CCME

External Quality Review

2018 ANNUAL SUMMARY REPORT

Submitted: May 20, 2019

Prepared on behalf of the
North Carolina Department of
Health and Human Services,
Division of Medical Assistance

2018 EQR Annual Summary Report

EXECUTIVE SUMMARY

The *42 Code of Federal Regulations (CFR) § 438.350* requires each state that contracts with Managed Care Organizations (MCOs) or Prepaid Inpatient Health Plans (PIHPs) to perform an annual External Quality Review (EQR). To comply with this regulation, the North Carolina Department of Health and Human Services' (NC DHHS) Division of NC Medicaid (formerly the Division of Medical Assistance, or DMA) contracted with The Carolinas Center for Medical Excellence (CCME), an External Quality Review Organization, to conduct the annual review of the PIHPs participating in North Carolina's Behavioral Health Managed Care initiative.

The findings discussed in this report are based on the External Quality Review (EQR) activities conducted during 2018 and include a summary of the mandatory activities:

- The PIHP's compliance with federal and state requirements
- Validation of the Performance Measures collected and reported
- Validation of Performance Improvement Projects conducted by each PIHP

In addition to the federally mandated activities, CCME conducted the child and adult versions of the *Experience of Care and Health Outcomes* (ECHO™) *Survey for Managed Behavioral Healthcare Organizations; the Provider Satisfaction Survey,* Encounter data validation; and semi-annual audits of each PIHP.

A. Mandatory Activities

Compliance with Federal and State Specified Requirements

CCME evaluated each PIHP's compliance with state and federal requirements using the Centers for Medicare & Medicaid Services' (CMS) *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations* and CCME's EQR standards. This review focused on administrative functions, committee minutes, enrollee and provider demographics, enrollee and provider educational materials, the quality improvement and medical management programs, program integrity, a file review of service authorization decisions and appeals, care coordination, credentialing, and grievances. The EQR standards used to determine the PIHP's compliance are included as *Attachment 1, External Quality Review Standards*.

Validation of Performance Measures

CCME validated the Performance Measures NC Medicaid selected for each PIHP following CMS' EQR *Protocol 2: Validation of Performance Measures Reported by the Managed Care Organization (MCO), Version 2.0 (September 2012)*. The measures validated are included in the *Table 1* and *Table 2*.

Table 1: (b) Waiver Performance Measures

(b) WAIVER MEASURES	
A.1. Readmission Rates for Mental Health	D.1. Mental Health Utilization - Inpatient Discharges and Average Length of Stay
A.2. Readmission Rates for Substance Abuse	D.2. Mental Health Utilization
A.3. Follow-up After Hospitalization for Mental Illness	D.3. Identification of Alcohol and other Drug Services
A.4. Follow-up After Hospitalization for Substance Abuse	D.4. Substance Abuse Penetration Rates
B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment	D.5. Mental Health Penetration Rates

Table 2: (c) Waiver Performance Measures

(c) WAIVER MEASURES	
Proportion of Level of Care evaluations completed at least annually for enrolled participants	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals
Proportion of Level of Care evaluations completed using approved processes and instrument	Proportion of Individual Support Plans that address identified health and safety risk factors
Proportion of New Level of Care evaluations completed using approved processes and instrument	Percentage of participants reporting that their Individual Support Plan has the services that they need
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	Proportion of individuals for whom an annual ISP and/or needed updates took place
Proportion of monitored Innovations providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame	Proportion of new Waiver participants who are receiving services according to their ISP within 45 days of ISP approval

Validation of Performance Improvement Projects

CCME validated a total of 24 Performance Improvement Projects (PIPs) across all of the PIHPs to confirm the projects were designed, conducted and reported in a methodologically sound manner consistent with the *CMS protocol*. Each PIHP chose various topics aimed at improving the clinical and non-clinical services provided to their Medicaid enrollees.

B. Process

The EQR for each PIHP was conducted in two parts:

1. The first was a Desk Review of materials and documents requested from each PIHP. *Attachment 2, Desk Materials Request*, contains an example of the requested materials.
2. The second part was an Onsite visit at each PIHP's office, which focused on areas not covered in the Desk Review or needing further clarification. Onsite activities included an entrance conference, additional document review, and interviews with the PIHPs' administration and staff. At the conclusion of each visit, CCME conducted an exit conference to discuss preliminary evaluation results and address any areas of concern.

Table 3 displays the dates of the EQRs conducted for each PIHP.

Table 3: External Quality Review Onsite Dates

PIHP	2018 EQR
Alliance Behavioral Healthcare (Alliance)	March 6 - March 7, 2019
Cardinal Innovations Healthcare Solutions (Cardinal)	January 23 - January 24, 2019
Eastpointe	November 14 - November 15, 2018
Partners Behavioral Health Management (Partners)	October 10 - October 11, 2018
Sandhills Center (Sandhills)	August 29 - August 30, 2018
Vaya Health (Vaya)	October 23 - October 24, 2018
Trillium Health Resources (Trillium)	May 30 - May 31, 2018

C. Overall Scores

To objectively compare the PIHPs for the current EQR, CCME applied a numerical score (points) to each standard's rating within a section to derive the overall score (percentage) for each PIHP. The overall score was calculated based on the following method:

3. Points are assigned to each rating ("Met" = 2 points and "Partially Met" = 1 point), excluding "Not Evaluated" and "Not Applicable" ratings from the calculation.

4. Each PIHP's total points are calculated by adding the earned points together.

5. The overall score (percentage) for each PIHP is calculated by dividing each of the PIHPs' total points by the total possible points (numbers of standards evaluated x 2 points).

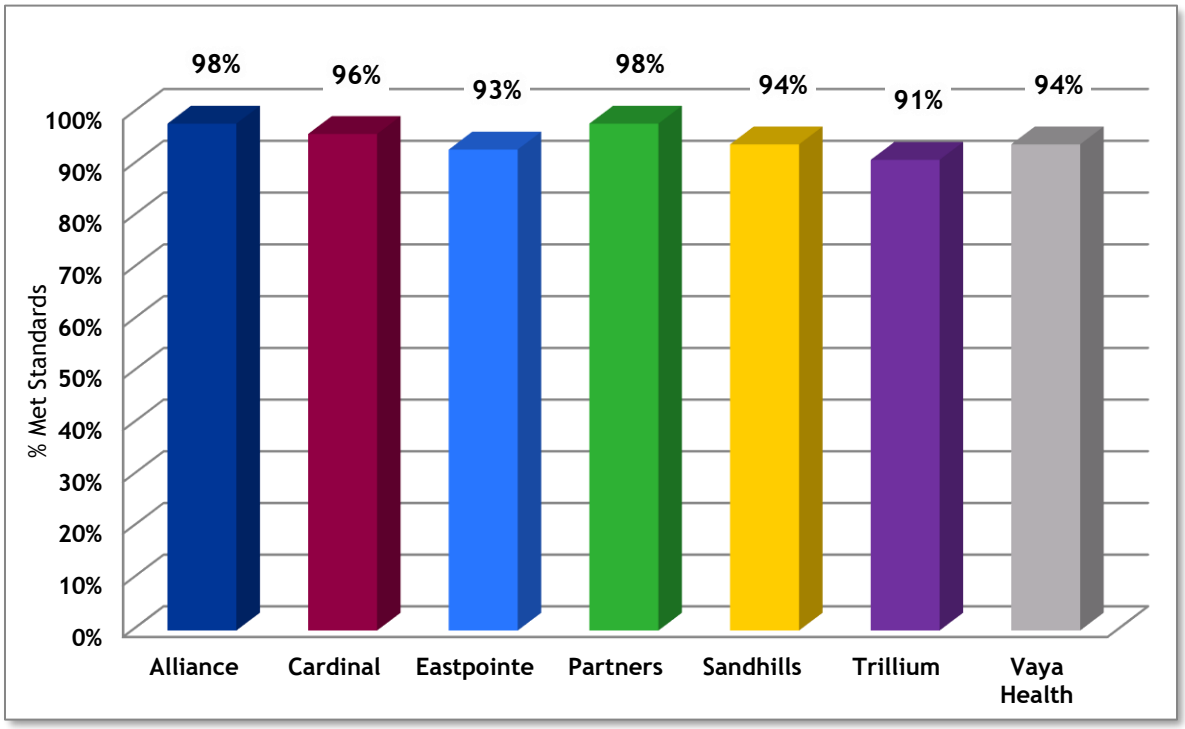
Table 4 illustrates the Overall Scores for each PIHP.

Table 4: Overall Scores for PIHPs

PIHP	Overall Score
Alliance	99%
Cardinal	98%
Eastpointe	96%
Partners	99%
Sandhills	97%
Trillium	95%
Vaya	96%

Figure 1 illustrates the percentage of "Met" standards each PIHP achieved during the 2018 EQRs.

Figure 1: Percentage of Met Standards



D. Overall Findings

Administration

Administrative functions of each PIHP were reviewed for the 2018 EQR. This involved a thorough examination of each PIHP's policies and procedures, organizational structure, confidentiality practices, and information systems capabilities. Overall, PIHPs showed improvement from the previous year's EQR administrative standards scores in the areas of policies and procedure management, organizational structure, and confidentiality practices. These improvements can be attributed to the PIHPs' efforts to successfully implement Corrective Action Plans and recommendations from the 2017 EQR.

Information Systems Capabilities Assessment

Each PIHP had a composite score of 90% or above with three out of the seven PIHPs scoring 95% on their ISCA review. No PIHP received a determination of "Not Met" on any review element. One area of weakness persists across all seven PIHPs and is related to the capturing, storing, and transmission to NC TRACKS of all diagnosis codes required in Encounter data.

Provider Services

The CCME review of Provider Services is composed of Credentialing and Recredentialing, and Network Adequacy (including Provider Accessibility, Provider Education, Clinical Practice Guidelines for Behavioral Health Management, Continuity of Care, and Practitioner Medical Records). The 2018 Provider Services EQR included 68 standards, compared to 67 standards in 2017. In the 2018 EQR, each PIHP met 52 of the 68 standards (76%), compared to 50 of the 67 standards (75%) in the 2017 EQR. A review of individual standards more accurately reflects the improvement by the PIHPs. For example, in the 2018 Provider Services EQR, only six standards had any PIHP with a score of "Not Met," as opposed to the 2017 EQR, when there were 10 standards with at least one PIHP with a score of "Not Met." Five PIHPs scored 91% or above in the 2017 Provider Services EQR, and, in the 2018 Provider Services EQR, six PIHPs scored 93% or above, with one PIHP scoring 100%. Five (Alliance, Eastpointe, Partners, Trillium, and Vaya) of the seven PIHPs improved their overall scores in the 2018 EQR, with one PIHP (Cardinal) maintaining the same score as 2017. The score of one PIHP (Sandhills) dropped slightly from the 2017 EQR (99%) to the 2018 EQR (97%).

The PIHPs improved their scores on most items in the credentialing/recredentialing file review. The most commonly-occurring issue in the files was the failure to query the *State Exclusion List*), which was added in the *DMA Contract* effective July 1, 2017. CCME recommends the PIHPs conduct a careful review of the newly-issued contract and any amendments each year, to ensure they are complying with new requirements.

In the area of network adequacy, despite some improvements in access, most PIHPs continue to fail to meet choice and distance standards for opioid treatment. Services for opioid treatment and services such as Substance Abuse-Comprehensive Outpatient Treatment (SACOT) present a special challenge for PIHPs serving sparsely-populated rural areas, or catchment areas covering many square miles. PIHPs not meeting access standards are able to file Exception Request with NC Medicaid, while continuing to seek solutions for meeting gaps.

Enrollee Services

For Enrollee Services, CCME reviewed relevant policies and procedures, enrollee rights information, enrollee educational materials, the member handbooks, the provider manuals, Call Center training materials, and the PIHP websites.

The PIHP member handbooks and websites are generally thorough and provide helpful information and resources to members and family members.

The overall score for the 2018 EQR, when compared to the 2017 EQR, revealed improvement for six PIHPs, and the same score for one PIHP. Alliance, Cardinal, Partners,

Sandhills, Trillium, and Vaya increased scores in 2018 over the 2017 EQR. Eastpointe remained the same at 89%.

The scores for the 2018 EQR for Enrollee Services range from 89% "Met" for Eastpointe and Trillium, to 94% "Met" for Alliance, Cardinal, Partners, Sandhills and Vaya.

Quality Improvement

CCME assessed each PIHP's Quality Improvement (QI) Program description, policies, committees that act on QI activities, provider QI participation, annual program evaluation, Performance Measures (PMs), and Performance Improvement Projects (PIPs). The 2018 EQR reveals each PIHP has a QI Program designed to monitor and improve the behavioral health outcomes and services their enrollees receive.

The overall score for the 2018 EQR, when compared to the 2017 EQR, revealed improvement in four PIHPs, the same score for two PIHPs, and a decrease for one PIHP. Alliance, Cardinal, Trillium, and Vaya increased scores in 2018 over the 2017 year. Partners and Sandhills remained the same. Eastpointe has a decrease.

The scores for the 2018 EQR for QI range from 76% "Met" for Eastpointe, to 100% "Met" for Alliance and Trillium.

Performance Measure Validation

The (b) Waiver measures validation scores were "Fully Compliant" for each PIHP with an average validation score of 100% across the 10 measures.

Ten (c) Waiver measures were validated for each PIHP. The average validation score was 100% for each PIHP.

Performance Improvement Project Validation

Alliance, Cardinal, Partners, Sandhills, and Trillium received all "High Confidence" validation decisions for their submitted PIPs. Eastpointe receive "High Confidence" in one PIP, "Confidence" in one PIP, and "Low Confidence" in two PIPs. Vaya received "High Confidence" in two PIPs and "Confidence" in two PIPs.

Utilization Management

The Utilization Management (UM) functions of CCME's EQR includes the review of the UM, Care Coordination and Transition to Community Living Initiative (TCLI) functions. The UM scores ranged from 100% for Partners and Alliance to 91% for Sandhills.

The overall UM score for three PIHPs (Vaya, Trillium and Sandhills) decreased during the 2018 EQR. The scores for Partners and Eastpointe increased while the scores for Alliance

and Cardinal were maintained from the previous year's EQR. The decreased UM scores across the PIHPs related mostly to the "Partially Met" standards addressing the TCLI program and the implementation of PIHP policies and procedures as evidenced in the Care Coordination files.

Grievances and Appeals

CCME's Grievances and Appeals EQR included evaluation of Grievance and Appeal policies and procedures, notification templates, provider manuals, member handbooks, and job descriptions. In addition, an extensive review of enrollee's grievance and appeal files was completed for each PIHP.

PIHPs in 2017 averaged an 89% score of "Met" Grievance and Appeal standards. In 2018, there was a 5% decrease in "Met" scores by the PIHPs. The percentage of "Met" standards decreased for Cardinal, Eastpointe, Trillium and Vaya. Alliance and Sandhills scored the same as last year and Partners increased their percentage of "Met" scores when compared to the 2017 EQR for Grievances and Appeals.

For Grievances, most of the PIHPs received Recommendations or Corrective Action to mitigate the disconnect within PIHP documentation and practice around the terms "grievance", "complaint" and "concern". For Appeals, the primary concerns that surfaced were around documentation and the processing of extended and expedited appeals.

Delegation

CCME's EQR of Delegation functions includes a review of the *Delegation Program Description*, relevant policies and procedures, the submitted Delegate List, Delegation Contracts, and Delegation Monitoring materials. There are two scored standards in the Delegation EQR. In the 2018 Delegation EQR, five of the seven PIHPs "Met" both standards. Sandhills scored "Partially Met" on the first standard, due to having a signed Scope of Work, rather than a Delegation Agreement and Business Associate Agreement (BAA), with one identified delegate. Eastpointe scored "Partially Met" on the second standard, due to failing to develop monitoring tools and monitor each Medical Director delegate, as indicated in the 2017 EQR. With the noted exception, the PIHPs are conducting regular monitoring of delegates, with some PIHPs meeting regularly with delegates to review delegate performance.

Program Integrity

The Program Integrity EQR resulted in five of the seven PIHPs receiving an overall score of 100% on their PI review. This compares favorably with the prior year's results where only three out of seven PIHPs had a compliant review. Six of the seven PIHPs scored 100% on the case file review section of the evaluation. This is a decrease from the prior year,

in which all seven PIHPs scored 100%. The deficient scores by two PIHPS resulted from the absence of required language from policies and/or procedures and the absence of required elements within the PI files. Compared to the previous year, however, the PIHPs have made progress in using data mining to identify potential cases of fraud.

Financial Services

Financial services of each PIHP were reviewed for the 2018 EQR. Financial Desk Materials were reviewed prior to the Onsite interview. PIHPs made improvements in process documentation, reconciliations, and updating of policies and procedures. Further improvements can be made in timely filing of reports, record retention standards, and references to standards in policy and procedure documentation.

E. Optional Activities

Encounter Data Validation

The results of the Encounter data validation found that only Sandhills' Encounter data submitted to NC Medicaid was complete and accurate. However, minor issues were noted with both Institutional and Professional encounters due to missing additional diagnosis codes. For the next review period, HMS recommends the PIHPs review NCTracks Encounter data to look at Encounters that pass front-end edits and are adjudicated to either a paid or denied status.

Semi-Annual Audits

PIHP Medicaid data from two six-month time periods in 2017 and 2018 is analyzed in this audit process. This analysis includes a claims audit, review of timeliness of provider payments, HIPAA Transaction Capability and Compliance, and financial solvency of each PIHP. In both Semi-Annual Audits, each PIHP was shown to be compliant in all categories analyzed.

Consumer Satisfaction Survey

The *2018 ECHO Consumer Satisfaction Surveys* were administered to assess consumer perceptions of the seven PIHPs. From each PIHP, 571 adult and 571 child enrollees were surveyed. Both the adult and child surveys showed there was variation in the PIHPs' scoring in the lowest and highest percentage categories and there was no consistency in low and high percentage performance.

Regarding overall rating by adult enrollees of counseling and treatment, Trillium's enrollees reported the highest satisfaction. Sandhills' enrollees reported the lowest satisfaction. Partners' adult enrollees gave the highest scores on two of the five composite items and four of the nine Care Coordination Items.

Regarding overall rating of counseling and treatment, Vaya's enrollees reported the highest satisfaction. Partners' enrollees reported the lowest satisfaction. Of the nine Care Coordination items, Sandhills received the highest scores on six of the nine items but lowest on two of the composite items. Vaya scored positively on six of the ten single item questions.

Tables within the expanded narrative of this report provide additional specific areas in which each PIHP may improve performance.

Provider Satisfaction Survey

The *2018 DHHS Provider Satisfaction Survey* was administered with the goal of assessing provider perceptions of the PIHPs. The seven participating PIHPs contributed a total 3,979 providers for inclusion in the survey.

Overall, provider satisfaction has increased from 2017 to 2018. In this year's results, providers are less satisfied than last year on six items, but more satisfied than last year on 17 of the 23 items. In 2018, providers reported being the most satisfied regarding accuracy of the authorizations issued. They are most concerned about the item "LME-MCO staff are referring consumers whose clinical needs match the service(s) my practice/agency provides." The question with the largest gain from a year ago involved the providers feeling satisfied regarding the timeliness and accuracy of claims processing by the PIHP. The largest decrease in satisfaction was for the item regarding easy access to LME-MCO staff for information, referrals, and scheduling of appointments.

METHODOLOGY

The EQR process was based on CMS protocols. The review focused on the three federally mandated EQR activities, which are compliance determination, PM validation, and PIP validation, as well as these optional activities: Encounter data validation; semi-annual audits; consumer satisfaction surveys; and provider satisfaction surveys. IPRO also conducted an Information System Capabilities Assessment (ISCA) audit and Medicaid Program Integrity Review.

CCME sent notification to the respective PIHP that the annual EQR was being initiated. This notification included the following:

- Materials requested for Desk Review
- Draft Onsite agenda
- PIHP EQR standards

CCME extended an invitation to each PIHP to participate in a pre-Onsite conference call with CCME and NC Medicaid for purposes of offering an opportunity to seek clarification on the review process and ask questions regarding any of the requested Desk Materials.

Each PIHP's review consisted of two segments:

1. The first was a Desk Review of materials and documents received from the PIHPs (see *Attachment 2*). These materials addressed or included administrative functions, committee minutes, member and provider demographics and educational materials, and the QI and medical management programs. The Desk Review also included credentialing, grievance, utilization, care coordination, case management, and appeal files.
2. The second segment was a two-day Onsite review conducted at the PIHPs' designated corporate offices in North Carolina. These visits focused on areas not covered in the Desk Review and areas needing clarification. CCME's Onsite activities included entrance and exit conferences as well as interviews with PIHP administration and staff. All interested parties were invited to the entrance and exit conferences. Some of the PIHPs' scores were affected by delays or failure to submit the requested documentation.

FINDINGS

The EQR findings are summarized in the remainder of this report and are based on the regulations set forth in 42 CFR § 438.358 and the contract requirements between the PIHP and NC Medicaid. Strengths, Weaknesses, Corrective Action Items, and Recommendations are identified where applicable.

During each PIHP's EQR, review standards were identified as meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), "Not Applicable," or "Not Evaluated." The results were recorded on a tabular spreadsheet, which was included in each PIHP's individual annual technical report that was submitted after their annual EQR.

***Note*:** Each section (e.g., Administration, Provider Services, etc.) within Findings provides a summary of the PIHP's Strengths, Weaknesses, and CCME Recommendations. These summaries are not inclusive for each PIHP, and each PIHP'S EQR report provides more details. In addition, each Findings section contains bar graphs that provide an overview of the PIHP's performance, representing the percentage of standards that received a "Met" score for the current year. There are also tables that present comparative PIHPs data.

A. Administration

CCME's Administrative review of each Prepaid Inpatient Health Plan (PIHP) for the 2017 External Quality Review (EQR) involved a thorough examination of each PIHP's policies and procedures, organizational structure, confidentiality practices, information systems, and Encounter data capture and reporting. Notable overall PIHP improvements from last year's EQR administrative standards scores related to policies and procedure management, organizational structure, and confidentiality practices. These improvements can be attributed to the PIHPs' efforts to successfully implement Corrective Actions and/or CCME Recommendations.

Each PIHP met the Administrative standards relating to policies and procedures, organizational staffing, and confidentiality practices. Trends within these reviews were primarily around PIHP Organizational Charts, policies and procedure management, and training of new staff on confidentiality. CCME provided Recommendations to address these concerns.

Policies and Procedures

Overall, PIHP policies and procedures were better organized than the previous year and all had evidence of annual review. CCME recommended Sandhills streamline their policy and procedure set, as they struggle to accurately and timely update and manage their policies and procedures. Sandhills' policies and procedures contain out-of-date information and can contradict one another. As a comparison, no other PIHP has more than 350 policies and procedures. The average number by the other PIHPs is 242. Sandhills has 732 policies and procedures. Conversely, Vaya made great progress in streamlining their policy and procedure set and addressed concerns from the past two EQRs. Vaya policies and procedures this year were in final, approved format, were all accounted for, and had evidence of annual review.

Organizational Staffing

DMA Contract requires involvement by the Medical Director in specific departments such as Credentialing, Utilization Management, and Quality Assurance. PIHPs typically have multiple medical staff to oversee all these required functions. CCME reviewed each PIHP's Medical Staff job descriptions, Organizational Chart, and conducted interviews with staff to learn the essential functions of all medical staff. Typically, the PIHPs' Organizational Charts did not accurately reflect the job functions as described by staff and or the job descriptions. CCME recommended to Partners, Vaya, Eastpointe, Cardinal, and Alliance to bolster the information within their Organizational Charts around the departmental oversight of Medical Directors, Chief Medical Officers (CMOs), and/or Associate Medical Directors (AMDs).

Confidentiality

Each PIHP had adequate policies and procedures in place to address confidentiality. Except for Vaya, each PIHP trains new staff on confidentiality within the first two days of employment and prior to exposure of Protected Health Information (PHI). During this year's Onsite, Vaya staff explained they generally train staff "within 30 days" but could not demonstrate this was prior to new staff being exposed to PHI. CCME has recommended to Vaya for the past two EQRs that this practice be addressed in Vaya's procedures and it was again recommended this year.

Information Systems Capabilities Assessment

The review of the PIHPs' systems capabilities involved off-site review of the PIHPs' responses to the CMS standard ISCA questionnaire, an Onsite interview with key staff, and live demonstration during the Onsite of the PIHPs' enrollment, claims, and reporting systems. Specific areas of focus under review include enrollment systems, claims systems, reporting data bases, and Encounter data submission.

At a high level, each PIHP had a composite score of 90% or above with three out of the seven PIHPs scoring 95% on their ISCA review. No PIHP received a determination of "Not Met" on any review element. This compares favorably with the prior year's results where two out of seven plans were noncompliant with the standard relating to capabilities of submitting required Encounter data elements to NC Medicaid. When compared to the previous year, there was also notable improvement by some PIHPs to reduce their claim denial rate.

One area of weakness persists across all seven PIHPs and is related to the capturing, storing, and transmission to NC TRACKS of all diagnosis codes required in Encounter data. The level of deficiency varies by PIHP. Some PIHPs capture and store the required codes but do not transmit all of them to NCTracks. Other PIHPs are not yet storing all codes within their own claims databases.

The 2018 EQR of each PIHP's administration resulted in a range of "Met" scores between 90% and 95% on the standards in these areas.

Figure 2: Administration

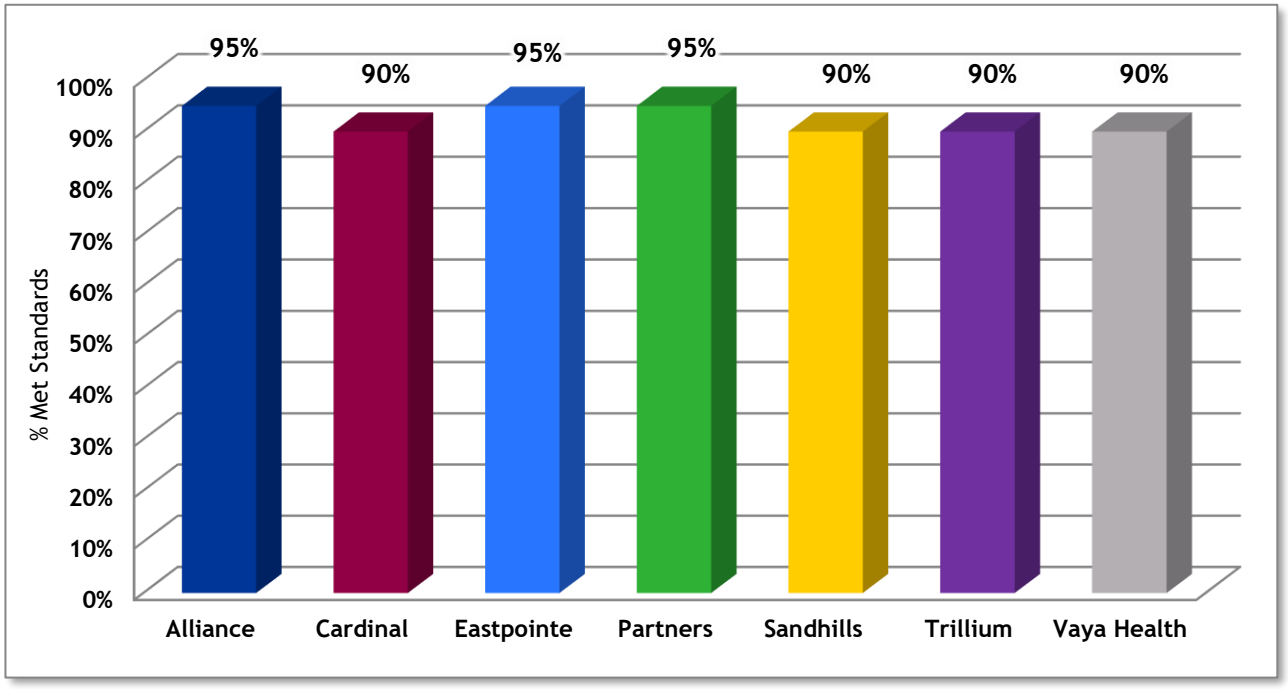


Table 5: Administration Comparative Data

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
I A. GENERAL APPROACH TO POLICIES AND PROCEDURES							
1. The PIHP has in place policies and procedures that impact the quality of care provided to enrollees, both directly and indirectly.	Met	Met	Met	Met	Met	Met	Met
I B. ORGANIZATIONAL CHART / STAFFING							
1. The PIHP's resources are sufficient to ensure that all health care products and services required by the State of North Carolina are provided to enrollees. At a minimum, this includes designated staff performing in the following roles:							

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
1.1 A full time administrator of day-to-day business activities;	Met	Met	Met	Met	Met	Met	Met
1.2 A physician licensed in the state where operations are based who serves as medical director, providing substantial oversight of the medical aspects of operation, including quality assurance activities;	Met	Met	Met	Met	Met	Met	Met
2. Operational relationships of PIHP staff are clearly delineated.	Met	Met	Met	Met	Met	Met	Met
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all PIHP staff positions.	Met	Met	Met	Met	Met	Met	Met
I C. CONFIDENTIALITY							
1. The PIHP formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
2. The PIHP provides HIPAA/confidentiality training to new employees and existing staff.	Met	Met	Met	Met	Met	Met	Met
I D. MANAGEMENT INFORMATION SYSTEMS							
1. Enrollment Systems							
1.1 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	Met	Met	Met	Met	Met	Met	Met
1.2 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
1.3 The MCO's enrollment system member screens store and track enrollment and demographic information.	Met	Met	Met	Met	Met	Met	Met
2. Claims System							
2.1 The MCO processes provider claims in an accurate and timely fashion.	Met	Met	Met	Met	Met	Met	Met
2.2 The MCO has processes and procedures in place to monitor review and audit claims staff.	Met	Met	Met	Met	Met	Met	Met
2.3 The MCO has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 diagnosis codes received on an 837 Institutional and 837 Professional file, capabilities of receiving and storing ICD-10 procedure codes on an 837 Institutional file.	Met	Partially Met	Met	Met	Partially Met	Partially Met	Partially Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
2.4 The MCO's claim system screens store and track claim information and claim adjudication/payment information.	Met	Met	Met	Met	Met	Met	Met
3. Reporting							
3.1 The MCO's data repository captures all enrollment and claims information for internal and regulatory reporting.	Met	Met	Met	Met	Met	Met	Met
3.2 The MCO has processes in place to back up the enrollment and claims data repositories.	Met	Met	Met	Met	Met	Met	Met
4. Encounter Data Submission							
4.1 The MCO has the capabilities in place to submit the State required data elements to DMA on the encounter data submission.	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met
4.2 The MCO has the capability to identify, reconcile and track the encounter data submitted to DMA.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
4.3 MCO has policies and procedures in place to reconcile and resubmit encounter data denied by DMA.	Met	Met	Met	Met	Met	Met	Met
4.4 The MCO has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to DMA	Met	Met	Met	Met	Met	Met	Met

Strengths

- All PIHPs "Met" the standards related to policies and procedures, organizational staffing, and confidentiality practices.
- Most PIHPs ensure new staff are trained on confidentiality prior to their exposure to PHI.
- Most PIHPs demonstrated adequate policy and procedure management.
- PIHP Enrollment, Claims and IT Staff are knowledgeable about their processes and are dedicated to improving Encounter data submissions and reducing the number of denials.
- PIHPs showed improved NCTracks Encounter acceptance rates since last year's EQR.
- PIHPs generally have effective data reconciliation processes and reports.

