CCME

External Quality Review

2020 ANNUAL SUMMARY REPORT

Submitted: July 30, 2021

Prepared on behalf of the
North Carolina Medicaid

2020 EQR Annual Summary Report

EXECUTIVE SUMMARY

The 42 Code of Federal Regulations *(CFR) § 438.350* requires each state that contracts with Managed Care Organizations (MCOs) or Prepaid Inpatient Health Plans (PIHP) to perform an annual External Quality Review (EQR). To comply with this regulation, North Carolina Medicaid (NC Medicaid) 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 during 2020 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 Provider Satisfaction Survey,* Encounter data validation, and Semi-annual audits of each PIHP.

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 in *Attachment 1, External Quality Review Standards*.

Validation of Performance Measures (PMs)

CCME validated the PMs 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 beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.
Proportion of beneficiaries reporting they have a choice between providers.
Percentage of level 2 and 3 incidents reported within required timeframes.
Percentage of beneficiaries who received appropriate medication.
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 PIPs 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.

Process

The EQR for each PIHP was conducted in two parts:

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

The following table displays the dates of the EQRs conducted for each PIHP.

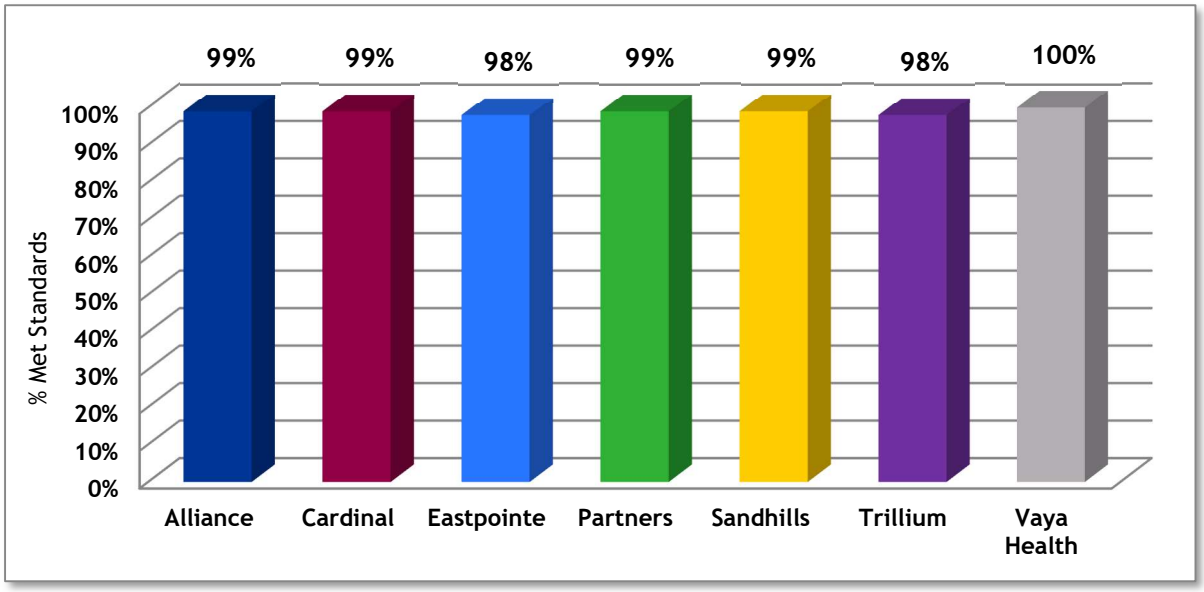
Table 3: External Quality Review Dates

PIHP	2020 EQR
Alliance Health (Alliance)	May 2021
Cardinal Innovations Healthcare Solutions (Cardinal)	April 2021
Eastpointe	March 2021
Partners Health Management (Partners)	June 2021
Sandhills Center (Sandhills)	January 2021
Vaya Health (Vaya)	February 2021
Trillium Health Resources (Trillium)	April 2021

Overall Scores

The following figures illustrate the percentage of "Met" standards each PIHP achieved during the 2020 EQRs. Due to COVID-19 pandemic, CCME implemented a focused review. This decision was based on the issuance by the State of the COVID-19 flexibilities PIHP Contract Amendment #9. This PIHP contract amendment stated PIHPs "shall be held harmless for any documentation or other PIHP errors identified through the EQR that are not directly related to member health and safety through the Term of the Amendment." This resulted in changes to some of the PIHPs' percentage of "Met" standards. Initially, Alliance met 98% of all EQR standards, Partners met 99%, and Vaya met 96% of all EQR standards, but these scores were changed to those indicated in Figure 1. The overall scores for Cardinal, Eastpointe, Sandhills, and Trillium did not change.

Figure 1: Percentage of Met Standards



Administration

42 CFR § 438.224 and 42 CFR § 438.242

Information Systems Capabilities Assessment

The review of the PIHPs' system capabilities involves the use of the Information Systems Capabilities Assessment (ISCA) tool and review of supporting documentation such as claim audit reports, enrollment workflows and Information Technology staffing patterns. This system analysis is completed as specified in the Centers for Medicaid and Medicare Services (CMS) protocol. During the Onsite, PIHP staff presented a member and claims systems review. Questions regarding the ISCA tool and Encounter denial reason codes were discussed with staff during the Onsites.

When compared to the previous year, two PIHPs improved their capture of claims data (Cardinal and Partners). There was improvement by three PIHPs in Encounter claims submission capability (Cardinal, Partners, and Sandhills).

While all standards were met across the seven PIHPs, there is still room for improvement in the areas of capture and reporting of data. As examples, Alliance is able to capture and store up to 29 ICD-10 Diagnosis codes for Institutional Encounters, however, they are only submitting up to 12 ICD-10 Diagnosis codes on an Institutional Encounter data extract to NCTracks, Similarly, Cardinal can capture ICD-10 Procedure codes yet, they do not receive them from their providers on Institutional claims. Further, Sandhills does not have the ability to submit ICD-10 Procedure codes on Encounter data extracts to NCTracks, Lastly, Trillium has the ability to capture ICD-10 Procedure codes for Professional claims but do not receive them on Institutional claims and Trillium does not have the ability to submit DRG codes on Encounter data extracts to NCTracks. With effort, all of these areas could be addressed.

Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

The Provider Services EQR was comprised of Credentialing and Recredentialing, including a review of how new providers are oriented, as well as a discussion of network gaps. In the 2019 EQR of Credentialing and Recredentialing, Eastpointe scored “Not Met” for one standard and “Partially Met” for one standard, Cardinal scored “Partially Met” for six standards, and Trillium scored “Partially Met” for two standards. Alliance, Partners, Sandhills and Vaya all received a score of “Met” for all Credentialing and Recredentialing standards in the 2019 EQR.

In the 2020 EQR, all seven PIHPs scored 100% for the Credentialing/Recredentialing standards, reflecting the PIHPs’ improvement in their credentialing and recredentialing files over the past several EQRs. For continued improvement, the PIHPs should ensure the credentialing/ recredentialing files submitted for the EQR are the complete files, with all required information, including, for example, the Ownership Disclosure information, or evidence of all required types of insurance. Some PIHPs also need to reconcile language across all documents to accurately reflect Credentialing Committee information such as the committee membership/composition, which members can vote, or what constitutes a quorum.

Quality Improvement

42 CFR § 438.330

The 2020 Quality Improvement (QI) EQR included Performance Measures (PMs) and Performance Improvement Projects (PIPs) validation. In the 2019 EQR, Eastpointe,

Sandhills and Vaya scored a "Partially Met" on meeting the requirements of the CMS protocol "Validating Performance Improvement Projects." The Partially Met scores were for varying reasons, including PIP reports not having benchmark rates for all indicators, the project aim and research question(s) not being documented clearly, and specific action plans not documented for indicators in which rates have not improved. The 2019 EQR validation scores for (b) Waiver and (c) Waiver Performance Measures were Fully Compliant with an average validation score of 100% for both areas.

In the 2020 EQR, CCME found that the 2019 Corrective Actions for the PIPs were implemented and maintained. Each PIHP scored a "Met" in this Quality Improvement section. Collectively, 35 PIPs scored in the "High Confidence" range, and one scored in the "Confidence" range. There were 18 Recommendations issued collectively that centered around showing rate improvements in the PIPs. The Performance Measure Query was accurate for (b) Waiver Measures and all measures were validated at 100%, Fully Compliant. All PIHP's (c) Waiver Measures met or exceeded State benchmarks and were validated at 100%, Fully Compliant.

Utilization Management

42 CFR § 438.208

The 2020 Utilization Management (UM) EQR consisted of a review of Care Coordination and Transition to Community Living (TCLI) functions. In the 2019 EQR of Care Coordination and TCLI, Trillium scored 100% of "Met" standards. Cardinal, Eastpointe, Sandhills and Vaya, scored "Partially Met" for one Care Coordination standard, and Alliance and Partners scored "Partially Met" for two Care Coordination standards. Alliance, Eastpointe, Partners, Sandhills, and Vaya scored "Partially Met" on one TCLI standard.

In the 2020 EQR, the PIHPs either improved or maintained a high percentage of "Met" for Care Coordination and TCLI standards. Alliance, Cardinal, Sandhills, Trillium, and Vaya scored 100% of "Met" standards. Eastpointe scored "Partially Met" on one Care Coordination standard, and Partners scored "Partially Met" on one TCLI standard. Recommendations to ensure policies and procedures align with the requirements of the *NC Medicaid Contract*, the NC Joint Communication Bulletins, Clinical Coverage Policies, and the federal regulations were issued to four PIHPs. The review of Care Coordination and TCLI files revealed significant improvements in producing the complete enrollee record, in the timeliness of progress notes and other Care Coordination and TCLI documentation. However, several PIHPs continue to struggle with non-compliance to their own policies and procedures and to the requirements of the *NC Medicaid Contract*.

Grievances and Appeals

42 CFR § 438, Subpart F, 42 CFR 483.430

PIHP compliance to contractual and federal regulations around Grievances and Appeals improved in the 2020 EQR. The PIHPs' average score of "Met" Grievance and Appeals standards increased from 85% in the 2019 EQR to 94% in the 2020 EQR.

In the 2020 EQR of Grievances, a common issue noted related to the PIHPs' inconsistent use of the terms for "an expression of dissatisfaction about any matter other than an Adverse Benefit Determination." This was also an issue noted in the 2019 EQRs. PIHPs typically use the terms "Grievance", "Complaint", "Concern", "Complaint/Grievance", etc. interchangeably in written materials such as policies, Enrollee Handbooks, Provider Manuals, and Grievance notifications. This inconsistency confuses the descriptions of Grievance processes and requirements in these public documents. Some PIHPs revised their written materials to reflect the use of a single term based on Recommendations and Corrective Actions from previous EQRs. However, three PIHPs still had documents that had not been completely revised to reflect one consistent term.

Another trend noted in the 2020 EQR of Grievances was a pattern of missing or incorrect language regarding the requirements when a PIHP extends the Grievance resolution timeframe. *42 CFR § 438.408 (c)(2)* outlines required written and verbal notifications from the PIHP to the enrollee regarding an extension, as well as the required timeframes for these notifications. Three PIHPs received Recommendations and Corrective Actions targeting missing or incorrect information within their Grievance policies, Provider Manuals, and Enrollee Handbook regarding the Grievance extension requirements.

The 2020 review of PIHP Appeal files showed PIHPs are compliant when resolving standard Appeals. However, PIHPs still struggle to process Appeals with more stringent Appeal requirements. Appeals such as verbal, extended, expedited, invalid, and withdrawn Appeals and Appeals of Administratively denied service authorizations are the most common types of appeals where PIHPs are out of compliance with providing the required verbal and written notifications.

Similarly, there was also a pattern of compliance issues within the PIHP's documentation around verbal, extended, expedited, invalid, and withdrawn Appeals and Appeals of Administratively denied service authorizations. Documentation such as the PIHP's Appeal procedure, Provider Manual, and Enrollee Handbook had missing or incorrect information around the required verbal and written notifications for these type of appeals. As a result, five of the PIHPs received a Corrective Action or Recommendation in the 2020 EQR to correct documentation to better guide staff in processing Appeals, as well as providing the public with accurate Appeal information.

Program Integrity

42 CFR § 438.455 and *1000* through*1008, 42 CFR § 1002.3(b)(3), 42 CFR 438.608 (a)(vii*

The 2020 EQR of each PIHP's Program Integrity (PI) program resulted in all PIHPs meeting 100% of the PI standards. This was an improvement in PIHP performance in PI when compared to last year's EQR. In the 2019 EQR, the PIHPs ranged in the percentage of "Met" scores from 92% (Vaya) to 100% (Alliance, Eastpointe, Partners and Trillium). There was evidence in this 2020 EQR that most of the PIHPs implemented all of the 2019 PI Corrective Actions and Recommendations.

All of the PIHPs demonstrated increased sophistication in data mining activities which can be seen in the percentage of investigations stemming from these activities. All of the PIHPs are now enrolled in Fraud Abuse Management System (FAMS) and several of the PIHPs and several are either working with the IBM team or have dedicated analytical personnel to developing new algorithms for detection. There is still room for improvement in the use of a standard case summary sheet as a single source for all key case review information.

Optional Activities

Encounter Data Validation

Based on the analysis of PIHP's Encounter data, it was concluded that the data submitted to NC Medicaid is complete and accurate as defined by NC Medicaid standards.

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 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 PIHPs. The goal is to ensure that PIHPs are reporting all paid claims as Encounters to NC Medicaid.

Semi-Annual Audits

North Carolina Senate Bill 208, Effective Operation of 1915(b)/(c) Waiver, requires that the Secretary of NC Department of Health and Human Services 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. HMS used statistical samples of Medicaid data from two six-month time periods in 2020 and 2021, March 1, 2020 through August 31, 2020 and September

2020 through February 2021. Both Semi Annual Audits conducted showed all PIHPs were compliant with the claims audit, timeliness of provider payments, financial solvency, and HIPAA transaction capability and compliance.

Enrollee Satisfaction Survey

Adult Survey

Regarding overall rating of counseling and treatment, Eastpointe's enrollees reported the highest satisfaction. Trillium's enrollees reported the lowest satisfaction. Vaya and Sandhills received the highest scores on two of the five composite items, and Vaya and Alliance received the highest scores on five of the ten single items. Vaya also received the highest score on five of the nine Care Coordination Items. All LME/MCOs received the lowest satisfaction scores for at least one item. All LME/MCOs except Cardinal received the highest satisfaction scores for at least one item.

Child Survey

Regarding overall rating of counseling and treatment, Eastpointe's enrollees reported the highest satisfaction and Cardinal's enrollees reported the lowest satisfaction. Of the four composite items, Partners received the highest scores on three of the items. Alliance and Vaya scored positively on five of the ten single item questions. Vaya enrollees also reported the highest satisfaction on four of the nine Care Coordination items. All LME/MCOs except Eastpointe received the lowest satisfactory scores for at least one item. All LME/MCOs except Cardinal received the highest satisfactory scores for at least one item.

Provider Satisfaction Survey

When rating overall satisfaction with the LME/MCOs, an average of 91% of the providers answered as either "Extremely Satisfied" or "Satisfied", a 2% increase from 2019. Partners and Sandhills had the highest percentage of satisfied providers with 96%. These two LME/MCOs also had the highest percentage of satisfied providers in the 2019 survey. Cardinal had the lowest rating of 88%, but an increase of 4% from the 2019 survey. Six of the LME/MCOs had an increase in overall satisfaction, including Partners, whose scores increased by 5% from 2019.

METHODOLOGY

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

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

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

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

Each PIHP's review consisted of two segments:

1. The first was a Desk Review of materials and documents received from the PIHPs (see *Attachment 2*). These materials addressed or included administrative functions, committee minutes, member and provider demographics and educational materials, and the QI and medical management programs. The Desk Review also included Credentialing, Grievance, utilization, Care Coordination, and Appeal files.

