CCME

External Quality Review

2021 ANNUAL SUMMARY REPORT

Submitted: April 21, 2022

Prepared on behalf of the
North Carolina Medicaid

2021 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, the North Carolina Department of Health and Human Services' (NC DHHS) Division of 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 2021 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

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 3*: *Review of Compliance with Medicaid and CHIP Managed Care Regulations* and CCME's EQR standards. This review focused on administrative functions, committee minutes, enrollee and provider demographics, enrollee and provider educational materials, the Quality Improvement (QI) and medical management programs, and a file review of denials, Appeals, approvals, case management, credentialing, and Grievances. The EQR standards used to determine the PIHP's compliance are included as *Attachment 1, External Quality Review Standards*.

Validation of Performance Measures (PMs)

CCME validated the Performance Measures (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 (October 2019)*. 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 (PIPs)

CCME validated 24 Performance Improvement Projects (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

Due to the 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 #11*. 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." The focused review included review of issues related to member health and safety and each PIHP's implementation of Corrective Actions and Recommendations issued in the previous EQR.

The focused review included comprehensive review of the PIHP's health systems capabilities and provider credentialing and recredentialing documentation and processes. The review also included validation of the PIHP's Performance Improvement Projects, Performance Measures, and Encounter data. Lastly, a thorough review of the PIHP's Utilization Management (UM), Grievances, and Appeals processes was conducted. The PIHP's network adequacy, availability of services, Sub contractual relationships, and Clinical Practice Guidelines (*42 CFR § 438.206, § 438.207*, *§ 438.230*, and *§ 438.236*, respectively) were not reviewed.

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 with each PIHP, 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. Due to the COVID-19 pandemic, all Onsite visits were conducted virtually.

The following table displays the dates of the 2021 EQR Onsites conducted for each PIHP.

Table 3: External Quality Review Dates

PIHP	2021 EQR Onsite
Alliance Health (Alliance)	February 2022
Eastpointe	October 2021
Partners Health Management (Partners)	March 2022
Sandhills Center (Sandhills)	September 2021
Vaya Health (Vaya)	September 2021
Trillium Health Resources (Trillium)	December 2021

Following the Onsite, draft reports were generated and submitted to the State for feedback and approval. There were several instances where the State determined the Corrective Actions issued by CCME were not "directly related to member health and safety". In those circumstances, the Corrective Actions were changed to best practice Recommendations and the related standards scored as "Met". In some cases, the State approved the PIHP EQR reports, scores, and Corrective Actions and released the reports to the PIHP. The PIHPs then disputed the findings with the State's legal Department, who overturned the Corrective Actions issued by CCME. This also resulted in changes in the PIHP's score and Corrective Actions. These changes impacted Alliance, Partners and Vaya's scores in the 2020 EQR and Alliance's score in the 2021 EQR.

Summary and Overall Findings

Administration

42 CFR § 438.224 and 42 CFR § 438.242

Information Systems Capabilities Assessment

All six PIHPs met 100% of the Administrative standards in this year's EQR. All PIHPs are capable of capturing all ICD-10 Diagnosis codes. Several of the PIHPs either demonstrated an improvement in their capability to capture and submit ICD-10 and Diagnosis Related

Group (DRG) codes from the previous EQR, or maintained their ability to capture and submit all codes. Those PIHPs that have not yet demonstrated this capability (Trillium and Vaya) have reported the improvements are currently being developed. PIHPs in general showed improvements in their acceptance rates for encounter data as well.

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 provider orientation as well as a discussion of network gaps. In the 2020 EQR, all PIHPs scored 100% for the Credentialing/Recredentialing standards.

In the 2021 EQR, all six PIHPs again scored 100% for the Credentialing/Recredentialing standards. 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. 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 2021 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's specific PIP Project Description Forms for validation, using CMS standard validation protocols. An Onsite discussion occurred to clarify measurement rates for each of the areas.

For the 2020 and 2021 EQR, the Performance Measure Query was accurate for (b) Waiver Measures, and all measures were validated at 100%, Fully Compliant. For the 2020 and 2021 EQR, Five (c) Waiver measures were validated for each PIHP. The average validation score was 100% for the 2020 and 2021 EQR.

In the 2020 EQR, each PIHP scored "Met" on 100% of the standards in the Quality Improvement section. Collectively, most issues centered around showing rate improvements in the PIPs. All 2020 PIP Recommendations were implemented unless the PIP was not submitted for the 2021 EQR and could not be evaluated. In the 2021 EQR, issues again centered around showing rate improvements in the PIPs.

Table 4: Results of the Validation PIPs shows all PIPs validated received a score within the High Confidence Range.

Table 4: Results of the Validation of PIPs

Project	Validation Score	Interventions
ALLIANCE		
7 DAY DHB SUD	79/79 = 100% High Confidence in Reported Results	New care management process, Peer Bridger Program, follow up phone calls.
7 Day DMH MH	73/74 = 98.6% High Confidence in Reported Results	Provider scorecard review, new care management process, follow up phone calls.
7 Day DMH SUD	79/79 = 100% High Confidence in Reported Results	Streamlining of processes to contact patients, value-based incentives, provider communication and education programs, assertive engagement, Provider scorecard review.
APM	73/74 = 98.6% High Confidence in Reported Results	HealthCrowd campaign for awareness, Point of Care testing, Provider scorecards, staff education, provider data reports.
SSD	79/79=100% High Confidence in Reported Results	HealthCrowd campaign for awareness, Point of Care testing, staff education, data sharing.
TCLI PCP Visits	Not Active	PCP visit tracking, staff education, provider communication programs.
EASTPOINTE		
Increase the Percent of Individuals Who Receive a 2nd Service Within or Less Than (≤) 14 Days to 35%	73/74=99% High Confidence in Reported Results	Education to Provider Network (staff at front desk who make appointments) on Initiation of Services; Technical assistance call with walk-in clinics regarding peer support being utilized to increase follow-up rates; Collaborate with state/local hospitals regarding scheduling follow up appointments; Identify transportation resources/Chief of QM reached out to local DSS to inquire about transportation resources.

Project	Validation Score	Interventions
Decrease Emergency Department (ED) admissions for Active Members to 20%	73/74=99% High Confidence in Reported Results	MH/SU Care Specialist call ED daily; Hospital Transition team are assigned to local hospitals to assist with discharge planning; Clinical Operations to hold interdepartmental meeting to address ED re-admissions concerns; Development of Provider Self-Audit Tool and Workflow; Data review and technical assistance calls with ACTT Providers.
Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD)	Not Validated	Provider Enrichment Forum led by Medical Director and Associate Medical Director; Associate Medical Director presented at May Provider Meeting on the importance of including Diabetes screening/ monitoring as a goal on the member's Person-Centered Plan (PCP).
Decrease Percentage of Members who Separate from TCLI Housing to 20% or Less Annually	73/74=99% High Confidence in Reported Results	One-on-one psychoeducation with natural supports. Provide motivational interviewing to TCLI members offering linkage to other supportive services and arranging trainings, monthly Meeting with TMS providers, Quarterly Meeting with IPS/SE, CST, and ACTT providers, Use of My Strengths app with members, ADANC Community Inclusion provider assists with decreasing separations, New CST service definition increases the clinical efficacy of the service, Permanent Supportive Housing (PSH) training, Motivational Interviewing training, and Engagement trainings, housing inspection forms presented to providers to assist members in identified areas.
PARTNERS		
Opioid Engagement	79/79=100% High Confidence in Reported Results	Transportation program, value-based contracting, provider training, member incentives, peer support services, office based Opioid Treatment centers, provider brainstorming meetings.

Project	Validation Score	Interventions
SUD Initiation and Engagement	79/79=100% High Confidence in Reported Results	Value-based contracts, provider training, housing initiative, provider specific data-reporting, recovery support services.
Registry of Unmet Needs Services	73/74=99% High Confidence in Reported Results	Long term community supports, community living and supports, day supports, in-home skills building.
Initial NC TOPPS Interviews	73/74=99% High Confidence in Reported Results	Provider scorecards, provider meetings, webinars, distribution list.
TCLI Housing Loss Reduction	73/74=99% High Confidence in Reported Results	Monthly visits, service provider discussions, lack of resource identification, communication, and outreach with members.
SANDHILLS		
Assure Consistent Connection to Community Services - Clinical	79/80 = 99% High Confidence in Reported Results	Make referrals to Care Coordination to facilitate referrals to follow-up services when appropriate; Continue technical assistance to providers with emphasis on follow up to community services.
TCLI Timeliness of Documentation Submission - Non-Clinical	74/79 = 94% High Confidence in Reported Results	TCLI staff are encouraged to complete and submit documentation immediately after each contact; When documentation isn't entered, it is recommended that staff complete and submit all documentation the morning of the following day; Staff are encouraged to not respond to calls or emails or schedule meetings until all notes have been entered.
NC-TOPPS Interview Data Accuracy- Non-Clinical	73/74 = 99% High Confidence in Reported Results	NCTOPPS training Presentation.

Project	Validation Score	Interventions
Routine Appointments kept- Non-Clinical	67/72 = 93% High Confidence in Reported Results	Continue sending reminder texts and reminder calls; Talk with a specific walk-in clinic provider to resume participation in the slot scheduler to allow for appointments to be scheduled in that area; Research how to improve appointments kept for consumers being released from prison.
TRILLIUM		
MST Utilization	78/79=100% High Confidence in Reported Results	Educating schools on MST services; DSS training, family education from care coordinators.
Super Measure MH	73/74=99% High Confidence in Reported Results	Claims data review and assessment, data unit reports weekly, denials alignment in files, communication between contract managers and designated provider caseloads, provider education, Rapid Response Team.
Super Measure SU	78/79=99% High Confidence in Reported Results	Health Connex ADT report, Opioid Treatment Centers, Rapid Response Team, provider education.
ED Utilization	79/79=100% High Confidence in Reported Results	Wellness Recovery Homes, SUD Host Homes, ACCT Plus Pilot, BHUCs, Power BI Dashboard reporting.
TCLI 90-Day Contact	79/79=100% High Confidence in Reported Results	Early report runs in Incedo, weekly report to RI, discrepancy data review, status checks on in-reach members for eligibility.

Project	Validation Score	Interventions
VAYA		
TCLI PN Housing Usage- Non Clinical	73/74=99% High Confidence in Reported Results	Real time inventory access, communication between department managers, Standard Operating Procedures (SOP) document.
Increase Rate of Routine Access to Care Calls Receiving Service Within 14 Days- Clinical	79/79=100% High Confidence in Reported Results	iPads for real time information on members, contact information of probation officers shared with Vaya managers, workflow/process documentation, text message reminders for appointments, mental health specialized probation officers.
Community Crisis Management – Clinical	72/72=100% High Confidence in Reported Results	Provider incentives and penalties, text message reminders, community planning for high-utilizers, interdisciplinary clinical reviews.
ADATC VIP- Clinical	84/84=100% High Confidence in Reported Results	Onsite/in-person care management, phone appointments for members, video conferencing with Complex Care Management, monthly check-in calls to enhance communication between CCM and ADATC departments.

Utilization Management

42 CFR § 438.208

In the 2020 EQR, four (Alliance, Sandhills, Trillium, and Vaya) of the six current PIHPs met 100% of the UM EQR standards. Eastpointe and Partners met 96% of the standards and received Corrective Actions to improve the compliance monitoring of Care Coordination documentation. Three (Alliance, Trillium, and Vaya) of the four PIHPs that met all of the standards also received Recommendations to better monitor Care Coordination documentation to improve upon the completeness, accuracy, and timeliness of documentation.

In the 2021 EQR, three (Alliance, Partners and Sandhills) of the six PIHPs met 100% of the UM EQR standards, and Eastpointe, Trillium, and Vaya met 96% of the standards. The

primary issues noted in the 2021 EQR were again noted in the Mental Health/Substance Use, Intellectual/Developmental Disability, and Transition to Community Living Initiative enrollee file reviews. With the exception of Partners, all PIHPs were encouraged to better monitor Care Coordination documentation for compliance issues and/or opportunities for quality improvement.

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 average score of "Met" Grievance and Appeals standards increased to 100% in the 2021 EQR from 94% in the 2020 EQR.

In the 2020 EQR, Partners and Vaya met 100% of the standards, Alliance and Cardinal met 95% of the standards, and Eastpointe, Sandhills, and Trillium met 90% of the standards.

In the 2021 EQR, all of the PIHPs met 100% of the Grievance and Appeals standards. An identified trend was that Grievance and Appeal requirements outlined in the *NC Medicaid Contract* were not consistently followed within the files reviewed. CCME continues to recommend PIHPs closely and routinely monitor Grievance and Appeal files to identify compliance issues and potential areas of quality improvement. Additionally, two PIHPs (Alliance and Partners) did not address findings from the 2021 EQR. As a result, the 2021 Recommendations were issued again to these two PIHPs.

Program Integrity

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

In the 2020 EQR, all six of the PIHPs met 100% of the PI standards. Eight Recommendations were issued across four PIHPs. Six of the eight Recommendations were addressed by the PIHPs. One Recommendation each was not addressed by Vaya and by Trillium. Most PIHPs updated key documents with *NC Medicaid Contract* language to address the 2020 PI Recommendations.

The 2021 EQR of each PIHP's Program Integrity program resulted in 100% of the standards being "Met". All PI case files reviewed for the 2021 EQR were organized, comprehensive, and compliant with *NC Medicaid Contract* requirements. The PIHPs demonstrated an increased commitment to using advanced analytics in conjunction with FAMS, as well as internal datamining efforts to identify possible cases of fraud, waste, and abuse. It was noted in the 2021 EQR that PIHPs enhanced provider and enrollee access to many PIHP training materials through their websites. This availability was particularly impactful in

ensuring both internal and external stakeholders received training materials during the many access issues created by COVID-19.

Corrective Action Plans and Recommendations from Previous EQR

For a PIHP not meeting requirements, CCME requires the plan to submit a Corrective Action Plan (CAP) for each standard identified as not fully met. CCME provides technical assistance to each health plan until all deficiencies are corrected. During the 2021 EQR, CCME assessed the degree to which the health plan implemented the actions to address deficiencies identified during the 2020 EQR. All PIHPs implemented their approved Corrective Action Plan with one exception. Eastpointe partially implemented a Corrective Action Plan that involved enhancing their quality and compliance monitoring of Care Coordination files. While Eastpointe did enhance their monitoring, the monitoring did not adequately identify and remedy compliance issues in the Care Coordination files submitted by Eastpointe in the 2021 EQR.

Overall Scores

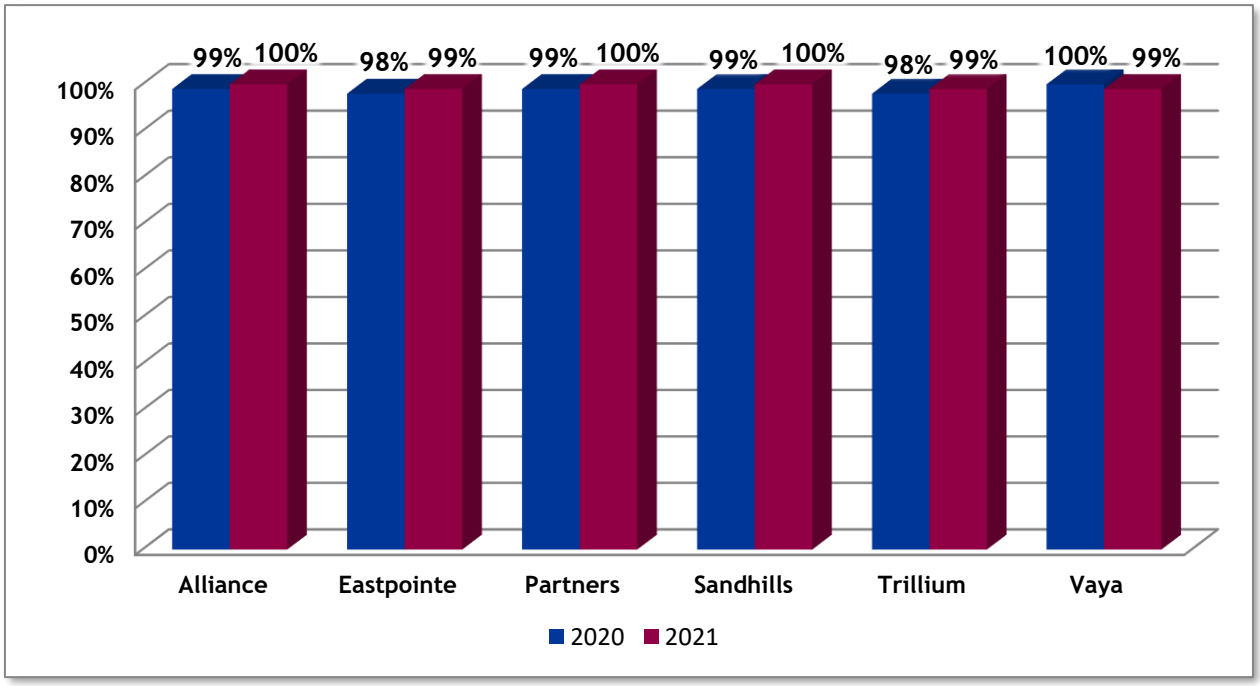
The following table illustrates the percentage of 2021 EQR standards scored as "Met", per each PIHP. It should be noted in 2020, there were seven PIHPs. Cardinal Innovations Healthcare's catchment area was dispersed across other PIHPs in 2021. This disbursement was completed and Cardinal closed in January of 2022.

Table 1: 2021 EQR Overall Scores for PIHPs

PIHP	2021 EQR Overall Score
Alliance	100%
Eastpointe	99%
Partners	100%
Sandhills	100%
Trillium	99%
Vaya	99%

Figure 1 demonstrates the PIHPs scores in the 2021 EQR as compared to the scores achieved in the 2020 EQR.

Figure 1: Comparative of Overall EQR scores by PIHP



Overall Recommendations

Evaluation of NC Medicaid's Quality Strategy

CCME recommends that NC Medicaid continue to use measures from the provider services, program integrity, performance measure, and performance improvement project validation as the primary means for assessing the Quality Strategy's success, as applied to the integrated behavioral health services delivered by its PIHPs.

The 2021 EQR assessment results, including the identification of PIHPs strengths, weaknesses, and Recommendations, attest to the positive impact of North Carolina DHHS quality strategy in monitoring plan compliance, improving quality of care, and aligning healthcare goals with priority topics. The Quality Strategy outlined several NC Medicaid goals and standards that align with CMS priority areas. Based on these goals and standards, CCME developed Recommendations to allow PIHPs to fulfill the goals of the Quality Strategy. *Table 6, NC Medicaid Quality Strategy Goals and Recommendations*, displays the recommendations for each goal.

Table 6: NC Medicaid Quality Strategy Goals and Recommendations

NC Medicaid Quality Strategy Goal	Recommendation
1. Ensure appropriate access to care	▪ Continue PIP projects focused on access to care for routine member visits ▪ Maintain policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements
2. Drive patient-centered, whole-person care	▪ Continue to monitor state-specific performance measures related to behavioral health and substance use outcomes for members ▪ Continue to monitor state-specific measures regarding use of services for mental health and substance use
3. Promote wellness and prevention	▪ Continue to monitor claims and encounter data to determine best utilization of services for optimal quality of care. ▪ Maintain transition of care processes and data-driven monitoring plans to ensure efficient care and continued access for beneficiaries. ▪ Continue assessing provider satisfaction regarding ability to find materials needed to provide services efficiently
4. Improve chronic condition management	▪ Continue to monitor clinical practice guidelines and revise as needed based on scientific and medical evidence ▪ Maintain and update referral processes and treatment plans based on best clinical practices
5. Work with communities to improve population health	▪ Maintain PIP activities related to TCLI for ensure members are able to sustain housing, employment, and access to support services
6. Pay for value	▪ Sustain comprehensive MH/SU, I/DD, and TCLI Care Coordination monitoring plans to incentivize value-based care

PIHP 2021 EQR Overall Strengths, Weaknesses, and Recommendations

Table 7 provides summary of key findings and Recommendations or opportunities for improvement. Specific details of Strengths, Weaknesses, and Recommendations can be found in the sections that follow.

