External Quality Review

2019 ANNUAL SUMMARY REPORT

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

2019 EQR Annual Summary Report

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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 (PIHP) 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 North Carolina Medicaid (NC Medicaid and 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 Managed Long-Term Services and Supports (MLTSS) Program.

The findings discussed in this report are based on the EQR activities conducted for 2019 and include a summary of the mandatory activities:

- The PIHP's compliance with federal and state requirements
- Validation of the Performance Measures (PMs) collected and reported
- Validation of Performance Improvement Projects (PIPs) 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 DHHS 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 (QI) and medical management programs, and a file review of denials, appeals, approvals, case management, 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 following two tables:

Table 1: 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

Table 2: C Waiver Measures

C WAIVER MEASURES	
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals.	Percentage of level 2 and 3 incidents reported within required timeframes.
Proportion of Individual Support Plans that address identified health and safety risk factors.	Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.
Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need.	Percentage of medication errors resulting in medical treatment.
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.	Percentage of beneficiaries who received appropriate medication.
Proportion of beneficiaries reporting they have a choice between providers.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.

Validation of Performance Improvement Projects

CCME validated 24 Performance Improvement Projects 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 a list 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. Due to COVID-19, the Onsite for Alliance was conducted virtually and Partners' Onsite was postponed to July of 2020.

Table 3 displays the dates of the EQR Onsite conducted for each PIHP.

Table 3: External Quality Review Onsite Dates

Health Plan	2019 EQR
Alliance Health (Alliance)	March 18 – March 19, 2020
Cardinal Innovations Healthcare Solutions (Cardinal)	January 29-January 30, 2020
Eastpointe Behavioral Health (Eastpointe)	November 20 – November 21, 2019
Partners Health Management (Partners)	Postponed to July 29 – July 30, 2020
Sandhills Center (Sandhills)	August 28 – August 29, 2019
Vaya Health (Vaya)	October 9 – October 10, 2019
Trillium Health Resources (Trillium)	June 5 – June 6, 2019

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:

1. Points were assigned to each rating ("Met" = 2 points and "Partially Met" = 1 point), excluding "Not Evaluated" and "Not Applicable" ratings from the calculation.
2. The total number achieved was calculated by adding the earned points together.
3. The final section score was derived by dividing the section's total points (total number achieved) by the total possible points for that section.
4. The overall score (percentage) was then calculated by averaging the final section scores for the seven PIHPs reviewed.

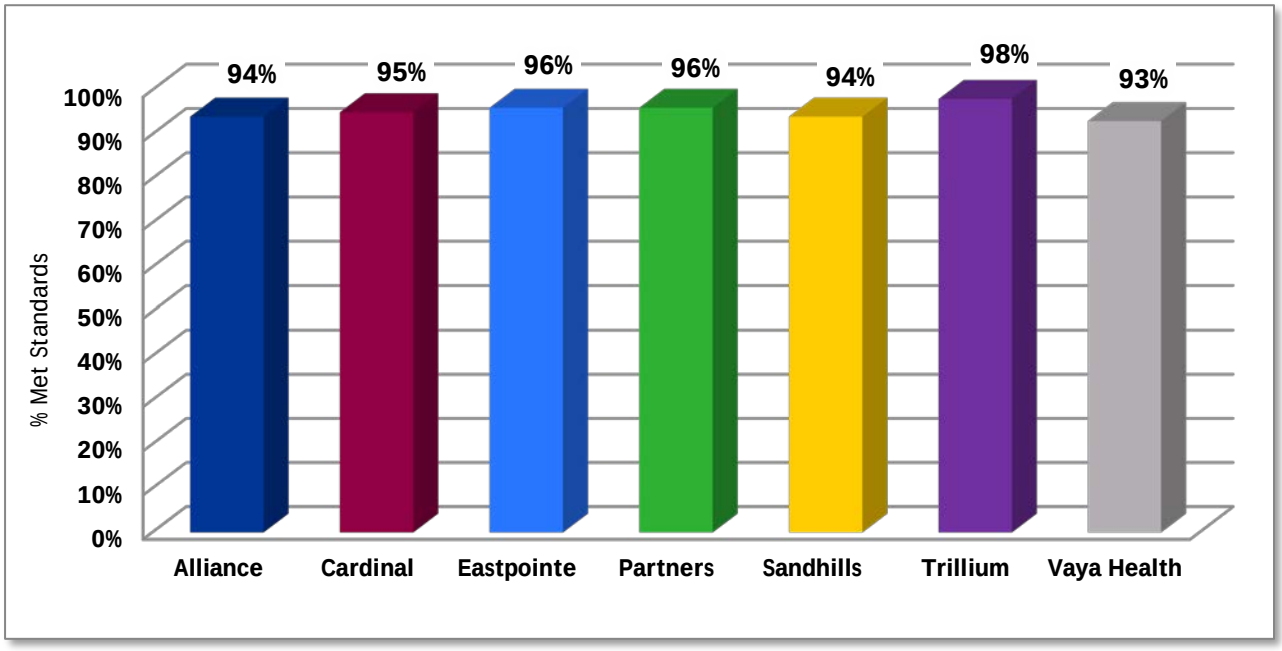
The scores were then averaged for each section and the PIHPs were assigned an overall score, as illustrated in Table 4.

Table 4: Overall Scores for PIHPs

Health Plan	Overall Score
Alliance	98%
Cardinal	98%
Eastpointe	98%
Partners	98%
Sandhills	97%
Vaya	95%
Trillium	99%

Figure 1 illustrates the percentage of "Met" standards each PIHP achieved during the 2019 EQRs.

Figure 1: Percentage of Met Standards



D. Overall Findings

Administration

Administrative functions of each PIHP were reviewed for the 2019 EQR. This involved a thorough examination of each PIHP's policies and procedures, organizational structure, and confidentiality practices. Overall PIHP improvements from last year's EQR administrative standards scores related to improvements in the Information Systems Capabilities Assessment (ISCA).

PIHPs met all of the standards related to management of policies and procedures, organizational chart/staffing, and confidentiality practices. While there were fewer Recommendations issued this year, the Recommendations were typically the same Recommendations given in the previous EQRs. CCME's primary concerns were the PIHPs' ability to adequately and timely manage and revise their policy and procedure sets, especially in the face of upcoming NC Medicaid Contract changes and NCQA accreditation. Some PIHPs continue to struggle to document in their Organizational Charts key changes to their departmental organization, particularly when they are enhancing their departments providing medical oversight.

Information Systems Capabilities Assessment

All of the PIHPs scored 90% or above, with three out of the seven PIHPs scoring 100% on their ISCA review. Areas of weakness that persist are related to the need for processes to capture,

store, and report/transmit all of required Encounter data in the form of Diagnosis codes to NCTracks. PIHPs need to update their Encounter data submission process to include Coordination of Benefits (COB) identifier and Healthcare Common Procedure Coding System (HCPCS) codes. PIHPs should update their Encounter data submission process to allow for all ICD-10 CM Diagnosis codes submitted on an Institutional and Professional 8371 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 837P, and the maximum number that is captured by NCTracks. NCTracks can also capture as many as 12 Diagnosis codes for Professional claims.

Provider Services

The EQR of Provider Services is comprised 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). In the 2019 EQR, six PIHPs scored 96% or above, with three PIHPs (Alliance, Partners, and Vaya) scoring 100%, compared to the 2018 Provider Services review, when six PIHPs scored 93% or above, with one PIHP (Alliance) scoring 100%. Four (Eastpointe, Partners, Trillium, and Vaya) of the PIHPs improved their overall scores in the 2019 review, with two PIHPs (Alliance and Sandhills) maintaining the same score as 2018. The score of one PIHP (Cardinal) dropped slightly from the 2018 review (96%) to the 2019 review (91%).

The score for most items in the credentialing/recredentialing file review was "Met". The only standard for which more than one PIHP scored "Partially Met" was "Ownership Disclosure is addressed", which was in the recredentialing file review.

All PIHPs scored 100% on the standards in "Adequacy of the Provider Network", "Clinical Practice Guidelines for Behavioral Health Management", "Continuity of Care", and "Practitioner Medical Records". Six of the seven PIHPs scored "Met" on all standards in the "Provider Education" section of the 2019 EQR. One PIHP (Eastpointe) scored "Partially Met" on one standard in the "Provider Education" section of the 2019 EQR. Reflective of the nationwide opioid epidemic, most PIHPs continue to fail to meet choice and distance standards for opioid treatment. PIHPs filed Exception Requests, approved by NC Medicaid, while they continue to pursue efforts to meet gaps.

Enrollee Services

CCME's review of Enrollee Services included relevant policies and procedures, member rights information, member educational materials, the enrollee handbooks, the provider manuals, Call Center training materials, and the PIHP websites.

Across all PIHPs, there were seven standards improved. Alliance, Eastpointe, Trillium, and Vaya all improved to a "Met" on 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…". Sandhills and Trillium both improved to a "Met" on the standard for "Enrollees are informed promptly in writing of…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."

Only two of the seven PIHPs had one standard each decrease in score from the 2018 EQR to the 2019 EQR. Alliance and Vaya both had one standard that decreased in score, and they received specific Corrective Action along with technical assistance on improvements to make.

Quality Improvement

CCME assessed each PIHP's Quality Improvement Program Description, policies and procedures, committees that act on QI activities, provider QI participation, annual program evaluation, Performance Measures (PMs), and Performance Improvement Projects (PIPs). The 2019 EQR showed each PIHP has a QI program that monitors and seeks to improve the behavioral health outcomes and services their enrollees receive.

When compared to the 2018 EQR, the overall PIHP scores for the 2019 EQR revealed improvement for one PIHP, the same score for two PIHPs, and a decrease for three PIHPs. Eastpointe increased scoring in 2019 over the 2018 year. Cardinal and Sandhills remained the same. Alliance and Vaya had a decrease in their Quality EQR score. For the 2019 EQR, the percentage of scores met in the 2019 EQR for QI ranged from 72% for Vaya, to 94% for Alliance, Cardinal, Eastpointe, Sandhills, and Trillium. Each PIHP that scored a 94% "Met" had one standard scored as "Partially Met".

Performance Measure Validation

The (b) Waiver measures validation scores showed, for each PIHP, Performance Measures were fully compliant with the measure specifications required by the CMS EQR protocol and the State Reporting guide. Ten (c) Waiver measures were validated for each PIHP and the average validation score was 100%.

Performance Improvement Project Validation

The 2019 Performance Improvement validation process showed less than "High Confidence" in the PIP results reported by Eastpointe, Sandhills and Vaya. Alliance, Cardinal, Partners, and Trillium received "High Confidence" validation findings for all of their submitted PIPs.

A summary of validation scores for each PIP, as well as validation decision category status, are presented in *Table 12: 2019 PIP Validation Results Summary* in the Quality Improvement section of this report.

Utilization Management

The Utilization Management (UM) functions of CCME's EQR include the review of the UM/Service Authorization, Care Coordination, and Transition to Community Living Initiative (TCLI) functions. The UM scores ranged from 89% for Partners and Alliance to 98% for Cardinal and Trillium.

In this year's EQR, the scores for Sandhills and Trillium increased, while the scores for Eastpointe, Cardinal, and Vaya, were maintained from the previous year's EQR. The overall UM score for Alliance and Partners decreased during the 2019 EQR. The review of Care Coordination and TCLI files revealed the need for increased monitoring of Care Coordination and TCLI documentation. Data driven monitoring plans will better achieve departmental benchmarks and improved documentation compliance to PIHP internal policies and procedures.

Grievances and Appeals

The EQR of grievances showed, while PIHPs improved their consistency when defining a "grievance", PIHPs' collective adherence to grievance standards decreased in the 2019 EQR by 33% when compared to the 2018 EQR of grievances. Several PIHPs received Recommendations and Corrective Actions to improve upon grievance procedural language. Policies and procedures were either incorrect or incomplete in detailing the PIHPs' requirements when grievances are extended, capturing consultations with subject matter experts within the grievance file, or documenting in procedures the State-required timeframe maintaining grievance files.

The EQR of grievance PIHP files showed that areas of noncompliance were typically related to PIHPs not complying with their own policies and procedures. For example, timeliness issues were noted in Alliance's grievance files in which a large portion of grievance acknowledgment notifications were sent outside the timeframe required by Alliance's policies and procedures. CCME frequently encouraged PIHPs to more closely monitor their grievance files to ensure increased compliance with policies and procedures.

The EQR of appeals showed PIHPs, collectively, improved their compliance with the appeals standards and NC Medicaid Contract requirements by 10%, when compared to the 2018 EQR. The most common issue noted in this year's EQR was the lack of clear and correct information regarding expedited and extended appeal requirements in the PIHPs' policies, procedures, provider manuals, and enrollee handbooks. All of the PIHPs received at least one Recommendation or Corrective Action related to expedited and/or extended appeals, and 40% of the Recommendations and Corrective Actions issued in the 2019 appeals EQR targeted issues related to expedited and extended appeals. While PIHPs typically resolved standard, expedited, and extended appeals in a timely fashion, most struggled to follow or document the internal steps required when processing expedited and extended appeals.

For the upcoming year, CCME recommends that all PIHPs enhance their monitoring of appeals to ensure compliance with the internal steps required throughout the appeal resolution process. PIHPs also need to ensure they release the appeal record to enrollees or their representatives in a manner that is compliant with their Protected Health Information policies and procedures. Lastly, the *NC Medicaid Contract, Attachment M, Section G.1* explains "the Enrollee, legally responsible person or a provider or other designated personal representative, acting on behalf of the Enrollee and with the Enrollee's signed consent may file and internal appeal." While most PIHPs have this definition in appeal related documentation, most have inconsistent documentation explaining that natural supports other than the provider can serve as a representative or that written consent from the enrollee is required to serve as a representative throughout the appeals process.

Delegation

CCME's EQR of Delegation functions included a review of the relevant policies and procedures, the submitted Delegate List, Delegation Contracts, and Delegation Monitoring materials, and the *Delegation Program Description* for those PIHPs who had a program description. The PIHPs have Delegation Agreements in compliance with the *NC Medicaid Contract Attachment B* requirements. The Delegation Agreements include Business Associate Agreements (BAA) with those delegates that have access to Protected Health Information (PHI). The PIHPs with Delegation Agreements for credentialing retain final decision-making for credentialing decisions. The PIHPs conduct regular monitoring of delegates, with some PIHPs meeting regularly with delegates to review delegate performance. There are two scored standards in the Delegation EQR. In the 2019 Delegation EQR, six of the PIHPs "Met" both standards. Sandhills scored "Partially Met" on the second standard.

Program Integrity

In this year's EQR, there was improvement noted across all PIHPs regarding the alignment of Program Integrity (PI) documentation with the requirements in the PIHP's *NC Medicaid Contract*. There was also evidence that PIHPs continue to improve upon their data mining targeting fraud, waste, and abuse, and CCME encourages PIHPs to continue to maximize their use of data mining activities.

Several PIHPs had PI file documentation that was missing or incomplete, impacting the overall scores in the PI files EQR standards. Primary areas of concern were missing National Provider Identification (NPI) numbers, documented communications between the PIHP and the providers, name/contact information for the PI investigator referral forms, incomplete case log wording and executive summaries, and inconsistent file naming conventions. CCME recommends that PIHPs 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 PI reporting, file consistency, and review.

Financial Services

In this year's EQR of PIHP financial functions, five of the seven PIHPs met 100% of the standards. Trillium scored a "Not Met" on the standard addressing the Medical Loss Ratio (MLR), as Trillium did not maintain the 85% Medical Loss Ratio percentage required by *42 CFR § 438.8* and the *NC Medicaid Contract*, *Section 12.3*. Vaya was required through a Corrective Action to enhance their Medicaid Funds Management policy by adding the five-business day requirement for Risk Reserve payments. For the upcoming year, CCME recommends that all PIHPs update their administrative cost allocation plan annually.

E. Optional Activities

Optional activities selected by the State included Encounter data validation, Semi-Annual Audits, and provider and enrollee satisfaction surveys.

Encounter Data Validation

The results of the Encounter data validation found the data submitted to NC Medicaid by Cardinal, Eastpointe, Sandhills, Trillium, and Vaya was complete and accurate. Alliance still had minor issues with their submission of Institutional encounters that need to be addressed in order to be fully compliant. For the next review period, it is recommended that the Encounter data from NCTracks be reviewed 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 PIHPs. Reviewing an extract from NCTracks would provide insight into how the State's Medicaid Management Information System (MMIS) is handling the encounter claims and could be reconciled back to reports requested from Alliance. The goal is to ensure that PIHPs are reporting all paid claims as encounters to NC Medicaid.

Semi-Annual Audits

PIHP Medicaid data from two six-month time periods in 2019 and 2020 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.

Enrollee Satisfaction Survey

The 2019 Experience of Care and Health Outcomes (ECHO™) Surveys were administered to assess enrollee perceptions of the seven PIHPs. From each PIHP, 571 adult and 571 child enrollees were surveyed. Both the adult and child enrollee satisfaction 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 the overall rating of counseling and treatment, Partners' adult enrollees reported the highest satisfaction. Vaya's adult enrollees reported the lowest satisfaction and Cardinal received the highest scores in six of the nine adult Care Coordination Items. Both Eastpointe and Alliance scored highest on three of the ten, single items. All PIHPs received the lowest satisfactory scores for at least one item within the adult surveys.

All PIHPs received the lowest satisfactory scores for at least one item within the child enrollee satisfaction surveys. Regarding the overall rating of counseling and treatment, Cardinal's child enrollees reported the lowest satisfaction. Of the nine child Care Coordination items, Vaya received the highest scores on three of the nine items and Eastpointe scored the lowest satisfaction in four of the nine items. Cardinal scored positively on four of the ten single item questions.

Provider Satisfaction Survey

Overall, provider satisfaction has increased from 2018 to 2019. In this year's results, providers are more satisfied than last year on all of the 23 items surveyed. In 2019, providers reported being the most satisfied regarding accuracy of the service authorizations issued by the PIHPs. This was also true in 2018. The question with the largest gain from a year ago involved the providers feeling satisfied regarding the consistency and accuracy of claims information given by PIHP staff. Providers were least satisfied with the clinical and service needs of referrals of enrollees from the PIHP and their match with the services offered by the provider. This was also the lowest scoring item in the 2018 survey analysis.

METHODOLOGY

The EQR process was based on CMS protocols. The review focused on the three federally mandated EQR activities, which are compliance determination, Performance Measure validation, and Performance Improvement Project validation, as well as these optional activities: Encounter data validation, semi-annual audits, enrollee satisfaction surveys, and provider satisfaction surveys.

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.

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.

The PIHPs were evaluated using the standards developed by CCME and approved by NC Medicaid. CCME scored each standard as fully meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), "Not Applicable," or "Not Evaluated." In the Findings section of this Annual Summary Report, the figures summarize the percentage of "Met" scores for each PIHP in each of the sections (e.g., Administration, Provider Services, etc.) evaluated in the EQR. The tables reflect the scores for each standard evaluated in the EQR. The arrows in the figures and tables indicate a change in the score from the previous review. For example, an arrow pointing up (⬆) would indicate the score for that standard improved from the previous review and a down arrow (⬇) indicates the standard was scored lower than the previous review. Scores without arrows indicate that there was no change in the score from the previous review.

Each section within Findings also 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 PIHP for the 2019 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.

Policies and Procedures

The issues noted in this year's review related primarily to the PIHPs effectively managing their policies and procedures. Further, as the PIHPs go through the process of obtaining NCQA accreditation, their policies and procedures are being revised to address NCQA requirements but displacing or contradicting their NC Medicaid contractual requirements. Alliance, Partners, Sandhills, and Trillium received Recommendations in this year's EQR on how best to track, revise, and maintain their policies and procedures, as well as ensure *NC Medicaid Contract* requirements are referenced within their policy and procedure sets. Alliance and Sandhills received similar feedback in 2018 but chose not to implement those best practices.

Moving forward, PIHPs need to ensure they have thoughtful, thorough, and nimble processes in place for revising policies and procedures. *NC Medicaid Contract* references should be prioritized in policies and procedures to ensure staff remain in compliance with contractual requirements.

Organizational Staffing

The primary issue noted during this year's EQR of PIHP staffing related to errors within the PIHP's Organizational Charts. While Organizational Charts are not required by the *NC Medicaid Contract*, they are the only documentation that demonstrates to internal staff and external stakeholders the PIHP's departmental structure, supervisory responsibilities, and medical/clinical oversight.

Five PIHPs, Cardinal, Partners, Sandhills, Trillium, and Vaya, received Recommendations to correct their Organizational Charts. Three of these PIHPs, Cardinal, Partners, and Vaya, lacked documentation demonstrating the "substantial involvement" of Medical Directors in each PIHP's Quality and Performance Improvement, credentialing, utilization review, and the monitoring of PIHP's Network Providers, as required by *NC Medicaid Contract, Section 7.1.3.* As an example, in the past three EQRs, CCME has recommended that Vaya's Organizational Chart reflect the departmental oversight by their Medical Services Department on their Organizational Chart. Documentation of the current job descriptions for the Medical Director and Associate Medical Director did not align with the oversight described during the Onsite. Vaya's response to this Recommendation was "Thank you for making the suggestion, but this item is not a requirement."