2. The second segment was a two-day Onsite review conducted at the PIHPs' designated corporate offices in North Carolina. These visits focused on areas not covered in the Desk Review and areas needing clarification. CCME's Onsite activities included entrance and exit conferences as well as interviews with PIHP administration and staff. All interested parties were invited to the entrance and exit conferences. Some of the PIHPs' scores were affected by delays or failure to submit the requested documentation.

FINDINGS

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

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

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

A. Administration

42 CFR § 438.224 and 42 CFR § 438.242

Information Systems Capabilities Assessment (ISCA)

The review of the PIHPs' systems capabilities involved review of the PIHPs' responses to the CMS standard ISCA questionnaire, interviews with key staff during the EQR Onsites, 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 (Cardinal and Partners). Three PIHPs showed improvement in Encounter claims submission capability (Cardinal, Partners, and Sandhills).

While all standards were met across the seven PIHPs, there is still room for improvement in the areas of capture and reporting of data. As examples, Alliance is able to capture and store up to 29 ICD-10 Diagnosis codes for Institutional Encounters. However, they are only submitting up to 12 ICD-10 Diagnosis codes on an Institutional Encounter data extract to NCTracks, Similarly, Cardinal can capture ICD-10 Procedure codes yet, they do not receive them from their providers on Institutional claims. Further, Sandhills does not

have the ability to submit ICD-10 Procedure codes on Encounter data extracts to NCTracks. Lastly, Trillium has the ability to capture ICD-10 Procedure codes for Professional claims but do not receive them on Institutional claims, and Trillium does not have the ability to submit DRG codes on Encounter data extracts to NCTracks. With effort, all of these areas could be addressed. Figure 2 and Table 4 present an overview of the PIHPs' performance in the Administrative section.

Figure 2: Administration

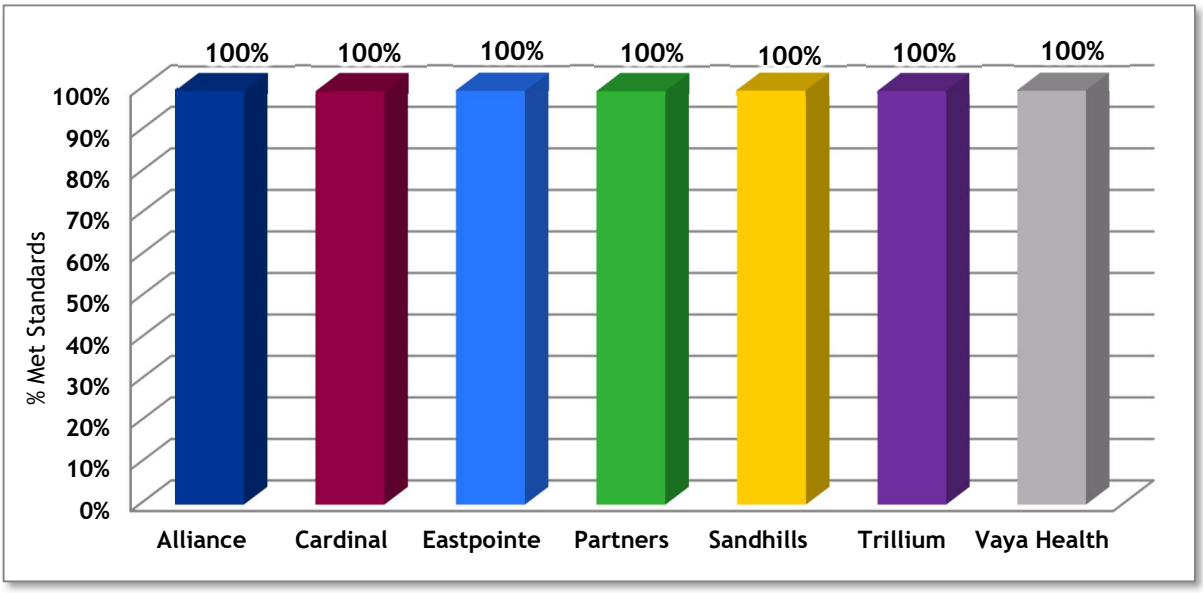


Table 4: Administration Comparative Data

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

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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
3. Reporting							
3.1 The PIHP's data repository captures all enrollment and claims information for internal and regulatory reporting.	Met	Met	Met	Met	Met ↑	Met	Met
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	Met ↑	Met	Met ↑	Met ↑	Met	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

- All seven PIHPs met 100% of the Administrative standards in this year's EQR.
- All PIHPs have the capability to submit all ICD-10 Diagnosis codes provided on the Encounter data extracts to NCTracks.
- Across the PIHPs, NCTracks Encounter data acceptance rates range between 95% and 100% monthly, for the combined Professional and Institutional extracts.

Weaknesses

- While Alliance is able to capture and store up to 29 ICD-10 Diagnosis codes for Institutional Encounters, they are only submitting up to 12 ICD-10 Diagnosis codes on an Institutional Encounter data extract to NCTracks.
- Though Cardinal and Trillium can capture ICD-10 Procedure codes, they do not receive them from their providers on Institutional claims. Sandhills does not have the ability to submit ICD-10 Procedure codes on Encounter data extracts to NCTracks.
- Trillium does not have the ability to submit DRG codes on Encounter data extracts to NCTracks.

Recommendations

- PIHPs should enhance Encounter data submission process to increase the number of ICD-10 Diagnosis codes included on an Institutional Encounter submission into NCTracks.
- PIHPs should ensure that their provides are submitting all required claims fields such as secondary diagnoses and making sure providers are not submitting the revenue code data in the procedure code field.

B. Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

The Provider Services EQR was comprised of Credentialing and Recredentialing, including a review of how new providers are oriented as well as a discussion of network gaps. CCME reviewed relevant policies and procedures, credentialing and recredentialing files, a sample of Credentialing Committee meeting minutes and materials for each PIHP, and select items on each PIHP's website. During an Onsite interview, the PIHP staff provided additional information, including information about the status of network gaps.

The 41 Credentialing/Recredentialing standards in the 2020 EQR remain the same as in the 2019 EQR. In the 2019 EQR of Credentialing and Recredentialing, Eastpointe scored "Not Met" for one standard and "Partially Met" for one standard, Cardinal scored "Partially Met" for six standards, and Trillium scored "Partially Met" for two standards. In the 2019 EQR, Alliance, Partners, Sandhills, and Vaya all received a score of "Met" for all Credentialing and Recredentialing standards. In the 2020 EQR, all seven PIHPs scored 100% for the Credentialing/Recredentialing standards.

Each PIHP has policies and procedures to guide the credentialing/recredentialing of providers. Some PIHPs also have other documents such as a *Credentialing Program*

Description, a *Credentialing Plan*, *Credentialing Bylaws*, or a *Credentialing Committee Charter*. 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, discusses, and makes credentialing decisions regarding provider applications that are "flagged" due to identified issues. The Credentialing Committee Meeting Minutes submitted for the EQR show that the committee at each PIHP met regularly with a quorum present at the meetings. Some of the PIHPs delegate some credentialing functions, such as to hospital systems for credentialing their practitioners, but the Credentialing Committee at each PIHP has the final authority to approve or disapprove credentialing and recredentialing applications.

The reviewed credentialing and recredentialing files were organized and contained appropriate information. Over the past several EQRs, the PIHPs have continued to improve their credentialing and recredentialing files. In the 2019 EQR, there were nine Credentialing or Recredentialing standards for which at least one PIHP scored a "Partially Met" or "Not Met". In the 2020 EQR, all PIHPs scored "Met" for all of the Credentialing or Recredentialing standards.

For the 2020 EQR, the most commonly-occurring issue for the submitted credentialing or recredentialing files was the failure to include all documents, such as the Ownership Disclosure information or documentation regarding required insurance, especially for licensed practitioners being credentialed/recredentialed for contracted agencies. When asked for the information, the PIHPs submitted the missing document(s), typically from the contracted agency file.

The other most frequently-occurring issue that resulted in a Recommendation to the PIHPs for the 2020 EQR was conflicting language across documents, especially regarding Credentialing Committee membership or what constitutes a quorum. The PIHPs need to ensure that the language across all documents is the same, such as ensuring the percentage that constitutes a quorum for Credentialing Committee meetings is the same in all documents that define what constitutes a quorum.

Under the COVID-19 flexibilities as outlined in *NC Medicaid Contract, Amendment #9*, the *Annual Network Adequacy and Accessibility Analysis* (gaps analysis) will be submitted "no later than ninety (90) calendar days after termination of the amendment." During the Onsite interviews, the staff of each PIHP provided an update regarding the status of the choice and access gaps identified in or subsequent to the last gaps analysis.

Figure 3 and Table 5 that follow provide an overview of the PIHPs' performance in the Provider Services section in the 2020 EQR.

Figure 3: Provider Services

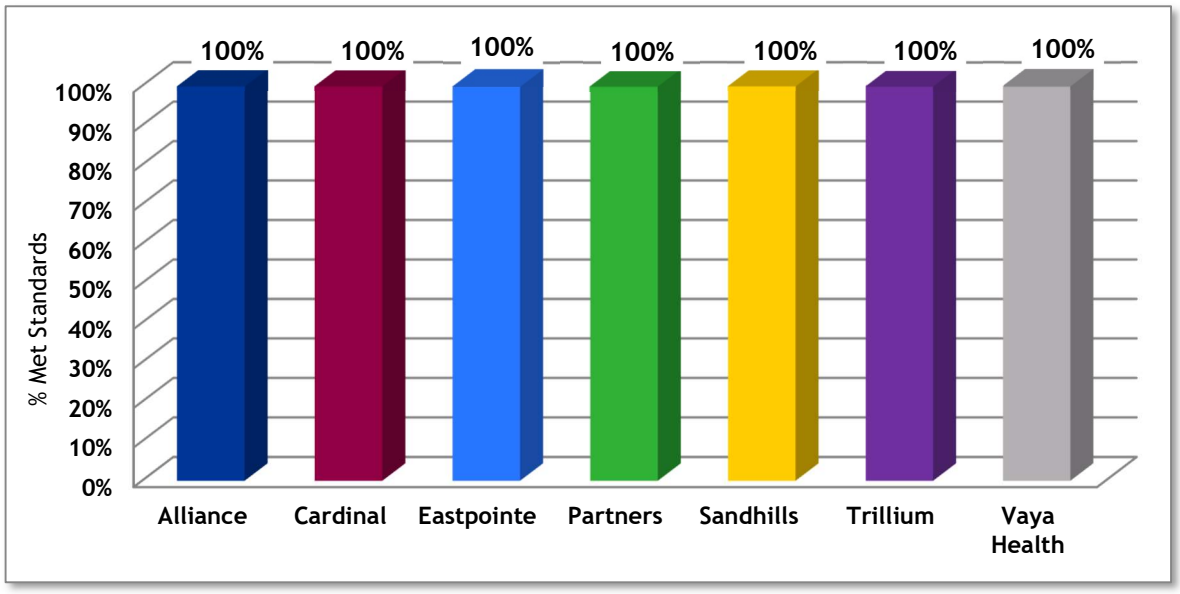


Table 5: Provider Services Comparative Data

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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	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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
3.1 Verification of information on the applicant including;							
3.1.1 Insurance requirements;	Met	Met ↑	Met	Met	Met	Met	Met
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees;	Met	Met	Met	Met	Met	Met	Met
3.1.3 Valid DEA certificate and/or CDS certificate;	Met	Met	Met	Met	Met	Met	Met
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	Met	Met	Met	Met	Met	Met	Met
3.1.5 Work History;	Met	Met	Met	Met	Met	Met	Met
3.1.6 Malpractice claims history;	Met	Met	Met	Met	Met	Met	Met
3.1.7 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
3.1.8 Query of the National Practitioner Data Bank (NPDB);	Met	Met	Met	Met	Met	Met	Met
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline) and query of the State Exclusion List;	Met	Met	Met	Met	Met	Met	Met
3.1.10 Query for the System for Awards Management (SAM);	Met	Met	Met	Met	Met	Met	Met
3.1.11 Query for Medicare and/or Medicaid sanctions Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE);	Met	Met	Met	Met	Met	Met	Met
3.1.12 Query of the Social Security Administration's Death Master File (SSADMF);	Met	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	Met ↑	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
3.1.16 Criminal background Check	Met	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
Recredentialing							
4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.	Met	Met	Met	Met	Met	Met	Met
4.1 Recredentialing every three years;	Met	Met	Met↑	Met	Met	Met	Met
4.2 Verification of information on the applicant, including:	Met	Met	Met	Met	Met	Met	Met
4.2.1 Insurance Requirements	Met	Met ↑	Met	Met	Met	Met	Met
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees;	Met	Met	Met	Met	Met	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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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
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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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	Met ↑	Met	Met	Met	Met ↑	Met
4.3 Site reassessment if the provider has had quality issues.	Met	Met	Met	Met	Met	Met	Met
4.4 Review of practitioner profiling activities	Met	Met	Met	Met	Met	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
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities	Met	Met	Met	Met	Met	Met	Met

Strengths, Weaknesses, and Recommendations are not inclusive for each PIHP. More details were included in the Provider Services section of each PIHP's *2020 External Quality Review Report*. The following is a sample of findings.

Strengths

- In response to COVID-19, each PIHP took actions to assist providers and ensure continued enrollee access to care.
- Credentialing/recredentialing files are well-organized and contain appropriate documentation.

- All PIHPs provide orientation for new providers. 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 or evidence of all required types of insurance. The PIHPs submitted the missing items upon request.

- At several of the PIHPs, procedures or other documents contained conflicting information regarding the Credentialing Committee, including items such as committee membership/composition or what constitutes a quorum.

Recommendations

- Ensure credentialing/recredentialing files submitted for the EQR are the complete files, with all required information, including, for example, the Ownership Disclosure information or evidence of all required types of insurance. For practitioners joining an already-contracted agency, this may be in the agency file but should be included in the practitioner file submitted for the EQR.

- Reconcile language across documents to accurately reflect Credentialing Committee information such as the committee membership/composition, which members can vote, or what constitutes a quorum.

C. Quality Improvement

42 CFR § 438.330

The 2020 Quality Improvement (QI) EQR included Performance Measures (PMs) and Performance Improvement Projects (PIPs) validation. CCME conducted a Desk Review of the submitted (b) and (c) Waiver Performance Measures and a review of each PIHP specific PIP Project Description Forms for validation, using CMS standard validation protocols. An Onsite discussion occurred to clarify measurement rates for each area.

In the 2019 EQR, Eastpointe, Sandhills, and Vaya received a score of "Partially Met" on meeting the requirements of the CMS EQR protocol *Validating Performance Improvement Projects*. The "Partially Met" scores were for varying reasons, including PIP reports not having benchmark rates for all indicators; the project aim and research question(s) not being documented clearly; and specific action plans not documented for indicators in which rates have not improved. The 2019 EQR validation scores for (b) Waiver and (c) Waiver Performance Measures were Fully Compliant, with an average validation score of 100% for both areas.