Table 7: PIHPs' 2021 Overall Strengths, Weaknesses, and Recommendations

	Strengths	Weaknesses	Recommendations
Quality	All PIHPs are capable of capturing all ICD-10 Diagnosis codes.	Several PIHPs do not have the ability to submit ICD-10 Procedure codes on encounter data extracts to NCTracks.	Continue to work with PIHP providers to ensure all diagnoses are submitted on claims. Update encounter data submission processes to ensure ICD-10 Procedure codes on Institutional encounter data extracts are sent to NCTracks.
	PIHPs in general showed improvements in their acceptance rates for encounter data	As at the last EQR, at some PIHPs, some documents contained conflicting information or errors regarding credentialing processes or the Credentialing Committee, including items such as committee membership/composition or what constitutes a quorum.	Reconcile language across documents to accurately reflect information regarding credentialing processes or Credentialing Committee information such as the committee membership/composition, which members can vote, or what constitutes a quorum.
	Credentialing/recredentialing files are well-organized and contain appropriate documentation. Some PIHPs have checklists to help guide the process.	Five out of six PIHPs had one or more (b) Waiver PMs that showed significant decline when compared to last year's (b) Waiver PM report.	Continue to monitor (b) Waiver PM rates to determine if rates with substantial improvement or decline represent a continued trend or an anomaly in the performance measures.
	Provider orientation and training materials are available via the website of several of the PIHPs. Newsletters and regular forums provide current information.	13 of 28 (46%) total PIPs validated did not show improvement.	Recommendations for improvement were given to each PIHP for the PIPs that did not show improvement in indicator rates.

	Strengths	Weaknesses	Recommendations
	All six of the PIHPs met the standards within this Quality Improvement EQR section.	While PIHP monitoring of Grievance and Appeal files has resulted in improved compliance in the EQR files reviews, PIHPs should continue to routinely review files for compliance issues and opportunities for quality improvement.	PIHPs would benefit from continuing to routinely monitor Grievance and Appeal files for compliance issues and opportunities for quality improvement. Monitoring efforts should focus on those non-standard Grievances and Appeals, such as withdrawn Grievances, expedited Appeals, and Grievances and Appeals where the PIHP extended the resolution timeframe.
	Many of the PIHPs have specific quality initiatives that are unique to their catchment areas and their members.	As at the last EQR, at some PIHPs, some documents contained conflicting information or errors regarding credentialing processes or the Credentialing Committee, including items such as committee membership/composition or what constitutes a quorum.	Reconcile language across documents to accurately reflect information regarding credentialing processes or Credentialing Committee information such as the committee membership/composition, which members can vote, or what constitutes a quorum.
	A total of 28 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%.		
	All of the PIHPs addressed or partially addressed the Corrective Actions and Recommendations issued in the 2020 UM EQR.		
	The completeness and accuracy of Care Coordination information in PIHP documentation (i.e., policies, enrollee handbooks, program descriptions, etc.) has significantly improved from previous EQRs.		

	Strengths	Weaknesses	Recommendations
	PIHP Grievance EQR scores improved over last year's review from 95% in the 2020 EQR to 98% in the 2021 EQR.		
	PIHP Appeal EQR scores improved over last year's review from 94% in the 2020 EQR to 100% in the 2021 EQR.		
	In the 2021 EQR of Appeals, improvement in the file review was credited to enhancements made by the PIHPs to their compliance monitoring of Appeal files.		
	All PI case files reviewed during the 2021 EQR were organized, comprehensive, and compliant with NC Medicaid Contract requirements		
	The PIHPs demonstrated an increased commitment to using advanced analytics in conjunction with FAMS, as well as internal datamining efforts to identify possible cases of fraud, waste, and abuse.		
	Enhanced access to many training materials was made possible through the provider and member websites. This availability was particularly impactful in ensuring both internal staff and providers received necessary training materials during the many access issues created by COVID-19.		

	Strengths	Weaknesses	Recommendations
Timeliness	Claims adjudication rates were demonstrated to be high by all PIHPs.		
	There was notable improvement in the PIHP documentation and files regarding expedited Appeals and Appeals where the PIHP extends the Appeal Resolution timeframe.	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.	Ensure credentialing and recredentialing files submitted for the EQR are the complete files, with all required information, including, for example, the Ownership Disclosure information. 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.
		A pattern of incomplete, inaccurate, and untimely Care Coordinator documentation continues to be evident within the MH/SU, I/DD, TCLI files submitted by the PIHPs for the EQRs.	By implementing data-driven processes for compliance monitoring of Care Coordination documentation, PIHPs will better identify areas needing quality and/or compliance improvement.
Access to Care	In response to COVID-19, the PIHPs took actions to ensure continued enrollee access to care. Some PIHPs provided additional assistance to address basic needs, including food insecurity and transportation needs.	While PIHP monitoring of Grievance and Appeal files has resulted in improved compliance in the EQR files reviews, PIHPs should continue to routinely review files for compliance issues and opportunities for quality improvement.	PIHPs would benefit from continuing to routinely monitor Grievance and Appeal files for compliance issues and opportunities for quality improvement. Monitoring efforts should focus on those non-standard Grievances and Appeals, such as withdrawn Grievances, expedited Appeals, and Grievances and Appeals where the PIHP extended the resolution timeframe.

BACKGROUND

As detailed in the *Executive Summary*, CCME, as the EQRO, conducts an EQR of the each PIHP contracted with NC Medicaid. Federal regulations require that EQRs include three mandatory activities: validation of performance improvement projects, validation of performance measures, and an evaluation of compliance with state and federal regulations for each health plan.

In addition to the mandatory activities, CCME validates consumer and provider surveys conducted by the CCOs, conducts provider access studies and directory validation, and conducts a behavioral health member satisfaction survey.

After completing the annual review of the required EQR activities for each PIHP, CCME submits a detailed technical report to NC Medicaid and the PIHP. This report describes the data aggregation and analysis, as well as the manner in which conclusions were drawn about the quality, timeliness, and access to care furnished by the plans. The report also contains the plan's strengths and weaknesses, recommendations for improvement, and the degree to which the plan addressed the Corrective Actions from the previous year's review, if applicable.

METHODOLOGY

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

Objectives

Federal regulations require MCOs to undergo a review to determine compliance with federal standards set forth in 42 CFR Part 438 Subpart D and the Quality Assessment and Performance Improvement (QAPI) program requirements described in 42 CFR § 438.330. Specifically, those requirements are:

- Availability of Services (§ 438.206, § 457.1230)
- Assurances of Adequate Capacity and Services (§ 438.207, § 457.1230)
- Coordination and Continuity of Care (§ 438.208, § 457.1230)
- Coverage and Authorization of Services (§ 438.210, § 457.1230, § 457.1228)
- Provider Selection (§ 438.214, § 457.1233)

- Confidentiality (§ 438.224)
- Grievance and Appeal Systems (§ 438.228, § 457.1260)
- Sub-contractual Relationships and Delegation (§ 438.230, § 457.1233)
- Practice Guidelines (§ 438.236, § 457.1233)
- Health Information Systems (§ 438.242, § 457.1233)
- Quality Assessment and Performance Improvement Program (§ 438.330, § 457.1240)

To assess the PIHP's compliance with the 11 Subpart D and QAPI standards as related to quality, timeliness, and access to care, CCME's review was divided into six areas. Those areas included a comprehensive review of the PIHP's health systems capabilities and provider credentialing and recredentialing documentation and processes. The review also included validation of the PIHP's Performance Improvement Projects, Performance Measures, and Encounter data. Lastly, a thorough review of the PIHP's Utilization Management (UM), Grievances, and Appeals processes was conducted. The PIHP's network adequacy, availability of services, Sub contractual relationships, and Clinical Practice Guidelines (42 CFR § 438.206, § 438.207, § 438.230, and § 438.236, respectively) were not reviewed. The following is a high-level summary of the review results for those areas.

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

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

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

Each PIHP's review consisted of two segments:

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

2. The second segment was an Onsite review. Due to the COVID-19 pandemic, all Onsite visits were conducted virtually in the 2020 and 2021 EQRs. 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. The second part was an Onsite visit with each PIHP, 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.

In some circumstances the State determined the Corrective Actions issued by CCME were not "directly related to member health and safety". The Corrective Actions were then changed to best practice Recommendations and the related standards scored as "Met".

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, 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*:** Within the "Findings" of each section of this report (e.g., Administration, Provider Services, etc.) a summary of the PIHP's Strengths, Weaknesses, and CCME Recommendations is provided. These summaries are not inclusive for each PIHP as each PIHP's individual EQR report provides more details. Each "Findings" section of this Annual Summary report contains bar graphs providing 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 PIHP data as compared to the 2020 EQR. The arrows indicate a change in the score from the previous review. For example, an up arrow (↑) would indicate the score for that standard improved from the previous review and a down arrow (↓) indicates the standard was scored lower than the previous review. Scores without arrows indicate that there was no change in the score from the previous review.

A. Administration

42 CFR § 438.224 and 42 CFR § 438.242

Information Systems Capabilities Assessment (ISCA)

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

In the 2020 EQR of the PIHPs' Administration, CCME issued eight Recommendations across six PIHPs. Three of the eight Recommendations were addressed by Alliance, Sandhills, and Vaya by updating the capabilities of the PIHP systems to capture and submit ICD-10 and Diagnosis Related Group (DRG) codes. Eastpointe did not fully address the Recommendation from the 2020 EQR. Trillium did not implement two Recommendations, stating during the Onsite interview that the Recommendations, which pertain to ICD-10 and DRG codes, are on their to-do list but have not yet been implemented. Vaya did not address two Recommendations for similar reasons.

Table 8 provides an overview of the findings in each of the PIHP's 2020 Administrative EQR and the subsequent follow up in the 2021 EQR regarding the findings.

Table 8: 2020 EQR Administrative Corrective Actions and Recommendations

2020 EQR Administrative Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Alliance		
4.1 The PIHP has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission.	***Recommendation: Update Alliance's encounter data submission process to allow submission of up to 25 ICD-10 Diagnosis codes included on Institutional encounters into NCTracks.***	**Y**
2021 EQR Follow up: During the 2021 Onsite discussion, Alliance reported they are submitting up to 24 ICD-10 Diagnosis codes for Institutional encounters and up to 12 ICD-10 Diagnosis codes for Professional encounters.		

2020 EQR Administrative Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Eastpointe		
4.4 The PIHP has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to NC Medicaid.	***Recommendation: Continue to work with providers and the State to reduce the number denied duplicate encounters from NCTracks, review the process of submitting the adjusted and voided encounters separately.***	**N**
2021 EQR Follow up: During the 2021 Onsite, Eastpointe stated that this issue has not been resolved completely and they are still encountering denials due to timing of the voided encounter submission to NCTracks.		
Partners		
2021 EQR Follow up: No Recommendations or Corrective Actions were issued in the 2020 Administrative EQR.		
Sandhills		
4.1 The MCO has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission	***Recommendation: Continue to work with providers and the State to increase the number of ICD-10 Procedure codes submitted into NCTracks.***	**Y**
2021 EQR Follow up: In the 2021 EQR, Sandhills demonstrated they are now able to capture and submit ICD-10 Procedure codes that are received.		
Trillium		
2.3 The MCO has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 Diagnosis codes received on an 837 Institutional and 837 Professional file, capabilities of receiving and storing ICD-10 Procedure codes on an 837 Institutional file.	***Recommendation: Work with the providers to increase the number of ICD-10 Procedure codes submitted on a claim.***	**N**
2021 EQR follow-up: During the Onsite, Trillium stated this Recommendation is on their to-do list, but has not yet been implemented.		

2020 EQR Administrative Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
4.1 The MCO has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission.	***Recommendation: Update Trillium's encounter data submission process to submit DRG codes on Institutional encounter data extracts to NCTracks.***	**N**
2021 EQR follow-up: During the Onsite, Trillium stated this Recommendation is on their to-do list, but has not yet been implemented.		
Vaya		
4.1 The MCO has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission.	***Recommendation: Update Vaya's encounter data submission process and work with the State to increase the number of ICD-10 Diagnosis codes submitted on an Institutional encounter to NCTracks.***	**N**
2021 EQR Follow up: Per Vaya, "WellSky reviewed the Procedure that creates the outgoing file to NCTracks. Although up to 25 are collected, initial submission of this change to send all to NCTracks denied the Claims having more than 12. The change had to be rolled back and the process to generate 837 Outgoing Institutional files still only sends 12. WellSky has prioritized this change to switch to send all the ICD-10 Diagnosis codes again to NCTracks. Once the sprint is completed, the change will be tested on a Build. The timing of this change has not been determined."		
4.1 The MCO has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission.	***Recommendation: Continue to work with providers and the State to submit ICD-10 Procedure codes on Institutional encounter data extracts to NCTracks.***	**N**
2021 EQR Follow up: Per Vaya, "Review of Outgoing 837I file records show that the ICD 10 Procedure Codes are not being sent to NCTracks. The codes are being captured in the Application. The Outgoing process for 837I generation is currently in development for changes. The timing of this change has not been determined by our vendor WellSky."		
4.1 The MCO has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission	***Recommendation: Update Vaya's encounter data submission process to submit DRG codes on Institutional encounter data extracts to NCTracks.***	**Y**
2021 EQR Follow up: Per Vaya, "Current Outgoing process to generate 837I files to NCTracks does include the submission of DRG." This capability was also observed during the live demonstration of Vaya's encounter and enrollment systems.		

While progress was noted in the 2021 EQR, there is still room for improvement in the areas of capture and reporting of data. As examples, Alliance, Trillium, and Vaya do not have the ability to submit ICD-10 Procedure codes on Institutional encounter data extracts to NCTracks. Additionally, Trillium does not have the ability to submit DRG codes on Institutional encounter data extracts to NCTracks. Vaya also does not have the ability to submit more than 12 ICD-10 Diagnosis codes on Institutional encounter data extracts to NCTracks.

In the 2021 EQR, it was noted several PIHPs (Alliance, Eastpointe, Partners, and Sandhills) showed improvements in their acceptance rates for encounter data as well as their capability to capture the DRG and ICD-10 Procedure codes on Institutional claims on the provider web portal and via HIPAA files. Claims adjudication rates for Institutional claims were demonstrated to be above 99% by all PIHPs except Vaya, which was 96.55%.

Figure 2 and Table 9 provide an overview of the percentage of EQR standards met by each PIHP in the Administration review in the 2020 and 2021 EQRs.

Figure 2: Administration Comparative data

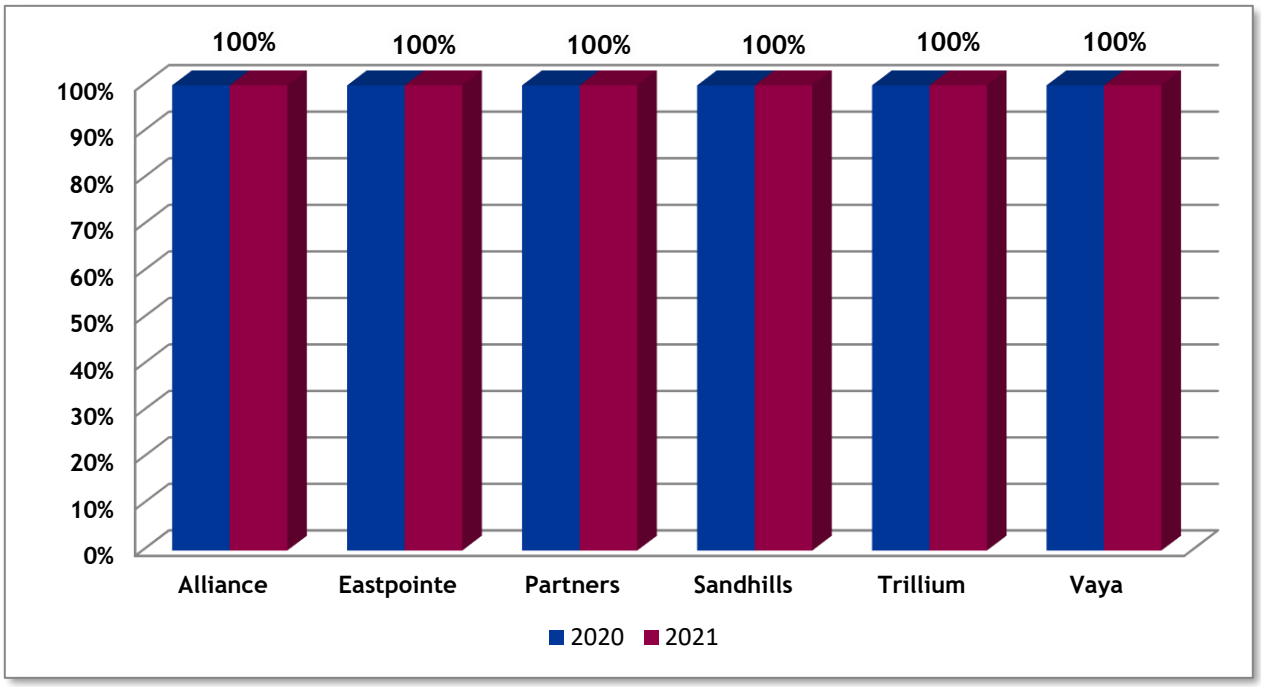


Table 9: Administration Comparative Data

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
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	***Strengths*** ▶ All PIHPs are capable of capturing all ICD-10 Diagnosis codes. ▶ PIHPs in general showed improvements in their acceptance rates for encounter data. ▶ Claims adjudication rates were demonstrated to be high by all PIHPs.
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	
1.3 The PIHP's enrollment system member screens store and track enrollment and demographic information.	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	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	▶ = Quality ▶ = Timeliness ▶ = Access to Care
2.2 The PIHP has processes and procedures in place to monitor review and audit claims staff.	Met	Met	Met	Met	Met	Met	***Weaknesses:*** ▶ Several PIHPs do not have the ability to submit ICD-10 Procedure codes on encounter data extracts to NCTracks.
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	***Recommendations:*** ▶ Continue to work with PIHP providers to ensure all diagnoses are submitted on claims. ▶ Update encounter data submission processes to ensure ICD-10 Procedure codes on Institutional encounter data extracts are sent to NCTracks.
2.4 The PIHP's claim system screens store and track claim information and claim adjudication/payment information.	Met	Met	Met	Met	Met	Met	
3. Reporting							
3.1 The PIHP's data repository captures all enrollment and claims information for internal and regulatory reporting.	Met	Met	Met	Met	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	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
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	
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	
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	
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	

Strengths

- All PIHPs are capable of capturing all ICD-10 Diagnosis codes.
- PIHPs in general showed improvements in their acceptance rates for encounter data.
- Claims adjudication rates were demonstrated to be high by all PIHPs.

Weaknesses

- Several PIHPs do not have the ability to submit ICD-10 Procedure codes on encounter data extracts to NCTracks.

Recommendations

- Continue to work with PIHP providers to ensure all diagnoses are submitted on claims.
- Update encounter data submission processes to ensure ICD-10 Procedure codes on Institutional encounter data extracts are sent to NCTracks.

B. Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

The Provider Services EQR included Credentialing and Recredentialing as well as a discussion of provider education and network adequacy. 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. The staff at each PIHP provided additional information during an Onsite interview.