Most PIHPs are reorganizing their current departmental structures in preparation for becoming a Standard Plan. Also, PIHPs have been expanding the functions and specialties within their Medical Services Departments to include medical staff with specialties such as population health, pharmacy, and substance use. PIHPs need to ensure Organizational Charts are kept up to date, accurate, and correctly identify the Medical Director oversight and "substantial involvement" in the activities required by *NC Medicaid Contract, Section 7.1.3.*

Confidentiality

There were no significant issues noted in the PIHPs' confidentiality practices and policies and procedures, with the exception of Vaya. For the past three EQRs, CCME has advocated that Vaya reflect in their Privacy Policy the timeframe for training new staff on Vaya's confidentiality practices. During the Onsite, staff can describe a timeframe based on their new staff orientation schedule. Further, staff can explain this training occurs prior to a new employee's access to Protected Health Information. However, Vaya's procedures continue to state new employees are trained "within a reasonable period of time," and that "best efforts will be made to ensure that all staff receive training before accessing PHI." CCME is not advocating for a specific timeframe, just that Vaya specify what their timeframe is. However, in this year's EQR, Vaya stated, "Vaya will not be implementing this recommendation beyond what is already in place that meets all requirements around how staff are trained on confidentiality and the timeliness thereof." It should be noted that no other PIHP struggles to specify a timeframe for training new staff on confidentiality.

Any other issues related to PIHP confidentiality practices were typically related to departments acting outside of the PIHP's policies and procedures. These issues were addressed through Corrective Actions and Recommendations specific to those EQR sections and departments.

Information Systems Capabilities Assessment (ISCA)

The review of the PIHPs' systems capabilities involved review of the PIHPs' responses to the CMS standard ISCA questionnaire, Onsite interview with key staff, and live demonstration 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.

When compared to the previous year, two PIHPs improved their capture of claims data (Sandhills and Trillium). Two PIHPs had a decrease in performance capturing and reporting enrollment and claims information for reporting (Sandhills and Partners). There was improvement by two PIHPs in encounter claims submission capability (Cardinal and Trillium), but Alliance, Eastpointe, Sandhills, and Vaya remain challenged in fully meeting this standard.

PIHPs still continue to have opportunity for improvement related to their policies and procedures. Most of the PIHPs do not have documented processes in place to capture, store, and

report/transmit all of required Encounter data in the form of Diagnosis codes to NCTracks. The level of deficiency varies by PIHP. Although there was improvement by three of the seven reporting PIHPs. Cardinal, Partners, Sandhills and Vaya continue to lack the capabilities to submit Encounter data to the State. Other PIHPs are not yet storing all codes within their own claims databases.

The 2019 EQR of each PIHP's Administration resulted in a range of "Met" scores between 90% and 100% on the standards in these areas. Figure 2 and Table 5 provide an overview of each PIHP's performance in this section. The arrows indicate a change in the score from the previous review.

Figure 2: Administration

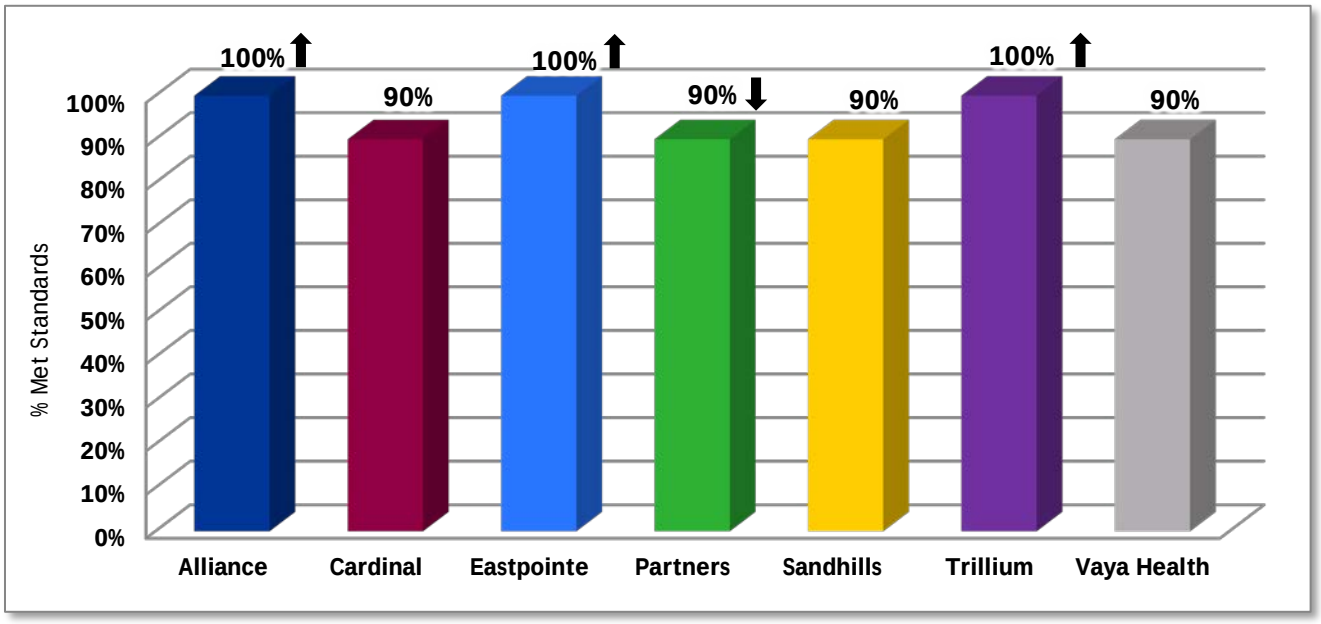


Table 5: Administration Comparative Data

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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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:							
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, including those that are required by NC Medicaid.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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
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 PIHP 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 PIHP is able to identify and review any errors identified during, or as a result, of the State enrollment file load process.	Met	Met	Met	Met	Met	Met	Met
1.3 The PIHP's enrollment system member screens store and track enrollment and demographic information.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
2. CLAIMS SYSTEM							
2.1 The PIHP processes provider claims in an accurate and timely fashion.	Met	Met	Met	Met	Met	Met	Met
2.2 The PIHP has processes and procedures in place to monitor review and audit claims staff.	Met	Met	Met	Met	Met	Met	Met
2.3 The PIHP 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. The PIHP has the capability of receiving and storing ICD-10 Procedure codes on an 837 Institutional file.	Met	Partially Met	Met	Partially Met	Met ↑	Met ↑	Partially Met
2.4 The PIHP'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 PIHP's data repository captures all enrollment and claims information for internal and regulatory reporting.	Met	Met	Met	Met	Partially Met ↓	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
3.2 The PIHP 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 PIHP has the capabilities in place to submit the State required data elements to NC Medicaid on the Encounter data submission.	Met ↑	Partially Met	Met ↑	Partially Met	Partially Met	Met ↑	Partially Met
4.2 The PIHP has the capability to identify, reconcile and track the Encounter data submitted to NC Medicaid.	Met	Met	Met	Met	Met	Met	Met
4.3 The PIHP has policies and procedures in place to reconcile and resubmit Encounter data denied by NC Medicaid.	Met	Met	Met	Met	Met	Met	Met
4.4 The PIHP has an Encounter data team/unit involved and knowledgeable in the submission and reconciliation of Encounter data to NC Medicaid.	Met	Met	Met	Met	Met	Met	Met

Strengths

- Most PIHPs are diversifying their Medical Services Departments to include specialists in areas such as population health, pharmacy, and substance use.
- 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 have the capability to identify, reconcile, and track Encounter data submitted to NC Medicaid, and most of the PIHPs exceeded the NC Medicaid standards for encounter submissions of less than 0.5% denial rate of Encounter data submissions.

- PIHPs generally have effective data reconciliation processes and reports, as well as back-up systems for enrollment and claims data repositories.
- Most PIHPs successfully managed fluctuations (either increases or decreases) in enrollment counts over time.

Weaknesses

- Five out of six PIHPs received Recommendations on how to best track, revise, and maintain their policies and procedures, as well as ensure *NC Medicaid Contract* requirements are referenced within their policy and procedure sets.
- Four PIHPs had incorrect or incomplete Organizational Charts. Three PIHPs did not have adequate documentation to demonstrate the Medical Director's or Associate Medical Director's "substantial involvement" in the activities defined in the *NC Medicaid Contract*.
- There is an opportunity for several PIHPs to correct State-required data elements to NC Medicaid on the Encounter data submission, particularly submitted third-party payer claims to include the appropriate COB identifier and Healthcare Common Procedure Coding System (HCPCS) codes.
- Although improvements were made based on the weaknesses noted in the prior year's report, the issue of PIHPS having the capability to store and submit all primary and secondary ICD-10 Diagnosis and Procedure codes on Institutional and/or Professional encounter, enrollment, diagnosis, and claims data continues for most PIHPs.

Recommendations

- PIHPs need to ensure they have thoughtful, thorough, and nimble processes in place for revising policies and procedures. *NC Medicaid Contract* references should be prioritized in policies and procedures to ensure staff remain in compliance with contractual requirements
- PIHPs need to ensure Organizational Charts are kept up to date, accurate, and correctly identify the Medical Director oversight and "substantial involvement" in the activities required by *NC Medicaid Contract, Section 7.1.3.*
- PIHPS should update their Encounter data submission process to include COB identifier and HCPCS codes.
- As was recommended in the prior year's Annual Summary Report, PIHPs should update their Encounter data submission process to capture all ICD-10 CM Diagnosis codes submitted on an Institutional and Professional 8371 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 837P, and the maximum number that is captured by NCTracks. NCTracks can capture as many as 12 Diagnosis codes for Professional claims.

B. Provider Services

The CCME review of Provider Services included relevant policies and procedures, provider orientation, 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, enrollee handbooks, 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 meeting minutes and materials for each PIHP.

One standard ("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.") was deleted in the 2019 Provider Services review, due to a change in the *NC Medicaid Contract* requirements. The 2019 EQR revealed improvement over 2018 in the percentage of standards with "Met" scores. In the 2019 Provider Services review, ten of the 67 standards (15%) included at least one PIHP with a score of "Partially Met" or "Not Met", compared to the 2018 Provider Services review, when 16 of the 68 standards (24%) 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 2019 Provider Services review, two or more PIHPs scored "Partially Met" or "Not Met" on only one standard, compared to the 2018 Provider Services review, where two or more PIHPs scored "Partially Met" or "Not Met" on three standards. Though there were six standards for which at least one PIHP scored "Not Met" in the 2018 Provider Services review, there was only one standard for which at least one PIHP scored "Not Met" in the 2019 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) or designee (such as the Associate Medical Director) 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 reviewed credentialing and recredentialing files were organized and contained appropriate information. For the 2018 EQR, the most commonly-occurring item for which the PIHPs received a score of "Partially Met" in the credentialing and recredentialing file review was in the area of "query for state sanctions" (query of *The North* Carolina *Medicaid Provider Termination and Exclusion* list, known as the *State Exclusion List).* All PIHPs met this standard in the 2019 EQR.

The PIHPs conducted the required annual *Network Adequacy and Accessibility Analysis* and created a Network Access Plan to address the identified gaps and needs. The most commonly identified gap/need continues to be related to opioid treatment, though most PIHPs have expanded service availability to address this gap. 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. When PIHPs do not meet choice and access standards, they can submit an Exception Request to NC Medicaid. Since most identified gaps in the current EQR were the same as the gaps identified by the PIHPs at the previous EQR, 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 2018 to 2019 for four PIHPs (Eastpointe, Partners, Trillium, Vaya). Trillium achieved the greatest improvement, with 87% "Met" in 2018 and 97% "Met" in 2019. The Provider Services score for two PIHPs (Alliance: 100%; Sandhills: 97%) was unchanged from 2018 to 2019. One PIHP (Cardinal) experienced a slight decrease in their Provider Services score from 2018 (96%) to 2019 (91%). Six PIHPs (Alliance, Eastpointe, Partners, Sandhills, Trillium, and Vaya) scored 96% or above, with three of those PIHPs (Alliance, Partners, and Vaya) achieving a score of 100% in the Provider Services EQR in 2019.

Figure 3 and Table 6 provide an overview of the PIHPs' performance in the Provider Services section in the 2019 EQR.

Figure 3: Provider Services

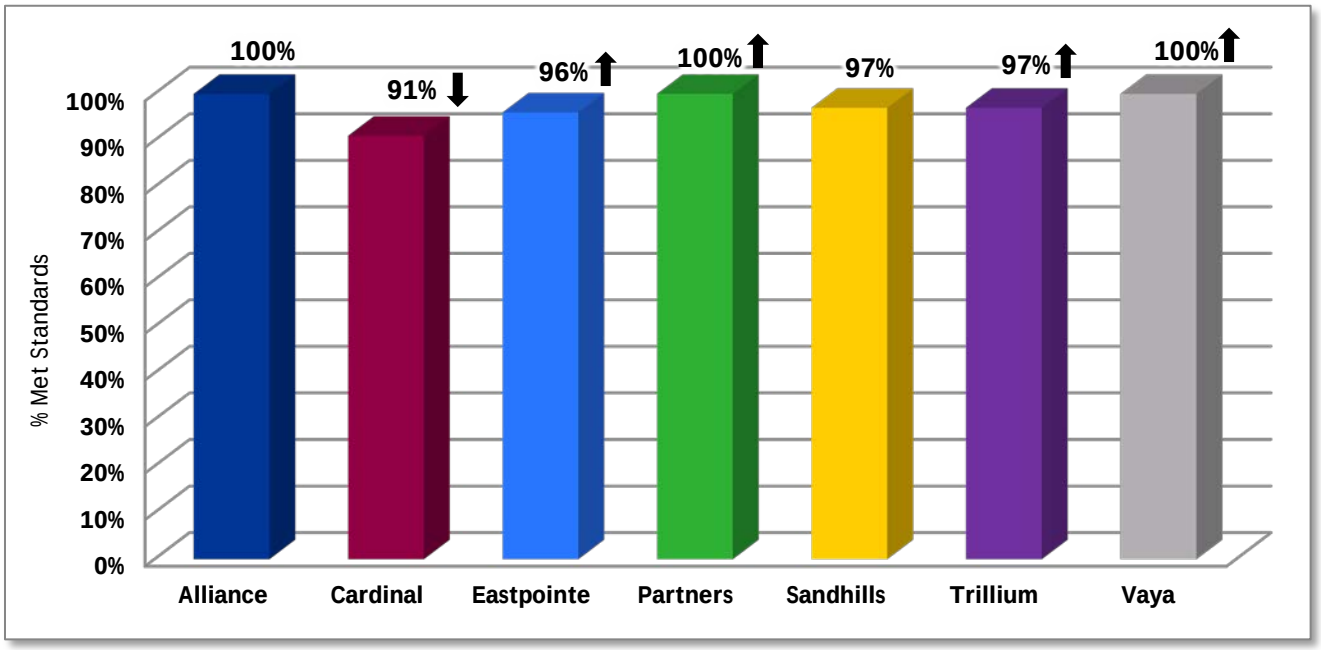


Table 6 Provider Services Comparative Data

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
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	Partially 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	Met↑	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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
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) and query of the State Exclusion List;	Met	Met	Met ↑	Met	Met ↑	Met ↑	Met ↑

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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 (SSADMF);	Met	Partially Met↓	Met	Met	Met	Met	Met
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	Met	Met↑	Met	Met	Met	Met	Met
3.1.14 Names of hospitals at which the physician has admitting privileges, if any.	Met	Met	Met	Met	Met	Met	Met
3.1.15 Ownership Disclosure is addressed;	Met	Partially Met↓	Met	Met	Met	Met	Met
3.1.16 Criminal background Check	Met	Partially Met↓	Met	Met	Met	Met	Met
3.2 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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
4.1 Recredentialing every three years;	Met	Met	Not Met↓	Met	Met	Met↑	Met
4.2 Verification of information on the applicant, including:							
4.2.1 Insurance Requirements	Met	Partially 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	Met↑	Met
4.2.3 Valid DEA certificate and/or CDS certificate;	Met	Met	Met	Met	Met	Met	Met
4.2.4 Board certification, 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
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, and query of the State Exclusion List;	Met	Met	Met↑	Met	Met↑	Met↑	Met↑

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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 (OIG LEIE);	Met	Met	Met	Met	Met	Met	Met
4.2.11 Query of the Social Security Administration's Death Master File	Met	Met ↑	Met	Met	Met	Met	Met
4.2.12 Query of the NPPES	Met	Met ↑	Met	Met	Met	Met	Met
4.2.13 Names of hospitals at which the physician has admitting privileges, if any.	Met	Met	Met	Met	Met	Met ↑	Met
4.2.14 Ownership Disclosure is addressed	Met	Partially Met ↓	Met	Met	Met	Partially 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	Partially Met ↑	Met
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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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 NC Medicaid, 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
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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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 ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	Met	Met	Met ↑	Met	Met	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	Met ↑
2. Initial provider education includes:							
2.1 PIHP purpose and mission;	Met	Met	Met	Met	Met	Met	Met
2.2 Clinical Practice Standards;	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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	Partially 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
2.11 Enrollee rights and responsibilities;	Met	Met	Met	Met	Met	Met ↑	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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 audits 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	Met ↑	Met	Met	Met

Strengths

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

Weaknesses

- Some of the credentialing/recredentialing files submitted for the EQR lacked required information, such as Ownership Disclosure information, evidence of all required types of insurance, or other items. There were no clear trends of specific missing items across files or across PIHPs.
- Some files were missing Primary Source Verification (PSV) of education of physicians and/or Physicians Assistants, or queries such as the Social Security Administration Death Master File. This also was not a clear trend, but, rather, a few isolated items in a few files.

- Broken links or incorrect URLs in various printed documents were an issue for several PIHPs.
- At two of the PIHPs, procedures or other documents contained conflicting information regarding the Credentialing Committee, including items such who chairs the meetings or what constitutes a quorum.

Recommendations

- Ensure credentialing/recredentialing files submitted for the EQR 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 credentialing and recredentialing files include required documentation such as Ownership Disclosure and required PSVs.
- Ensure PIHP materials, including policies and procedures and provider manuals, contain the correct links or URLs.
- Reconcile language across documents to accurately reflect Credentialing Committee information such as who chairs the committee.

C. Enrollee Services

CCME's review of Enrollee Services included relevant policies and procedures, member rights information, member educational materials, the enrollee handbooks, the provider manuals, Call Center training materials, and the Prepaid Inpatient Health Plan (PIHP) websites.

When compared to the 2018 EQR, all PIHPs scored the same or higher on their percentage of "Met" standards in the 2019 EQR of Enrollee Services. For the 2019 EQR, Cardinal, Eastpointe, Partners, Sandhills, and Trillium met 100% of the Enrollee Services standards. Alliance and Vaya met 94% of the enrollee standards in both the 2018 and 2019 EQR.

Across all PIHPs, only two PIHPs, Alliance and Vaya, had one standard each decrease in score from the 2018 EQR to the 2019 EQR. They both received specific Corrective Action along with technical assistance to address noncompliant issues. Alliance did not meet the standard for notifying enrollees annually of their right to request and obtain written materials produced for enrollee use. Vaya partially met the standard requiring PIHPs to inform enrollees of the termination of their provider within fifteen (15) calendar days after the PIHP receives notice of provider termination. Vaya did not complete the Corrective Action associated. They responded with, "Vaya Health disputes this corrective action and will be formally requesting dispute resolution from DHHS pursuant to Attachment B, Section 1.10 of Contract # DMA-MCO-2018-7."

All PIHPs met 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…". This was an improvement for five PIHPs and the other two PHIPs met this standard in 2018 as well as 2019. This standard shows the most improvement over last year.

Sandhills and Trillium both improved their score from 2018 to 2019 and met the Standard "Enrollees are informed promptly in writing of…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."

The PIHPs typically performed well in informing enrollees of their rights and resources available to them. Information available to enrollees on PIHPs' websites include provider directories, links to enrollee trainings, enrollee handbooks, etc. Five of seven PIHPs received Recommendations directed at improving upon the information available to enrollees on their website. Additionally, most PIHPs could improve upon their website's ease of accessibility, clear and concise information, and timely update of information available to enrollees.

Figure 4 and Table 7 provide an overview of the PIHPs' performance in the Enrollee Services section for the 2019 EQR.

Figure 4: Enrollee Services

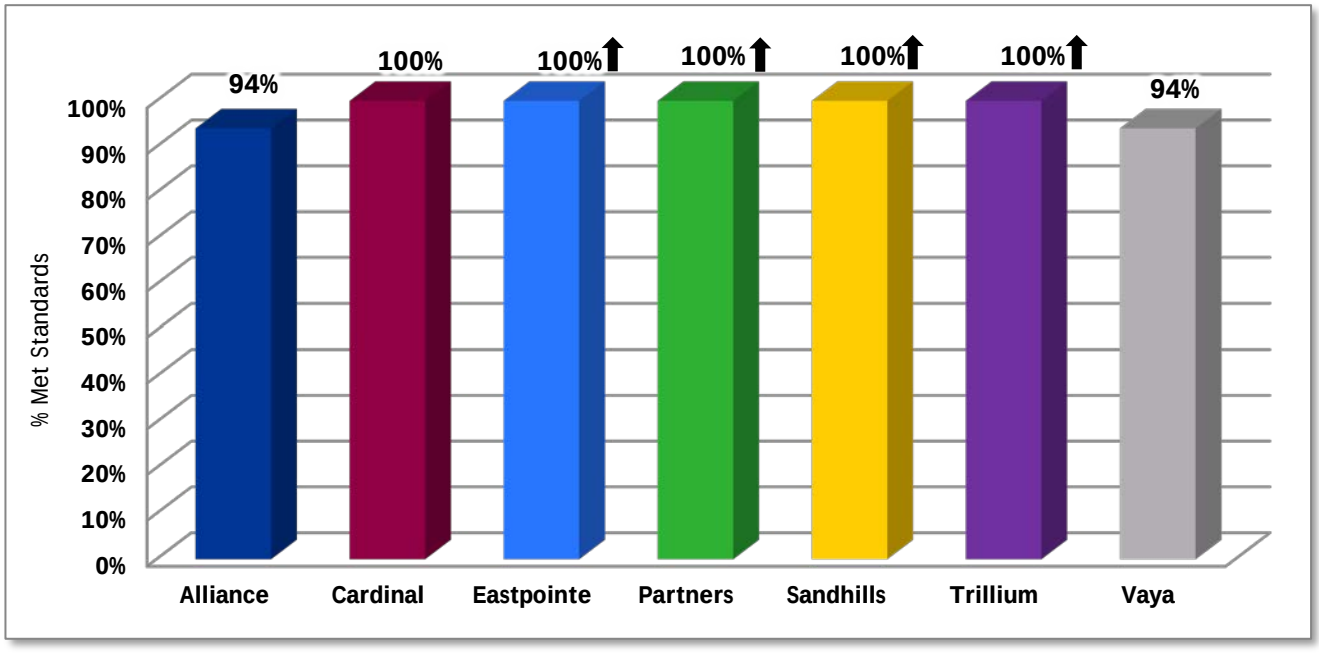


Table 7: Enrollee Services Comparative Data

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
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;							

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
2.6 To request and receive a copy of his or her medical record, except as set forth in *45 CFR. §164.524* and in *NCGS § 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 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:	Met ↑	Met	Met ↑	Met ↑	Met	Met ↑	Met ↑

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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 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, as set forth in *42 CFR § 438.100;*							
1.5 An explanation of the Enrollee's responsibilities and rights and protection;							

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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;							
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:							

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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;							

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
1.11.5 A statement that, subject to the provisions of the NC Medicaid 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 NC Medicaid 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;							

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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, rules, and policies regarding the treatment of minors;							
1.18 The enrollee's right to recommend changes in the PIHP's policies and procedures;							
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);*							

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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;							
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 *42 CFR § 438.10 (g)*.							
2. Enrollees are notified annually of their right to request and obtain written materials produced for Enrollee use.	Not Met ↓	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
3. Enrollees are informed promptly in writing of (1) any "significant change" in the information specified in *42 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 NC Medicaid 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	Met ↑	Met ↑	Partially Met ↓
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	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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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
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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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
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

- The PIHP enrollee handbooks and websites are generally thorough and provide helpful information and resources to members and family members.
- In this year's EQR, all PIHPs scored the same or higher on their total percentage of "Met" standards when compared to the 2018 EQR.
- Across all PIHPs, there were seven standards where scoring improved.