In the 2020 EQR, the 2019 Corrective Actions for the PIPs were implemented and maintained. Each PIHP received a score of "Met" in this QI section. Collectively, 37 PIPs scored in the "High Confidence" range. Collectively, there were 18 Recommendations issued that centered around showing improvement in the PIPs. Each PIHP has one or more PIP that did not show improvement. The number of PIPs not showing improvement in indicator rates was 49% collectively, and the number of PIPs not showing improvement in indicator rates for each PIHP is:

- Alliance = 5 PIPs showed no improvement
- Cardinal = 1 PIP showed no improvement
- Eastpointe = 3 PIPs showed no improvement
- Partners = 3 PIPs showed no improvement
- Sandhills = 1 PIP showed no improvement
- Trillium = 3 PIPs showed no improvement
- Vaya = 2 PIPs showed no improvement

Recommendations were given to each PIHP based on the specific PIPs that did not show improvement. For example, at Partners, a Recommendation was given for the Reducing ED Utilization of Active Members PIP to monitor interventions started in January 2020, including high touch care management, social detriments of health (SDOH) screening, crisis response training, and new member outreach to determine if the rate starts to improve toward (or decline from) goal rate. Another example includes a Recommendation given to Sandhills to continue interventions and determine if specific interventions are more beneficial as the COVID-19 crisis continues to limit contact with enrollees for the TCLI Transition Days PIP. Other Recommendations were issued but were not part of a trend for each PIHP.

For the 2020 EQR, the Performance Measure Query was accurate for (b) Waiver Measures, and all measures were validated at 100%, Fully Compliant, although there were some measures that had a substantial (>10%) rate decrease. In most cases, it was recommended to continue with current interventions for these (b) Waiver Measures. All PIHP's (c) Waiver Measures met or exceeded State benchmarks and were validated at 100%, Fully Compliant. Figure 4 and Table 6 demonstrate each PIHP's percentage of met standards in the Quality review, as well as the 2020 EQR standards and their scores of each PIHP.

Figure 4: Quality Improvement

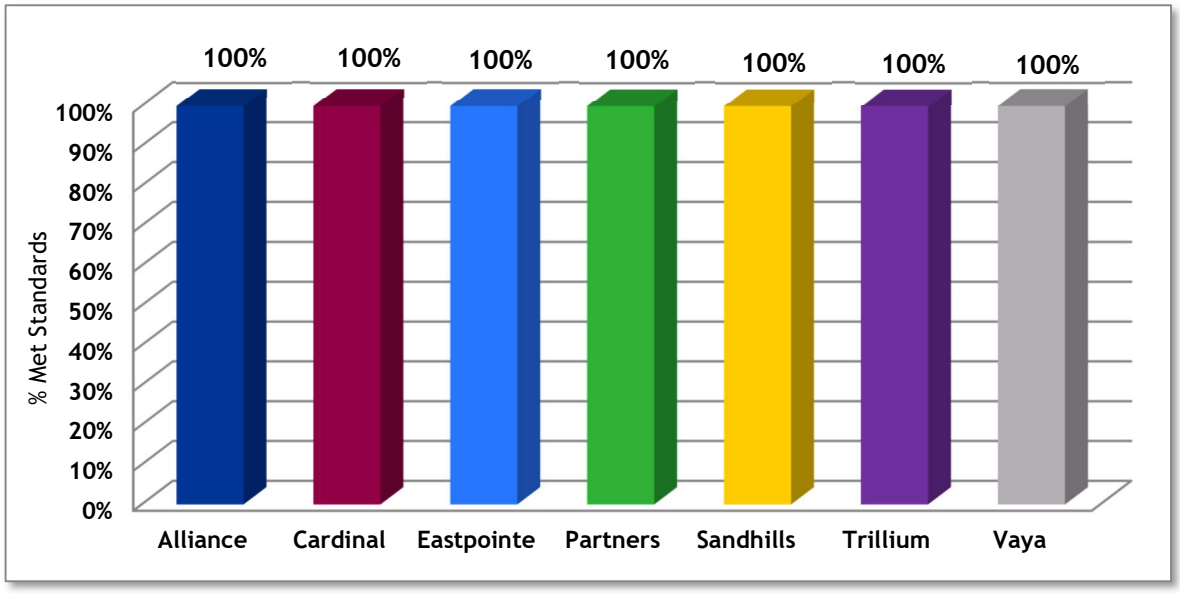


Table 6: Quality Improvement Comparative Data

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
IV A. 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 B. 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	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 protocol, *EQR Protocol 2: Validation of Performance Measures*. The validation process assesses the production of the latest measures by the PIHP to ensure what is submitted to NC Medicaid complies with the measure specifications, as defined in the *North Carolina LME-MCO Performance Measurement and Reporting Guide (September 17, 2013, Revised October 2014)*.

(b) Waiver Performance Measures

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

Table 7: (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 8 gives an overview of the 2020 (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 8: 2020 (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

Five (c) Waiver measures were validated for each PIHP. The average validation score was 100%. The reported percentages for each PIHP's measures are within *Table 9: 2020 (c) Waiver PM Validation Results Summary*, and the validation percentage for each PIHP's (c) Waiver measures is at the bottom of each column:

Table 9: 2020 (c) Waiver PM Validation Results Summary

Measure	Percentages Reported						
	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.	99.03%	100%	99.91%	100%	100%	98.73%	100%
Proportion of beneficiaries reporting they have a choice between providers.	99.03%	100%	99.81%	100%	100%	98.73%	100%
Percentage of level 2 and 3 incidents reported within required timeframes.	88%	90.15%	97.06%	86.11%	88.3%	85%	92.86%
Percentage of beneficiaries who received appropriate medication.	100%	100%	100%	100%	100%	100%	99.87%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.	92.86%	100%	100%	100%	100%	100%	100%
Average Validation Score & Audit Designation	**100% Fully Compliant**	**100% Fully Compliant**	**100% Fully Compliant**	**100% Fully Compliant**	**100% Fully Compliant**	**100% Fully Compliant**	**100% Fully Compliant**

Note: Annual rates reported by the PIHP at the time of the individual 2020 EQR.

Performance Improvement Project Validation Results

The validation of PIPs was conducted in accordance with the protocol developed by CMS titled, *EQR Protocol 1: Validating Performance Improvement Projects, October 2019*. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of each project.

All PIHPs received "High Confidence" validation decisions for all submitted PIPs. A summary of validation scores for each PIP, as well as validation decision category status, is presented in *Table 10: 2020 PIP Validation Results Summary*.

Table 10: 2020 PIP Validation Results Summary

PROJECT	VALIDATION SCORE	VALIDATION DECISION
ALLIANCE		
7-Day Super Measure – Medicaid DHB SUD*	79/79 = 100%	High Confidence in Reported Results
7-Day Super Measure – State DMH MH*	73/74 = 98.6%	High Confidence in Reported Results
7-Day Super Measure – State DMH SUD*	79/79 = 100%	High Confidence in Reported Results
Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM)*	73/74 = 98.6%	High Confidence in Reported Results
HEDIS Antipsychotic Adherence (SAA)*	73/74 = 98.6%	High Confidence in Reported Results
Diabetes Screenings for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (HEDIS SSD)*	79/79 = 100%	High Confidence in Reported Results
Transitions to Community Living Initiative (TCLI) Improve In-Reach Contact Rate	73/74 = 98.6%	High Confidence in Reported Results
CARDINAL		
Diabetes Screening for Individuals with Schizophrenia and Bipolar Disorder Who Are Using Anti-psychotic Medications*	79/79 = 100%	High Confidence in Reported Results
Metabolic Monitoring for Children and Adolescents on Anti-psychotics*	79/79 = 100%	High Confidence in Reported Results

PROJECT	VALIDATION SCORE	VALIDATION DECISION
Metabolic Monitoring for Adults on Anti-psychotics*	79/79 = 100%	High Confidence in Reported Results
TCLI Supported Employment	68/73 = 93%	High Confidence in Reported Results
Improving Timely Routine Access to Care	78/79 = 99%	High Confidence in Reported Results
EASTPOINTE		
Increase percentage of members who received a face-to-face service within 48 hours to 70%*	79/79 = 100%	High Confidence in Reported Results
Decrease state psychiatric hospital 30-day readmissions for high-risk members*	79/79= 100%	High Confidence in Reported Results
Increase the percentage of individuals who receive a 2nd service within or less than 14 days*	73/74 = 99%	High Confidence in Reported Results
Decrease Emergency Department admissions for active members to 20%*	73/74 = 99%	High Confidence in Reported Results
Decrease percentage of members who separate from transition to community living housing to 20% or less annually*	73/74 = 99%	High Confidence in Reported Results
Increase approval rate of Medicaid Encounter Claims to 95%	84/84 = 100%	High Confidence in Reported Results
Increase Follow up after discharge appointments to 40%	79/79 = 100%	High Confidence in Reported Results
PARTNERS		
Promoting Follow up Within 7 Days for Mental Health Treatment*	73/74=99%	High Confidence in Reported Results
Promoting Follow up Within 7 Days for SUD Treatment*	74/79=94%	High Confidence in Reported Results
ED Utilization*	68/74= 92%	High Confidence in Reported Results

PROJECT	VALIDATION SCORE	VALIDATION DECISION
PCP Referrals to Behavioral Health	79/79=100%	High Confidence in Reported Results
TCLI Member Housing Loss Reduction	74/74=99%	High Confidence in Reported Results
SANDHILLS		
Increase EBP for Medication Management*	79/80 = 99%	High Confidence in Reported Results
Assure Consistent Connection to Community Services Following FBC Services*	79/80 = 99%	High Confidence in Reported Results
Access to Routine BH Assessments	84/90 = 93%	High Confidence in Reported Results
TCLI Transition Days	72/74 = 97%	High Confidence in Reported Results
TRILLIUM		
Supermeasures SU*	73/74 = 99%	High Confidence in Reported Results
Supermeasures MH*	73/74 = 99%	High Confidence in Reported Results
ED Utilization*	79/79 = 100%	High Confidence in Reported Results
Utilization of MST*	73/74 = 99%	High Confidence in Reported Results
Monitoring of In-Reach Contacts for TCLI	84/84 = 100%	High Confidence in Reported Results
VAYA		
Access to Care: Routine*	79/79 = 100%	High Confidence in Reported Results
Community Crisis Management*	78/79=99%	High Confidence in Reported Results
ADATC VIP*	84/84 = 100%	High Confidence in Reported Results
TCLI PN Housing Usage	95/95 = 100%	High Confidence in Reported Results

**Indicates clinical focused PIP*

Strengths

- All seven of the PIHPs met the standards within this QI EQR section.
- Many of the PIHPs have specific quality initiatives that are unique to their catchment areas and their members.
- A total of 37 PIPs were validated. All validation decisions scored "High Confidence".
- Validation results for all (b) Waiver and (c) Waiver Performance Measures for all PIHPs were Fully Compliant at 100%.

Weaknesses

- 18 of 37 (49%) total PIPs validated did not show improvement.
  - Alliance = 5 PIPs did not show improvement
  - Cardinal = 1 PIP did not show improvement
  - Eastpointe = 3 PIPs did not show improvement
  - Partners = 3 PIPs did not show improvement
  - Sandhills = 1 PIP did not show improvement
  - Trillium = 3 PIPs did not show improvement
  - Vaya = 2 PIPs did not show improvement

Recommendations

The following Recommendations were given to each PIHP for the PIPs that did not show improvement in indicator rates.

Alliance:

- Continue current interventions for the (b) Waiver Performance Measure Follow-up After Hospitalization for Substance Abuse.
- For the 7-Day Super Measure, continue the current interventions of incentives, education, open access, provider scorecards, and Peer Bridger Programs. Determine if additional interventions should be implemented to improve rate toward the 40% benchmark.
- For the Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM) PIP, continue the current interventions of HealthCrowd campaign, planning for point of care testing, provider scorecards, and patient level data analysis. Determine if additional interventions should be implemented to improve rate toward the 35% benchmark.

- For the HEDIS Antipsychotic Adherence (SAA) PIP, continue the current interventions of HealthCrowd campaign, provider scorecards, and patient level data analysis. Determine if additional interventions should be implemented to improve the rate toward the 60% benchmark.
- For the TCLI Improve In-Reach Contact Rate PIP, continue the current interventions of data tracking/monitoring, assignments, and 80 day no contact tracking to determine if rate will improve to the goal of 95%.

Cardinal:

- For the Improving Timely Routine Access to Care PIP, continue to monitor the mobile engagement for members, use of calendars with providers, provider cancellation processes, confirming member information, and outreach to new providers. Continue to evaluate for Medicaid-specific member reasons for lack of attendance.
- For the TCLI Supported Employment PIP, remove the numerator and denominator labels and call them “number per quarter” and “number per year”. Create goal columns with quarterly goal and yearly goal and add the goal values to those columns. Since the results are not rates, the numerator and denominator labels can be omitted.

Eastpointe:

- Reduce the number of concurrent active PIPs to allow more focused improvement efforts on each individual PIP.
- The PIP workgroup on November 12, 2020 noted that they are going to focus on education to providers on initiation of services. Continue the initial interventions and the most recent interventions and monitor for improvement for the Increase the Percentage of Individuals Who Receive a 2nd Service Within or Less Than 14 Days PIP.
- The March 2020 PIP workgroup meeting focused on implementation of self-study tool and workflow, care specialists, and d/c team. Continue these interventions to determine if they reduce ED admissions for the Decrease Emergency Department Admissions for Active Members to 20% PIP.
- Determine if Freedom Funds can help keep the rate decreasing for the Decrease Percentage of Members Who Separate From Transition to Community Living Housing to 20% or Less Annually PIP. Work on increasing compliance of members and providing consistent information, as documented.

Partners:

- Continue current interventions for the (b) Waiver Performance Measure for the combined services rate of 7-day Follow-up After Hospitalization for Mental Illness, working to increase this rate.

- For the Promoting Follow up Within 7 Days for Mental Health Treatment PIP, continue to monitor interventions, especially given the new requirements for peer support, to determine if rates begins to improve. Determine if the engagement specialist and provider communication are resulting in improvement. Continue working on contact information for enrollees.

- For the Promoting Follow up Within 7 Days for SUD Treatment PIP, update the PIP report so that results in the table and graph are matched.

- For the Reducing ED Utilization of Active Members PIP, monitoring interventions started in January 2020, including high touch care management, SDOH screening, crisis response training, and new member outreach. Continue to monitor to determine if the rate starts to improve (decline) toward goal rate.

- For the Reducing ED Utilization of Active Members PIP, include annotations on the report to allow the reader to know the benchmark/final target rate and the short-term goal rate.

- For the TCLI-Member Housing Loss Reduction PIP, the interventions are noted in the report and address barriers. Continue interventions to determine if the upcoming rates improve based on monthly visits, service provider discussions, and identification of lack of resources associated with evictions.

Sandhills:

- Add a chi square or Fisher's exact test to compare rates and report the p-value in the results for the PIPs.

- Omit the Fisher's exact test as a method for validating the sample and use a random function in Excel as an alternative to generate random selection for the Access to Routine BH Assessments PIP.

- Add information in the Data Collection section on how the caller enters the data and the database system used for data collection for the Access to Routine BH Assessments PIP.

- Continue interventions and determine if specific interventions are more beneficial as the COVID-19 crisis continues to limit contact with enrollees for the TCLI Transition Days PIP.

Trillium:

- Identify and implement a plan to determine if family refusal can be mitigated; continue working on improving access; continue interventions of childcare coordinator training and education for families, schools, and DSS for the MST Utilization PIP.

- Continue with current active interventions and examine rate after review of internal process and protocols for scheduling are completed; data analysis for dually covered members is recommended to assess the impact on the measure for the Supermeasures MH PIP.

- Continue with current active interventions and examine rate after review of internal process and protocols for scheduling are completed; data analysis for dually covered members is recommended to assess the impact on the measure for the Supermeasures SU PIP.

Vaya:

- Continue interventions that focus on the hospital population for SUD Medicaid and Non-Medicaid admissions for the Community Crisis Management PIP, as those are not improving.

- Continue with documented interventions to get clarity on the process for managing TCLI housing, including real time updates for the TCLI PN Housing Usage PIP.