In the 2021 EQR, all PIHPs scored 100% on the Credentialing/Recredentialing standards. All PIHPs received at least one Recommendation, with Eastpointe receiving the most, with four Recommendations. As in the 2020 EQR, the most commonly occurring issue resulting in a Recommendation was conflicting information or errors across documents regarding credentialing processes or the Credentialing Committee, including items such as committee membership, composition, or what constitutes a quorum. Some PIHPs continue to 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.

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. A Credentialing Committee composed of PIHP staff members and network providers is chaired by the Chief Medical Officer (CMO) at all PIHPs except for Alliance and Eastpointe, where the committee is chaired by the Associate Medical Director.

At all PIHPs, credentialing and recredentialing applications with no identified issues ("flags") are approved by the CMO or designee (such as the Associate Medical Director). Applications with "flags" are reviewed by and voted on by the Credentialing Committee. Credentialing Committee meeting minutes reviewed for the EQR show that the committee at each PIHP met regularly with a quorum present at the meetings. Meeting minutes clearly reflect the discussions and decision-making of the committee. Some 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. As at 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.

Under the COVID-19 flexibilities as outlined in *NC Medicaid Contract Amendment #11*, the *Annual Network Adequacy and Accessibility Analysis* (gaps analysis) "will be submitted no later than ninety (90) calendar days after termination of the amendment." NC DHHS notified PIHPs in January 2021 to submit the *SFY 2020 and 2021 Network Adequacy and Accessibility Analysis* by July 1, 2021, "although we will consult with the LME-MCOs if this date needs to be extended based on the evolving state of the COVID-19 pandemic. LME-MCOs are required to complete the 2020 analysis for Medicaid in its entirety."

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 *Network Adequacy and Accessibility Analysis* report. Some PIHPs attributed gaps to access and choice specifications that were updated in January 2020.

Table 10 provides an overview of the findings in each of the PIHP's 2020 Provider Services EQR and CCME's review to identify if the findings were addressed by the PIHP.

Table 10: 2020 EQR Provider Services Corrective Actions and Recommendations

2020 EQR Provider Services Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Alliance		
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.	***Recommendation: Revise Procedure 6030, the Credentialing Committee meeting minutes template, and any other documents that list Credentialing Committee membership to accurately reflect membership and voting status. For example, as the CMO is a non-voting member of the committee, include the CMO in the list of non-voting members in Procedure 6030. As the CMO and Credentialing Supervisor are non-voting members of the Credentialing Committee, ensure that designation is clear on the Credentialing Committee meeting minutes.***	**N**
2021 EQR Follow up: In this 2021 EQR, Alliance partially addressed the Recommendation. Alliance revised Procedure 6030 to include the Chief Medical Officer (CMO) as a non-voting member and revised the Credentialing Committee meeting minutes to clearly delineate the voting members and the non-voting members. However, some documents continue to list conflicting information regarding Credentialing Committee membership.		
Eastpointe		
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.	***Recommendation: Reconcile the language within the Credentialing Manual about the process (applications go to CAQH and are sent to Medversant, versus applications are submitted to the MCO, etc.)***	N
2021 EQR Follow up: In this 2021 EQR, conflicting language remains in the *Provider Credentialing Operations Manual/Plan* regarding the process (applications go to CAQH and are sent to Medversant, versus applications are submitted to the MCO, etc.). The Recommendation to revise the conflicting language continues in this EQR.		
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.	***Recommendation: Revise the Credentialing By-Laws, the Credentialing Manual, and any other documents that reference the composition of the Credentialing Committee, to consistently reflect the composition of the Credentialing Committee, reconciling both the composition of the provider representative members and the position titles of the non-voting members.***	N
2021 EQR Follow up: In this 2021 EQR, Eastpointe addressed some of the conflicting language in the *Credentialing Committee By-Laws* and the *Provider Credentialing Manual/Plan* regarding the composition of the provider representative members and the position titles of members of the Credentialing Committee. Some conflicting language remains, resulting in the Recommendation continuing in this EQR.		

2020 EQR Provider Services Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
4.1 Recredentialing every three years	***Recommendation: In order to comply with the Eastpointe Credentialing Manual, ensure: providers are recredentialed within three years of the initial credentialing or the most recent recredentialing; the Credentialing Committee is notified when the AMD approves provisional credentialing/ recredentialing; and quality of care issues are discussed with the Credentialing Committee.***	Y
2021 EQR Follow up: All recredentialing files submitted for the 2021 EQR showed recredentialing occurred within three years of the previous credentialing or recredentialing.		
Partners		
2021 EQR Follow up: No Recommendations or Corrective Actions were issued in the 2020 Provider Services EQR.		
Sandhills		
2021 EQR Follow up: No Recommendations or Corrective Actions were issued in the 2020 Provider Services EQR.		
Trillium		
3.1.15 Credentialing: Ownership Disclosure is addressed	***Recommendation: Ensure credentialing files include Ownership Disclosure information, in addition to the disclosure regarding ownership of "5% or more in the organizations that bill Medicaid for services." See NC Medicaid Contract, Attachment O and Section 1.13 and Section 1.14. As noted on the Desk Review Materials list, "For practitioners joining an already-contracted agency, this may be in the agency file, but should be included in the submitted practitioner file."***	Y
2021 EQR Follow up: All credentialing files submitted for the 2021 EQR included Ownership Disclosure information.		

2020 EQR Provider Services Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
4.2.14 Recredentialing: Ownership Disclosure is addressed	***Recommendation: Ensure recredentialing files include Ownership Disclosure information, in addition to the disclosure regarding ownership of "5% or more in the organizations that bill Medicaid for services." See NC Medicaid Contract, Attachment O and Section 1.13 and Section 1.14. As noted on the Desk Review Materials list, "For practitioners joining an already-contracted agency, this may be in the agency file, but should be included in the submitted practitioner file."***	Y
2021 EQR Follow up: All recredentialing files submitted for the 2021 EQR included Ownership Disclosure information.		
Vaya		
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.	***Recommendation: Revise the Credentialing Committee Charter, Policy 2891 (designated as the Credentialing Program Description), and any other documents that detail credentialing processes, to consistently reflect who will chair the Credentialing Committee meetings in the absence of the CMO.***	N
2021 EQR Follow up: This issue was discussed during the Vaya Onsite Review in February 2021 and included as a Recommendation in the report issued in April 2021. In this 2021 EQR, there was no revision in the language in the *Credentialing Committee Charter* (*CCC*) and the *Credentialing Program Description* (*CPD*) regarding who will chair the Credentialing Committee meetings in the absence of the Chief Medical Officer (CMO). On the *2020 EQR Best Practice Recommendations* Vaya submitted with the Desk Materials in September 2021, the "Vaya Health Comments" state, "Vaya will revise the Credentialing Committee Charter and Credentialing Program Description to reflect who will chair the Credentialing Committee meetings in the absence of the CMO." During the Onsite, Vaya confirmed the Recommendation has not yet been implemented. This remains a Recommendation for this EQR.		

2020 EQR Provider Services Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
3.1.1 Insurance requirements	***Recommendation: Verify credentialing files contain proof of all of the required insurance coverages or the relevant statement about why it is not required (for example, a written statement from Licensed Practitioners that they do not transport clients, so are not required to obtain automobile liability insurance).*** ***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 insurance. If the practitioner is not named on the Certificate of Insurance, a letter from the provider agency or insurance company indicating that the practitioner is covered under the policy is acceptable. See NC Medicaid Contract Attachment B, Section 7.7, NC Medicaid Contract, Attachment O, NC Medicaid Contract Attachment B, Section 7.9.***	**Y**
2021 EQR Follow up: In this 2021 EQR, the submitted files included proof of professional liability (PL) insurance. In some agencies, the Licensed Practitioner (LP) must provide their own PL insurance, and those Certificates of Insurance (COIs) are in the submitted files. For other LPs, the agency insurance covers them, and those files include the agency COI. Vaya verified that, if the applicant is covered by a contracted provider's insurance, the COI is maintained in the agency file. The submitted files for Licensed Independent Practitioners (LIPs) also contained proof of required insurance or an attestation as to why it was not required, such as the LIP does not transport consumers.		
3.1.15 Credentialing: Ownership Disclosure is addressed	***Recommendation: Verify whether there are managing employees for all applicants. Include documentation in the credentialing files to verify Ownership Disclosure is addressed, including by the agency for the employee. If Vaya does not keep a copy of the relevant ownership disclosure information in the individual credentialing file, retrieve copies from the relevant file and upload as part of the credentialing files for the Desk Review. See NC Medicaid Contract Attachment B, Section 1.13 & Attachment O, #5 and #6.***	**Y**
2021 EQR Follow up: In this 2021 EQR, Ownership Disclosure information was not provided in the submitted Desk Materials for one initial credentialing file. Vaya submitted the documentation in response to CCME's request on the Missing Desk Materials list.		

2020 EQR Provider Services Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
4.2.14 Recredentialing: Ownership Disclosure is addressed	***Recommendation: Verify whether there are managing employees for all applicants. Include documentation in the credentialing files to verify Ownership Disclosure is addressed, including by the agency for the employee. If Vaya does not keep a copy of the relevant ownership disclosure information in the individual credentialing file, retrieve copies from the relevant file and upload as part of the credentialing files for the Desk Review. See NC Medicaid Contract Attachment B, Section 1.13 & Attachment O, #5 and #6.***	**Y**
2021 EQR Follow up: In this 2021 EQR, Ownership Disclosure information was not provided in the submitted Desk Materials for two recredentialing files. Vaya submitted the documentation in response to CCME's request on the Missing Desk Materials list.		

Figure 3 and Table 11 that follow provide an overview of the PIHPs' performance in the Provider Services section in the 2021 EQR.

Figure 3: Provider Services Comparative data

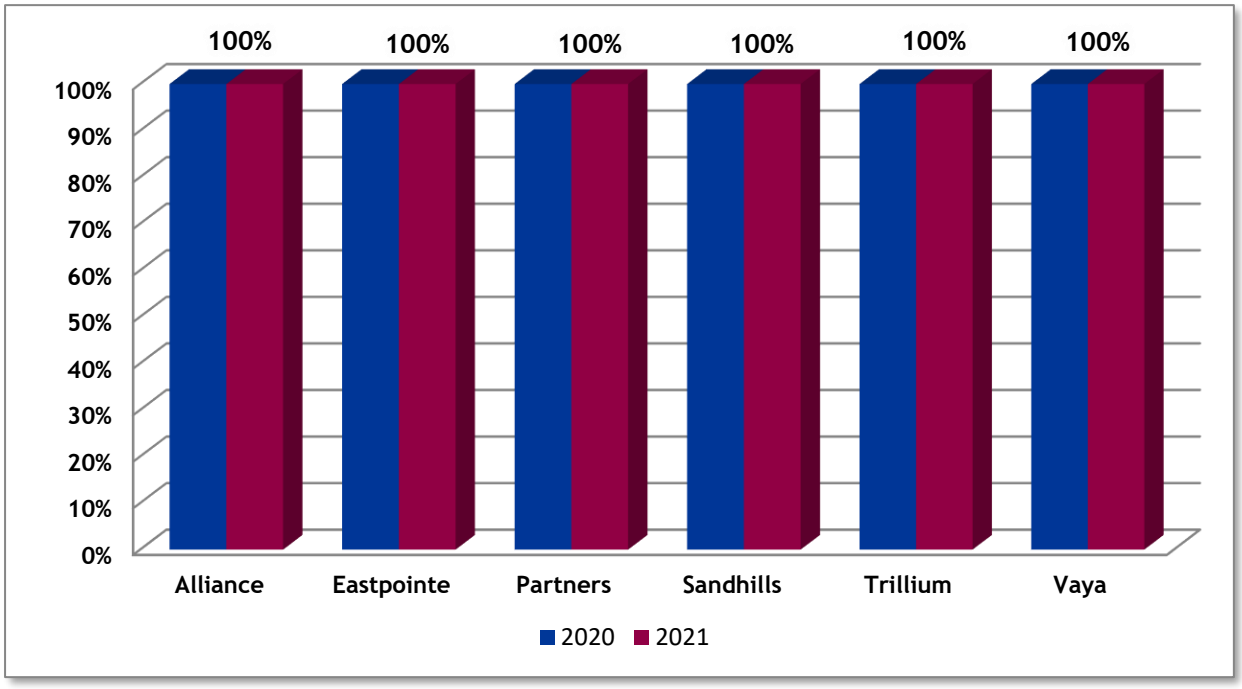


Table 11: Provider Services Comparative Data

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
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	***Strengths*** ▶ Credentialing/recredentialing files are well-organized and contain appropriate documentation. Some PIHPs have checklists to help guide the process. ▶ In response to COVID-19, the PIHPs took actions to ensure continued enrollee access to care. Some PIHPs provided additional assistance to address basic needs including food insecurity and transportation needs. ▶ Provider orientation and training materials are available via the website of several of the PIHPs. Newsletters and regular forums provide current information.
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	
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	
3.1 Verification of information on the applicant including;							
3.1.1 Insurance requirements;	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	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	▶ = Quality ▶ = Timeliness ▶ = Access to Care
3.1.3 Valid DEA certificate and/or CDS certificate;	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	
3.1.5 Work History;	Met	Met	Met	Met	Met	Met	
3.1.6 Malpractice claims history;	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	
3.1.8 Query of the National Practitioner Data Bank (NPDB);	Met	Met	Met	Met	Met	Met	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	▶ = Quality ▶ = Timeliness ▶ = Access to Care
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	
3.1.10 Query for the System for Awards Management (SAM);	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	
3.1.12 Query of the Social Security Administration's Death Master File (SSADMF);	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	
3.1.14 Names of hospitals at which the physician has admitting privileges, if any.	Met	Met	Met	Met	Met	Met	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
3.1.15 Ownership Disclosure is addressed;	Met	Met	Met	Met	Met	Met	***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. ▶ As at the last EQR, at some PIHPs, some documents contained conflicting information or errors regarding credentialing processes or the Credentialing Committee, including items such as committee membership/composition or what constitutes a quorum.
3.1.16 Criminal background Check	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	
4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.	Met	Met	Met	Met	Met	Met	
4.1 Recredentialing every three years;	Met	Met	Met	Met	Met	Met	
4.2 Verification of information on the applicant, including:	Met	Met	Met	Met	Met	Met	
4.2.1 Insurance Requirements	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	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
4.2.3 Valid DEA certificate and/or CDS certificate;	Met	Met	Met	Met	Met	Met	***Recommendations*** ▶ Ensure credentialing/ recredentialing files submitted for the EQR are the complete files, with all required information, including, for example, the Ownership Disclosure information. 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 information regarding credentialing processes or Credentialing Committee information such as the committee membership/ composition, which members can vote, or what constitutes a quorum.
4.2.4 Board certification, if claimed by the applicant;	Met	Met	Met	Met	Met	Met	
4.2.5 Malpractice claims since the previous credentialing event;	Met	Met	Met	Met	Met	Met	
4.2.6 Practitioner attestation statement;	Met	Met	Met	Met	Met	Met	
4.2.7 Requery of the National Practitioner Data Bank (NPDB);	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	
4.2.9 Requery of the SAM;	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	
4.2.11 Query of the Social Security Administration's Death Master File	Met	Met	Met	Met	Met	Met	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	▶ = Quality ▶ = Timeliness ▶ = Access to Care
4.2.12 Query of the NPPES	Met	Met	Met	Met	Met	Met	
4.2.13 Names of hospitals at which the physician has admitting privileges, if any.	Met	Met	Met	Met	Met	Met	
4.2.14 Ownership Disclosure is addressed	Met	Met	Met	Met	Met	Met	
4.3 Site reassessment if the provider has had quality issues.	Met	Met	Met	Met	Met	Met	
4.4 Review of practitioner profiling activities	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	
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities	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 *2021 External Quality Review Report*. The following is a sample of findings.

Strengths

- Credentialing/recredentialing files are well-organized and contain appropriate documentation. Some PIHPs have checklists to help guide the process.
- In response to COVID-19, the PIHPs took actions to ensure continued enrollee access to care. Some PIHPs provided additional assistance to address basic needs such as food insecurity and transportation needs.
- Provider orientation and training materials are available via the website of several of the PIHPs. Newsletters and regular forums provide current information.

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.
- As at the last EQR, at some PIHPs, some documents contained conflicting information or errors regarding credentialing processes or 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. 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 information regarding credentialing processes or 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 2021 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's specific PIP Project Description Forms for validation, using CMS standard validation protocols. An Onsite discussion occurred to clarify measurement rates for each of the areas.

In the 2020 EQR, each PIHP received a score of "Met" in the Quality Improvement section. Collectively, all 37 PIPs scored in the "High Confidence" range. There were 18 Recommendations issued collectively that centered around showing rate improvements in the PIPs. Each PIHP had 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 was:

- Alliance = 5 PIPs 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

Table 12 displays the Project, Recommendations, and information about whether the Recommendation was implemented. Not Applicable (N/A) indicates the PIP was not submitted for the 2021 EQR and could not be evaluated.

Table 12: 2020 EQR PIP Recommendations

Project(s)	Recommendation	Recommendation Implemented in 2021 (Y/N/NA)
ALLIANCE		
APM	***Recommendation: 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.***	**Y**
7 Day DMH MH	***Recommendation: Continue the current interventions of incentives, education, open access, provider scorecards, and Peer Bridger Programs. Determine if additional interventions should be implemented to improve the rate toward the 40% benchmark.***	**Y**
SAA	***Recommendation: Continue the current interventions of HealthCrowd campaign, provider scorecards, and patient level data analysis. Determine if additional interventions should be implemented to improve rate toward the 60% benchmark.***	**N/A**

Project(s)	Recommendation	Recommendation Implemented in 2021 (Y/N/NA)
TCLI	*Recommendation: Continue the current interventions of data tracking/monitoring, assignments, and 80 day no contact tracking to determine if the rate will improve to the goal of 95%.*	N/A
EASTPOINTE		
Increase the percentage of individuals who receive a 2nd service within or less than 14 days- Clinical: Initiation/Engagement Medicaid	*Recommendation: The PIP workgroup on 11/12/20 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.*	Y
Decrease emergency department admissions for active members to 20%- Clinical	*Recommendation: March 2020 PIP workgroup meeting focused on implementation of self-study tool and workflow; as well as care specialist; d/c team; and care specialists. Continue these interventions to determine if they reduce ED admissions.*	Y
Decrease percentage of members who separate from transition to community living housing to 20% or less annually- Clinical/TCLI	*Recommendation: Determine if Freedom Funds can help keep rate decreasing; work on increasing compliance of members and providing consistent information, as documented.*	Y
PARTNERS		
Promoting follow up within 7 days for mental health treatment- Clinical	*Recommendation: Continue to monitor interventions, especially given the new requirements for peer support to determine if rate begins to improve. Determine if engagement specialist and provider communication are resulting in improvement. Continue working on contact information for consumers.*	N/A
Promoting follow up within 7 days for SUD treatment- Clinical	*Recommendation: Update report so that results in Table and Graph are matched.*	N/A
Reducing ED utilization of active members-Clinical	*Recommendation: Include annotations on the report to allow the reader to know the benchmark/final target rate and the short-term goal rate.*	N/A

Project(s)	Recommendation	Recommendation Implemented in 2021 (Y/N/NA)
TCLI Housing Loss Reduction- Non Clinical	***Recommendation: 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.***	**Y**
SANDHILLS		
Increase EBP for Medication Management	***Recommendation: Add a chi square or Fisher's exact test to compare rates and report the p-value.***	N/A: There is no data available for this PIP due to pause on data audits.
Assure Consistent Connection to Community Services Following FBC Services	***Recommendation: Add a chi square or Fisher's exact test to compare rates and report the p-value***	**Y**
Access to Routine BH Assessments	***Recommendation: 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.***	**Y**
Access to Routine BH Assessments	***Recommendation: Add information in the Data Collection section on how the caller enters the data and the database system used for data collection.***	**Y**
TCLI Transition Days	***Recommendation: Continue interventions and determine if specific interventions are more beneficial as the COVID-19 crisis continues to limit contact with consumers.***	**Y**
TRILLIUM		
MST Utilization	*Recommendation: 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.*	**Y**

Project(s)	Recommendation	Recommendation Implemented in 2021 (Y/N/NA)
Super Measure MH	*Recommendation: 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 impact on the measure*	**Y**
Super Measure SU	*Recommendation: 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 impact on the measure.*	**Y**
VAYA		
Community Crisis Management	*Recommendation: Continue interventions that focus on hospital for SUD Medicaid and Non-Medicaid admissions, as those are not improving. Focus on interventions that are unique to that population. MH rates are declining, which is improvement.*	**Y**
TCLI PN Housing Usage	*Recommendation: Continue listed interventions to get clarity on the process for managing housing, including real time updates.*	**Y**

Table 13, outlines the interventions implemented by the PIHPs to address the 2020 EQR findings.

