CCME

2018 External Quality Review

CARDINAL INNOVATIONS HEALTHCARE

Submitted: February 22, 2019

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

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 requires State Medicaid Agencies that contract with Prepaid Inpatient Health Plans (PIHPs) to evaluate their compliance with the state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358 (42 CFR § 438.358)*. This review determines the level of performance demonstrated by Cardinal Innovations Healthcare (Cardinal). This report contains a description of the process and the results of the 2018 External Quality Review (EQR) The Carolinas Center for Medical Excellence (CCME) conducted on behalf of the North Carolina Department of Health and Human Services (NC DHHS) and North Carolina Medicaid (NC Medicaid), formerly the Division of Medical Assistance (DMA).

Goals of the review include the following:

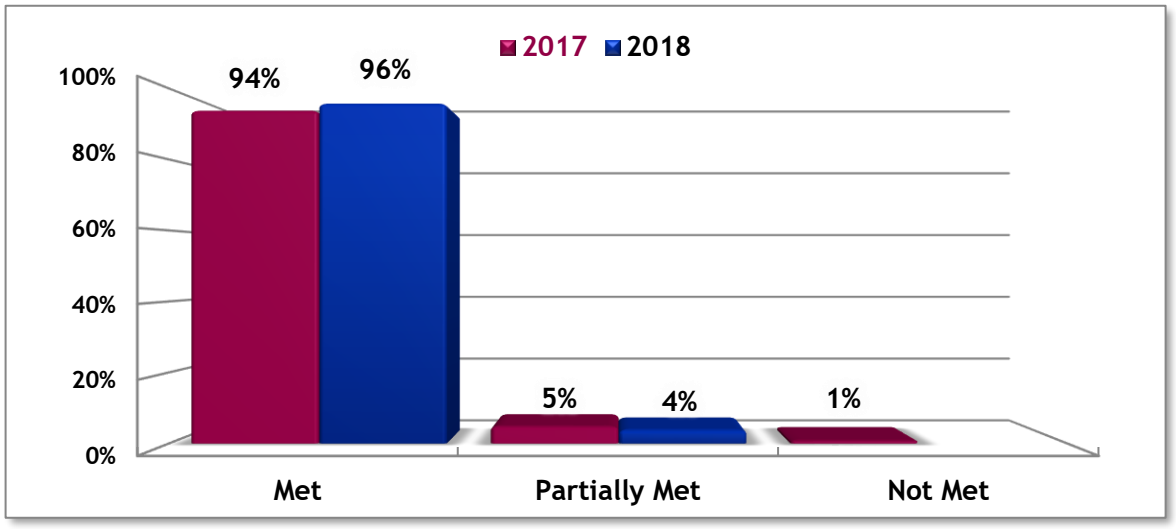
- Determine if Cardinal complies with service delivery as mandated by their *DMA Contract*
- Provide feedback for potential areas of further improvement
- Verify the delivery and determine the quality of contracted health care services

The process used for the EQR was based on the Centers for Medicare and Medicaid Services (CMS) protocols for EQR of Medicaid Managed Care Organizations (MCOs) and PIHPs. The review includes a Desk Review of documents, a two-day Onsite visit, compliance review, validation of performance improvement projects (PIPs), validation of performance measures (PMs), validation of encounter data, an Information System Capabilities Assessment (ISCA) Audit, and a Medicaid Program Integrity review of the health plan.

A. Overall Findings

The 2018 Annual EQR reflects that Cardinal achieved a "Met" score for 96% of the standards reviewed. As *Figure 1* indicates, 4% of the standards were scored as "Partially Met," and none of the standards scored as "Not Met." One standard in the Program Integrity section was scored as "Not Applicable". The percentage for "Not Applicable" scores was less than 1% and so is not reflected in the *Figure 1*. *Figure 1* also provides a comparison of Cardinal's 2017 review results to 2018 results.

Figure 1: Annual EQR Review Comparative Results



B. Overall Recommendations

Recommendations that address each of the review findings are addressed in detail under each respectively labeled section of this report. CCME identified the following global recommendations for improvement, which should be implemented in conjunction with CCME's detailed recommendations in each section.

Administration

The Administration EQR is comprised of four sections: required assessment and evaluation of the health plan's policies and procedures, organizational staffing, management of protected health information, and information system capabilities using the Information Systems Capabilities Assessment (ISCA).