D. Utilization Management

42 CFR § 438.208

The 2020 EQR for Utilization Management (UM) focus on a review of the Care Coordination (CC), and the Transition to Community Living Initiative (TCLI) programs. CCME reviewed relevant CC and TCLI policies and procedures, Program Descriptions and Plans, enrollee notifications, Provider Manuals, Enrollee Handbooks, and job descriptions. A sample of files of enrollees participating in Mental Health/Substance Use Disorder (MH/SUD), Intellectual/Developmental Disability (I/DD), and TCLI Care Coordination were also reviewed. During the Onsite Interviews, PIHP staff provided additional information, including modification made to CC and TCLI programs in order to adhere to the COVID-19 flexibilities as outlined in *NC Medicaid Contract, Amendment #9*.

In the 2019 EQR, most PIHPs scored a high percentage of "Met" on CC and TCLI standards. In the 2020 EQR, the PIHPs either improved or maintained a high percentage of "Met" standards. Five PIHPs (Alliance, Cardinal, Sandhills, Trillium, and Vaya) scored 100% of "Met" CC and TCLI standards.

In accordance with *42 CFR § 438.208 (b*), all PIHPs had comprehensive policies and procedures in place to guide the delivery of CC to enrollees. However, the age requirement for enrollees to engage in Complex Case Management services did not align with *NC Medicaid Contract, Section 6.11.3.(c) (g),* which lists the ages as five to 21 years. The PIHPs defined ages that were not required by *NC Medicaid Contract*. Furthermore, information in the Enrollee Handbook often did not match what was listed in policy and

procedures. Three PIHPs (Alliance, Eastpointe, and Trillium) received Recommendations to revise policies and procedures and Enrollee Handbooks to reflect enrollment requirements for Complex Case Management that align with NC Medicaid contractual requirements.

Additionally, an update to the NC Innovations Waiver, issued on April 29, 2020, was not reflected in policies and procedures, and the Enrollee Handbook. *NC Joint Communication Bulletin #J362* allows PIHPs to exceed the waiver cost limit of $135,000 when one of three criteria are met. Recommendations to four PIHPs (Alliance, Cardinal, Eastpointe, and Trillium) consisted of updating policies and procedures, Enrollee Handbooks, and PIHP websites to include the exemptions to the NC Innovations Waiver cost limits as cited in *NC Joint Communication Bulletin #J362*.

To assure the coordination and continuity of care, a review of MH/SU, I/DD, and TCLI enrollee files was conducted. The review revealed significant improvement in producing the complete enrollee record, the timeliness of progress notes, and more proactive engagement with enrollees to address barriers to service and other crises. However, there are gaps in face-to-face visits an incomplete Home and Community-Based Service (HCBS) checklist, and inconsistent discharge practices to varying degrees for several of the PIHPs. For example, *NC Medicaid Contract, Section 6.3 (h)*, requires I/DD Care Coordinators to complete monthly face-to-face visits with enrollees receiving residential supports. The review found that some PIHPs conducted the face-to-face visits quarterly. Moreover, COVID-19 flexibilities, as outlined in *NC Medicaid Contract, Amendment #9,* allowed PIHPs to conduct face-to-face visits with the enrollee via phone or two-way video. However, it was found that some Care Coordinators only contacted the service provider. Corrective Actions issued to two PIHPs (Eastpointe and Partners) centered on the need to enhance the current monitoring plans by including a manual process that targets contractual compliance within CC and TCLI documentation and the PIHP's policies and procedures. Three PIHPs (Alliance, Trillium, and Vaya) received similar Recommendations. Figure 5 and Table 11 provide an overview of the PIHPs' performance in the UM section.

Figure 5: Utilization Management

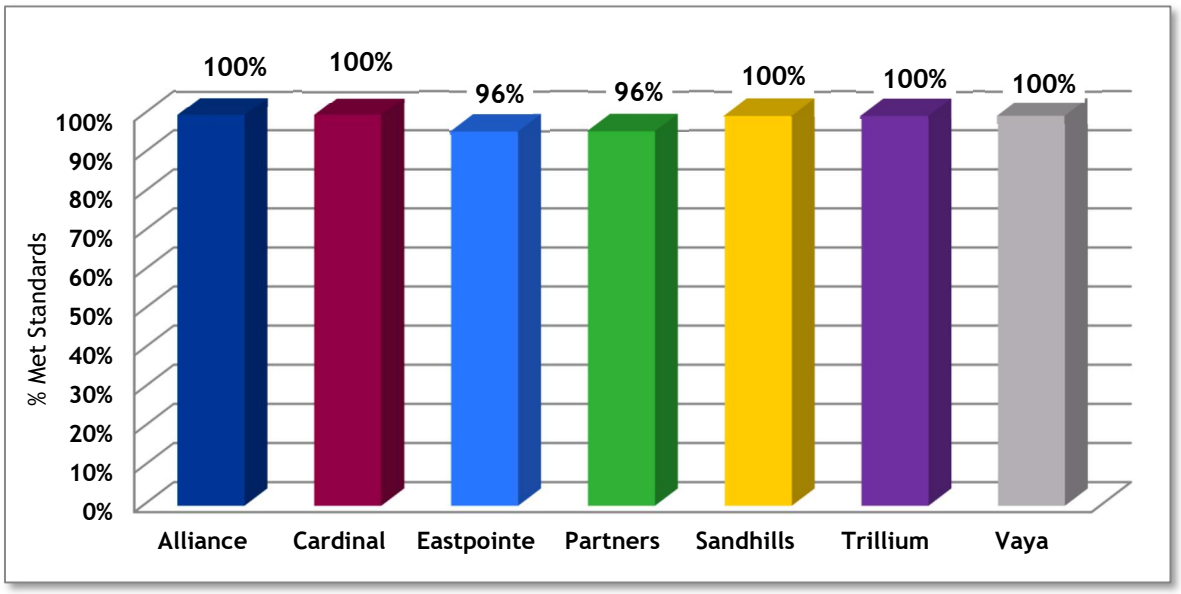


Table 11: Utilization Management Comparative Data

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
IV.A. Care Coordination							
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	Met	Met	Met	Met	Met	Met	Met
2. The case coordination program includes:							
2.1 Staff available 24 hours per day, seven days per week to perform telephone assessments and crisis interventions:	Met	Met	Met	Met	Met	Met	Met
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
2.3 Assess each Medicaid enrollee identified as having special health care needs;	Met	Met	Met	Met	Met	Met	Met
2.4 Develop treatment plans for enrollees that meet all requirements;	Met	Met	Met	Met	Met	Met	Met
2.5 Quality monitoring and continuous quality improvement;	Met ↑	Met	Met	Met	Met	Met	Met
2.6 Determine of which Behavioral Health Services are medically necessary;	Met	Met	Met	Met	Met	Met	Met
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	Met	Met	Met	Met	Met	Met	Met
2.8 Coordinate care with each Enrollee's provider;	Met	Met	Met	Met	Met	Met	Met
2.9 Provide follow-up activities for Enrollees;	Met	Met	Met	Met ↑	Met	Met	Met
2.10 Ensure privacy for each Enrollee is protected.	Met	Met	Met	Met	Met	Met	Met
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.	Met ↑	Met ↑	Partially Met	Met ↑	Met ↑	Met	Met ↑

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
IV.B. Transition to Community Living Initiative (TCLI)							
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
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 *NC Medicaid Contract*.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to 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.	Met ↑	Met	Met ↑	Partially Met	Met ↑	Met	Met ↑

Strengths, Weaknesses, and Recommendations are not inclusive for each PIHP. More details were included in the UM section of each PIHP 2019 External Quality Review Report. The following is a sample of findings.

Strengths

- Most PIHPs showed improvement in producing the complete enrollee record, the timeliness of progress notes, and other CC and TCLI documentation.
- Several PIHP implemented comprehensive and data-driven monitoring plans to target and measure compliance of Care Coordination documentation.
- All PIHPs increased engagement with enrollees and executed quality Care Coordination activities during the NC COVID-19 Stay-at-Home Order.

Weaknesses

- For a second year, PIHP policies and procedures did not consistently capture requirements found in the *NC Medicaid Contract*, the *Joint Communication Bulletins*, *Clinical Coverage Policies*, and the federal regulations.

- The review of MH/SU, I/DD and TCLI records showed patterns of non-compliance in most PIHP's enrollee records. Findings included non-compliance in monthly monitoring of residential supports and incomplete HCBS checklists for I/DD, and inconsistent discharge processes for MH/SU and TCLI.

Recommendations

- PIHPs need to ensure that policies and procedures capture the requirements of the *NC Medicaid Contract*, the *NC Joint Communication Bulletins*, *Clinical Coverage Policies*, and the federal regulations.

- PIHPs need to enhance the current documentation monitoring plan to routinely review the quality and completeness of MH/SU, I/DD and TCLI Care Coordination activities (e.g., CC face to face, HCBS monitoring, discharge activities, follow up activities, etc.)

E. Grievances and Appeals

42 CFR § 438, Subpart F, 42 CFR 483.430

The EQR of the PIHPs' Grievance and Appeal functions included a Desk Review of policies and procedures, Grievance and Appeal files, the Grievances and Appeals Logs, the PIHPs' Provider Operations Manuals, the PIHPs' Enrollee Handbooks, and information about Grievances and Appeals available on the PIHPs' websites. An Onsite discussion with Grievance and Appeal staff occurred to further clarify Grievance and Appeal documentation and processes. The PIHPs' average score of "Met" Grievance and Appeals standards increased from 85% in the 2019 EQR to 94% in the 2020 EQR.

Grievances

In the 2020 EQR, a common issue noted related to the PIHPs' inconsistent use of the terms for "an expression of dissatisfaction about any matter other than an Adverse Benefit Determination." This was also an issue noted in the 2019 EQRs. PIHPs typically use the terms "Grievance", "Complaint", "Concern", "Complaint/Grievance", etc. interchangeably in written materials such as policies, Enrollee Handbooks, Provider Manuals, and Grievance notifications. This inconsistency confuses the descriptions of Grievance processes and requirements in these public documents. In the 2020 EQR, it was evident the PIHPs revised their written materials to reflect the use of a single term based

on Recommendations and Corrective Actions from the previous EQR. However, Alliance, Partners, and Sandhills still had documents that had not been completely revised to reflect one consistent term.

Another trend noted in the 2020 EQR was a pattern of missing or incorrect language regarding the requirements when a PIHP extends the Grievance Resolution timeframe. *42 CFR § 438.408 (c)(2)* outlines required written and verbal notifications from the PIHP to the enrollee regarding an extension, as well as the required timeframes for these notifications. Eastpointe, Sandhills, and Trillium received Recommendations and Corrective Actions targeting missing or incorrect information within their Grievance policies, Provider Manuals, and Enrollee Handbook regarding the Grievance extension process.

Also, in the 2020 EQR there was improvement noted in the documentation of consultations with PIHP subject matter experts (SMEs), such as the Chief Medical Officer, Legal Department, Quality of Care Committees, etc. In previous EQRs, staff explained and policies reflected that Grievances are frequently staffed with PIHP SMEs. However, these consultations were not being captured within the Grievance files. In this year's EQR, PIHPs were able to demonstrate consultations around high risk or quality of care Grievances were occurring and captured within the Grievance file.

As a result of the PIHPs' efforts to address compliance findings in the previous EQRs of Grievances, the PIHPs' percentage of standards scored as "Met" increased from 94% in the 2019 EQR to 95% in the 2020 EQR.

Appeals

The 2020 EQR showed the PIHPs improved their compliance with Appeal federal regulations and *NC Medicaid Contract* requirements. In the 2019 EQR, the PIHPs met 77% of the Appeal EQR standards. In the 2020 EQR, the combined PIHP compliance with the Appeals standards increased to 94%.

The 2020 review of PIHP Appeal files showed PIHPs are compliant when resolving standard Appeals. However, PIHPs still struggle to process Appeals with more stringent Appeal requirements. Appeals such as verbal, extended, expedited, invalid, and withdrawn Appeals and Appeals of Administratively denied service authorizations are the most common types of appeals where PIHPs are out of compliance with providing the required verbal and written notifications. Corrective Actions and Recommendations were issued to six of the seven PIHPs (Alliance, Cardinal, Partners, Sandhills, Trillium and Vaya) to enhance their current Appeal monitoring processes to more closely those Appeals for compliance issues.

Similarly, there was also a pattern of incorrect or missing information around these types of appeals within the PIHPs' documentation such as the Appeal procedure, Provider Manual, and Enrollee Handbook. As a result, five of the PIHPs received a Corrective Action or Recommendation in the 2020 EQR to correct documentation. Alliance, Cardinal, and Sandhills had incorrect information in their Appeals procedure regarding expedited, extended, and/or invalid Appeals. Trillium had incorrect information in their *Provider Manual* and *Member & Family Handbook* regarding the requirement of the PIHP to notify the enrollee of their right to file a grievance if the PIHP extends the Appeal resolution timeframe. Eastpointe's *Enrollee/Member and Family Handbook* also did not have complete information regarding the required PIHP notifications related to extended Appeals. This notification is required by *42 CFR § 438.408 (c)(2)*.

Lastly, for the standard related to timeliness guidelines for resolution of the Appeal as specified in the contract, all PIHPs scored "Met". This was an improvement for both Eastpointe and Sandhills. This improvement was a result of the enhanced monitoring both PIHPs placed on monitoring resolution timeframes over the past year.

Figure 6 provides an overview of the EQR of PIHP Grievances and Appeals and indicates which of PIHPs' scores increased or decreased since the previous EQR.

Figure 6: Grievances and Appeals

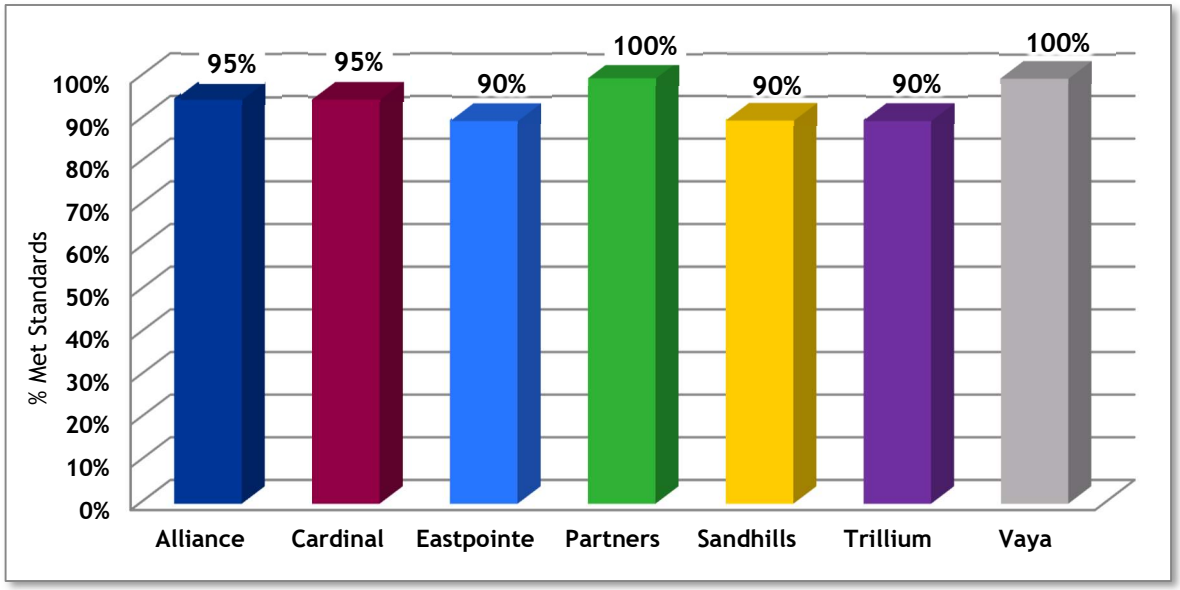


Table 12: Grievances and Appeals Comparative Data

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
V.A. GRIEVANCES							
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee Grievances in a manner consistent with contract requirements, including, but not limited to:	Met	Met	Met	Met	Met	Met	Met
1.1 Definition of a Grievance and who may file a Grievance;	Met	Met	Met ↑	Met	Met	Met	Met
1.2 The procedure for filing and handling a Grievance;	Met	Met	Met	Met	Met	Met	Met
1.3 Timeliness guidelines for resolution of the Grievance as specified in the contract;	Met	Met	Partially Met	Met	Met	Partially Met ↓	Met
1.4 Review of all Grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	Met	Met	Met	Met	Met	Met	Met
1.5 Maintenance of a log for oral Grievances and retention of this log and written records of disposition for the period specified in the contract.	Met	Met	Met	Met	Met	Met	Met ↑
2. The PIHP applies the Grievance policy and procedure as formulated.	Met ↑	Met	Partially Met ↓	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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
V.B. APPEALS							
1. The PIHP formulates and acts within policies and procedures for registering and responding to enrollee and/or provider Appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	Met	Met	Met	Met	Met	Met	Met
1.1 The definitions of an Appeal and who may file an Appeal;	Met ↑	Met	Met ↑	Met	Met ↑	Met	Met
1.2 The procedure for filing an Appeal;	Met ↑	Met ↑	Met	Met ↑	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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
1.5 Timeliness guidelines for resolution of the Appeal as specified in the contract;	Met	Met	Met ↑	Met	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	Met ↑	Met ↑	Met	Met	Met
2. The PIHP applies the Appeal policies and procedures as formulated.	Partially Met	Partially Met	Met	Met ↑	Partially Met ↓	Met	Met ↑
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	Met	Met	Met	Met	Met ↑	Met	Met
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	Met	Met	Met ↑	Met	Met	Not Met ↓	Met

Strengths

- As a result of implementing Recommendations and Corrective Actions issued in past EQRs, most PIHPs have improved language in their policies, procedures, Provider Manuals and Member Handbooks to outline Grievance requirements and processes in compliance with their *NC Medicaid Contract* and federal regulations
- As a whole, the PIHPs improved their percentage of "Met" Appeals scores from 77% in 2019 to 90% in the 2020 EQR.