Weaknesses

- There is still room for improvement on the information available to enrollees on the PIHP websites.

Recommendations

- PIHPs should continue to improve the information available to enrollees on their websites. Improvements could include ease of accessibility, clear and concise information, and timely update of information available could be improved upon by all PIHPs.

D. Quality Improvement

CCME assessed each PIHP's Quality Improvement Program (QIP) Description, policies and procedures, committees that act on Quality Improvement (QI) activities, provider QI participation, annual program evaluation, Performance Measures (PMs), and Performance Improvement Projects (PIPs). The 2019 EQR showed each PIHP has a QI program that monitors and improves the behavioral health outcomes and services their enrollees receive.

Each PIHP has a formal and detailed description of their Quality Management (QM) Program, a quality work plan, a formal committee overseeing the quality program, a written annual QI program evaluation, and varying degrees of provider participation in QI initiatives and projects.

There have been many improvements to each PIHP's annual QI evaluation documentation. The one standard, in general, that gained the most improvement in the Quality section of the 2019 EQRs is the standard addressing the PIHPs' annual written summary and assessment of the effectiveness of the QI program. Eastpointe and Cardinal met this standard that was not met or partially met in the 2018 EQR. Sandhills and Trillium both had specific Recommendations for this standard in 2018 that were implemented in 2019.

There are three areas, overall, that need the most improvement. First, the standard focusing on the QI program, including monitoring of provider compliance with PIHP practice guidelines, was not met in the 2019 EQR for two PIHPs, Partners and Vaya. This is a standard that neither Vaya nor Partners had met in previous EQRs.

Secondly, the PIHPs fall short with implementing significant measures to address quality problems identified through the *Experience of Care and Health Outcomes (ECHO™) Survey* (enrollee satisfaction survey). More information about this survey is detailed in the Optional Activities section of this report. In general, there is a lack of documentation and tracking from year to year on lower scoring survey items, what interventions were implemented, and the impact of those interventions in subsequent year's survey results. Alliance, Cardinal, and Trillium scored a "Partially Met", and Partners and Vaya scored a "Not Met" on this standard. Vaya disputed this score is formally requesting a resolution. To date, this dispute has not been resolved. Eastpointe and Sandhills are the two PIHPs who met this standard by following Corrective Actions and Recommendations from the 2018 EQR.

Lastly, Eastpointe, Sandhills, and Vaya scored "Partially Met" and received Corrective Actions or Recommendations for issues identified through the Performance Improvement Project (PIP) validation process. For these PIHPs, the validation process showed less than "High Confidence" in the reported results of specific PIPs. These findings are detailed in Table 12, where PIPs are noted to have "Confidence" in the reported results.

Figure 5 and Table 8 provide an overview of the PIHPs' performance in the Quality Improvement section in the 2019 EQR.

Figure 5: Quality Improvement

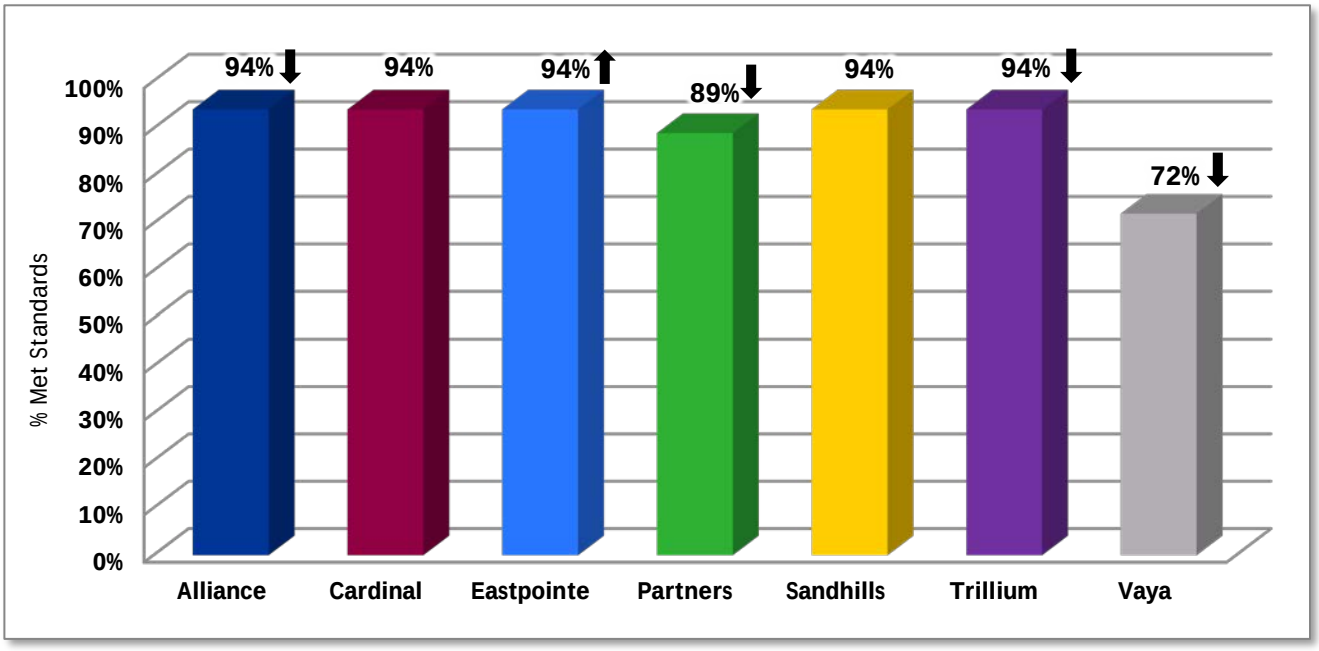


Table 8: Quality Improvement Comparative Data

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	Not Met ↓

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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	Met ↑	Met	Met	Met	Met
4. The PIHP implements significant measures to address quality problems identified through the enrollee satisfaction survey.	Partially Met ↓	Partially Met ↓	Met	Not Met ↓	Met	Partially Met ↓	Not Met ↓
5. The PIHP reports the results of the enrollee satisfaction survey to providers.	Met	Met	Met	Met	Met	Met	Met
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	Not 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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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	Met ↑	Met	Met
3. The QI Committee meets at regular intervals.	Met	Met	Met ↑	Met	Met	Met	Met
4. Minutes are maintained that document proceedings of the QI Committee.	Met	Met	Met	Met	Met	Met	Met
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	Partially Met ↓	Met	Partially Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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	Partially 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	Met ↑	Met ↑	Met	Met	Met	Met
2. The annual report of the QI program is submitted to the QI Committee and to the PIHP Board of Directors.	Met	Met	Met	Met	Met	Met	Met

Performance Measure Validation Summary

CCME conducted an independent validation of (b) and (c) Waiver Performance Measures selected by NC Medicaid. The validations were done in compliance with the CMS-developed *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 ten (b) Waiver Performance Measures 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

Table 10 gives an overview of the 2019 (b) Waiver 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: 2019 (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 reported percentages for each PIHP's measures are within the table, and the validation percentages for each PIHP's (c) Waiver measures is at the bottom of each column:

Table 11: 2019 (c) Waiver PM Validation Results Summary

Measure	Percentages Reported						
	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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 and safety risk factors.	97.05%	100%	100%	100%	100%	100%	100%
Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need.	100%	100%	100%	100%	100%	99.83%	100%
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.	100%	100%	99.81%	100%	100%	99.77%	100%
Proportion of beneficiaries reporting they have a choice between providers.	100%	100%	99.81%	100%	100%	99.77%	100%

Measure	Percentages Reported						
	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
Percentage of level 2 and 3 incidents reported within required timeframes.	91.5%	89.36%	100%	91.07%	80%*	91.53%	92.1%
Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.	100%	100%	100%	100%	100%	100%	100%
Percentage of medication errors resulting in medical treatment.	NA	0%	NA	NA	NA	NA	0%
Percentage of beneficiaries who received appropriate medication.	100%	91.49%	100%	100%	100%	100%	99.8%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.	100%	100%	100%	100%	100%	92%	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**

Note: Annual rates reported by the PIHP at the time of the individual 2019 EQR.

** = below benchmark*

Performance Improvement Project Validation Results

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

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

Table 12: 2019 PIP Validation Results Summary

PROJECT	VALIDATION SCORE	2020 VALIDATION DECISION
ALLIANCE		
*Care Coordination Clinical Contacts During Hospitalization	90/90 = 100%	High Confidence in Reported Results
Access to Care Routine: Routine/Urgent Callers (non Clinical)	89/90 = 99%	High Confidence in Reported Results
Call Center IDD/TAT	90/90 = 100%	High Confidence in Reported Results
Increase TCL IPS-SE Referrals	90/90 = 100%	High Confidence in Reported Results
CARDINAL INNOVATIONS		
*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 appointment that occurs within 7 and30 days of SA-related community hospital and SA-related facility-based crisis discharges	90/90 = 100%	High Confidence in Reported Results
*Diabetes screening for individuals with schizophrenia and bipolar disorder who are using anti-psychotic medications	79/79 = 100%	High Confidence in Reported Results
*Adherence to antipsychotic medications for individuals with schizophrenia	79/79 = 100%	High Confidence in Reported Results

PROJECT	VALIDATION SCORE	2020 VALIDATION DECISION
*Metabolic monitoring for children and adolescents on antipsychotics	90/90 = 100%	High Confidence in Reported Results
*Metabolic monitoring for adults on antipsychotics	90/90 = 100%	High Confidence in Reported Results
Treatment authorization requests	90/90 = 100%	High Confidence in Reported Results
Improving timely access to care	84/85 = 99%	High Confidence in Reported Results
EASTPOINTE		
*Increase number of individuals in the priority population served by a fidelity provider to 50% monthly	95/95 = 100%	High Confidence in Reported Results
*Increase percentage of members who received a face to face service within 48 hours to 70%	83/85 = 98%	High Confidence in Reported Results
*Decrease state psychiatric hospital 30-day readmissions for high risk members	84/85 = 99%	High Confidence in Reported Results
*Increase the percentage of individuals who receive a 2nd service within or less than 14 days	85/90 = 94%	High Confidence in Reported Results
*Decrease Emergency Department admissions for active members to 20%	90/91 = 99%	High Confidence in Reported Results
*Decrease percentage of members who separate from Transition to Community Living Initiative (TCLI) housing to 20% or less annually	42/47 = 89%	Confidence in Reported Results
Increase approval rate of Medicaid Encounter Claims to 95%	95/95 = 100%	High Confidence in Reported Results
PARTNERS BEHAVIORAL HEALTH		
*Promoting follow up within 7 days for mental health treatment	84/85 = 99%	High Confidence in Reported Results
*Promoting follow up within 7 days for SUD treatment	84/85 = 99%	High Confidence in Reported Results

PROJECT	VALIDATION SCORE	2020 VALIDATION DECISION
PCP referrals to Behavioral Health	84/85 = 99%	High Confidence in Reported Results
*ED Utilization	84/85 = 99%	High Confidence in Reported Results
SANDHILLS		
*Maximizing the Benefit of Child Mental Health Level III	90/90 = 100%	High Confidence in Reported Results
Shaping the Network	80/90 = 89%	Confidence in Reported Results
Access to Routine BH Assessments	105/111 = 95%	High Confidence in Reported Results
TCLI Transition Days	79/85 = 93%	High Confidence in Reported Results
TRILLIUM HEALTH RESOURCES		
*Supermeasures – Substance Use (SU)	85/85 = 100%	High Confidence in Reported Results
*Supermeasures-Mental Health (MH)	84/85 = 99%	High Confidence in Reported Results
Increasing Provider Satisfaction Related to the Appeals Process for Denial, Reduction, or Suspension of Service(s)	90/90 = 100%	High Confidence in Reported Results
Monitoring of In-Reach Contacts for TCLI	80/85 = 94%	High Confidence in Reported Results
VAYA HEALTH		
*Increase rate of routine access to care calls receiving service within 14 days	74/85 = 87%	Confidence in Reported Results
*Community crisis management	57/67 = 85%	Confidence in Reported Results
*ADATC VIP	90/90 = 100%	High Confidence in Reported Results
TCLI- Increasing Housing	95/95 = 100%	High Confidence in Reported Results

**Indicates clinical focused PIP*

Strengths

- Many of the PIHPs have specific quality initiatives that are unique to their catchment areas and their members.
- All PIHPs had a written summary and assessment of the effectiveness of the QI program for this EQR period. This standard, in general, is the standard that gained the most improvement in the Quality section from the 2018 EQR to the 2019 EQR.
- A total of 35 PIPs were validated. Thirty-one validation decisions scored "High Confidence" and four validation decisions scored "Confidence".
- Validation results for all (b) Waiver and (c) Waiver measures for all PIHPs were 100%.
- Sandhills and Eastpointe have a specific process for documenting, tracking, and improving lower scoring enrollee survey results. All lower scoring enrollee satisfaction survey items are documented, including measures implemented to address each item.

Weaknesses

- Two of the PIHPs continue to fall short on monitoring of provider compliance with PIHP practice guidelines. Partners and Vaya have not had a solid process for monitoring provider compliance with practice guidelines throughout the past three years. Other PIHPs have improved in this area over the past 3 years.
- Five of the seven PIHPs need to develop a solid process for implementing significant measures to address quality problems identified through the enrollee satisfaction survey. This area has consistently needed improvements over the past three years.
- Three of the PIHPs scored "Partially Met" on validation of Performance Improvement Projects. Those PIHPs scored less than "High Confidence" in the reported results of specific PIPs.

Recommendations

- Continue to hone the process for monitoring provider's adherence to Clinical Practice Guidelines.
- Continually and promptly document and track lower scoring enrollee satisfaction survey items, implement interventions, measure the impact of interventions in each year's survey results, and analyze survey trends from year to year.
- Verify that PIP reports have benchmark rates for all indicators, the project aim and research question(s) clearly documented, and specific action plans documented for indicators in which rates have not improved.

E. Utilization Management

CCME's External Quality Review (EQR) of Utilization Management (UM) functions included review of the UM, Care Coordination (CC), and the Transition to Community Living Initiative (TCLI) programs. CCME reviewed relevant UM, CC, and TCLI policies and procedures, Program Descriptions and Plans, enrollee notifications, provider manuals, enrollee handbooks, and job descriptions. A sample of files from the UM, CC, and TCLI programs were also reviewed.

In this year's EQR of UM, most PIHPs either improved or maintained a high percentage of "Met" UM EQR standards. Individually, the percentage of standards that were scored "Met" ranged from 89% (Partners and Alliance) to 98% (Cardinal and Trillium).

Regarding service authorization/UM functions, the 2019 EQR showed three PIHPs (Cardinal, Eastpointe, and Sandhills) met 100% of the service authorization/UM standards. This was primarily based on these PIHPs implementing Recommendations and Corrective Actions from the previous year's EQR.

All PIHPs had comprehensive UM Plans/Program Descriptions, policies and procedures that outline the process for processing service authorization requests. Corrective Actions were issued to Alliance, Trillium, and Vaya to enhance procedural language. Alliance needed to bolster details within their procedures that explains the expectations on staff to obtain additional information when processing a service authorization request. Expectations regarding how that coordination is documented was also needed. Trillium had no documentation explaining the requirement of their providers to use a specific clinical assessment tool for children ages three to six years old. Vaya has a policy that identified a cost limit for enrollees accessing services through Innovations and EPSDT. Per the *NC Medicaid Contract*, *Medicaid Clinical Coverage Policy 8P*, and feedback from State staff during the Onsite, no cost limits are allowed in this circumstance. Vaya's Corrective Action was aimed at aligning the procedural language with the requirements in the *NC Medicaid Contract* and *Clinical Coverage 8P*; however, Vaya submitted a response to this Corrective Action which stated, "Vaya Health disputes this corrective action and will be formally requesting dispute resolution from DHHS pursuant to Attachment B, Section 1.10 of Contract # DMA-MCO-2018-7." To date, this dispute has not been resolved.

The EQR of each PIHP's UM service authorization decisions included review of 25 service authorization approval files and 25 service authorization denial files. Within these files was a distribution of mental health/substance use and intellectual and developmental disabilities service authorization decisions. Overall, PIHPs rendered decisions on service authorization requests within the required timeframes and by appropriately credentialed peer reviewers. A Corrective Action was issued to Partners to develop a monitoring process that ensures the complete signature and credentials of the peer reviewer is documented and meets the requirements outlined in *NC Medicaid Contract 8.2.2.1.f*. Recommendations were made to

Cardinal and Trillium to ensure service authorization files consistently capture the full name and credentials of UM reviewers.

The EQR of Care Coordination includes review of Mental Health and Substance Use (MH/SU) Care Coordination, Intellectual and Developmental Disabilities (I/DD) Care Coordination, and TCLI programs. All PIHPs had comprehensive policies and procedures in place to guide the delivery of Care Coordination to the enrollees. However, the MH/SU, I/DD, and TCLI file review revealed an overall lack of compliance with the PIHPs' procedural requirements. Five PIHPs (Alliance, Cardinal, Eastpointe, Partners, and Sandhills) received Corrective Actions aimed at improving compliance within the MH/SU and I/DD files, and five PIHPs (Alliance, Eastpointe, Partners, Sandhills and Vaya) received similar Corrective Actions for TCLI file documentation. Examples of issues noted within the files reviewed were patterns of late progress note entries, incomplete progress notes, untimely Home and Community Based Services (HCBS) monitoring, untimely Quality of Life surveys, and inconsistent engagement, follow up and discharge practices by Care Coordinators. All PIHPs report Care Coordination documentation is monitored for accuracy and completeness, but most report a sample of documentation is reviewed in individual supervision. This method does not generate any qualitative data by which PIHPs can determine the degree of procedural compliance across care coordinators, departments, time, etc. Corrective Actions issued to PIHPs centered on the need for the development of comprehensive and data driven monitoring plans that target and measure compliance of Care Coordination documentation to PIHPs policies and procedures.

In the past two years, several PIHPs have implemented new care management platforms which offer PIHPs increased capabilities such as care coordination caseload data, dashboards measuring compliance with required care coordination activities, and data analysis related to population health. However, transitioning platforms and changing data entry processes have created some challenges for PIHPs. As an example, neither Alliance nor Vaya was able to produce complete enrollee records for this year's EQR, and Alliance had this same issue the previous year. In this year's EQR, both Alliance and Vaya were issued Corrective Actions to ensure complete enrollee care coordination records could be produced for the purpose of internal monitoring, court cases, audits, and EQRs.

Figure 6 and Table 13 provide an overview of the PIHPs' performance in the Utilization Management section of the 2019 EQR.