Weaknesses

- It is rare that Medical staff oversight (i.e., Medical Directors, CMOs, AMDs) is accurately reflected in the PIHP's Organizational Chart.
- PIHPs do not consistently capture, store and report procedure and diagnosis codes for all Professional and Institutional encounters. This is especially the case for secondary diagnosis codes.
- Several PIHPs still have high volumes of denied and uncorrected claims in NCTracks.

Recommendations

- PIHPs should ensure Medical Staff oversight and functions are accurately reflected on their Organizational Charts.
- PIHPs should update their Encounter data submission process to allow for all ICD-10 CM diagnosis codes submitted on an Institutional and Professional 837 HIPAA file submitted to NCTracks. Twenty-five ICD-10 diagnosis codes are the maximum number of diagnosis codes that can be submitted on an 837I, and the maximum number that is captured by NCTracks. NCTracks can capture as many as 12 diagnosis codes for Professional claims.
- PIHPs with issues related to denials should continue working with NC Medicaid to resolve the provider taxonomy code and procedure code mismatches to increase Encounter data acceptance rates.

B. Provider Services

The CCME review of Provider Services included relevant policies and procedures, provider training and educational materials, provider manuals, provider network information, clinical practice guidelines, annual *Network Adequacy and Accessibility Analysis (Gaps Analysis)* reports, access and availability information, and the Prepaid Inpatient Health Plan (PIHP) websites. The credentialing and recredentialing reviews included a file review as well as a review of Credentialing Committee minutes and meeting materials.

One new standard ("The PIHP has a process for handling abandoned records, as required by the contract") was added in the 2018 Provider Services review. The 2018 EQR revealed a slight improvement over 2017 in the percentage of standards with "Met" scores. In the 2018 Provider Services review, 16 of the 68 standards (24%) included at least one PIHP with a score of "Partially Met" or "Not Met". In the 2017 Provider Services review, 17 of the 67 standards (25%) included at least one PIHP with a score of "Partially Met" or "Not Met".

The improvement is more evident when comparing the number of standards for which two or more PIHPs scored less than "Met". In the 2017 Provider Services review, two or more PIHPs scored "Partially Met" or "Not Met" on 11 standards, compared to the 2018 Provider Services review, where two or more PIHPs scored "Partially Met" or "Not Met" on only three standards. Though there were 10 standards for which at least one PIHP scored "Not Met" in the 2017 Provider Services review, there were only six standards for which at least one PIHP scored "Not Met" in the 2018 Provider Services review.

Each PIHP has policies and procedures for the credentialing/recredentialing of providers. Some PIHPs also have a *Credentialing Program Description*, and/or a *Credentialing Plan*, and /or *Credentialing Bylaws*. At each PIHP, the Chief Medical Officer (CMO) approves

"clean" applications, and a Credentialing Committee, composed of PIHP employees and network providers, reviews other provider applications and makes the credentialing decisions. Credentialing Committees at all PIHPs met regularly with a quorum present at the meetings.

The credentialing and recredentialing files were organized and contained appropriate information. The most commonly-occurring item for which the PIHPs received a score of "Partially Met" in the credentialing and recredentialing file review for the 2018 EQR was in the area of "query for state sanctions". Four of the seven PIHPs received a score of "Partially Met" for this standard in both credentialing and recredentialing because they failed to conduct the query of *The North Carolina Medicaid Provider Termination and Exclusion list* (known as the *State Exclusion List*), as required by *DMA Contract Attachment B, Sections 1.14.4* and *7.6.4.* It is of note that this query was added as a requirement in the *DMA Contract* that was effective July 1, 2017, and the PIHPs that did not conduct the query reported they had overlooked the requirement.

During the period covered by the current EQR, the annual gaps and needs analysis process and the required report template were undergoing revision, resulting in a delayed submission deadline. The revised report, named the *Community Mental Health, Substance Use and Developmental Disabilities Services Network Adequacy and Accessibility Analysis Requirements for North Carolina LME/MCOs,* was due by September 21, 2018. Because of the report revisions and delayed submission due date, most PIHPs did not have a new report for review during the EQR. Onsite discussion with each PIHP included a review of the status of previously-identified gaps and progress towards meeting the choice and access requirements, as well any newly-identified gaps and needs.

The PIHPs create a Network Development Plan to address the identified gaps and needs. The most commonly identified gap/need continues to be related to opioid treatment. When PIHPs do not meet choice and access standards, they can submit an *Exception Request* to NC Medicaid. CCME recommends PIHPs continue to work to expand services to meet identified gaps.

The overall percentage of "Met" scores in the Provider Services area improved from 2017 to 2018 for five PIHPs (Alliance, Eastpointe, Partners, Trillium, Vaya). Eastpointe achieved the greatest improvement (81% in 2017 and 93% in 2018). The Provider Services score (96%) for one PIHP (Cardinal) was unchanged from 2017 to 2018. One PIHP (Sandhills) experienced a slight decrease in their Provider Services score from 2017 (99%) to 2018 (97%). Six PIHPs (Alliance, Cardinal, Eastpointe, Partners, Sandhills and Vaya) scored 93% or above. One PIHP (Alliance) achieved a score of 100% in the Provider Services EQR in 2018.

Figure 3 and *Table 6* that follow provide an overview of the PIHPs' performance in the Provider Services section in the 2018 EQR.

Figure 3: Provider Services

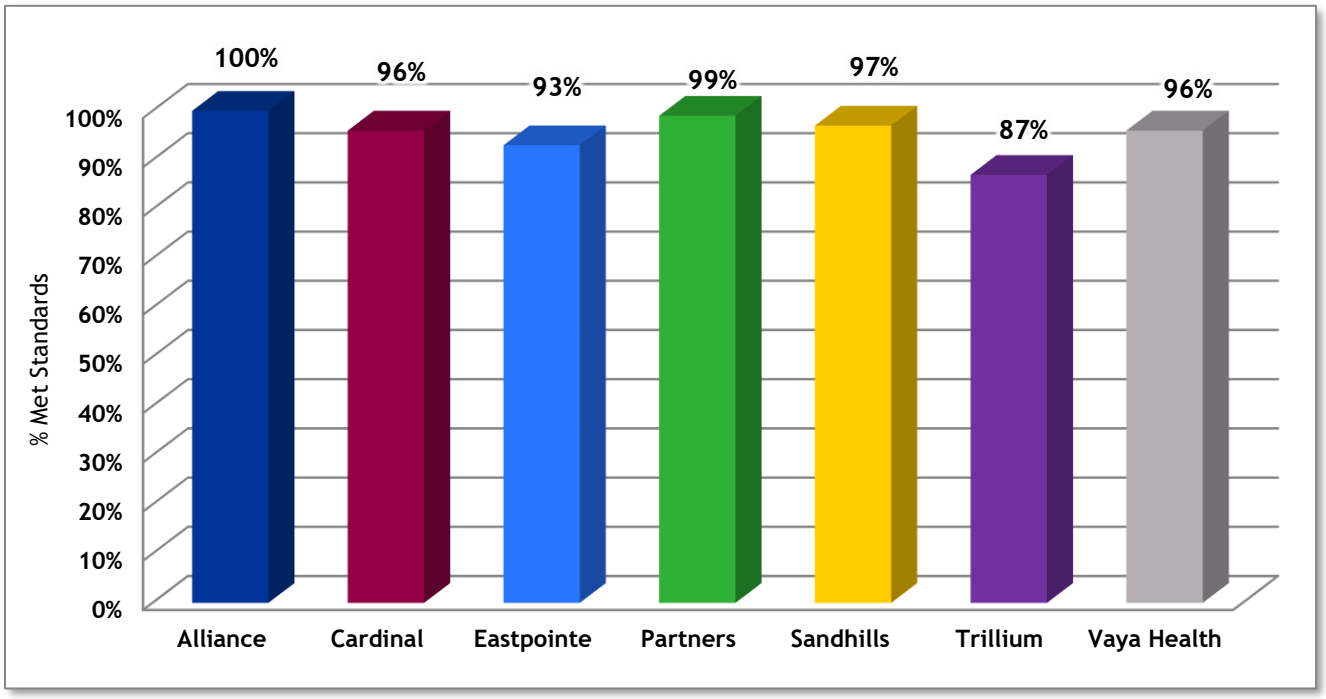


Table 6: Provider Services Comparative Data

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
I A. CREDENTIALING							
1. The PIHP formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements	Met	Met	Met	Met	Met	Met	Met
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the PIHP	Met	Met	Partially Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
3.The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of provider	Met	Met	Met	Met	Met	Met	Met
3.1 Verification of information on the applicant including;							
3.1.1 Insurance requirements;	Met	Met	Met	Met	Met	Met	Met
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees	Met	Met	Met	Met	Met	Met	Met
3.1.3 Valid DEA certificate; and/or CDS certificate	Met	Met	Not Met	Met	Met	Met	Met
3.1.4 Professional education and training, or board certificate if claimed by the applicant	Met	Met	Met	Met	Met	Met	Met
3.1.5 Work History	Met	Met	Met	Met	Met	Met	Met
3.1.6 Malpractice claims history	Met	Met	Met	Met	Met	Met	Met
3.1.7 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
3.1.8 Query of the National Practitioner Data Bank (NPDB)	Met	Met	Met	Met	Met	Met	Met
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	Met	Met	Partially Met	Met	Partially Met	**Partially Met**	**Partially Met**
3.1.10 Query for the System for Awards Management (SAM)	Met	Met	Met	Met	Met	Met	Met
3.1.11 Query for Medicare and/or Medicaid sanctions Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE)	Met	Met	Met	Met	Met	Met	Met
3.1.12 Query of the Social Security Administration's Death Master File	Met	Met	Met	Met	Met	Met	Met
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES)	Met	Partially Met	Met	Met	Met	Met	Met
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility	Met	Met	Met	Met	Met	Met	Met
3.1.15 Ownership Disclosure is addressed	Met	Met	Met	Met	Met	Met	Met
3.1.16 Criminal background Check	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.	Met	Met	Met	Met	Met	Not Met	Met
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days	Met	Met	Met	Met	Met	Met	Met
II A RECREDENTIALING							
4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies	Met	Met	Met	Met	Met	Met	Met
4.1 Recredentialing every three years	Met	Met	Met	Met	Met	Not Met	Met
4.2 Verification of information on the applicant, including:							
4.2.1 Insurance Requirements	Met	Met	Met	Met	Met	Met	Met
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees	Met	Met	Met	Met	Met	Partially Met	Met
4.2.3 Valid DEA certificate; and/or CDS certificate	Met	Met	Met	Met	Met	Met	Met
4.2.4 Board certificate if claimed by the applicant	Met	Met	Met	Met	Met	Met	Met
4.2.5 Malpractice claims since the previous credentialing event	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
4.2.6 Practitioner attestation statement	Met	Met	Met	Met	Met	Met	Met
4.2.7 Requery of the National Practitioner Data Bank (NPDB)	Met	Met	Met	Met	Met	Met	Met
4.2.8 Requery for state sanctions and/or license limitations (State Board of Examiners for specific discipline) since the previous credentialing event	Met	Met	Partially Met	Met	Partially Met	Partially Met	Partially Met
4.2.9 Requery of the SAM	Met	Met	Met	Met	Met	Met	Met
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event	Met	Met	Met	Met	Met	Met	Met
4.2.11 Query of the Social Security Administration's Death Master File	Met	Partially Met	Met	Met	Met	Met	Met
4.2.12 Query of the NPPES	Met	Partially Met	Met	Met	Met	Met	Met
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility	Met	Met	Met	Met	Met	Not Met	Met
4.2.14 Ownership Disclosure is addressed	Met	Met	Met	Met	Met	Met	Met
4.3 Site reassessment if the provider has had quality issues.	Met	Met	Met	Met	Met	Met	Met
4.4 Review of practitioner profiling activities	Met	Met	Met	Met	Met	Not Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
5. The PIHP formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the PIHP for serious quality of care or service issues	Met	Met	Met	Met	Met	Met	Met
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities	Met	Met	Met	Met	Met	Met	Met
II B. ADEQUACY OF THE PROVIDER NETWORK							
1. The PIHP maintains a network of providers that is sufficient to meet the health care needs of enrollees and is consistent with contract requirements	Met	Met	Met	Met	Met	Met	Met
1.1 Enrollees have a Provider location within a 30 – mile distance of 30 minutes' drive time of their residence. Rural areas are 45 miles and 45 minutes. Longer distances as approved by DMA are allowed for facility based or specialty providers.	Met	Met	Met	Met	Met	Met	Met
1.2 Enrollees have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the enrollee may utilize an out-of-network specialist with no benefit penalty	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
1.3 The sufficiency of the provider network in meeting enrollee demand is formally assessed at least annually	Met	Met	Met	Met	Met	Met	Met
1.4 Providers are available who can serve enrollees with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs	Met	Met	Met	Met	Met	Met	Met
1.5 The PIHP demonstrates significant efforts to increase the provider network when it is identified as not meeting enrollee demand	Met	Met	Met	Met	Met	Met	Met
2. Provider Accessibility							
2.1 The PIHP formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Met	Met	Partially Met	Met	Met	Partially Met	Met
II C. PROVIDER EDUCATION							
1. The PIHP formulates and acts within policies and procedures related to initial education of providers	Met	Met	Met	Met	Met	Met	Partially Met
2. Initial provider education includes:							
2.1 PIHP purpose and mission;	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
2.2 Clinical Practice Standards;	Met	Met	Met	Met	Met	Met	Met
2.3 Provider responsibilities;	Met	Met	Met	Met	Met	Met	Met
2.4 PIHP closed network requirements, including nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability.	Met	Met	Met	Met	Met	Met	Met
2.5 Access standards related to both appointments and wait times;	Met	Met	Met	Met	Met	Met	Met
2.6 Authorization, utilization review, and care management requirements;	Met	Met	Met	Met	Met	Met	Met
2.7 Care Coordination and discharge planning requirements;	Met	Met	Met	Met	Met	Met	Met
2.8 PIHP dispute resolution process;	Met	Met	Met	Met	Met	Met	Met
2.9 Complaint investigation and resolution procedures;	Met	Met	Met	Met	Met	Met	Met
2.10 Compensation and claims processing requirements, including required electronic formats, mandated timelines, and coordination of benefits requirements;	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
2.11 Enrollee rights and responsibilities;	Met	Met	Met	Met	Met	Not Met	Met
2.12 Provider program integrity requirements that include how to report suspected fraud, waste and abuse, training requirements as outlined in the False Claims Act, and other State and Federal requirements.	Met	Met	Met	Met	Met	Met	Met
3. The PIHP provides ongoing education to providers regarding changes and/or additions to its programs, practices, enrollee benefits, standards, policies and procedures.	Met	Met	Met	Met	Met	Met	Met
II D. CLINICAL PRACTICE GUIDELINES FOR BEHAVIORAL HEALTH MANAGEMENT							
1. The PIHP develops clinical practice guidelines for behavioral health management of its enrollees that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists	Met	Met	Met	Met	Met	Met	Met
2. The PIHP communicates the clinical practice guidelines for behavioral health management and the expectation that they will be followed for PIHP enrollees to providers	Met	Met	Met	Met	Met	Met	Met
II E. CONTINUITY OF CARE							
1. The PIHP monitors continuity and coordination of care between providers	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
II F. PRACTITIONER MEDICAL RECORDS							
1. The PIHP formulates policies and procedures outlining standards for acceptable documentation in the enrollee's medical records maintained by providers	Met	Met	Met	Met	Met	Met	Met
2. The PIHP monitors compliance with medical record documentation standards through formal periodic medical record audit and addresses any deficiencies with the providers	Met	Met	Met	Met	Met	Met	**Met**
3. The PIHP has a process for handling abandoned records, as required by the contract.	Met	Met	Met	Partially Met	Met	Met	Met

Strengths, Weaknesses, and Recommendations are not inclusive for each PIHP. More details were included in the Provider Services section of each PIHP's *2018 External Quality Review Report*. The following is a sample of findings.

Strengths

- The PIHP provider manuals provide enough information to assist providers.
- Several PIHPs have a separate toll-free number for providers.
- Credentialing/recredentialing files are well-organized and contain appropriate documentation, with a few exceptions.
- Each PIHP creates a Network Development Plan to address gaps and needs.
- Several PIHPs offer provider orientation and training materials via the PIHP website.

Weaknesses

- Some credentialing/recredentialing files submitted for Desk Review lacked required items, including, for example, proof of all required types of insurance, or a statement as to why specific insurance was required, as well as a statement from the provider agency verifying a practitioner was covered under the agency insurance, when that is

the case. The PIHPs provided some items in response to the Onsite Document Request List, and some items at the Onsite Review, but were sometimes unable to provide required items.

- The applications in some credentialing/recredentialing files were missing the Ownership Disclosure. This was more often the case for practitioners joining already-contracted agencies.
- The most commonly occurring omission from credentialing/recredentialing files was Primary Source Verification (PSV) of the query of the *State Exclusion List,* with four of the PIHPs acknowledging they had failed to complete the query.
- Examples of other PSVs that were not found in at least some of the credentialing/ recredentialing files are PSV of physician education when the physician is not board certified or does not have Educational Commission for Foreign Medical Graduates (ECFMG), PSV of all clinical licenses when a practitioner has more than one license, and the supervision contract for Licensed Psychological Associates (LPAs) or practitioners with an associate license (such as Licensed Clinical Social Worker-A or Licensed Professional Counselor-A).
- The policies and procedures of two PIHPs had inaccurate language regarding at least one of the timeframes for access to care required by *DMA Contract Attachment S* (2 hours for emergency care, 1 hour for life-threatening emergencies, and 14 calendar days for routine appointments).

Recommendations

- Ensure the credentialing and recredentialing files submitted for Desk Review are the complete files, including the proof of all types of insurance or a statement verifying why a specific insurance is not required, as well as a statement from the provider agency, verifying a practitioner is covered under the agency insurance, when that is the case.
- Verify that credentialing and recredentialing files include the Ownership Disclosure.
- Conduct required PSVs and retain the documentation in the credentialing/ recredentialing file.
- Ensure PIHP materials, including policies and procedures, contain the correct timeframes for access to care, as required by *DMA Contract Attachment S*.

C. Enrollee Services

CCME's review of Enrollee Services included relevant policies and procedures, member rights information, member educational materials, the member handbooks, the provider

manuals, Call Center training materials, and the Prepaid Inpatient Health Plan (PIHP) websites.

The PIHP member handbooks and websites are generally thorough and provide helpful information and resources to members and family members.

The overall score for the 2018 EQR, when compared to the 2017 External Quality Review (EQR), revealed improvement for six PIHPs, and the same score for one PIHP. Alliance, Cardinal, Partners, Sandhills, Trillium, and Vaya increased scores in 2018 over the 2017 review. Eastpointe remained the same at 89%.

From these comparisons, Sandhills shows the most improvement from the 2017 to the 2018 Enrollee Services EQR, increasing overall score 10 percentage points.

A standard needing improvement for five of the PIHPs is, "Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid Waiver managed care program which they are contractually entitled, including:". There are 28 sub-standards that are reviewed to score this one standard. All PIHPs except Sandhills and Cardinal received a "Partially Met" for this standard. The Corrective Actions for each PIHP varied within these sub-standards. The sub-standards with two or more PIHPs receiving Corrective Actions include the following:

- 1.9 Where to find a list or directory of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients (a written list of current Network Providers shall be provided by PIHP to any Enrollee upon request.) (Eastpointe, Partners, and Vaya received Corrective Action)
- 1.11.4 The locations at which providers and hospitals furnish the Emergency Services and Post Stabilization services covered under the contract. (Alliance, Eastpointe, Partners, Trillium, and Vaya received Corrective Action)
- 1.15 Procedures for obtaining out-of-area or out-of-state coverage of services, if special procedures exist. (Alliance and Eastpointe received Corrective Action)

Another standard under the Enrollee PIHP Program Education section with two or more PIHPs receiving Corrective Action was the following:

- 3. Enrollees are informed promptly in writing of (1) any "significant change" in the information specified in CFR 438.10 (f) (61) and 438.10 (g) at least 30 calendar days before the intended effective date of the change; and (2) termination of their provider within fifteen (15) calendar days after PIHP receives notice that DMA or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider.

Sandhills and Trillium both received a "Partially Met" on this standard, specifically for the area "Enrollees are informed promptly in writing of (2) termination of their provider within fifteen (15) calendar days after PIHP receives notice that DMA or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider."

Figure 4 and *Table 7* that follow provide an overview of the PIHPs' performance in the Enrollee Services section in the 2018 EQR.

Figure 4: Enrollee Services

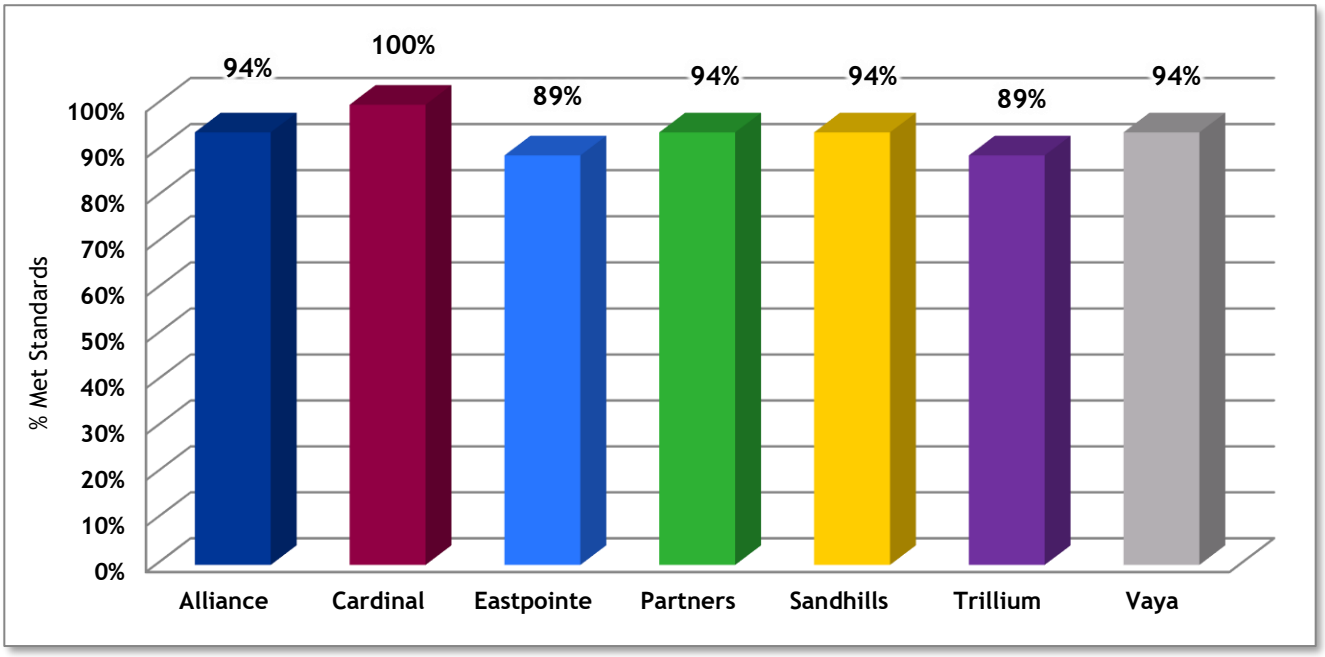


Table 7: Enrollee Services Comparative Data

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
III A. ENROLLEE RIGHTS AND RESPONSIBILITIES							
1. The PIHP formulates policies outlining enrollee rights and procedures for informing enrollees of these rights.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
2. Enrollee rights include, but are not limited to, the right:	Met	Met	Met	Met	Met	Met	Met
2.1 To be treated with respect and due consideration of dignity and privacy;							
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand;							
2.3 To participate in decisions regarding health care;							
2.4 To refuse treatment;							
2.5 To be free from any form of restraint of seclusion used as a means of coercion, discipline, convenience or retaliation;							
2.6 To request and receive a copy of his or her medical record, except as set forth in 45 C.F.R. §164.524 and in N.C.G.S. § 122C-53(d), and to request that the medical record be amended or corrected in accordance with 45 CFR Part 164.							

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
2.7 Of enrollees who live in Adult Care Homes to report any suspected violation of their enrollee rights, to the appropriate regulatory authority as outlined in NCGS§ 131-D21.							
III B. ENROLLEE PIHP PROGRAM EDUCATION							
1. Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid Waiver managed care program which they are contractually entitled, including:	Partially Met	Met	Partially Met	Partially Met	Met	Partially Met	Partially Met
1.1 A description of the benefits and services provided by the PIHP and of any limitations or exclusions applicable to covered services. These descriptions must have sufficient detail to ensure the Enrollees understand the benefits to which they are entitled and may include a web link to the PIHP Benefit Plan. This includes a descriptions of all Innovations Waiver services and supports;							

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
1.2 Benefits include access to a 2nd opinion from a qualified health care professional within the network, or arranges for the enrollees to obtain one outside the network, at no cost to the enrollee;							
1.3 Updates regarding program changes;							
1.4 A description of the procedures for obtaining benefits, including authorizations and EPSDT criteria;							
1.5 An explanation of the Enrollee's responsibilities and rights and protection;							
1.6 An explanation of the Enrollee's rights to select and change Network Providers							
1.7 The restrictions, if any, on the enrollee's right to select and change Network Providers							
1.8 The procedure for selecting and changing Network Providers							

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
1.9 Where to find a list or directory of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients (a written list of current Network Providers shall be provided by PIHP to any Enrollee upon request);							
1.10 The non-English languages, if any, spoken by each Network Provider;							
1.11 The extent to which, and how, after-hours and emergency coverage are provided, including:							
1.11.1 What constitutes an Emergency Behavioral Health Condition, Emergency Services, and Post Stabilization Services in accordance with 42 CFR§ 438.114 and EMTALA;							
1.11.2 The fact that prior authorization is not required for emergency services;							

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
1.11.3 The process and procedures for obtaining Emergency Services, the use of 911 telephone services or the equivalent;							
1.11.4 The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under the contract;							
1.11.5 A statement that, subject to the provisions of the DMA this contract, the Enrollee has a right to use any hospital or other setting for Emergency care;							
1.12 The PIHP's policy on referrals for Specialty Care to include cost sharing, if any, and how to access Medicaid benefits that are not covered under this Contract;							

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
1.13 Any limitations that may apply to services obtained from Out-of Network Providers, including disclosures of the Enrollee's responsibility to pay for unauthorized behavioral health care services obtained from Out-of Network Providers, and the procedures for obtaining authorization for such services.							
1.14 How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost-sharing;							
1.15 Procedures for obtaining out-of-area or out-of-state coverage or services, if special procedures exist;							
1.16 Information about medically necessary transportation services by the department of Social Services in each country;							
1.17 Identification and explanation of State laws and rules Policies regarding the treatment of minors;							
1.18 The enrollee's right to recommend changes in the PIHP's policies and procedures							

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
1.19 The procedure for recommending changes in the PIHP's policies and procedures;							
1.20 The Enrollee's right to formulate Advance Directives;							
1.21 The Enrollee's right to file a grievance concerning non-actions, and the Enrollee's right to file an appeal if PIHP takes an action against an Enrollee;							
1.22 The accommodations made for non-English speakers, as specified in 42 CFR §438.10(c)(5);							
1.23 Written information shall be made available in the non-English languages prevalent in the PIHP's services area.							
1.24 The availability of oral interpretation service for non-English languages and how to access the service;							
1.25 The availability of interpretation of written information in prevalent languages and how to access those services;							
1.26 Information on how to report fraud and abuse; and							

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
1.27 Upon an Enrollee's request, the PIHP shall provide information on the structure and operation of the agency and any physician incentive plans.							
1.28 Information on grievance, appeal and fair hearing procedures and information specified in CFR §438.10 (g) and CFR §438.10 (f) (6).							
2. Enrollees are notified annually of their right to request and obtain written materials produced for Enrollee use.	Met	Met	Met	Met	Met	Met	Met
3. Enrollees are informed promptly in writing of (1) any "significant change" in the information specified in CFR 438.10 (f) (61) and 438.10 (g) at least 30 days before calendar days before the intended effective date of the change; and (2) . termination of their provider within fifteen (15) calendar days after PIHP receives notice that DMA or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider.	Met	Met	Met	Met	Partially Met	Partially Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
4. Enrollee program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation of prevalent non-English languages as required by the contract.	Met	Met	Partially Met	Met	Met	Met	Met
5. The PIHP maintains and informs Enrollees of how to access a toll-free vehicle for 24-hours Enrollee access to coverage information from the PIHP, including the availability of free oral translation services for all languages and care management services such as crisis interventions.	Met	Met	Met	Met	Met	Met	Met
III C. BEHAVIORAL HEALTH AND CHRONIC DISEASE MANAGEMENT EDUCATION							
1. The PIHP enables each enrollee to choose a Provider upon enrollment and PIHP provides assistance as needed.	Met	Met	Met	Met	Met	Met	Met
2. The PIHP informs enrollees about the behavioral health education services that are available to them and encourages them to utilize these benefits.	Met	Met	Met	Met	Met	Met	Met
3. The PIHP tracks the participation of enrollees in the behavioral health education services.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
III D. CALL CENTER							
1. The PIHP provides customer services that are responsible to the needs of the Enrollees and their families. Services include:	Met	Met	Met	Met	Met	Met	Met
1.1 Respond appropriately to inquiries by enrollees and their family members (including those with limited English proficiency);	Met	Met	Met	Met	Met	Met	Met
1.2 Connect enrollees, family members and stakeholders to crisis services when clinically appropriate;	Met	Met	Met	Met	Met	Met	Met
1.3 Provide information to enrollees and their family members on where and how to access behavioral health services;	Met	Met	Met	Met	Met	Met	Met
1.4 Train its staff to recognize third-party insurance issues, recipient appeals, and grievances and to route these issues to the appropriate individual;	Met	Met	Met	Met	Met	Met	Met
1.5 Answer phones and respond to inquiries from 8:30 a.m. until 5:00 p.m. weekdays;	Met	Met	Met	Met	Met	Met	Met
1.6 Process referrals twenty-four (24) hours per day, seven (7) days per week; 365 days per year; and	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
1.7 Process Call Center linkage and referral requests for services twenty-four (24) hours per day, seven (7) days per week, 365 days per year.	Met	Met	Met	Met	Met	Met	Met

Strengths, Weaknesses, and Recommendations are not inclusive for each plan. More details were included in the Enrollee Services section of each plan's *2018 External Quality Review Report*. The following is a sample of findings.