Table 13: 2020 EQR PIP Recommendations

Project	Validation Score	Interventions
ALLIANCE		
7 DAY DHB SUD	79/79 = 100% High Confidence in Reported Results	New care management process, Peer Bridger Program, follow up phone calls
7 Day DMH MH	73/74 = 98.6% High Confidence in Reported Results	Provider scorecard review, new care management process, follow up phone calls

7 Day DMH SUD	79/79 = 100% High Confidence in Reported Results	Streamlining of processes to contact patients, value-based incentives, provider communication and education programs, assertive engagement, Provider scorecard review
APM	73/74 = 98.6% High Confidence in Reported Results	HealthCrowd campaign for awareness, Point of Care testing, Provider scorecards, staff education, provider data reports
SSD	79/79=100% High Confidence in Reported Results	HealthCrowd campaign for awareness, Point of Care testing, staff education, data sharing
TCLI PCP Visits	Not Active	PCP visit tracking, staff education, provider communication programs
EASTPOINTE		
Increase the Percent of Individuals Who Receive a 2nd Service Within or Less Than (≤) 14 Days to 35%	73/74=99% High Confidence in Reported Results	Education to Provider Network (staff at front desk who make appointments) on Initiation of Services; Technical assistance call with walk-in clinics regarding peer support being utilized to increase follow-up rates; Collaborate with state/local hospitals regarding scheduling follow up appointments; Identify transportation resources/Chief of QM reached out to local DSS to inquire about transportation resources.
Decrease Emergency Department (ED) admissions for Active Members to 20%	73/74=99% High Confidence in Reported Results	MH/SU Care Specialist call ED daily; Hospital Transition team are assigned to local hospitals to assist with discharge planning; Clinical Operations to hold interdepartmental meeting to address ED re-admissions concerns; Development of Provider Self-Audit Tool and Workflow; Data review and technical assistance calls with ACTT Providers.
Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD)	Not Validated	Provider Enrichment Forum led by Medical Director and Associate Medical Director; Associate Medical Director presented at May Provider Meeting on the importance of including Diabetes screening/ monitoring as a goal on the member's Person-Centered Plan (PCP).

Decrease Percentage of Members who Separate from TCLI Housing to 20% or Less Annually	73/74=99% High Confidence in Reported Results	One-on-one psychoeducation with natural supports. Provide motivational interviewing to TCLI members offering linkage to other supportive services and arranging trainings, monthly Meeting with TMS providers, Quarterly Meeting with IPS/SE, CST, and ACTT providers, Use of My Strengths app with members, ADANC Community Inclusion provider assists with decreasing separations, New CST service definition increases the clinical efficacy of the service, Permanent Supportive Housing (PSH) training, Motivational Interviewing training, and Engagement trainings, housing inspection forms presented to providers to assist members in identified areas.
PARTNERS		
Opioid Engagement	79/79=100% High Confidence in Reported Results	Transportation program, value-based contracting, provider training, member incentives, peer support services, office based Opioid Treatment centers, provider brainstorming meetings
SUD Initiation and Engagement	79/79=100% High Confidence in Reported Results	Value-based contracts, provider training, housing initiative, provider specific data-reporting, recovery support services.
Registry of Unmet Needs Services	73/74=99% High Confidence in Reported Results	Long term community supports, community living and supports, day supports, in-home skills building
Initial NC TOPPS Interviews	73/74=99% High Confidence in Reported Results	Provider scorecards, provider meetings, webinars, distribution list
TCLI Housing Loss Reduction	73/74=99% High Confidence in Reported Results	Monthly visits, service provider discussions, lack of resource identification, communication, and outreach with members
SANDHILLS		
Assure Consistent Connection to Community Services - Clinical	79/80 = 99% High Confidence in Reported Results	Make referrals to Care Coordination to facilitate referrals to follow-up services when appropriate; Continue technical assistance to providers with emphasis on follow up to community services

TCLI Timeliness of Documentation Submission - Non-Clinical	74/79 = 94% High Confidence in Reported Results	TCLI staff are encouraged to complete and submit documentation immediately after each contact; When documentation isn't entered, it is recommended that staff complete and submit all documentation the morning of the following day; Staff are encouraged to not respond to calls or emails or schedule meetings until all notes have been entered
NC-TOPPS Interview Data Accuracy- Non-Clinical	73/74 = 99% High Confidence in Reported Results	NCTOPPS training Presentation
Routine Appointments kept- Non-Clinical	67/72 = 93% High Confidence in Reported Results	Continue sending reminder texts and reminder calls; Talk with a specific walk-in clinic provider to resume participation in the slot scheduler to allow for appointments to be scheduled in that area; Research how to improve appointments kept for consumers being released from prison.
TRILLIUM		
MST Utilization	78/79=100% High Confidence in Reported Results	Educating schools on MST services, DSS training, family education from care coordinators
Super Measure MH	73/74=99% High Confidence in Reported Results	Claims data review and assessment, data unit reports weekly, denials alignment in files, communication between contract managers and designated provider caseloads, provider education, Rapid Response Team.
Super Measure SU	78/79=99% High Confidence in Reported Results	Health Connex ADT report, Opioid Treatment Centers, Rapid Response Team, provider education
ED Utilization	79/79=100% High Confidence in Reported Results	Wellness Recovery Homes, SUD Host Homes, ACCT Plus Pilot, BHUCs, Power BI Dashboard reporting
TCLI 90-Day Contact	79/79=100% High Confidence in Reported Results	Early report runs in Incedo, weekly report to RI, discrepancy data review, status checks on in-reach members for eligibility

VAYA		
TCLI PN Housing Usage- Non Clinical	73/74=99% High Confidence in Reported Results	Real time inventory access, communication between department managers, Standard Operating Procedures (SOP) document
Increase Rate of Routine Access to Care Calls Receiving Service Within 14 Days- Clinical	79/79=100% High Confidence in Reported Results	iPads for real time information on members, contact information of probation officers shared with Vaya managers, workflow/process documentation, text message reminders for appointments, mental health specialized probation officers
Community Crisis Management – Clinical	72/72=100% High Confidence in Reported Results	Provider incentives and penalties, text message reminders, community planning for high-utilizers, interdisciplinary clinical reviews
ADATC VIP- Clinical	84/84=100% High Confidence in Reported Results	Onsite/in-person care management, phone appointments for members, video conferencing with Complex Care Management, monthly check-in calls to enhance communication between CCM and ADATC departments

In the 2021 EQR, a total of 28 PIPs were submitted. Each PIHP has one or more PIPs that did not show improvement. There were 12 Recommendations issued collectively that centered around showing rate improvements in the PIPs. The number of PIPs not showing improvement in indicator rates was 46% collectively, and the number of PIPs not showing improvement in indicator rates for each PIHP was:

- Alliance = 2 PIPs
- Eastpointe = 2 PIPs
- Partners = 3 PIPs
- Sandhills = 1 PIP
- Trillium = 3 PIPs
- Vaya = 1 PIPs

Recommendations were given to each PIHP based on the specific PIPs that did not show improvement. For example, CCME recommended Trillium improve the Utilization of ED PIP by determining if specific processes at discharge or if member education would improve the rate and increase follow-up treatment to the 80% goal. And, at Alliance, CCME recommended for the 7 Day Follow Up for DHB SUD PIP that Alliance “continue

working to determine reasons for low referrals in the Peer Bridger program that might impact rates. The census issues with facilities may also be a factor and should be evaluated further to determine if differences in format reporting are affecting the ability to reach members." At Sandhills, for the Routine Appointments Kept PIP, CCME recommended that Sandhills determine if there are other specific barriers to keeping appointments and continue to evaluate the impact of the funding and location changes as related to lack of appointments being kept. Other Recommendations were issued but were not part of a trend for each PIHP.

For the 2021 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 and substantial (>10%) rate increase. In most cases, it was Recommended to continue to monitor (b) Waiver performance measure rates to determine if rates with substantial improvement or decline represent a continued trend or an anomaly in the PMs. All PIHP's (c) Waiver Measures met or exceeded State benchmarks and were validated at 100%, Fully Compliant.

Figure 4 provides an overview of the percentage of EQR standards met by each PIHP in the Quality review in the 2020 and 2021 EQRs.

Figure 4: Quality Improvement Comparative data

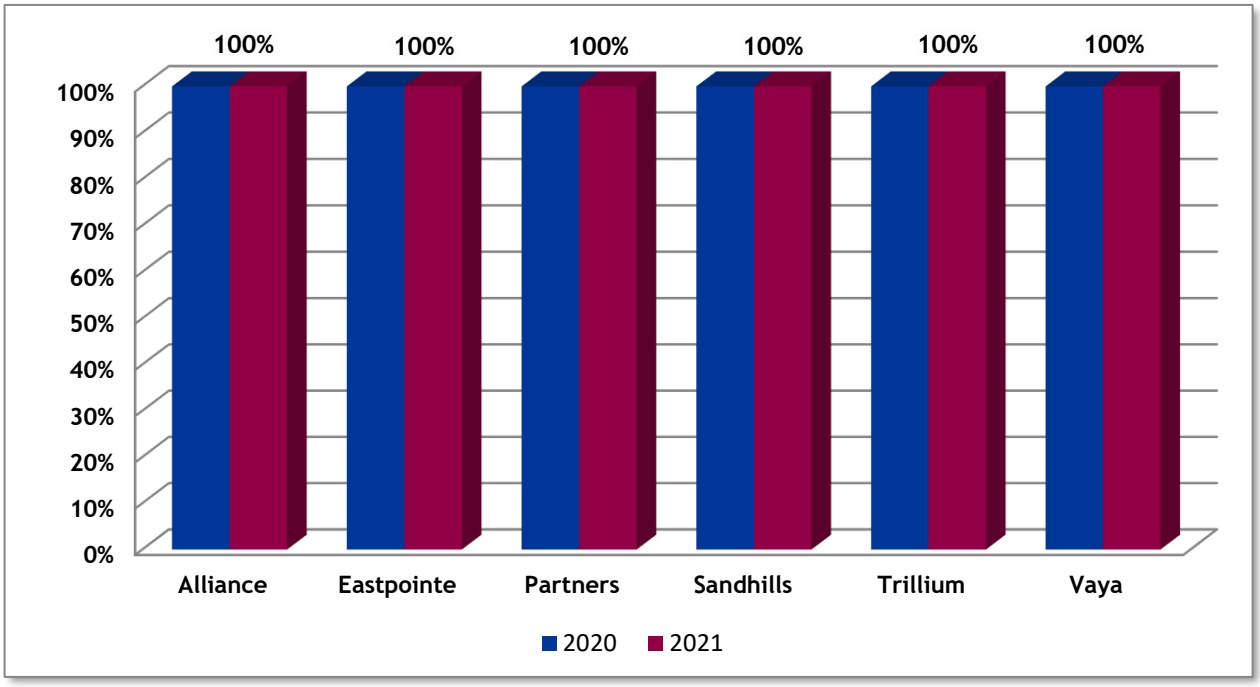


Table 14: Quality Improvement Comparative Data

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	▶ = Quality ▶ = Timeliness ▶ = Access to Care
III. 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	***Strengths*** ▶ All six of the PIHPs met the standards within this Quality Improvement EQR section. ▶ Many of the PIHPs have specific quality initiatives that are unique to their catchment areas and their members. ▶ A total of 28 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%.
2. 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	***Weaknesses*** ▶ Five out of six PIHPs had one or more (b) Waiver PMs that showed significant decline when compared to last year's (b) Waiver PM report. ▶ 13 of 28 (46%) total PIPs validated did not show improvement.

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	▶ = Quality ▶ = Timeliness ▶ = Access to Care
III. B Quality Improvement Projects							***Recommendations***
1. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	Met	Met	Met	Met	Met	Met	▶ Continue to monitor (b) Waiver PM rates to determine if rates with substantial improvement or decline represent a continued trend or an anomaly in the performance measures. ▶ Recommendations for improvement were given to each PIHP for the PIPs that did not show improvement in indicator rates.

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 15: (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 15 gives an overview of the 2021 (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 16: 2021 (b) Waiver PM Validation Results Summary

Measures	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya
A.1	100%	100%	100%	100%	100%	100%
A.2	100%	100%	100%	100%	100%	100%
A.3	100%	100%	100%	100%	100%	100%
A.4	100%	100%	100%	100%	100%	100%
B.1	100%	100%	100%	100%	100%	100%
D.1	100%	100%	100%	100%	100%	100%
D.2	100%	100%	100%	100%	100%	100%
D.3	100%	100%	100%	100%	100%	100%
D.4	100%	100%	100%	100%	100%	100%
D.5	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 17: 2021 (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 17: 2021 (c) Waiver PM Validation Results Summary

Measure	Percentages Reported					
	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.	99.6%	99.75%	100%	100%	99.52%	100%
Proportion of beneficiaries reporting they have a choice between providers.	99.6%	99.75%	100%	100%	99.52%	100%
Percentage of level 2 and 3 incidents reported within required timeframes.	86.7%	96%	91.4%	96.79%	88.10%	92.86%
Percentage of beneficiaries who received appropriate medication.	100%	100%	97.9%	99.92%	100%	99.87%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.	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**

Note: Annual rates reported by the PIHP at the time of the individual 2021 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 18: 2021 PIP Validation Results Summary*.

Table 18: 2021 PIP Validation Results Summary

PROJECT	VALIDATION SCORE	VALIDATION DECISION
ALLIANCE		
7-Day Super Measure – Medicaid DHB SUD*	73/74 = 99%	High Confidence in Reported Results
7-Day Super Measure – State DMH MH*	79/79 = 100%	High Confidence in Reported Results
7-Day Super Measure – State DMH SUD*	79/79 = 100%	High Confidence in Reported Results
APM	79/79 = 100%	High Confidence in Reported Results
SSD	79/79 = 100%	High Confidence in Reported Results
TCLI PCP Visits	73/74 = 99%	High Confidence in Reported Results
EASTPOINTE		
Increase the Percent of Individuals Who Receive a 2nd Service Within or Less Than (≤) 14 Days to 35%	73/74 = 99%	High Confidence in Reported Results
Decrease Emergency Department (ED) admissions for Active Members to 20%	79/79 = 100%	High Confidence in Reported Results
Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD)	76/79 = 96%	High Confidence in Reported Results
Decrease Percentage of Members who Separate from TCLI Housing to 20% or Less Annually	74/74 = 100%	High Confidence in Reported Results
PARTNERS		
Opioid Engagement	79/79 = 100%	High Confidence in Reported Results

PROJECT	VALIDATION SCORE	VALIDATION DECISION
SUD Initiation and Engagement	79/79 = 100%	High Confidence in Reported Results
Registry of Unmet Needs Services	73/74 = 99%	High Confidence in Reported Results
Initial NC TOPPS Interviews	73/74 = 99%	High Confidence in Reported Results
TCLI Housing Loss Reduction	73/74 = 99%	High Confidence in Reported Results
SANDHILLS		
Assure Consistent Connection to Community Services	79/80 = 99%	High Confidence in Reported Results
NC-TOPPS Interview Data Accuracy	74/79 = 94%	High Confidence in Reported Results
Routine Appointments kept	73/74 = 99%	High Confidence in Reported Results
TCLI Timeliness Documentation Submission	67/72 = 93%	High Confidence in Reported Results
TRILLIUM		
Supermeasures SU*	73/74 = 99%	High Confidence in Reported Results
Supermeasures MH*	78/79 = 100%	High Confidence in Reported Results
ED Utilization*	78/79 = 99%	High Confidence in Reported Results
Utilization of MST*	79/79 = 100%	High Confidence in Reported Results
TCLI 90 Day Contact	79/79 = 100%	High Confidence in Reported Results
VAYA		
TCLI PN Housing Usage	73/74 = 99%	High Confidence in Reported Results
Increase Rate of Routine Access to Care Calls Receiving Service Within 14 Days	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

**Indicates clinical focused PIP*

Strengths, Weaknesses, and Recommendations are not inclusive for each PIHP. More details were included in the Quality Improvement section of each PIHP's *2021 External Quality Review Report*. The following is a sample of findings.

Strengths

- All six of the PIHPs met the standards within this Quality Improvement EQR section.
- Many of the PIHPs have specific quality initiatives that are unique to their catchment areas and their members.
- A total of 28 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

- Five out of six PIHPs had one or more (b) Waiver PMs that showed significant decline when compared to last year's (b) Waiver PM report.
- 13 of 28 (46%) total PIPs validated did not show improvement.
    - Alliance = 2 PIPs
    - Eastpointe = 2 PIPs
    - Partners = 3 PIPs
    - Sandhills = 1 PIP
    - Trillium = 3 PIPs
    - Vaya = 1 PIPs

Recommendations

- Continue to monitor (b) Waiver PM rates to determine if rates with substantial improvement or decline represent a continued trend or an anomaly in the performance measures.
- Recommendations for improvement were given to each PIHP for the PIPs that did not show improvement in indicator rates.

D. Utilization Management

42 CFR § 438.208

The 2021 EQR of Utilization Management (UM) encompassed a review of the PIHPs' Care Coordination functions, including the Mental Health/Substance Use (MH/SU), Intellectual/ Developmental Disability (I/DD), and TCLI Care Coordination programs. CCME reviewed relevant policies and procedures, Program Descriptions and Plans, enrollee notifications, Provider Manuals, Enrollee Handbooks, and job descriptions. A sample of 10 files of enrollees participating in MH/SU, I/DD, and TCLI Care Coordination were also selected by the PIHPs and reviewed by CCME. During the Onsite Interviews, PIHP staff provided additional information, including modifications made to Care Coordination and TCLI functions in order to adhere to the COVID-19 flexibilities as outlined in *NC Medicaid Contract, Amendment #11.*

In the 2020 EQR, four (Alliance, Sandhills, Trillium, and Vaya) of the six PIHPs met 100% of the UM EQR standards. Eastpointe and Partners met 96% of the standards and received Corrective Actions to improve compliance monitoring of Care Coordination documentation. Three (Alliance, Trillium, and Vaya) of the four PIHPs that met all of the standards also received Recommendations to better monitor Care Coordination documentation to improve upon the completeness, accuracy, and timeliness of documentation. The 2020 EQR of MH/SU, I/DD and TCLI files revealed that documentation was often incomplete, inaccurate, or out of compliance with the PIHP's policies or contractual requirements.

Table 19 provides an overview of the findings in each of the PIHP's 2020 Utilization Management EQRs and CCME's review to identify if the findings were addressed by the PIHP.