Weaknesses

- Some PIHPs continue use the terms "Concerns", "Complainant", and "Complaint" interchangeably within their written documentation, which confuses descriptions of the Grievance process.
- Within their written documentation, PIHPs do not consistently and correctly explain the PIHP requirements around extensions to the Grievance resolution timeframe when extended by the PIHP. These requirements are outlined in *42 CFR § 438.408 (c)(2)*.

- PIHPs still struggle to process Appeals with more stringent PIHP requirements, such as verbal, extended, expedited, invalid, and withdrawn Appeals and Appeals of Administratively denied service authorizations.

- There is also a pattern of incorrect or missing information within PIHP written documentation (for example, Appeal procedures, Provider Manual, Enrollee Handbook) around verbal, extended, expedited, invalid, and withdrawn Appeals and Appeals of Administratively denied service authorizations.

Recommendations

- PIHPs should adopt one general term for "an expression of dissatisfaction about any matter other than an Adverse Benefit Determination", the ensure it is consistently used throughout all written materials such as the Enrollee Handbook, Grievance resolution notifications, Provider Manual, etc.

- There is a need for PIHPs to thoroughly review *42 CFR § 438.408 (c)(2)* and ensure all written documentation reflects the required steps when the PIHP extends the Grievance Resolution timeframe.

- PIHPs need to enhance their Appeal monitoring processes to review for other compliance besides just the Appeal resolution timeframe. The monitoring process should focus on those Appeals that require intricate steps by PIHPs when processing verbal, extended, expedited, and withdrawn Appeals and Appeals of Administratively Denied Service Authorizations.

- Within their written documentation, PIHPs do not consistently and correctly explain the PIHP requirements around processing and resolving verbal, extended, expedited, invalid, and withdrawn Appeals and Appeals of Administratively denied service authorizations.

F. Program Integrity

42 CFR § 438.455 and *1000* through *1008, 42 CFR § 1002.3(b)(3), 42 CFR 438.608 (a)(vii)*

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 interview with key compliance, legal, and investigations staff occurred to discuss the documentation and file review findings. This open-ended discussion allowed the PIHPs to describe in detail their processes, policies, and procedures related to detecting, investigating, and resolving alleged incidents of fraud, waste, and abuse. The Onsite interview also covered any

substantive changes in staff, policies, and volume of investigations as well as follow-up on any Recommendations or Corrective Actions issued in the 2019 EQR.

The 2020 EQR of each PIHP's PI program resulted in all PIHPs meeting 100% of the PI standards. This was an improvement in PIHP performance in PI when compared to the 2019 EQR. In the 2019 EQR, the PIHPs ranged in the percentage of "Met" scores from 92% (Vaya) to 100% (Alliance, Eastpointe, Partners, and Trillium). The 2020 EQR shows that most of the PIHPs implemented all of the 2019 PI Corrective Actions and Recommendations.

All of the PIHPs demonstrated increased sophistication in data mining activities, which can be seen in the percentage of investigations stemming from these activities. All of the PIHPs are now enrolled in Fraud Abuse Management System (FAMS), and several of the PIHPs are either working with the IBM team or have dedicated analytical personnel to develop new algorithms for detection. In the 2020 EQR, there were no cases of enrollee fraud from any of the PIHPs.

While all seven of the PIHPs met all of the required elements of review, CCME observed that there is still room for improvement in the use of a standard case summary sheet as a single source for all key case review information. Alliance and Partners have no single summary file. Vaya lacks a case aging tracker to alert unit management if a case investigation has not been initiated within ten days. These minor enhancements of process could reduce error and provide overall management of the PI case load. Figure 7 and Table 13 provide an overview of the PIHPs' performance in the Program Integrity 2020 EQR.

Figure 7: Program Integrity

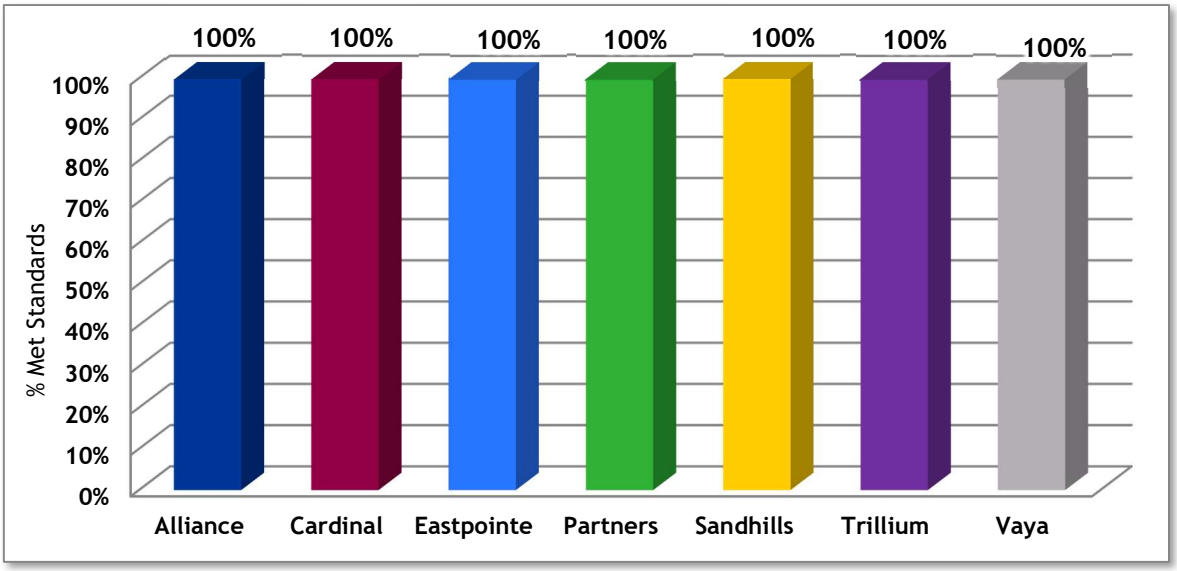


Table 13: Program Integrity Comparative Data

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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
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
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 CFR § 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 NC 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 by Division as provided in Section 13.2 – Monetary Penalties.	Met	Met	Met	Met	Met	Met	Met

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
9. In accordance with *42 CFR § 438.608(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.	Met	Met	Met	Met	Met	Met	Met

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

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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
10.3 In accordance with Attachment Y – Audits/Self-Audits/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.	Met	Met	Met	Met	Met	Met	Met
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;	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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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
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

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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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.	Met	Met	Met	Met	Met ↑	Met	Met
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);	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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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	Met
13.8 Total Sample Amount of Funds Investigated per Service Type.	Met	Met	Met	Met	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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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
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

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

Standard	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
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.							

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	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	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

- All PIHPs have now successfully implemented the FAMs system and are using data mining initiatives as part of their regular processes.
- PIHPs have continued to work towards reducing their backlog of PI cases.

Weaknesses

- PIHPs do not consistently utilize standard case summary sheet as a single source for all key case review information.

Recommendations

- All PIHPs would benefit from the use of a standard case summary sheet to provide a concise overview of the status of each investigation.

OPTIONAL ACTIVITY REVIEW RESULTS

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. NC Medicaid 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 2019 through December 2019. All claims paid should be submitted and accepted as a valid Encounter to NC Medicaid. The review included the following:

- A review of the PIHP's Information Systems Capability Assessment (ISCA) response
- A review of NC Medicaid's Encounter Data Acceptance Report
- Analysis of the PIHP's Encounter data elements

ISCA Review

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

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

the PIHP. The PIHP is required to resubmit Encounters for claims that may be rejected due to compliance errors or NC Medicaid edits marked as "DENY" in the individual report received.

HMS focused on the PIHP's response to Section *V. Encounter Data Submission* of the ISCA form related to all 837 Institutional and Professional claims paid from January 2019 through December 2019. *Table 14: Summary of ISCA Review* provides an overview of the ISCA review responses.

Table 14: Summary of ISCA Review

Claim Type	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Accepted	Percent Denied
Alliance					
Institutional	80,372	79,301	553	518	0.64%
Professional	1,999,519	1,990,578	6,317	2,624	0.13%
Total	2,079,891	2,069,879	6,870	3,142	0.15%

In 2019, Alliance submitted 2,027,891 unique Encounters to the State. To date, less than 1% of all 2019 Encounters submitted have not been corrected and accepted by NC Medicaid. Over the past few years, Alliance has made significant improvements to their Encounter submission process, increasing their acceptance rate and quality of Encounter data year over year. Overall denial rates, including resubmissions, have dropped from 7.13% in 2016 to 0.15% in 2019. The PIHP has a detailed reconciliation and correction process in place to ensure that all denials are reviewed, corrected, and resubmitted to NC Medicaid.

Claim Type	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Accepted	Percent Denied
Cardinal					
Institutional	115,585	115,323	254	8	0.01%
Professional	2,154,866	2,148,335	5,900	631	0.03%
Total	2,270,451	2,263,658	6,154	639	0.03%

In 2019, Cardinal submitted 2,270,451 unique Encounters to the State. To date, less than 1% of all 2019 Encounters submitted have not been corrected and accepted by NC Medicaid. Since 2016, Cardinal has made significant improvements to their Encounter submission process, increasing their acceptance rate and quality of Encounter data year over year. During that period, the overall denial rate, including resubmissions, dropped from 35% in 2016 to 0.03% in 2019. Cardinal has a dedicated Encounter Data Reconciliation Team which follows a detailed reconciliation and correction process to ensure that all denials are reviewed, corrected, and resubmitted to NC Medicaid.

Claim Type	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Accepted	Percent Denied
Eastpointe					
Institutional	111,732	88,989	17,212	5,531	5%
Professional	1,255,975	1,182,776	34,462	38,737	3%
Total	1,367,707	1,271,765	51,674	44,268	3%

In 2019, Eastpointe submitted 1,367,707 unique Encounters to the State. To date, 3% of all 2019 Encounters submitted have not been corrected and accepted by NC Medicaid. This figure represents an improvement in comparison to the 15% denial rate in 2018. However, it is noticeably higher compared to its peers. Additionally, Eastpointe has seen large fluctuations in denial rates between 2016 and 2019 (3% to 27%), including a regression in 2018 when the denial rate increased to 15% compared to 8% in 2017. Eastpointe took Corrective Actions in the latter part of 2018 to address these issues. The low denial rates seen during the second half of 2018 seemed to suggest that the new protocols Eastpointe implemented have been effective in eliminating erroneous submissions. However, another uptick in early 2019, which account for most of the denials seen in 2019, suggests that these issues require consistent monitoring to eliminate the duplicate denials.

Claim Type	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Accepted	Percent Denied
Partners					
Institutional	82,139	81,722	190	227	0.28%
Professional	1,364,357	1,356,233	8,040	84	0.01%
Total	1,446,496	1,437,955	8,230	311	0.02%

In 2019, Partners submitted 1,446,496 unique Encounters to the State. To date, 0.02% of all Encounters submitted have not been corrected and accepted by NC Medicaid. During the past four review periods, Partners has made significant improvements to their Encounter submission process, increasing their acceptance rate and quality of Encounter data year over year. Those process improvements are best reflected in the reduction of initial denials from 79,566 in 2016 to 8,541 in 2019. Compared to claims submitted in prior years, Partners continued to decrease the total number of initial denials and outstanding denials each year. According to Partners' response and review of NC Medicaid's acceptance report, 24% of all outstanding and ongoing denials are still related to invalid Taxonomy codes for the billing and rendering Provider. Partners has identified a strategy to continue to reduce, correct, and resubmit Encounter denials.

Claim Type	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Accepted	Percent Denied
Sandhills					
Institutional	32,606	30,537	239	1,830	5.61%
Professional	1,235,317	1,217,873	12,641	4,803	0.39%
Total	1,267,923	1,248,410	12,880	6,633	0.52%

In 2019, Sandhills submitted 1,267,923 unique Encounters to the State. Similar to the prior year, less than 1% of all 2019 Encounters submitted have not been corrected and accepted by NC Medicaid. However, Institutional claims saw a large increase in denial rate, up from 0.45% to 5.61%. A review of NC Medicaid 's acceptance report showed that most of the Institutional denials occurred in May 2019. Many of these denials were not resubmitted and accepted by NC Medicaid in 2019. Despite this fact, the overall denial rate in 2019 still decreased slightly compared to 2018. Overall, 28% of all denials were related to Taxonomy codes. Combined with an overall reduction in number of denials and decreasing share of Taxonomy code related denials, Sandhills continues to do a good job of reconciling and mitigating denials. Sandhills has developed several strategies for correcting Encounter denials.

Claim Type	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Accepted	Percent Denied
Trillium					
Institutional	52,943	52,004	400	539	1.02%
Professional	1,066,362	1,065,922	240	200	0.02%
Total	1,119,305	1,117,926	640	739	0.07%

In 2019, Trillium submitted 1,119,305 unique Encounters to the State. To date, 0.07% of all Encounters submitted in 2019 have not been corrected and accepted by NC Medicaid. This figure represents an improvement in comparison to the 1.29% denial rate seen in 2018. Each year, Trillium has made significant improvements to their Encounter submission process, increasing their acceptance rate and quality of Encounter data year over year. The review showed an increase in acceptance rate from 92% to 99.93% between 2017 and 2019, well above NC Medicaid's expectations. Trillium's very high acceptance rate in 2019 is even more notable when factoring in the increase in number of Encounters over the past few years.