Strengths

- Each PIHP has a reliable process to notify enrollees annually of their right to request and obtain written materials.
- The overall call center statistics at each PIHP meet or exceed NC Medicaid minimum standards.
- All PIHP websites provide enrollees with valuable information about the PIHP, obtaining services, crisis intervention, and educational/training opportunities.

Weaknesses

- Each PIHP except Sandhills received a "Partially Met" for the standard, "Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid Waiver managed care program which they are contractually entitled, including."
- Sandhills and Trillium both received a "Partially Met" for "Enrollees are informed promptly in writing of (1) any "significant change" in the information specified in CFR 438.10 (f) (61) and 438.10 (g) at least 30 calendar days before the intended effective date of the change; and (2) termination of their provider within fifteen (15) calendar days after PIHP receives notice that DMA or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider."

Recommendations

- For the standard, "Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid Waiver managed care program which they are contractually entitled,

including", PIHPs have different sub-standards that have Recommendations and Corrective Actions that were customized for them on their 2018 EQR Report.

- Sandhills and Trillium have individual Corrective Action items pertaining to "Enrollees are informed promptly in writing of (2) termination of their provider within fifteen (15) calendar days after PIHP receives notice that DMA or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider.

D. Quality Improvement

CCME assessed each PIHP's Quality Improvement Program (QIP) description, policies, committees that act on QI activities, provider QI participation, annual program evaluation, Performance Measures (PMs), and Performance Improvement Projects (PIPs). The 2018 EQR reveals each PIHP has a QI program that monitors and improves the behavioral health outcomes and services their enrollees receive.

The overall PIHP scores for the 2018 EQR, when compared to the 2017 EQR, revealed improvement in four PIHPs, the same score for two PIHPs, and a decrease for one PIHP. Alliance, Cardinal, Trillium, and Vaya increased scores in 2018 over the 2017 year. Partners and Sandhills remained the same. Eastpointe had a decrease in their Enrollee EQR score from 83% to 76%. The scores for the 2018 EQR for QI range from 76% "Met" for Eastpointe, to 100% "Met" for Alliance and Trillium.

Throughout the 2018 EQRs, CCME evaluated several standards as a "Met" at each PIHP. Each PIHP has a formal and detailed description of their Quality Management (QM) Program, evaluates and shares their enrollee surveys, has a quality work plan, has a formal committee overseeing the quality program, and has varying degrees of provider participation in QI initiatives and projects.

Eastpointe and Vaya both received a "Partially Met" on standard D2: The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects." This is an improvement over last year when five PIHPs scored a "Partially Met" on this Standard (Alliance, Eastpointe, Sandhills, Trillium, and Vaya). Alliance, Sandhills, and Vaya improved to a "Met" score for this 2018 EQR.

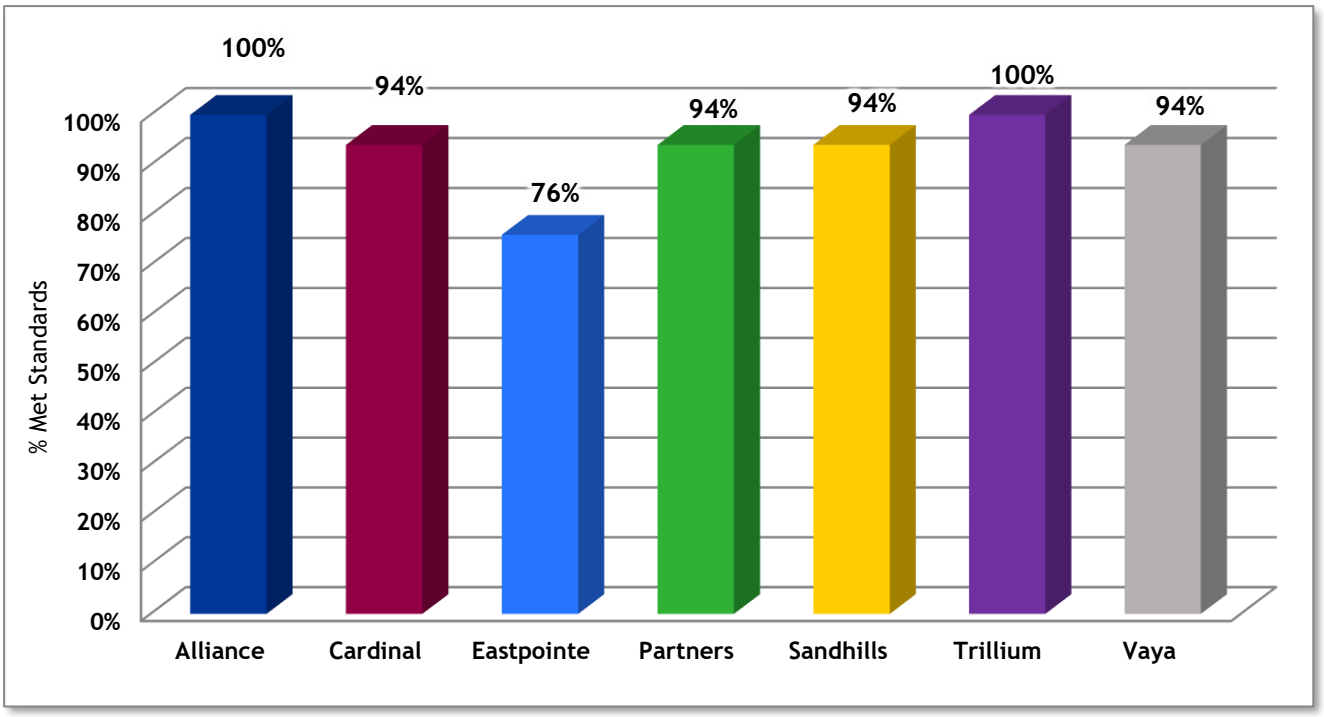
Another area of improvement from the 2017 to 2018 EQR is around the enrollee satisfaction surveys. Each PIHP "Met" each of the three standards dealing with enrollee surveys. In the previous EQR two scored "Partially Met" and two scored "Not Met" throughout the three measures dealing with enrollee surveys. Cardinal and Vaya are credited with this significant improvement.

Three PIHPs have Recommendations regarding provider QIP monitoring and offering feedback. Although the measure was "Met" by each PIHP, improvements can be made in provider QIP monitoring and feedback.

For the standard F1: A written summary and assessment of the effectiveness of the QI program for the year is prepared annually, Eastpointe received a "Not Met" and Cardinal received a "Partially Met." Sandhills and Trillium both have specific Recommendations for this standard. This standard, in general, is the standard that needs the most improvement in the Quality section of the 2018 EQRs.

Figure 5 shows the percentage of "Met" standards for each PIHP in the Quality section. They range from 76% to 100%.

Figure 5: Quality Improvement



Some PIHPs have a standard that was scored less than a "Met" that was not part of a trend across all PIHPs or even a common issue with another PIHP. The scores are detailed in Table 8 titled Quality Improvement Comparative Data. Each PIHP's Annual EQR Report addresses the details of each of the standards that scored less than a "Met" in more detail than this summary.

Table 8: Quality Improvement Comparative Data

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
IV A. THE QUALITY IMPROVEMENT PROGRAM							
1.The PIHP formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to enrollees.	Met	Met	Met	Met	Met	Met	Met
2.The scope of the QI program includes monitoring of provider compliance with PIHP practice guidelines.	Met	Met	Met	Not met	Met	Met	Met
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	Met	Met	Not Met	Met	Met	Met	Met
4. The PIHP implements significant measures to address quality problems identified through the enrollees' satisfaction survey.	Met	Met	Met	Met	Met	Met	Met
5.The PIHP reports the results of the enrollee satisfaction survey to providers.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
6. The PIHP reports to the Quality Improvement Committee on the results of the enrollee satisfaction survey and the impact of measures taken to address those quality problems that were identified.	Met	Met	Met	Met	Met	Met	Met
7. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, time frame for implementation and completion, and the person(s) responsible for the project(s).	Met	Met	Met	Met	Met	Met	Met
IV B. QUALITY IMPROVEMENT COMMITTEE							
1. The PIHP has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	Met	Met	Met	Met	Met	Met	Met
2. The composition of the QI Committee reflects the membership required by the contract.	Met	Met	Met	Met	Partially Met	Met	Met
3.The QI Committee meets at regular intervals.	Met	Met	Partially Met	Met	Met	Met	Met
4. Minutes are maintained that document proceedings of the QI Committee.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
IV C. PERFORMANCE MEASURES							
1.Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	Met	Met	Met	Met	Met	Met	Met
IV D. QUALITY IMPROVEMENT PROJECTS							
1.Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	Met	Met	Met	Met	Met	Met	Met
2.The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	Met	Met	Partially Met	Met	Met	Met	Partially Met
IV E. PROVIDER PARTICIPATION IN QUALITY IMPROVEMENT ACTIVITIES							
1.The PIHP requires its providers to actively participate in QI activities.	Met	Met	Met	Met	Met	Met	Met
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	Met	Met	Met	Met	Met	Met	Met
IV F. ANNUAL EVALUATION OF THE QUALITY IMPROVEMENT PROGRAM							
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	Met	Partially Met	Not Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
2.The annual report of the QI program is submitted to the QI Committee and to the PIHP Board of Directors.	Met	Met	Not Applicable	Met	Met	Met	Met

Performance Measure Validation Summary

CCME conducted an independent validation of (b) and (c) Waiver PMs selected by NC Medicaid. The validations were done in compliance with the CMS-developed protocol EQR Protocol 2: Validation of Performance Measures Reported by the Managed Care Organization Version 2.0 (September 2012). This process assesses the production of the latest measures by the PIHP to ensure what is submitted to NC Medicaid complies with the measure specifications, as defined in the North Carolina LME-MCO Performance Measurement and Reporting Guide (September 17, 2013, Revised October 2014).

(b) Waiver Performance Measures

CCME conducted the validation of 10 (b) Waiver PMs selected by NC Medicaid for each PIHP. They include the following:

Table 9: (b) Waiver Measures

(b) WAIVER MEASURES	
A.1. Readmission Rates for Mental Health	D.1. Mental Health Utilization - Inpatient Discharges and Average Length of Stay
A.2. Readmission Rates for Substance Abuse	D.2. Mental Health Utilization
A.3. Follow-up After Hospitalization for Mental Illness	D.3. Identification of Alcohol and other Drug Services
A.4. Follow-up After Hospitalization for Substance Abuse	D.4. Substance Abuse Penetration Rates
B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment	D.5. Mental Health Penetration Rates

Tables 10 and *11* give an overview of the 2018 validation scores for each measure. The validation scores are "Fully Compliant" for each PIHP with an average validation score of 100% across the 10 measures.

Table 10: 2018 (b) Waiver PM Validation Results Summary

Measures	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
A.1	100%	100%	100%	100%	100%	100%	100%
A.2	100%	100%	100%	100%	100%	100%	100%
A.3	100%	100%	100%	100%	100%	100%	100%
A.4	100%	100%	100%	100%	100%	100%	100%
B.1	100%	100%	100%	100%	100%	100%	100%
D.1	100%	100%	100%	100%	100%	100%	100%
D.2	100%	100%	100%	100%	100%	100%	100%
D.3	100%	100%	100%	100%	100%	100%	100%
D.4	100%	100%	100%	100%	100%	100%	100%
D.5	100%	100%	100%	100%	100%	100%	100%

(c) Waiver Performance Measures

Ten (c) Waiver measures were validated for each PIHP. The average validation score was 100%. The validation percentages for each PIHP's (c) Waiver measures are as follows:

Table 11: 2018 (c) Waiver PM Validation Results Summary

Measure	Percentages Reported						
	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
Proportion of Level of Care evaluations completed at least annually for enrolled participants	100%	100%	100%	100%	100%	100%	100%
Proportion of Level of Care evaluations completed using	100%	100%	100%	100%	100%	100%	100%

Measure	Percentages Reported						
	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
approved processes and instrument							
Proportion of New Level of Care evaluations completed using approved processes and instrument	100%	100%	100%	100%	100%	100%	100%
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	100%	100%	100%	100%	100%	100%	100%
Proportion of monitored Innovations providers wherein all staff completed all mandated training (excluding restrictive interventions) within the require time frame	100%	100%	100%	100%	100%	100%	100%
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	100%	100%	100%	100%	100%	100%	100%
Proportion of Individual Support Plans that address identified health	100%	100%	100%	100%	100%	100%	100%

Measure	Percentages Reported						
	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
and safety risk factors							
Percentage of participants reporting that their Individual Support Plan has the services that they need	100%	100%	100%	100%	100%	100%	100%
Proportion of individuals for whom an annual ISP and/or needed updates took place	100%	100%	100%	100%	100%	100%	100%
Proportion of new Waiver participants who are receiving services according to their ISP within 45 days of ISP approval	100%	100%	100%	100%	100%	100%	100%
Average Validation Score & Audit Designation	**100% FULLY COMPLIANT**	**100% FULLY COMPLIANT**	**100% FULLY COMPLIANT**	**100% FULLY COMPLIANT**	**100% FULLY COMPLIANT**	**100% FULLY COMPLIANT**	**100% FULLY COMPLIANT**

Performance Improvement Project Validation Results

Alliance, Cardinal, Partners, Sandhills, and Trillium received all "High Confidence" validation decisions for their submitted PIPs. Eastpointe receive "High Confidence" in one PIP, "Confidence" in one PIP, and "Low Confidence" in two PIPs. Vaya received "High Confidence" in two PIPs and "Confidence" in two PIPs.

A summary of validation scores for each PIP, as well as validation decision category status, are presented in *Table 12*.

Table 12: 2018 PIP Validation Results Summary

PROJECT	VALIDATION SCORE	VALIDATION DECISION
ALLIANCE		
Access to Care – Routine Urgent	85/90=94%	High Confidence in Reported Results
TCLI Housing Turn-around Time	73/78=94%	High Confidence in Reported Results
*Access to Care – Emergent	90/90=100%	High Confidence in Reported Results
*Care Coordination Clinical Contacts	78/78=100%	High Confidence in Reported Results
CARDINAL		
Increase Timely Submission of Quality of Life Surveys	90/90=100%	High Confidence in Reported Results
Improving the Percentage of Follow-up Appointments that Occurs Within 7 and 30 Days of Mental Health Specific Community Hospital and Facility Based Crisis Discharges	90/90=100%	High Confidence in Reported Results
Improving the Percentage of Follow-up Appointments that Occurs Within 7 and 30 Days of SA Related Community Hospital and SA Related Facility Based Crisis Discharges	90/90=100%	High Confidence in Reported Results
EASTPOINTE		
*Increase number of individuals in the priority population served by a fidelity provider to 50% monthly	74/80=93%	High Confidence in Reported Results
Increase the percentage of individuals who received a 2nd service within or less than 14 days to 35%	51/80=64%	Low Confidence in Reported Results
*Decrease state psychiatric hospital 30-day readmissions for high risk members	58/90=64%	Low Confidence in Reported Results
*Decrease emergency department admissions for active members to 20%	42/52=81%	Confidence in Reported Results

PROJECT	VALIDATION SCORE	VALIDATION DECISION
PARTNERS		
*Promoting follow up within 7 days for mental health treatment	86/91=95%	High Confidence in Reported Results
*Promoting follow up within 7 days for SUD treatment	91/91=100%	High Confidence in Reported Results
TCLI Transitioned in 90 days	86/91=95%	High Confidence in Reported Results
PCP referrals to Behavioral Health	84/84=100%	High Confidence in Reported Results
SANDHILLS		
*Maximizing the Benefit of Child Mental Health Level III	79/85=93%	High Confidence in Reported Results
*EBP Specialty	84/85=99%	High Confidence in Reported Results
Access to Routine BH Assessments	105/111=95%	High Confidence in Reported Results
TCLI Transition Days	78/85=92%	High Confidence in Reported Results
TRILLIUM		
*Increasing the use of Admission, Discharge and Transfer (ADT) data	90/90=100%	High Confidence in Reported Results
*Supermeasures-Mental Health (MH)	77/77=100%	High Confidence in Reported Results
Transition to Community Living Initiative (TCLI)	95/95=100%	High Confidence in Reported Results
VAYA		
*Follow-up after discharge from inpatient substance abuse disorder treatment	62/62=100%	High Confidence in Reported Results
*Inpatient Rapid Readmission	74/85=87%	Confidence in Reported Results
Integrated Care for Innovations Waiver Participants	56/78=72%	Confidence in Reported Results
TCLI- Increasing Housing	57/62=92%	High Confidence in Reported Results

**Indicates clinical focused PIP*

Strengths

- Each PIHP has a formal and detailed description of their QM Program, evaluates and shares their enrollee surveys, has a quality work plan, has a formal committee overseeing the quality program, and has varying degrees of provider participation in QI initiatives and projects.
- Four PIHPs show an overall scoring improvement (Alliance, Cardinal, Trillium, and Vaya)
- Two PIHPs scored 100% "Met" (Alliance and Trillium)
- All PIHPs "Met" each of the three standards dealing with enrollee surveys. In the previous EQR two scored "Partially Met" two scored "Not Met" throughout the three measures dealing with enrollee surveys. Cardinal and Vaya are credited with this significant improvement.

Weaknesses

- Four PIHPs have Recommendations or Corrective Actions to improve the Annual QI Program Evaluation.
- Three PIHPs have Recommendations regarding provider QIP monitoring and offering feedback.

Recommendations

- Make improvements to the Annual QI Program Evaluation specified in the PIHP specific 2018 EQR Reports.
- Make improvements regarding provider QIP monitoring and feedback as requested in PIHP specific 2018 EQR Reports.

E. Utilization Management

CCME's EQR of Utilization Management (UM) functions included review of the UM Program, the Care Coordination Program, and the Transition to Community Living Initiative (TCLI) Program. CCME reviewed relevant policies and procedures, UM Plans, UM and Care Coordination Program Descriptions, UM enrollee notifications, provider manuals, member handbooks, and TCLI job descriptions. CCME also completed a review of UM Authorization Review, Care Coordination, and TCLI files. An Onsite discussion provided additional clarification of UM, Care Coordination and TCLI processes.

The UM overall PIHP scores ranged from 100% of "Met" UM standards for Partners and Alliance to 91% "Met" Standards for Sandhills. The decrease in overall score is related to

the increase of 13 "Partially Met" scores compared to nine (9) "Partially Met" scores in the 2017 EQR.

Each PIHP has an UM Plan. The PIHPs also have policies and procedures that generally provide an overview of the UM Program that include guidelines and or standards used for making UM decisions. In the past year, Sandhills implemented the use of an assessment tool for children aged 3-6 years, but this was not added to their policies and or procedures. This resulted in one of the "Partially Met" score for Sandhills.

The review of UM service authorization decision files demonstrated that the PIHPs have improved their compliance to timeframes required for UM decision and notifications. An area needing attention in the Cardinal UM files was the lack of credentials within signatures of decision makers. This is required by *DMA Contract, Section 8.2.2.1* and resulted in a "Partially Met" score for Cardinal.

The Care Coordination file review found inconsistent documentation by staff in the enrollee's record at four of the seven PIHPs. Corrective Actions and Recommendations were aimed at enhancing the PIHP's monitoring of enrollee records to ensure Care Coordination contacts and assessments are thoroughly and timely documented.

All PIHPs had TCLI policies and procedures and certification requirements for Peer Support Specialists were present in six PIHPs' policies and procedures. Trillium's policies and procedures were lacking this detail which resulted in a "Partially Met" score for the standard for Trillium. The standard addressing the use and completion of the TCLI Transition Tool was "Met" by six PIHPs.

Details regarding the completion of TCLI Transition Tool were not included in Vaya's TCLI policy and procedure. Further, the TCLI Transition Tool was not present in any of the file where the tool was required. This resulted in a "Partially Met" score for Vaya. As a part of their Corrective Action, Vaya worked with the state to clear up confusion regarding the previous use of an alternative to the TCLI Transition tool.

There was an improvement in the documentation and monitoring of "one-time Transitional funds" from the 2017 EQR. Six PIHPs included information about these funds and the process for accessing and monitoring them within their policies and procedures. Trillium's TCLI policies and procedures are lacking this detail, however, which resulted in a "Partially Met" score for Trillium.

The *Quality of Life (QOL) Survey* standard during the 2018 EQR, demonstrated continued improved compliance at all PIHPs. All seven PIHPs "Met" this standard. Overall, the file reviewed contained the document, and documentation regarding the completion of the

survey was present in progress notes. On occasion, anomalies were found regarding the *QOL Survey* in the file review but clarification was provided during the Onsite visit that explained the anomalies.

Five PIHPs had materials developed to educate internal and external stakeholders about TCLI. Trillium did not include the details about TCLI services and who could qualify for the services in their *Provider Manual* as indicated in their 2017 Corrective Action Plan response. Sandhills also did not add information about the TCLI Program in their *Member Handbook* as recommended in the 2017 EQR. As a result, Trillium and Sandhills received "Partially Met" scores again for this year's EQR.

Generally, PIHP TCLI files showed most TCLI enrollees are linked with intensive services such as Assertive Community Treatment Team (ACT) and Community Support Team, few enrollees are linked with the B3 Peer Support Services, and even fewer linked with B3 Supportive Employment (SE). During Onsite discussions, TCLI staff provided explanations that ranged from a lack of SE providers, to a lack of ACT providers meeting fidelity, inadequate referral responses by providers, and enrollee resistance. All PIHPs could describe formal and informal initiates aimed at increasing referrals to B3 services, when appropriate.

Eastpointe's TCLI file review showed neither Peer Support services nor Supported Employment were even mentioned in the progress notes reviewed. This includes several members who, per the TCLI notes, stated that they wanted obtain employment. Similarly, the Vaya TCLI files provided for this year's EQR showed there was no mention of TCLI One-Time Transitional Funds in any progress notes. A "Partially Met" score was given to both Eastpointe and Vaya regarding the implementation of their own policies and procedures that direct staff to explain available resources. The direction given to improve compliance was that Eastpointe TCLI management increase their monitoring of progress notes to ensure there is, minimally, discussion with enrollees of the availability of B3 services and Vaya TCLI management do the same, in regard to the TCLI One-Time Transitional Funds.

Figure 6 and *Table 13* provide an overview of the PIHPs performance in the Utilization Management section.

Figure 6: Utilization Management

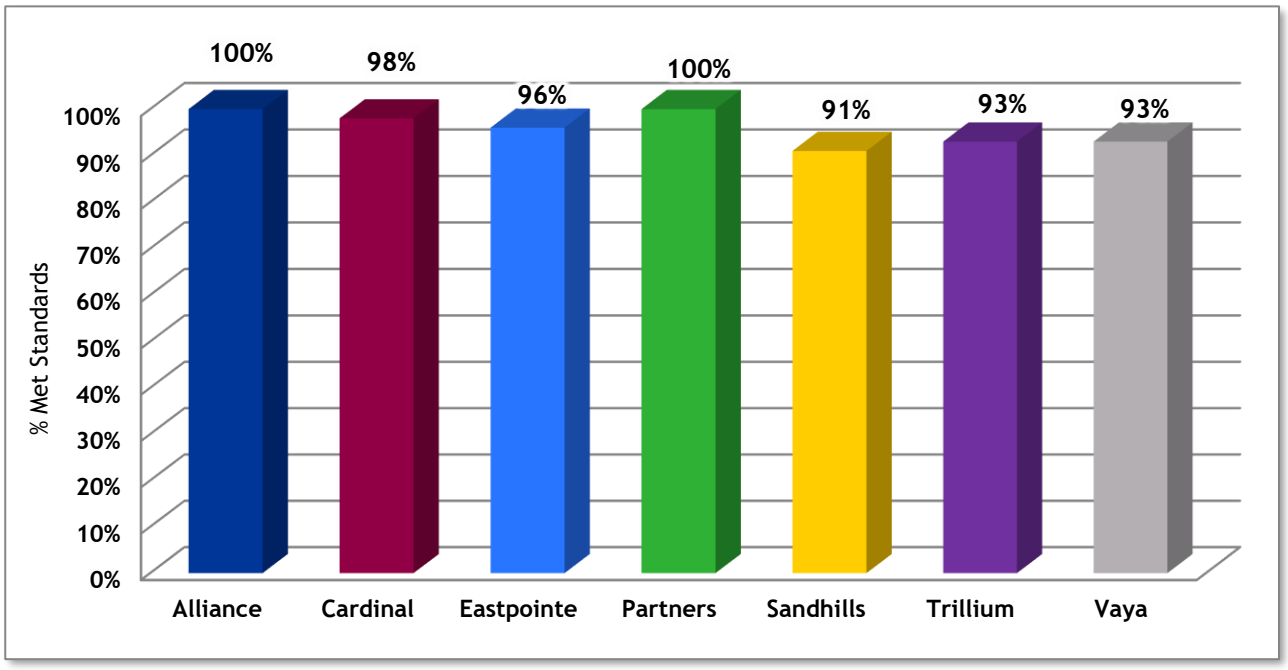


Table 13: Utilization Management Comparative Data

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
V A. THE UTILIZATION MANAGEMENT PROGRAM							
1. The PIHP formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	Met	Met	Met	Met	Met	Met	Met
1.1 structure of the program;	Met	Met	Met	Met	Met	Met	Met
1.2 lines of responsibility and accountability;	Met	Met	Met	Met	Met	Met	Met
1.3 guidelines / standards to be used in making utilization management decisions;	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	Met	Met	Met	Met	Met	Met	Met
1.5 consideration of new technology;	Met	Met	Met	Met	Partially Met	Met	Met
1.6 the appeal process, including a mechanism for expedited appeal;	Met	Met	Met	Met	Met	Met	Met
1.7 the absence of direct financial incentives to provider or UM staff for denials of coverage or services;	Met	Met	Met	Met	Met	Met	Met
1.8 mechanisms to detect underutilization and overutilization of services.	Met	Met	Met	Met	Met	Met	Met
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	Met	Met	Met	Met	Met	Met	Met
3. The UM program design is reevaluated annually, including Provider input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	Met	Met	Met	Met	Met	Met	Met
V B. MEDICAL NECESSITY DETERMINATIONS							
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	Met	Met	Met	Met	Partially Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	Met	Met	Met	Met	Met	Met	Met
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	Met	Met	Met	Met	Met	Met	Met
4. Utilization management standards/criteria are consistently applied to all enrollees across all reviewers.	Met	Met	Met	Met	Met	Met	Met
5. Emergency and post stabilization care are provided in a manner consistent with contract and federal regulations.	Met	Met	Met	Met	Met	Met	Met
6. Utilization management standards/criteria are available for Providers.	Met	Met	Met	Met	Met	Met	Met
7. Utilization management decisions are made by appropriately trained reviewers.	Met	Met	Met	Met	Met	Met	Met
8. Initial utilization decisions are made promptly after all necessary information is received.	Met	Partially Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
9. Denials							
9.1 A reasonable effort that is not burdensome on the enrollee or the provider is made to obtain all pertinent information prior to making the decisions to deny services.	Met	Met	Met	Met	Met	Met	Met
9.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	Met	Met	Met	Met	Met	Met	Met
9.3 Denial decisions are promptly communicated to the provider and enrollee and include the basis for the denials of service and the procedure for appeal.	Met	Met	Met	Met	Met	Met	Met
V C. CARE COORDINATION							
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	Met	Met	Met	Met	Met	Met	Met
2. The case coordination program includes:							
2.1 Staff available 24 hours per day, seven days per week to perform telephone assessments and crisis interventions;	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	Met	Met	Met	Met	Met	Met	Met
2.3 Assess each Medicaid enrollee identified as having special health care needs;	Met	Met	Met	Met	Met	Met	Met
2.4 Develop treatment plans for enrollees that meet all requirements;	Met	Met	Met	Met	Met	Met	Met
2.5 Quality monitoring and continuous quality improvement;	Met	Met	Met	Met	Met	Met	Met
2.6 Determine of which Behavioral Health Services are medically necessary;	Met	Met	Met	Met	Met	Met	Met
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	Met	Met	Met	Met	Met	Met	Met
2.8 Coordinate care with each Enrollee's provider;	Met	Met	Met	Met	Met	Met	Met
2.9 Provide follow-up activities for Enrollees;	Met	Met	Met	Met	Met	Met	Met
2.10 Ensure privacy for each Enrollee is protected.	Met	Met	Met	Met	Met	Met	Met
3. The PIHP applies the Care Coordination policies and procedures as formulated.	Met	Met	Partially Met	Met	Partially Met	Met	Partially Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
V D. TRANSITION TO COMMUNITY LIVING INITIATIVE							
1. Transition to Community Living functions are performed by appropriately licensed, or certified, and trained staff.	Met	Met	Met	Met	Met	Partially Met	Met
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements includes all required elements.	Met	Met	Met	Met	Met	Met	Met
2.1 Care Coordination activities occur as required.	Met	Met	Met	Met	Met	Met	Partially Met
2.2 Person Centered Plans are developed as required.	Met	Met	Met	Met	Met	Met	Met
2.3 Assertive Community Treatment, Peer Support Services, and Supported Employment services are included in the individual's transition, if applicable.	Met	Met	Met	Met	Met	Met	Met
2.4 A mechanism is in place to provide one-time transitional supports, if applicable.	Met	Met	Met	Met	Met	Partially Met	Met
2.5 QOL Surveys are administered timely.	Met	Met	Met	Met	Met	Met	Met
3. A diversion process is in place for individuals considering admissions into an Adult Care Home (ACH).	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to DMA within the timeframes determined by DMA.	Met	Met	Met	Met	Met	Met	Met
5. The PIHP will develop a TCLI communication plan that includes materials and training about crisis hotline, services for enrollees with limited English proficiency and also to for external and internal stakeholders providing information on the TCL initiative, resources, and system navigation tools, etc.	Met	Met	Met	Met	Partially Met	Partially Met	Met
6. A review of files demonstrates the PIHP is following appropriate TCL policies, procedures and processes, as required by NC DMA, and developed by the PIHP.	Met	Met	Partially Met	Met	Met	Met	Partially Met

Strengths

- The UM Program policies and procedures describe and support the functions of the UM Program.
- The Onsite interview provided an understanding of the CMO's/ Medical Director or designees' involvement in the UM Program.
- Care Coordination policies and procedures are in place and support the functions of Care Coordination.
- The *Quality of Life Surveys* were present in files when appropriate.