Table 19: 2020 EQR Utilization Management Corrective Actions and Recommendations

2020 EQR Utilization Management Corrective Actions and Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Alliance		
Assess each Medicaid enrollee identified as having special health care needs	***Recommendation: Revise the Individual and Family Handbook to reflect the ages to administer the CANS and the CALOCUS to children and adolescents as listed in the NC Medicaid Contract Sections 7.4.2. and 7.4.3.***	**Y**
2021 EQR Follow up: The 2021 review of the *Individual and Family Handbook* found that Alliance updated the ages to administer the CANS and the CALOCUS as listed in the *NC Medicaid Contract, Sections 7.4.2. and 7.4.3.*		

2020 EQR Utilization Management Corrective Actions and Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Determination of which Behavioral Health Services are medically necessary;	***Recommendation: Revise Procedure 2009 and the Innovations Individual and Family Handbook to include the exemption to the waiver cost limits /funding cap as listed in NC Joint Communication Bulletin #J362.***	**Y**
2021 EQR Follow up: For the 2021 EQR, Alliance updated Procedure 2009 ICF-IID, Deinstitutionalization Planning, by removing the reference regarding funding caps. Though the *Innovations Individual and Family Handbook* still states, "The individual budget cannot total more than the Innovations Waiver cost limit of $135,000 per year", it also states that enrollees can request services and supports to exceed the base budget.		
Provide follow-up activities for Enrollees;	***Recommendation: Include in Procedure 2015, Management of New/Open NC Innovations Slots, a follow-up process that confirms the member or LRP requests to delay or decline to participate in the Innovations Waiver.***	**Y**
2021 EQR Follow up: For the 2021 EQR, Alliance updated Procedure 2015, Management of New/Open NC Innovations Slots, to include a thorough follow up process that confirms the request made by the member or Legally Responsible Person (LRP) to delay or decline participation in the Innovations Waiver.		
The PIHP applies the Care Coordination policies and procedures as formulated.	***Recommendation: Enhance the current monitoring process to include a manual record review that routinely reviews the frequency of Care Coordinator contact with members receiving residential support.*** ***Ensure that the monitoring process includes the frequency of monitoring, departmental benchmarks for compliance, and how and when outcomes of monitoring are reviewed and reported.***	**Y**
2021 EQR Follow up: For the 2021 EQR, the review of the submitted MH/SU and I/DD Care Coordination files found that the frequency of Care Coordinator contact with members met *NC Medicaid Contract* requirements. Alliance also updated the *Care Coordination Monitoring Tool and the Care Management Dept Documentation Summary* to capture, track, and report the outcome of the monitoring process. This improvement in compliance was credited to Alliance's enhanced monitoring process.		
QOL Surveys are administered timely.	***Recommendation: Develop, document, and implement a comprehensive monitoring plan that will review the timeliness and completeness of Quality of Life Surveys at the required timeframes.***	**Y**
2021 EQR Follow up: For the 2021 EQR, Alliance submitted *The Care Coordination Documentation Monitoring Tool* template and a completed tool demonstrating six months of TCLI files monitoring. In further support of the use of this tool, the 2021 review of TCLI files showed all Quality of Life Surveys were implemented, which was an improvement from the previous EQR.		

2020 EQR Utilization Management Corrective Actions and Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Eastpointe		
Assess each Medicaid enrollee identified as having special health care needs;	***Recommendation: Update Policy C-3.4.16 Complex Case Management, and the Enrollee/Member and Family Handbook to reflect the criteria listed in NC Medicaid Contract Section 6.11.3.(c) g, for Children with Complex Needs.***	**Y**
2021 EQR Follow up: In the 2021 EQR, it was noted Eastpointe updated the *Enrollee/Member and Family Handbook* and Policy C-3.4.16 Complex Case Management to accurately reflect the contractual criteria.		
Determination of which Behavioral Health Services are medically necessary;	***Recommendation: Update Policy C-3.3.22 Resource Allocation and Individual Budgets to include the exclusion to waiver cost limits as listed in NC Joint Communication Bulletin J362.***	**Y**
2021 EQR Follow up: In the 2021 EQR, it was noted Eastpointe revised Policy C-3.3.22 Complex Case Management to accurately reflect exclusions and waiver cost limits outlined in *NC Joint Communication Bulletin J362*.		
The PIHP applies the Care Coordination policies and procedures as formulated.	***Corrective Action: Develop and document an enhanced quality monitoring process that routinely reviews I/DD Care Coordination documentation. This quality monitoring process should review I/DD progress notes and I/DD Monitoring Checklists for completeness, accuracy and compliance with Eastpointe policies and the NC Medicaid Contract and NC Medicaid Contract Amendment #11, Section 9. The quality monitoring process should also include routine review of ISPs to ensure they are person-centered and reflect the needs identified in assessments and other support tools.***	**N**
2021 EQR Follow up: This Corrective Action was partially implemented. For the 2021 EQR, Eastpointe updated the I/DD Monitoring plan, but CCME identified discrepancies in Care Coordination progress notes and other documentation.		

2020 EQR Utilization Management Corrective Actions and Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Partners		
Provide follow-up activities for Enrollees	***Recommendation: Update Policy and Procedure 9.05, the MHSU Care Management Program Description, and the TCLI How-to Manual to include the process for transferring enrollees to a new PIHP to ensure the continuation of services and support.***	**Y**
2021 EQR Follow up: In the 2021 EQR, the review of Policy and Procedure 9.05, the *MHSU Care Management Program Description*, and the *TCLI How-to Manual* found that Partners addressed the Recommendation by adding the process for transferring enrollees to a new PIHP.		
The PIHP applies the Care Coordination policies and procedures as formulated.	***Recommendation: Develop, document, and implement a process that routinely reviews the required State Monitoring Checklists for completeness and compliance with NC Clinical Coverage Policy 8P and NCDHHS HCBS Final Rule Transition Plan.*** ***Recommendation: Enhance the current monitoring plan to include a comprehensive review of Care Management documentation for enrollees scheduled for discharge or transfer to another PIHP as outlined in Partners Policy and Procedure 9.05.***	**Y**
2021 EQR Follow up: Partners updated the monitoring requirements to ensure a comprehensive review of Care Management documentation is conducted for enrollees discharging or transferring from TCLI. Partners also revised their *Comprehensive Case Record Review Checklist* to ensure Care Coordination documentation is complete and compliant.		
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.	***Corrective Action: Enhance the current monitoring plan to include a comprehensive review of files scheduled for discharge from TCLI and transfer to another PIHP. Ensure that the discharge and transfer process adhere to Partners Policy and Procedure 9.05 and the NC Transitions to Community Living Initiative (TCLI) In-Reach and Transition Manual.***	**Y**
2021 EQR Follow up: In the 2021 EQR, the review of TCLI files found that files scheduled for discharge followed Partners Policy and Procedure 9.05, and the *NC Transitions to Community Living Initiative (TCLI) In-Reach and Transition Manual*.		

2020 EQR Utilization Management Corrective Actions and Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Sandhills		
NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	***Recommendation: Add an explanation of Home and Community Based Services (HCBS) and the use of the required State Monitoring Checklist to a procedure, relevant I/DD Care Coordination manual, or I/DD document.***	**Y**
2021 EQR Follow up: In this 2021 EQR, Sandhills addressed the Recommendation and updated Procedure I/DD CC2, I/DD Care Coordination Monitoring of Plan Implementation.		
Trillium		
Assess each Medicaid enrollee identified as having special health care needs;	***Recommendation: Update the procedure for Complex Case Management to reflect the age requirement listed in NC Medicaid Contract, Section 6.11.3 (c), g, for Children with Complex Needs.***	**Y**
2021 EQR Follow up: Trillium updated the Complex Case Management Procedure to reflect the age requirement listed in *NC Medicaid Contract, Section 6.11.3 (c), g*, for Children with Complex Needs.		
Quality monitoring and continuous quality improvement;	***Recommendation: Revise the current monitoring plans for I/DD, MH/SU and TCLI to implement a data-driven process that identifies the frequency of Care Manager contacts, departmental benchmarks for compliance, and how and when outcomes of member contacts are captured, reviewed, and reported.***	**Y**
2021 EQR Follow up: Trillium updated the monitoring plans for MH/SU, I/DD and TCLI Departments to include compliance review of the frequency of Care Managers contacts, departmental benchmarks, and internal reporting. However, the files reviewed for this 2021 EQR showed the monitoring plan is still not effectively identifying compliance issues within Care Management documentation. While Trillium addressed this 2020 Recommendation, CCME again recommended they continue to revise and enhance their Care Management documentation.		
NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	***Recommendation: Revise the I/DD Monitoring Plan to reflect the service delivery monitoring requirements for residential services as outlined in NC Medicaid Contract, Section 6.11.3 (h) and NC Clinical Coverage Policy 8P.***	**Y**
2021 EQR Follow up: Trillium revised the monitoring plan for the I/DD Department to reflect Innovations monitoring requirements of enrollees receiving residential services, as outlined in *NC Medicaid Contract, Section 6.11.3 (h)* and *NC Clinical Coverage Policy 8P*. The review found that the I/DD Care Management files submitted by Trillium were compliant with the required monitoring of enrollees receiving residential supports.		

2020 EQR Utilization Management Corrective Actions and Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The PIHP applies the Care Coordination policies and procedures as formulated.	***Recommendation: Document and implement a process that routinely reviews I/DD Care Manager contacts to ensure members participating in residential supports receive monthly, face-to-face contacts. Include in this process a routine review of the HCBS Monitoring Check Sheets for compliance with NC Medicaid Contract, Section 6.11.3.h., NC Clinical Coverage Policy 8P and NCDHHS HCBS Final Rule Transition Plan.***	**Y**
2021 EQR Follow up: Trillium implemented a process that routinely reviews I/DD Care Manager contacts with members receiving residential supports and the HCBS Monitoring Check Sheets.		
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.	***Recommendation: Document and implement a process that routinely reviews TCLI Care Managers' progress notes to ensure this documentation is compliant with the TCLI Care Management Monitoring Plan.***	**Y**
2021 EQR Follow up: Trillium implemented a process that routinely reviewed TCLI Care Managers' progress notes to ensure compliance with the TCLI Care Management Monitoring Plan. The files reviewed also showed improvement from the previous year's EQR.		
Vaya		
The PIHP applies the Care Coordination policies and procedures as formulated.	***Recommendation: Enhance the current documentation monitoring plan to include routine review of timeliness of MH/SU and I/DD Care Management activities (e.g., discharge activities, follow-up activities, HCBS monitoring, etc.), as well as the quality and completeness of Care Managers' documentation.***	**N**
2021 EQR Follow up: In this 2021 EQR, Vaya partially addressed the Recommendation. Vaya updated the *Complex Care Management Quality Improvement & Monitoring Plan*. However, issues were identified in the timeliness and documenting of MH/SU Care Management progress notes.		

In the 2021 EQR, three (Alliance, Partners and Sandhills) of the six PIHPs met 100% of the UM EQR standards, and Eastpointe, Trillium, and Vaya met 96% of the standards. The primary issues noted in the 2021 EQR were again noted in the MH/SU, I/DD, and TCLI file reviews. With the exception of Partners, all PIHPs were encouraged to better monitor Care Coordination documentation for compliance issues and/or opportunities for improvement.

CCME provided technical assistance around methods to generate a data-driven process for Care Coordination documentation monitoring. For example, most of the PIHPs have recently implemented new Care Management platforms (e.g., Jiva, TruCare, Incedo, etc.) but have yet to maximize the built-in functions of the platform, such as Care Coordinator task reminders, late progress note alerts, lack of Care Coordinator engagement notifications, and the potential reports those functions can generate. CCME also encouraged PIHPs to move away from subjective record reviews during individual Care Coordinators' supervision and move towards a more global and data-driven process. By developing and implementing monitoring scoring tools, establishing departmental or regional compliance benchmarks, and routinely reviewing the data, PIHPs can better identify compliance trends, opportunities for improvement, and/or the need for staff training around Care Coordination documentation requirements.

Figure 5 and Table 20 provide an overview of the percentage of UM EQR standards met by each PIHP in the 2020 and 2021 EQRs.

Figure 5: Utilization Management Comparative data

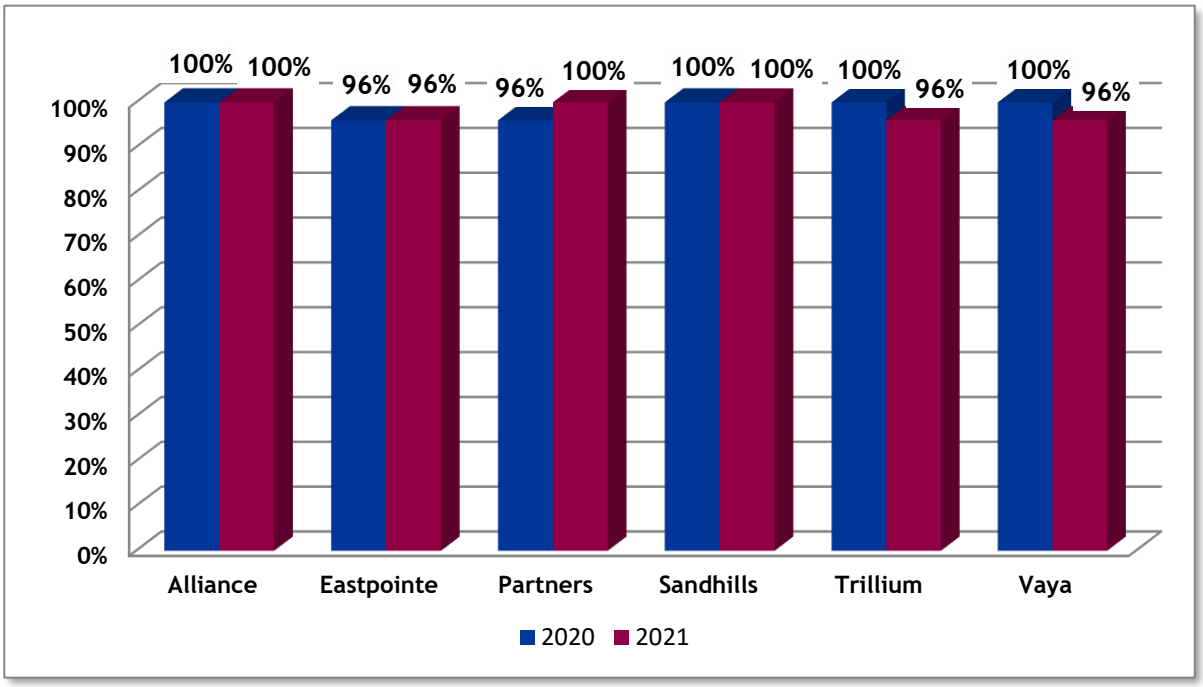


Table 20: Utilization Management Comparative Data

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	▶ = Quality ▶ = Timeliness ▶ = Access to Care
IV. A Care Coordination							***Strengths***
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	▶ All of the PIHPs addressed or partially addressed the Corrective Actions and Recommendations issued in the 2020 UM EQR. ▶ The completeness and accuracy of Care Coordination information in PIHP documentation (i.e., policies, enrollee handbooks, program descriptions, etc.) has significantly improved from previous EQRs.
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	
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	Met	Met	Met	Met	Met	Met	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
2.3 Assess each Medicaid enrollee identified as having special health care needs;	Met	Met	Met	Met	Met	Met	
2.4 Develop treatment plans for enrollees that meet all requirements;	Met	Met	Met	Met	Met	Met	
2.5 Quality monitoring and continuous quality improvement;	Met	Met	Met	Met	Met	Met	
2.6 Determine of which Behavioral Health Services are medically necessary;	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	Partially Met↓	
2.8 Coordinate care with each Enrollee's provider;	Met	Met	Met	Met	Met	Met	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	▶ = Quality ▶ = Timeliness ▶ = Access to Care
2.9 Provide follow-up activities for Enrollees;	Met	Met	Met	Met	Met	Met	***Weaknesses*** ▶ A pattern of incomplete, inaccurate, and untimely Care Coordinator documentation continues to be evident within the MH/SU, I/DD, TCLI files submitted by the PIHPs for the EQRs. ***Recommendations*** ▶ By implementing data-driven processes for compliance monitoring of Care Coordination documentation, PIHPs will better identify areas needing quality and/or compliance improvement.
2.10 Ensure privacy for each Enrollee is protected.	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	
3. The PIHP applies the Care Coordination policies and procedures as formulated.	Met	Partially Met	Met	Met	Partially Met ↓	Met	
IV. B Transition to Community Living Initiative							
1. Transition to Community Living functions are performed by appropriately licensed, or certified, and trained staff.	Met	Met	Met	Met	Met	Met	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
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	
2.1 Care Coordination activities occur as required.	Met	Met	Met	Met	Met	Met	
2.2 Person Centered Plans are developed as required.	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	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
2.4 A mechanism is in place to provide one-time transitional supports, if applicable.	Met	Met	Met	Met	Met	Met	
2.5 QOL Surveys are administered timely.	Met	Met	Met	Met	Met	Met	
3. Transition, diversion, and discharge processes are in place for TCLI enrollees as outlined in the DOJ Settlement and DHHS Contract.	Met	Met	Met	Met	Met	Met	
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	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
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	
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 ↑	Met	Met	Met	

Strengths

- All of the PIHPs addressed or partially addressed the Corrective Actions and Recommendations issued in the 2020 UM EQR.
- The completeness and accuracy of Care Coordination information in PIHP documentation (i.e., policies, enrollee handbooks, program descriptions, etc.) has significantly improved from previous EQRs.

Weaknesses

- A pattern of incomplete, inaccurate, and untimely Care Coordinator documentation continues to be evident within the MH/SU, I/DD, TCLI files submitted by the PIHPs for the EQRs.

Recommendations

- By implementing data-driven processes for compliance monitoring of Care Coordination documentation, PIHPs will better identify areas needing quality and/or compliance improvement.

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 average score of "Met" Grievance and Appeals standards increased to 100% in the 2021 EQR from 94% in the 2020 EQR.

Grievances

In the 2020 EQR, the PIHPs met 95% of the Grievance EQR standards. In the 2021 EQR, the combined PIHP compliance with the Grievance standards increased to 100%.

Table 21 outlines the 2020 EQR findings and the 2021 EQR assessment of whether those findings were addressed by the PIHPs.

Table 21: 2020 EQR Grievance Corrective Actions and Recommendations

2020 EQR Grievance Corrective Actions and Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Alliance		
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:	***Recommendations: Revise Procedure 6503, Management, and Investigation of Grievances to consistently use the term "Grievance".***	**Y**
2021 EQR Follow Up: Alliance updated the procedure in the version revised on July 11, 2021. The term Grievance is consistently used now.		
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:	***Recommendation: Within the Provider Operations Manual in the For Medicaid Related Grievances section, on pages 62-63, use one term "Grievance" or "Grievant" to reflect the Grievance process.***	**N**
2021 EQR Follow Up: The *Provider Operations Manual* provided in the 2021 EQR Desk Materials was revised on September 16, 2020, went into effect on October 16, 2020, and is the same manual published on Alliance's website. This was the same version of the *Provider Operations Manual* reviewed in the 2020 EQR, so there was no evidence Alliance implemented this Recommendation.		
1.1 Definition of a Grievance and who may file a Grievance	***Recommendations: Within Procedure 6503, Management, and Investigation of Grievances, include the definition of "Grievant" in the "Definitions" section.***	**Y**
2021 EQR Follow Up: The term "Grievant" was added to the Definitions section of Procedure 6503, Management and Investigation of Grievances.		
1.3 Timeliness guidelines for resolution of the Grievance as specified in the contract;	***Recommendation: Revise the Provider Operations Manual (pg. 62) to reflect that Grievances are resolved in 90 days, as required by Alliance Procedure 6503.***	**N**
2021 EQR Follow Up: The *Provider Operations Manual* provided in the 2021 EQR Desk Materials was revised September 16, 2020, effective October 16, 2020 and is the same manual published on Alliance's website. This was the same version of the *Provider Operations Manual* reviewed in the 2020 EQR. Therefore, there was no evidence Alliance implemented this Recommendation.		