Claim Type	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Accepted	Percent Denied
Vaya					
Institutional	42,237	40,592	483	1,162	2.75%
Professional	1,808,136	1,770,387	23,358	14,391	0.80%
Total	1,850,373	1,810,979	23,841	15,553	0.84%

In 2019, Vaya submitted 1,850,373 unique Encounters to the State. To date, 1% of all 2019 Encounters submitted have not been corrected and accepted by NC Medicaid. In recent years, Vaya has made significant improvements to their Encounter submission process, increasing their acceptance rate and quality of Encounter data year over year, increasing the acceptance rate from 73% to over 99%. However, 2019 saw a slight uptick in denials compared to the prior year. Most of this increase was concentrated among institutional Encounter submissions, which saw a 2.75% denial rate. Overall, 30.3% of all denials were Taxonomy code related, while 8.6% were due to suspected duplicates. Despite this, the overall denial rate in 2019 held relatively steady.

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 2019 through December 2019. Each PIHP pulled all claims adjudicated and submitted to NC Medicaid during 2019 and sent to HMS via a Secure File Transfer Portal (SFTP).

To evaluate the data, HMS imported the 837I and 837P data extracts and loaded them to a consolidated data base. After data onboarding was completed, HMS used proprietary, internally-designed data analysis tools to review each data element, focusing on the required data elements defined. These tools evaluate the presence of data in each field within a record, as well as whether the value for the field is within accepted State standards. The results of these checks were compared with general expectations for each data field and to the CMS standards adopted for Encounter data. *Table 15: Encounter Data Quality Standards* depicts the specific data expectation and validity criteria applied.

Table 15: 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
PIHP ID	Critical Data Element	100% valid

Data Quality Standards for Evaluation of Submitted Encounter Data Fields Adapted and Revised from CMS Encounter Validation Protocol		
Data Element	**Expectation**	**Validity Criteria**
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)
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-10-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.

Data Quality Standards for Evaluation of Submitted Encounter Data Fields Adapted and Revised from CMS Encounter Validation Protocol		
Data Element	**Expectation**	**Validity Criteria**
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]).
Patient Discharge Status Code (Hospital)	Should be valid codes for inpatient claims, with the most common code being "Discharged to Home." For outpatient claims, the code can be "not applicable."	For inpatient claims, expect >90% "Discharged to Home." Expect 1%–5% for all other values (except "not applicable" or "unknown").
Revenue Code	If the facility uses a UB04 claim form, this should always be present	100% valid

In addition to performing an evaluation of the submitted Encounter data, an HMS Analyst reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all Encounters submitted, accepted, and denied for each PIHP. The report is tracked by 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

Based on the analysis of PIHP's Encounter data, it was concluded that the data submitted to NC Medicaid is complete and accurate as defined by NC Medicaid standards. 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 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 PIHPs. The goal is to ensure that PIHPs are reporting all paid claims as Encounters to NC Medicaid.

Table 16 provides a summary of the Encounter data validation findings and related Recommendations.

Table 16: Overall Validation Results and Recommendations

Alliance		
Issue	**Findings**	**Recommendations**
Additional Diagnosis Codes	The secondary diagnosis was populated in more than 53% of all institutional claims but only 12.9% 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. However, all claims should be complete and accurate at all times and these figures suggest that some providers are not as diligent in coding and submitting Additional Diagnosis codes.	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 and, as a result, there were noticeable improvements in 2019. In addition, HMS recommends that Alliance identify providers who never or very rarely submit Additional Diagnosis codes and perform an outreach to remind them of their obligation to ensure that the claims they submit to Alliance are complete and accurate.

Cardinal		
Issue	**Findings**	**Recommendations**
Procedure Code	The Procedure code should be populated 99% of the time. In the Encounter data provided by Cardinal, 96.8% of claims contained a valid value in the Procedure code field. Among those flagged for issues, 220 of those claims contained a Revenue code instead of a Procedure code.	This issue was also highlighted during the 2017 and 2018 Encounter data validation reviews. The error rate did drop in 2019, but still there were 220 claims that contained a Revenue code in the Procedure code field. However, these errors did not appear to have affected provider reimbursements, as the Institutional claims in question were paid a set rate such as per diem. In the latter part of 2019, Cardinal adopted system edits to validate Procedure codes, which is expected to correct the issue moving forward.
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 nine digits followed by and alpha character. Of the Encounters submitted, 170 records were invalid. This is a smaller number than what was seen in 2018. 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 each Encounter being submitted matches to the state provided eligibility prior to submission. In some instances, the issue could be caused due to timing issues such as enrollees moving from the state program to Medicaid. In such cases, Cardinal should ensure the claim is paid under the correct program and that the proper identification number is submitted to NC Medicaid. Cardinal already validates 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.

Additional Diagnosis Codes	Other Diagnosis codes were populated less than 14% of the time for Professional claims. The absence of Other Diagnosis codes does not appear to be a mapping issue within Cardinal, but likely driven by some providers not coding beyond the Primary Diagnosis code. This value is not required by Cardinal when adjudicating the claim. Therefore, certain providers may not be submitting Other Diagnosis codes even in cases where they are present when submitting claims via Provider Web Portal or 837P.	Cardinal should work closely with their provider community and encourage them to submit all applicable Diagnosis codes, behavioral and medical. This information is key for measuring member health, identifying areas of risk, and evaluating quality of care.

Eastpointe		
Issue	**Findings**	**Recommendations**
Other Diagnosis	Principal and Admitting Diagnosis code was consistently populated where appropriate. However, Other Diagnosis codes were often missing, especially on Professional claims. This issue has been present since the 2017 review, when it was noted that only the Principal and Secondary Diagnosis codes were being submitted. In general, claims from certain providers are missing the Other Diagnosis code at an extremely high rate, including instances where they are missing on 100% of the claims. In the meantime, claims from other providers frequently show Other Diagnosis codes. This suggests that some providers are simply not coding Other Diagnosis codes or failing to map them onto the claims.	Eastpointe should continue to educate its providers on the importance of ensuring that the information on all claims are complete and accurate, including the Diagnosis codes. This effort should include urging providers to review their billing software to make sure all available Diagnosis codes are being mapped to the 837s. For providers who submit claims via the web portal, Eastpointe should advise them to review all the information to make sure the claim is complete and accurate, rather than simply copying a previously billed claim and changing only the date of service, Procedure code, and billed charges. Eastpointe should also continue to review the 837 Encounter mapping to ensure that providers are reporting all applicable Diagnosis Codes and that the PIHP is reporting them to NC Medicaid.

Submission of Duplicate Records or Incorrect Voids and Adjustments	Similar to 2018, the majority of the denials in 2019 resulted from their being suspected duplicates. While the overall denial rate has dropped significantly, it remains relatively high due to a large number of suspected duplicate denials.	Eastpointe should review the processes for selecting and submitting Encounter records. This review should encompass the following areas: • Identification and routing out claims based on program (Medicaid vs State-funded) • Selection of new Encounters to report • Mechanisms for tracking Encounter records that have been submitted • Posting 835 response files from NCTracks • Correcting and re-submitting previously denied Encounters • Mechanism for tracking re-submissions • Submission of voids and adjustments By analyzing the denials, Eastpointe should be able to determine which area is creating the highest number of denials. In the case of suspected duplicates, it is likely caused by resubmitting the same Encounter records more than once, or the timing of when void and adjustment to previous Encounters are submitted. This is an avoidable issue and improvements in tracking of Encounter submissions should drastically eliminate the suspected duplicate denials.

Partners		
Issue	**Findings**	**Recommendations**
Other Diagnosis Codes	The principal diagnosis was populated for 100% of the claims. However, less than 20% of all Encounter records show at least one valid Other Diagnosis code. Given that Partners currently reports the maximum number of Diagnosis codes accepted by NCTracks, the low figure suggests that many providers may not be reporting the Other Diagnosis codes. A closer examination reveals that some providers never report beyond the Primary/Principal Diagnosis code.	Partners should continue to perform outreach to providers, with a particular focus on those who never submit the Other Diagnosis codes. This information is key for measuring member health, identifying areas of risk, and evaluating quality of care.
Procedure Codes	The Procedure code for institutional claims should be populated 99% of the time. For the current review period, HMS found that 77% of institutional claim line items contained a valid value in the Procedure code field. The excluded line item charges where the Revenue code is sufficient for defining the service that was rendered.	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. Procedure codes were populated 98.76% of the time and, in each instance, a valid value present. However, when isolating for institutional claims, the figure drops significantly to 77%.

Sandhills		
Issue	**Findings**	**Recommendations**
Taxonomy code for Billing and Rendering providers	Taxonomy values were consistently populated; however, this is the most frequent denial reason among Sandhills' Encounter submissions. This information is key for passing the front end edits put in place by the State and to effectively price the claim. NCTracks is expecting the correct combination of NPI, Taxonomy code, and Procedure code. The Taxonomy code did not always match up with the Taxonomy values enrolled in NCTracks for the Billing and/or Rendering Provider and the service that was provided. These errors result in denials by the NC Medicaid that must be corrected and resubmitted.	Continue to follow the process built by Sandhills and AlphaMCS. As time passes and providers are educated, the initial denials due to invalid Taxonomy codes should naturally go down. Sandhills realized such improvement in 2019. The total number of denials related to the Taxonomy code has dropped significantly. Even in terms of percentage share of all denials, denials related to Taxonomy code accounted for a smaller percentage. In 2017 and 2018, invalid taxonomies made up 70% and 48% of all denials, respectively. This figure was 28% for 2019 and clearly shows the progress Sandhills has made. However, Taxonomy code remains, by far, the most common denial reason, suggesting there is still room for improvement through continued provider education and by following the processes to ensure reconciliation of Taxonomy codes between the provider, Sandhills, and NCTracks.
Other Diagnosis	Other Diagnosis codes were often missing, especially on Professional claims. Principal and admitting diagnoses were populated consistently, and Sandhills has made notable progress in reporting additional Diagnosis codes. However, too many Professional claims are missing additional Diagnosis codes.	Sandhills made significant progress in reporting additional Diagnosis codes, especially on Institutional claims. Some improvements were also seen in Professional claims. However, there are many providers who never report more than one Diagnosis code. To address this issue, it is recommended that Sandhills alert such providers to remind them to ensure that submitted claims are complete and accurate, including Diagnosis codes.

Trillium		
Issue	**Findings**	**Recommendations**
Additional Diagnosis Codes	Other Diagnosis codes were populated less than 17% of the time for Professional claims. This is a slight improvement compared to 13% that was seen on 2018 dates of service. The absence of Other Diagnosis codes does not appear to be a mapping issue within Trillium, but likely driven by some providers not coding beyond the Primary Diagnosis code. This value is not required by Trillium when adjudicating the claim, therefore, certain providers may not be submitting Other Diagnosis codes, even in cases where they are present when submitting claims via Provider Web Portal or 837P.	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.

Vaya		
Issue	**Findings**	**Recommendations**
Other Diagnosis	Principal Diagnosis codes were populated consistently where appropriate. However, Other Diagnosis codes were infrequently populated with only 17.7% of all Encounter records containing Other Diagnosis codes. One notable improvement was seen in institutional Encounters. Vaya completed a Corrective Action in 2019 and began submitting Other Diagnosis codes on Institutional claims.	We recommend that Vaya continue to educate its providers on the importance of complete and accurate coding. Vaya should also continue monitoring the reporting of Diagnosis codes and continue to take appropriate steps to improve both the quality and quantity of the Diagnosis code reporting. This would enable Vaya and NC Medicaid to get a more complete picture of the morbidities within the demographics it serves.

Invalid Procedure Code	During the review of 2019 Encounter data, HMS found that an outpatient institutional claim had paid despite the Procedure code being invalid. More specifically, the Encounter was an Emergency Department visit and there were two (2) evaluations and management (E&M) codes billed, both of which were paid by Vaya. The first E&M code was valid but there was a second E&M code "998325," which also paid. This error points to two separate issues. First, an invalid Procedure code should never be accepted by Vaya's system. This claim should have been rejected back to the provider. Second, this errant code is the second E&M code on the claim. It is unusual for two (2) separate E&M codes to be billed on the same Emergency Department Encounter. It is possible that a second E&M code should never have been billed.	We recommend that Vaya investigate this claim to determine how this claim was accepted and paid. Once the cause is identified, Vaya should update its claiming edits – both "front-end" and "back-end" – and ensure that invalid Procedure codes are rejected, regardless of how they are submitted. Vaya should also request more information from the provider to verify that a second E&M procedure was indeed performed and documented.

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 17 and 18 provide an overview of the HMS audits of the PIHPs' claims data and performance timeliness. HMS used random, stratified sampling method to assess claim processing and financial accuracy of claims processed and paid by PIHPs during two six-month time periods in 2020 and 2021. Additionally, HMS analyzed all claims to assess timeliness of payments to providers. All PIHPs were compliant with claims processing, financial accuracy, and timeliness of payments during those two six-month periods. Both Semi Annual Audits conducted showed all PIHPs were compliant with the claims audit, timeliness of provider payments, financial solvency, and HIPAA transaction capability and compliance.

Table 17: Claims Accuracy and Timeliness Review - Summary Findings March 2020 - August 2020

PIHP	Timeliness of Provider Payment (Within 30 Days)		Claims Processing Accuracy		Financial Accuracy	
	Results	Finding	Results	Finding	Results	Finding
Alliance	99.62%	Compliant	99.99%	Compliant	99.99%	Compliant
Cardinal	99.99%	Compliant	99.86%	Compliant	99.93%	Compliant
Eastpointe	100%	Compliant	99.91%	Compliant	99.90%	Compliant
Partners	100%	Compliant	100%	Compliant	100%	Compliant
Sandhills	100%	Compliant	99.89%	Compliant	99.96%	Compliant
Trillium	100%	Compliant	99.94%	Compliant	99.96%	Compliant
Vaya	99.92%	Compliant	99.24%	Compliant	99.82%	Compliant

Data were based on a statistical sample of Medicaid claims processed from March 1, 2020 through August 31, 2020 for each PIHP.

Table 18: Claims Accuracy and Timeliness Review - Summary Findings September 2020 - February 2021

PIHP	Timeliness of Provider Payment (Within 30 Days)		Claims Processing Accuracy		Financial Accuracy	
	Results	Finding	Results	Finding	Results	Finding
Alliance	99.42%	Compliant	99.99%	Compliant	99.99%	Compliant
Cardinal	100%	Compliant	99.96%	Compliant	99.97%	Compliant
Eastpointe	100%	Compliant	95.95%	Compliant	99.97%	Compliant
Partners	100%	Compliant	100%	Compliant	100%	Compliant
Sandhills	100%	Compliant	99.97%	Compliant	99.98%	Compliant
Trillium	100%	Compliant	99.99%	Compliant	99.98%	Compliant
Vaya	99.93%	Compliant	99.84%	Compliant	99.92%	Compliant

Data were based on a statistical sample of Medicaid claims processed from September 1, 2020 through February 28, 2021 for each PIHP.

Tables 19 through 26 provide an overview of the results of the financial solvency review. Tables 19 and 26 provide a snapshot of current ratios. HMS analyzed each PIHP's financial reports and reviewed total assets and liabilities at the end of each month. A current ratio greater than 1.0 indicates that total assets are greater than outstanding liabilities and is therefore considered compliant. Time periods are noted in each table. For this audit period, HMS found that all PIHPs were compliant.

Table 19: Financial Solvency Review - Summary Findings (Current Ratio > 1.0 is Compliant)

PIHP	March 2020	April 2020	May 2020	June 2020	July 2020	August 2020
Alliance	2.56	2.59	2.37	2.90	2.61	3.00
Cardinal	1.93	1.87	2.02	1.99	2.26	2.18
Eastpointe	2.03	1.93	1.77	1.56	1.57	1.67
Partners	1.03	1.31	1.51	2.11	2.16	2.20
Sandhills	3.14	3.39	3.31	4.12	3.24	3.08
Trillium	1.41	1.31	1.39	1.77	1.69	1.79
Vaya	3.40	3.15	2.74	3.73	3.13	2.99

Data were based on financial information combined for state and Medicaid funds March 1, 2020, through August 31, 2020 for each PIHP.