Weaknesses

- The Care Coordination file review found inconsistent documentation by staff in the enrollee's record at four of the seven PIHPs.

- PIHP policies and procedures frequently do not include adequate detail outlining the TCLI program and DOJ settlement requirements.

Recommendations

- Care Coordination and TCLI files need to be closely monitored to ensure documentation is complete, accurate, timely and in accordance with PIHP policies and procedures.
- PIHPs need to ensure their TCLI policies and procedures capture the requirements of the DOJ settlement such as access to One Time Transition funds and B3 services, and implementation of TCLI In-Reach and Transition tools.

F. Grievances and Appeals

Grievances

CCME's External Quality Review (EQR) of the PIHPs' Grievance functions included review of relevant policies and procedures, the PIHPs' organizational chart, grievance notifications to enrollees, provider manuals, member handbooks, relevant job descriptions, relevant data, and grievance files for each PIHP. An Onsite interview at each PIHP provided additional information and clarification regarding the grievance processes.

Overall, PIHPs improved compliance with grievance standards. In the 2017 EQR, a combined total of eight grievance standards were "Partially Met." In the 2018 EQR, PIHPs "Met" all standards with exception of Trillium, where one grievance standard was "Partially Met." PIHP improvements from the previous year were typically the result of successfully implementing EQR Corrective Action and or CCME Recommendations.

Each PIHP had complete sets of policies and/or procedures related to grievances. Several PIHPs had separate categories and processes for grievances, complaints, concerns, etc. This led to varying degrees of confusion as evidenced by definitions within policies and procedures, provider manuals, data reporting and grievance/complaint/concern notifications to enrollees. Most were able to demonstrate they could keep these categories, processes and reporting relatively separate. The Trillium file review contained significant inconsistencies in the use of the terms "grievance" and "complaint." Notifications to enrollees vacillated between these two terms, which follow two different processes, per Trillium's procedures. As a result, Trillium received a score of "Partially Met" on the standard related to implementing the definitions and processes required by Trillium policies and procedures.

Another identified weakness across all PIHPs was procedural language addressing extensions to the grievance resolution timeframe. While extending grievance resolution

timeframes is a practice PIHPs rarely use, the notifications steps required by *DMA Contract* and federal regulations were frequently incomplete within PIHP policies and procedures. As a result, CCME gave Recommendations to include the exact *DMA Contract* language to Alliance, Cardinal, Partners and Vaya policies and or procedures.

Appeals

The EQR of the appeal process at the PIHPs involves review of Appeal policies and procedures, a minimum of 25 appeal files, PIHP provider manuals and member handbooks, appeal information on the PIHP's website, and the PIHP's log of appeals. Onsite discussion provided additional clarification of the PIHP's appeal processes.

Review of appeal files show PIHPs are generally compliant with the required appeal processing timeframe but struggled to consistently document the required steps of the appeal process in their policies, procedures, and stakeholder resources. For example, Sandhills, Trillium, Cardinal, Eastpointe, and Alliance have incomplete or incorrect definitions of who can file an appeal in their policies and procedures. CCME spelled out the specific *DMA Contract* references and language that needed to be included in each of the PIHP's policies and procedures.

The most common error within PIHP policies and procedures was incomplete information regarding expedited appeals and extensions to the appeal resolution timeframe. While these appeal situations may be the least common, file review showed appeal staff struggled to comply with and document the required notification steps involved in expedited and extended appeals.

PIHPs report they monitor a portion of processed appeals for compliance. This is generally a monitoring of appeal resolution timeframes and not the other required appeal steps such as expedited notifications, extension notifications, documentation of Medical Director consultation, confirmation of guardianship, etc. CCME Recommended to Alliance, Cardinal, Partners, Sandhills and Vaya that they enhance their monitoring processes to confirm compliance with required appeal steps and notifications.

In July of 2017, the code of federal regulations was revised to allow appellants to file an appeal within 60 days of the mailing date of the adverse benefit determination. Each PIHP updated their policies and procedures to reflect this change from 30 days, however, Alliance, Cardinal, and Eastpointe did not update their provider manuals to reflect this new timeframe.

Overall, staff were well versed in the requirements of processing appeals. Enhancing the PIHPs' appeals policies and procedures and current monitoring of appeals will better guide them and confirm compliance with *DMA Contract* requirements.

Figure 7: Grievances and Appeals

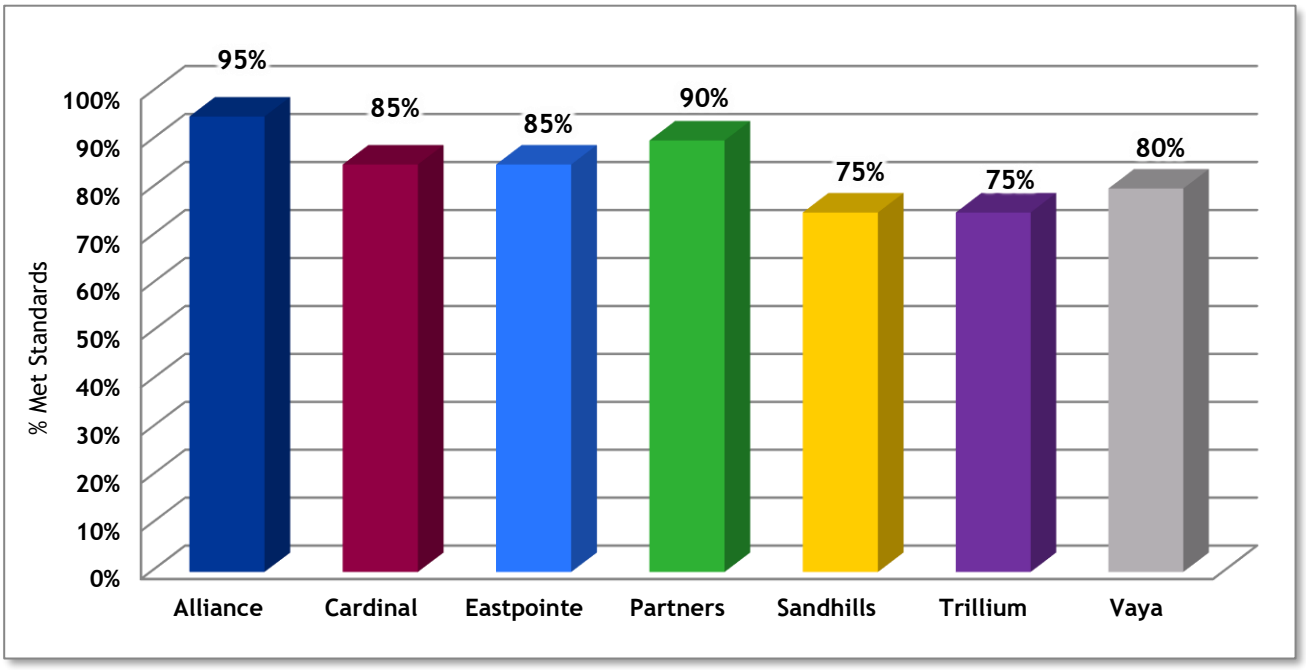


Table 14: Grievances and Appeals Comparative Data

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
VI A. GRIEVANCES							
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee grievances in a manner consistent with contract requirements, including, but not limited to:	Met	Met	Met	Met	Met	Met	Met
1.1 Definition of a grievance and who may file a grievance;	Met	Met	Met	Met	Met	Met	Met
1.2 The procedure for filing and handling a grievance;	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	Met	Met	Met	Met	Met	Met	Met
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	Met	Met	Met	Met	Met	Met	Met
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	Met	Met	Met	Met	Met	Met	Met
2. The PIHP applies the grievance policy and procedure as formulated.	Met	Met	Met	Met	Met	Partially Met	Met
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	Met	Met	Met	Met	Met	Met	Met
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
VI B. APPEALS							
1. The PIHP formulates and acts within policies and procedures for registering and responding to enrollee and/or provider appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	Met	Met	Met	Met	Met	Met	Met
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	Met	Met	Partially Met	Met	Partially Met	Partially Met	Partially Met
1.2 The procedure for filing an appeal;	Met	Met	Met	Partially Met	Partially Met	Met	Partially Met
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	Met	Met	Met	Met	Met	Met	Met
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	Met	Partially Met	Met	Met	Partially Met	Met	Partially Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	Met	Partially Met	Met	Partially Met	Partially Met	Partially Met	Partially Met
1.6 Written notice of the appeal resolution as required by the contract;	Met	Met	Met	Met	Met	Met	Met
1.7 Other requirements as specified in the contract.	Met	Met	Partially Met	Met	Met	Partially Met	Met
2. The PIHP applies the appeal policies and procedures as formulated.	Partially Met	Partially Met	Met	Met	Partially Met	Partially Met	Met
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	Met	Met	Met	Met	Met	Met	Met
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	Met	Met	Partially Met	Met	Met	Met	Met

Strengths

- PIHPs, collectively, improved their achievement of grievance standards from the previous year's EQR.
- PIHPs improved upon their compliance with appeal resolution timeframe requirements. This was true for both standard and expedited appeals.

Weaknesses

- PIHPs overlap and often conflate the definitions, processing, and reporting of grievances, and complaints.
- Most PIHPs are missing or lack complete contract language within their grievance policies and or procedures that address extensions to the grievance resolution timeframe.
- PIHPs struggle to consistently document the required steps of the appeal process in their policies, procedures, and stakeholder resources. This is especially true for appeals that are expedited and or extended.
- Appeal file reviews showed PIHP staff inconsistently followed and documented requirements for processing appeals. While resolution timeframes were generally "Met," steps such as acknowledging appeals, notifying appellants about expedited or extended appeals, documentation of Medical Director consultation, confirmation of guardianship, etc. were most frequently missed or not documented.
- Some PIHPs do not timely update their policies and/or procedures, or PIHP and stakeholder documentation when there is a *DMA Contract* of federal regulation change.

Recommendations

- Ensure the terms "grievance" and "complaint" are adequately and consistently defined across all PIHP documentation and that staff can discern between the two so that grievances and complaints are processed as required.
- Routinely review the *DMA Contract* and federal regulations to confirm appeal policies, procedures, and stakeholder resources align with the specific appeal language and requirements outlined by the state and federal government.
- Enhance PIHP monitoring of appeals to ensure all required steps for processing appeals are consistently occurring and are accurately documented.
- When changes occur to the *DMA Contract*, develop a comprehensive and timely process for updating appeal policies and/or procedures, provider manuals, member handbooks, PIHP website information, PIHP desk references, etc.

G. Delegation

CCME's External Quality Review (EQR) of Delegation functions includes a review of the submitted Delegate List, Delegation Contracts, and Delegation Monitoring materials. The *DMA Contract, Attachment B, Section 11, Subcontracts*, and *42 CFR §432.230* governs delegation agreements. Additionally, each Prepaid Inpatient Health Plan (PIHP) has policies or procedures or both, and some PIHPs have a *Delegation Program Description*, to provide direction for delegation functions and the PIHP oversight of delegates.

All PIHPs have a Delegation Agreement with an outside entity for peer review services. Five PIHPs have a Delegation Agreement for call roll-over or overflow calls or Screening-Triage-Referral services. Of these five, four of the Delegation Agreements are with another PIHP (Partners and Vaya cover roll-over calls for each other; Sandhills and Eastpointe have a Delegation Agreement with Cardinal for roll-over calls). Two PIHPs (Cardinal and Sandhills) have Delegation Agreements with hospitals for credentialing of hospital clinical staff, and one PIHP (Eastpointe) has a Delegation Agreement with a Credentials Verification Organization. The PIHPs with Delegation Agreements for credentialing retain final decision-making for credentialing decisions. Delegation Agreements include Business Associate Agreements (BAA) with those delegates that have access to Protected Health Information (PHI).

The *DMA Contract Attachment, Section 11.1.1 d*, requires the PIHPs to "monitor the subcontractor's performance on an ongoing basis, at least annually, and subject it to formal review according to a periodic schedule consistent with industry standards". The PIHPs monitor the delegates through regular reports, such as monthly call metrics reports from delegates performing call roll-over or overflow call functions. Several of the PIHPs meet regularly with delegates to review delegate performance.

Five PIHPs (Alliance, Cardinal, Partners, Trillium, Vaya) scored "Met" for both standards in the Delegation review in 2018. Four of these five PIHPs also scored "Met" for both standards in the 2017 Delegation review, with Trillium improving its score (50%) from the 2017 Delegation review to 100% in the 2018 Delegation review.

Two PIHPs (Eastpointe, Sandhills) scored "Met" for one standard and "Partially Met" for the other standard, resulting in a score of 50% for their 2018 Delegation review. Eastpointe also scored 50% in the 2017 Delegation review and did not address the sole Corrective Action item from the 2017 review. Sandhills scored 100% in the 2017 Delegation review but failed to execute a Delegation Agreement with a delegate, resulting in the score of 50% for the 2018 Delegation review.

Figure 8 and *Table 15* provide an overview of the PIHPs' performance in the Delegation section in the 2018 EQR.

Figure 8: Delegation

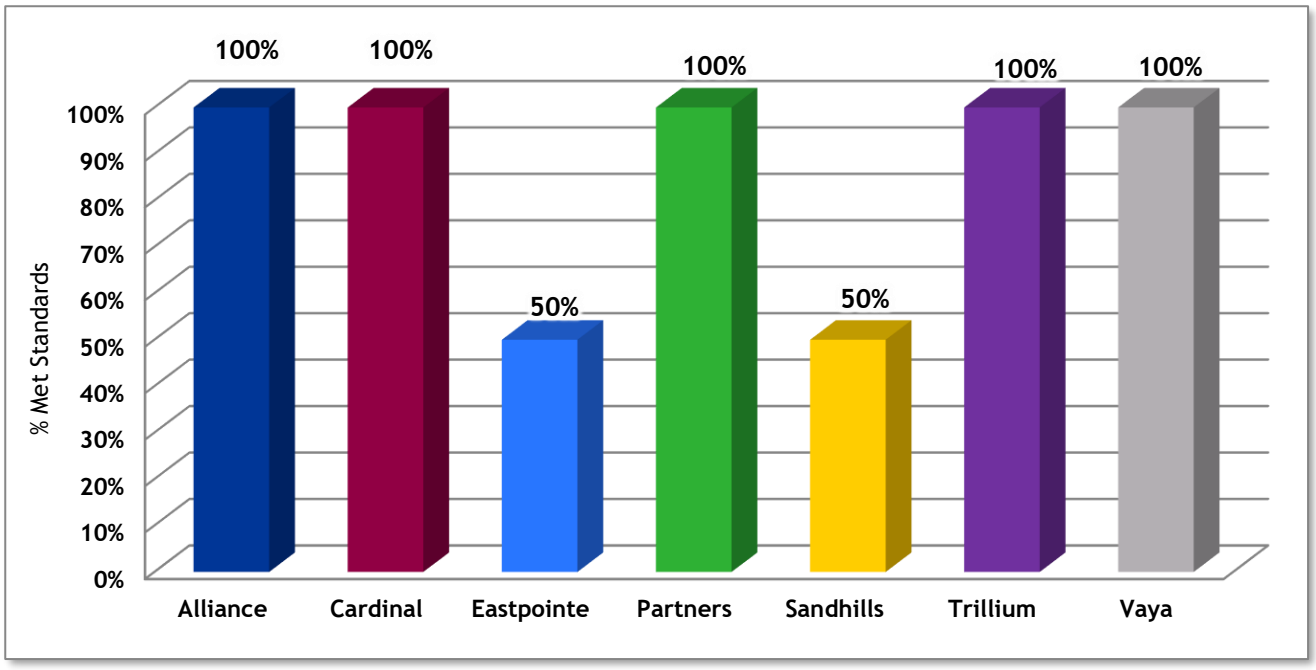


Table 15: Delegation Comparative Data

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
VII Delegation							
1. The PIHP has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	Met	Met	Met	Met	Partially Met	Met	Met
2. The PIHP conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the PIHP if the PIHP were directly performing the delegated functions.	Met	Met	Partially Met	Met	Met	Met	Met

Strengths, Weaknesses, and Recommendations are not inclusive for each PIHP. More details were included in the Delegation section of each PIHP's *2018 External Quality Review Report*. The following is a sample of findings.

Strengths

- The PIHPs have fully executed Delegation Agreements with delegates, including BAAs for those delegates who have access to PHI.
- The PIHPs monitor the delegates through regular reports, such as monthly call metrics reports from delegates performing call roll-over or overflow call functions. Several of the PIHPs meet regularly with delegates to review delegate performance.
- Each PIHP has policies or procedures or both, and some PIHPs have a *Delegation Program Description*, to provide direction for delegation functions and the PIHP oversight of delegates.

Weaknesses

- Minor documentation issues were discussed with several of the PIHPs. Examples of this include the (Alliance) Delegation Agreements referencing policies and procedures from the original agreement (versus current policies and procedures), the Delegation Agreement Amendment (at Cardinal) referencing a BAA that was not included in the Amendment (for an evergreen contract), and Delegation Assessment forms or checklists (Sandhills, Trillium, Vaya) not including the *State Exclusion List*.
- Delegation monitoring for the contracted Medical Director consultants was not completed at Eastpointe. This was also identified as a Weakness in the 2017 EQR.
- Partners' *Delegation Program Description* indicates the annual assessment of a delegate is not needed if the delegate is Utilization Review Accreditation Commission (URAC) accredited.
- Sandhills had a signed "Scope of Work", rather than a Delegation Agreement, with an identified delegate.

Corrective Actions

- Eastpointe was asked to develop monitoring tools specific to each Medical Director delegate. The monitoring tools should include monitoring items to protect Eastpointe against any real or perceived conflicts of interest. This was an unaddressed Corrective Action from the 2017 EQR.
- Sandhills was asked to execute a delegation agreement with a BAA for the identified delegate with whom they had a signed Scope of Work.

Recommendations

- PIHPs (Alliance, Cardinal) should ensure references in the Delegation Agreements and Amendments are current and correct, and should verify the Delegation Agreements include referenced documents (policies and procedures, current BAAs).
- Delegation Assessment forms or checklists (Sandhills, Trillium, Vaya) and processes should be revised to include the *State Exclusion List*.
- To comply with the requirement in *DMA Contract Attachment B,* section *11.1.2 d,* Partners should revise the *Delegation Program Description,* and conduct regular monitoring, including at least an annual assessment, of its delegates, even if they are URAC accredited.

H. Program Integrity

Each EQR of PIHP Program Integrity (PI) functions consists of a Desk Review PIHP's documentation to assess their compliance with federal and state regulations and the *DMA Contract*. This documentation generally included PI case files, policies and procedures, and the PIHP's *Compliance Plan*. An Onsite interview with key Compliance staff occurred with Investigations and Legal staff to review the documentation and file review findings. This open-ended discussion allowed the PIHP to describe in detail their processes and procedures related to detecting, investigating and resolving alleged incidents of fraud, waste, and abuse.

Five of the seven PIHPs had an overall score of 100% on their PI review. This compares favorably with the prior year's results where only three out of seven PIHPs had a compliant review. Six of the seven PIHPs scored 100% on the case file review section of the evaluation. This is a decrease from the prior year, in which all seven PIHPs scored 100%. The deficiency that impacted the scoring for the file review this year related to several missing National Provider Identification (NPI) numbers from the Vaya PI case files.

Overall, the PIHPs have strong PI functions that are well staffed and trained. The PIHPs generally have effective policies and procedures in place. However, two of the seven PIHPs were found to have deficiencies in policy and/or procedure wording as compared to the required language in their contract with NC Medicaid. CCME gave Recommendations to Alliance and Vaya to bolster their policy and/or procedural language related to the lifting of payment suspensions when instructed by NC Medicaid (*DMA Contract, Section 14.2.4*).

PI file documentation varied across PIHPs in level of organization. Common items such as a referral forms, case log wording, executive summaries, and file naming conventions were inconsistent across PIHP case files. Based on this variation, CCME gave

Recommendations to better standardize and improve the overall organization of the PIHPs' PI files.

Compared to the previous year, the PIHPs have made progress in using data mining to identify potential cases of fraud. Examples of these efforts by the PIHPs include comparing dates of inpatient and outpatient services for the same members, code comparisons to identify upbilling, and billing for deceased members. There was evidence within the PI files reviewed of investigations that resulted from these improved data mining efforts.

Figure 9: Program Integrity

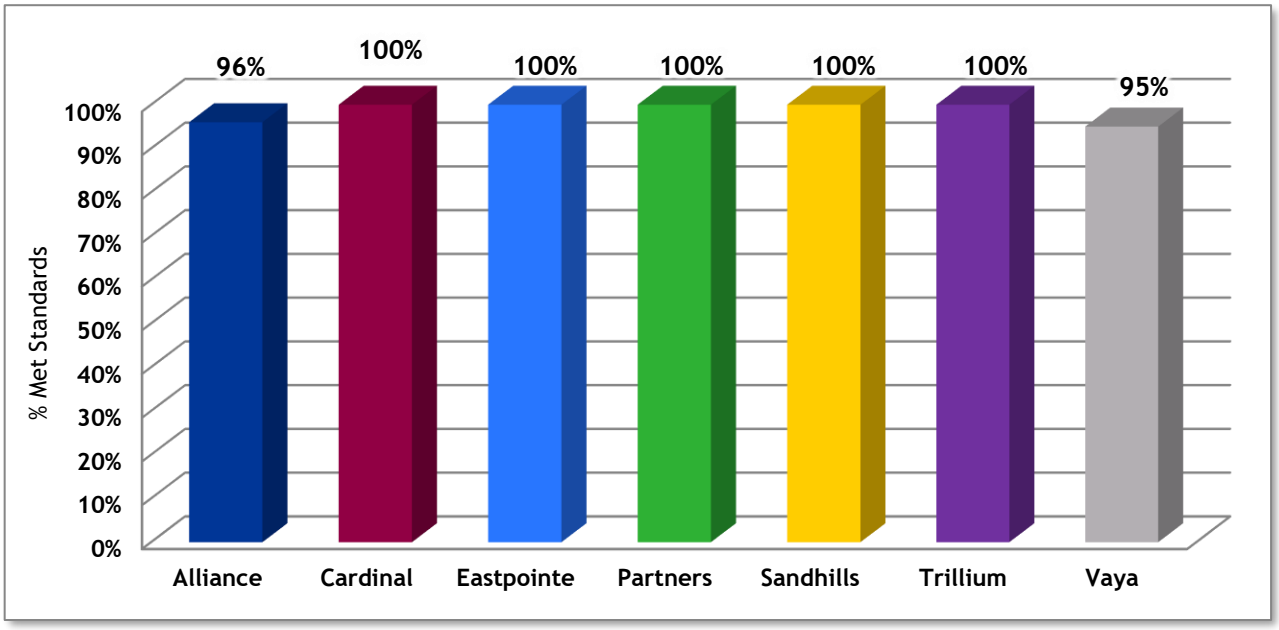


Table 16: Program Integrity Comparative Data

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
VIII A. GENERAL REQUIREMENTS							
1. PIHP shall be familiar and comply with Section 1902(a)(68) of the Social Security Act, 42 C.F.R. Parts 438,455 and 1000 through 1008, as applicable, including proper payments to Providers and methods for detection of fraud and abuse.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
2. PIHP shall have and implement policies and procedures that guide and require PIHP's, and PIHP's officers', employees', agents' and subcontractors,' compliance with the requirements of this Section 14.	Met	Met	Met	Met	Met	Met	Met
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	Met	Met	Met	Met	Met	Met	Met
4. PIHP shall investigate all grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	Met	Met	Met	Met	Met	Met	Met
VIII B. FRAUD AND ABUSE							
1. PIHP shall establish and maintain a written Compliance Plan consistent with 42 C.F.R. 438.608 that is designed to guard against fraud and abuse. The Compliance Plan shall be submitted to the DMA Contract Administrator on an annual basis.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
2. PIHP shall designate, however named, a Compliance Officer who meets the requirements of 42 C.F.R. 438.608 and who retains authority to report directly to the CEO and the Board of Directors as needed irrespective of administrative organization. PIHP shall also establish a regulatory compliance committee on the PIHP board of directors and at the PIHP senior management level that is charged with overseeing PIHP's compliance program and compliance with requirements under this Contract. PIHP shall establish and implement policies outlining a system for training and education for PIHP's Compliance Officer, senior management, and employees in regard to the Federal and State standards and requirements under DMA Contract in accordance with 42 CFR 438.608(a)(1)(iv).	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
3. PIHP shall establish and implement a special investigations or program integrity unit, however named, that is responsible for PIHP program integrity activities, including identification, detection, and prevention of fraud, waste and abuse in the PIHP Closed Provider Network. PIHP shall identify an appropriately qualified contact for Program Integrity and Regulatory Compliance issues as mutually agreed upon by PIHP and DMA. This person may or may not be the PIHP Compliance Officer or the PIHP Contract Administrator.	Met	Met	Met	Met	Met	Met	Met
4. PIHP shall participate in quarterly Program Integrity meetings with DMA Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the N.C. Department of Justice ("MFCU/ MID').	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
5. PIHP shall participate in monthly meetings with DMA Program Integrity, in the most productive setting, either telephonically or in person at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.	Met	Met	Met	Met	Met	Met	Met
6. PIHP shall designate appropriately qualified staff to attend the monthly meetings, and the parties shall work collaboratively to minimize duplicative or unproductive meetings and information	Met	Met	Met	Met	Met	Met	Met
7. PIHP shall also make Regulatory Compliance minutes and Program Integrity minutes, redacted as deemed appropriate by PIHP, available for review upon request by DMA.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
8. PIHP's written Compliance Plan shall, at a minimum include:							
8.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(66) of the Social Security Act;	Met	Met	Met	Met	Met	Met	Met
8.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing and development of corrective action initiatives;	Met	Met	Met	Met	Met	Met	Met
8.3 Enforcement of standards through well-publicized disciplinary guidelines;	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
8.4 Provision for full cooperation by PIHP and PIHP's employees, contractors, and Providers with any investigation conducted by Federal or State authorities, including DMA or MFCU/MID, and including promptly supplying all data and information requested for their respective investigations	Met	Met	Met	Met	Met	Met	Met
9. In accordance with 42 CFR 436.606(a)(vii), PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under DMA Contract, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under DMA Contract; and making documentation of investigations and compliance available as requested by the State.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse.	Met	Met	Met	Met	Met	Met	Met
10.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse;	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
10.2 Detailed workflow of the PIHP process for taking a complaint from inception through closure. This process shall include procedures for logging the complaint, determining if the complaint is valid, assigning the complaint, investigating, appeal, recoupment, and closure. The detailed workflow needs to differentiate the steps taken for fraud versus abuse; PIHP shall establish and implement policies for treatment of recoveries of all overpayments from PIHP to Providers and contracted agencies, specifically including retention policies for treatment of recoveries of overpayments due to fraud, waste, or abuse. The retention policies shall include processes, timeframes, and required documentation for payment of recoveries of overpayments to the State in situations where PIHP is not permitted to retain some or all of the recoveries of overpayments. This provision shall not apply to any amount of recovery to be retained under False Claims Act cases or through other investigations.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
10.3 In accordance with Attachment Y – Audits/Self-Audits/Investigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.	Met	Met	Met	Met	Met	Met	Met
10.4 Process for tracking overpayments, collections, and reporting on Attachment Y– Audits/Self-Audits/Investigations	Met	Met	Met	Met	Met	Met	Met
10.5 Process for handling self-audits and challenge audits;	Met	Met	Met	Met	Met	Met	Met
10.6 Process for using data mining to determine leads;	Met	Met	Met	Met	Met	Met	Met
10.7 Process for informing PIHP employees, subcontractors and providers regarding the False Claims Act;	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
10.8 If PIHP makes or receives annual payments of at least $5,000,000, PIHP shall establish and maintain written policies for all employees, contractors or agents that detail information about the False Claims Act and other Federal and State laws as described in the Social Security Act 1902(a)(66), including information about rights of employees to be protected as whistleblowers.	Met	Met	Met	Met	Met	Met	Met
10.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains DMA-standardized elements or a DMA-approved template;	Met	Met	Met	Met	Met	Met	Met
10.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding overpayments, assessments, penalties, or fees due to any State or Federal agency deemed applicable by PIHP, subject to the accessibility of such financial information in a readily available database or other search mechanism.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
11. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements. Nothing in this Contract is intended to address any requirement for PIHP to offer Providers written notice of the process for appealing to the NC Office of Administrative Hearings or any other forum.	Met	Met	Met	Met	Met	Met	Met
12. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to DMA within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
13. In each case where PIHP refers to DMA an allegation of fraud involving a Provider, PIHP shall provide DMA Program Integrity with the following information on the DMA approved template:							
13.1 Subject (name, Medicaid provider ID, address, provider type);	Met	Met	Met	Met	Met	Met	Partially Met
13.2 Source/origin of complaint;	Met	Met	Met	Met	Met	Met	Met
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	Met	Met	Met	Met	Met	Met	Met
13.4 Description of suspected intentional misconduct, with specific details including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations or policies violated; and dates of suspected intentional misconduct;	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
13.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;	Met	Met	Met	Met	Met	Met	Met
13.6 All communications between PIHP and the Provider concerning the conduct at issues, when available.	Met	Met	Met	Met	Met	Met	Met
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and;	Met	Met	Met	Met	Met	Met	Met
13.8 Sample/exposed dollar amount, when available.	Met	Met	Met	Met	Met	Met	Met
14. In each case where PIHP refers suspected Enrollee fraud to DMA, PIHP shall provide DMA Program Integrity with the following information on the DMA approved template:							
14.1 The Enrollee's name, birth date, and Medicaid number;	NA	NA	NA	NA	NA	NA	NA
14.2 The source of the allegation;	NA	NA	NA	NA	NA	NA	NA
14.3 The nature of the allegation, including the timeframe of the allegation in question;	NA	NA	NA	NA	NA	NA	NA