Figure 6: Utilization Management

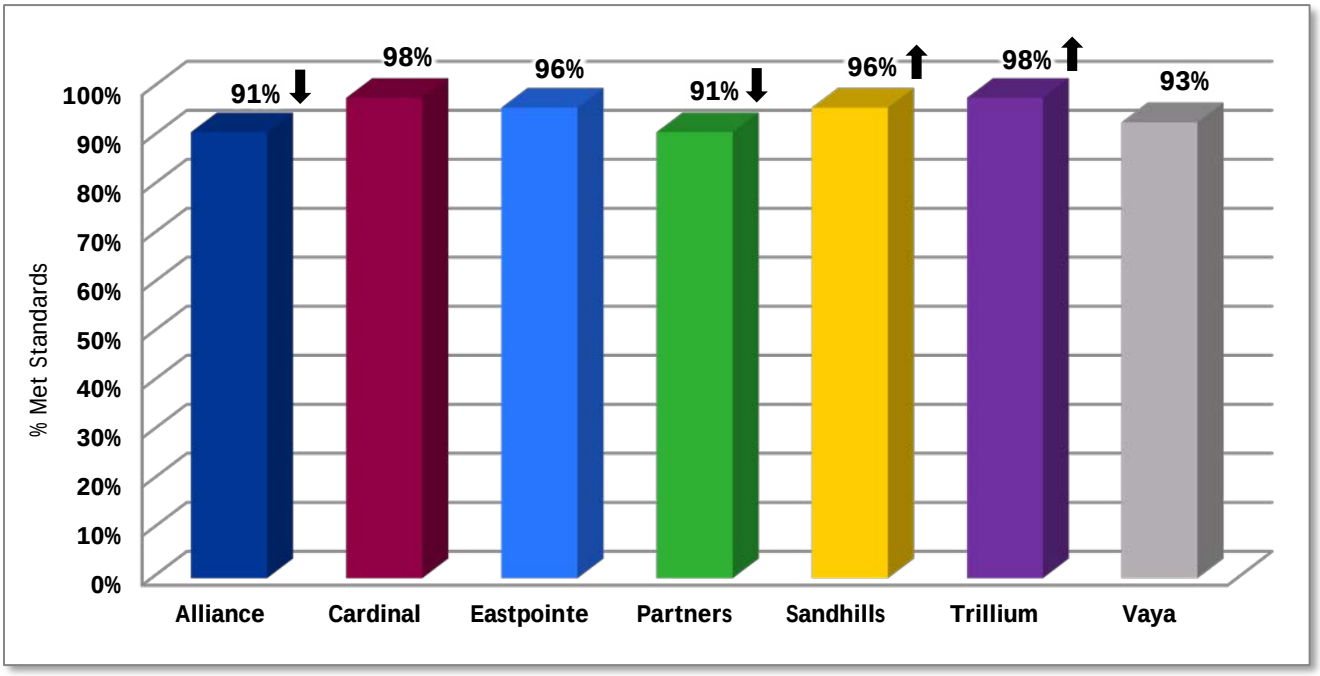


Table 13: Utilization Management Comparative Data

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
V.A. 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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
1.3 guidelines/standards to be used in making utilization management decisions;	Met	Met	Met	Met	Met	Met	Partially Met ↓
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	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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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	Met ↑	Partially Met ↓	Met
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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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	Met ↑	Met	Met	Met	Met	Met
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.	Partially 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	Partially 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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
V.C. CARE COORDINATION							
1. The PIHP utilizes care coordination techniques to ensure 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
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;	Partially Met↓	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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	Partially Met↓	Met	Met	Met
2.10 Ensure privacy for each Enrollee is protected.	Met	Met	Met	Met	Met	Met	Met
2.11 NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	Met	Met	Met	Met	Met	Met	Met
3. The PIHP applies the Care Coordination policies and procedures as formulated.	Partially Met↓	Partially Met↓	Partially Met	Partially 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	Met ↑	Met
2. The PIHP has policies and procedures that address the Transition to Community Living activities and 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	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, Supported Employment, Psychosocial Rehabilitation, and other services as set forth in the DOJ Settlement 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	Met ↑	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
2.5 QOL Surveys are administered timely.	Met	Met	Met	Met	Met	Met	Met
3. Transition, diversion and discharge processes are in place for TCLI enrollees as outlined in the DOJ Settlement and DHHS Contract.	Met	Met	Met	Met	Met	Met	Met
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to *NC Medicaid* within the timeframes determined by *NC Medicaid*.	Met	Met	Met	Met	Met	Met	Met
5. The PIHP will develop a TCLI communication plan for external and internal stakeholders providing information on the TCLI 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.	Met	Met	Met	Met	Met ↑	Met ↑	Met
6. A review of files demonstrates the PIHP is following appropriate TCLI policies, procedures, and processes, as required by *NC Medicaid*, and developed by the PIHP.	Partially Met ↓	Met	Partially Met ↓	Partially Met ↓	Partially Met	Met	Partially Met

Strengths

- Most PIHPs either improved or maintained a high percentage of "Met" UM EQR standards.
- Several PIHPs have implemented new care management platforms which offer PIHPs increased capabilities, such as care coordination caseload data, dashboards measuring compliance with required care coordination activities, and data analysis related to population health.

Weaknesses

- PIHP policies and procedures did not consistently capture *NC Medicaid Contract*, Clinical Coverage policies, and federal regulation requirements. PIHPs also struggled to ensure policies and procedures capture the routine, internal steps staff take when processing service authorization requests and how those steps should be documented.
- Review of the MH/SU, I/DD and TCLI file documentation showed all PIHPs, to varying degrees, had patterns of noncompliance with their own policies and procedures. For example, late progress note entries, incomplete progress notes, untimely Home and Community Based Services (HCBS) monitoring, untimely Quality of Life surveys, and inconsistent engagement, follow up, and discharge practices by Care Coordinators.
- Alliance and Vaya were unable to produce complete enrollee records for the EQR of Care Coordination.

Recommendations

- PIHP policies and procedures need to consistently capture *NC Medicaid Contract*, Clinical Coverage policies, and federal regulation requirements. PIHPs also should ensure policies and procedures capture the internal steps staff take when processing service authorization requests.
- PIHPS need to enhance monitoring plans that routinely review Care Coordination documentation for timeliness of activities (e.g., documentation of completed activities, follow up activities, HCBS monitoring, Quality of Life surveys, etc.), as well as the quality and completeness of Care Coordinator documentation, including cases targeted for discharge. Monitoring should be data driven to measure the degree to which Care Coordination documentation is compliant with the PIHP's policies and procedures.
- As PIHPs move towards more sophisticated Care Management platforms, PIHPs need to ensure they are able to produce complete enrollee records in chronological order.

F. Grievances and Appeals

The Grievances and Appeals EQR included a Desk Review of policies and procedures, a minimum of 20 grievance files, a minimum of 25 appeal files, the Grievances and Appeals Logs, provider and enrollee handbooks, and information about grievances and appeals available on each PIHP's website. Onsite discussions further clarified the PIHPs' processes around resolving grievances and appeals.

Grievances

The PIHPs' collective adherence to grievance standards decreased in the 2019 EQR by 33% when compared to the 2018 EQR of grievances. PIHPs typically received Recommendations and Corrective Actions to improve upon grievance procedural language. Policies and procedures were, at times, either incorrect or incomplete in detailing the PIHPs' requirements when grievances are extended, when capturing consultations with subject matter experts within the grievance file, or when specifying the State-required timeframe for PIHPs to maintain grievance files. Eastpointe received a Corrective Action to ensure policies and procedures reflect all of the required, internal steps PIHPs must take when processing and providing notice regarding grievances extended by the PIHP. Vaya received a Corrective Action to add to their policies and procedures that grievance files are maintained for the timeframes defined in *NC Medicaid Contract, Attachment M, Section B.2.*

While PIHPs improved their overall consistency when defining a "grievance", Eastpointe's written documentation regarding the definition of a grievance (versus a "complaint") and who can file a grievance was unclear. Eastpointe received Corrective Actions to revise their grievance policies, procedures, enrollee handbook, and provider manual to clearly define grievances and who may file them.

In the EQR of grievance files, areas of noncompliance were typically related to PIHPs not complying to their own policies and procedures. For example, in 40% of the files reviewed in this year's EQR, Alliance sent grievance acknowledgment notifications outside the timeframe required by their policies and procedures. Alliance was issued a Corrective Action to closely monitor all grievance notifications for compliance. The EQR of grievance PIHP files showed that grievances, overall, are resolved within 30 days versus the 90 day timeframe required by the *NC Medicaid Contract*.

Also noted in the EQR of grievance files was a lack of documentation when grievance staff consult with subject matter experts. Most PIHPs can describe a routine workflow for reviewing high risk or quality of care grievances with PIHP quality of care committees, medical or pharmacy staff, legal departments, etc. However, Cardinal, Eastpointe, Trillium, and Vaya did not have consistent documentation within the grievance files of this consultation. CCME recommended these PIHPs ensure all internal steps taken by staff are captured within the

grievance files, especially any consultations that occur when processing high risk or quality of care grievances. Similarly, Partners was issued a Recommendation to closely monitor "high priority" grievances, as there was an indication in the file review staff may not be documenting in the grievance record the immediate steps they take when responding to "high priority" grievances. Immediate response is required by Partners' grievance policy.

Appeals

The 2019 EQR showed the PIHPs improved their compliance with the appeals standards and *NC Medicaid Contract* requirements. In the 2018 EQR, the PIHPs met 71% of the appeal EQR standards. In 2019, the combined PIHP compliance with the appeal standards increased to 81%.

Overall, PIHPs improved the documentation within their policies, procedures, provider manuals, and enrollee handbooks accurately explaining the appeals process. Review of appeal files show PIHPs are typically compliant with resolving and providing notice of standard appeals within the required timeframes. However, PIHPs still struggle to accurately explain expedited and extended appeal requirements in their policies, procedures, provider manuals, and enrollee handbooks. As a result, staff struggle to process these types of appeals in compliance with the *NC Medicaid Contract* and federal regulations. All of the PIHPs received at least one Recommendation or Corrective Action related to expedited and/or extended appeals, and 40% of the Recommendations and Corrective Actions issued in the 2019 appeals EQR targeted issues related to expedited and extended appeals.

The most common issue noted was PIHPs' lack of correct and consistent information about the required notifications related to expedited and extended appeals. PIHPs are required to provide multiple notifications, oral and written, while processing expedited and extended appeals and there are required timeframes for those notifications to occur. As with standard appeals, PIHPs showed an overall pattern of resolving these types of appeals within the required timeframes, but were either untimely in providing notification throughout the resolution or did not capture within the appeal record that the notifications occurred.

All PIHPs report they routinely monitor a portion of processed appeals for compliance with their policies and procedures. This is generally a monitoring of appeal resolution timeframes and not a monitoring of the compliance of other required notifications and timeliness of these notifications throughout the resolution process. Alliance, Cardinal, Partners, and Vaya all received Corrective Actions aimed at improving their monitoring processes to ensure compliance with and documentation of all steps required while processing appeals, especially extended and expedited appeals. Most PIHPS were unaware of the compliance issues noted in the EQR of the PIHP appeal files, which further supports the need for all PIHPs to enhance their monitoring of the appeals process, particularly expedited, extended, invalid, and withdrawn appeals.

Another concern noted in this year's review was the inconsistent definition of who can file an appeal across PIHP policies, procedures, enrollee handbooks, and provider manuals. This resulted in the issuance of Corrective Actions to four of seven PIHPs: Alliance, Eastpointe, Partners and Sandhills. The *NC Medicaid Contract, Attachment M, Section G.1* explains "The Enrollee, legally responsible person or a provider or other designated personal representative, acting on behalf of the Enrollee and with the Enrollee's signed consent may file an internal appeal." For example, only one of Sandhills' eighteen appeals policies and procedures correctly states the requirement of signed consent by the enrollee or legal guardian when anyone other than the enrollee or legal guardian files an appeal. Similar inconsistencies were noted in Sandhills' provider manual and enrollee handbook.

Another concern noted in this year's review was the lack of procedural guidance and oversight when appeals departments release PHI to the enrollee, legal guardians, or designated representative. *The NC Medicaid Contract, Attachment M Section G.3.c* requires PIHPs to "provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records and any new or additional evidence considered, relied upon, or generated by PIHP in connection with the appeal of the adverse benefit determination." While all PIHPs have comprehensive policies and procedures regarding the release of Protected Health Information (PHI), few consider the appeals record as PHI or follow the procedural steps required in their own PHI policies and procedures. PIHP confidentiality procedures require specific steps, such as vetting the clinical information through the PIHP Medical Records Department, reviewing for the sensitivity of information being released, and complying with federal regulations before releasing substance use information. However, the EQR revealed that PIHP staff failed to document these steps in the reviewed files. This lack of documentation made it difficult for CCME to discern the degree of noncompliance. As a result, Cardinal, Eastpointe, and Trillium received either Recommendations or Corrective Actions to enhance their policies and procedures to better guide staff when releasing the appeal record.

Figure 7 provides an overview of the EQR of PIHP grievance and appeals and indicates which of the PIHPs' scores increased or decreased since the previous EQR.

Figure 7: Grievances and Appeals

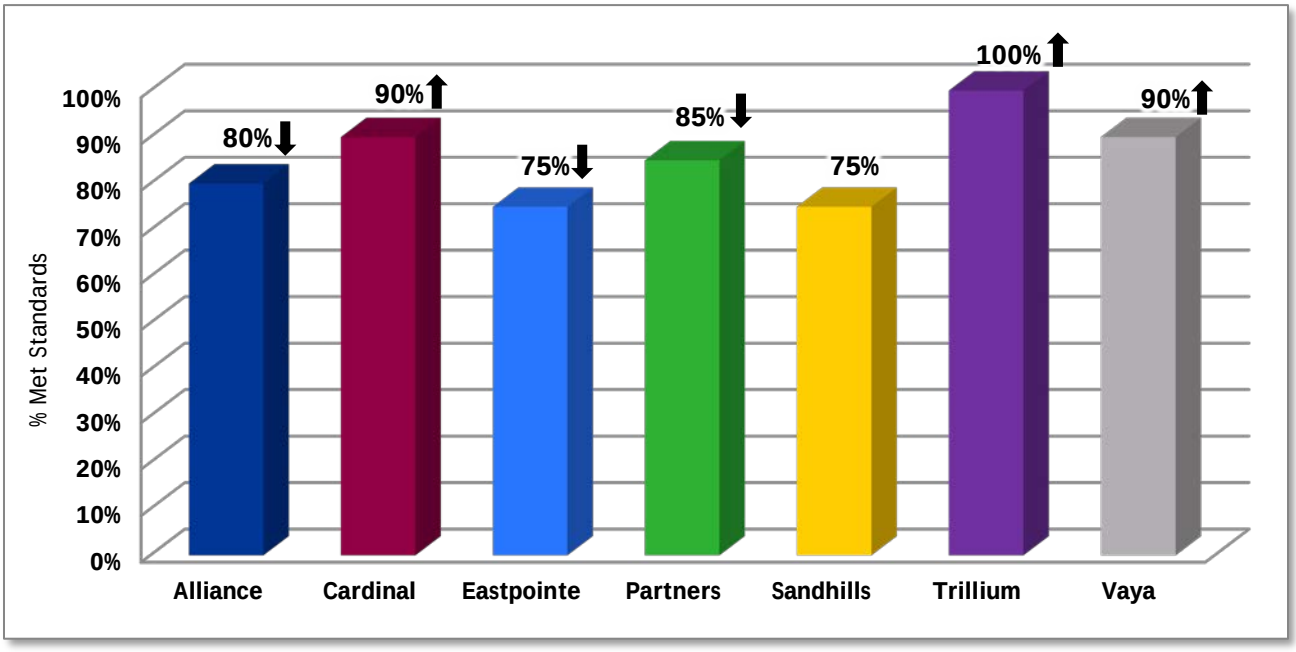


Table 14: Grievances and Appeals Comparative Data

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	Partially Met↓	Met	Met	Met	Met
1.2 The procedure for filing and handling a grievance;	Met	Met	Met	Met	Met	Met	Met
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	Met	Met	Partially Met↓	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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	Partially Met ↓
2. The PIHP applies the grievance policy and procedure as formulated.	Partially Met ↓	Met	Met	Met	Met	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
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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
1.1 The definitions of an appeal and who may file an appeal;	Partially Met↓	Met	Partially Met	Met	Partially Met	Met↑	Met↑
1.2 The procedure for filing an appeal;	Partially Met↓	Partially Met↓	Met	Partially Met	Partially Met	Met	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	Met↑	Met	Met	Partially Met	Met	Met↑
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	Met	Met↑	Partially Met↓	Met↑	Partially Met	Met↑	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	Partially Met↓	Met	Met↑	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
2. The PIHP applies the appeal policies and procedures as formulated.	Partially Met	Partially Met	Met	Partially Met↓	Met↑	Met↑	Partially Met↓
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	Met	Met	Met	Met	Partially 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

- Overall, PIHPs process grievances within the timeframes required in the *NC Medicaid Contract*.
- In the past year, PIHPs typically improved upon the documentation within their policies, procedures, provider manuals, enrollee handbooks, and websites to more accurately explain the appeals process and related requirements.
- PIHP appeals staff are well-versed in the requirements around the processing of standard appeals.

Weaknesses

- As with previous EQRs, PIHP policies and procedures still do not consistently and correctly capture all of the grievance requirements outlined in the *NC Medicaid Contract*.
- PIHPs monitor grievance resolution timeframes but do not monitor to ensure grievance files contain documentation of all the internal steps staff take when processing and resolving grievances.

- As with previous EQRs, PIHPs still struggle to accurately explain expedited and extended appeal requirements in their policies, procedures, provider manuals, and enrollee handbooks.
- Most PIHPS were unaware of the compliance issues noted in the EQR of the PIHP appeal files and don't monitor anything other than the resolution timeframes for standard and expedited appeals. PIHPs are required to provide multiple notifications, oral and written, while processing expedited and extended appeals and there are required timeframes for those notifications to occur.
- Most PIHPs struggle to consistently document the definition of who can file an appeal across their policies, procedures, enrollee handbooks and provider manuals.
- While all PIHPs have comprehensive policies and procedures regarding the release of Protected Health Information (PHI), few consider the appeals record as PHI or follow the steps required in their own PHI policies and procedures.

Recommendations

- PIHPs need to accurately detail the grievance requirements outlined in their *NC Medicaid Contract*, policies, procedures, provider manuals, and enrollee handbooks.
- PIHPs should monitor grievance files to ensure compliance with the *NC Medicaid Contract* and each PIHP's grievance policies and procedures. Monitoring should include that all internal steps taken by staff to resolve grievances are captured within the grievance record.
- PIHPs need to accurately detail expedited and extended appeal requirements in their policies, procedures, provider manuals, and enrollee handbooks.
- PIHPs should monitor more than just compliance with the appeal resolution timeframes, and focus on all the steps required when resolving appeals, especially those steps related to expedited and extended appeals.
- *NC Medicaid Contract, Attachment M, Section G.1* states, "The Enrollee, legally responsible person or a provider or other designated personal representative, acting on behalf of the Enrollee and with the Enrollee's signed consent may file and internal appeal." PIHPs need to ensure the definition of who can file an appeal is consistently reflected throughout their policies, procedures, enrollee handbooks, and provider manuals.
- PIHPs need to enhance their policies and procedures to provide guidance to staff on how to provide the enrollee's appeal file and remain compliant with PIHP policies, procedures, the *NC Medicaid Contract*, and state and federal requirements, as well as the expectation for staff to document the steps taken when releasing the appeal file.

G. Delegation

CCME's External Quality Review (EQR) of Delegation functions included a review of the submitted Delegate List, Delegation Contracts, and Delegation Monitoring materials. The *NC Medicaid Contract, Attachment B, Section 11*, *Subcontracts*, and *42 CFR § 432.230* govern delegation agreements. Additionally, each Prepaid Inpatient Health Plan (PIHP) has policies and procedures, 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. Most of the PIHPs have a Delegation Agreement for call roll-over or overflow calls or Screening-Triage-Referral services. All of the call roll-over or overflow call Delegation Agreements are with another PIHP. Until June 30, 2019, Partners and Vaya had a Delegation Agreement to cover roll-over calls for each other. As of July 1, 2019, Vaya and Alliance have a Delegation Agreement to cover roll-over calls for each other, and Partners has a Delegation Agreement with Cardinal to cover Partners' roll-over calls. Eastpointe and Sandhills each have a Delegation Agreement with Cardinal for roll-over calls. Cardinal and Trillium do not have a Delegation Agreement for coverage of 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. All Delegation Agreements include Business Associate Agreements (BAA) with those delegates that have access to Protected Health Information (PHI).

The *NC Medicaid Contract Attachment B, 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 metric reports from delegates performing call roll-over or overflow call functions, and InterRater Reliability reports from delegates performing Peer Review or Appeal Review. Several of the PIHPs meet regularly with delegates to review delegate performance.

Four PIHPs (Alliance, Cardinal, Trillium, and Vaya) scored "Met" for both standards in the Delegation review in 2019. These four PIHPs also scored "Met" for both standards in the 2018 Delegation review. Eastpointe improved its score (50%) from the 2018 Delegation review to 100% in the 2019 Delegation review. One PIHP (Sandhills) scored "Met" for one standard and "Partially Met" for the other standard, resulting in a score of 50% for their 2019 Delegation review. Sandhills also scored 50% in the 2018 Delegation review.

Figure 8 and Table 15 provide an overview of the PIHPs' performance in the Delegation section in the 2019 EQR.