2020 EQR Grievance Corrective Actions and Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
1.3 Timeliness guidelines for resolution of the Grievance as specified in the contract;	***Recommendations: Revise the Provider Operations Manual (pg.62) to include, Alliance will "make reasonable efforts to give the enrollee prompt oral notice of the delay" and written notice "within 2 calendar days" when Alliance extends the Grievance Resolution timeframe as required by Alliance Procedure 9603, 42 CFR § 438.408 (c)(2)(ii), and Attachment M of Alliance's NC Medicaid Contract.***	**N**
2021 EQR Follow Up: The *Provider Operations Manual* provided in the 2021 EQR Desk Materials was revised on September 16, 2020, went into effect on October 16, 2020, and is the same manual published on Alliance's website. This was the same version of the *Provider Operations Manual* reviewed in the 2020 EQR, so there was no evidence Alliance implemented this Recommendation.		
Eastpointe		
1.3 Timeliness guidelines for resolution of the Grievance as specified in the contract.	***Corrective Action: Add language to Policy Q-6.4.4 that Eastpointe will notify enrollees of their right to file a Grievance if the enrollee disagrees with Eastpointe's decision to extend the Grievance resolution timeframe. This will bring Eastpointe's policy into compliance with NC Medicaid Contract, Attachment M.6 and 42 CFR § 438.408 (c)ii.***	**Y**
2021 EQR Follow Up: Eastpointe provided Policy Q-6.4.4, revised June 16, 2021, that included the information on the right to file a Grievance if the Grievant disagrees with Eastpointe's Grievance resolution extension.		
2. The PIHP applies the Grievance policy and procedure as formulated.	***Corrective Action: Develop, document, and implement a monitoring plan to increase compliance with required Grievance notifications. This monitoring plan should include the timeline for implementation, frequency of monitoring, staff that will implement the monitoring, compliance benchmarks, and how and when outcomes of monitoring are captured, reviewed, and reported. Monitoring should ensure Grievance notifications are compliant with Eastpointe's Grievance policies, NC Medicaid Contract, Attachment M, and 42 CFR § 438.408 (b)2. Include in this monitoring plan the timeframe by which Eastpointe will resolve any provider Grievances placed on hold by Provider Monitoring Department.***	**Y**
2021 EQR Follow Up: The 2021 EQR shows evidence that Eastpointe is using the Grievance & Appeal Documentation Checklist to monitor resolutions times and issue timely notifications.		

2020 EQR Grievance Corrective Actions and Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Partners		
1.1 Definition of a Grievance and who may file a Grievance	***Recommendation: Within Policy and Procedure 6.00U, Grievance Management, the Member Handbook and the Provider Operations Manual, select and define one term for "an expression of dissatisfaction about any matter other than an Adverse Benefit Determination 42 C.F.R. 438.400(b)." and consistently use it within Procedure 6.00U, Grievance Management, the Member Handbook, the Provider Operations Manual, and all print material.***	**N**
2021 EQR Follow up: Partners updated the term Grievance/Complaint in the Policy and Procedure and in the *Provider Operations Manual*. The *Member Handbook* continues to contain the terms Grievance and Complaint separately throughout the handbook. There were no instances of using the term Grievance/Complaint in the *Member Handbook*.		
Sandhills		
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee Grievances in a manner consistent with contract requirements.	***Recommendation: Revise the Medicaid/State Provider Manual to consistently use the term "Grievance."***	**Y**
2021 EQR Follow up: In this 2021 EQR, it was noted there is consistent use of the term Grievance throughout the *Medicaid/State Provider Manual* updated November 4, 2020.		
1.3 Timeliness guidelines for resolution of the Grievance as specified in the contract;	***Recommendation: Add information to the Member Handbook regarding the process followed when Sandhills extends the Grievance resolution timeframe. Include the notifications required by 42 CFR § 438.408 (c)(1) and (c)(2).***	**Y**
2021 EQR Follow up: Page 24 of the *Member Handbook* (May 18, 2021) explains the extension process and notifications that are given when Sandhills or the member extends the Grievance resolution timeframe.		

2020 EQR Grievance Corrective Actions and Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Trillium		
1.3 Timeliness guidelines for resolution of the Grievance as specified in the contract	***Corrective Action: Revise the Grievance Process and Scope procedure to ensure the 90-day Grievance resolution timeframe is applied to all types of Grievances, not only provider-related Grievances.***	**Y**
2021 EQR Follow Up: The Grievance Process and Scope procedure was updated to include the 90-day Grievance resolution timeframe applies to all types of Grievances.		
1.3 Timeliness guidelines for resolution of the Grievance as specified in the contract	***Corrective Action: Ensure the process required by 42 CFR § 438.408 (c) is documented in the Grievance procedure to reflect all Grievances may be extended by Trillium.***	**Y**
2021 EQR Follow Up: Trillium revised the Grievance Process and Scope procedure to include the following required notifications when Trillium extends the Grievance resolution timeframe: • Make reasonable efforts to give the enrollee prompt oral notice of the delay. • Within two calendar days, give the enrollee written notice of the reason for the decision to extend the timeframe. • Inform the enrollee of the right to file a Grievance if he or she disagrees with that decision.		
1.3 Timeliness guidelines for resolution of the Grievance as specified in the contract	***Corrective Action: Ensure the process required by 42 CFR § 438.408 (c) is documented in the Complaint procedure to reflect all complaints may be extended by Trillium.***	**Y**
2021 EQR Follow Up: The Complaint Process and Scope procedure was revised to define the process when Trillium extends the Complaint resolution timeframe, as required by *42 CFR § 438.408 (c)*, including that Trillium may extend the Complaint resolution timeframe up to 14 calendar days if: • The enrollee requests the extension. • Trillium shows (to the satisfaction of NC Medicaid, upon its request) that there is need for additional information and how the delay is in the enrollee's interest. • Trillium extends the Complaint resolution timeframes, Trillium will: Make reasonable efforts to give the enrollee prompt oral notice of the delay. Within two calendar days, give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a Grievance if he or she disagrees with that decision.		

2020 EQR Grievance Corrective Actions and Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
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	***Recommendation: Include in the Grievance Process and Scope procedure how and where consultations with the Chief Medical Officer (CMO) and other members of the Executive Team are captured within Grievance files.***	**Y**
2021 EQR Follow Up: Page two of Section V in the Grievance Process and Scope procedure now states, "Documentation of any consultation and/or notification to the Chief Medical Officer or other Clinical Leadership, will be entered in the software platform Grievance module, under the specific Grievance record."		
Vaya		
2. The PIHP applies the Grievance policy and procedure as formulated.	***Recommendation: Enhance Vaya's monitoring process to ensure all Grievance acknowledgement and resolution letters are completed within the timeframes required by Policy 2607, Grievances and Complaints, NC Medicaid Contact and Attachment M, and 42 CFR § 438.408 (b)1.***	**Y**
2021 EQR Follow up: In the 2021 EQR, the file review demonstrated that Vaya's monitoring process resulted in a decrease of late resolution letters from two in the 2020 EQR to none in the 2021 EQR. There was one late Grievance acknowledgment notification noted in both review years.		
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	***Recommendation: Enhance the monitoring of the Grievance Log to ensure the Log contains only Grievances, as defined in Policy 2607, Grievances and Complaints.***	**Y**
2021 EQR Follow up: In the 2021 EQR, there was evidence that Vaya addressed this Recommendation as the Grievance Log only contained Grievance files and no Complaints.		

In the 2021 EQR of Grievances, the most common issue noted was the PIHPs' compliance with required notification timeframes. Four of the six PIHPs (Alliance, Eastpointe, Sandhills, and Vaya) received a Recommendation to enhance their compliance monitoring of Grievance files to ensure notifications are issued as required by *NC Medicaid Contract, Attachment M, Section C* and *42 CFR § 438*. Most of the PIHPs routinely monitor Grievance files and compliance improved from previous EQRs. However, minor

compliance issues were still noted in the 2021 EQR Grievance files reviewed. CCME continues to recommend PIHPs hone their monitoring processes of Grievances to ensure all required steps and notifications are occurring. This is particularly important for non-standard Grievances, such as Grievances that are submitted then later withdrawn.

In addition to this finding, two PIHPs (Alliance and Partners) received Recommendations in the 2020 EQR that were not implemented. Alliance failed to address two of the four Recommendations issued in the 2020 EQR and Partners did not address one Recommendation. As a result, these Recommendations were issued again in the 2021 EQR for Alliance and Partners.

Appeals

In the 2020 Appeals EQR, the average PIHP score of "Met" standards was 94%. In the 2021 EQR, the average PIHP compliance score increased to 100%.

Table 22 outlines the review of the Corrective Actions and Recommendations issued in the 2020 EQR and the findings from the 2021 EQR for each.

Table 22: 2020 Appeal EQR Corrective Actions and Recommendations

2020 EQR Appeal Corrective Actions and Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Alliance		
1.5 Timeliness guidelines for resolution of the Appeal as specified in the Contract	***Corrective Action: Within Procedure 6505, correct the language explaining the required written and verbal notifications from Alliance when Alliance extends the Appeal resolution timeframe. The language within these documents should reflect the language in 42 CFR § 438.408 (c)(2) and Alliance's NC Medicaid Contract, Attachment M, Section G.6 and should be added to both the standard Appeals and expedited Appeals sections of the procedure.***	**Y**
2021 EQR Follow Up: Alliance revised Procedure 6505 in both the Standard Medicaid Appeal and Expedited Medicaid Appeal sections to now accurately state, "Alliance shall make reasonable efforts to give the Enrollee prompt oral notice of the delay. Alliance will notify the member of the extension in writing within 2 calendar days".		

2020 EQR Appeal Corrective Actions and Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
1.5 Timeliness guidelines for resolution of the Appeal as specified in the Contract	***Corrective Action: Correct the Individual and Family Handbook to state:*** 1. ***Written resolution of an expedited Appeal will be provided within 72 hours of the receipt of the Appeal (See Alliance's Procedure 6505, III. Medicaid Appeals, Section C.8)*** 2. ***The 30-day Appeal resolution timeframe can be expedited (See 42 CFR § 438.408, Section (b) 2, NC Medicaid Contract, Attachment M, Section G.4 and Procedure 6505, III. Medicaid Appeals, Section B.1.g)*** 3. ***Written notification of an extension to the Appeal resolution timeframe by Alliance will be provided "within 2 calendar days" (See 42 CFR § 438.408 (c)(2), NC Medicaid Contract, Attachment M, Section G.6 (ii)).*** ***Alliance will notify the enrollee of their right to file a Grievance if they disagree with Alliance's decision to extend the Appeal resolution timeframe. (See 42 CFR § 438.408 (c)(2)(ii), NC Medicaid Contract, Attachment M, Section G.6.ii and Alliance's Procedure 6505, III. Medicaid Appeals, Sections B.1.g and C.5).***	**Y**
2021 EQR Follow Up: There was evidence in the 2021 EQR that Alliance revised the *Individual and Family Handbook* to include the required notifications for expedited Appeals and Appeals where Alliance extends the Appeal resolution timeframe.		
1.2 The procedure for filing an Appeal	***Recommendation: Update the Provider Operations Manual Table of Contents to reflect the correct pages for Appeal information.***	**Y**
2021 EQR Follow Up: Review of the *Provider Operations Manual* submitted for this 2021 EQR showed the Table of Contents directs readers to the correct page numbers for Appeal information.		

2020 EQR Appeal Corrective Actions and Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
1.2 The procedure for filing an Appeal	***Recommendation: Revise page 64 of the Individual and Family Handbook to reflect enrollees have 60 days from the mailing date of the Adverse Benefit Determination timeframe to file an Appeal.***	**Y**
2021 EQR Follow Up: Page 62 of the *Individual and Family Handbook* now correctly reflects that enrollees have 60 days from the mailing date of the Adverse Benefit Determination to file an Appeal.		
1.5 Timeliness guidelines for resolution of the Appeal as specified in the Contract	***Recommendation: Correct the Provider Operations Manual to reflect the verbal and written notifications Alliance issues when Alliance extends the Appeal resolution timeframe. Include the timeframes for these verbal and written notifications, as required by 42 CFR § 438.408 (c)(2) and NC Medicaid Contract, Attachment M, Section G.6.***	**N**
2021 EQR Follow Up: The *Provider Operations Manual* provided in the 2021 EQR Desk Materials was revised on September 16, 2020, went into effect on October 16, 2020, and is the same manual published on Alliance's website. This was the same version of the *Provider Operations Manual* reviewed in the 2020 EQR, so there was no evidence Alliance implemented this Recommendation.		
2. The PIHP applies the Appeal policies and procedures as formulated.	***Recommendation: Revise the monitoring process and Peer Review Tool to ensure expedited, extended, invalid, and withdrawn Appeals are routinely reviewed for compliance issues. For these Appeals, check to ensure all verbal and written notifications are provided in compliance with NC Medicaid Contract, Attachment M and 42 CFR § 438.406 and § 408.***	**Y**
2021 EQR Follow Up: Alliance revised the *Appeal Peer Review Tool* to ensure required verbal and written notifications for expedited, extended, invalid, and withdrawn Appeals are occurring and documented by staff.		
Eastpointe		
1.7 Other requirements as specified in the contract.	***Recommendation: Add to the Provider Operations Manual that Eastpointe will notify the enrollee of his right to file a Grievance if Eastpointe extends the Appeal resolution timeframe.***	**Y**
2021 EQR Follow Up: The *Provider Operations Manual FY 2021-2022*, effective July 1, 2021, was revised in the past year to state Eastpointe will notify the enrollee of their right to file a Grievance if the enrollee disagrees with Eastpointe's extension to the Appeal resolution timeframe.		

2020 EQR Appeal Corrective Actions and Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Partners		
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	***Recommendation: Continue Partners' Appeal monitoring process and focus on those Appeals that require intricate steps when processing, such as verbal, extended, expedited, and withdrawn Appeals, along with Appeals of Administratively Denied Service Authorizations.***	**Y**
2021 EQR Follow up: In the Onsite interview, Partners explained they implemented a focused Appeals monitoring process after the 2020 EQR. Every Appeals Specialist has one Appeal per month monitored, with a focus on those Appeals requiring intricate steps (i.e., verbal, extended, expedited, and withdrawn Appeals, along with Appeals of Administratively Denied Service Authorizations.)		
Sandhills		
1.4 A mechanism for expedited Appeal where the life or health of the enrollee would be jeopardized by delay;	***Corrective Action: Revise Sandhills' policies and procedures to state the requirement that Sandhills notify the enrollee of his or her right to file a Grievance if Sandhills denied a request to expedite an Appeal. See NC Medicaid Contract, Attachment M, Section H.1.***	Y
2021 EQR Follow up: In the 2021 EQR, there was evidence that Sandhills revised and published Sandhills' Appeal procedures to consistently detail the enrollee's right to file a Grievance if Sandhills denies a request to expedite an Appeal.		
2. The PIHP applies the Appeal policies and procedures as formulated.	***Corrective Action: Enhance the current Appeals monitoring process to ensure compliance of Appeal processes and notifications, especially those Appeals initiated orally.***	Y
2021 EQR Follow Up: Fields have been added to the audit tool to capture acknowledgement standards required by the *NC Medicaid Contract* for Appeals initiated orally. The revised audit tool was provided for review.		
1.1 The definitions an Appeal and who may file an Appeal;	***Recommendation: Define a "reasonable timeframe" for correcting errors identified in Member Handbook and Medicaid/State Provider Manual and publishing them on Sandhills' website. Add this timeframe to an applicable procedure.***	Y
2021 EQR Follow up: In the 2021 EQR, it was noted the *Member Handbook* (published May 18, 2021) and *Medicaid/State Provider Manual* (published November 13, 2020) are current on the Sandhills' website.		

2020 EQR Appeal Corrective Actions and Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	***Recommendation: In the enhanced Appeals monitoring process, include routine review of the Appeals Log to ensure data and documentation within the log are complete and accurate.***	Y
2021 EQR Follow up: In this 2021 EQR of Appeals, it was noted the Appeal monitoring process now includes a review of the Appeals Log. Further, dates of acknowledgements, notifications, resolutions, and decisions were accurately captured on the Appeal Log when compared to the 10 Appeal files reviewed in the 2021 EQR,		
Trillium		
1.7 Other requirements as specified in the contract.	***Corrective Action: Detail in the Appeal procedure the process staff follow when releasing the Appeals record or reference the Member Access to Protected Health Information procedure in the Medicaid Clinical Reconsideration Process procedure.***	**Y**
2021 EQR Follow Up: The Medicaid Clinical Reconsideration Process procedure now explains Trillium will provide protected information/documentation in compliance with Trillium's Member Access to Protected Health Information procedure.		
1.2 The procedure for filing an Appeal	***Recommendation: Revise the Provider Manual and the Member and Family Handbook to clarify that any written request can initiate the Appeal process.***	**Y**
2021 EQR Follow Up: It was noted in the 2021 EQR Trillium revised the *Provider Manual*. The manual now correctly states any written request can initiate the Appeal process, and Trillium's *Reconsideration Review Request form* is not required.		
1.2 The procedure for filing an Appeal	***Recommendation: Revise the Member and Family Handbook to consistently state that enrollees have 60 days from the mailing date of the Adverse Benefit Determination notification to request an Appeal.***	**Y**
2021 EQR Follow Up: Trillium revised the *Member and Family Handbook* to state Appeals must be filed within 60 days of the mailing date of the Adverse Benefit Determination notification.		

2020 EQR Appeal Corrective Actions and Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
1.5 Timeliness guidelines for resolution of the Appeal as specified in the contract	***Recommendation: Add to the Provider Manual and the Member and Family Handbook that Trillium is required to notify the enrollee of their right to file a Grievance if Trillium extends the Appeal resolution timeframe.***	**Y**
2021 EQR Follow Up: In the past year, Trillium revised the manual and handbook to inform members of their right to file a Grievance if they disagree when Trillium extends the Appeal resolution timeframe.		
2. The PIHP applies the Appeal policies and procedures as formulated	***Recommendation: Monitor all Appeal notifications to ensure required contractual language is not deleted through the automation process.***	**Y**
2021 EQR Follow Up: During the 2021 Onsite, Trillium explained they implemented a "double review" of notifications before they are released to monitor notifications for compliance issues. This monitoring process was noted to have improved the compliance of the notifications reviewed in the 2021 EQR Appeal file review.		
Vaya		
2. The PIHP applies the appeal policies and procedures as formulated.	***Recommendation: Develop, document, and implement an enhanced monitoring process to ensure all Appeals notifications, oral and written, are issued within the timeframes required by Policy 2384, Member Appeals of Adverse Decisions, NC Medicaid Contract, Attachment M, and 42 CFR § 438.***	**Y**
2021 EQR Follow up: In the 2021 EQR, overall improvement in compliance and accuracy was noted in the Appeal files when compared to the 2020 EQR. This improvement was credited to the Appeal monitoring process implemented by Vaya.		
4. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	***Recommendation: As a part of the enhanced Appeals monitoring process, routinely review the full Appeal Log for data entry errors or omissions, including Appeal data related to expedited, extended, invalid, and withdrawn Appeals.***	**Y**
2021 EQR Follow up: For the 2021 EQR, the data within the Appeal Log matched the data within the Appeal files reviewed. This improvement was credited to the Appeal monitoring process implemented by Vaya.		