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;	NA	NA	NA	NA	NA	NA	NA
14.5 Contact information for PIHP staff persons with practical knowledge of the allegation;	NA	NA	NA	NA	NA	NA	NA
14.6 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation; and	NA	NA	NA	NA	NA	NA	NA
14.7 The legal and administrative status of the case.	NA	NA	NA	NA	NA	NA	NA
15. PIHP and DMA shall mutually agree on program integrity and monitoring forms, tools, and letters that meet the requirements of State and Federal law, rules, and regulations, and are consistent with the forms, tools and letters utilized by other PIHPs.	Met	Met	Met	Met	Met	Met	Met
16. PIHP shall use the DMA Fraud and Abuse Management System (FAMS) or a DMA approved alternative data mining technology solution to detect and prevent fraud, waste and abuse in managed care.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
17. If PIHP uses FAMS, PIHP shall work with the DMA designated Administrator to submit appropriate claims data to load into the DMA Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. If PIHP uses FAMS, PIHP shall notify the DMA designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
18. PIHP shall submit to the DMA Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month. Section 9.8 Fraud and Abuse Reports. In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to DMA Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not limited to overpayments and self-audits. The monthly report shall be due by 11:59p.m. on the tenth (10th) of each month in the format as identified in Attachment Y. PIHP shall also report to DMA Program Integrity all Network Provider contract terminations and non-renewals initiated by PIHP, including the reason for the termination or non-renewal and the effective date. The only report shall be due by 11:59p.m. on the tenth (10th) day of each month in the format as identified in attachment Z – Terminations, Provider Enrollment Denials, Other Actions. Compliance with the reporting requirements of Attachments X, Y and Z and any mutually approved template shall be considered compliance with the reporting requirements of this Section.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
19. PIHP shall submit to the DMA Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month. Section 9.8 Fraud and Abuse Reports. In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to DMA Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not limited to overpayments and self-audits. The monthly report shall be due by 11:59p.m. on the tenth (10th) of each month in the format as identified in Attachment Y. PIHP shall also report to DMA Program Integrity all Network Provider contract terminations and non-renewals initiated by PIHP, including the reason for the termination or non-renewal and the effective date. The only report shall be due by 11:59p.m. on the tenth (10th) day of each month in the format as identified in attachment Z – Terminations, Provider Enrollment Denials, Other Actions. Compliance with the reporting requirements of Attachments X, Y and Z and any mutually approved template shall be considered compliance with the reporting requirements of this Section.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
20. On a quarterly basis, DMA shall review a sample of cases where the PIHP's Special Investigation Unit has identified overpayments, investigated or audited a provider. The results of these reviews will be discussed during the PIHP monthly Program Integrity meetings to assure that DMA is providing consistent guidance on expectations with regard to referrals for potential cases of fraud. DMA shall also determine what additional technical assistance may be available to PIHP to support PIHP's efforts in making referrals.	Met	Met	Met	Met	Met	Met	Met
VIII C. PROVIDER PAYMENT SUSPENSIONS AND OVERPAYMENTS							
1.1 In the circumstances described in Section 14.3 (c) above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.	Partially Met	Met	Met	Met	Met	Met	Not Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
2. Upon receipt of a payment suspension notice from DMA Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of DMA Program Integrity's suspension and lasting until PIHP is notified by DMA Program Integrity in writing that the suspension has been lifted.	Partially Met	Met	Met	Met	Met	Met	Met
3. PIHP shall provide to DMA all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.	Met	Met	Met	Met	Met	Met	Met
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to DMA Program Integrity due to allegations of suspected fraud without prior written approval from DMA Program Integrity or the MFCU/MID.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
5. Notwithstanding the foregoing, nothing herein shall be construed as prohibiting PIHP from taking any action against a Network Provider in accordance with the terms and conditions of any written agreement with a Network Provider, including but not limited to prepayment review, identification and collection of overpayments, suspension of referrals, de-credentialing, contract nonrenewal, suspension or termination or other sanction, remedial or preventive efforts necessary to ensure continuous, quality care to Enrollees, regardless of any ongoing investigation being conducted by DMA, MFCU/MID or other oversight agency, to the extent that such action shall not interfere with Enrollee access to care or with any such ongoing investigation being conducted by DMA, MFCU/MID or other oversight agency.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
6. In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with N.C.G.S. 108C-5, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery.	Met	Met	Met	Met	Met	Met	Not Met
7. The MFCU/MID reserves the right to prosecute or seek civil damages regardless of payments made by the Provider to PIHP. The Parties shall work collaboratively to develop a plan for the disbursement of the share of monies that are recovered and returned to the state by the MFCU/MID for fraudulent claims paid by PIHP. DMA will examine options to refund returned funds to PIHP and/or to appropriately account for these recoveries in the rate setting process.	Met	Met	Met	Met	Met	Met	Met

Strengths

- The PIHPs have a well-integrated PI function with touch points to compliance, quality and provider relations committees but also have the necessary independence.
- Each PIHP has well defined compliance and fraud prevention plans.
- When combining all the PI files reviewed for this year's EQR, the total number of files contained 99.76% of the required elements.
- The PIHPs improved their data mining efforts over the past year.

Weaknesses

- Alliance and Vaya need to bolster their policy and/or procedural language related to the lifting of payment suspensions when instructed by NC Medicaid (*DMA Contract, Section 14.2.4*).
- PI file documentation varied across PIHPs in level of organization. Common items such as a referral forms, case log wording, executive summaries, and file naming conventions were inconsistent across PIHP case files.

Recommendations

- For the PIHPs found to be less than fully compliant with *DMA Contract, Section 14.2.4,* policies should be updated to explicitly address the process and timing of imposing and lifting of payment suspensions if instructed to do so by NC Medicaid.
- PIHPs can improve their workflows by systematically capturing and storing PI case file information. The use of standardized referral forms, case notes and executive summaries will improve reporting and review.

I. Financial Services

CCME's financial services EQR review consisted of a pre-Onsite review of Desk Materials, followed by an Onsite interview.

The Desk Materials CCME reviewed included finance policies and procedures, audited financial statements, current year balance sheets and income statements, NC Medicaid monthly financial reports, current year budget, Medicaid Risk Reserve (MRR) account bank statement, medical loss ratio (MLR) calculation, and finance staffing. While non-Medicaid financial information was reviewed, more emphasis was placed on Medicaid reports and processes.

The Onsite visit focused on interviewing PIHP staff about compliance with the finance EQR standards and clarifying questions about Desk Materials. An exit interview was done at the end of the Onsite visit to discuss preliminary findings and concerns, if any.

The PIHPs made improvements from prior years in their 820/834 file analyses. Most PIHPs use financial dashboards to effectively communicate key ratios to management staff. Each PIHP uses the appropriate accounting systems for segregating Medicaid from non-Medicaid funds.

Some of the areas for improvement include the following:

- Not all PIHPs "Met" the record retention standard of ten years for Medicaid records as required by the *DMA Contract*.
- NC Medicaid reports were not always filed timely
- PIHP MRR payments were not always made within five business days of the capitation payment
- PIHP should monitor MLR to make sure it does not fall under 85% *DMA Contract* requirement.

Based on the EQR, six of the seven plans achieved 100% "Met" scores and the remaining plan, Trillium, had one "Partially Met" score, for an average score of 89% "Met" standards.

Figure 10 displays an overview of the PIHPs' performance in the Financial Services section. Each bar represents the percentage of standards that received a "Met" score for the 2018 review year. *Table 17* shows the PIHP performance across all of the individual Financial standards.

Figure 10: Financial Services

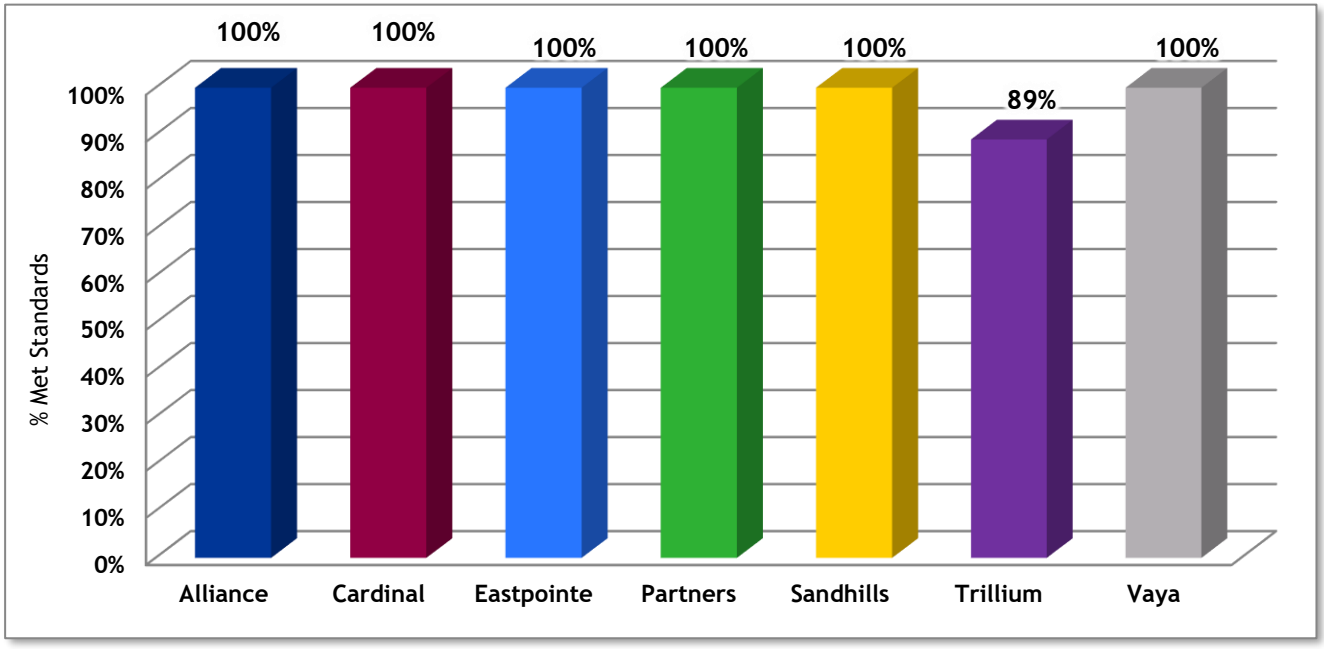


Table 17: Financial Services Comparative Data

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
IX FINANCIAL							
1. The PIHP has policies and systems in-place for submitting and reporting financial data.	Met	Met	Met	Met	Met	Met	Met
2. The PIHP has and adheres to a cost allocation plan that meets the requirements of 42 CFR 433.34.	Met	Met	Met	Met	Met	Met	Met
3. PIHP maintains detailed records of the administrative costs and expenses incurred as required by the DMA contract. (DMA Contract, Section 8.3).	Met	Met	Met	Met	Met	Met	Met
4. Maintains an accounting system in accordance with 42 CFR 433.32 (a).	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
5. The PIHP follows a record retention policy of retaining records for ten years.	Met	Met	Met	Met	Met	Partially Met	Met
6. The PIHP maintains a restricted risk reserve account with a federally guaranteed financial institution.	Met	Met	Met	Met	Met	Met	Met
7. The required minimum balance of the Risk Reserve Account meets the requirements of the DMA contract. (DMA Contract, Section 1.8 Restricted Risk Reserve Account)	Met	Met	Met	Met	Met	Met	Met
8. All funds received by PIHP are accounted for by tracking Title XIX Medicaid expenditures separately from services provided using other funding, as required by the DMA contract (DMA Contract, Section 1.9).	Met	Met	Met	Met	Met	Met	Met
9. The Medical Loss Ratio (MLR) meets the requirements of 42 CFR 438.8 and the DMA contract (Amendment 2, Section 12.3 Item k).	Met	Met	Met	Met	Met	Met	Met

Strengths

- Each PIHP improved their 820/834 file analysis and reconciliation processes.
- Most PIHPs use financial dashboards to communicate key ratios to management staff.
- All PIHPs maintained their restricted reserve accounts with federally guaranteed financial institutions, and most are making timely deposits. No withdrawals were made from these funds.
- All PIHPs use appropriate accounting systems and general ledger structure for segregating Medicaid funds and identifying administrative costs.

Weaknesses

- Not all of the PIHPs "Met" the record retention standard of 10 years for Medicaid records required by *DMA Contract*, *Section 8.3.2*.
- Policies and procedures did not always include the update date and were not always updated within one year.
- Policies did not always have proper details about staff responsibility and contract references.
- NC Medicaid reports were not always filed timely by the 20th of the month.
- MRR deposits were not always paid within five business days of the receipt of the capitation payment.

Recommendations

- Policies and procedures should be developed for finance record retention, administrative cost allocation plan, and monthly submission of NC Medicaid reports.
- Policies and procedures need details of staff responsibilities and references to CFR or *DMA Contract* standards.
- Policies and procedures should be updated and published annually.
- NC Medicaid reports should be filed timely.
- PIHP staff should be formally educated about policy changes.
- PIHP MRR payments should be made within five business days, and PIHP policies should document this deadline in their risk reserve policies and procedures.
- PIHPs should monitor the MLR to make sure it does not fall under the 85% *DMA Contract* requirement.
- PIHPs should add a 10-year financial record requirement to their record retention policy and procedures, as required by *DMA Contract*, *Section 8.3.2*.
- PIHPs should improve their documentation for incurred but not reported (IBNR) liability.
- Any changes made to monthly NC Medicaid financial reports should be communicated to NC Medicaid staff.

OPTIONAL ACTIVITY REVIEW RESULTS

A. Encounter Data Validation

Background

North Carolina Senate Bill 371 requires that each PIHP submit Encounter data "for payments made to providers for Medicaid and state-funded mental health, intellectual/developmental disabilities, and substance abuse disorder services. DHHS may use Encounter data for purposes including, but not limited to, setting PIHP capitation rates, measuring the quality of services managed by PIHPs, assuring compliance with state and federal regulations, and for oversight and audit functions." To use the Encounter data as intended and provide proper oversight, NC Medicaid must be able to deem the data complete and accurate.

CCME contracted with Health Management Systems (HMS) to perform Encounter data validation for each PIHP. The scope of this review, guided by the CMS Encounter Data Validation Protocol, was focused on measuring the data quality and completeness of claims paid by the PIHP for the period of January 2017 through December 2017. All clams paid should be submitted and accepted as a valid Encounter to NC Medicaid. The review included the following:

- A review of the PIHP's response to the Information Systems Capability Assessment (ISCA)
- A review of NC Medicaid's Encounter data acceptance report
- Analysis of the PIHP's Encounter data elements

ISCA Review

NC Medicaid requires each PIHP to submit Encounter data for all paid claims weekly via 837 Institutional and Professional transactions. The companion guides follow the standard ASC X12 transaction set with a few modifications to the use of some segments. For example, the PIHP must submit their provider number and paid amount to the NC Medicaid in the Contract Information CN104 and CN102 segment of Claim Information Loop 2300.

The 837 files are transmitted securely to CSRA and parsed using an electronic data interchange (EDI) validator to check for errors and produce a 999 response to confirm receipt and identify any compliance errors. The behavioral health Encounter claims are then validated by applying a list of edits provided by the state and adjudicated by the Medicaid Management Information System (MMIS). Using existing Medicaid pricing methodology and the billing or rendering provider, the appropriate Medicaid-allowed

amount is calculated for each Encounter claim in order to shadow price what was paid by the PIHP. The PIHP is required to resubmit Encounters for claims that may be rejected due to compliance errors or NC Medicaid edits marked as "DENY" in the individual report received.

HMS focused on the PIHP's response to Section *V. Encounter Data Submission* of the ISCA form related to all 837 Institutional and Professional claims paid from January 2017 through December 2017. *Table 18: Summary of ISCA Review* provides an overview of the ISCA review responses.

Table 18: Summary of ISCA Review

Claim Type	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Accepted	Total
Alliance					
Institutional	106,893	102,277	2,618	1,998	2%
Professional	2,357,894	2,196,805	123,870	37,219	2%
Total	2,464,787	2,299,082	126,488	39,217	2%

Looking at claims with dates of service in 2017, Alliance submitted 2,464,787 unique Encounters to the State. 2% of all Encounters submitted had not been corrected and accepted by NC Medicaid. Compared to claims submitted and accepted in 2016, Alliance has improved on the number of initial denials and total number of outstanding denials for claims submitted in 2017. For denials month over month, Alliance showed significant improvements in the number of claims initially accepted starting in September of 2017.

Claim Type	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Accepted	Total
Cardinal					
Institutional	104,459	99,646	2,547	2,266	2%
Professional	1,817,486	1,515,997	27,149	274,340	15%
Total	1,921,945	1,615,643	29,696	276,606	14%

Cardinal submitted 1,921,945 unique Encounters to the State. 14% of all Encounters submitted had not been corrected and accepted by NC Medicaid. Compared to claims submitted in 2016, Cardinal has decreased the number of initial denials and total number of outstanding denials for claims submitted in 2017. For denials month over month, Cardinal showed significant improvements in the number of claims initially accepted starting in November of 2017.

Claim Type	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Accepted	Total
Eastpointe					
Institutional	118,891	98,319	18,114	2,458	2%
Professional	1,885,955	1,558,893	161,105	165,957	9%
Total	2,004,846	1,657,212	179,219	168,415	8%

Looking at claims with dates of service in 2017, Eastpointe submitted 2,004,846 unique Encounters to the State. 8% of all Encounters submitted had not been corrected and accepted by NC Medicaid. Compared to claims submitted in 2016, Eastpointe had decreased the number of initial denials and total number of outstanding denials for claims submitted in 2017. However, there were a large number of 2016 claims that were outstanding that Eastpointe is not planning to submit. The reason for the large number of outstanding Encounters is due to the transition by Eastpointe to a different claims processing system. Because of the age of the Encounters, there is not an easy way to submit them successfully without turning off numerous edits that did not exist in 2016. NC Medicaid should revisit the outstanding Encounters and ensure that both parties are comfortable with the gap of 2016 Encounters in NCTracks.

Claim Type	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Accepted	Total
Partners					
Institutional	65,365	64,951	56	358	1%
Professional	1,281,939	1,232,678	44,972	4,289	0%
Total	1,347,304	1,297,629	45,028	4,647	0%

Looking at claims with dates of service in 2017, Partners submitted 1,347,304 unique Encounters to the State. Less than 1% of all Encounters submitted had not been corrected and accepted by NC Medicaid. Compared to claims submitted in 2016, Partners has decreased the number of initial denials and total number of outstanding denials for claims submitted in 2017.

Claim Type	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Accepted	Total
Sandhills					
Institutional	31,204	28,989	2,048	167	1%
Professional	1,138,552	1,002,336	95,689	40,527	4%
Total	1,169,756	1,031,325	97,737	40,694	3%

Sandhills submitted 1,169,756 unique Encounters to the State. 3% of all 2017 Encounters submitted had not been corrected and accepted by NC Medicaid. This was a big improvement compared to last year's review for which Sandhills had a denial rate of 12% for 2016 Encounters submitted.

Claim Type	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Accepted	Total
Trillium					
Institutional	46,723	46,335	26	362	1%
Professional	827,711	688,673	70,905	68,133	8%
Total	874,434	735,008	70,931	68,495	8%

Looking at claims with dates of service in 2017, Trillium submitted 874,434 unique Encounters to the State. 8% of all Encounters submitted had not been corrected and accepted by NC Medicaid. The rejection rate is significantly better than 2016, which was 29%.

Claim Type	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Accepted	Total
Vaya					
Institutional	44,650	42,121	154	2,375	5%
Professional	1,770,587	1,598,936	79,276	92,375	5%
Total	1,815,237	1,641,057	79,430	94,750	5%

Looking at claims with dates of service in 2017, Vaya submitted 1,815,237 unique Encounters to the state. Less than 5% of all Encounters submitted had not been corrected and accepted by NC Medicaid. Compared to claims submitted in 2016, Vaya has decreased the number of initial denials and total number of outstanding denials for claims submitted in 2017. The PIHP had also done a great job cleaning up outstanding denials from 2016 with less than 1% still in error.

Analysis of Encounters

The analysis of Encounter data evaluated whether each PIHP submitted complete, accurate, and valid data to NC Medicaid for all claims paid between January 2017 through December 2017. Each PIHP pulled all claims adjudicated and submitted to NC Medicaid during 2007 and sent to HMS via SFTP.

To evaluate the data, HMS imported the 837I and 837P data extracts and loaded them to a consolidated data base. After data onboarding was completed, HMS used proprietary, internally-designed data analysis tools to review each data element, focusing on the required data elements defined. These tools evaluate the presence of data in each field within a record, as well as whether the value for the field is within accepted standards. Results of these checks were compared with general expectations for each data field and to the CMS standards adopted for Encounter data. *Table 19: Encounter Data Quality Standards* depicts the specific data expectation and validity criteria applied.

Table 19: Encounter Data Quality Standards

Data Quality Standards for Evaluation of Submitted Encounter Data Fields Adapted and Revised from CMS Encounter Validation Protocol		
Data Element	**Expectation**	**Validity Criteria**
Recipient ID	Should be valid ID as found in the State's eligibility file. Can use State's ID unless State also accepts Social Security Number.	100% valid
Recipient Name	Should be captured in such a way that makes separating pieces of name easy. Expect data to be present and of good quality	85% present. Lengths should vary, but there should be at least some last names of >8 digits and some first names of < 8 digits, validating that fields have not been truncated. Also, a high percentage of names should have at least a middle initial.
Recipient Date of Birth	Should not be missing and should be a valid date.	< 2% missing or invalid
MCO/PIHP ID	Critical Data Element	100% valid
Provider ID	Should be an enrolled provider listed in the provider enrollment file.	95% valid
Attending/Rendering Provider ID	Should be an enrolled provider listed in the provider enrollment file (will accept the MD license number if it is listed in the provider enrollment file).	> 85% match with provider file using either provider ID or MD license number
Provider Location	Minimal requirement is county code, but zip code is strongly advised.	> 95% with valid county code > 95% with valid zip code (if available)
Place of Service	Should be routinely coded, especially for physicians.	> 95% valid for physicians > 80% valid across all providers

Data Quality Standards for Evaluation of Submitted Encounter Data Fields Adapted and Revised from CMS Encounter Validation Protocol		
Data Element	**Expectation**	**Validity Criteria**
Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% non-missing and valid on physician or other applicable provider type claims (e.g., other practitioners)
Principal Diagnosis	Well-coded except by ancillary type providers.	> 90% non-missing and valid codes (using International Statistical Classifications of Diseases, Ninth Revision, Clinical Modification [ICD- 9-CM] lookup tables) for practitioner providers (not including transportation, lab, and other ancillary providers)
Other Diagnosis	This is not expected to be coded on all claims even with applicable provider types, but should be coded with a fairly high frequency.	90% valid when present
Dates of Service	Dates should be evenly distributed across time.	If looking at a full year of data, 5%– 7% of the records should be distributed across each month.
Unit of Service (Quantity)	The number should be routinely coded.	98% nonzero <70% should have one if Current Procedural Terminology (CPT) code is in 99200–99215 or 99241–99291 range.
Procedure Code	Critical Data Element	99% present (not zero, blank, or 8- or 9-filled). 100% should be valid, State-approved codes. There should be a wide range of procedures with the same frequency as previously encountered.

Data Quality Standards for Evaluation of Submitted Encounter Data Fields Adapted and Revised from CMS Encounter Validation Protocol		
Data Element	**Expectation**	**Validity Criteria**
Procedure Code Modifier	Important to separate out surgical procedures/ anesthesia/assistant surgeon, not applicable for all procedure codes.	> 20% non-missing. Expect a variety of modifiers both numeric (CPT) and Alpha (Healthcare Common Procedure Coding System [HCPCS]).
Patient Discharge Status Code (Hospital)	Should be valid codes for inpatient claims, with the most common code being "Discharged to Home." For outpatient claims, the code can be "not applicable."	For inpatient claims, expect >90% "Discharged to Home." Expect 1%–5% for all other values (except "not applicable" or "unknown").
Revenue Code	If the facility uses a UB04 claim form, this should always be present	100% valid

In addition to performing an evaluation of the submitted Encounter data, an HMS Analyst reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all Encounters submitted, accepted, and denied for each PIHP. The report is tracked by check write, which made it difficult to tie back to ISCA responses and the submitted Encounter files since only the Date of Service for each is available.

Results and Recommendations

The results of the Encounter data validation found that only Sandhills' Encounter data submitted to NC Medicaid was complete and accurate. However, minor issues were noted with both Institutional and Professional encounters due to missing additional diagnosis codes. *Table 20: Overall Validation Results and Recommendations* provides an overview of the results of each PIHP's Encounter data validation review results and the recommendations HMS provided.

For the next review period, HMS recommends reviewing NCTracks Encounter data to look at Encounters that pass front-end edits and are adjudicated to either a paid or denied status. It is difficult to reconcile the various tracking reports with the data submitted by the PIHP. Reviewing an extract from NCTracks would provide insight into how the State's MMIS handles the Encounter claims and could be reconciled back to reports requested from the PIHPs. The goal is to ensure each PIHP is reporting all paid claims as Encounters to NC Medicaid.

Table 20: Overall Validation Results and Recommendations

Alliance		
Issue	**Findings**	**Recommendations**
Procedure Code	The procedure code for Institutional claims should populated 99% of the time. In the Encounter data provided, HMS found that the field was populated 59% of the time with valid values; in all other instances the value was null.	Alliance should ensure that the appropriate data validation checks and that claims submitted through their portal or an 837 should be denied by Alliance without the proper revenue code and procedure code combination. Alliance should review their 837-Encounter creation and Encounter data extract process to ensure that an invalid procedure code is not transmitted to NC Medicaid, even when the data is invalid based on the provider claim submission.
Diagnosis Codes	The secondary diagnosis was not populated at all for Institutional claims. This value is not required by Alliance when adjudicating the claim, therefore, not a requirement of the provider when submitting via Provider Portal or 837.	Alliance should work closely with their provider community and encourage them to submit all applicable diagnosis codes, behavioral and medical. This information is key for measuring member health, identifying areas of risk, and evaluating quality of care. Alliance did confirm that they are capturing additional diagnosis codes and made changes to report them to NC Medicaid in their Encounter submission in 2018. HMS will validate this update in our 2018 Encounter data review.
Based on the analysis of Alliance's Encounter data, HMS concluded that the data submitted to NC Medicaid is not complete and accurate. Minor issues still exist with their submission of Institutional Encounters and need to be addressed in order to be compliant. Alliance should take Corrective Action to resolve the issues identified with procedure codes and diagnosis codes, and continue to work on improving all up-front denials. Alliance has outlined a great approach and implemented several key practices to ensure that their front-end denials continue to decrease as well as their total outstanding Encounter denials. It is HMS's expectation that Alliance will be able to demonstrate accurate and complete data for Encounters submitted in 2018 and moving forward.		

Cardinal		
Issue	**Findings**	**Recommendations**
Procedure Code	The procedure code for Institutional claims should be populated 99% of the time. In the Encounter data provided, HMS found that the field was populated 37% of the time with invalid values. Screenshots provided by Cardinal reflected that the provider was submitting the revenue code for both the revenue code field and procedure code field.	Cardinal should ensure that the appropriate data validation checks are in place in their provider portal to prevent revenue codes from being submitted in the procedure code fields. Claims submitted through the portal or an 837 should be denied by Cardinal without the proper revenue code and procedure code combination. Cardinal should review their 837-Encounter creation and Encounter data extract process to ensure that an invalid procedure code is not transmitted to NC Medicaid, even when the data is invalid based on the provider claim submission.
Diagnosis Code	The secondary diagnosis was populated less than 12% for Professional claims. This value is not required by Cardinal when adjudicating the claim, therefore, not a requirement of the provider when submitting via Provider Portal or 837.	Cardinal should work closely with their provider community and encourage them to submit all applicable diagnosis codes, behavioral and medical. This information is key for measuring member health, identifying areas of risk, and evaluating quality of care.
Discharge Status	Patient Discharge Status is not populated for any of the Institutional claims. This is a required field and should be captured more than 90% of the time for Inpatient claims. During the ISCA review, Cardinal revealed that this field is captured during claim submission.	Cardinal should update their process to ensure the provider is submitting discharge statuses for the appropriate inpatient services and capture and carry through the discharge status for claims to their data warehouse. Going forward, this will enable Cardinal to report the value in their Encounters to NC Medicaid. The PIHP should review and update their 837-formatting process to ensure the field is submitted to NC Medicaid moving forward.

Cardinal		
Issue	**Findings**	**Recommendations**
Taxonomy code and Attending/Rendering providers	Rendering provider ID and taxonomy values were not consistently populated. This information is key for passing the front-end edits put in place by the State and to effectively price the claim. This impacts pricing since NCTracks is expecting the correct combination of NPI, taxonomy and procedure code. When values were populated, the taxonomy code did not always match up with the taxonomy values enrolled in NCTracks for the Billing and/or Rendering Provider. These errors result in denials by NC Medicaid that must be corrected and resubmitted.	As outlined in their ISCA response, Cardinal has a process in place to review denials and correctly resubmit to the State Encounters that were denied due to invalid or missing taxonomy. Cardinal should continue to follow their current process as well as monitor the front-end edits that were implemented in 2017 and 2018 to prevent these errors at the point of claim submission and to ensure they are working as intended. The Encounter data reviewed, and NC Medicaid check write report reflects significant improvement over the last few months of 2017, which indicates the process in place is making a positive impact.

Based on the analysis of Cardinal's Encounter data, HMS concluded that the data submitted to NC Medicaid is not complete and accurate. Minor issues were noted with both Institutional and Professional Encounters. Cardinal should take Corrective Action to resolve the issues identified with procedure code and diagnosis codes, and continue work on improving taxonomy denials.