Figure 8: Delegation

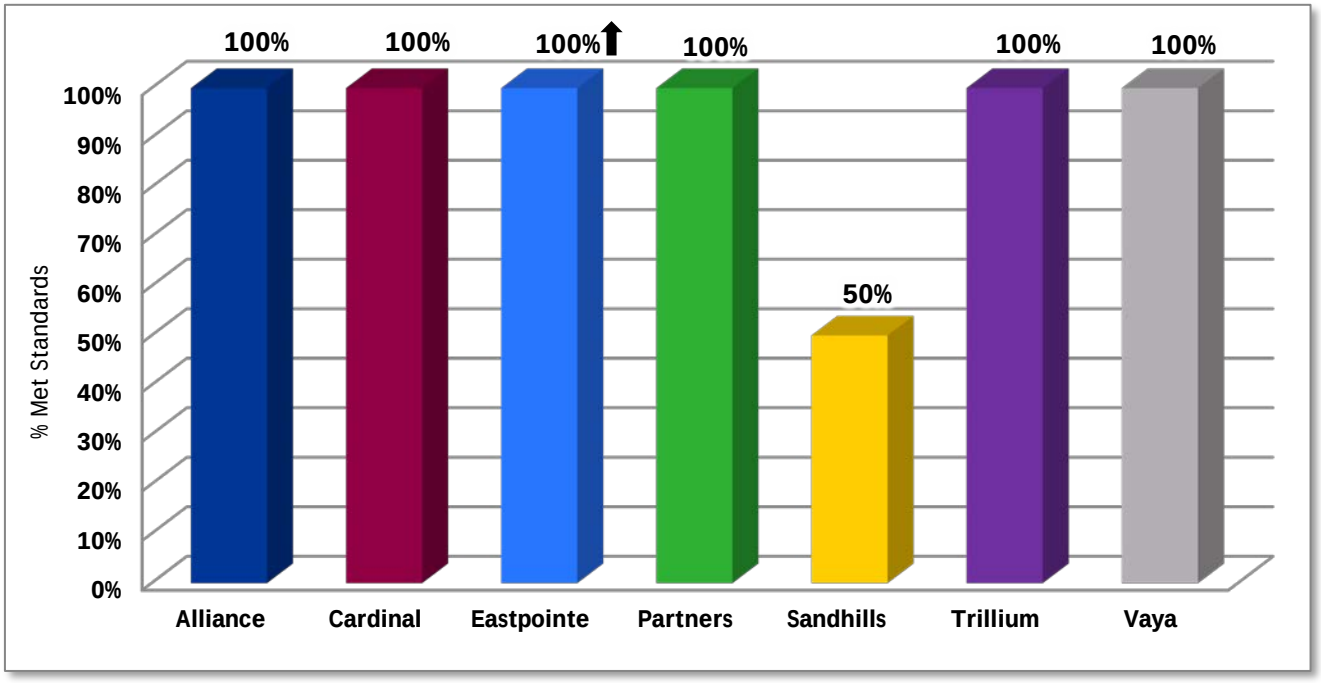


Table 15: Delegation Comparative Data

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	Met ↑	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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	Met ↑	Met	Partially Met ↓	Met	Met

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 and procedures to provide direction for delegation functions and the PIHP oversight of delegates.

Weaknesses

- Sandhills' *Annual Monitoring Review* summary for their Call Roll-Over delegate lacked detailed monitoring information, including the timeframe covered by the report. The summary was neither dated nor signed.
- Vaya's *Delegation Assessment* form completed for their Call Roll-Over delegate did not include the timeframe covered by the assessment, which was also an issue at the previous EQR.
- Vaya Policy 2303 includes, "reporting delegation oversight no less than annually to the Quality Improvement Committee (QIC)." QIC meeting minutes supplied by Vaya did not include reporting of delegation oversight of their Peer Review/Utilization Management delegate during the review period for the current EQR. This was also an issue at the previous EQR.

Recommendations

- Sandhills: Ensure the *Annual Monitoring Summary* reports include the timeframe covered by the report, comply with procedure CORE 9a, Delegation Oversight and Delegation Contracts, including information about any Corrective Actions, and are signed and dated.
- Vaya:
  - Report delegation oversight in a QIC meeting annually, as referenced in Vaya Policy 2303, or revise the policy to eliminate the reference to annual reporting by the QIC.
  - For Delegation Assessments, include the timeframe covered by the assessment.

H. Program Integrity

The EQR of each PIHP's Program Integrity (PI) functions included a Desk Review of the PIHP's documentation to assess their compliance with federal and state regulations and the *NC Medicaid Contract*. The Desk Review documentation included PI case files, policies, procedures, and the PIHP's Compliance Plan. An Onsite interview with key compliance, legal, and investigations staff occurred to discuss 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. The interview also covered any substantive changes in staff, policies, volume of investigations, as well as follow up on any Recommendations or Corrective Actions that may have been in place since the last EQR.

Three of the seven PIHPs, Eastpointe, Partners and Trillium, met 100% of the PI standards. This is a decrease from the prior year's EQR ,when five out of seven PIHPs had a fully-compliant review. Three PIHPs (Cardinal, Eastpointe, and Sandhills) scored lower than the prior year, and Alliance scored better, in this year's PI EQR, increasing their overall score from 96% to 98%.

One area of improvement across all of the PIHPs was their alignment of policies, procedures, and PI related documentation to the *NC Medicaid Contract*. This was primarily a result from the PIHPs addressing CCME Recommendations and Corrective Actions from the 2018 EQRs. However, two (Cardinal and Vaya) of the seven PIHPs were found to have deficiencies in documentation available to staff, as compared to the required language in their contract with NC Medicaid. Cardinal needed to provide additional detail to their PI policies and procedures to differentiate the internal processes for investigating fraud versus investigating waste and abuse. Similarly, there was no language in any Vaya policy that documented Vaya's requirement, per *NC Medicaid Contract, 14.3.4*, to ensure there is no interference with Enrollee's access to care during any investigation. Vaya stated in their Corrective Action Plan report, "Vaya Health disputes this corrective action and will be formally requesting dispute resolution from DHHS pursuant to

Attachment B, Section 1.10 of Contract # DMA-MCO-2018-7." To date, this Corrective Action has not been resolved.

In this year's review of the PI files, the average score of the six PIHPs was 94.7% with the PI file standards. Three of the of the seven PIHPs, Cardinal, Partners, and Trillium, scored 100% on the PI file standards, as compared to six of seven PIHPs last year. This is a decrease from the prior year, when all seven PIHPs scored 100%. PIHP scores were primarily impacted by missing required documentation within the PI files such as provider National Provider Identification (NPI) numbers, documented communications between the PIHP and the providers, and name/contact information for the PI investigator. For example, *NC Medicaid Contract, Section 14.2.9* requires PIHPs to provide NC Medicaid Program Integrity with "Contact information for PIHP staff persons with practical knowledge of the workings of the relevant programs." Vaya scored one "Not Met" in the file review standards as fourteen (14) of fifteen (15) files submitted for Vaya's EQR lacked this required information.

PI file documentation varied across PIHPs in level of organization. Common items such as a referral forms, case log wording, completeness of executive summaries, and file naming conventions were inconsistent across PIHP case files. Based on this variation, CCME provided technical support and Recommendations to help standardize and improve the overall organization of the PIHPs' PI files.

Across the last two EQRs, there has been a gradual increase in data mining activities by most PIHPS, as there was evidence within the PI files reviewed of provider investigations stemming from these activities. For example, there was evidence of PIHPs comparing dates of inpatient and outpatient services for the same members, code comparisons to identify upbilling, and identification of billing for deceased members. All of the PIHPs are now enrolled in Fraud Abuse Management System (FAMS) and several of the PIHPs indicate they intend to use investigation packages to identify potential enrollee fraud in the coming year. NC Medicaid reported a noted improvement in the PIHP's reporting of suspected cases of Fraud, Waste and Abuse to the State, both in terms of timeliness and volume.

Figure 9: Program Integrity

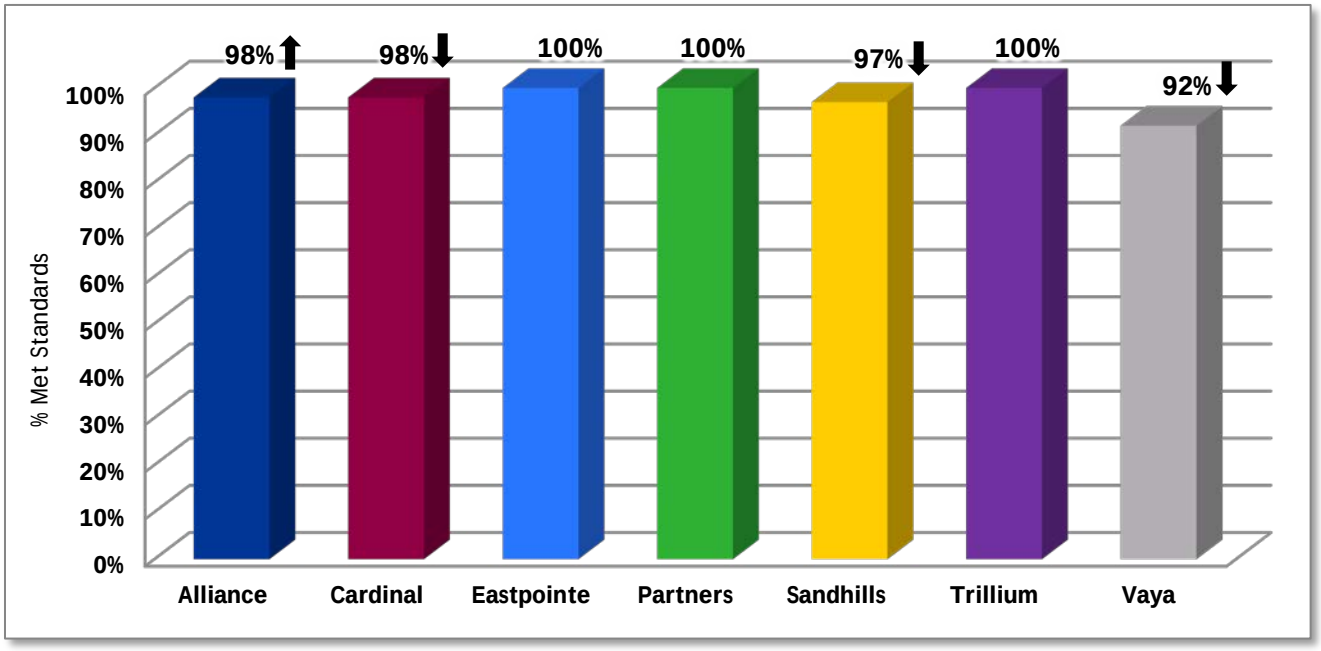


Table 16: Program Integrity Comparative Data

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 CFR § 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
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 of the NC Medicaid contract.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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 CFR 438.608* that is designed to guard against fraud and abuse. The Compliance Plan shall be submitted to the NC Medicaid 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 NC Medicaid 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 NC Medicaid. This person may or may not be the PIHP Compliance Officer or the PIHP Contract Administrator. In addition, PIHP shall identify a primary point of contact within the Special Investigations Unit to receive and respond to data requests from MFCU/MID. The MFCU/ MID will copy the PIHP Contract Administrator on all such requests.	Met	Met	Met	Met	Met	Met	Met
4. PIHP shall participate in quarterly Program Integrity meetings with NC Medicaid 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 send staff to participate in monthly meetings with Division Program Integrity staff, 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	Met	Met	Met	Met	Met	Met	Met
7. The Division recognizes that the scope of the PIHP's Regulatory Compliance Committee includes issues beyond those related to Program Integrity. Within seven (7) business days of a request by the Division, PIHP shall also make portions of the PIHP's Regulatory Compliance and Program Integrity minutes relating to Program Integrity issues available for review, but the PIHP may, redact other portions of the minutes not relating to Regulatory Compliance or Program Integrity issues.	Met	Met	Met	Met	Met	Met	Met
8. PIHP's written Compliance Plan shall, at a minimum include:							

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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
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 NC Medicaid or MFCU/MID, and including promptly supplying all data in a uniform format provided by NC Medicaid and information requested for their respective investigations within seven (7) business days or within an extended timeframe determined	Met	Met	Met	Met	Met	Met	Partially Met↓

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
by Division as provided in Section 13.2 – Monetary Penalties.							
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 *NC Medicaid 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 *NC Medicaid Contract*; and making documentation of investigations and compliance available as requested by the State. PIHP shall include in each monthly Attachment Y Report, all overpayments based on fraud or abuse identified by PIHP during the prior month. PIHP shall be penalized One Hundred Dollars ($100) for each overpayment that is not specified in an Attachment Y Report within the applicable month. In addition, PIHP shall	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
have and implement written policies and procedures to guard against fraud and abuse.							
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
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	Met	Partially Met↓	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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/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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
10.4 Process for tracking overpayments and collections, based on fraud or abuse, including Program Integrity and Provider Monitoring activities initiated by PIHP 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
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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
10.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains NC Medicaid -standardized elements or a NC Medicaid -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
9. 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
10. 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 NC Medicaid within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	Met	Met	Met	Met	Partially Met ↓	Met	Met
11. In each case where PIHP refers to NC Medicaid an allegation of fraud involving a Provider, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:							

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
13.1 Subject (name, Medicaid provider ID, address, provider type);	Met	Met	Met	Met	Met	Met	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
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	Not Met ↓
13.8 Total Sample Amount of Funds Investigated per Service Type.	Met	Met	Met	Met	Partially Met ↓	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
14. In each case where PIHP refers suspected Enrollee fraud to NC Medicaid, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:							
14.1 The Enrollee's name, birth date, and Medicaid number;	Met	Met	Met	Met	Met	Met	Met
14.2 The source of the allegation;	Met	Met	Met	Met	Met	Met	Met
14.3 The nature of the allegation, including the timeframe of the allegation in question;	Met	Met	Met	Met	Met	Met	Met
14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;	Met	Met	Met	Met	Met	Met	Met
14.5 Contact information for PIHP staff persons with practical knowledge of the allegation;	Met	Met	Met	Met	Met	Met	Met
14.6 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation; and	Met	Met	Met	Met	Met	Met	Met
14.7 The legal and administrative status of the case.	Met	Met	Met	Met	Met	Met	Met
14.8 Any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers;	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
14.9 Details that relate to the original allegation that PIHP received which triggered the investigation;	Met	Met	Met	Met	Met	Met	Met
14.10 Period of Service Investigated – PIHP shall include the timeframe of the investigation and/or timeframe of the audit, as applicable.;	Met	Met	Met	Met	Met	Met	Met
14.11 Information on Biller/Owner;	Met	Met	Met	Met	Met	Met	Met
14.12 Additional Provider Locations that are related to the allegations;	Met	Met	Met	Met	Met	Met	Met
14.13 Legal and Administrative Status of Case.	Met	Met	Met	Met	Met	Met	Met
15. PIHP and NC Medicaid 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 NC Medicaid Fraud and Abuse Management System (FAMS) or a NC Medicaid 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 NC Medicaid designated Administrator to submit appropriate claims data to load into the NC Medicaid Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. If PIHP uses FAMS, PIHP shall notify the NC Medicaid designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.	Partially Met↓	Met	Met	Met	Met	Met	Met
18. PIHP shall submit to the NC Medicaid 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 or the next business day if the 10th day is a non-business day (i.e. weekend or State or PIHP holiday). Section 9.8 Fraud and Abuse Reports. In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to NC Medicaid Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not limited to	Met	Met	Met	Met	Met	Met	Partially Met↓

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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 NC Medicaid 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.							
VIII 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, NC Medicaid Program Integrity shall complete a preliminary investigation to determine whether there is sufficient evidence to warrant a full investigation. If NC Medicaid determines that a full investigation is warranted, NC Medicaid							

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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, NC Medicaid shall provide written notification to PIHP of the status of each such referral. If MFCU/ MID indicates that suspension will not impact their investigation, NC Medicaid may send a payment suspension notice to the Provider and notify PIHP. If the MFCU/ MID indicates that payment suspension will impact the investigation, NC Medicaid 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.							

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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.	Met ↑	Met	Met	Met	Met	Met	Partially Met ↑
2. Upon receipt of a payment suspension notice from NC Medicaid Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of NC Medicaid Program Integrity's suspension and lasting until PIHP is notified by NC Medicaid Program Integrity in writing that the suspension has been lifted.	Met ↑	Met	Met	Met	Met	Met	Met
3. PIHP shall provide to NC Medicaid 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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to NC Medicaid Program Integrity due to allegations of suspected fraud without prior written approval from NC Medicaid Program Integrity or the MFCU/MID. If PIHP takes administrative action, including issuing a Notice of Overpayment based on such fraud that precedes the submission date of a Division referral, the State will adjust the PIHP capitated payment in the amount of the original overpayment identified or One Thousand Dollars ($1,000) per case, whichever amount is greater.	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 NC Medicaid, 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 NC Medicaid, MFCU/MID or other oversight agency.	Met	Met	Met	Met	Met	Met	Not 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	Met ↑

Strengths

- In the past year, PIHPs have further aligned their policies, procedures, and PI related documentation to the requirements in their *NC Medicaid Contract*.
- Across the last two EQRs, there has been a gradual increase in data mining activities by most PIHPS, as there was evidence within the PI files reviewed of provider investigations stemming from these activities.

Weaknesses

- Several PIHPs had PI file documentation that was missing or incomplete. Primary areas of concern were missing National Provider Identification (NPI) numbers, documented communications between the PIHP and the providers, name/contact information for the PI investigator referral forms, incomplete case log wording and executive summaries, and inconsistent file naming conventions.
- While there was evidence in the 2019 EQR that PIHPs are improving upon their data mining efforts to identify fraud, waste, and abuse, there continues to room to increase these efforts.

Recommendations

- 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.
- PIHPs should continue to maximize FAMS and other data mining efforts to identify potential fraud, waste, and abuse.

I. Financial Services

CCME's Financial Services EQR consisted of a pre-Onsite review of Desk Materials, followed by Onsite interview of finance staff. The Desk Materials CCME reviewed included finance policies and procedures, audited financial statements, current year balance sheets and income statements, monthly Medicaid financial reports, current year budget, Medicaid Risk Reserve account bank statement, Medical Loss Ratio calculation, and finance staffing.

The Onsite visit focused on interviewing PIHP staff about compliance with the finance EQR standards, and clarifying questions about Desk Materials. A list of EQR standards questions was used, with additional questions specific to the PIHP.

The PIHPs made improvements from prior years by referencing Codes of Federal Regulations in policies and procedures. Most PIHPs made efforts to correct the prior year's Recommendations to policies and procedures. Several PIHPs made innovative improvements, such as going to electronic accounting records, obtaining certification for Incurred But Not Reported (IBNR) liability, and detailed monthly analysis of fund balance by funding source.

Alliance, Cardinal, Eastpointe, Partners and Sandhills met 100% of the Finance EQR standards in the 2019 EQR. Trillium scored a "Not Met" on the standard addressing the Medical Loss Ratio (MLR), as Trillium did not maintain the 85% Medical Loss Ratio percentage required by *42 CFR § 438.8* and the *NC Medicaid Contract, Section 12.3*. The 2018 EQR of Vaya's Financial Services identified one policy enhancement related to adding the five-business day requirement for Risk

Reserve payments to their Medicaid Funds Management policy. *NC Medicaid Contract, Section 1.8.1* requires PIHPs "on a monthly basis, deposit into the restricted risk reserve account a minimum amount equal to two (2%) of the capitation payments received from DMA until the amount in the risk reserve account equals fifteen percent (15%) of the total annualized cost of this Contract. Deposits shall be made within five (5) business days of receiving the monthly capitation payment." This revision was not implemented, and Vaya received a "Partially Met" in this year's EQR. In their Corrective Action response, Vaya stated, "Vaya Health disputes this corrective action and will be formally requesting dispute resolution from DHHS pursuant to Attachment B, Section 1.10 of Contract # DMA-MCO-2018-7." To date, this dispute has not been resolved.

Figure 10 displays an overview of the PIHPs' performance in the Financial Services EQR. Table 17 shows the breakdown of each standard and each PIHP's score for the EQR Finance standards.

Figure 10: Financial Services

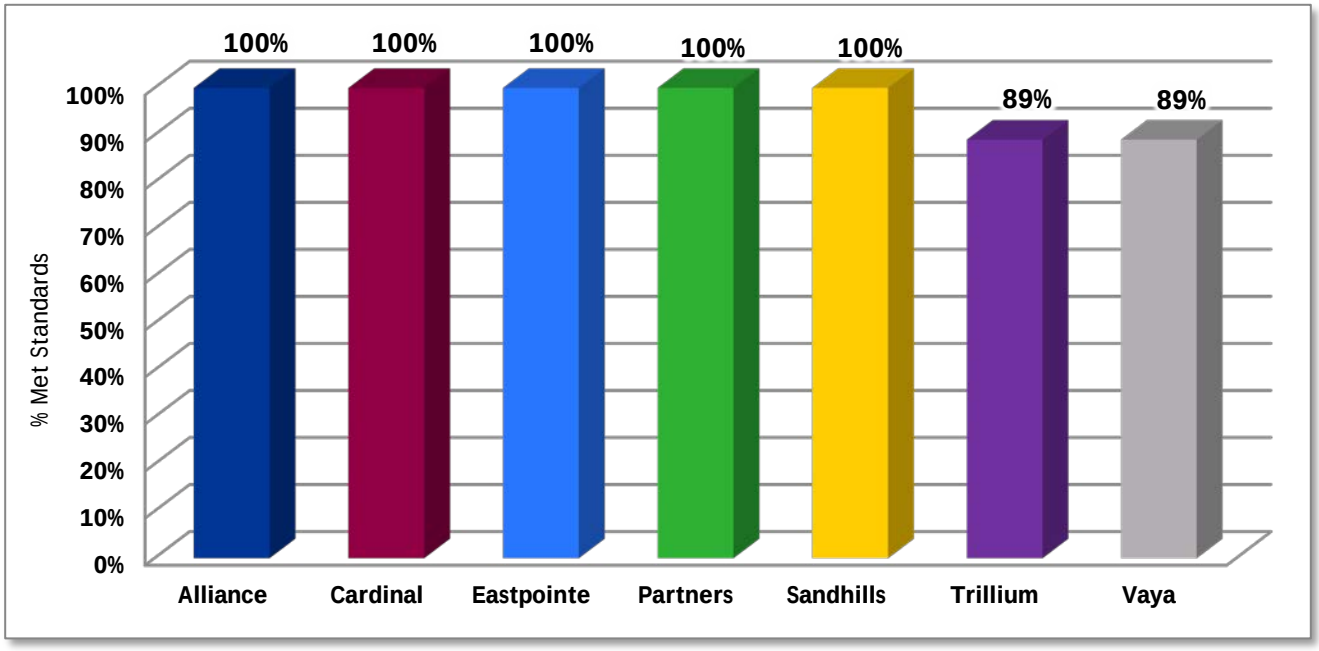


Table 17: Financial Services Comparative Data

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	Partially Met↓

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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 *NC Medicaid Contract*.	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
5. The PIHP follows a record retention policy of retaining records for ten years. (*NC Medicaid Contract, Section 8.3.2* and *Amendment 4, Section 31)*.	Met	Met	Met	Met	Met	Met ↑	Met
6. The PIHP maintains a restricted risk reserve account with a federally guaranteed financial institution in accordance with *NC Medicaid Contract*.	Met	Met	Met	Met	Met	Met	Met
7. The required minimum balance of the Risk Reserve Account meets the requirements of the *NC Medicaid Contract*.	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 *NC Medicaid Contract*.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
9. The Medical Loss Ratio (MLR) meets the requirements of *42 CFR § 438.8* and the *NC Medicaid Contract*.	Met	Met	Met	Met	Met	Not Met↓	Met

Strengths

- Most PIHPs improved their policies and procedures to include references to their contract with NC Medicaid and/or federal regulations.
- Most PIHPs made substantial efforts to correct prior Recommendations to policies and procedures.
- Several PIHPs made innovative improvements, such as going to electronic accounting records, obtaining certification for IBNR liability, and detailed monthly analysis of fund balance by funding source.