Table 20: Financial Solvency Review - Summary Findings (Current Ratio > 1.0 is Compliant)

PIHP	September 2020	October 2020	November 2020	December 2020	January 2021	February 2021
Alliance	2.77	2.79	2.70	2.84	2.88	2.75
Cardinal	1.66	1.58	1.59	1.89	1.83	1.75
Eastpointe	1.98	2.03	2.07	2.29	2.28	2.45
Partners	2.33	2.33	2.26	2.24	2.28	2.38
Sandhills	3.69	3.10	3.81	3.90	5.16	5.11
Trillium	1.47	1.59	1.64	1.59	1.40	1.42
Vaya	3.22	2.73	2.73	2.35	2.41	2.32

Data were based on financial information combined for state and Medicaid funds from September 1, 2020 through February 28, 2021 for each PIHP.

Tables 21 and 22 provide an overview of each PIHP's profitability for each month. HMS analyzed each PIHP's financial reports and reviewed total expenses for each month and how they compare to total revenue for that month. To be deemed non-compliant, PIHP must show three (3) consecutive months where monthly expenses exceeded monthly revenue. Time periods are noted in each table. For this audit period, HMS found that all PIHPs were compliant.

Table 21: Financial Solvency Review – Total Expenses

PIHP	March 2020	April 2020	May 2020	June 2020	July 2020	August 2020
Alliance	87%	98%	105%	76%	86%	85%
Cardinal	89%	84%	79%	98%	87%	93%
Eastpointe	98%	96%	98%	103%	93%	87%
Partners	99%	97%	98%	79%	93%	90%
Sandhills	105%	99%	111%	98%	98%	95%
Trillium	106%	108%	97%	80%	97%	92%
Vaya	101%	98%	99%	76%	89%	90%

Data were based on financial information combined for state and Medicaid funds March 1, 2020, through August 31, 2020 for each PIHP.

Table 22: Financial Solvency Review – Total Expenses

PIHP	September 2020	October 2020	November 2020	December 2020	January 2021	February 2021
Alliance	89%	87%	92%	83%	95%	96%
Cardinal	88%	96%	90%	87%	90%	102%
Eastpointe	87%	103%	84%	80%	96%	80%
Partners	90%	94%	92%	93%	98%	89%
Sandhills	84%	91%	85%	91%	87%	92%
Trillium	109%	102%	95%	105%	106%	88%
Vaya	92%	102%	90%	92%	92%	85%

Data were based on financial information combined for state and Medicaid funds for September 1, 2020 through February 28, 2021 for each PIHP.

Tables 23 and 24 provide an overview of defensive interval ratios. HMS analyzed cash plus current investments reported by PIHP at the end of each month and compared to daily operating expenses. After excluding all non-cash expenses, HMS calculated defensive interval ratios for each month to assess the number of days PIHP can continue to be solvent at the current level of expenses even if revenue were to be disrupted. To be deemed non-compliant, PIHP must show three (3) consecutive months where the defensive interval ratio fell below 30. Time periods are noted in each table. For this audit period, HMS found that all PIHPs were compliant.

Table 23: Financial Solvency Review – Defensive Interval Summary Findings

PIHP	March 2020	April 2020	May 2020	June 2020	July 2020	August 2020
Alliance	53.48	50.02	54.25	53.40	59.42	64.00
Cardinal	44.62	48.70	42.44	55.28	62.39	62.58
Eastpointe	36.82	32.27	30.94	24.40	35.67	35.89
Partners	27.98	38.07	46.31	47.09	62.05	62.37
Sandhills	72.98	73.59	67.98	55.74	70.44	75.90
Trillium	27.45	28.02	34.32	31.71	37.57	41.81
Vaya	57.24	59.87	66.21	68.88	76.65	83.24

Data were based on financial information combined for state and Medicaid funds March 1, 2020, through August 31, 2020 for each PIHP.

Table 24: Financial Solvency Review – Defensive Interval Summary Findings

PIHP	September 2020	October 2020	November 2020	December 2020	January 2021	February 2021
Alliance	65.50	75.88	74.73	91.42	80.72	75.35
Cardinal	46.51	47.67	54.52	64.43	64.29	53.09
Eastpointe	32.50	41.50	43.60	55.02	41.89	51.68
Partners	67.71	65.98	71.03	75.56	71.16	71.10
Sandhills	78.78	79.17	82.97	84.02	81.68	75.43
Trillium	31.48	37.87	38.90	33.33	33.93	39.74
Vaya	78.21	78.54	90.54	9.26	96.93	100.36

Data were based on financial information combined for state and Medicaid funds from September 1, 2020 through February 28, 2021.

Tables 25 and 26 provide an overview of PIHP's compliance with HIPAA transactions. HMS analyzed each type of HIPAA transactions submitted to NC Medicaid to determine whether they are compliant with X12N transaction standards. Time periods are noted in each table. For this audit period, HMS found that all PIHPs were compliant.

Table 25: HIPAA Transaction Review - Summary Findings

PIHP	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 financial information combined for state and Medicaid funds March 1, 2020, through August 31, 2020 for each PIHP.

Table 26: HIPAA Transaction Review - Summary Findings

PIHP	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 financial information combined for state and Medicaid funds from September 1, 2020 through February 28, 2021.

Consumer Satisfaction Survey

The *2020 ECHO Consumer Satisfaction Surveys* were administered from August 24, 2020 through November 18, 2020 to assess consumer perceptions of the seven LME/MCOs. CCME's subcontractor, DataStat, implemented this survey and analyzed the data. The results from this survey provide NC Medicaid a method to monitor the service quality of each LME/MCO, as well as the quality of care received from the LME/MCO's networks of providers.

Survey Description

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program, which is funded by the Agency for Healthcare Research & Quality (AHRQ), supports, and provides surveys for assessing different health care settings[1]. In preparation for the 2020 survey, NC Medicaid chose the *CAHPS* adult and child versions of the *ECHO Survey for Managed Behavioral Healthcare Organizations, version 3.0*, specifically, surveys 252A (Adult –English), 252B (Adult – Spanish), and 255 (Child). Each survey has more than 50 questions providing specific details and insight into the counseling and treatment enrollees receive, as well as the quality of health care services provided by the LME/MCO.

Consumer Survey Assistance

CCME requested consumer information from each of the seven LME/MCOs in a standard format. The letter to the LME/MCOs 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

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

- A designation of the types of services the enrollee receives; Mental Health (MH), Substance Use (SU), and/or Intellectual/Developmental Disabilities (I/DD) services

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

Consumer Survey Assistance

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

Survey Implementation

The survey was administered using a paper, direct-mail strategy with phone follow-up. Additionally, a link to a web-based survey was included in all mailed survey packets and reminder postcards. Table 27 provides an overview of the survey activities.

Table 27: Survey Administration Timeline

Task	Month / Year
Surveys mailed	August 24, 2020
1st mailing of reminder postcards	August 31, 2020
2nd mailing of survey packets	September 7, 2020
2nd mailing of reminder postcards	September 14, 2020
3rd mailing of survey packets	September 21, 2020
Survey closed	November 18, 2020

Adult Survey Sample and Response Rate

A total random sample of 3,997 cases was drawn of adult enrollees from the LME/MCOs. Sampling was based on population proportions for I/DD, SU, and MH enrollees. A final random sample of 571 enrollees from each LME/MCO was selected. The sample was

drawn from a list of all eligible adult (ages 18 and older) Medicaid beneficiaries provided by each LME/MCO.

Table 28: Final Response Rate and Number of Completed Surveys by LME/MCO - Adult Sample

LME/MCO	Survey Response Rate	Number of Completed Surveys
Alliance	13%	74
Cardinal	16%	92
Eastpointe	13%	73
Partners	13%	74
Sandhills	14%	77
Trillium	16%	92
Vaya	16%	92
NC Overall	**14%**	**574**

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

Findings Summary - Adult

The results of the survey are summarized in Table *TBD*. The table provides results in the four categories recommended by the Agency for Healthcare Research Quality (AHRQ), as follows:

- Global Ratings: measures of overall ranking of the quality of counseling and treatment received by respondents
- Composite Measures: aggregates of multiple questions measuring similar dimensions of care and treatment using the same scale
- Single Item Measures: single questions selected as key topics to track from the survey

- Care Coordination Measures: single questions selected as a gauge of enrollee satisfaction with Care Coordinators

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

Conclusion

Table TBD, 2020 Consumer Satisfaction Survey Findings Summary - Adult Sample, displays the NC overall percentages on Global, Composite, and Individual items, as described in the "Findings" section of this report. The table offers specific areas in which each LME/MCO may improve performance.

Regarding overall rating of counseling and treatment, Eastpointe's enrollees reported the highest satisfaction. Trillium's enrollees reported the lowest satisfaction. Vaya and Sandhills received the highest scores on two of the five composite items, and Vaya and Alliance received the highest scores on five of the ten single items. Vaya also received the highest score on five of the nine Care Coordination Items. All LME/MCOs received the lowest satisfaction scores for at least one item. All LME/MCOs except Cardinal received the highest satisfaction scores for at least one item.

Table 29: 2020 Consumer Satisfaction Survey Findings Summary – Adult Sample

Item	NC Aggregate Adult (%)	LME/MCOs with Highest and Lowest Category Percentage	
		High	Low
GLOBAL			
Overall Rating of Counseling and Treatment	70%	Eastpointe (78%)	Trillium (63%)
COMPOSITE			
Getting Treatment Quickly	68%	Vaya (75%)	Sandhills (59%)
How Well Clinicians Communicate	91%	Eastpointe (94%)	Cardinal (88%)
Getting Treatment and Information from the LME/MCO	53%	Sandhills (69%)	Alliance (13%)

Item	NC Aggregate Adult (%)	LME/MCOs with Highest and Lowest Category Percentage	
		High	Low
Perceived Improvement	56%	Vaya (61%)	Eastpointe (49%)
Information About Treatment Options	53%	Sandhills (62%)	Partners (46%)
SINGLE ITEM			
Office Wait (seen within 15 minutes)	73%	Vaya (86%)	Partners (58%)
Told About Medication Side Effects	80%	Alliance (90%)	Partners (71%)
Including Family and Friends	57%	Vaya (63%)	Eastpointe (49%)
Information to Manage Condition	80%	Alliance (90%)	Vaya (69%)
Patient Rights Information	88%	Vaya (94%)	Cardinal (83%)
Patient Feels He or She Could Refuse Treatment	77%	Vaya (88%)	Sandhills (68%)
Privacy of treatment information	94%	Eastpointe (100%)	Trillium (90%)
Cultural Competency	97%	Alliance, Eastpointe, Partners, Sandhills, Trillium, and Vaya (100%)	Cardinal (83%)

Item	NC Aggregate Adult (%)	LME/MCOs with Highest and Lowest Category Percentage	
		High	Low
Amount Helped	81%	Alliance (91%)	Cardinal (77%)
Treatment After Benefits Are Used Up	62%	Alliance (80%)	Trillium and Vaya (33%)
CARE COORDINATION			
Access to Care Coordinator	89%	Vaya (96%)	Cardinal (78%)
Care Coordinator responds in timely manner	88%	Trillium (95%)	Cardinal (74%)
Care Coordinator helps with answers to questions	91%	Eastpointe (100%)	Cardinal (79%)
Care Coordinator helps find services/support	84%	Vaya (96%)	Sandhills (71%)
Care Coordinator asks how best to support me	91%	Vaya (96%)	Cardinal (84%)
Received draft of Person Centered Plan to review	86%	Alliance and Sandhills (92%)	Cardinal (79%)
Satisfied with Person Centered Plan	90%	Eastpointe (100%)	Cardinal (75%)
Revisions were added to plan if requested	44%	Sandhills and Vaya (100%)	Alliance, Partners, and Trillium (0%)
Care Coordinator discusses appeal process and submission	57%	Eastpointe (86%)	Partners (43%)

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 LME/MCO was selected. The sample was drawn from a list of all eligible children (ages 12 to 17) Medicaid beneficiaries provided by each LME/MCO. The survey was provided in English and Spanish. Table 30 provides the response rates for each LME/MCO.

Table 30: Final Response Rate and Number of Completed Surveys by LME/MCO- Child Sample

LME/MCO	Survey Response Rate	Number of Completed Surveys
Alliance	14%	80
Cardinal	11%	61
Eastpointe	12%	68
Partners	13%	75
Sandhills	11%	61
Trillium	13%	76
Vaya	15%	85
NC Overall	**13%**	**506**

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

Findings Summary - Child

The results of the survey are summarized in Table 31 using the three categories recommended by AHRQ, as follows:

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

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

Conclusion

Table 31, 2020 Consumer Satisfaction Survey Findings Summary - Child Sample, displays the NC overall percentages on Global, Composite, and Individual items, as described in the "Findings" section of this report. Table 31 offers specific areas in which each LME/MCO may improve performance.

Regarding overall rating of counseling and treatment, Eastpointe's enrollees reported the highest satisfaction and Cardinal's enrollees reported the lowest satisfaction. Of the four composite items, Partners received the highest scores on three of the items. Alliance and Vaya scored positively on five of the ten single item questions. Vaya enrollees also reported the highest satisfaction on four of the nine Care Coordination items. All LME/MCOs except Eastpointe received the lowest satisfactory scores for at least one item. All LME/MCOs except Cardinal received the highest satisfactory scores for at least one item.

Table 31: Consumer Satisfaction Survey Findings Summary - Child Sample

Item	NC Aggregate Child (%)	LME/MCOs with Highest and Lowest Category Percentage	
		High	Low
GLOBAL			
Overall Rating of Counseling and Treatment	64%	Eastpointe (79%)	Cardinal (43%)
COMPOSITE			
Getting Treatment Quickly	69%	Partners (81%)	Cardinal (58%)
How Well Clinicians Communicate	90%	Partners (95%)	Cardinal (86%)
Getting Treatment and Information from the LME/MCO	50%	Trillium (63%)	Cardinal (21%)

Item	NC Aggregate Child (%)	LME/MCOs with Highest and Lowest Category Percentage	
		High	Low
Perceived Improvement	59%	Partners (65%)	Cardinal (51%)
SINGLE ITEMS			
Office Wait (seen within 15 minutes)	73%	Vaya (86%)	Partners (58%)
Told About Medication Side Effects	80%	Alliance (90%)	Partners (71%)
Told about different treatments available	59%	Vaya (69%)	Partners (50%)
Information to Manage Condition	80%	Alliance (90%)	Vaya (69%)
Patient Rights Information	88%	Vaya (94%)	Cardinal (83%)
Patient Feels He or She Could Refuse Treatment	77%	Vaya (88%)	Sandhills (68%)
Privacy of treatment information	94%	Eastpointe (100%)	Trillium (90%)
Cultural Competency	97%	Alliance, Eastpointe, Partners, Sandhills, Trillium, and Vaya (100%)	Cardinal (83%)
Amount Helped	81%	Alliance (91%)	Cardinal (77%)

Item	NC Aggregate Child (%)	LME/MCOs with Highest and Lowest Category Percentage	
		High	Low
Treatment After Benefits Are Used Up	62%	Alliance (80%)	Trillium and Vaya (33%)
CARE COORDINATION ITEMS			
Access to Care Coordinator	89%	Vaya (96%)	Cardinal (78%)
Care Coordinator responds in timely manner	88%	Trillium (95%)	Cardinal (74%)
Care Coordinator helps with answers to questions	91%	Eastpointe (100%)	Cardinal (79%)
Care Coordinator helps find services/support	84%	Vaya (96%)	Sandhills (71%)
Care Coordinator asks how best to support me	91%	Vaya (96%)	Cardinal (84%)
Received draft of Person Centered Plan to review	86%	Alliance and Sandhills (92%)	Cardinal (79%)
Satisfied with Person Centered Plan	90%	Eastpointe (100%)	Cardinal (75%)
Revisions were added to plan if requested	44%	Sandhills and Vaya (100%)	Alliance, Partners, and Trillium (0%)

Item	NC Aggregate Child (%)	LME/MCOs with Highest and Lowest Category Percentage	
		High	Low
Care Coordinator discusses appeal process and submission	57%	Eastpointe (86%)	Partners (43%)

Provider Satisfaction Survey

The *2020 DHHS Provider Satisfaction Survey* was administered from October to December 2020 with the goal of assessing provider perceptions of the LME/MCOs. The survey used Likert-like scales for questions that categorized the LME/MCOs' performance 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 32 provides an overview of the survey administration.