Eastpointe		
Issue	**Findings**	**Recommendations**
Procedure Code	The procedure code for Institutional claims should populated 99% of the time. In the Encounter data provided, HMS found that the field was populated less than 36% of the time with valid values. These fields are required to properly adjudicate the claim and should be provided by the provider given the types of services being billed and supporting revenue codes provided.	Eastpointe should check their claims processing system and data warehouse to ensure the procedure code is correctly captured. Eastpointe should deny claims submitted through the portal or an 837 without the proper revenue code and procedure code combination. Eastpointe should double check their 837-Encounter creation process and Encounter data extract process to ensure data was not lost or manipulated during transformation.
Diagnosis Code	Two items need to be addressed as it relates to diagnosis codes. The secondary diagnosis was populated less than 11% for Professional claims and only the admitting and principal diagnosis was provided for Institutional claims. In addition, there are never more than two diagnosis codes provided/submitted in the Encounter data for Professional or Institutional claims.	The diagnosis issue will require action by Eastpointe and NC Medicaid. NC Medicaid will need to work with the PIHPs and CSRA to determine what additional non-behavioral health diagnosis codes should be submitted and accepted when available. Currently, NCTracks will deny any Encounter with a non-behavioral health diagnosis regardless of the position of the diagnosis code value (i.e. primary, secondary, tertiary, etc.). There are behavioral health services provided by the PIHPs that require medical services and medical diagnosis codes. Eastpointe will need to work collaboratively with the state and AlphaMCS to ensure they can capture and report all diagnosis codes once NCTracks has been updated to accept them. Eastpointe indicated that they are capturing all submitted diagnosis codes and can begin to transmit once NC Medicaid has a mechanism to accept the additional values.
Taxonomy code for Billing and Rendering providers	Taxonomy values were not consistently populated with valid data. This information is key for passing the front-end edits put in place by the State and to effectively price the claim. This impacts pricing since NCTracks is expecting the correct combination of NPI, taxonomy and procedure code. When values were populated, the taxonomy code did not always match up with the taxonomy values enrolled in NCTracks for	As outlined in their ISCA response, Eastpointe has a process in place to review denials and correctly resubmit Encounters to the State that were denied due to invalid or missing taxonomy. Eastpointe should continue to follow their current process. The Encounter data reviewed, and NC Medicaid check write report reflects significant improvement over last year.

Eastpointe		
Issue	**Findings**	**Recommendations**
	the Billing and/or Rendering Provider. These errors result in denials by NC Medicaid that must be corrected and resubmitted.	
Based on the analysis of Eastpointe's Encounter data, HMS concluded that the data submitted to NC Medicaid is not complete and accurate. Minor issues were noted with both Institutional and professional Encounters. Eastpointe should take Corrective Action to resolve the issues identified with procedure code and diagnosis codes, as well as continue work on improving taxonomy denials.		

Partners		
Issue	**Findings**	**Recommendations**
Recipient Id	The Recipient Id was not consistently populated with valid data for Professional or Institutional claims. This information is key for passing the front-end edits put in place by the State and to effectively price the claim. All Recipient Ids should be a ten-byte, alpha numeric field. The value was always populated; however, not always with the correct length or expected format.	Partners should check their claims processing system and data warehouse to ensure the Recipient Id is properly captured. Claims submitted through the portal or an 837 would be denied by Partners. Partners should double check their 837-Encounter creation process and Encounter data extract process to ensure data was not lost or manipulated during transformation.
Dates of Service	A valid date of service is required to properly adjudicate a claim. This issue only occurred in the Institutional claims data provided.	Dates of service are a required field. Partners should be unable to pay Institutional claims without this information. The MCO should check their claims processing system and data warehouse to ensure the field is required and properly captured. If captured correctly, Partners should double check their 837-Encounter creation process and

Partners		
Issue	**Findings**	**Recommendations**
		Encounter data extract process to ensure data was not lost during transformation.
Diagnosis Code	Two items need to be addressed as it relates to diagnosis codes. The principal diagnosis was not populated for 100% of the claims. Typically, the claim would be denied by Partners when adjudicating claim, and denied by NC Medicaid when submitted as an Encounter record. Also, there are never more than 2 diagnosis codes provided/submitted in the Encounter data for Professional or Institutional claims.	The missing principal diagnosis code is not large enough to exceed the threshold outlined in the Data Quality Standards table above (>90%); however, Partners should review the data being captured and submitted to ensure that claims are never submitted without a principal diagnosis. The second part noted above will require action by Partners and NC Medicaid. NC Medicaid will need to work with the PIHPs and CSRA to determine what additional non-behavioral health diagnosis codes should be submitted and accepted when available. Currently, NCTracks will deny any Encounter with a non-behavioral health diagnosis regardless of the position of the diagnosis code value (i.e. primary, secondary, tertiary, etc.). There are behavioral health services provided by the PIHPs that require medical services and medical diagnosis codes. Partners will need to work collaboratively with the state and AlphaMCS to ensure they can capture and report all diagnosis codes once NCTracks is updated to accept them.

Based on the analysis of Partners' Encounter data, HMS concluded that the data submitted to NC Medicaid is not complete and accurate. Minor issues were noted with both Institutional and professional Encounters. Based on Partners' ISCA response, overview of the AlphaMCS system, and limited number of data anomalies, HMS believes that the errors are associated with the creation of the 837 rather than the data received and maintained. Partners should take Corrective Action to resolve the issues identified with Recipient ID, Dates of Service, and diagnosis codes.

Sandhills		
Issue	**Findings**	**Recommendations**
Taxonomy code for Billing and Rendering providers	Taxonomy values were consistently populated; however, this is the primary denial for all Sandhills' Encounters submitted. This information is key for passing the front-end edits put in place by the State and to effectively price the claim. NCTracks is expecting the correct combination of NPI, taxonomy and procedure code. The taxonomy code did not always match up with the taxonomy values enrolled in NCTracks for the Billing and/or Rendering Provider. These errors result in denials by the NC Medicaid that must be corrected and resubmitted.	Continue to follow the process built by Sandhills and AlphaMCS. As time passes and providers are educated, the initial denials due to invalid taxonomy codes should naturally go down. Denials have already dropped dramatically overall and specifically for invalid taxonomy codes. In the 2017 review, invalid taxonomies made up 70% of all denials, and now only account for 48% of denials.
Other Diagnosis	Other Diagnosis was only populated 6% of the time for Institutional and Professional claims. Principal and admitting diagnoses were populated consistently where appropriate, however, no more than one additional diagnosis was received for any claim. Sandhills should be capturing up to the maximum allowed.	Sandhills should expand the number of diagnosis codes being captured in their system. This update will also require Sandhills to modify their 837 mapping to ensure all diagnosis codes captured are sent to NC Medicaid moving forward.

Based on the analysis of Sandhills' Encounter data, HMS concluded that the data submitted to NC Medicaid is complete and accurate. However, minor issues were noted with both Institutional and professional Encounters due to missing additional diagnosis codes. Sandhills should take Corrective Action to resolve the issues identified specifically with Billing Taxonomy, Rendering Taxonomy, and missing diagnosis codes. As indicated in Sandhills' ISCA response, they have already defined a strategy to address issues with invalid or missing taxonomy codes, as well as a reconciliation process to address all NC Medicaid denials noted in the report above. The issue with missing diagnosis codes does not impact the ability to price the claims; however, it will have an impact to NC Medicaid's ability to provide proper oversight and measure effectiveness. Sandhills should work with AlphaMCS to capture all diagnosis codes as transmit to NC Medicaid as soon as possible.

Trillium		
Issue	**Findings**	**Recommendations**
Taxonomy code for billing and rendering providers	Taxonomy values were consistently populated for Institutional claims; however, both the Rendering/Attending Provider Id and Specialty were missing for 61% of the claims. This is the primary denial for all Trillium Encounters submitted. This information is key for passing the front-end edits put in place by the State and to effectively price the claim. NCTracks is expecting the correct combination of NPI, taxonomy and procedure code. The taxonomy code did not always match up with the taxonomy values enrolled in NCTracks for the Billing and/or Rendering Provider. These errors result in denials by the NC Medicaid that must be corrected and resubmitted.	As outlined in their ISCA response, Trillium has a process in place to review denials and correctly resubmit Encounters to the State that were denied due to invalid or missing taxonomy. Trillium should continue to follow their current process and HMS will continue to monitor to ensure that the issue improves.
Procedure Code	The procedure code should be populated 99% of the time. In the Encounter files provided, HMS found that the procedure code was populated more than 85% of the time with invalid values for Institutional claims. The Professional claims were accurate for 100% of the claims received. For Institutional claims, the procedure code was populated with a mix of valid procedure codes and revenue codes. Revenue codes should never be received or populated in the procedure code field.	Procedure codes are a required field to correctly pay the claim. Trillium should check their claims processing system and data warehouse to ensure the field is required and properly captured. Trillium should also ensure that the appropriate data validation checks are in place in their provider portal to prevent revenue codes from being submitted in the procedure code fields. If captured correctly, Trillium should double check their 837-Encounter creation process and EDI translator to ensure the data was not lost during transformation.

Trillium		
Issue	**Findings**	**Recommendations**
Based on the analysis of Trillium's Encounter data, HMS concluded that the data submitted to NC Medicaid is not complete or accurate as defined by NC Medicaid standards. Trillium should take Corrective Action to resolve the issues identified specifically with taxonomy denials and procedure codes for Institutional claims. As indicated in Trillium's ISCA response, they have already defined a strategy to address issues with invalid or missing taxonomy codes, as well as a reconciliation process to address all NC Medicaid denials noted in the report above. Compared to claims reviewed from 2016, Trillium's denial rate has dropped from 29% to 9%.		

Vaya		
Issue	**Findings**	**Recommendations**
Procedure Code	The procedure code for Institutional claims should be populated 99% of the time. In the Encounter files provided, HMS found that the field was populated less than 45% of the time. These fields are required to correctly adjudicate the claim and should be provided by the provider given the types of services being billed and supporting revenue codes provided.	Vaya should check their claims processing system and data warehouse to ensure the procedure code is properly captured. Vaya should deny claims submitted through the portal or an 837 without the proper revenue code and procedure code combination. Vaya should double check their 837-Encounter creation process and Encounter data extract process to ensure data was not lost or manipulated during transformation.

Vaya		
Issue	**Findings**	**Recommendations**
Diagnosis Code	Two items need to be addressed as it relates to diagnosis codes. The secondary diagnosis was not populated less than 8% for Professional claims and only the admitting and principal diagnosis was provided for Institutional claims. Also, there are never more than 2 diagnosis codes provided/submitted in the Encounter data for Professional or Institutional claims.	The diagnosis issue will require action by Vaya and NC Medicaid. NC Medicaid will need to work with the PIHPs and CSRA to determine what additional non-behavioral health diagnosis codes should be submitted and accepted when available. Currently, NCTracks will deny any Encounter with a non-behavioral health diagnosis regardless of the position of the diagnosis code value (i.e. primary, secondary, tertiary, etc.). There are behavioral health services provided by the PIHPs that require medical services and medical diagnosis codes. Vaya will need to work collaboratively with the state and AlphaMCS to ensure they can capture and report all diagnosis codes once NCTracks is updated to accept them.

Based on the analysis of Vaya's Encounter data, HMS concluded that the data submitted to NC Medicaid is not complete and accurate. Minor issues were noted with both Institutional and professional Encounters. Vaya should take Corrective Action to resolve the issues identified with procedure code and diagnosis codes.

B. Semi-Annual Audits

North Carolina Senate Bill 208 Effective Operation of 1915(b)/(c) Waiver requires that the Secretary of NC DHHS certify each PIHP is in compliance with the provisions of *S.L. 2011-264*, as amended by *Section 13 of S.L. 2012-151*, as well as all applicable federal, state, and contractual requirements. CCME contracted with HMS to complete four required tasks. Those tasks include claims audit, timeliness of provider payments, HIPAA Transaction Capability and Compliance, and financial solvency. *Tables 21 and 22* provide an overview of the HMS audits of the PIHPs' claims data and performance timeliness. HMS used statistical samples of Medicaid data from September 2017 to February 2018 for the first audit and March 2018 through August 2018 for the second audit.

Table 21: Claims Accuracy and Timeliness Review: Summary Findings September 2017- February 2018

PIHP	Timeliness of Provider Payment (Within 30 Days)		Claims Processing Accuracy		Financial Accuracy	
	Results	Finding	Results	Finding	Results	Finding
Alliance	99.86%	Compliant	99.97%	Compliant	99.94%	Compliant
Cardinal	99.90%	Compliant	99.97%	Compliant	99.97%	Compliant
Eastpointe	99.93%	Compliant	100%	Compliant	100%	Compliant
Partners	99.94%	Compliant	100%	Compliant	100%	Compliant
Sandhills	99.96%	Compliant	99.93%	Compliant	99.96%	Compliant
Trillium	100%	Compliant	99.41%	Compliant	99.66%	Compliant
Vaya	99.97%	Compliant	100%	Compliant	99.98%	Compliant

Note: Data were based on a statistical sample of Medicaid claims processed from September 1, 2017 through February 28, 2018 for each PIHP.

Table 22: Claims Accuracy and Timeliness Review: Summary Findings March 2018- August 2018

PIHP	Timeliness of Provider Payment (Within 30 Days)		Claims Processing Accuracy		Financial Accuracy	
	Results	Finding	Results	Finding	Results	Finding
Alliance	98.03%	Compliant	99.94%	Compliant	99.95%	Compliant
Cardinal	99.99%	Compliant	100%	Compliant	100%	Compliant
Eastpointe	99.94%	Compliant	99.98%	Compliant	100%	Compliant
Partners	99.96%	Compliant	100%	Compliant	100%	Compliant
Sandhills	100%	Compliant	99.94%	Compliant	99.95%	Compliant
Trillium	100%	Compliant	99.81%	Compliant	99.90%	Compliant
Vaya	99.92%	Compliant	100%	Compliant	100%	Compliant

Note: Data were based on a statistical sample of Medicaid claims processed from March 1 to August 31, 2018 for each PIHP.

The six following tables provide an overview of the results of the financial solvency review. A current ratio greater than 1.0 is considered compliant. HMS used data based on financial information combined for state and Medicaid funds for each PIHP. Time periods are noted in each table.

Table 23: Financial Solvency Review – Summary Findings (Current Ratio > 1.0 is Compliant)

PIHP	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018
Alliance	3.43	3.78	3.75	3.23	3.54	3.72
Cardinal	4.15	4.44	4.12	4.05	3.75	3.95

PIHP	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018
Eastpointe	3.09	3.26	3.03	2.66	2.92	2.71
Partners	4.46	5.06	4.70	3.82	4.78	4.23
Sandhills	7.61	8.31	7.93	6.44	8.50	8.85
Trillium	2.57	2.67	2.36	2.14	1.84	1.88
Vaya	3.22	3.42	3.44	2.83	3.27	3.31

Note: Data were based on financial information combined for state and Medicaid funds September 1, 2017 through February 28, 2018 for each PIHP.

Table 24: Financial Solvency Review – Summary Findings (Current Ratio > 1.0 is Compliant)

PIHP	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
Alliance	3.82	3.52	4.05	3.14	3.31	3.13
Cardinal	3.77	3.67	3.89	3.26	3.83	3.38
Eastpointe	2.77	2.81	2.91	2.90	2.90	3.40
Partners	4.07	3.79	4.06	3.29	5.11	3.49
Sandhills	7.89	7.69	8.55	7.94	7.26	6.03
Trillium	1.88	1.92	2.00	1.95	2.22	2.13
Vaya	3.29	3.15	3.58	3.46	3.46	3.60

Note: Data were based on financial information combined for state and Medicaid funds from March 1, 2018 through August 31, 2018 for each PIHP.

Table 25: Financial Solvency Review – Total Expenses

PIHP	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018
Alliance	99%	100%	90%	92%	109%	90%
Cardinal	95%	100%	103%	95%	105%	97%
Eastpointe	91%	96%	93%	97%	96%	94%
Partners	93%	94%	100%	101%	99%	109%
Sandhills	90%	111%	93%	86%	103%	77%
Trillium	96%	108%	111%	94%	123%	70%
Vaya	100%	96%	93%	101%	100%	97%

Note: Data were based on financial information combined for state and Medicaid funds from September 1, 2017 through February 28, 2018 for each PIHP.

Table 26: Financial Solvency Review – Total Expenses

PIHP	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
Alliance	91%	100%	102%	108%	99%	104%
Cardinal	97%	98%	103%	115%	91%	109%
Eastpointe	101%	91%	94%	97%	99%	96%
Partners	98%	102%	98%	126%	80%	118%
Sandhills	104%	97%	105%	112%	107%	104%
Trillium	100%	93%	98%	103%	86%	96%
Vaya	115%	92%	102%	94%	112%	104%

Note: Data were based on financial information combined for state and Medicaid funds for March 1, 2018 through August 31, 2018 for each PIHP.

All PIHPs were compliant for the financial solvency review.

Table 27: Financial Solvency Review – Defensive Interval Summary Findings

PIHP	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018
Alliance	105.20	91.67	95.68	103.59	92.44	96.37
Cardinal	52.37	9617	91.58	107.08	87.72	88.71
Eastpointe	105.85	103.46	108.22	117.68	109.64	105.35
Partners	101.80	94.21	95.72	98.64	92.16	85.00
Sandhills	163.33	154.10	162.33	195.85	163.21	177.11
Trillium	60.01	56.66	55.91	75.01	48.03	52.30
Vaya	85.11	84.33	86.24	89.56	84.28	90.21

Note: Data were based on financial information combined for state and Medicaid funds from September 1, 2017 through February 28, 2018 for each PIHP.

Table 28: Financial Solvency Review – Defensive Interval Summary Findings

PIHP	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
Alliance	102.55	94.75	92.84	71.90	77.42	69.18
Cardinal	96.68	94.41	89.35	75.02	92.25	74.24
Eastpointe	101.03	114.41	115.08	100.95	97.34	110.63
Partners	93.29	89.95	94.06	66.25	89.86	58.16
Sandhills	147.70	162.10	147.54	129.88	145.68	135.72
Trillium	57.13	62.00	58.67	53.73	61.93	58.06
Vaya	87.30	79.74	75.66	80.21	71.13	69.63

Note: Data were based on financial information combined for state and Medicaid funds from March 1, 2018 through August 31, 2018.

Table 29: HIPAA Transaction Review: Summary Findings

PIHP	Enrollment (820)	Health Care Claim Transaction Set (837i and 837p)	Health Care Claim Payment / Advice Transaction Set (835)	Benefit Enrollment and Maintenance Set (834)	Health Care Eligibility / Benefit Inquiry and Response (270/271)
Alliance	Compliant	Compliant	Compliant	Compliant	Compliant
Cardinal	Compliant	Compliant	Compliant	Compliant	Compliant
Eastpointe	Compliant	Compliant	Compliant	Compliant	Compliant
Partners	Compliant	Compliant	Compliant	Compliant	Compliant
Sandhills	Compliant	Compliant	Compliant	Compliant	Compliant
Trillium	Compliant	Compliant	Compliant	Compliant	Compliant
Vaya	Compliant	Compliant	Compliant	Compliant	Compliant

Note: Data were based on financial information combined for state and Medicaid funds from September 1, 2017 through February 28, 2018.

Table 30: HIPAA Transaction Review: Summary Findings

PIHP	Enrollment (820)	Health Care Claim Transaction Set (837i and 837p)	Health Care Claim Payment / Advice Transaction Set (835)	Benefit Enrollment and Maintenance Set (834)	Health Care Eligibility / Benefit Inquiry and Response (270/271)
Alliance	Compliant	Compliant	Compliant	Compliant	Compliant
Cardinal	Compliant	Compliant	Compliant	Compliant	Compliant
Eastpointe	Compliant	Compliant	Compliant	Compliant	Compliant
Partners	Compliant	Compliant	Compliant	Compliant	Compliant
Sandhills	Compliant	Compliant	Compliant	Compliant	Compliant
Trillium	Compliant	Compliant	Compliant	Compliant	Compliant

PIHP	Enrollment (820)	Health Care Claim Transaction Set (837i and 837p)	Health Care Claim Payment / Advice Transaction Set (835)	Benefit Enrollment and Maintenance Set (834)	Health Care Eligibility / Benefit Inquiry and Response (270/271)
Vaya	Compliant	Compliant	Compliant	Compliant	Compliant

Note: Data were based on financial information combined for state and Medicaid funds from March 1, 2018 through August 31, 2018.

A finding of "Compliant" indicates CCME found the PIHP was compliant with outlined requirements. All PIHPs were compliant for the HIPAA Transaction Review.

C. Consumer Satisfaction Survey

The *2018 ECHO Consumer Satisfaction Surveys* were administered from August 8, 2018 through October 10, 2018 to assess consumer perceptions of the seven PIHPs. CCME's subcontractor, DataStat, implemented this survey and analyzed the data. The results from this survey provide NC Medicaid a method to monitor the service quality of each PIHP, as well as the quality of care received from the PIHPs' networks of providers.

Survey Description

The Consumer Assessment of Healthcare Providers and Systems (*CAHPS*®) program, which is funded by the Agency for Healthcare Research & Quality (AHRQ), supports and provides surveys for assessing different health care settings[1]. In preparation for the 2018 survey, NC Medicaid chose the *CAHPS* adult and child versions of the *ECHO Survey for Managed Behavioral Healthcare Organizations, version 3.0*, specifically, surveys 252A (Adult – English), 252B (Adult – Spanish), and 255 (Child). Each survey has more than 50 questions providing specific details and insight into the counseling and treatment enrollees receive, as well as the quality of health care services provided by the PIHP.

Consumer Survey Assistance

CCME requested consumer information from each of the seven PIHPs in a standard format. The letter to the PIHPs requested the following information:

- Medicaid ID and full name
- Date of birth
- Name of guardian, if applicable

[1] Additional information regarding the CAHPS surveys can be found at the following AHRQ website: https://cahps.ahrq.gov/index.html . Specific information regarding the ECHO survey can be accessed at: https://cahps.ahrq.gov/surveys-guidance/echo/index.html.

- Recipient gender
- Contact information as available (address, telephone)
- Duration of enrollment
- Date of most recent visit
- Indication if Spanish language materials are required
- A designation of the types of services the enrollee receives; Mental Health (MH), Substance Use (SU), and/or Intellectual/Developmental Disabilities (I/DD) services

Data from each of the PIHPs was analyzed to ensure all required fields were provided and the population numbers fit with historical counts from past years. The sampling process was then initiated.

Consumer Survey Assistance

A toll-free telephone number was provided where respondents could request more information. The process accommodated languages other than English and Spanish.

Survey Implementation

The survey was administered using a paper, direct-mail strategy with phone follow-up. *Table 31* provides an overview of the survey activities.

Table 31: Survey Administration Timeline

Task	Month / Year
Surveys mailed	August 8, 2018
1st mailing of reminder postcards	August 15, 2018
2nd mailing of survey packets	August 29, 2018
Phone calls to survey non respondents	September 19, 2018
Survey closed	October 10, 2018

Adult Survey Sample and Response Rate

A total random sample of 3,997 cases was drawn of adult enrollees from the PIHPs. Sampling was based on population proportions for enrollees with intellectual/developmental disability (I/DD), substance use (SU), and mental health (MH) diagnoses. A final random sample of 571 enrollees from each PIHP was selected. The sample was drawn from a list of all eligible adult (ages 18 and older) Medicaid beneficiaries provided by each PIHP.

Table 32: Final Response Rate
and Number of Completed Surveys by PIHP - Adult Sample

PIHP	Survey Response Rate	Number of Completed Surveys
Alliance	16.0%	70
Cardinal	12.8%	99
Eastpointe	18.2%	75
Partners	13.8%	89
Sandhills	16.4%	76
Trillium	20.1%	111
Vaya	16.7%	92
NC Overall	**16.0%**	**612**

A completed survey is defined as a valid response to 50% of the key items. The PIHP with the highest response rate was Trillium. Cardinal members had the lowest response rate.

Findings Summary - Adult

The results of the survey are summarized in *Table 33*. The table provides results in the four categories recommended by AHRQ, which are:

- Global Ratings are measures of overall ranking of the quality of counseling and treatment received by respondents.
- Composite Measures are aggregates of multiple questions measuring similar dimensions of care and treatment using the same scale.
- Single Item Measures are single questions selected as key topics to track from the survey.
- Care Coordination Measures are single questions selected as a gauge of enrollee satisfaction with care coordinators.

For each reportable measure, the aggregate result is provided (average percentage of PIHP respondents choosing “8,” “9,” or “10”), as well as the PIHPs with the highest and lowest positive response for each measure.

Conclusion

Table 33, 2018 Consumer Satisfaction Survey Findings Summary - Adult Sample, displays the NC overall percentages on global, composite, and individual items. There was variation in the PIHPs' scoring in the lowest and highest percentage categories and there was no consistency in low and high percentage performance. The table points to areas in where PIHPs may improve performance. Regarding overall rating of counseling and treatment, Trillium's enrollees reported the highest satisfaction. Sandhills' enrollees reported the lowest satisfaction. Partners received the highest scores on two of the five composite items and four of the nine Care Coordination Items. All PIHPs received the lowest satisfactory scores for at least one item.

Table 33: 2018 Consumer Satisfaction Survey Findings Summary – Adult Sample

	NC Aggregate Adult (%)	PIHPs with Highest and Lowest Category Percentage	
		High	Low
GLOBAL			
Overall Rating of Counseling and Treatment	69.7%	Trillium (75%)	Sandhills (59.0%)
COMPOSITE			
Getting Treatment Quickly	58.6%	Eastpointe (72.8%)	Sandhills (50.4%)
How Well Clinicians Communicate	88.4%	Partners (91.8%)	Cardinal (82.8%)
Getting Treatment and Information from the PIHP	49.8%	Alliance (71.9%)	Vaya (28.9%)
Perceived Improvement	55.7%	Partners (66.0%)	Alliance (50.4%)
Information About Treatment Options	54.2%	Cardinal (61.3%)	Alliance (46.8%)
SINGLE ITEM			
Office Wait (seen within 15 minutes)	71.8%	Trillium (76.9%)	Sandhills (63.4%)
Told About Medication Side Effects	79.5%	Alliance (84.6%)	Cardinal (75.5%)
Including Family and Friends	53.7%	Cardinal (59.3%)	Alliance (41.9%)

	NC Aggregate Adult (%)	PIHPs with Highest and Lowest Category Percentage	
		High	Low
Information to Manage Condition	80.6%	Eastpointe (84.1%)	Partners (72.3%)
Patient Rights Information	85.9%	Eastpointe (95.2%)	Vaya (75.0%)
Patient Feels He or She Could Refuse Treatment	82.4%	Trillium (85.2%)	Alliance (74.2%)
Privacy of treatment information	93.3%	Partners (97.8%)	Eastpointe (90.2%)
Cultural Competency	80.8%	Alliance and Sandhills (100%)	Vaya (50%)
Amount Helped	83.2%	Vaya (89.9%)	Sandhills (69.4%)
Treatment After Benefits Are Used Up	50.0%	Sandhills (80.0%)	Alliance (0%)
CARE COORDINATION			
Access to Care Coordinator	82.1%	Partners (88.9%)	Sandhills (61.4%)
Care Coordinator responds in timely manner	84.5%	Partners (94.4%)	Alliance (80.0%)
Care Coordinator helps with answers to questions	82.3%	Partners (94.4%)	Alliance (80.0%)
Care Coordinator helps find services/support	78.9%	Sandhills (92.9%)	Eastpointe (66.7%)
Care Coordinator asks how best to support me	83.8%	Alliance (100%)	Trillium and Vaya (75.0%)
Received draft of Person Centered Plan to review	84.6%	Cardinal (100%)	Eastpointe (76.9%)
Satisfied with Person Centered Plan	83. 8%	Cardinal (93.3%)	Eastpointe (76.9%)
Revisions were added to plan if requested*	44.4%	Cardinal, Eastpointe, Partners (100%)	Sandhills (0%)
Care Coordinator discusses appeal process and submission	50.68%	Partners (71.4%)	Alliance (14.3%)

Child Survey Sample and Response Rate

A total random sample of 3,997 cases was drawn of child enrollees. Sampling was based on population proportions for enrollees with IDD, SA, and MH diagnoses. A final random sample of 571 enrollees from each PIHP was selected.

The sample was drawn from a list of all eligible child (ages 12 to 17) Medicaid beneficiaries provided by each PIHP. The survey was provided in English and Spanish.

Table 34 provides the response rates for each PIHP.

Table 34: Final Response Rate and Number of Completed Surveys by PIHP- Child Sample

PIHP	Survey Response Rate	Number of Completed Surveys
Alliance	15.1%	86
Cardinal	18.3%	104
Eastpointe	17.4%	99
Partners	20.2%	115
Sandhills	19.2%	109
Trillium	21.1%	120
Vaya	21.2%	121
NC Overall	**18.9%**	**754**

A completed survey is defined as a valid response to 50% of the key items. Trillium had the highest response rate and Sandhills had the lowest.

Findings Summary - Child

The results of the survey are summarized in *Table 34* using the three categories recommended by AHRQ, which are:

- Global Ratings are measures of overall ranking of the quality of counseling and treatment received by respondents.
- Composite Measures are aggregates of multiple questions measuring similar dimensions of care and treatment using the same scale.
- Care Coordination Measures are single questions selected as a gauge of enrollee satisfaction with care coordinators.

For each reportable measure, the aggregate result is provided (average percentage of PIHP respondents choosing "8," "9," or "10"), as well as the PIHPs with the highest and lowest positive response for each measure.

Conclusion

Table 35, 2018 Consumer Satisfaction Survey Findings Summary - Child Sample, displays the NC overall percentages on global, composite, and individual items. There was variation in the PIHPs' scoring in the lowest and highest percentage categories and there was no consistency in low and high percentage performance. *Table 35* points to areas in where PIHPs may improve performance. Regarding overall rating of counseling and treatment, Vaya's enrollees reported the highest satisfaction. Partners' enrollees reported the lowest satisfaction. Of the nine Care Coordination items, Sandhills received the highest scores on six of the nine items but lowest on two of the composite items. Vaya scored positively on six of the ten single item questions. All PIHPs, except Trillium and Vaya, received the lowest satisfactory scores for at least one item.