In the 2021 Appeals EQR, there was notable improvement in the PIHP documentation and files regarding expedited Appeals and Appeals where the PIHP extends the Appeal Resolution timeframe. In the previous EQRs, PIHP documentation and Appeal processes failed to address all of the required notifications outlined in *42 CFR § 438.408 (c)(2)*. Five of six of the PIHPs addressed the 2020 Appeals EQR Recommendations to either revise documentation or better monitor expedited or extended Appeals to ensure compliance with the required notifications. Alliance did not address the 2021 Recommendation to correct their Provider Operations Manual to accurately explain the notifications required by *42 CFR § 438.408 (c)(2)(ii)* and this Recommendation was again issued in the 2021 EQR. Additionally, only Alliance and Vaya received 2021 EQR Recommendations to address minor compliance issues related to expedited and extended Appeals files.

In the 2021 EQR of Appeals, improvement in the file review was credited to enhancements made by the PIHPs to their compliance monitoring of Appeal files. However, there continues to be opportunities for improvement in the monitoring of Appeals. PIHPs would benefit from focusing their monitoring on Appeals requiring multiple written and verbal notifications, such as expedited Appeals and Appeals where the PIHP extended the Appeal resolution timeframe. Further, monitoring of non-standard Appeals, such as withdrawn Appeals, invalid Appeals, and Appeals of administratively denied services authorization requests would help PIHPs ensure all Appeals are processed in compliance with *NC Medicaid Contract, Attachment M* and Federal regulations.

Figure 6 and Table 23 that follow provide an overview of the PIHPs' performance in the Grievances and Appeals section in the 2021 EQR.

Figure 6: Grievances and Appeals Comparative data

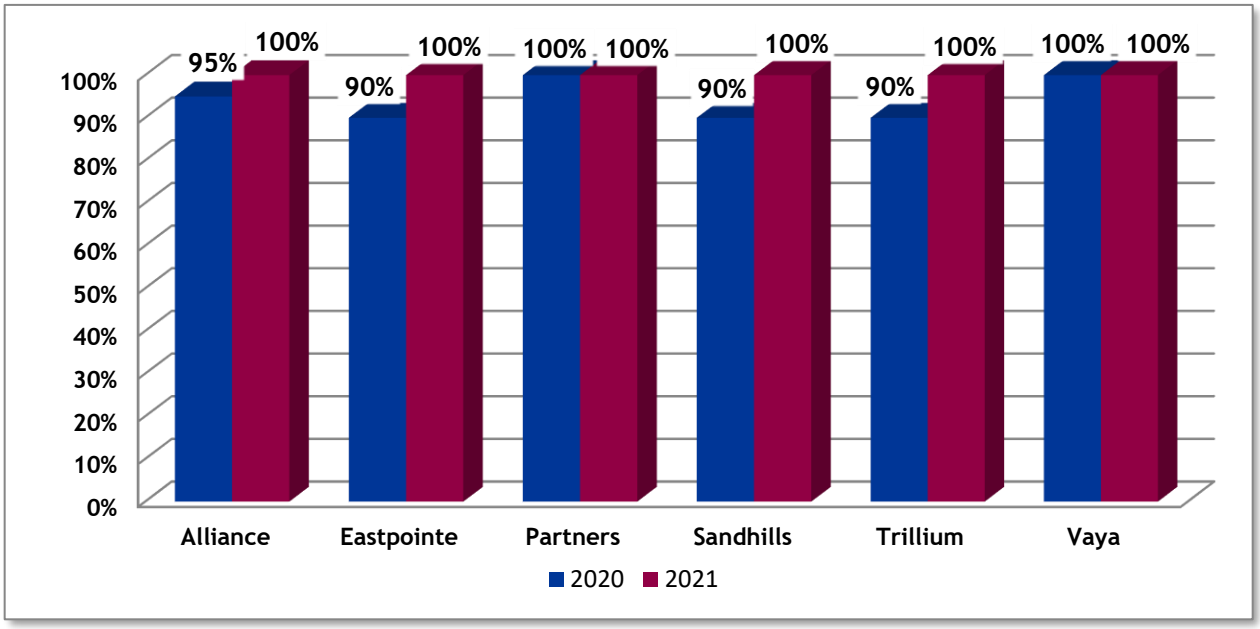


Table 23: Grievances and Appeals Comparative Data

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
V. A GRIEVANCES							***Strengths***
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	▶ PIHP Grievance EQR scores improved over last year's review from 95% in the 2020 EQR to 100% in the 2021 EQR. ▶ PIHP Appeal EQR scores improved over last year's review from 94% in the 2020 EQR to 100% in the 2021 EQR. ▶ In the 2021 EQR of Appeals, improvement in the file review was credited to enhancements made by the PIHPs to their compliance monitoring of Appeal files. ▶ There was notable improvement in the PIHP documentation and files regarding expedited Appeals and Appeals where the PIHP extends the Appeal Resolution timeframe.
1.1 Definition of a Grievance and who may file a grievance;	Met	Met	Met	Met	Met	Met	
1.2 The procedure for filing and handling a Grievance;	Met	Met	Met	Met	Met	Met	
1.3 Timeliness guidelines for resolution of the Grievance as specified in the contract;	Met	Met ↑	Met	Met	Met ↑	Met	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	▶ = Quality ▶ = Timeliness ▶ = Access to Care
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	***Weaknesses*** ▶ While PIHP monitoring of Grievance and Appeal files has resulted in improved compliance in the EQR files reviews, PIHPs should continue to routinely review files for compliance issues and opportunities for quality improvement. ***Recommendations*** ▶ PIHPs would benefit from continuing to routinely monitor Grievance and Appeal files for compliance issues and opportunities for quality improvement. Monitoring efforts should focus on those non-standard Grievances and Appeals, such as withdrawn Grievances, expedited Appeals, and Grievances and Appeals where the PIHP extended the resolution timeframe.
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	
2. The PIHP applies the Grievance policy and procedure as formulated.	Met	Met ↑	Met	Met	Met	Met	
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	Met	Met	Met	Met	Met	Met	
4. The PIHP applies the Grievance policy and procedure, as formulated.	Met	Met	Met	Met	Met	Met	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
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	
1.1 The definitions of an appeal and who may file an Appeal;	Met	Met	Met	Met	Met	Met	
1.2 The procedure for filing an Appeal;	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	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
1.4 A mechanism for expedited Appeal where the life or health of the enrollee would be jeopardized by delay;	Met	Met	Met	Met ↑	Met	Met	
1.5 Timeliness guidelines for resolution of the Appeal as specified in the contract;	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	
1.7 Other requirements as specified in the contract.	Met	Met	Met	Met	Met	Met	
2. The PIHP applies the Appeal policies and procedures as formulated.	Met	Met	Met	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	
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	Met	Met	Met	Met	Met ↑	Met	

Strengths

- PIHP Grievance EQR scores improved over last year's review from 95% in the 2020 EQR to 100% in the 2021 EQR.
- PIHP Appeal EQR scores improved over last year's review from 94% in the 2020 EQR to 100% in the 2021 EQR.
- In the 2021 EQR of Appeals, improvement in the file review was credited to enhancements made by the PIHPs to their compliance monitoring of Appeal files.
- There was notable improvement in the PIHP documentation and files regarding expedited Appeals and Appeals where the PIHP extends the Appeal Resolution timeframe.

Weaknesses

- While PIHP monitoring of Grievance and Appeal files has resulted in improved compliance in the EQR files reviews, PIHPs should continue to routinely review files for compliance issues and opportunities for quality improvement.

Recommendations

- PIHPs would benefit from continuing to routinely monitor Grievance and Appeal files for compliance issues and opportunities for quality improvement. Monitoring efforts should focus on those non-standard Grievances and Appeals, such as withdrawn Grievances, expedited Appeals, and Grievances and Appeals where the PIHP extended the resolution timeframe.

F. Program Integrity

42 CFR § 438.455 and 1000 through1008, 42 CFR § 1002.3(b)(3), and 42 CFR 438.608 (a)(vii)

The 2021 Program Integrity EQR included a thorough Desk Review of PIHP Program Integrity (PI) functions. The review included policies and procedures related to Special Investigative Unit (SIU) investigations, Provider Overpayments, and related aspects of compliance. The EQR also reviewed PI staffing, workflows, reports, training materials, committee minutes, data mining, and a file review of active PI investigation cases. For each PIHP, an Onsite discussion occurred with key staff such as Program Integrity, Claims, Waiver Programs, and Special Investigations staff and PIHP Compliance Officers.

In the 2020 EQR, all of the PIHPs met 100% of the PI standards. Eight Recommendations were issued across four PIHPs. Six of the eight Recommendations were addressed by the PIHPs. One Recommendation each was not addressed by Vaya and by Trillium. Most PIHPs updated key documents with *NC Medicaid Contract* language to address the 2020 PI Recommendations.

Table 24 provides an overview of the 2020 EQR PI findings for each of the PIHPs and the follow up on the 2020 findings in the 2021 EQR.

Table 24: 2020 EQR Program Integrity Corrective Actions and Recommendations

2020 EQR Program Integrity Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Alliance		
2021 EQR Follow up: No Recommendations or Corrective Actions were issued in the 2020 Program Integrity EQR.		
Eastpointe		
2021 EQR Follow up: No Recommendations or Corrective Actions were issued in the 2020 Program Integrity EQR.		
Partners		
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:	***Recommendation: Ensure staff complete and routinely update the Investigative Summary form to provide an overview of the investigation and its current status within the investigative process.***	**Y**
2021 EQR Follow up: In the 2021 EQR, evidence was provided that demonstrated Partners addressed this 2020 Recommendation. In the 2021 EQR, Partners provided a Report of Investigation (ROI) document for all cases referred to NC Medicaid Program Integrity and reported all remaining cases have Ethicspoint summaries.		
Sandhills		
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	***Recommendation: Define the frequency of the ongoing BOD Compliance training in their Corporate Compliance Plan to ensure this training is occurring consistently.***	**Y**

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).*		
2021 EQR Follow up: Sandhills indicated in Sandhills Center Corporate Compliance and Internal Audit Plan - FY 2020-2021that its Human Resources department provides initial and annual orientation and education programs, which include an overview of corporate compliance.		
Trillium		
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 *NCGS 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.	***Recommendation: Add specific language to procedures describing the collection of provider funds process, when instructed in writing by NC Medicaid. See NC Medicaid contract, Section 14.3.5.***	**N**
2021 EQR Follow up: Trillium did not include this language in its policies or procedures, in the *Provider Manual,* nor in any training or communication documentation provided by Trillium for review.		

2020 EQR Program Integrity Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Vaya		
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.	***Recommendation: Develop, document, and implement a strategy that ensures Regulatory Compliance minutes are submitted to NC Medicaid within seven days of the State's request.***	**Y**
2021 EQR Follow up: Vaya has implemented this Recommendation. NC Medicaid staff indicated that they have been receiving all required minutes since March 2021.		
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.	***Recommendations: Add language to Vaya PI policies detailing the contractual requirement of initiating preliminary investigations within ten business days of receipt of a potential allegation of fraud.*** ***Develop, document, and implement a monitoring plan that routinely reviews the PI files for timely initiation of preliminary investigations as required by NC Medicaid Contract, Section 14.2.8.***	**Y**
2021 EQR Follow up: This Recommendation was addressed. Vaya included the required timelines in policies. The 2021 file review found all files implemented within the required timeframe.		
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;	***Recommendation: Develop, document, and implement a monitoring plan that routinely reviews PI files to ensure information on the NC Medicaid approved template is complete and accurate and contains the information required by NC Medicaid Contract, Section 14.2.9.***	**Y**
2021 EQR Follow up: This Recommendation was addressed by Vaya. Additionally, the 2021 file review found that Vaya included all information on the NC Medicaid approved template.		

2020 EQR Program Integrity Recommendations		
Standard	**EQR Comments**	**Implemented Y/N/NA**
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.	***Recommendation: Add language to a Vaya PI policy detailing the process and timeframes required by NC Medicaid Contract for submission of the monthly NCID holders/FAMS-users report to the State.***	**N**
2021 EQR Follow up: This Recommendation was not addressed. Vaya has elected not to implement this in policy. During the Onsite, Vaya expressed that not all contract language needs to be included in their policies.		

The 2021 EQR of each PIHP's Program Integrity program resulted in 100% of the standards being "Met". All PI case files reviewed for the 2021 EQR were organized, comprehensive, and compliant with *NC Medicaid Contract* requirements. PIHPs demonstrated increased commitment to using advanced analytics in conjunction with the Financial Analysis and Management System (FAMS), as well as internal datamining efforts to identify possible cases of fraud, waste, and abuse. During Onsite discussion, several PIHPs explained innovative reports and collaborative efforts being used to identify and even predict possible cases of fraud.

All PIHPs reported an emphasis on increasing collaboration and communication with external stakeholders, such as providers and members. Enhanced access to many training materials was made possible through the provider and member websites. This availability was particularly impactful in ensuring both internal staff and providers received necessary training materials during the many access issues related to COVID-19.

Figure 7 and Table 25 provide an overview of the percentage of EQR standards met by each PIHP in the Program Integrity review in the 2020 and 2021 EQRs.

Figure 7: Program Integrity Comparative data

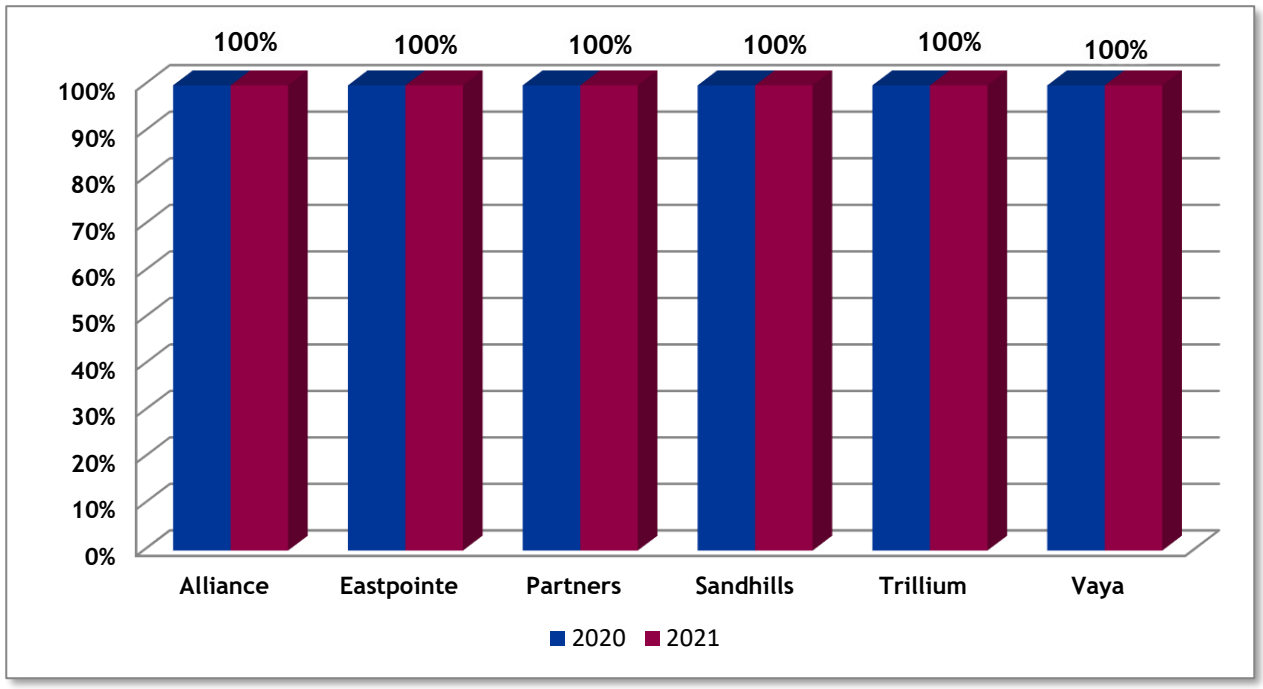


Table 25: Program Integrity Comparative Data

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	▶ = Quality ▶ = Timeliness ▶ = Access to Care
VI. A. General Requirements							
1. PIHP shall be familiar and comply with *Section 1902(a)(68)* of the Social Security Act, *42 CFR § 438.455* and *1000* through *1008*, as applicable, including proper payments to Providers and methods for detection of fraud and abuse.	Met	Met	Met	Met	Met	Met	***Strengths*** ▶ All PI case files reviewed during the 2021 EQR were organized, comprehensive, and compliant with NC Medicaid Contract requirements. ▶ The PIHPs demonstrated an increased commitment to using advanced analytics in conjunction with FAMS, as well as internal datamining efforts to identify possible cases of fraud, waste, and abuse. ▶ Enhanced access to many training materials was made possible through the provider and member websites. This availability was particularly impactful in ensuring both internal staff and providers received necessary training materials during the many access issues created by COVID-19.
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	
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	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
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	
VI. B. Fraud and Abuse							
1. PIHP shall establish and maintain a written Compliance Plan consistent with *42 CFR § 438.608* that is designed to guard against fraud and abuse. The Compliance Plan shall be submitted to the NC Medicaid Contract Administrator on an annual basis.	Met	Met	Met	Met	Met	Met	
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	Met	Met	Met	Met	Met	Met	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
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	Met	Met	Met	Met	Met	Met	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	▶ = Quality ▶ = Timeliness ▶ = Access to Care
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 North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the N.C. Department of Justice ("MFCU/ MID').	Met	Met	Met	Met	Met	Met	
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	
7. The Division recognizes that the scope of the PIHP's	Met	Met	Met	Met	Met	Met	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
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.							
8. PIHP's written Compliance Plan shall, at a minimum include:							
8.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(66) of the Social Security Act;	Met	Met	Met	Met	Met	Met	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
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	
8.3 Enforcement of standards through well-publicized disciplinary guidelines;	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 DHB 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	
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	Met	Met	Met	Met	Met	Met	

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	Met	Met	Met	Met	Met	Met	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
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;	Met	Met	Met	Met	Met	Met	
10.2 Detailed workflow of the PIHP process for taking a complaint from inception through closure. This process shall include procedures for logging the complaint, determining if the complaint is valid, assigning the complaint, investigating, appeal, recoupment, and closure. The detailed workflow needs to differentiate the steps taken for fraud versus abuse; PIHP shall establish and implement policies for treatment of recoveries of all overpayments from PIHP to Providers and contracted agencies, specifically including retention policies for treatment of recoveries of overpayments due to fraud, waste, or abuse. The retention policies shall include processes, timeframes, and required documentation for	Met	Met	Met	Met	Met	Met	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
payment of recoveries of overpayments to the State in situations where PIHP is not permitted to retain some or all of the recoveries of overpayments. This provision shall not apply to any amount of recovery to be retained under False Claims Act cases or through other investigations.							
10.3 In accordance with Attachment Y – Audits/Self-Audits/Investigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an· overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.	Met	Met	Met	Met	Met	Met	
10.4 Process for tracking overpayments and collections, based on fraud or abuse, including Program Integrity and Provider Monitoring activities initiated by PIHP and reporting on Attachment Y – Audits/Self-Audits/Investigations;	Met	Met	Met	Met	Met	Met	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
10.5 Process for handling self-audits and challenge audits;	Met	Met	Met	Met	Met	Met	
10.6 Process for using data mining to determine leads;	Met	Met	Met	Met	Met	Met	
10.7 Process for informing PIHP employees, subcontractors, and providers regarding the False Claims Act;	Met	Met	Met	Met	Met	Met	
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	
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	
10.10 Process for obtaining financial information on	Met	Met	Met	Met	Met	Met	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
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.	Met	Met	Met	Met	Met	Met	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
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	
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	
13.2 Source/origin of complaint;	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	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
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	
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	
13.6 All communications between PIHP and the Provider concerning the conduct at issues, when available.	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	
13.8 Total Sample Amount of Funds Investigated per Service Type.	Met	Met	Met	Met	Met	Met	
14. In each case where PIHP refers suspected Enrollee fraud to NC Medicaid, PIHP shall provide NC Medicaid Program Integrity with the following							

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	▶ = Quality ▶ = Timeliness ▶ = Access to Care
information on the NC Medicaid approved template:							
14.1 The Enrollee's name, birth date, and Medicaid number;	Met	Met	Met	Met	Met	Met	
14.2 The source of the allegation;	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	
14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;	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	
14.6 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation; and	Met	Met	Met	Met	Met	Met	
14.7 The legal and administrative status of the case.	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	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
14.9 Details that relate to the original allegation that PIHP received which triggered the investigation;	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	
14.11 Information on Biller/Owner;	Met	Met	Met	Met	Met	Met	
14.12 Additional Provider Locations that are related to the allegations;	Met	Met	Met	Met	Met	Met	
14.13 Legal and Administrative Status of Case.	Met	Met	Met	Met	Met	Met	
15. PIHP and NC Medicaid shall mutually agree on program integrity and monitoring forms, tools, and letters that meet the requirements of State and Federal law, rules, and regulations, and are consistent with the forms, tools and letters utilized by other PIHPs.	Met	Met	Met	Met	Met	Met	
16. PIHP shall use the NC Medicaid Fraud and Abuse Management System (FAMS) or a NC Medicaid approved alternative data mining	Met	Met	Met	Met	Met	Met	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
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.	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	Met	Met	Met	Met	Met	Met	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
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.							

