of $500 per member, per occurrence under the violation, "Failure to ensure that a Member receives the appropriate means of transportation as specified in 42 C.F.R. § 440.170 and as specified Section V.C.5. Non-Emergency Transportation."[26]

Legal services advocates in North Carolina, based on communications with Medicaid members, reported during that NEMT service denials and ride no-shows were significant problems across the various plans during that time, but the sanctions for NEMT do not reflect this. The only reported CAPs in the 2024 MCPAR addressing NEMT and NEAT were for claims processing. Further, BlueCross is the only plan upon which the state imposed liquidated damages, as reported in the 2025 MCPAR, again for claims processing deficiencies.[27]

The MCPAR also details the number of grievances each plan resolved during the reporting year. The NC MCPAR grievance metrics are:

- Overall grievances resolved,
- Active grievances,
- Grievances filed on behalf of LTSS users,
- Grievances for which timely resolution was provided by plan, and
- Grievances resolved by type of service line.

More context in the MCPAR could help explain, for example, how a plan like WellCare can receive and resolve the most grievances for NEMT services, yet still be the only plan that did not receive a CAP or assessed liquidated damages for NEMT and NEAT claims processing.

Advocate communications with the state Medicaid agency indicated it was developing an NEMT monitoring tool to better capture trip information and apply penalties monthly. Any penalties applied for NEMT under this effort that rise to the level of sanctions should show in the next MCPAR. While the MCPAR will indicate the number and monetary amount of

[25] *Id.* at tbl. 1: PHP Liquidated Damages.
[26] *Id.*
[27] *Infra* App. A, tbl. 5.

sanctions, it would also be helpful to advocates and the public for the State to include more information on State responses to identified problems on issues like NEMT that impact the day-to-day experiences of enrollees.

Time Lag

Another oversight deficiency of the MCPAR is the significant time lag between when issues are flagged, when action is taken, and when it is reported out. The MCPARs are submitted to CMS up to 180 days after the end of the contract year and posted to the state website up to 30 days after that. Using the AmeriHealth sanction mentioned above, the call center failed to meet the expectations of the agreement between October 2023 and June 2024. The State assessed the liquidated damages in October 2024, and the sanction is marked remediated in the MCPAR as of February 2025. The MCPAR was completed and submitted to CMS on December 27, 2025, and finally posted to the state's website in late January 2026. Thus, the public reporting of the sanction on AmeriHealth occurred over a year after it was imposed on the plan and over two years after the violation occurred. The MCPAR is therefore useful at providing an annual record of oversight and accountability activities but advocates often have a need for more frequent assessments and updates on the state's oversight activities. Nothing in federal regulations prevents North Carolina from posting sanction and remediation information with much less delay.

Recent Federal Guidance on MCPAR

CMS released an Informational Bulletin in March 2026 that summarized and clarified a few changes to MCPAR with the intent of enhancing the usefulness of the information collected, further standardizing states' responses, and streamlining the reporting to reduce the burden on states in compiling the MCPAR. The changes since the beginning of 2025: [28]

- CMS now sends standardized feedback to states on data quality issues identified in their MCPAR submissions to aid reporting improvements
- States may now opt out of MCPAR questions related to availability, accessibility, and network adequacy if they submit a new Network Adequacy and Access Assurances Report (NAAAR) for the same reporting period; and

[28] CMS, Medicaid and CHIP Managed Care Monitoring and Oversight Informational Bulletin (Mar 12, 2026), https://www.medicaid.gov/federal-policy-guidance/downloads/cib03112026.pdf.

- Questions were refined to capture enrollment for risk-based managed care programs and remove content that is captured in the Medical Loss Ratio Summary Report and NAAAR.

These changes may reduce redundancy of information collected on managed care by CMS and streamline the process of completing and submitting the MCPAR, but they do not address the deficiencies identified above.

Recommendations

1. Strengthen Transparency and Public Reporting

While it may be unrealistic to expect that federal reporting on MCPAR will change again in the near term, there are a few ways that North Carolina can change how it reports on the existing MCPAR to make its data more transparent, useful for quality improvement, and more responsive to issues identified by advocates. These recommendations are likely useful in other states as well.

- **Transparency of MCPARs**
  The MCPAR is a good starting point for enhanced public reporting of managed care activities and oversight. Improvements in how the state compiles MCPAR will strengthen its usefulness as an oversight tool. These changes should ensure that detailed sanctions information within the MCPARs indicates whether the CAPs and liquidated damages are for new or ongoing plan actions as well as including additional specifics on the reasons for sanctions. These details could be added to the description of the sanctions the state provides in the MCPAR report. The fields for entering this information are open-ended text boxes. In future guidance, CMS could also amend its instructions or technical assistance to ask states to provide more detailed sanctions descriptions, but the state can do this without action from CMS.

- **Develop a Public Sanctions Dashboard**
  North Carolina reports compliance actions imposed on managed care plans in the MCPAR and in the quarterly 1115 Demonstration Waiver Monitoring Reports.[29] Although the 1115 monitoring reports leave out the names of the plans that are subject to CAPs

[29] N.C. Dep't of Health & Human Servs., Medicaid Reform Demonstration, Medicaid Section 1115 Monitoring Reports, https://medicaid.ncdhhs.gov/reports/1115-demonstration-waiver-monitoring-reports#ManagedCareHealthyOpportunitiesPilotMonitoringReports-4155 (visited Mar 2, 2026).

or sanctions, they do provide details about benchmarks not met and subsequent actions that the plans must take. The MCPAR and 1115 Demonstration Waiver Monitoring Reports provide differing but partially overlapping sanction information. These redundant sources on compliance actions are required of the state by CMS. For advocates, having sanctions information in multiple places is problematic. The State should create a user-friendly online dashboard summarizing MCO performance, sanctions, and remediation status, modeled on dashboards from states like California and Florida.[30] Other oversight tools could be included like the NEMT tracking and penalties applied tool developed by the State mentioned above. Publicly release trend monitoring reports created by the beneficiary support system, previously the North Carolina Medicaid Ombudsman but now a state-run function. A public sanctions dashboard brings these various reporting outputs together, reduces redundancy, increases access to sanctions information, and allows the state to report on sanctions activity more frequently than once per contract year.