Table 32: Survey Administration Timeline

Task	Month / Year
Initial survey sent	**April 15, 2021**
First reminder sent	**April 22, 2021**
Reminder calls began	**May 6, 2021**

Data collection terminated	**May 27, 2021**

The *Provider Satisfaction Survey* was administered over a six-week period using a Web survey protocol. The team 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 LME/MCO network. A survey was considered complete if it fulfilled NC Medicaid's requirements. The response rate was calculated as the total number of completed surveys divided by the total number of links sent via email not returned as undeliverable.

Provider Information

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

Distribution of Surveys

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

Provider Satisfaction Survey Assistance

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

Survey Invitations and Response Rate

Table 33 provides the aggregate itemization of the survey response rate.

Table 33: Provider Satisfaction Survey Response Rate

	NC Overall	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
Initial Email Invitation Sent	4355	1607	806	239	407	458	453	385
†Email bounce back with non-delivery message	500	278	73	9	48	43	26	23
*Completed usable surveys	1740	432	388	133	201	195	213	178
Response Rate	**45.1%**	**32.5%**	**52.9%**	**57.8%**	**56.0%**	**47.0%**	**49.9%**	**49.2%**

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

The seven LME/MCOs contributed a total 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 LME/MCOs, an average of 91% of the providers answered as either “Extremely Satisfied” or “Satisfied”, a 2% increase from 2019. Partners and Sandhills had the highest percentage of satisfied providers with 96%. These

two LME/MCOs also had the highest percentage of satisfied providers in the 2019 survey. Cardinal had the lowest rating of 88%, but an increase of 4% from the 2019 survey. Six of the LME/MCOs had an increase in overall satisfaction, including Partners, whose scores increased by 5% from 2019. The results of all the LME/MCOs are shown in Figure 8 and, for the purpose of easy comparison, percentages are rounded to the full percentage point.

Figure 8: Overall Provider Satisfaction with LME/MCO; Comparative of 2019 and 2020

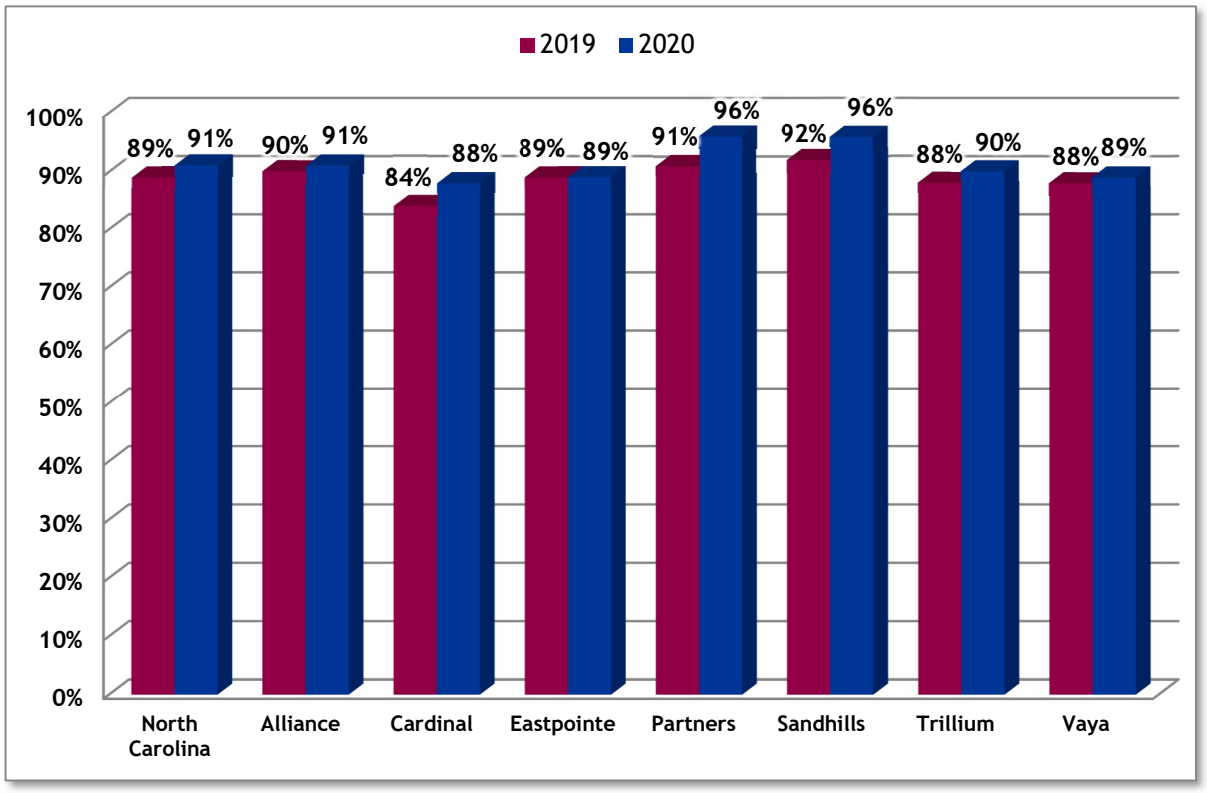


Table 34 shows a summary of the percentage of positive answers for each of the "Agree" or "Satisfied", Likert scale questions in the survey. The table lists the LMEs/MCOs having the highest and lowest percentage for that question.

Table 34 - "Agree" and "Satisfied" Responses 2020 Summary

Question	NC Aggregate 2019 (%)	NC Aggregate 2020 (%)	Change (%)	LME/MCO	
				2020 Highest Score	2020 Lowest Score
Question 6: LME-MCO staff is easily accessible for information, referrals, and	86%	88%	+2%	Partners (96%)	Vaya (84%)

Question	NC Aggregate 2019 (%)	NC Aggregate 2020 (%)	Change (%)	LME/MCO	
				2020 Highest Score	2020 Lowest Score
scheduling of appointments.					
Question 7: LME-MCO staff are referring consumers whose clinical needs match the service(s) my practice/agency provides.	80%	81%	+1%	Alliance (90%)	Cardinal (74%)
Question 8: LME-MCO staff responds quickly to provider needs.	84%	87%	+3%	Partners (92%)	Cardinal (82%)
Question 9: When I speak with LME-MCO staff about claims issues, I am given consistent and accurate information.	88%	89%	+1%	Eastpointe (92%)	Cardinal (83%)
Question 10: LME-MCO's communications to its provider network are informative and helpful.	NA*	92%	NA*	Partners (95%)	Cardinal (88%)
Question 11: The LME-MCO Network Department keeps providers informed of changes that affect my local Provider Network.	89%	93%	+4%	Partners (95%)	Vaya (89%)
Question 12: The LME-MCO Network Department staff are knowledgeable and answer questions consistently and accurately.	87%	89%	+2%	Partners (94%)	Cardinal (83%)
Question 13: The LME/MCO staff conduct fair and thorough investigations.	89%	93%	+4%	Partners (96%)	Cardinal (89%)
Question 14: LME/MCO requests for corrective action plans and other supporting materials are fair and reasonable.	90%	93%	+3%	Partners (97%)	Vaya (89%)
Question 15: Trainings are informative and meet our needs as a provider/agency.	91%	91%	0%	Partners (96%)	Cardinal (86%)

Question	NC Aggregate 2019 (%)	NC Aggregate 2020 (%)	Change (%)	LME/MCO	
				2020 Highest Score	2020 Lowest Score
Question 17: Denials for treatment and services are explained.	86%	88%	+2%	Sandhills (91%)	Cardinal (83%)
Question 18: My agency is satisfied with the appeals process for denial, reduction, or suspension of service(s).	83%	87%	+4%	Eastpointe (93%)	Cardinal (77%)
Question 19: The LME/MCO's website is a useful tool for helping my agency find the tools and materials needed to provide services	85%	87%	+2%	Eastpointe (91%)	Vaya (79%)
Question 20: I receive appropriate notice on the need to recredential.	NA*	95%	NA*	Sandhills (98%)	Alliance (91%)
Question 21: The credentialing/recredentialing process occurs in a timely manner.	NA*	90%	NA*	Sandhills (94%)	Alliance (83%)
Question 22: Provider Relations Credentialing Staff are friendly and knowledgeable.	NA*	96%	NA*	Partners (98%)	Eastpointe (92%)

**NA=Some questions in the 2020 Provider Satisfaction survey that routinely scored high in previous years were exchanged for these questions more pertinent to the State's current interest. Therefore, no comparison score could be made.*

Note: Question 16 was not a Likert scale question, so satisfaction could not be measured.

Trends for the high and low scorers are visible when looking across the LME/MCOs. Partners consistently had the highest positive percentage of all LME/MCOs. Partners scored highest on 9 of 17 questions. Cardinal scored the lowest satisfaction score on 9 of the 17 questions.

Conclusion

Overall, provider satisfaction has increased from 2019 to 2020. In this year's results, providers are more satisfied than last year on all of the 17 items surveyed. In 2020, providers reported being the most satisfied regarding the knowledge and friendliness of Provider Relations/Credentialing staff. Providers are least satisfied with referrals from

the LME/MCOs and the match with the referred enrollee's clinical needs with the services the provider's practice/agency provides. This question was also the lowest scoring item in the 2019 Provider Satisfaction survey. In the individual LME/MCO reports, opportunities for improvement such as this are highlighted in hopes that LME/MCOs will take steps each year to improve upon their score.

Attachment 1: 2020 NC EQR Standards

Prepaid Inpatient Health Plan (PIHP) Standards For 2020 Focused External Quality Review

I. Administration

A. 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 found 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 National Practitioner Data Bank (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.

III. Quality Improvement

A. Performance Measures

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

B. 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".

IV. Utilization Management

A. 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.

B. 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.

V. 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.

VI. 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 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.

2. PIHP shall designate, however named, a Compliance Officer who meets the requirements of *42 CFR.* 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) business 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 issue, 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.

Attachment 2: 2020 NC EQR Desk Materials List

PIHP

Focused External Quality Review 2020

MATERIALS REQUESTED FOR DESK REVIEW

****Please note that the lists requested in items 9, 10, and 19.a must be uploaded by no later than November 6, 2020. The remainder of items must be uploaded by no later than November 23, 2020.**

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/procedure. *(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.
3. Description of major changes in operations such as expansions, new technology systems implemented, etc. Include any major changes to PIHP functions related to COVID-19.
4. A summary of the status of all Corrective Action items from the previous External Quality Review. Please include evidence of Corrective Action implementation.
5. List of providers credentialed/recredentialed in the last 12 months (October 2019 through September 2020). Include the date of approval of initial credentialing and the date of approval of recredentialing.
6. A description of the Quality Improvement, Utilization Management, and Care Coordination Programs. Include a Credentialing Program Description and/or Plan, if applicable.
7. Minutes of committee meetings for the following committees:
   a. Credentialing (for the three, most recent committee meetings)
   b. UM (for the three, most recent committee meetings)
   c. Any clinical committee meeting minutes showing discussion of Clinical Practice Guidelines impacted by COVID-19.
8. 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.
9. **By November 6, 2020**, submit a copy of the complete Appeal log for the months of October 2019 through September 2020. Please indicate on the log: the Appeal type (standard, expedited, extended, withdrawn, or invalid), the service appealed, the date the Appeal was received, and the date of Appeal resolution.

10. **By November 6, 2020**, submit a copy of the complete Grievances log for the months of October 2019 through September 2020. Please indicate on the log: the nature of the Grievance, the date received, and the date of Grievance resolution.

11. Copies of all Appeal notification templates used for expedited, invalid, extended, and withdrawn Appeals.

12. For Appeals and Grievances, please submit a description of your monitoring process that reviews compliance of oral and written notifications, completeness of documentation within the Appeal and Grievance records, accuracy of Appeal and Grievance logs, etc. Provide details regarding frequency of monitoring and any benchmarks, performance metrics, and reporting of monitoring outcomes.

13. Please submit a summary of new provider orientation processes and include a list of materials and training provided to new providers.

14. For MH/SU, I/DD, and TCLI Care Coordination, please submit a description of your monitoring plan that reviews compliance of Care Coordinator documentation. Include in the description the elements reviewed (timeliness of progress notes, timeliness of Innovations monitoring, timeliness of Quality of Life surveys, review of quality, completeness of discharge notes, accuracy of documentation, etc.). Provide details regarding frequency of monitoring, and any benchmarks, performance metrics, and reporting of monitoring outcomes.

15. For Care Coordination enrollees files, please provide:
    a. three MH/SU Care Coordination enrollee files (two active since 2018 and one recently discharged)
    b. three I/DD Care Coordination enrollee files (two active since 2018 and one recently discharged)
    c. four TCLI Care Coordination enrollee files (one active since 2018, one who received In-Reach, one who transitioned to the community and one recently discharged).

NOTE: Care Coordination enrollee files should include all progress/contact notes, monitoring tools, Quality of Life surveys, and any notifications sent to or received from the enrollees.

16. 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 beneficiaries reporting they have a choice between providers.
Percentage of level 2 and 3 incidents reported within required timeframes.
Percentage of beneficiaries who received appropriate medication.
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.

17. 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.)

18. Provide copies of the following Credentialing/Recredentialing files:
    a. Credentialing files for the five most recently credentialed practitioners/agency (as listed below)
        i. One licensed practitioner who is joining an already contracted agency
        ii. One non-MD, Licensed Independent Practitioner (i.e., clinician who will have their own contract)
        iii. One physician
        iv. One practitioner with an associate licensure (e.g., LCSW-A, LMFT-A, etc.)
        v. One file for a network provider agency

NOTE: 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, all credentialing files should include all of the following:

A. Insurance:
    1. 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
    2. 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.

B. Other:
    1. 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).

2. Ownership disclosure information/form (For practitioners joining an already-contracted agency, this may be in the agency file, but should be included in the submitted practitioner file).

b. Recredentialing files for the five most recently recredentialed practitioners/agency (as listed below)
   i. One licensed practitioner who is joining an already contracted agency
   ii. One non-MD, Licensed Independent Practitioner (i.e., clinician who will have their own contract)
   iii. One physician
   iv. One practitioner with an associate licensure (e.g., LCSW-A, LMFT-A, etc.)
   v. One file for a network provider agency

NOTE: 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, all recredentialing files should include all of the following:

A. Insurance:
1. 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.
2. 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.

B. Other:
1. 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).
2. 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).
3. Site visit/assessment reports if the provider has had a quality issue or a change of address.
4. Ownership disclosure information/form (For practitioners joining an already-contracted agency, this may be in the agency file, but should be included in the submitted practitioner file).

19. a. **By November 6, 2020**, submit a copy of the complete listing of Program Integrity case files active during October 2019 through September 2020. On this list, provide the following for each case file:

    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

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

Section	Question Number	Attachment
Enrollment Systems	1b	Enrollment system loading process
Enrollment Systems	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.

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

a. Include all adjudicated claims (paid and denied) from January 1, 2019 – December 31, 2019. 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.

b. Provide a report of all paid claims by service type from January 1, 2019 – December 31, 2019. 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 Kyung Lee of HMS at (978) 902-0031.