Table 35: Consumer Satisfaction Survey Findings Summary - Child Sample

	NC Aggregate Child (%)	PIHPs with Highest and Lowest Category Percentage	
		High	Low
GLOBAL			
Overall Rating of Counseling and Treatment	71.1%	Vaya (80.8%)	Partners (63.5%)
COMPOSITE			
Getting Treatment Quickly	65.3%	Trillium (74%)	Alliance (57.6%)
How Well Clinicians Communicate	87.9%	Alliance (94.7%)	Partners (84.1%)
Getting Treatment and Information from the PIHP	36.7%	Vaya (44.0%)	Sandhills (28.9%)
Perceived Improvement	65.9%	Alliance (69.1%)	Cardinal (61.2%)
Information About Treatment Options	36.7%	Vaya (44.0%)	Sandhills (28.9%)
SINGLE ITEMS			

	NC Aggregate Child (%)	PIHPs with Highest and Lowest Category Percentage	
		High	Low
Office Wait (seen within 15 minutes)	75.4%	Vaya (81.3%)	Sandhills (67.2%)
Told About Medication Side Effects	85.4%	Sandhills (88.0%)	Eastpointe (82.5%)
Told about different treatments available	74.0%	Eastpointe and Vaya (82.7%)	Sandhills (65.6%)
Information to Manage Condition	76.7%	Eastpointe (84.6%)	Cardinal (68.3%)
Patient Rights Information	88.9%	Eastpointe (94.3%)	Sandhills (84.7%)
Patient Feels He or She Could Refuse Treatment	86.1%	Vaya (93.2%)	Alliance (76.1%)
Privacy of treatment information	94.6%	Vaya (98.7%)	Cardinal (91.4%)
Cultural Competency	73.7%	Sandhills, Trillium and Vaya (100%)	Partners (0%)
Amount Helped	77.7%	Vaya (83%)	Eastpointe (69.9%)
Treatment After Benefits Are Used Up	65.4%	Cardinal (90.9%)	Alliance (44.4%)
CARE COORDINATION ITEMS			
Access to Care Coordinator	78.1%	Trillium (89.3%)	Eastpointe (65.0%)
Care Coordinator responds in timely manner	78.8%	Trillium (89.3%)	Alliance (66.7%)
Care Coordinator helps with answers to questions	77.7%	Sandhills (93.1%)	Eastpointe (60.0%)
Care Coordinator helps find services/support	75.5%	Sandhills (86.2%)	Alliance (58.3%)
Care Coordinator asks how best to support me	77.8%	Cardinal (86.8)	Partners (64.5%)
Received draft of Person Centered Plan to review	86.3%	Sandhills (95.5%)	Eastpointe (64.47%)
Satisfied with Person Centered Plan	85.7%	Sandhills (91.7%)	Eastpointe (82.%)

	NC Aggregate Child (%)	PIHPs with Highest and Lowest Category Percentage	
		High	Low
Revisions were added to plan if requested*	27.3%	Sandhills (50.0%)	Alliance (0%)
Care Coordinator discusses appeal process and submission	64.2%	Sandhills (78.6%)	Alliance (44.4%)

D. Provider Satisfaction Survey

The *2018 DHHS Provider Satisfaction Survey* was administered from October to December 2018 with the goal of assessing provider perceptions of the PIHPs. The survey used Likert-like scales for questions that categorized the PIHPs' abilities in the following three areas:

- Interacting with network providers
- Providing training and support to providers
- Providing Medicaid Waiver materials to help providers strengthen their practice

CCME's subcontractor, DataStat, conducted the survey on behalf of NC Medicaid and CCME. *Table 36* provides an overview of the survey implementation.

Table 36: Survey Administration Timeline

Task	Month / Year
Initial survey sent	October 29, 2018
First reminder sent	November 1, 2018
Reminder calls began	November 14, 2018
Data collection terminated	December 10, 2018

The *Provider Satisfaction Survey* was administered over a four-week period using a Web survey protocol. The team made reminder calls to any non-responding provider offices and sent email reminder requests twice a week, beginning during the second week of the field period and continuing until the end of data collection.

Sampling Methods

The provider file request included at a minimum:

- Provider's full name
- Provider ID
- Email address
- Mailing address
- Office telephone number

An email notification was sent with a link to the electronic survey to all providers with valid email addresses. The number of surveys distributed, returned, and identified as "completed" were tracked in an attempt to get a minimum of 30% provider response in each PIHP network. A survey was considered complete if it fulfilled NC Medicaid's requirements. The response rate was calculated as the total number of completed surveys divided by the total number of links sent via email not returned as undeliverable.

Provider Information

Provider files were submitted through the DataStat Transfer Center, a website using 128-bit encryption to securely transfer files. Each file was checked for accuracy and completeness. Using matching algorithms, duplicate data entries were removed so respondents were represented only once.

Distribution of Surveys

On day one of the field period, a personalized email invitation was sent that contained standard text approved by NC Medicaid. The invitation email also contained a unique hyperlink directing the individual to the web survey.

Provider Satisfaction Survey Assistance

Follow-up efforts were ceased when any individual notified DataStat that he/she did not want to participate in the survey. Throughout the field period, a toll-free assistance line was available from 9:00 a.m. to 8:00 p.m., EST, Monday through Friday. Calls outside these hours were referred to voicemail for follow up the next business day. This toll-free phone number appeared on emails and the survey website. Additionally, the offer of email support was provided through a link that appeared on all pages of the survey, as well as on FAQ and Help screens.

Survey Invitations and Response Rate

Table 37 provides the aggregate itemization of the survey response rate.

Table 37: Provider Satisfaction Survey Response Rate

	NC Overall	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
Initial Email Invitation Sent	3979	1339	801	285	364	466	328	396
†Email bounce back with non-delivery message	303	166	59	5	21	21	9	22
*Completed usable surveys	2575	671	551	217	264	325	248	299
Response Rate	**70.0%**	**57.2%**	**74.3%**	**77.5%**	**77.0%**	**73%**	**77.7%**	**79.9%**

*Note: Response Rate = completed usable surveys/total eligible cases. *Included in response rate numerator. †Excluded from response rate denominator.*

The seven participating PIHPs contributed a total 4,152 provider records for inclusion in the survey. A provider record was considered ineligible for the survey if the provider's email address or name was missing. Those with duplicate email addresses or NPI numbers were also removed, for a final total of 3,979 provider records included in the survey.

Findings Summary

When rating overall satisfaction with the PIHPs, an average of 87% of the providers answered as either “Extremely Satisfied” or “Satisfied”. This is a 2% increase from 2017. Sandhills had the highest percentage of satisfied providers with 92%, while Eastpointe had the lowest rating with 81%. Five of the PIHPs had an increase in overall satisfaction, one had a decrease in overall satisfaction, and one PIHP had no change in overall satisfaction between 2017 and 2018. The results of all the PIHPs are shown in *Figure 11*.

Figure 11: Overall Satisfaction with PIHP; Comparative of 2017 and 2018

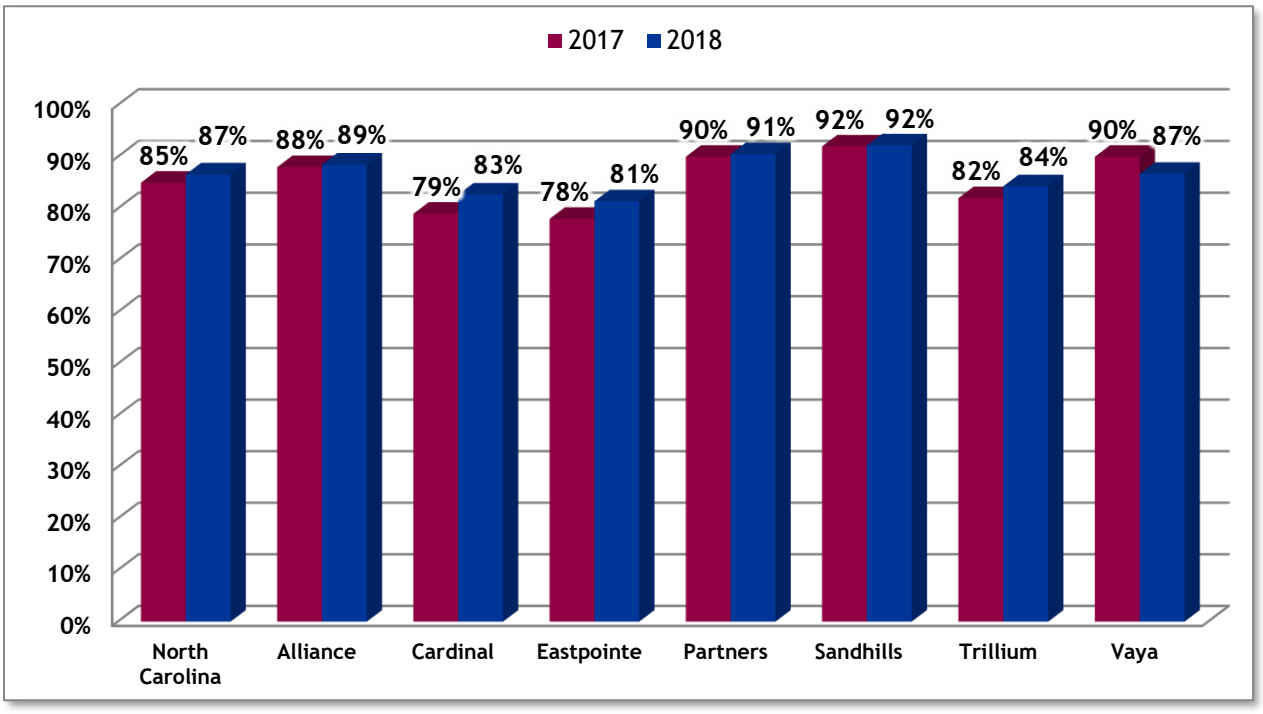


Figure 12: Overall Provider Satisfaction with PIHP; Comparative of 2016 and 2017

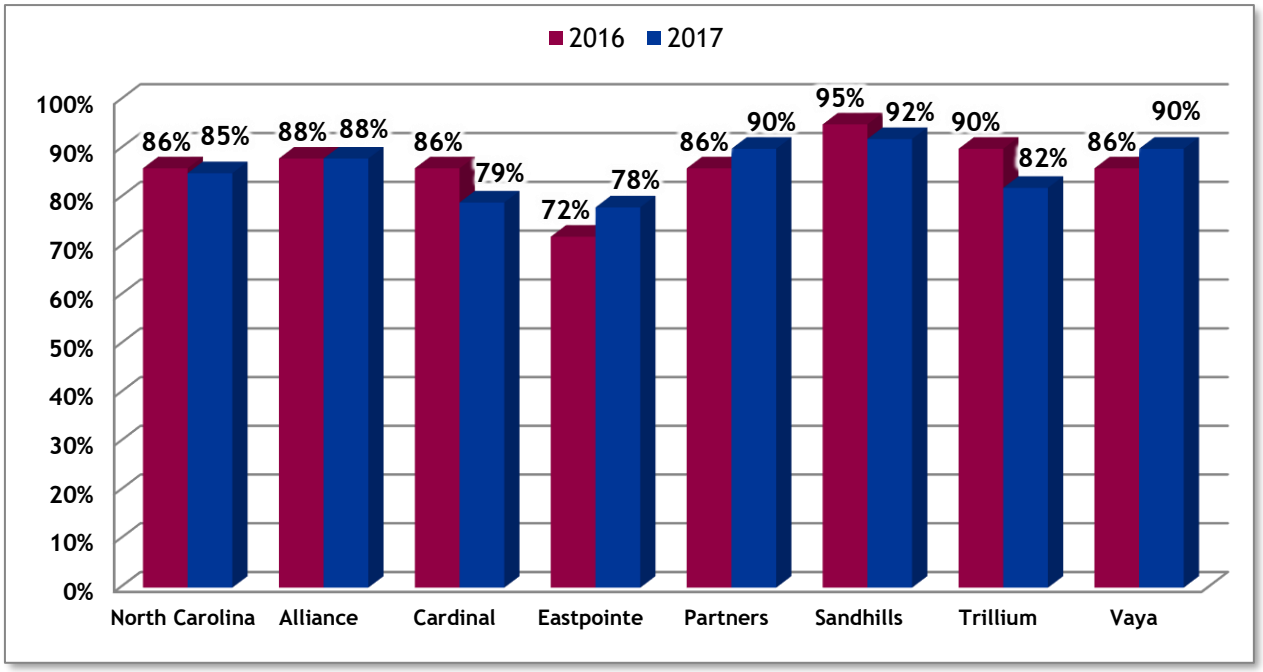


Table 38 shows a summary of the percentage of positive answers for each of the "Agree" or "Satisfied" questions in the survey. The table lists the aggregates for 2017 and 2018, the change from 2017 to 2018, and the PIHPs having the highest and lowest percentage for that question.

Table 38 - "Agree" and "Satisfied" Responses 2018 Summary

Question	NC Aggregate 2017 (%)	NC Aggregate 2018 (%)	Change (%)	PIHP	
				Highest Score	Lowest Score
Question 5: LME-MCO staff is easily accessible for information, referrals, and scheduling of appointments.	85.6%	83.9%	-1.7	Sandhills (90.5%)	Trillium (78.2%)
Question 6: LME-MCO staff are referring consumers whose clinical needs match the service(s) my practice/agency provides.	78.4%	79.4%	+1.0	Alliance (88.4%)	Cardinal (73.9%)
Question 7: LME-MCO staff responds quickly to provider needs.	80.1%	80.8%	+0.7	Sandhills (89.1%)	Eastpointe (75.4%)

Question	NC Aggregate 2017 (%)	NC Aggregate 2018 (%)	Change (%)	PIHP	
				Highest Score	Lowest Score
Question 8: Customer Service is responsive to local community stakeholders.	84.7%	86.1%	+1.4	Sandhills (91.6%)	Trillium (81.0%)
Question 9: When I speak with staff about claims issues I am given consistent and accurate information.	84.3%	84.5%	+0.2	Sandhills (88.9%)	Cardinal (79.2%)
Question 10: Claims trainings meet my needs.	86.4%	88.8%	+2.4	Sandhills (91.2%)	Cardinal (85.1%)
Question 11: Our claims are processed in a timely and accurate manner.	91.6%	94.4%	+2.8	Sandhills (97.0%)	Vaya (91.5%)
Question 12: Information Technology trainings are informative and meet my agency's needs.	87.9%	89.1%	+1.2	Sandhills (93.7%)	Eastpointe (85.7%)
Question 13: Provider Network meetings are informative and helpful.	87.8%	87.1%	-0.7	Alliance (92.5%)	Trillium (76.6%)
Question 14: Provider Network keeps providers informed of changes that affect my local Provider Network.	85.6%	87.1%	+1.5	Partners (91.2%)	Cardinal (82.8%)
Question 15: Provider Network staff is knowledgeable and answer questions consistently and accurately.	83.5%	84.3%	+0.8	Sandhills (92.1%)	Eastpointe (78.7%)
Question 16: Our interests as a network provider are being adequately addressed in the local Provider Council.	80.1%	80.9%	+0.8	Sandhills (85.2%)	Cardinal (74.9%)
Question 17: How would you rate your overall satisfaction with Provider Network?	85.6%	85.5%	-0.1	Sandhills (91.2%)	Eastpointe (80.5%)
Question 18: The LME-MCO staff conducts fair and thorough investigations.	86.9%	88.1%	+1.2	Sandhills (91.1%)	Cardinal (84.8%)
Question 19: After the audit or investigation, LME-MCO requests for corrective action plans and other supporting materials are fair and reasonable.	88.4%	88.9%	+0.5	Vaya (92.7%)	Eastpointe (82.2%)

Question	NC Aggregate 2017 (%)	NC Aggregate 2018 (%)	Change (%)	PIHP	
				Highest Score	Lowest Score
Question 20: Technical assistance and information provided by staff is accurate and helpful.	89.1%	89.1%	0	Sandhills (91.6%)	Cardinal (85.8%)
Question 21: Trainings are informative and meet our needs as a provider/agency.	87.7%	89.9%	+2.2	Sandhills (94.1%)	Cardinal (86.9%)
Question 23: Authorizations for treatment and services are made within the required timeframes.	91.6%	91.8%	+0.2	Partners (95.5%)	Cardinal (83.7%)
Question 24: Denials for treatment and services are explained.	85.7%	85.1%	-0.6	Sandhills (88.7%)	Cardinal (81.1%)
Question 25: The authorizations issued are accurate.	95.2%	95.1%	-0.1	Partners (97.7%)	Cardinal (91.6%)
Question 26: My agency is satisfied with the appeals process for denial, reduction, or suspension of service(s).	80.6%	81.9%	+1.3	Sandhills (84.9%)	Cardinal (78.2%)
Question 27: The LME-MCOs website has been a useful tool for helping my agency find the tools and materials needed to provide services.	82.9%	84.1%	+1.2	Partners (89.6%)	Eastpointe (78.0%)
Question 28: Please rate your overall satisfaction with the LME-MCO.	86.2%	86.7%	+0.5	Sandhills (92.2%)	Eastpointe (81.4%)

Trends for the high and low scorers are visible when looking across the PIHPs. Sandhills consistently had the highest positive percentage of all PIHPs with 16 of 23 questions. Cardinal ranked lowest on 12 of 23 questions.

Conclusion

Overall, provider satisfaction has increased from 2017 to 2018. In this year's results, providers are less satisfied than last year on six items, but more satisfied than last year on 17 of the 23 items. In 2018, providers reported being the most satisfied regarding accuracy of the authorizations issued. They are most concerned about the item "LME-MCO staff are referring consumers whose clinical needs match the service(s) my practice/agency provides." The question with the largest gain from a year ago involved the providers feeling satisfied regarding the timeliness and accuracy of claims processing

by the PIHP. The largest decrease in satisfaction was for the item regarding easy access to LME-MCO staff for information, referrals, and scheduling of appointments.

ATTACHMENTS

- Attachment 1: External Quality Review Standards
- Attachment 2: Desk Materials Request

A. Attachment 1: External Quality Review Standards

Prepaid Inpatient Health Plan (PIHP) Standards For External Quality Review

I. Administration

A. General Approach to Policies and Procedures
1. The PIHP has in place policies and procedures that impact the quality of care provided to Enrollees, both directly and indirectly.

B. Organizational Chart / Staffing
1. The PIHP's resources are sufficient to ensure that all health care products and services required by the State of North Carolina are provided to enrollees. At a minimum, this includes designated staff performing in the following roles:
   1.1 a full time administrator of day-to-day business activities;
   1.2 A physician licensed in the state where operations are based who serves as Medical Director, providing substantial oversight of the medical aspects of operation, including quality assurance activities.
2. Operational relationships of PIHP staff are clearly delineated.
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all PIHP staff positions, including those that are required by DMA contract.

C. Confidentiality
1. The PIHP formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.
2. The PIHP provides HIPAA/confidentiality training to new employees and existing staff.

D. Management Information Systems
1. Enrollment Systems
   1.1 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.
   1.2 The MCO is able to identify and review any errors identified during, or as a result, of the State enrollment file load process.
   1.3 The MCO's enrollment system member screens store and track enrollment and demographic information.

2. Claims System
   2.1 The MCO processes provider claims in an accurate and timely fashion.
   2.2 The MCO has processes and procedures in place to monitor review and audit claims staff.
   2.3. The MCO has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 diagnosis codes received on an 837 Institutional and 837 Professional file, capabilities of receiving and storing ICD-10 procedure codes on an 837 Institutional file.
   2.4 The MCO's claim system screens store and track claim information and claim adjudication/payment information.

3. Reporting
   3.1 The MCO's data repository captures all enrollment and claims information for internal and regulatory reporting.
   3.2 The MCO has processes in place to back up the enrollment and claims data repositories.

4. Encounter Data Submission
   - 4.1 The MCO has the capabilities in place to submit the State required data elements to DMA on the encounter data submission.
   - 4.2 The MCO has the capability to identify, reconcile and track the encounter data submitted to DMA.
   - 4.3 MCO has policies and procedures in place to reconcile and resubmit encounter data denied by DMA.
   - 4.4 The MCO has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to DMA.

II. Provider Services

A. Credentialing and Recredentialing

1. The PIHP formulates and acts within policies and procedures related to the credentialing and recredentialing of health care Providers in a manner consistent with contractual requirements.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the PIHP.
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of Provider.
   - 3.1 Verification of information on the applicant, including:
     - 3.1.1 Insurance requirements
     - 3.1.2 Current valid license to practice in each state where the Practitioner will treat Enrollees;
     - 3.1.3 Valid DEA certificate; and/or CDS certificate
     - 3.1.4 Professional education and training, or board certification if claimed by the applicant;
     - 3.1.5 Work history;
     - 3.1.6 Malpractice claims history;
     - 3.1.7 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;
     - 3.1.8 Query of the National Practitioner Data Bank (NPDB);
     - 3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);
     - 3.1.10 Query of the System for Award Management (SAM);
     - 3.1.11 Query for Medicare and/or Medicaid sanctions Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE);
     - 3.1.12 Query of the Social Security Administration's Death Master File (SSADMF);
     - 3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);
     - 3.1.14 In good standing at the hospital designated by the Provider as the primary admitting;
     - 3.1.15 Ownership Disclosure is addressed;
     - 3.1.16 Criminal background Check.
   - 3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.
   - 3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.

4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.
    - 4.1 Recredentialing every three years;
    - 4.2 Verification of information on the applicant, including:
        - 4.2.1 Insurance requirements;
        - 4.2.2 Current valid license to practice in each state where the Practitioner will treat Enrollees;
        - 4.2.3 Valid DEA certificate; and/or CDS certificate;
        - 4.2.4 Board certification if claimed by the applicant;
        - 4.2.5 Malpractice claims since the previous credentialing event;
        - 4.2.6 Practitioner attestation statement;
        - 4.2.7 Requery of the NPDB;
        - 4.2.8 Requery for state sanctions and/or license limitations (State Board of Examiners for the specific discipline) since the previous credentialing event;
        - 4.2.9 Requery of the SAM;
        - 4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (OIG LEIE);
        - 4.2.11 Query of the Social Security Administration's Death Master File;
        - 4.2.12 Query of the NPPES;
        - 4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility.
        - 4.2.14 Ownership Disclosure is addressed.
    - 4.3 Site reassessment if the provider has had quality issues.
    - 4.4 Review of Provider profiling activities.
5. The PIHP formulates and acts within written policies and procedures for suspending or terminating a Practitioner's affiliation with the PIHP for serious quality of care or service issues.
6. Organizational Providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.

B. Adequacy of the Provider Network
1. The PIHP maintains a network of Providers that is sufficient to meet the health care needs of Enrollees and is consistent with contract requirements.
    - 1.1 Enrollees have a Provider located within a 30-mile distance or 30 minutes' drive time of their residence. Rural areas are 45 miles and 45 minutes. Longer distances as approved by DMA are allowed for facility based or specialty Providers.
    - 1.2 Enrollees have access to specialty consultation from a Network Provider located within reasonable traveling distance of their homes. If a Network Specialist is not available, the Enrollee may utilize an out-of-network Specialist with no benefit penalty.
    - 1.3 The sufficiency of the Provider Network in meeting Enrollee demand is formally assessed at least annually.
    - 1.4 Providers are available who can serve Enrollees with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.
    - 1.5 The PIHP demonstrates significant efforts to increase the Provider Network when it is identified as not meeting Enrollee demand.
2. Provider Accessibility
    - 2.1 The PIHP formulates and insures that Practitioners act within written policies and procedures that define acceptable access to Practitioners and that are consistent with contract requirements.

C. Provider Education
1. The PIHP formulates and acts within policies and procedures related to initial education of Providers.

2. Initial Provider education includes:
   - 2.1 PIHP purpose and mission;
   - 2.2 Clinical practice standards;
   - 2.3 Provider responsibilities;
   - 2.4 PIHP closed network requirements, including nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability;
   - 2.5 Access standards related to both appointments and wait times;
   - 2.6 Authorization, utilization review, and care management requirements;
   - 2.7 Care Coordination and discharge planning requirements;
   - 2.8 PIHP dispute resolution process;
   - 2.9 Complaint investigation and resolution procedures;
   - 2.10 Compensation and claims processing requirements, including required electronic formats, mandated timelines, and coordination of benefits requirements;
   - 2.11 Enrollee rights and responsibilities;
   - 2.12 Provider program integrity requirements that include how to report suspected fraud, waste and abuse, training requirements as outlined in the False Claims Act, and other State and Federal requirements.

3. The PIHP provides ongoing education to Providers regarding changes and/or additions to its programs, practices, Enrollee benefits, standards, policies and procedures.

D. Clinical Practice Guidelines for Behavioral Health Management
1. The PIHP develops clinical practice guidelines for behavioral health management of its Enrollees that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent Network Specialists.

2. The PIHP communicates the clinical practice guidelines for behavioral health management and the expectation that they will be followed for PIHP Enrollees to Providers.

E. Continuity of Care
1. The PIHP monitors continuity and coordination of care between Providers.

F. Practitioner Medical Records
1. The PIHP formulates policies and procedures outlining standards for acceptable documentation in the Enrollee medical records maintained by Providers.

2. The PIHP monitors compliance with medical record documentation standards through formal periodic medical record audit and addresses any deficiencies with the Providers.

3. The PIHP has a process for handling abandoned records as required by the contract.

III. Enrollee Services

A. Enrollee Rights
1. The PIHP formulates policies outlining enrollee rights and procedures for informing enrollees of these rights.

2. Enrollee rights include, but are not limited to, the right:
   - 2.1 To be treated with respect and due consideration of dignity and privacy;
   - 2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;
   - 2.3 To participate in decisions regarding health care;
   - 2.4 To refuse treatment;
   - 2.5 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;

2.6 To request and receive a copy of his or her medical record, except as set forth in 45 C.F.R. §164.524 and N.C.G.S. § 122C-53(d), and to request that the medical record be amended or corrected in accordance with 45 CFR Part 164.

2.7 Of Enrollees who live in Adult Care Homes to report any suspected violation of an Enrollee right to the appropriate regulatory authority as outlined in N.C.G.S. § 131D-21.

B. Enrollee PIHP Program Education

1. Within 14 days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid Waiver program which they are contractually entitled, including:

1.1 A description of the benefits and services provided by the PIHP and of any limitations or exclusions applicable to covered services. These descriptions must have sufficient detail to ensure the Enrollees understand the benefits to which they are entitled and may include a web link to the PIHP Benefit Plan. This includes a descriptions of all Innovations Waiver services and supports;

1.2 Benefits include access to a 2nd opinion from a qualified health care professional within the network, or arranges for the Enrollee to obtain one outside the network, at no cost to the Enrollee;

1.3 Updates regarding program changes;

1.4 A description of the procedures for obtaining benefits, including authorizations and EPSDT criteria;

1.5 An explanation of the Enrollee's responsibilities and rights and protections as set forth in 42 CFR§438.100;

1.6 An explanation of the Enrollee's right to select and change Network Providers;

1.7 The restrictions, if any, on the Enrollee's right to select or change Network Providers;

1.8 The procedures for selecting and changing Network Providers;

1.9 Where to find a list or directory of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients (a written list of current Network Providers shall be provided by PIHP to any Enrollee upon request);

1.10 The non-English languages, if any, spoken by each Network Provider;

1.11 The extent to which, and how, after–hours and emergency coverage are provided, including:

1.11.1 What constitutes an Emergency Behavioral Health Condition, Emergency Services, and Post Stabilization Services in accordance with 42 CFR§ 438.114 and EMTALA;

1.11.2 The fact that prior authorization is not required for emergency services;

1.11.3 The process and procedures for obtaining Emergency Services, the use of 911 telephone services or the equivalent;

1.11.4 The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under the contract;

1.11.5 A statement that, subject to the provisions of the DMA contract, the Enrollee has a right to use any hospital or other setting for Emergency care.

1.12 The PIHP's policy on referrals for Specialty Care to include cost sharing, if any, and how to access Medicaid benefits that are not covered under the DMA contract;

1.13 Any limitations that may apply to services obtained from Out-of Network Providers, including disclosures of the Enrollee's responsibility to pay for unauthorized behavioral health care services obtained from Out-of Network Providers, and the procedures for obtaining authorization for such services;

1.14 How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost-sharing;

1.15 Procedures for obtaining out-of-area or out-of-state coverage or services; if special procedures exist;
1.16 Information about medically necessary transportation services by the department of Social Services in each county;
1.17 Identification and explanation of State laws and rules regarding the treatment of minors;
1.18 The Enrollee's right to recommend changes in the PIHP's policies and services;
1.19 The procedure for recommending changes in the PIHP's policies and services;
1.20 The Enrollee's right to formulate Advance Directives;
1.21 The Enrollee's right to file a grievance concerning non-actions and the Enrollee's right to file an appeal if PIHP takes an action against an Enrollee;
1.22 The accommodations made for non-English speakers, as specified in 42 CFR §438.10(c)(5);
1.23 Written information shall be made available in the non-English languages prevalent in the PIHP's services area;
1.24 The availability of oral interpretation services for non-English languages and how to access the service;
1.25 The availability of interpretation of written information in prevalent languages and how to access those services;
1.26 Information on how to report fraud and abuse;
1.27 Upon an Enrollee's request, the PIHP shall provide information on the structure and operation of the agency and any physician incentive plans.
1.28 Information on grievance, appeal and fair hearing procedures and information specified in CFR §438.10 (g).

2. Enrollees are notified annually of their right to request and obtain written materials produced for Enrollee use.

3. Enrollees are informed promptly in writing of (1) any "significant change" in the information specified in CFR 438.10 (f) (61) and 438.10 (g) at least 30 days before calendar days before the intended effective date of the change; and (2) termination of their provider within fifteen (15) calendar days after PIHP receives notice that DMA or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider.

4. Enrollee program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.

5. The PIHP maintains and informs Enrollees of how to access a toll-free vehicle for 24-hour Enrollee access to coverage information from the PIHP, including the availability of free oral translation services for all languages and care management services such as crisis interventions.

C. Behavioral Health and Chronic Disease Management Education
1. The PIHP enables each Enrollee to choose a Provider upon enrollment and provides assistance as needed.

2. The PIHP informs Enrollees about the Behavioral Health Education Services that are available to them and encourages Enrollees to utilize these benefits.

3. The PIHP tracks the participation of Enrollees in the Behavioral Health Education Services.

D. Call Center
1. The PIHP provides customer services that are responsible to the needs of the Enrollees and their families. Services include:
1.1 Respond appropriately to inquiries by Enrollees and their family Enrollees (including those with limited English proficiency);

1.2 Connect Enrollees, family Enrollees, and stakeholders to crisis services when clinically appropriate;
1.3 Provide information to Enrollees and their family members on where and how to access behavioral health services;
1.4 Train its staff to recognize, third-party insurance issues, recipient appeals, and grievances and to route these issues to the appropriate individual or PIHP department;
1.5 Answer phones and respond to inquiries from 8:30 a.m. until 5:00 p.m. weekdays;
1.6 Process referrals 24 hours per day, 7 days per week; 365 days per year; and
1.7 Process Call Center linkage and referral requests for services twenty-four (24) hours per day, seven (7) days per week, 365 days per year.