Weaknesses

- PIHPs did not always update their administrative cost allocation plan annually.
- Not all the PIHPs had details in policies specific to contract requirements. Examples include the five-day requirement after capitation payment for risk reserve payment, the 10-year record retention requirement for Medicaid records, and due dates of monthly Medicaid cost reports required by NC Medicaid.

Recommendations

- All PIHPs should update their administrative cost allocation plan annually.
- PIHPs should add detail in policies specific to contract requirements, including the five-day requirement after capitation payment for risk reserve payment deposit, the 10-year record retention requirement for Medicaid records, and monthly Medicaid cost reports due to the State by the 20th of each month.

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 2018 through December 2018. 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 NC Medicaid in the 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.

The review 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 2018 through December 2018.*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	Percent Denied
Alliance					
Institutional	83,757	80,052	2,398	1,307	1.56%
Professional	1,931,570	1,924,817	5,055	1,698	0.09%
Total	2,015,327	2,004,869	7,453	3,005	0.15%
Looking at claims with dates of service in 2018, Alliance submitted 2,015,327 unique encounters to the State. To date, less than 1% of all 2018 encounters submitted have not been corrected and accepted by NC Medicaid. Each year Alliance has made significant improvements to their encounter submission process, increasing their acceptance rate and quality of Encounter data year over year. The table below reflects the increase in acceptance rate from 93% to over 99%, well above NC Medicaid's expectations The PIHP has a detailed reconciliation and correction process in place to ensure that all denials are reviewed, corrected, and resubmitted to NC Medicaid. Alliance has a dedicated team of two claim analysts responsible for reviewing and resubmitting denied encounter claims. After a check write cycle, Alliance receives an 835 from NCTracks to review denials. The team relies on the remark codes to narrow down the true denial reasons and make corrections. Alliance works closely with the providers to communicate issues, make them aware of corrections, and even educate the provider on how to avoid future encounter denials. The majority of denials are based on provider setup. Analysts verify the provider record in NCTracks and update the AlphaMCS system or send a provider upload file to NCTracks to update the needed information and to process claims.					
Claim Type	**Submitted**	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Accepted**	**Percent Denied**
Cardinal					
Institutional	117,138	114,238	2,879	21	0.02%
Professional	2,054,629	1,999,406	51,914	3,309	0.16%
Total	2,171,767	2,113,644	54,793	3,330	0.15%
Looking at claims with dates of service in 2018, Cardinal submitted 2,171,767 unique encounters to the State. To date, less than 1% of all 2018 encounters submitted have not been corrected and accepted by NC Medicaid. Each year Cardinal has made significant improvements to their encounter submission process, increasing their acceptance rate and quality of Encounter data year over year. The table below reflects the increase in acceptance rate from 65% to 99%, well above NC Medicaid's expectations. The					

PIHP has a detailed reconciliation and correction process in place to ensure that all denials are reviewed, corrected, and resubmitted to NC Medicaid. Cardinal has a dedicated Encounter Data Reconciliation Team. This team consists of a Manager, Supervisor, and five Encounter Reconciliation Analyst responsible for investigating all denied encounters. Cardinal is determining the denial reason by using the EOB code and description found on the 835 file. If the provider data is missing in NCTracks, they request the provider to submit a Manage Change Request to add that data prior to resubmission of denied Encounter claim. If the denied Encounter claim was caused by provider billing error, the team works with the front line claims team to educate the provider on how to bill a correct claim. In addition to the dedicated encounter staff, Cardinal has implemented various system enhancements including rewriting the 837 to update formatting issues and adding additional edits to ensure appropriate claim values are being submitted by providers.

Claim Type	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Accepted	Percent Denied
Eastpointe					
Institutional	190,071	146,460	25,459	18,152	10%
Professional	2,048,364	1,573,805	166,435	308,124	15%
Total	2,238,435	1,720,265	191,894	326,276	15%

Looking at claims with dates of service in 2018, Eastpointe submitted 2,238,435 unique encounters to the State. To date, 15% of all 2018 encounters submitted have not been corrected and accepted by NC Medicaid which is almost double the denial rate from 2017. Eastpointe should be making improvements to their encounter submission process, increasing their acceptance rate and quality of Encounter data year over year. Eastpointe experienced a sizeable increase in encounter denials in 2018 compared to 2017. Upon a close examination of the denials during the Onsite audit, it was discovered that the increase in denials was due to errors in file submissions. More specifically, there were two types of submission errors. First, a large number of duplicate records were submitted in February, March, and July of 2018. As Encounter data had already been submitted, these duplicate submissions resulted in a significant number of denials. In total, 211,388 denials resulted from multiple transmissions of the same encounter record. The second type of submission error occurred in August 2018. A total of 49,224 records intended to void and adjust previous encounter submissions were denied due to lack of history records. This submission appears to have been caused by a timing issue where the voids and adjustments were created before all the 835 return files from NCTracks for previous encounter submissions had been posted in Eastpointe's system.

Claim Type	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Accepted	Percent Denied
Partners					
Institutional	75,313	74,414	88	811	1%
Professional	1,288,153	1,276,806	9,646	1,701	0%
Total	1,363,466	1,351,220	9,734	2,512	0%

Looking at claims with dates of service in 2018, Partners submitted 1,363,466 unique encounters to the State. To date, less than 1% of all encounters submitted have not been corrected and accepted by NC Medicaid. Compared to claims submitted in 2017, Partners has decreased the number of initial denials and total number of outstanding denials for claims submitted in 2018. According to Partners' response and review of NC Medicaid 's acceptance report, 31% of all outstanding and ongoing denials are still related to invalid Taxonomy codes for the billing and rendering Provider. Partners' strategy to continue to reduce, correct and resubmit encounter denials resulted in a decrease in denied claims from 4% to less than 1%.

Claim Type	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Accepted	Percent Denied
Sandhills					
Institutional	30,734	29,855	743	136	0.4%
Professional	1,168,590	1,140,606	22,648	5,336	0.5%
Total	1,199,324	1,170,461	23,391	5,472	0.5%

Looking at claims with dates of service in 2017, Sandhills submitted 1,199,324 unique encounters to the State. To date, less than 1% of all 2018 encounters submitted have not been corrected and accepted by NC Medicaid. Each year Sandhills has made significant improvements to their encounter submission process, increasing their acceptance rate and quality of Encounter data year over year, well above NC Medicaid's expectations. According to Sandhills' response and review of NC Medicaid's acceptance report, 35% of all ongoing denials are related to invalid Taxonomy Codes for the Billing and Rendering Provider. The PIHP has a detailed reconciliation and correction process in place to ensure that all denials are reviewed, corrected, and resubmitted to NC Medicaid. Sandhills developed several strategies for correcting encounter denials.

Claim Type	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Accepted	Percent Denied
Trillium					
Institutional	49,564	47,787	296	1,481	3%
Professional	899,461	872,120	16,601	10,740	1%
Total	949,025	919,907	16,897	12,221	1%

Looking at claims with dates of service in 2018, Trillium submitted 949,025 unique encounters to the State. To date, 1% of all 2018 encounters submitted have not been corrected and accepted by NC Medicaid. Each year Trillium has made significant improvements to their encounter submission process, increasing their acceptance rate and quality of Encounter data year over year. According to Trillium's response and the evaluation of the submitted Encounter data, most of the outstanding and ongoing denials are related to invalid taxonomy codes for the Billing Provider ID. Going forward, Trillium continues to implement several strategies to reduce the number of denied encounters.

Claim Type	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Accepted	Percent Denied
Vaya					
Institutional	42,787	42,110	287	390	1%
Professional	1,867,695	1,831,671	22,048	13,976	1%
Total	1,910,482	1,873,781	22,335	14,366	1%

Looking at claims with dates of service in 2018, Vaya submitted 1,910,482 unique encounters to the State. To date, 1% of all 2018 encounters submitted have not been corrected and accepted by NC Medicaid. Each year Vaya has made significant improvements to their encounter submission process, increasing their acceptance rate and quality of Encounter data year over year, well above NC Medicaid's expectations. Vaya has established an encounter team responsible for investigating all denied Encounters. The encounters team coordinates denial research, and requests corrections from other departments or from the encounter billing provider, depending on the denial reason. Vaya relies on the Encounter Summary by MCO CheckWrite and an encounter denial detail report listing the header and line edits issued by the State, as well as numerous other parameters for all encounter Transaction Control Numbers (TCNs) that deny. The PIHP has a detailed reconciliation and correction process in place to ensure that all denials are reviewed, corrected, and resubmitted to NC Medicaid.

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 2018 through December 2018. Each PIHP pulled all claims adjudicated and submitted to NC Medicaid during 2019 and sent via a secured file transfer protocol (SFTP).

To evaluate the data, 837I and 837P data extracts were imported and loaded to a consolidated database. After data onboarding was completed, proprietary, internally-designed data analysis tools were used to review each data element, focusing on the required data elements. 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
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)

Data Quality Standards for Evaluation of Submitted Encounter Data Fields Adapted and Revised from CMS Encounter Validation Protocol		
Data Element	**Expectation**	**Validity Criteria**
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.
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]).

Data Quality Standards for Evaluation of Submitted Encounter Data Fields Adapted and Revised from CMS Encounter Validation Protocol		
Data Element	**Expectation**	**Validity Criteria**
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, the Encounter Acceptance Report maintained weekly by NC Medicaid was reviewed. This report reflects all Encounters submitted, accepted, and denied for each PIHP. The report is tracked by CheckWrite, 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 the data submitted to NC Medicaid by Cardinal, Eastpointe, Partners, Sandhills, Trillium, and Vaya was complete and accurate. Alliance still had minor issues with their submission of Institutional encounters that need to be addressed in order to be compliant. Other minor issues for all PIHPs were noted with both Institutional and Professional encounters related to Diagnosis codes, Procedure codes, and Recipient IDs. *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 provided.

For the next review period, it is recommended that the Encounter data from NCTracks be reviewed 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 is handling the encounter claims and could be reconciled back to reports requested from Alliance. The goal is to ensure that PIHPs are 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 be populated 99% of the time. In the Encounter data provided, it was found that the field was populated 45% of the time with valid values; in all other instances the value was null. Valid Procedure codes are needed to better understand the services provided and are usually required to adjudicate the claim appropriately. Given the types of services provided, the provider should have entered additional Procedure codes in support of the line level Revenue code supplied. For example, Revenue code 636 indicates an injectable; however, additional detail is needed to determine the type of injection/drug. There were many instances where the Revenue code was provided without the appropriate Healthcare Common Procedure Coding System (HCPCS). The same issue was noted in the review of 2017 encounters.	Alliance should ensure that the appropriate data validation checks are in place and that claims submitted through the 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. The HCPCS may not be required to adjudicate the claim but it is required to understand the level of services provided.
Diagnosis Codes	The secondary diagnosis was populated in less than 1% of all Institutional claims and only 10% of Professional 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. This update will be updated in the 2018 Encounter data review.

Based on the analysis of Alliance's Encounter data, we have 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 code and Diagnosis codes, as well as continue to work on improving all up front denials. For the next review period, it is recommended that the Encounter data from NCTracks be reviewed 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 is handling the encounter claims and could be reconciled back to reports requested from Alliance. The goal is to ensure that Alliance is reporting all paid claims as encounters to NC Medicaid.

Cardinal		
Issue	**Findings**	**Recommendations**
Procedure Code	The Procedure code for Institutional claims should be populated 99% of the time. In the Encounter data provided, only 67% of claims contained a value in the Procedure code field and 1% of values were populated with a Revenue code instead of a valid Procedure code.	This issue was present in the review of 2017 encounters, but at a much higher error rate. Cardinal should ensure that the appropriate data validation checks are in place in their provider portal to prevent Revenue codes 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.
Recipient ID	The Recipient ID should be populated 100% of the time with valid values. NC Medicaid is expecting a 10-byte alphanumeric value, specifically 9 digits following by an alpha character. Of the encounters submitted, 553 records were invalid. There was a mix of SSN values with the hyphen included and values less than 10 bytes in length.	Cardinal's eligibility data is driven by the 834 and Global Eligibility File (GEF) provided by NC Medicaid. Cardinal should ensure that each encounter being submitted matches to the State-provided eligibility prior to submission. They already validate that the member is eligible prior to claim payment, so the correct Recipient or Medicaid ID should be captured and available for submission. If the claim being submitted by the provider does not contain a valid Recipient ID, the claim should be denied. If the claim is being submitted through the provider portal, the provider should be limited to only select or enter a valid ID on record with the PIHP.

Based on the analysis of Cardinal's Encounter data, we have concluded that the data submitted to NC Medicaid is complete and accurate as defined by NC Medicaid standards. The two issues identified were only apparent in the Institutional claims submitted and are minimal considering the volume of claims and the method for adjudication (Revenue code vs Procedure code). Cardinal should take corrective action to ensure they are capturing and reporting valid Procedure codes for Institutional claims when required for the reported Revenue code, and only submitting the expected 10-byte alphanumeric Recipient ID. For the next review period, it is recommended that the Encounter data from NCTracks be reviewed 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 is handling the encounter claims and could be reconciled back to reports requested from Cardinal. The goal is to ensure that Cardinal is reporting all paid claims as encounters to NC Medicaid.

Eastpointe		
Issue	**Findings**	**Recommendations**
Procedure Code	The Procedure code for Institutional claims should be populated 99% of the time. In the Encounter data provided, 61% of the claims were populated with a Revenue code instead of a valid Procedure code. 6% of the Institutional claims missing a valid Procedure code, require one based on the Revenue code provided on the claim.	Eastpointe should check their claims processing system and data warehouse to ensure the Procedure Code is being captured appropriately. Claims submitted through the portal or an 837 should be denied by Eastpointe without the proper Revenue code and Procedure code combination. Eastpointe should double check their 837 encounter creation process and Encounter data extract process to make sure data was not lost or manipulated during transformation.
Other Diagnosis	Principal and admitting diagnosis was populated consistently where appropriate; however, additional Diagnosis codes were not populated consistently for Professional claims. This issue was also present in the 2017 review. The Professional claims contained up to twelve Diagnosis codes which is an improvement from the 2017 review in which only the principal and secondary diagnosis was provided. However, additional Diagnosis codes were only populated 10% of the time, which is considerably low, especially in comparison to the consistency of the data in the Institutional claims which was 58%.	Eastpointe should educate providers and validate their 837 encounter mapping to ensure that providers are reporting all applicable Diagnosis codes and the PIHP is reporting them.

Based on the analysis of Eastpointe's Encounter data, we have concluded that the data submitted to NC Medicaid is complete and accurate as defined by NC Medicaid standards. One issue noted related to the consistency of Diagnosis codes being reported to NC Medicaid for Professional claims. Although the additional Diagnosis codes do not impact adjudication, the codes are key for reporting, evaluating member health, and factors that will be used in a value based payment model. Eastpointe should review and revise their 837 mapping immediately. Eastpointe should also take action to ensure they are capturing and reporting valid Procedure codes for Institutional claims when required for the reported Revenue code. For the next review period, it is recommended that the Encounter data from NCTracks be reviewed 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 is handling the encounter claims and could be reconciled back to reports requested from Eastpointe. The goal is to ensure that Eastpointe is reporting all paid claims as encounters to NC Medicaid.

Partners		
Issue	**Findings**	**Recommendations**
Recipient ID	The Recipient Id was not consistently populated with valid data for Professional 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 that is recognizable by the State is being captured appropriately. One possible solution is to review how Partner's validate the recipient information in the system against GEF, and create exception reports to flag potential issues for manual review. Partners should also double check their 837 encounter creation process and encounter data extract process to make sure data was not lost or manipulated during transformation.
Billing Provider ID	A valid billing provider NPI number is required in order to properly adjudicate a claim. This issue only occurred in the Professional claims involving one providers.	The issue occurred involving claims that was submitted manually through the portal. The provider appears to have been loaded into the system initially with an incorrect NPI number. The issue has since been corrected. However, some claims still paid while the incorrect information was in the system, leading to incorrect encounter data submission. And while this problem seems isolated and highly likely occur with 837 transactions (since the NPI number submitted on the 837 by the provider would not have matched the incorrect NPI number in Partners' system), Partners should review data validation rules and how provider information get validated and captured in the system during provider enrollment.

Provider Taxonomy	Provider Taxonomy codes were not consistently populated with a valid code. 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, Partners has a process in place to review 835 files and correctly resubmit encounters to the State that were denied due to invalid or missing Taxonomy. Partners should continue to follow their current process as well as monitor the front end edits in the local system to prevent these errors at the point of claim submission to ensure they are working as intended. The encounter data reviewed and NC Medicaid check write report reflects significant improvement compared to 2016 and 2017, so we know the process in place is making a positive impact.
Diagnosis Codes	The principal diagnosis was populated for 100% of the claims, which show a notable improvement compared to 2018. Additionally, Partners made great progress in capturing additional Diagnosis codes. Consequently, many Institutional and Professional claims now carry multiple Diagnosis codes, suggesting improvements in medical coding practices. However, most claims do not show additional Diagnosis codes.	The missing additional Diagnosis codes do not exceed the threshold outlined in the Data Quality Standards table above, as there is no explicit figure for additional diagnosis. However, additional Diagnosis code should be populated with high frequency and Partners should continue to remind providers to code additional behavioral health diagnoses when appropriate. Separately, NC Medicaid will need to work with the plans 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 plans that require medical services and medical Diagnosis codes. Partners will need to work collaboratively with the State and Alpha to ensure they can capture and report all Diagnosis codes once NCTracks has been updated to accept.
Procedure Codes	The Procedure code for Institutional claims should be populated 99% of the time. In the encounter data provided, 57% of claims contained a value in the Procedure code field. Adjusting for Revenue codes that do not require corresponding Procedure codes, this figure increases to 98%. Additionally, some Professional claims had invalid Procedure codes.	Overall, there has been a notable improvement in the quality of data as Partners just barely missed meeting the Data Quality Standards threshold target for Procedure codes (>99%). Procedure codes, when populated, were almost always valid. Partners should continue to monitor and make sure that Procedure codes submitted by providers are valid. And in case of Institutional claims, encourage providers to code procedures when appropriate. Partners does a commendable job of denying outpatient

		Institutional claims when certain Revenue codes are submitted without a Procedure code (e.g. Revenue code '0450'.) In other cases, Partners indicated that they pay line items that are missing Procedure codes at the RCC rate. While this payment arrangement may be consistent with how providers are contracted, we urge Partners to review requirements to ensure providers are submitting Procedure codes so that services that were rendered can be identified (e.g. submitting a Procedure code when billing Revenue code '0250'.)
Based on the analysis of Partners' encounter data, we have 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 Alpha system, and limited number of data anomalies, HMS believes that some of the errors are isolated cases that can be mitigated in the future by reviewing and modifying data validation rules, as necessary. Overall, Partners has shown continue improvements in the quality of encounter data and this is consistent with the reductions seen in the rate of denials on first time encounter submissions. However, some of the errors noted above are critical in nature. Therefore, Partners should review and take corrective action to resolve the issues identified above. Lastly, for the next review period, HMS is recommending that the encounter data from NCTracks be reviewed 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 LME/MCO. Reviewing an extract from NCTracks would provide insight into how the State's MMIS is handling the encounter claims and could be reconciled back to reports requested from Partners. The goal is to ensure that Partners is reporting all paid claims as encounters to NC Medicaid.		

Sandhills		
Issue	**Findings**	**Recommendations**
Other Diagnosis	Other Diagnosis was only populated 6% of the time for Institutional and Professional claims. Principal and admitting diagnosis was populated consistently where appropriate, however, no more than one additional diagnosis was received for any claim. This issue was present in the 2017 review. 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, we have concluded that the data submitted to NC Medicaid is complete and accurate as defined by NC Medicaid standards. Their biggest issue was noted with the number of Diagnosis codes being reported to NC Medicaid for both Professional and Institutional claims. Although the additional Diagnosis codes do not impact adjudication, the codes are key for reporting, evaluating member health, and factors that will be used in a value based payment model. Sandhills should review and revise their 837 mapping immediately. For the next review period, it is recommended that the Encounter data from NCTracks be reviewed 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 is handling the encounter claims and could be reconciled back to reports requested from Sandhills. The goal is to ensure that Sandhills is reporting all paid claims as encounters to NC Medicaid. We also recommend that medical records be requested from providers to ensure the PIHP is receiving and capturing the correct information.

Trillium		
Issue	**Findings**	**Recommendations**
Procedure Code	The Procedure code should be populated 99% of the time with valid values. In the encounter files provided, the Procedure code was populated within the 99% threshold. However, for both Institutional and Professional 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.	During the Onsite ISCA review, sample claims reviewed within their claims processing system showed that their provider portal allows the submission of invalid values. Trillium 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. Trillium should also update the 837 mapping to avoid submitting invalid values in the Procedure code field.
Additional Diagnosis Codes	Additional Diagnosis codes were populated less than 13% for Professional claims. The missing Diagnosis codes did not appear to be a mapping issue on Trillium's behalf, but likely driven by what providers are submitting. This value is not required by Trillium when adjudicating the claim, therefore, not a requirement of the provider when submitting via Provider Portal or 837.	Trillium 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.