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
VI. 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							

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
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.	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	Met	Met	Met	Met	Met	Met	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
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.	Met	Met	Met	Met	Met	Met	
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	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
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	
6. In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment,	Met	Met	Met	Met	Met	Met	

Standard	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya	= Quality = Timeliness = Access to Care
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.							

Strengths

- All PI case files reviewed during the 2021 EQR were organized, comprehensive, and compliant with NC Medicaid Contract requirements.
- The PIHPs demonstrated an increased commitment to using advanced analytics in conjunction with FAMS, as well as internal datamining efforts to identify possible cases of fraud, waste, and abuse.
- Enhanced access to many training materials was made possible through the provider and member websites. This availability was particularly impactful in ensuring both internal staff and providers received necessary training materials during the many access issues created by COVID-19.

FINDINGS SUMMARY

Overall, the PIHPs sustained or showed improvements over the past year. The average PIHP EQR score increased from 98.8% to 99.5%. *Figure 8: Annual EQR Focused Review Comparison* reflects the total percentage of standards scored as "Met" for the 2020 through 2021 EQRs. The percentages highlighted in green indicate an improvement over the prior review findings. Those highlighted in yellow represent a reduction in the prior review's findings.

Figure 8: Annual EQR Focused Review Comparisons

EQR SECTION	ALLIANCE		EASTPOINTE		PARTNERS		SANDHILLS		TRILLIUM		VAYA	
	2020	2021	2020	2021	2020	2021	202	2021	2020	2021	2020	2021
Administration	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Provider Services	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Quality Improvement	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Utilization Management	100%	96%	96%	96%	96%	100%	100%	100%	100%	98%	96%	100%
Grievances and Appeals	95%	95%	90%	100%	100%	100%	90%	100%	90%	100%	100%	100%
Program Integrity	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 26: Compliance Results for Part 438 Subpart D and QAPI Standards provides an overview of the EQR review results for *Part 438 Subpart D* and QAPI standards for the past two focused EQR reporting cycles (2020 and 2021). Scores were determined by aligning the EQR sections with the appropriate CFRs, then determining what percentage of these standards were met, per each CFR.

Table 26: Compliance Results for Part 438 Subpart D and QAPI Standards

	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya
2021						
Availability of Services (*§438.206*)	*NA	*NA	*NA	*NA	*NA	*NA
Assurance of Adequate Capacity and Services (*§438.207*)	*NA	*NA	*NA	*NA	*NA	*NA
Coordination and Continuity of Care (*§438.208*)	100%	96%	96%	100%	100%	100%
Coverage and Authorization of Services (*§438.210*)	100%	98%	100%	100%	98%	98%
Provider Selection Provider (*§438.214*)	100%	100%	100%	100%	100%	100%
Confidentiality (*§438.224*)	100%	100%	100%	100%	100%	100%
Grievance and Appeal Systems (*§438.228*)	100%	90%	100%	90%	90%	100%
Subcontractual Relationships and Delegation (*§438.230*)	*NA	*NA	*NA	*NA	*NA	*NA
Practice Guidelines (*§438.236*)	*NA	*NA	*NA	*NA	*NA	*NA
Health Information Systems (*§438.242*)	100%	100%	100%	100%	100%	100%
Quality Assessment and Performance Improvement Program (*§438.330*)	100%	100%	100%	100%	100%	100%

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	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya
2020						
Availability of Services (*§438.206*)	*NA	*NA	*NA	*NA	*NA	*NA
Assurance of Adequate Capacity and Services (*§438.207*)	*NA	*NA	*NA	*NA	*NA	*NA
Coordination and Continuity of Care (*§438.208*)	100%	96%	100%	100%	96%	96%
Coverage and Authorization of Services (*§438.210*)	100%	98%	98%	100%	100%	98%
Provider Selection Provider (*§438.214*)	100%	100%	100%	100%	100%	100%
Confidentiality (*§438.224*)	100%	100%	100%	100%	100%	100%
Grievance and Appeal Systems (*§438.228*)	100%	100%	100%	100%	100%	100%
Subcontractual Relationships and Delegation (*§438.230*)	*NA	*NA	*NA	*NA	*NA	*NA
Practice Guidelines (*§438.236*)	*NA	*NA	*NA	*NA	*NA	*NA
Health Information Systems (*§438.242*)	100%	100%	100%	100%	100%	100%
Quality Assessment and Performance Improvement Program (*§438.330*)	100%	100%	100%	100%	100%	100%

= Indicates compliance scores of 75% or higher in the 2021 EQR.

ATTACHMENTS

- Attachment 1: 2021 NC EQR Standards
- Attachment 2: 2021 NC EQR Desk Materials

Attachment 1: 2021 NC EQR Standards

Prepaid Inpatient Health Plan (PIHP) Standards For 2021 Focused External Quality Review

I. Administration

D. Management Information Systems

1. Enrollment Systems

1.1 The PIHP capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.

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

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

2. Claims System

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

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

2.3. The PIHP has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal, including all ICD-10 diagnosis codes received on an 837 Institutional and 837 Professional file. The PIHP has the capability of receiving and storing ICD-10 procedure codes on an 837 Institutional file.

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

3. Reporting

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

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

4. Encounter Data Submission

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

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

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

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

II. Provider Services

A. Credentialing and Recredentialing

1. The PIHP formulates and acts within policies and procedures related to the credentialing and recredentialing of health care Providers in a manner consistent with contractual requirements.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the PIHP.
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of Provider.
   - 3.1 Verification of information on the applicant, including:
     - 3.1.1 Insurance requirements
     - 3.1.2 Current valid license to practice in each state where the Practitioner will treat Enrollees;
     - 3.1.3 Valid DEA certificate; and/or CDS certificate
     - 3.1.4 Professional education and training, or board certification if claimed by the applicant;
     - 3.1.5 Work history;
     - 3.1.6 Malpractice claims history;
     - 3.1.7 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;
     - 3.1.8 Query of the National Practitioner Data Bank (NPDB);
     - 3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline) and query of the *State Exclusion List*;
     - 3.1.10 Query of the System for Award Management (SAM);
     - 3.1.11 Query for Medicare and/or Medicaid sanctions Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE);
     - 3.1.12 Query of the Social Security Administration's Death Master File (SSADMF);
     - 3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);
     - 3.1.14 Names of hospitals at which the physician has admitting privileges, if any.

3.1.15 Ownership Disclosure is addressed;
3.1.16 Criminal background Check.

3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.

4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.
   4.1 Recredentialing every three years;
   4.2 Verification of information on the applicant, including:
      4.2.1 Insurance requirements;
      4.2.2 Current valid license to practice in each state where the Practitioner will treat Enrollees;
      4.2.3 Valid DEA certificate; and/or CDS certificate;
      4.2.4 Board certification if claimed by the applicant;
      4.2.5 Malpractice claims since the previous credentialing event;
      4.2.6 Practitioner attestation statement;
      4.2.7 Requery of the NPDB;
      4.2.8 Requery for state sanctions and/or license limitations (State Board of Examiners for the specific discipline) since the previous credentialing event and query of the *State Exclusion List*;
      4.2.9 Requery of the SAM;
      4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (OIG LEIE);
      4.2.11 Requery of the Social Security Administration's Death Master File;
      4.2.12 Requery of the NPPES;
      4.2.13 Names of hospitals at which the physician has admitting privileges, if any.
      4.2.14 Ownership Disclosure is addressed.
   4.3 Site reassessment if the provider has had quality issues.
   4.4 Review of Provider profiling activities.

5. The PIHP formulates and acts within written policies and procedures for suspending or terminating a Practitioner's affiliation with the PIHP for serious quality of care or service issues.

6. Organizational Providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.

III. Quality Improvement

C. Performance Measures

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

D. Quality Improvement Projects

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

IV. Utilization Management

C. Care Coordination

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

D. Transition to Community Living Initiative (TCLI)

1. Transition to Community Living Initiative (TCLI) functions are performed by appropriately licensed, or certified, and trained staff.
2. The PIHP has policies and procedures that address the TCLI activities and includes all required elements
   - 2.1 Care Coordination activities occur as required.
   - 2.2 Person Centered Plans are developed as required.
   - 2.3 Assertive Community Treatment, Peer Support, Supported Employment, Community Support Team, Psychosocial Rehabilitation, and other services as set forth in the DOJ Settlement are included in the individual's transition, if applicable.

2.4 A mechanism is in place to provide one-time transitional supports, if applicable.
2.5 Quality of Life Surveys are administered timely.

3. Transition, diversion, and discharge processes are in place for TCLI members as outlined in the DOJ Settlement and DHHS Contract.
4. Clinical Reporting Requirements: The PIHP will submit the required data elements and analysis to NC Medicaid within the timeframes determined by NC Medicaid.
5. The PIHP will develop a TCLI communication plan for external and internal stakeholders providing information on the TCLI initiative, resources, and system navigation tools, etc. This plan should include materials and training about the PIHP's crisis hotline and services for enrollees with limited English proficiency.
6. A review of files demonstrates the PIHP is following appropriate TCLI policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.

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 C.F.R. 438.608 that is designed to guard against fraud and abuse. The Compliance Plan shall be submitted to the *NC Medicaid Contract* Administrator on an annual basis.

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

3. PIHP shall establish and implement a special investigations or program integrity unit, however named, that is responsible for PIHP program integrity activities, including identification, detection, and prevention of fraud, waste, and abuse in the PIHP Closed Provider Network. PIHP shall identify an appropriately qualified contact for Program Integrity and Regulatory Compliance issues as mutually agreed upon by PIHP and NC Medicaid. This person may or may not be the PIHP Compliance Officer or the PIHP Contract Administrator. In addition, PIHP shall identify a primary point of contact within the Special Investigations Unit to receive and respond to data requests from MFCU/MID. The MFCU/ MID will copy the PIHP Contract Administrator on all such requests.

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

5. PIHP shall send staff to participate in monthly meetings with NC Medicaid Program Integrity staff either telephonically or in person, at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.

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

7. Within seven (7) business days of a request by the Division, PIHP shall also make portions of the PIHP's Regulatory Compliance and Program Integrity minutes relating to Program Integrity issues available for review, but the PIHP may, redact other portions of the minutes not relating to Regulatory Compliance or Program Integrity issues.

8. PIHP's written Compliance Plan shall, at a minimum include:

8.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(66) of the Social Security Act;

8.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing, and development of corrective action initiatives;

8.3 Enforcement of standards through well-publicized disciplinary guidelines;

8.4 Provision for full cooperation by PIHP and PIHP's employees, contractors, and Providers with any investigation conducted by Federal or State authorities, including NC Medicaid or MFCU/MID, and including supplying all data in a uniform format provided by NC Medicaid and information requested for their respective investigations within seven (7) days or within an extended timeframe determined by the Division as provided in *NC Medicaid Contract* Section 13.2-Monetary Penalties.

9. In accordance with *42 CFR § 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.

10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse.

10.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse.

10.2 Detailed workflow of the PIHP process for taking a complaint from inception through closure. This process shall include procedures for

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

10.3 In accordance with Attachment Y - Audits/Self-Audits/lnvestigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an· overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.

10.4 Process for tracking overpayments and collections based on fraud or abuse, including Program Integrity and Provider Monitoring activities initiated by PIHP and reporting on Attachment Y – Audits/Self- Audits/lnvestigations.

10.5 Process for handling self-audits and challenge audits.

10.6 Process for using data mining to determine leads.

10.7 Process for informing PIHP employees, subcontractors, and providers regarding the False Claims Act.

10.8 If PIHP makes or receives annual payments of at least $5,000,000, PIHP shall establish and maintain written policies for all employees, contractors, or agents that detail information about the False Claims Act and other Federal and State laws as described in the Social Security Act 1902(a)(66), including information about rights of employees to be protected as whistleblowers.

10.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains NC Medicaid-standardized elements or a NC Medicaid-approved template;

10.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding overpayments, assessments, penalties, or fees due to any State or Federal agency deemed applicable by PIHP, subject to the

accessibility of such financial information in a readily available database or other search mechanism.

11. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements. Nothing in this contract is intended to address any requirement for PIHP to offer Providers written notice of the process for appealing to the NC Office of Administrative Hearings or any other forum.
12. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to NC Medicaid within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.
13. In each case where PIHP refers to NC Medicaid an allegation of fraud involving a Provider, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:
    - 13.1 Subject (name, Medicaid provider ID, address, provider type);
    - 13.2 Source/origin of complaint;
    - 13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;
    - 13.4 Description of suspected intentional misconduct, with specific details including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations, or policies violated; and dates of suspected intentional misconduct;
    - 13.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;
    - 13.6 All communications between PIHP and the Provider concerning the conduct at issues, when available.
    - 13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and
    - 13.8 Total Sample Amount of Funds Investigated per Service Type
14. In each case where PIHP refers suspected Enrollee fraud to NC Medicaid, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:
    - 14.1 The Enrollee's name, birth date, and Medicaid number;
    - 14.2 The source of the allegation;

14.3 The nature of the allegation, including the timeframe of the allegation in question;

14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;

14.5 Contact information for PIHP staff persons with practical knowledge of the allegation;

14.6 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation; and

14.7 The legal and administrative status of the case.

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

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

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

14.11 Information on Biller/Owner;

14.12 Additional Provider Locations that are related to the allegations;

14.13 Legal and Administrative Status of Case.

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

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

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

18. PIHP shall submit to the NC Medicaid Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month or the next business day if the 10th day is a non-business day (i.e., weekend or State or PIHP holiday). In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to NC Medicaid Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but

not limited to overpayments and self-audits. The monthly report shall be due by 11:59 p.m. on the tenth (10th) of each month in the format as identified in Attachment Y. PIHP shall also report to NC Medicaid Program Integrity all Network Provider contract terminations and non-renewals initiated by PIHP, including the reason for the termination or non-renewal and the effective date. The only report shall be due by 11:59p.m. on the tenth (10th) day of each month in the format as identified in attachment Z – Terminations, Provider Enrollment Denials, Other Actions. Compliance with the reporting requirements of Attachments X, Y and Z and any mutually approved template shall be considered compliance with the reporting requirements of this Section.

C. Provider Payment Suspensions and Overpayments

1. Within thirty (30) business days of receipt from PIHP of referral of a potential credible allegation of fraud, NC Medicaid Program Integrity shall complete a preliminary investigation to determine whether there is sufficient evidence to warrant a full investigation. If NC Medicaid determines that a full investigation is warranted, NC Medicaid shall make a referral within five (5) business days of such determination to the MFCU/ MID and will suspend payments in accordance with *42 CFR § 455.23*. At least monthly, NC Medicaid shall provide written notification to PIHP of the status of each such referral. If MFCU/ MID indicates that suspension will not impact their investigation, NC Medicaid may send a payment suspension notice to the Provider and notify PIHP. If the MFCU/ MID indicates that payment suspension will impact the investigation, NC Medicaid shall temporarily withhold the suspension notice and notify PIHP. Suspension of payment actions under this Section 14.3 shall be temporary and shall not continue if either of the following occur: PIHP or the prosecuting authorities determine that there is insufficient evidence of fraud by the Provider; or Legal proceedings related to the Provider's alleged fraud are completed and the Provider is cleared of any wrongdoing.

    1.1 In the circumstances described in Section 14.3 (c) above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.

2. Upon receipt of a payment suspension notice from NC Medicaid Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of NC Medicaid Program Integrity's suspension and lasting until PIHP is notified by NC Medicaid Program Integrity in writing that the suspension has been lifted.

3. PIHP shall provide to NC Medicaid all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to NC Medicaid Program Integrity due to allegations of suspected fraud without prior written approval from NC Medicaid Program Integrity or the MFCU/MID. If PIHP takes administrative action, including issuing a Notice of Overpayment based on such fraud that precedes the submission date of a Division referral, the State will adjust the PIHP capitated payment in the amount of the original overpayment identified or One Thousand Dollars ($1,000) per case, whichever amount is greater.
5. Notwithstanding the foregoing, nothing herein shall be construed as prohibiting PIHP from taking any action against a Network Provider in accordance with the terms and conditions of any written agreement with a Network Provider, including but not limited to prepayment review, identification and collection of overpayments, suspension of referrals, de-credentialing, contract nonrenewal, suspension or termination or other sanction, remedial or preventive efforts necessary to ensure continuous, quality care to Enrollees, regardless of any ongoing investigation being conducted by NC Medicaid, MFCU/MID or other oversight agency, to the extent that such action shall not interfere with Enrollee access to care or with any such ongoing investigation being conducted by NC Medicaid, MFCU/MID or other oversight agency.
6. In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with N.C.G.S. 108C-5, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery.

Attachment 2: 2021 NC EQR Desk Materials List

PIHP

Focused External Quality Review 2021

MATERIALS REQUESTED FOR DESK REVIEW

__Please note that the lists requested in items 22, 23, and 41.a must be uploaded by no later than TBD. The remainder of items must be uploaded by no later than TBD.__**

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.

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

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

6. 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.

7. 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.

8. **By TBD, a copy of the complete Appeal log for the months of TBD through TBD. 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 notification.

9. **By TBD, a copy of the complete Grievances log for the months of TBD through TBD. Please indicate on the log: the nature of the Grievance, the date received, and the date of Grievance resolution.

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

9. 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.

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

11. 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.

12. 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 recently discharged).

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

13. 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.

14. 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.)

15. Provide copies of the following files:

a. Credentialing files for the four most recently credentialed practitioners (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

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:

i. Insurance:

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

B. For practitioners joining already-contracted agencies, include copies of the proof of insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.

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

iii. Ownership disclosure information/form.

c. Recredentialing files for the four most recently credentialed practitioners (as listed below)

- One licensed practitioner who is joining an already contracted agency
- One non-MD, Licensed Independent Practitioner (i.e., clinician who will have their own contract)
- One physician
- One practitioner with an associate licensure (e.g., LCSW-A, LMFT-A, etc.)
- One file for a network provider agency

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:

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

ii. Insurance:

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

B. For practitioners joining already-contracted agencies, include copies of the proof of insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.

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

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

v. Ownership disclosure information/form.

NOTE: Appeals, Grievances, MH/SU, I/DD, and TCLI Care Coordination files will be selected from the logs submitted on TBD. A request will then be sent to the plan to send electronic copies of the files to CCME. The entire file will be needed.

16. Provide the following for Program Integrity:
    a. **File Review: Please produce a listing of all active files during the review period (TBD through TBD) by TBD. The list should include the following information:
        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

17. 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.

18. 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.