IV. Quality Improvement

A. The Quality Improvement (QI) Program
1. The PIHP formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to Enrollees.
2. The scope of the QI program includes monitoring of provider compliance with PIHP practice guidelines.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.
4. The PIHP implements significant measures to address quality problems identified through the enrollee satisfaction survey.
5. The PIHP reports the results of the enrollee satisfaction survey to providers.
6. The PIHP reports to the Quality Improvement Committee on the results of the enrollee satisfaction survey and the impact of measures taken to address those quality problems that were identified.
7. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).

B. Quality Improvement Committee
1. The PIHP has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.
2. The composition of the QI Committee reflects the membership required by the contract.
3. The QI Committee meets at regular intervals.
4. Minutes are maintained that document proceedings of the QI Committee.

C. Performance Measures
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol “Validation of Performance Measures”.

D. Quality Improvement Projects
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.
2. The study design for QI projects meets the requirements of the CMS protocol “Validating Performance Improvement Projects”.

E. Provider Participation in Quality Improvement Activities
1. The PIHP requires its providers to actively participate in QI activities.

2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.

F. Annual Evaluation of the Quality Improvement Program

1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.

2. The annual report of the QI program is submitted to the QI Committee and to the PIHP Board of Directors.

V. Utilization Management

A. The Utilization Management (UM) Program

1. The PIHP formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:
   - 1.1 Structure of the program;
   - 1.2 Lines of responsibility and accountability;
   - 1.3 Guidelines/standards to be used in making utilization management decisions;
   - 1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;
   - 1.5 Consideration of new technology;
   - 1.6 The appeal process, including a mechanism for expedited appeal;
   - 1.7 The absence of direct financial incentives to Provider or UM staff for denials of coverage or services;
   - 1.8 Mechanisms to detect underutilization and overutilization of services.

2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.

3. The UM program design reevaluated annually, including Provider input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.

B. Medical Necessity Determinations

1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.

2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.

3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.

4. Utilization management standards/criteria are consistently applied to all Enrollees across all reviewers.

5. Emergency and poststabilization care is provided in a manner consistent with the contract and federal regulations.

6. Utilization management standards/criteria are available to Providers.

7. Utilization management decisions are made by appropriately trained reviewers.

8. Initial utilization decisions are made promptly after all necessary information is received.

9. Denials
   - 9.1 A reasonable effort that is not burdensome on the Enrollee or the Provider is made to obtain all pertinent information prior to making the decision to deny services.
   - 9.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.

9.3 Denial decisions are promptly communicated to the Provider and Enrollee and include the basis for the denial of service and the procedure for appeal.

C. Care Coordination

1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.
2. The care coordination program includes:
   - 2.1 Staff available 24 hours per day, seven days per week to perform telephone assessments and crisis interventions;
   - 2.2 Referral process for Enrollees to a Network Provider for face-to-face pretreatment assessment;
   - 2.3 Assess each Medicaid enrollee identified as having special health care needs;
   - 2.4 Guide the development of treatment plans for enrollees that meet all requirements;
   - 2.5 Quality monitoring and continuous quality improvement;
   - 2.6 Determination of which Behavioral Health Services are medically necessary;
   - 2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;
   - 2.8 Coordinate care with each Enrollee's Providers;
   - 2.9 Provide follow-up activities for Enrollees;
   - 2.10 Ensure privacy for each Enrollee is protected.
3. The PIHP applies the Care Coordination policies and procedures as formulated.

D. Transition to Community Living Initiative

1. Transition to Community Living functions are performed by appropriately licensed, or certified, and trained staff.
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements
   - 2.1 Care Coordination activities occur as required.
   - 2.2 Person Centered Plans are developed as required.
   - 2.3 Assertive Community Treatment, Peer Support Services, and Supported Employment services are included in the individual's transition, if applicable.
   - 2.4 A mechanism is in place to provide one-time transitional supports, if applicable.
   - 2.5 QOL Surveys are administered timely.
3. A diversion process is in place for individuals considering admission into an Adult Care Home (ACH).
4. Clinical Reporting Requirements: The PIHP will submit the required data elements and analysis to DMA within the timeframes determined by DMA.
5. The PIHP will develop a TCLI communication plan for external and internal stakeholders providing information on the TCL initiative, resources, and system navigation tools, etc. This plan should include materials and training about the PIHP's crisis hotline and services for enrollees with limited English proficiency.
6. A review of files demonstrates the PIHP is following appropriate TCL policies, procedures and processes, as required by NC DMA, and developed by the PIHP.

VI. Grievances and Appeals

A. Grievances

1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee grievances in a manner consistent with contract requirements, including, but not limited to:
   - 1.1 Definition of a grievance and who may file a grievance;

1.2 The procedure for filing and handling a grievance;
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.

2. The PIHP applies the grievance policy and procedure as formulated.

3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.

4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.

B. Appeals

1. The PIHP formulates policies and procedures for registering and responding to Enrollee and/or Provider appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;
1.2 The procedure for filing an appeal;
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a Practitioner with the appropriate medical expertise who has not previously reviewed the case;
1.4 A mechanism for expedited appeal where the life or health of the Enrollee would be jeopardized by delay;
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;
1.6 Written notice of the appeal resolution as required by the contract;
1.7 Other requirements as specified in the contract.

2. The PIHP applies the appeal policies and procedures as formulated.

3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.

4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.

VII. Delegation

1. The PIHP has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.

2. The PIHP conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the PIHP if the PIHP were directly performing the delegated functions.

VIII. Program Integrity

A. General Requirements

1. PIHP shall be familiar and comply with Section 1902(a)(68) of the Social Security Act, 42 C.F.R. Parts 438,455 and 1000 through 1008, as applicable, including proper payments to Providers and methods for detection of fraud and abuse.

2. PIHP shall have and implement policies and procedures that guide and require PIHP's, and PIHP's officers', employees', agents' and subcontractors,' compliance with the requirements of this Section 14.

3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.

4. PIHP shall investigate all grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.

B. Fraud and Abuse

1. PIHP shall establish and maintain a written Compliance Plan consistent with 42 C.F.R. 438.608 that is designed to guard against fraud and abuse. The Compliance Plan shall be submitted to the DMA Contract Administrator on an annual basis.

2. PIHP shall designate, however named, a Compliance Officer who meets the requirements of 42 C.F.R. 438.608 and who retains authority to report directly to the CEO and the Board of Directors as needed irrespective of administrative organization. PIHP shall also establish a regulatory compliance committee on the PIHP board of directors and at the PIHP senior management level that is charged with overseeing PIHP's compliance program and compliance with requirements under this Contract. PIHP shall establish and implement policies outlining a system for training and education for PIHP's Compliance Officer, senior management, and employees in regard to the Federal and State standards and requirements under DMA Contract in accordance with 42 CFR 438.608(a)(1)(iv).

3. PIHP shall establish and implement a special investigations or program integrity unit, however named, that is responsible for PIHP program integrity activities, including identification, detection, and prevention of fraud, waste and abuse in the PIHP Closed Provider Network. PIHP shall identify an appropriately qualified contact for Program Integrity and Regulatory Compliance issues as mutually agreed upon by PIHP and DMA. This person may or may not be the PIHP Compliance Officer or the PIHP Contract Administrator.

4. PIHP shall participate in quarterly Program Integrity meetings with DMA Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the N.C. Department of Justice ("MFCU/ MID').

5. PIHP shall participate in monthly meetings with DMA Program Integrity, in the most productive setting, either telephonically or in person at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.

6. PIHP shall designate appropriately qualified staff to attend the monthly meetings, and the parties shall work collaboratively to minimize duplicative or unproductive meetings and information.

7. PIHP shall also make Regulatory Compliance minutes and Program Integrity minutes, redacted as deemed appropriate by PIHP, available for review upon request by DMA.

8. PIHP's written Compliance Plan shall, at a minimum include:
   - 8.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(66) of the Social Security Act;
   - 8.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing and development of corrective action initiatives;
   - 8.3 Enforcement of standards through well-publicized disciplinary guidelines;
   - 8.4 Provision for full cooperation by PIHP and PIHP's employees, contractors, and Providers with any investigation conducted by Federal or State authorities, including DMA or MFCU/MID, and including promptly supplying all data and information requested for their respective investigations.

9. In accordance with 42 CFR 436.606(a)(vii), PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing

of compliance risks as required under DMA Contract, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under DMA Contract; and making documentation of investigations and compliance available as requested by the State.

10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse.
    - 10.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse.
    - 10.2 Detailed workflow of the PIHP process for taking a complaint from inception through closure. This process shall include procedures for logging the complaint, determining if the complaint is valid, assigning the complaint, investigating, appeal, recoupment, and closure. The detailed workflow needs to differentiate the steps taken for fraud versus abuse; PIHP shall establish and implement policies for treatment of recoveries of all overpayments from PIHP to Providers and contracted agencies, specifically including retention policies for treatment of recoveries of overpayments due to fraud, waste, or abuse. The retention policies shall include processes, timeframes, and required documentation for payment of recoveries of overpayments to the State in situations where PIHP is not permitted to retain some or all of the recoveries of overpayments. This provision shall not apply to any amount of recovery to be retained under False Claims Act cases or through other investigations.
    - 10.3 In accordance with Attachment Y - Audits/Self-Audits/lnvestigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an· overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.
    - 10.4 Process for tracking overpayments and collections, and reporting on Attachment Y – Audits/Self- Audits/lnvestigations.
    - 10.5 Process for handling self-audits and challenge audits.
    - 10.6 Process for using data mining to determine leads.
    - 10.7 Process for informing PIHP employees, subcontractors and providers regarding the False Claims Act.
    - 10.8 If PIHP makes or receives annual payments of at least $5,000,000, PIHP shall establish and maintain written policies for all employees, contractors or agents that detail information about the False Claims Act and other Federal and State laws as described in the Social Security Act 1902(a)(66), including information about rights of employees to be protected as whistleblowers.
    - 10.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains DMA-standardized elements or a DMA-approved template;
    - 10.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding overpayments, assessments, penalties, or fees due to any State or Federal agency deemed applicable by PIHP, subject to the accessibility of such financial information in a readily available database or other search mechanism.

11. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements. Nothing in this Contract is intended to address any requirement for PIHP to offer Providers written notice of the process for appealing to the NC Office of Administrative Hearings or any other forum.

12. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to DMA within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.

13. In each case where PIHP refers to DMA an allegation of fraud involving a Provider, PIHP shall provide DMA Program Integrity with the following information on the DMA approved template:
    - 13.1 Subject (name, Medicaid provider ID, address, provider type);
    - 13.2 Source/origin of complaint;
    - 13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;
    - 13.4 Description of suspected intentional misconduct, with specific details including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations or policies violated; and dates of suspected intentional misconduct;
    - 13.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;
    - 13.6 All communications between PIHP and the Provider concerning the conduct at issues, when available.
    - 13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and
    - 13.8 Sample/exposed dollar amount, when available.

14. In each case where PIHP refers suspected Enrollee fraud to DMA, PIHP shall provide DMA Program Integrity with the following information on the DMA approved template:
    - 14.1 The Enrollee's name, birth date, and Medicaid number;
    - 14.2 The source of the allegation;
    - 14.3 The nature of the allegation, including the timeframe of the allegation in question;
    - 14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;
    - 14.5 Contact information for PIHP staff persons with practical knowledge of the allegation;
    - 14.6 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation; and
    - 14.7 The legal and administrative status of the case.

15. PIHP and DMA shall mutually agree on program integrity and monitoring forms, tools, and letters that meet the requirements of State and Federal law, rules, and regulations, and are consistent with the forms, tools and letters utilized by other PIHPs.

16. PIHP shall use the DMA Fraud and Abuse Management System (FAMS) or a DMA approved alternative data mining technology solution to detect and prevent fraud, waste and abuse in managed care.

17. If PIHP uses FAMS, PIHP shall work with the DMA designated Administrator to submit appropriate claims data to load into the DMA Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. If PIHP uses FAMS, PIHP shall notify the DMA designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.

18. PIHP shall submit to the DMA Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month. In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to DMA Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not

limited to overpayments and self-audits. The monthly report shall be due by 11:59 p.m. on the tenth (10th) of each month in the format as identified in Attachment Y. PIHP shall also report to DMA Program Integrity all Network Provider contract terminations and non-renewals initiated by PIHP, including the reason for the termination or non-renewal and the effective date. The only report shall be due by 11:59p.m. on the tenth (10th) day of each month in the format as identified in attachment Z – Terminations, Provider Enrollment Denials, Other Actions. Compliance with the reporting requirements of Attachments X, Y and Z and any mutually approved template shall be considered compliance with the reporting requirements of this Section.

C. Provider Payment Suspensions and Overpayments

1. Within thirty (30) business days of receipt from PIHP of referral of a potential credible allegation of fraud, DMA Program Integrity shall complete a preliminary investigation to determine whether there is sufficient evidence to warrant a full investigation. If DMA determines that a full investigation is warranted, DMA shall make a referral within five (5) business days of such determination to the MFCU/ MID and will suspend payments in accordance with 42 CFR § 455.23. At least monthly, DMA shall provide written notification to PIHP of the status of each such referral. If MFCU/ MID indicates that suspension will not impact their investigation, DMA may send a payment suspension notice to the Provider and notify PIHP. If the MFCU/ MID indicates that payment suspension will impact the investigation, DMA shall temporarily withhold the suspension notice and notify PIHP. Suspension of payment actions under this Section 14.3 shall be temporary and shall not continue if either of the following occur: PIHP or the prosecuting authorities determine that there is insufficient evidence of fraud by the Provider; or Legal proceedings related to the Provider's alleged fraud are completed and the Provider is cleared of any wrongdoing.
    1.1 In the circumstances described in Section 14.3 (c) above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.
2. Upon receipt of a payment suspension notice from DMA Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of DMA Program Integrity's suspension and lasting until PIHP is notified by DMA Program Integrity in writing that the suspension has been lifted.
3. PIHP shall provide to DMA all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to DMA Program Integrity due to allegations of suspected fraud without prior written approval from DMA Program Integrity or the MFCU/MID.
5. Notwithstanding the foregoing, nothing herein shall be construed as prohibiting PIHP from taking any action against a Network Provider in accordance with the terms and conditions of any written agreement with a Network Provider, including but not limited to prepayment review, identification and collection of overpayments, suspension of referrals, de-credentialing, contract nonrenewal, suspension or termination or other sanction, remedial or preventive efforts necessary to ensure continuous, quality care to Enrollees, regardless of any ongoing investigation being conducted by DMA, MFCU/MID or other oversight agency, to the extent that such action shall not interfere with Enrollee access to care or with any such ongoing investigation being conducted by DMA, MFCU/MID or other oversight agency.
6. In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with N.C.G.S. 108C-5, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until

the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery.

7. The MFCU/MID reserves the right to prosecute or seek civil damages regardless of payments made by the Provider to PIHP. The Parties shall work collaboratively to develop a plan for the disbursement of the share of monies that are recovered and returned to the state by the MFCU/MID for fraudulent claims paid by PIHP. DMA will examine options to refund returned funds to PIHP and/or to appropriately account for these recoveries in the rate setting process.

IX. Financial

1. The PIHP has policies and systems in-place for submitting and reporting financial data.
2. The PIHP has and adheres to a cost allocation plan that meets the requirements of 42 CFR 433.34.
3. PIHP maintains detailed records of the administrative costs and expenses incurred as required by the DMA contract.
4. Maintains an accounting system in accordance with 42 CFR 433.32 (a).
5. The PIHP follows a record retention policy of retaining records for ten years.
6. The PIHP maintains a restricted risk reserve account with a federally guaranteed financial institution in accordance with DMA contract.
7. The required minimum balance of the Risk Reserve Account meets the requirements of the DMA contract.
8. All funds received by PIHP are accounted for by tracking Title XIX Medicaid expenditures separately from services provided using other funding, as required by the DMA contract.
9. The Medical Loss Ratio (MLR) meets the requirements of 42 CFR 438.8 and the DMA contract.

B.Attachment 2: Desk Materials Request

PIHP NAME

External Quality Review 2018

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy. *(Please do not embed files within word documents)*

2. Organizational chart of all staff members including names of individuals in each position including their degrees and licensure, and include any current vacancies. In addition, please include any positions currently filled by outside consultants/vendors. Further, please include any positions currently filled by outside consultants/vendors. Further, please indicate staffing structure for Transitions Community Living Initiative (TCLI) program.

3. Current Medical Director, medical staff job descriptions.

4. Job descriptions for positions in the Transitions to Community Living Initiative (TCLI).

5. Description of major changes in operations such as expansions, new technology systems implemented, etc.

6. A summary of the status of all best practice recommendations and corrective action items from the previous External Quality Review.

7. Documentation of all services planning and provider network planning activities (e.g., geographic assessments, provider network adequacy assessments, annual network development plan, enrollee demographic studies, population needs assessments) that support the adequacy of the provider base.

8. List of new services added to the provider network in the past 12 months (TBD-TBD) by provider.

9. List of executed single case agreements by provider and level of care during the past 12 months (TBD-TBD).

10. Network turnover rate for the past 12 months (TBD-TBD) including a list of providers that were terminated by cause and list of providers that did not have their contracts renewed. For five providers termed in the last 12 months (TBD-TBD), who were providing service to enrollees at the time of the termination notice, submit the termination letter to or from the provider, and the notification (of provider termination) letters sent to three consumers who were seeing the provider at the time of the termination notice.

11. List of providers credentialed/recredentialed in the last 12 months (TBD-TBD).

12. A current provider manual and provider directory.

13. A description of the Quality Improvement, Utilization Management, and Care Coordination Programs. Include a Credentialing Program Description and/or Plan, if applicable.

14. The Quality Improvement work plans for 2017 and 2018.

15. The most recent reports summarizing the effectiveness of the Quality Improvement, Utilization Management, and Care Coordination Programs.

16. Minutes of committee meetings for the months of TBD-TBD for **all** committees reviewing or taking action on enrollee-related activities. For example, quality committees, quality subcommittees, credentialing committees, compliance committee, etc.

    All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

17. Membership lists and a committee matrix for **all** committees, including the professional specialty of any non-staff members. Please indicate which members are voting members. Include the required quorum for each committee.

18. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.

19. Copies of the most recent provider profiling activities conducted to measure contracted provider performance.

20. Results of the most recent office site reviews, record reviews and a copy of the tools used to complete these reviews.

21. A copy of staff handbooks/training manuals, orientation and educational materials, and scripts used by Call Center personnel, if applicable.

22. A copy of the enrollee handbook and any statement of the enrollee bill of rights and responsibilities if not included in the handbook.

23. A copy of any enrollee and provider newsletters, educational materials and/or other mailings, including the packet of materials sent to new enrollees and the materials sent to enrollees annually.

24. A copy of the Grievance, Complaint and Appeal logs for the months of TBD-TBD. Please indicate the disability type (MH/SA, I/DD) and whether the enrollee is in the TCLI program for each entry.

25. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.

26. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal PIHP compliance with these standards.

27. Practice guidelines developed for use by practitioners, including references used in their development, when they were last updated and how they are disseminated. Also, policies and procedures for researching, selecting, adopting, reviewing, updating, and disseminating practice guidelines.

28. All information supplied as orientation to new providers, including a copy of the provider handbook or manual.

29. A copy of the provider contract/application.

30. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the PIHP, and any reports of activities submitted by the subcontractor to the PIHP. Also, completed evaluations of entities conducted before delegation is granted.

31. Contracts for all delegated entities.

32. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used. Include annual evaluation, if applicable.

33. Please provide an excel spreadsheet with a list of enrollees that have been placed in care coordination since April 2015. Please indicate the disability type (MH/SA, I/DD).

34. Please provide an excel spreadsheet with a list of enrollees that have been placed in the TCLI program since April 2015. Please include the following: number of individuals transitioned to the community, number of individuals currently receiving Care Coordination, number of individuals connected to services and list of services receiving, number of individuals choosing to remain in ACH connected to services and list of services receiving.

35. Information regarding the following selected Performance Measures:

(b) WAIVER MEASURES	
A.1. Readmission Rates for Mental Health	D.1. Mental Health Utilization - Inpatient Discharges and Average Length of Stay
A.2. Readmission Rate for Substance Abuse	D.2. Mental Health Utilization
A.3. Follow-up After Hospitalization for Mental Illness	D.3. Identification of Alcohol and other Drug Services
A.4. Follow-up After Hospitalization for Substance Abuse	D.4. Substance Abuse Penetration Rate
B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment	D.5. Mental Health Penetration Rate

(c) WAIVER MEASURES	
Proportion of Level of Care evaluations completed at least annually for enrolled participants	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals
Proportion of Level of Care evaluations completed using approved processes and instrument	Proportion of Individual Support Plans that address identified health and safety risk factors
Proportion of New Level of Care evaluations completed using approved processes and instrument	Percentage of participants reporting that their Individual Support Plan has the services that they need
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	Proportion of individuals for whom an annual plan and/or needed update took place
Proportion of monitored Innovations providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame	Proportion of new Waiver participants who are receiving services according to their ISP within 45 days of ISP approval

Required information includes the following for each measure:

a. Data collection methodology used (administrative, medical record review, or hybrid) including a full description of those procedures;
b. Data validation methods/ systems in place to check accuracy of data entry and calculation;
c. Reporting frequency and format;
d. Complete exports of any lookup / electronic reference tables that the stored procedure / source code uses to complete its process;
e. Complete calculations methodology for numerators and denominators for each measure, including:
    i. The actual stored procedure and / or computer source code that takes raw data, manipulates it, and calculates the measure as required in the measure specifications;
    ii. All data sources used to calculate the numerator and denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    iii. All specifications for all components used to identify the population for the numerator and denominator;
f. The latest calculated and reported rates provided to the State.

In addition, please provide the name and contact information (including email address) of a person to direct questions specifically relating to Performance Measures if the contact will be different from the main EQR contact.

36. Documentation of all Performance Improvement Projects (PIPs) completed or planned in the last year, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. research question (s), analytic plans, reasons for choosing the topic including how the topic impacts the Medicaid population overall, measurement definitions, qualifications of

personnel collecting/abstracting the data, barriers to improvement and interventions planned or implemented to address each barrier, calculated result, results, etc.)

37. Summary description of quality oversight of the Transition to Community Living Initiative, including monitoring activities, performance metrics, and results.
38. Data and/or reports for the Transition to Community Living Initiative (e.g., numbers of in-reach completed, housing slots filled, completed transitions, numbers of enrollees in supported employment, numbers of enrollees assigned to assertive community treatment [ACT], etc.) for the period TBD-TBD.
39. Call performance statistics for the period of TBD-TBD, including average speed of answer, abandoned calls, and average call/handle time for customer service representatives (CSRs).
40. Provide electronic copies of the following files:
    a. Credentialing files for 12 most recently credentialed practitioners (should include 6 licensed practitioners who work at agencies and 6 Licensed Independent Practitioners, include at least two physicians). Please also include four files for network provider agencies and/or hospitals and/or psychiatric facilities, in any combination. The credentialing files should include all of the following:

Proof of all insurance coverages. For practitioners joining already-contracted agencies, include copies of the insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.	Notification of the effective date of credentialing.
Site visit reports. If practitioner is joining an agency that previously had a site visit, include the report; for licensed sites, include verification of DHSR licensure for the site.	Ownership disclosure information/form

    b. Recredentialing files for 12 most recently recredentialed practitioners (should include 6 licensed practitioners who work at agencies and 6 Licensed Independent Practitioners, include the files of at least two MDs). Also, please include four files of network provider agencies and/or hospitals and/or psychiatric facilities, in any combination.

The Recredentialing files should include all of the following:

Proof of original credentialing date and all recredentialing dates, including the current recredentialing	Site visit/assessment reports, if the provider has had a quality issue or a change of address.
Proof of all insurance coverages .For practitioners who are employed at already-contracted agencies, include copies of the	Ownership disclosure information/form

insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.	

c. Ten MH/SA, ten I/DD and five TCLI files medical necessity approvals made from TBD-TBD, including any medical information and approval criteria used in the decision. Please select MEDICAID ONLY files and submit the entire file.

d. Ten MH/SA, ten I/DD and five TCLI files medical necessity denial files for any denial decisions made from TBD-TBD. Include any medical information and physician review documentations used in making the denial determination. Please include all correspondence or notifications sent to providers and enrollees. Please select MEDICAID ONLY files and submit the entire file.

NOTE: Appeals, Grievances, Care Coordination and TCLI files will be selected from the logs received with the desk materials. A request will then be sent to the plan to send electronic copies of the files to CCME. The entire file will be needed.

41. Provide the following for Program Integrity:
    a. File Review: Please produce a listing of all active files during the review period (TBD-TBD) including:
        i. Date case opened
        ii. Source of referral
        iii. Category of case (enrollee, provider, subcontractor)
        iv. Current status of the case (opened, closed)
    b. Program Integrity Plan and/or Compliance Plan.
    c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.
    d. Workflow of process of taking complaint from inception through closure.
    e. All 'Attachment Y' reports collected during the review period.
    f. Provider Manual and Provider Application.
    g. Enrollee Handbook.
    h. Subcontractor Agreement/Contract Template.
    i. Training and educational materials for the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse and the False Claims Act.
    j. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse.
    k. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors and employees.

l. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to DMA or any other State or Federal agency.
m. Code of Ethics and Business Conduct.
n. Internal and/or external monitoring and auditing materials.
o. Materials pertaining to how the PIHP captures and tracks complaints.
p. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
    i. DMA approved reporting templates.
q. Sample Data Mining Reports.
r. DMA Monthly Meeting Minutes for entire review period, including agendas and attendance lists.
s. Monthly reports of NCID holders/FAMS-users in PIHP.
t. Any program or initiatives the plan is undertaking related to Program Integrity including documentation of implementation and outcomes, if appropriate.
u. Corrective action plans including any relevant follow-up documentation.
v. Policies/Procedures for:
    i. Program Integrity
    ii. HIPAA and Compliance
    iii. Internal and external monitoring and auditing
    iv. Annual ownership and financial disclosures
    v. Investigative Process
    vi. Detecting and preventing fraud
    vii. Employee Training
    viii. Collecting overpayments
    ix. Corrective Actions
    x. Reporting Requirements
    xi. Credentialing and Recredentialing Policies
    xii. Disciplinary Guidelines

42. Provide the following for the Information Systems Capabilities Assessment (ISCA):
    a. A completed ISCA.
    b. See the last page of the ISCA for additional requested materials related to the ISCA.

Section	Question Number	Attachment
Enrollment Systems	1b	Enrollment system loading process
Enrollment Systems	1e	Enrollment loading error process
Enrollment Systems	1f	Enrollment loading completeness reports
Enrollment Systems	2c	Enrollment reporting system load process
Enrollment Systems	2e	Enrollment reporting system completeness reports
Claims Systems	2	Claim process flowchart
Claims Systems	2t	Claim exception report.

Claims Systems	3e	Claim reporting system completeness process / reports.
Claims Systems	3h	Physician and institutional lag triangles.
Reporting	1a	Overview of information systems
DMA Submissions	1d	Workflow for DMA submissions
DMA Submissions	2b	Workflow for DMA denials
DMA Submissions	2e	DMA outstanding claims report

c. A copy of the IT Disaster Recovery Plan.
d. A copy of the most recent disaster recovery or business continuity plan test results.
e. An organizational chart for the IT/IS staff and a corporate organizational chart that shows the location of the IT organization within the corporation.

43. Provide the following for Financial Reporting:

a. Most recent annual audited financial statements.
b. Most recent annual compliance report
c. Most recent two months' State-required DMA financial reports.
d. Most recent two months' balance sheets and income statements including associated balance sheet and income statement reconciliations.
e. Most recent months' capitation/revenue reconciliations.
f. Most recent reconciliation of claims processing system, general ledger, and the reports data warehouse. Provide full year reconciliation if completed.
g. Most recent incurred but not reported claims medical expense and liability estimation. Include the process, work papers, and any supporting schedules.
h. Any other most recent month-end financial/operational management reports used by PIHP to monitor its business. Most recent two months' claims aging reports.
i. Most recent two months' receivable/payable balances by provider. Include a detailed list of all receivables/payables that ties to the two monthly balance sheets.
j. Any P&Ps for finance that were changed during the review period.
k. PIHP approved annual budget for fiscal year in review.
l. P&Ps regarding program integrity (fraud, waste, and abuse) including a copy of PIHP's compliance plan and work plan for the last twelve months.
m. Copy of the last two program integrity reports sent to DMA's Program Integrity Department.
n. An Excel spreadsheet listing all of the internal and external fraud, waste, and abuse referrals, referral agent, case activity, case status, case outcome (such as provider education, termination, recoupment and recoupment amount, recoupment reason) for the last twelve months.
o. A copy of PIHP's Special Investigation Unit or Program Integrity Unit Organization chart, each staff member's role, and each staff member's credentials.
p. List of the internal and external program integrity trainings delivered by PIHP in the past year.
q. Description and procedures used to allocate direct and overhead expenses to Medicaid and State funded programs, if changed during the review period.
r. Claims still pending after 30 days.

s. Bank statements for the restricted reserve account for the most recent two months.
t. A copy of the most recent cost allocation plan.
u. A copy of the PIHP's accounting manual.
v. A copy of the PIHP's general ledger chart of accounts.
w. Any finance Corrective Action Plan
x. Detailed medical loss ratio calculation, including the following requirements under CFR § 438.8:
    1. Total incurred claims
    2. Expenditures on quality improvement activities
    3. Expenditures related to PI requirements under §438.608
    4. Non-claims costs
    5. Premium revenue
    6. Federal, state and local taxes, and licensing and regulatory fees
    7. Methodology for allocation of expenditures
    8. Any credibility adjustment applied
    9. The calculated MLR
    10. Any remittance owed to State, if applicable
    11. A comparison of the information reported with the audited financial report required under §438.3 (m)
    12. The number of member months

44. Provide the following for Encounter Data Validation (EDV):
    a. Include all adjudicated claims (paid and denied) from January 1, 2017 – December 31, 2017. Follow the format used to submit encounter data to DMA (i.e., 837I and 837P). If you archive your outbound files to DMA, you can forward those to HMS for the specified time period. In addition, please convert each 837I and 837P to a pipe delimited text file or excel sheet using an EDI translator. If your EDI translator does not support this functionality, please reach out immediately to HMS.
    b. Provide a report of all paid claims by service type from January 1, 2017 – December 31, 2017. Report should be broken out by month and include service type, month and year of payment, count, and sum of paid amount.

NOTE: EDV information should be submitted via the secure FTP to HMS. This site was previously set up during the first round of Semi-Annual audits with HMS. If you have any questions, please contact Nathan Burgess of HMS at (919) 714-8476.