Based on the analysis of Trillium's Encounter data, we have concluded that the data submitted to NC Medicaid is complete and accurate as defined by NC Medicaid standards. There are minor issues with the Procedure code value in both the Professional and Institutional encounters that Trillium should review and revise in their 837 mapping. Overall, Trillium has corrected all issues previously identified in the 2016 and 2017 Encounter data validation reports and made significant strides ensuring they are submitting complete and accurate data to NC Medicaid.

Vaya		
Issue	**Findings**	**Recommendations**
Other Diagnosis	Principal and admitting diagnosis was populated consistently where appropriate; however, additional Diagnosis codes were not populated consistently for Institutional or Professional claims. Institutional claims were not transmitted with any additional Diagnosis codes other than principal and admitting. This issue was present in the 2017 review. The Professional claims contained up to ten Diagnosis codes which is an improvement from the 2017 review in which only the principal and secondary diagnosis was provided. Vaya noted in their ISCA response that up to twelve Diagnosis codes were being provided, which is the maximum number that can be accepted by NCTracks; however, that did not prove true in our review of the Encounter data. Vaya should be capturing up to the maximum allowed and submitting to NC Medicaid.	Vaya should expand the number of Diagnosis codes being captured in their system. This update will also require Vaya to modify their 837 mapping to ensure all Diagnosis codes captured are sent to NC Medicaid moving forward for both Institutional and Professional claims.

Based on the analysis of Vaya's Encounter data, we have concluded that the data submitted to NC Medicaid is complete and accurate as defined by NC Medicaid standards. Their biggest issue was noted with the number of Diagnosis codes being reported to NC Medicaid for both Professional and Institutional claims. Although the additional Diagnosis codes do not impact adjudication, the codes are key for reporting, evaluating member health, and factors that will be used in a value-based payment model. Vaya should review and revise their 837 mapping immediately. For the next review period, it is recommended that the Encounter data from NCTracks be reviewed 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 is handling the encounter claims and could be reconciled back to reports requested from Vaya. The goal is to ensure that Vaya is reporting all paid claims as encounters to NC Medicaid. We also recommend that medical records be requested from providers to ensure the PIHP is receiving and capturing the correct information.

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 compliant 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 audits of the PIHPs' claims data and performance timeliness. Statistical samples of Medicaid data from two six-month time periods in 2019 and another in 2020 were used.

Table 21: Claims Accuracy and Timeliness Review: Summary Findings
March 2019 - August 2019

Health Plan	Timeliness of Provider Payment (Within 30 Days)		Claims Processing Accuracy		Financial Accuracy	
	Results	Finding	Results	Finding	Results	Finding
Alliance	99.84%	Compliant	99.97%	Compliant	99.99%	Compliant
Cardinal	99.97%	Compliant	99.97%	Compliant	99.99%	Compliant
Eastpointe	100%	Compliant	99.98%	Compliant	99.99%	Compliant
Partners	99.99%	Compliant	100%	Compliant	100%	Compliant
Sandhills	99.5%	Compliant	100%	Compliant	100%	Compliant
Trillium	100%	Compliant	99.10%	Compliant	99.57%	Compliant
Vaya	99.98%	Compliant	99.65%	Compliant	99.93%	Compliant

Data were based on a statistical sample of Medicaid claims processed from March 1, 2019 to August 31, 2019 for each PIHP.

Table 22: Claims Accuracy and Timeliness Review: Summary Findings
September 2019- February 2020

Health Plan	Timeliness of Provider Payment (Within 30 Days)		Claims Processing Accuracy		Financial Accuracy	
	Results	Finding	Results	Finding	Results	Finding
Alliance	99.80%	Compliant	99.92%	Compliant	99.97%	Compliant
Cardinal	99.99%	Compliant	99.98%	Compliant	99.99%	Compliant

Health Plan	Timeliness of Provider Payment (Within 30 Days)		Claims Processing Accuracy		Financial Accuracy	
	Results	Finding	Results	Finding	Results	Finding
Eastpointe	100%	Compliant	100%	Compliant	100%	Compliant
Partners	99.99%	Compliant	99.99%	Compliant	99.99%	Compliant
Sandhills	100%	Compliant	100%	Compliant	100%	Compliant
Trillium	100%	Compliant	99.90%	Compliant	99.96%	Compliant
Vaya	100%	Compliant	99.99%	Compliant	100%	Compliant

Data were based on a statistical sample of Medicaid claims processed from September 1, 2019 to February 29, 2020 for each PIHP.

The following six tables provide an overview of the results of the financial solvency review. A current ratio greater than 1.0 is considered compliant. Combined State and Medicaid funds were reviewed for each PIHP. Time periods are noted in each table.

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

PIHP	March 2019	April 2019	May 2019	June 2019	July 2019	August 2019
Alliance	2.48	2.78	2.61	2.64	2.29	2.14
Cardinal	2.64	2.57	2.43	2.43	2.22	2.18
Eastpointe	4.05	4.14	4.56	4.29	4.76	4.96
Partners	1.41	1.25	1.27	1.05	1.16	1.15
Sandhills	6.53	7.84	6.38	6.38	5.61	4.93
Trillium	2.92	2.84	3.02	2.06	2.29	2.15
Vaya	2.84	3.28	3.03	2.80	3.01	3.08

Data were based on a statistical sample of Medicaid claims processed from March 1, 2019 to August 31, 2019 for each PIHP.

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

PIHP	September 2019	October 2019	November 2019	December 2019	January 2020	February 2020
Alliance	2.12	2.30	2.11	2.03	2.17	2.22
Cardinal	2.12	2.00	2.27	2.29	2.27	2.31
Eastpointe	3.68	3.33	3.03	3.24	1.75	1.74
Partners	1.10	1.06	.96	1.02	1.03	1.03
Sandhills	4.67	4.60	4.37	3.78	3.77	3.97
Trillium	2.23	1.90	1.82	1.54	1.55	1.68
Vaya	2.95	3.01	2.99	2.80	2.97	2.88

Data were based on a statistical sample of Medicaid claims processed from September 1, 2019 to February 29, 2020 for each PIHP.

Table 25: Financial Solvency Review – Total Expenses

Health Plan	March 2019	April 2019	May 2019	June 2019	July 2019	August 2019
Alliance	92%	98%	102%	107%	94%	95%
Cardinal	98%	108%	106%	105%	106%	101%
Eastpointe	94%	104%	97%	101%	98%	98%
Partners	92%	113%	101%	122%	88%	96%
Sandhills	102%	108%	107%	115%	106%	105%
Trillium	88%	104%	94%	99%	93%	94%
Vaya	103%	100%	101%	101%	98%	99%

Data were based on a statistical sample of Medicaid claims processed from March 1, 2019 to August 31, 2019 for each PIHP.

Table 26: Financial Solvency Review – Total Expenses

Health Plan	September 2019	October 2019	November 2019	December 2019	January 2020	February 2020
Alliance	100%	93%	102%	94%	91%	92%
Cardinal	94.91%	106.74%	92.77%	99.81%	101.91%	93.28%
Eastpointe	97%	95%	97%	97%	101%	97%
Partners	99%	99%	103%	98%	102%	103%
Sandhills	97%	110%	91%	98%	101%	87%
Trillium	93%	116%	93%	99%	105%	90%
Vaya	97%	101%	96%	98%	99%	95%

Data were based on a statistical sample of Medicaid claims processed from September 1, 2019 to February 29, 2020 for each PIHP.

All PIHPs were compliant for the financial solvency review.

Table 27: Financial Solvency Review – Defensive Interval Summary Findings

Health Plan	March 2019	April 2019	May 2019	June 2019	July 2019	August 2019
Alliance	76.71	64.64	71.19	63.46	51.10	49.05
Cardinal	55.60	47.30	45.67	43.43	46.19	43.79
Eastpointe	90.11	81.48	103.78	79.93	86.89	81.64
Partners	33.36	28.22	30.13	27.93	30.35	32.10
Sandhills	141.12	94.05	104.24	94.81	101.04	100.82
Trillium	79.06	65.84	76.48	49.46	58.37	51.34
Vaya	72.83	62.56	66.61	64.25	66.91	66.50

Data were based on a statistical sample of Medicaid claims processed from March 1, 2019 to August 31, 2019 for each PIHP.

Table 28: Financial Solvency Review – Defensive Interval Summary Findings

Health Plan	September 2019	October 2019	November 2019	December 2019	January 2020	February 2020
Alliance	47.67	50.42	48.03	56.94	54.17	50.74
Cardinal	40.06	36.16	51.15	52.55	50.75	54.12
Eastpointe	84.33	62.42	71.10	87.83	33.54	32.00
Partners	34.58	30.17	26.67	32.32	29.63	29.82
Sandhills	103.39	89.74	89.33	89.40	83.77	84.38
Trillium	56.64	44.69	43.19	42.49	37.00	41.51
Vaya	66.45	63.52	62.54	65.71	64.73	62.54

Data were based on a statistical sample of Medicaid claims processed from September 1, 2019 to February 29, 2020 for each PIHP.

Table 29: HIPAA Transaction Review: Summary Findings

Health Plan	Enrollment (820)	Benefit Enrollment and Maintenance Set (834)	Health Care Claim Transaction Set (837i and 837p)	Health Care Claim Payment / Advice Transaction Set (835)	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

Data were based on a statistical sample of Medicaid claims processed from March 1, 2019 to August 31, 2019 for each PIHP.

Table 30: HIPAA Transaction Review: Summary Findings

Health Plan	Enrollment (820)	Benefit Enrollment and Maintenance Set (834)	Health Care Claim Transaction Set (837i and 837p)	Health Care Claim Payment / Advice Transaction Set (835)	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

Data were based on a statistical sample of Medicaid claims processed from September 1, 2019 to February 29, 2020 for each PIHP.

Both Semi Annual Audits conducted showed all PIHPs were compliant with the claims audit, timeliness of provider payments, HIPAA transaction capability and compliance, and financial solvency.

C. Enrollee Satisfaction Survey

The 2019 Experience of Care and Health Outcomes (ECHO™) were administered from August 8, 2019 through October 9, 2019 to assess enrollee perceptions of the seven PIHPs. CCME's subcontractor, DataStat, implemented this survey and analyzed the data. The results from this survey provide a method for NC Medicaid 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. In preparation for the 2019 survey, NC Medicaid chose the CAHPS® adult and child versions of the Experience of Care and Health Outcomes (ECHO™) Survey for Managed Behavioral Healthcare Organizations, version 3.0. Specifically, surveys 252A (Adult –English), 252B (Adult – Spanish), and 255 (Child) were implemented. 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.

Enrollee Satisfaction Information

CCME requested enrollee 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
- 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 receive: 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.

Enrollee Satisfaction Survey Assistance

A toll-free telephone number was provided at which 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, 2019
1st mailing of reminder postcards	August 15, 2019
2nd mailing of survey packets	August 28, 2019
Phone calls to survey non respondents	September 18, 2019
Survey closed	October 9, 2019

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 I/DD, SU, and MH enrollees. 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	15.6%	88
Cardinal	13.3%	75
Eastpointe	11.8%	66
Partners	15.6%	86
Sandhills	13.5%	74
Trillium	14.8%	111
Vaya	18.6%	81
NC Overall	**14.7%**	**572**

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, 2019 Enrollee 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 offers specific areas in which each PIHP may improve performance. Regarding overall rating of counseling and treatment, Partners' enrollees reported the highest satisfaction. Vaya's enrollees reported the lowest satisfaction. Partners received the highest scores on three of the five composite items, and Cardinal received the highest scores in six of the nine Care Coordination Items. Both Alliance and Eastpointe scored highest on three of the ten single items. All PIHPs received the lowest satisfactory scores for at least one item.

Table 33: 2019 Enrollee Satisfaction Survey Findings Summary – Adult Sample

Item	NC Aggregate Adult (%)	PIHPs with Highest and Lowest Category Percentage	
		High	Low
GLOBAL			
Overall Rating of Counseling and Treatment	68.4%	Partners (75.6%)	Vaya (61.2%)
COMPOSITE			
Getting Treatment Quickly	57.9%	Partners (63%)	Trillium (51.9%)
How Well Clinicians Communicate	86.9%	Partners (89.5%)	Cardinal (84.4%)
Getting Treatment and Information from the PIHP	43.2%	Sandhills (61.5%)	Eastpointe (21.6%)
Perceived Improvement	56.0%	Alliance (65.3%)	Partners (51.2%)
Information About Treatment Options	53.3%	Partners (61.3%)	Sandhills (40%)
SINGLE ITEM			
Office Wait (seen within 15 minutes)	68.6%	Cardinal (78.7%)	Eastpointe (61.1%)
Told About Medication Side Effects	76.9%	Alliance (85%)	Sandhills (67.6%)

Item	NC Aggregate Adult (%)	PIHPs with Highest and Lowest Category Percentage	
		High	Low
Including Family and Friends	52.1%	Partners (63%)	Sandhills (36.8%)
Information to Manage Condition	78.8%	Alliance (82.2%)	Cardinal (73.9%)
Patient Rights Information	86.7%	Partners (91.1%)	Vaya (82.1%)
Patient Feels He or She Could Refuse Treatment	77.8%	Trillium (83.3%)	Alliance (66%)
Privacy of treatment information	92.0%	Eastpointe (100%)	Vaya (87.9%)
Cultural Competency	60.7%	Alliance and Eastpointe (100%)	Trillium (40%)
Amount Helped	80.7%	Cardinal (90.4%)	Eastpointe (43.8%)
Treatment After Benefits Are Used Up	64.4%	Eastpointe (100%)	Vaya (40%)
CARE COORDINATION			
Access to Care Coordinator	80.5%	Alliance (90.3%)	Partners (66.7%)
Care Coordinator responds in timely manner	79.3%	Cardinal (94.7%)	Trillium (68.2%)
Care Coordinator helps with answers to questions	81.9%	Cardinal (94.7%)	Partners (66.7%)
Care Coordinator helps find services/support	75.2%	Sandhills (88.2%)	Vaya (60.7%)
Care Coordinator asks how best to support me	80.4%	Cardinal (89.5%)	Eastpointe and Vaya (71.4%)
Received draft of Person Centered Plan to review	78.8%	Cardinal (92.3%)	Eastpointe (62.5%)
Satisfied with Person Centered Plan	81.6%	Cardinal (100%)	Partners (66.7%)
Revisions were added to plan if requested	10.5%	Trillium (50%)	Eastpointe, Partners, Sandhills, and Vaya (0%)
Care Coordinator discusses appeal process and submission	51.3%	Cardinal (66.7%)	Partners (36.4%)

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 I/DD, SU, and MH enrollees. 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	16.5%	94
Cardinal	12.5%	71
Eastpointe	14.5%	83
Partners	17.3%	99
Sandhills	16.1%	92
Trillium	19.3%	110
Vaya	13.8%	79
NC Overall	**15.7%**	**628**

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 35 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, 2019 Enrollee 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 offers specific areas in which each PIHP may improve performance. Regarding overall rating of counseling and treatment, Partners' enrollees reported the highest satisfaction, and Cardinal's enrollees reported the lowest satisfaction. Of the nine Care Coordination items, Partners and Vaya received the highest scores on three of the nine items, and Eastpointe scored the lowest satisfaction in four of the nine items. Cardinal scored positively on four of the ten single item questions. All PIHPs received the lowest satisfactory scores for at least one item.

Table 35: Enrollee Satisfaction Survey Findings Summary - Child Sample

Item	NC Aggregate Child (%)	PIHPs with Highest and Lowest Category Percentage	
		High	Low
GLOBAL			
Overall Rating of Counseling and Treatment	65.8%	Partners (71.2%)	Cardinal (58.1%)
COMPOSITE			
Getting Treatment Quickly	60.8%	Partners (68.1%)	Eastpointe (54.3%)
How Well Clinicians Communicate	89.5%	Vaya (94.7%)	Partners (86.1%)
Getting Treatment and Information from the PIHP	46.2%	Alliance (66.8%)	Sandhills (23.2%)
Perceived Improvement	62.3%	Sandhills (70%)	Cardinal (51.9%)
Information About Treatment Options	46.2%	Alliance (66.8%)	Sandhills (23.2%)
SINGLE ITEMS			
Office Wait (seen within 15 minutes)	73.7%	Partners (83.3%)	Eastpointe (61.2%)
Told About Medication Side Effects	82.4%	Cardinal (87.2%)	Partners (77.6%)

Item	NC Aggregate Child (%)	PIHPs with Highest and Lowest Category Percentage	
		High	Low
Told about different treatments available	70.2%	Cardinal (79.5%)	Sandhills (64.9%)
Information to Manage Condition	76.7%	Eastpointe (84.6%)	Cardinal (68.3%)
Patient Rights Information	88.6%	Vaya (93.5%)	Alliance (81.7%)
Patient Feels He or She Could Refuse Treatment	87.2%	Partners (95.5%)	Sandhills (65.8%)
Privacy of treatment information	95.9%	Cardinal (100%)	Partners (90.8%)
Cultural Competency	73.3%	Cardinal, Sandhills, and Vaya (100%)	Partners and Trillium (50%)
Amount Helped	76.6%	Trillium (80.9%)	Cardinal (70.4%)
Treatment After Benefits Are Used Up	67.2%	Eastpointe (100%)	Trillium (28.6%)
CARE COORDINATION ITEMS			
Access to Care Coordinator	79.8%	Vaya (92.9%)	Sandhills (71.4%)
Care Coordinator responds in timely manner	85.8%	Partners (95.5%)	Eastpointe (66.7%)
Care Coordinator helps with answers to questions	82.2%	Partners (90.9%)	Alliance (72%)
Care Coordinator helps find services/support	75%	Sandhills and Vaya (85.7%)	Eastpointe (66.7%)
Care Coordinator asks how best to support me	79.5%	Trillium (88.24%)	Sandhills (71.4%)
Received draft of Person Centered Plan to review	83.5%	Vaya (100%)	Alliance (77.3%)
Satisfied with Person Centered Plan	84%	Cardinal (95%)	Partners (70.6%)
Revisions were added to plan if requested	31.3%	Partners (80%)	Alliance, Cardinal, Eastpointe, Trillium, and Vaya (0%)
Care Coordinator discusses appeal process and submission	70%	Trillium (92.3%)	Eastpointe (42.9%)

D. Provider Satisfaction Survey

The *2019 DHHS Provider Satisfaction Survey* was administered from October to December 2019 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 administration.

Table 36: Survey Administration Timeline

Task	Month / Year
Initial survey sent	**October 7, 2019**
First reminder sent	**October 10, 2019**
Reminder calls began	**October 28, 2019**
Data collection terminated	**November 22, 2019**

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., ET, 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	4201	1460	782	293	372	463	446	385
†Email bounce back with non-delivery message	317	143	46	3	53	36	18	18

	NC Overall	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
*Completed usable surveys	2430	595	540	198	225	289	308	275
Response Rate	**62.6%**	**45.2%**	**73.4%**	**68.3%**	**70.5%**	**67.7%**	**72.0%**	**74.9%**

*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 of 4,313 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 4,201 provider records included in the survey.

Findings Summary

When rating overall satisfaction with the PIHPs, an average of 89% of the providers answered as either "Extremely Satisfied" or "Satisfied", a 2% increase from 2018. Sandhills had the highest percentage of satisfied providers with 91.85%, yet this was a .4% decrease from their 2018 score. Cardinal had the lowest rating of 83.91%, but an increase of 1.2% from 2018. Six of the PIHPs had an increase in overall satisfaction, including Eastpointe, whose scores increased by almost 8% from 2018. The results of all the PIHPs are shown in *Figure 11*, and, for the purpose of easy comparison, percentages are rounded.

Figure 11: Overall Provider Satisfaction with PIHP; Comparative of 2018 and 2019

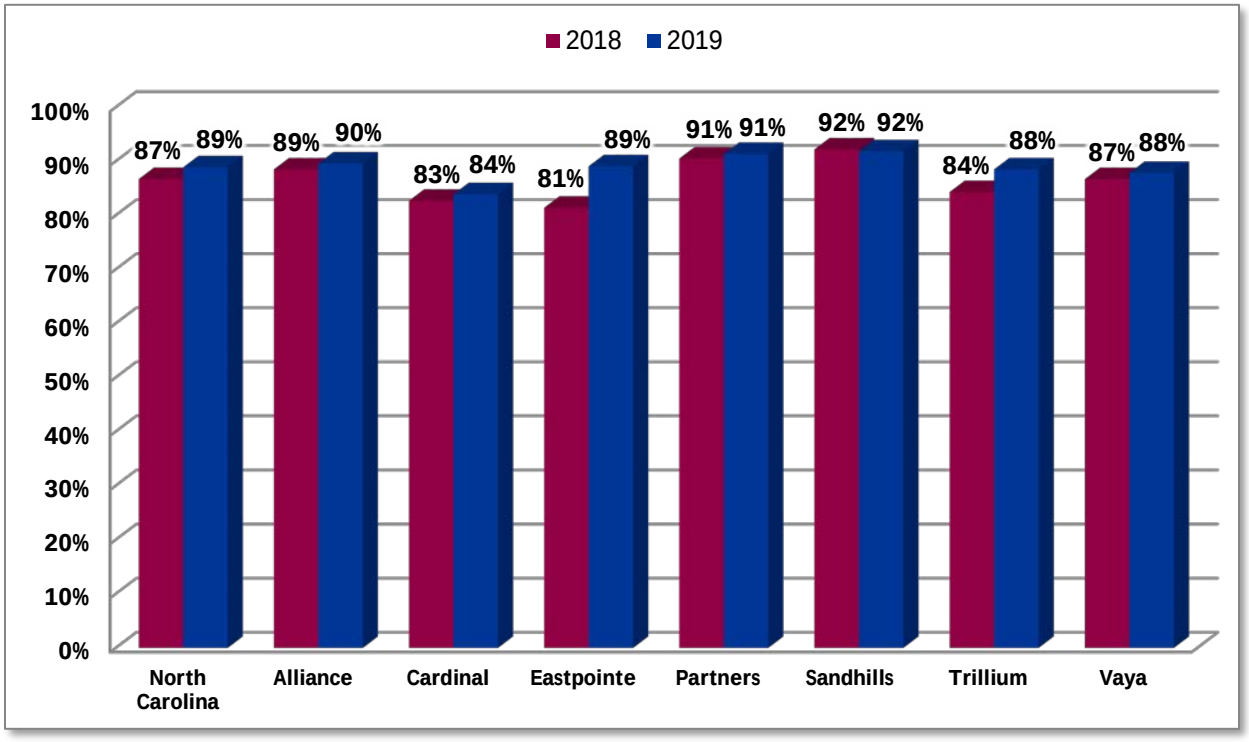


Table 38 shows a summary of the percentage of positive answers for each of the "Agree" or "Satisfied" questions in the survey. The table lists the aggregates for 2018 and 2019, the change from 2018 to 2019, and the PIHPs having the highest and lowest percentage for that question.