Recommendations were made to maximize Cardinal's *Organizational Chart* and the policy and procedure governing policy and procedure management. These recommendations are detailed in the respective section and tabular spreadsheet.

Cardinal continues to work with NC Medicaid and its providers to address the encounter data denials related to missing and invalid provider taxonomy codes. Since December 2017, Cardinal improved its denial rate for encounters submitted to NCTracks.

The Cardinal Innovations Enterprise (CIE) claims system processes up to 12 ICD-10 diagnosis codes for Professional claims and up to 22 ICD-10 diagnosis codes for Institutional claims. Cardinal should update the CIE claim system and provider web portal to allow for ICD-10 procedure codes to be submitted and to be stored in their claims processing and reporting system. In addition, Cardinal should update their submission

process to NCTracks to submit ICD-10 procedure and Diagnosis Related Group (DRG) codes to NCTracks.

Provider Services

The Provider Services review includes Network Adequacy, Credentialing, and Recredentialing. The "Partially Met" items for this review are in the areas of Credentialing and Recredentialing. The practitioner credentialing and recredentialing files are well organized and contain appropriate information. The review of the organizational files showed inconsistent documentation of some elements of the credentialing/recredentialing process, including some Primary Source Verifications (PSVs). In response to CCME's request, Cardinal provided some documents, but did not provide others.

The *Provider Manual* has six-and-a-half pages of "Resources" that would likely be very helpful to providers. Though the Cardinal website has an online Resource Library and an "Events" calendar, clear information about available training and training information is lacking on the website, in the *Provider Manual*, and in the *Orientation Companion*. In general, the website was difficult to navigate, and specific items often could not be located.

CCME recommends Cardinal adopt processes to ensure required queries for credentialing and recredentialing are conducted and the documentation is retained. CCME also recommends Cardinal provide clear information directing providers to available training and resources, and that Cardinal make the website search results more relevant to users.

Enrollee Services

The Enrollee Services review focuses on enrollee rights and responsibilities, enrollee PIHP program education, behavioral health and chronic disease management education, and the Cardinal Call Center. Within 14 days of the initial request for services, Cardinal provides new enrollees with a letter called the Enrollee Mailer. The letter directs members to the PIHP website for the *Member & Family Handbook*, *The Individual and Family Guide*, and *Notice of Privacy Practices*. Cardinal completed a substantial amount of work on the website Provider Search since the last EQR. The online search feature allows users to filter their searches to customize the search for a contracted provider name or provider agency. Provider education level and credentials is listed within the provider search, which is an addition since last year. Cardinal informs members about the educational services that are available to them and encourages them to use the benefits. The website's Events page has many activities listed that are held by Cardinal and within the community. The Access Call Center is functional at all times to answer and process calls appropriately. All Access Call Center reported statistics meet NC Medicaid standards.

Quality Improvement

This section reviews the Quality Improvement (QI) Program, QI Committee, performance measures, PIPs, provider participation in QI, and the annual evaluation of the QI Program. In response to the last EQR, Cardinal focused on three Clinical Practice Guidelines and those guidelines are reviewed during focused and routine Utilization Management (UM) Reviews. The main QI Committee is the Continuous Quality Improvement (CQI) Committee and they meet every month as stated in the *CQI Committee Charter*. Global CQI (GCQI) Committee is made up of providers and Cardinal staff and meets quarterly. GCQI reports updates to CQI. The only "Partially Met" standard is related to the QI Annual Evaluation. The 2017-2018 CQI Annual Work Plan Evaluation was included in the 2018-2019 *Annual Quality Strategy & Performance Improvement Plan* document. It does not provide an analysis and evaluation of the overall effectiveness of the QI program. CCME asks that Cardinal create an annual program evaluation that contains an analysis and evaluation of the overall effectiveness of the goals in the QI program. Specific projects related to the goals can be documented and analyzed. If a goal is not met at the end of the year, identified barriers should be listed and the interventions planned for next year documented in this evaluation. If the goal is met, explain what interventions contributed to meeting the goal and how the goal will be maintained.