2. Enhance the Impact of Sanctions Through Contract Changes

- **Increase Monetary Penalties**
  Consider raising the dollar amounts of liquidated damages generally so that they are meaningful relative to MCO revenues and create a real deterrent effect. This would require amending or renegotiating the contract.

- **Implement Compound Financial Sanctions**
  Implement a compound sanctioning structure, with escalating penalties for repeat offenses or failure to remediate deficiencies within specified timeframes. This would also require amending or renegotiating the contract.

3. State Changes to Managed Care Oversight

- **Broaden Use of Non-Monetary Sanctions**
  The managed care contract allows North Carolina to impose non-monetary sanctions,

[30] Cal. Dep't of Health Care Servs., Administrative and/or Financial Sanction Letters, https://www.dhcs.ca.gov/services/Pages/Admin-FinancialSanctions.aspx (last visited May 5, 2025); *See,* Cal. Dep't of Managed Health Care, Enforcement Actions, https://wpso.dmhc.ca.gov/dashboard/EnforcementActions.aspx (last visited May 5, 2025). *See also,* Fla. Agency for Health Care Admin., Compliance Action Dashboard, https://bi.ahca.myflorida.com/t/ABICC/views/MedicaidManagedCare_15604365119380/ActionsTaken? (last visited May 7, 2025).

like temporary management, enrollment freezes, payment withholds, and, where necessary, contract termination for persistent or egregious noncompliance.[31] With the exception of CAPS, none of the sanctions reported in the MCPAR fall into these non-monetary categories. The State should study the use of non-monetary sanctions in other states to determine if these types of sanctions may have more and longer lasting impacts on plan performance than the current use of liquidated damages.

- **Re-establish Funding for an Independent Medicaid Ombudsman Program** Mentioned above, the North Carolina Medicaid Ombudsman as operated by an external entity had a successful track record of providing services and support to Medicaid beneficiaries helping them answer questions, addressing issues they were having accessing services, and providing legal referrals when necessary. This role was assumed by the State in January 2026 with a smaller staff offering more limited services. The State should re-establish funding to an independent Ombudsman program, staffed by legal advocacy groups, to answer questions and hear concerns from beneficiaries to provide a clearer, more robust pathway to help the State identify potential problems. Reports from the Ombudsman program should be publicly available.

Conclusion

MCPARs are an important tool for Medicaid managed care oversight by the public. They provide a source of data reporting to identify deficiencies, enforce accountability, and drive continuous improvement. While North Carolina has met expectations posting MCPARs and documenting sanctions to promote MCO compliance, further enhancements are needed to ensure that enforcement actions are impactful, transparent, and aligned with both federal expectations and national best practices.

[31] N.C. MCO Contract, *supra* note 6.

Appendix A

Table 3: 2023 Liquidated Damages and Corrective Action Plans Imposed on North Carolina Standard Plans

2023 Liq. damages & CAPs[32]	Network File	Call Center	Network Adequacy	Preferred Drug List	Welcome Packets	Privacy & Security Conditions
AmeriHealth Caritas	$1 million	$20,000 (2 counts)	$227,000	$400,000 (2 counts)	CAP only (2 counts)	
BCBS	$2,000	$20,000	$30,000	$400,000 (2 counts)	CAP only (2 counts)	$2,750
Carolina Complete	CAP only		CAP only		CAP only	$500
United Healthcare			$15,000	CAP only	CAP only (2 counts)	
WellCare	$14,800	$30,000	$90,000		CAP only (2 counts)	$1,000

[32] The five MCOs received sanctions for: network file discrepancy - failure to load provider information; call center noncompliance; failing to meet network adequacy standards; preferred drug list performance standards noncompliance; failure to mail member welcome packets within contractually obligated timeframes; and failure to comply with contractual confidentiality, privacy, and security protections.

Table 4: 2024 Liquidated Damages and Corrective Action Plans Imposed on North Carolina Standard Plans					
2024 Liq. damages & CAPs	Call Center	Network Adequacy	Claims Processing NEMT & NEAT	Welcome Packets	Privacy & Security Conditions
AmeriHealth Caritas	$15,000	$245,000	CAP only		$5,000 (2 counts)
BCBS	$50,000	CAP only	CAP only		$102,500 (2 counts)
Carolina Complete	$15,000	$5,000	CAP only	CAP only	$1,500
United Healthcare	$10,000	$151,120	CAP only	$7,500	$49,000
WellCare	$35,000 (2 counts)	$190,000		$500	

Table 5: 2025 Liquidated Damages and Corrective Action Plans Imposed on North Carolina Standard Plans				
2025 Liq. damages & CAPs	Call Center	Claims Processing NEMT & NEAT	Welcome Packets	Privacy & Security Conditions
AmeriHealth Caritas	$90,000 (2 counts)		$7,500	$1,500
BCBS	$75,000 (2 counts)	$144,750	$7,500	$2,000 (2 counts)
Carolina Complete	$70,000 (2 counts)			$3,000 (2 counts)
United Healthcare	$95,000 (2 counts)			$1,000
WellCare	$75,000 (2 counts)			