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

Question	NC Aggregate 2018 (%)	NC Aggregate 2019 (%)	Change (%)	PIHP	
				Highest Score	Lowest Score
Question 5: LME-MCO staff is easily accessible for information, referrals, and scheduling of appointments.	83.9%	86.4%	+2.5	Sandhills (90.7%)	Trillium (82.6%)
Question 6: LME-MCO staff are referring consumers whose clinical needs match the service(s) my practice/agency provides.	79.4%	80.3%	+0.9	Alliance (87.8%)	Vaya (74.3%)

Question	NC Aggregate 2018 (%)	NC Aggregate 2019 (%)	Change (%)	PIHP	
				Highest Score	Lowest Score
Question 7: LME-MCO staff responds quickly to provider needs.	80.8%	83.6%	+2.8	Sandhills (90.7%)	Cardinal (79.1%)
Question 8: Customer Service is responsive to local community stakeholders.	86.1%	87.5%	+1.4	Sandhills (92.0%)	Vaya (84.0%)
Question 9: When I speak with staff about claims issues, I am given consistent and accurate information.	84.5%	87.8%	+3.2	Partners (91.5%)	Cardinal (81.9%)
Question 10: Claims trainings meet my needs.	88.8%	89.9%	+1.1	Eastpointe (94.7%)	Vaya (85.3%)
Question 11: Our claims are processed in a timely and accurate manner.	94.4%	94.7%	+0.3	Trillium (98.6%)	Vaya (92.5%)
Question 12: Information Technology trainings are informative and meet my agency's needs.	89.2%	91.5%	+2.3	Eastpointe (94.96%)	Alliance (88.24%)
Question 13: Provider Network meetings are informative and helpful.	87.0%	87.9%	+0.9	Sandhills (92.7%)	Cardinal (81.3%)
Question 14: Provider Network keeps providers informed of changes that affect my local Provider Network.	87.1%	89.2%	+2.1	Eastpointe (94.2%)	Cardinal (84.9%)
Question 15: Provider Network staff is knowledgeable and answer questions consistently and accurately.	84.3%	86.4%	+2.1	Sandhills (92.3%)	Trillium (82.9%)
Question 16: Our interests as a network provider are being adequately addressed in the local Provider Council.	80.9%	83.4%	+2.5	Sandhills (89.8%)	Cardinal (72.6%)
Question 17: How would you rate your overall satisfaction with Provider Network?	85.5%	88.5%	+3.0	Partners (91.2%)	Cardinal (84.1%)

Question	NC Aggregate 2018 (%)	NC Aggregate 2019 (%)	Change (%)	PIHP	
				Highest Score	Lowest Score
Question 18: The LME-MCO staff conducts fair and thorough investigations.	88.1%	89.3%	+1.2	Trillium (91.0%)	Cardinal (85.4%)
Question 19: After the audit or investigation, LME-MCO requests for corrective action plans and other supporting materials are fair and reasonable.	88.9%	90.2%	+1.3	Alliance (92.9%)	Cardinal (87.0%)
Question 20: Technical assistance and information provided by staff is accurate and helpful.	89.1%	90.9%	+1.8	Partners (94.6%)	Trillium (88.0%)
Question 21: Trainings are informative and meet our needs as a provider/agency.	89.9%	90.6%	+0.7	Sandhills (94.7%)	Cardinal (86.3%)
Question 23: Authorizations for treatment and services are made within the required timeframes.	91.8%	93.6%	+1.8	Partners (96.2%)	Cardinal (88.0%)
Question 24: Denials for treatment and services are explained.	85.1%	85.6%	+0.5	Sandhills (89.2%)	Cardinal (82.0%)
Question 25: The authorizations issued are accurate.	95.1%	96.6%	+1.5	Partners (98.9%)	Cardinal (93.9%)
Question 26: My agency is satisfied with the appeals process for denial, reduction, or suspension of service(s).	81.9%	82.7%	+0.8	Eastpointe (87.7%)	Cardinal (74.5%)
Question 27: The LME-MCOs website has been a useful tool for helping my agency find the tools and materials needed to provide services.	84.1%	85.3%	+1.2	Sandhills (89.6%)	Cardinal (81.0%)
Question 28: Please rate your overall satisfaction with the LME-MCO.	86.7%	88.9%	+2.2	Sandhills (91.9%)	Cardinal (83.9%)

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 10 of 23 questions. Cardinal ranked lowest on 15 of 23 questions.

Conclusion

Overall, provider satisfaction has increased from 2018 to 2019. In this year's results, providers are more satisfied than last year on all of the 23 items surveyed. In 2019, providers reported being the most satisfied regarding accuracy of the service authorizations issued by the PIHPs. This was also true in 2018. The question with the largest gain from a year ago involved the providers feeling satisfied regarding the consistency and accuracy of claims information given by PIHP staff. Providers were least satisfied with the clinical and service needs of referrals of enrollees from the PIHP and their match with the services offered by the provider. This was also the lowest scoring item in the 2018 survey analysis.

A. Attachment 1: 2019 NC EQR 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 NC Medicaid.

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 PIHP 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 PIHP is able to identify and review any errors identified during, or as a result, of the State enrollment file load process.

   1.3 The PIHP's enrollment system member screens store and track enrollment and demographic information.

2. Claims System

   2.1 The PIHP processes provider claims in an accurate and timely fashion.

   2.2 The PIHP has processes and procedures in place to monitor, review and audit claims staff.

   2.3. The PIHP 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. The PIHP has the capability of receiving and storing ICD-10 Procedure codes on an 837 Institutional file.

2.4 The PIHP's claim system screens store and track claim information and claim adjudication/payment information.

3. Reporting

3.1 The PIHP's data repository captures all enrollment and claims information for internal and regulatory reporting.

3.2 The PIHP has processes in place to back up the enrollment and claims data repositories.

4. Encounter Data Submission

4.1 The PIHP has the capabilities in place to submit the State required data elements to NC Medicaid on the Encounter data submission.

4.2 The PIHP has the capability to identify, reconcile and track the Encounter data submitted to NC Medicaid.

4.3 PIHP has policies and procedures in place to reconcile and resubmit Encounter data denied by NC Medicaid.

4.4 The PIHP has an Encounter data team/unit involved and knowledgeable in the submission and reconciliation of Encounter data to NC Medicaid.

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) and query of the *State Exclusion List*;

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 Names of hospitals at which the physician has admitting privileges, if any.

3.1.15 Ownership Disclosure is addressed;

3.1.16 Criminal background Check.

3.2 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 and query of the *State Exclusion List*;

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 Requery of the Social Security Administration's Death Master File;

4.2.12 Requery of the NPPES;

4.2.13 Names of hospitals at which the physician has admitting privileges, if any.

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 NC Medicaid 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 ensures 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 CFR § 164.524* and *NCGS § 122C-53(d)*, and to request that the medical record be amended or corrected in accordance with *45 CFR § 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 *NCGS § 131 D-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, including 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 *NC Medicaid 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 *NC Medicaid 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 *42 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 *42 CFR 438.10 (f) (61)* and *438.10 (g)* at least 30 days calendar days before the intended effective date of the change; and (2) termination of their provider within fifteen (15) calendar days after the PIHP receives notice that NC Medicaid 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 members (including those with limited English proficiency);

1.2 Connect Enrollees, family members, 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.

2.11 NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.

3. The PIHP applies the Care Coordination policies and procedures as formulated.

D. Transition to Community Living Initiative (TCLI)

1. Transition to Community Living Initiative (TCLI) functions are performed by appropriately licensed, or certified, and trained staff.

2. The PIHP has policies and procedures that address the TCLI 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, Supported Employment, Community Support Team, Psychosocial Rehabilitation, and other services as set forth in the DOJ Settlement 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 Quality of Life Surveys are administered timely.

3. Transition, diversion and discharge processes are in place for TCLI members as outlined in the DOJ Settlement and DHHS Contract.
4. Clinical Reporting Requirements: The PIHP will submit the required data elements and analysis to NC Medicaid within the timeframes determined by NC Medicaid.
5. The PIHP will develop a TCLI communication plan for external and internal stakeholders providing information on the TCLI 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 TCLI policies, procedures and processes, as required by NC Medicaid, 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 grievance log 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 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:

1.1 The definitions of 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, and analyzed for patterns and potential quality improvement opportunities, and reviewed in 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 CFR § 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 of the *NC Medicaid Contract*.
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 *NC Medicaid 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 *NC Medicaid 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 NC Medicaid. This person may or may not be the PIHP Compliance Officer or the PIHP Contract Administrator. In addition, PIHP shall identify a primary point of contact within the Special Investigations Unit to receive and respond to data requests from MFCU/MID. The MFCU/ MID will copy the PIHP Contract Administrator on all such requests.
4. PIHP shall participate in quarterly Program Integrity meetings with NC Medicaid Program Integrity, the State of NC Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the N.C. Department of Justice ("MFCU/ MID').
5. PIHP shall send staff to participate in monthly meetings with NC Medicaid Program Integrity staff 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. Within seven (7) business days of a request by the Division, PIHP shall also make portions of the PIHP's Regulatory Compliance and Program Integrity minutes relating to Program Integrity issues available for review, but the PIHP may, redact other portions of the minutes not relating to Regulatory Compliance or Program Integrity issues.
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 NC Medicaid or MFCU/MID, and including supplying all data in a uniform format provided by NC Medicaid and information requested for their respective investigations within seven (7) days or within an extended timeframe determined by the Division as provided in *NC Medicaid Contract* Section 13.2-Monetary Penalties.
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 *NC Medicaid 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 *NC Medicaid Contract*; and making documentation of investigations and compliance available as requested by the State. PIHP shall include in each monthly Attachment Y Report, all overpayments based on fraud or abuse identified by PIHP during the prior month. PIHP shall be penalized One Hundred Dollars ($100) for each overpayment that is not specified in an Attachment Y Report within the applicable month. In addition, PIHP shall have and implement written policies and procedures to guard against fraud and abuse.

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 based on fraud or abuse, including Program Integrity and Provider Monitoring activities initiated by PIHP 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 NC Medicaid-standardized elements or a NC Medicaid-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 NC Medicaid 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 NC Medicaid an allegation of fraud involving a Provider, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid 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 Total Sample Amount of Funds Investigated per Service Type

14. In each case where PIHP refers suspected Enrollee fraud to NC Medicaid, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid 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.

    14.8 Any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers;

    14.9 Details that relate to the original allegation that PIHP received which triggered the investigation;

    14.10 Period of Service Investigated – PIHP shall include the timeframe of the investigation and/or timeframe of the audit, as applicable.;

    14.11 Information on Biller/Owner;

    14.12 Additional Provider Locations that are related to the allegations;

    14.13 Legal and Administrative Status of Case.

15. PIHP and NC Medicaid 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 NC Medicaid Fraud and Abuse Management System (FAMS) or a NC Medicaid 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 NC Medicaid designated Administrator to submit appropriate claims data to load into the NC Medicaid Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. If PIHP uses FAMS, PIHP shall notify the NC Medicaid 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 NC Medicaid 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 or the next business day if the 10th day is a non-business day (i.e. weekend or State or PIHP holiday). In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report

to NC Medicaid 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 NC Medicaid 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, NC Medicaid Program Integrity shall complete a preliminary investigation to determine whether there is sufficient evidence to warrant a full investigation. If NC Medicaid determines that a full investigation is warranted, NC Medicaid 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, NC Medicaid shall provide written notification to PIHP of the status of each such referral. If MFCU/ MID indicates that suspension will not impact their investigation, NC Medicaid may send a payment suspension notice to the Provider and notify PIHP. If the MFCU/ MID indicates that payment suspension will impact the investigation, NC Medicaid 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 NC Medicaid Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of NC Medicaid Program Integrity's suspension and lasting until PIHP is notified by NC Medicaid Program Integrity in writing that the suspension has been lifted.

3. PIHP shall provide to NC Medicaid 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 NC Medicaid Program Integrity due to allegations of suspected fraud without prior written approval from NC Medicaid Program Integrity or the MFCU/MID. If PIHP takes administrative action, including issuing a Notice of Overpayment based on such fraud that precedes the submission date of a Division referral, the State will adjust the PIHP capitated payment in the amount of the original overpayment identified or One Thousand Dollars ($1,000) per case, whichever amount is greater.

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 NC Medicaid, 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 NC Medicaid, 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.

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 *NC Medicaid 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 (*NC Medicaid Contract Section 8.3.2* and *Amendment 4, Section 31*).
6. The PIHP maintains a restricted risk reserve account with a federally guaranteed financial institution in accordance with *NC Medicaid Contract*.
7. The required minimum balance of the Risk Reserve Account meets the requirements of the *NC Medicaid 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 *NC Medicaid Contract*.
9. The Medical Loss Ratio (MLR) meets the requirements of *42 CFR § 438.8* and the *NC Medicaid Contract.*

B. Attachment 2: 2019 NC EQR Desk Materials List

External Quality Review 2019

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy and procedure 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, licensure, and any certifications required for their position. Include any current vacancies. In addition, 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 and 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) by provider.

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

10. List of providers credentialed/recredentialed in the last 12 months (TBD). Include the date of approval of initial credentialing and the date of approval of recredentialing.

11. A current provider manual and provider directory.

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

13. Copies of all current policies and procedures, as well as a complete index which includes policy and procedure 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)*

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

15. Current Medical Director and Medical Staff job descriptions.

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

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

18. A summary of the status of all best practice Recommendations and Corrective Action items from the previous External Quality Review.

19. 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.

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

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

22. List of providers credentialed/recredentialed in the last 12 months (TBD). Include the date of approval of initial credentialing and the date of approval of recredentialing.

23. A current provider manual and provider directory.

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

25. The Quality Improvement work plans for TBD and TBD.

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

27. Minutes of committee meetings for the months of 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, evidence of electronic votes) 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.

28. 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.

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

30. Copies of the most recent provider profiling activities conducted to measure contracted provider performance (for example, provider report cards, dashboards, etc.).

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

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

33. 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.

34. A copy of the complete Appeal log for the months of TBD. Please indicate on the log appeal type (standard or expedited), the service appealed, the date the appeal was received, the resolution date, and if the resolution timeframe was extended, who requested the extension. Also include on the log those appeals that were withdrawn or deemed invalid.

35. A copy of the complete Grievances log. Please indicate on the log the nature of the grievance, the date received, and the date resolved. If the grievance resolution timeframe was extended, please include who requested the extension.

36. Copies of all letter templates used for Utilization Management, Grievances, and Appeals. This includes all acknowledgement, adverse benefit determination, resolution, extension, invalid, expedited, etc. notifications.

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

38. Clinical 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. Results of the most recent monitoring of provider compliance with Clinical Practices Guidelines.

39. All information supplied at orientation to new providers, including, for example, the Welcome letter and any orientation materials. If the new provider orientation is provided via the PIHP website,

provide a link to the location of the orientation materials. Please also provide the location of ongoing provider training materials and/or calendar of training events.

40. 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. Include pre-delegation assessments conducted for any delegates added/contracted during the timeframe covered by the current EQR.
41. Contracts and relevant amendments for all delegated entities, including Business Associate Agreements for delegates handling PHI.
42. 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 evaluations, if applicable, and indicate to which committees delegate monitoring is reported.
43. Please provide an excel spreadsheet with a list of enrollees that have been placed in care coordination since TBD. Please indicate the disability type (MH/SU, I/DD).
44. Please provide an excel spreadsheet with a list of enrollees that have been placed in the TCLI program since TBD. 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.
45. 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 beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals
Proportion of beneficiaries reporting they have a choice between providers.	Proportion of Individual Support Plans that address identified health and safety risk factors
Percentage of level 2 and 3 incidents reported within required timeframes.	Percentage of participants reporting that their Individual Support Plan has the services that they need
Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.	Percentage of beneficiaries who received appropriate medication.
Percentage of medication errors resulting in medical treatment.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.

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.

46. 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.)

47. Summary description of quality oversight of the Transition to Community Living Initiative, including monitoring activities, performance metrics, and results.

48. Data, Dashboards 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 receiving ACT, Supported Employment, Peer Support Services, Community Support Team, Psychosocial Rehabilitation, etc. for the period TBD.

49. Call performance statistics for the period of TBD, including average speed of answer, abandoned calls, and average call/handle time for customer service representatives (CSRs).

50. Provide copies of the following files:
    a. Credentialing files for the 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 4 files for network provider agencies and/or hospitals and/or psychiatric facilities, in any combination.

Please submit the full credentialing file, from the date of the application/attestation, to the notification of approval of credentialing. In addition to the application and notification of credentialing approval, the credentialing files should include all of the following:

i. Insurance:

A. Proof of all required insurance, or a signed and dated statement/waiver/attestation from the practitioner/agency indicating why specific insurance coverage is not required.

B. For practitioners joining already-contracted agencies, include copies of the proof of 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.

ii. All PSVs conducted during the current process, including current supervision contracts for all LPAs and all provisionally-licensed practitioners (*i.e.*, LCAS-A, LCSW-A).

iii. Ownership disclosure information/form.

b. Recredentialing files for the 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 4 files of network provider agencies and/or hospitals and/or psychiatric facilities, in any combination.
Please submit the full recredentialing file, from the date of the application/attestation, to the notification of approval of recredentialing. In addition to the recredentialing application, the recredentialing files should include all of the following:

i. Proof of original credentialing date and all recredentialing dates, including the current recredentialing (this is usually a letter to the provider, indicating the effective date).

ii. Insurance:

A. Proof of all required insurance, or a signed and dated statement/waiver/attestation from the practitioner/agency indicating why specific insurance coverage is not required.

B. For practitioners joining already-contracted agencies, include copies of the proof of 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.

iii. All PSVs conducted during the current process, including current supervision contracts for all LPAs and all provisionally-licensed practitioners (*i.e.*, LCAS-A, LCSW-A).

iv. Site visit/assessment reports, if the provider has had a quality issue or a change of address.

v. Ownership disclosure information/form.

c. Ten MH/SU, ten I/DD and five TCLI files medical necessity approvals made from 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/SU, ten I/DD and five TCLI files medical necessity denial files for any denial decisions made from 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.

51. Provide the following for Program Integrity:
    a. File Review: Please produce a listing of all active files during the review period (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. All 'Attachment Z' reports collected during the review period.
    g. Provider Manual and Provider Application.
    h. Enrollee Handbook.
    i. Subcontractor Agreement/Contract Template.
    j. 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.
    k. 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.
    l. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors and employees.
    m. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to NC Medicaid or any other state or federal agency.
    n. Code of Ethics and Business Conduct.
    o. Internal and/or external monitoring and auditing materials.
    p. Materials pertaining to how the PIHP captures and tracks complaints.
    q. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
        i. NC Medicaid approved reporting templates.
    r. Sample Data Mining Reports.
    s. NC Medicaid Monthly Meeting Minutes for entire review period, including agendas and attendance lists.
    t. Monthly reports of NCID holders/FAMS-users in PIHP.
    u. Any program or initiatives the plan is undertaking related to Program Integrity including documentation of implementation and outcomes, if appropriate.
    v. Corrective action plans including any relevant follow-up documentation.
    w. 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

52. Provide the following for the Information Systems Capabilities Assessment (ISCA):

c. 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	1f	Enrollment loading error process reports
Enrollment Systems	1g	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	2p	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
NC Medicaid Submissions	1d	Workflow for NC Medicaid submissions
NC Medicaid Submissions	2b	Workflow for NC Medicaid denials
NC Medicaid Submissions	2e	NC Medicaid 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.

53. 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 NC Medicaid 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 NC Medicaid'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 administrative 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:
    i. Total incurred claims
    ii. Expenditures on quality improvement activities
    iii. Expenditures related to PI requirements under §438.608
    iv. Non-claims costs
    v. Premium revenue

vi. Federal, state and local taxes, and licensing and regulatory fees
vii. Methodology for allocation of expenditures
viii. Any credibility adjustment applied
ix. The calculated MLR
x. Any remittance owed to the State, if applicable
xi. A comparison of the information reported with the audited financial report required under §438.3 (m)
xii. The number of member months

y. A copy of the PIHP's annual MLR report.

54. Provide the following for Encounter Data Validation (EDV):

d. Include all adjudicated claims (paid and denied) from January 1, 2018 – December 31, 2018. Follow the format used to submit Encounter data to NC Medicaid (i.e., 837I and 837P). If you archive your outbound files to NC Medicaid, 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.

e. Provide a report of all paid claims by service type from January 1, 2018 – December 31, 2018. 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.