Utilization Management

The EQR of Utilization Management (UM) includes review of UM Treatment Authorization Requests (TAR)s, Care Coordination and Transition to Community Living (TCLI) programs. All standards within this section were "Met". CCME offers five recommendations, three of which are focused on Cardinal's practice of extending TAR processing time frames. Recommendations for TCLI focused on enhancing the current policy and procedure to better describe monitoring of Transition Year Stability Resource (TYSR) funds and increasing linkages of TCLI members to Supported Employment. UM Reviewer and Peer Reviewer electronic signatures within the TARs also did not include credentials of the decision makers. This requires corrective action by Cardinal.

Grievances and Appeals

The Grievance EQR review "Met" all standards and contains two recommendations. While *Policy and Procedure 5050* contains most elements of the grievance process, details describing required justification by Cardinal for extending the grievance time frame are lacking. In addition, Cardinal needs to include the details regarding the oral and written notifications to members when Cardinal extends the grievance timeframe, per *42 CFR § 438.408*.

Review of Cardinal's appeal files showed staff did not consistently follow required *DMA Contract*, federal regulations, and Cardinal's policies and procedures when processing appeals. CCME traced most of these inconsistencies to missing information within

Cardinal's appeal policy and procedure. In addition, CCME could not find evidence that Cardinal adequately tracks, trends, and analyzes appeals data. Enhancing Cardinal's current appeals policy and procedure, including referencing specific *DMA Contract* requirements and federal regulations, training staff on appeal requirements, and honing the tracking and monitoring of appeals will help Cardinal improve compliance with appeal requirements. Minor modifications to Cardinal's *Provider Manual* and website are also recommended.

Delegation

Cardinal reported five current delegated entities. Delegation Agreements are in place with all delegated entities, and Cardinal monitors its delegates. A contract amendment was fully executed with Behavioral Health Management (BHM) in May 2018. The amendment references a replacement Business Associates Agreement (BAA), but it was not in the reviewed agreement, and Cardinal was unable to provide it. A BAA was part of the evergreen contract with BHM that was executed in 2013. CCME recommends that Cardinal ensure referenced replacement documents are executed and retained.

Program Integrity

Cardinal's Program Integrity policies and procedures are in good order and case files were fully compliant. The PIHP has a well-integrated Program Integrity function with touch points to Compliance, Quality and Provider Relations committees, as well as the ability to operate independently. Cardinal made progress in using data mining to identify potential cases of fraud. Examples include comparing dates of inpatient and outpatient services for the same members, code comparisons to identify upbilling, and billing for deceased members. CCME noted evidence that data mining initiatives generated investigations.

One Corrective Action item from the prior year's EQR, related to timeliness of initiating investigations, was addressed by Cardinal in the current review period. In addition, NC Medicaid informed CCME that Cardinal increased its level of referral to Medicaid Investigations Division.

Financial Services

Cardinal received all "Met" scores for the 2018 Financial Services EQR. One policy and procedure enhancement is identified. CCME recommends adding language to *Policy and Procedure* 2150, *Fiscal Records Retention* to reflect the requirement of Cardinal to retain all Medicaid records for ten year as noted in Section 8.3.2 of the *DMA Contract*.

Encounter Data Validation

Based on the analysis of Cardinal's encounter data, we have concluded that the data submitted to NC Medicaid is not complete and accurate. Minor issues were noted with

both Institutional and Professional encounters. Cardinal should resolve the issues identified with procedure code and diagnosis codes, as well as continue work on improving taxonomy denials.

For the next review period, HMS is recommending that the encounter data from NCTracks be reviewed to look at encounters that pass front-end edits and are adjudicated to either a paid or denied status. It is difficult to reconcile the various tracking reports with the data submitted by the LME/MCO. Reviewing an extract from NCTracks would provide insight into how the State's Medicaid Management Information System (MMIS) is handling the encounter claims and could be reconciled back to reports requested from Cardinal. The goal is to ensure that Cardinal is reporting all paid claims as encounters to NC Medicaid.

METHODOLOGY

The process used for the EQR was based on the CMS protocols for EQRs of MCOs and PIHPs. This review focused on the three federally mandated EQR activities: compliance determination, validation of Performance Measures, and validation of Performance Improvement Projects, as well as an optional activity in the area of Encounter Data Validation, conducted by CCME's subcontractor, HMS. Additionally, as required by CCME's contract with NC DHHS, an ISCA Audit and Medicaid Program Integrity (PI) review of the health plan was conducted by CCME's subcontractor, IPRO.

On November 28, 2018, CCME sent notification to Cardinal that the annual EQR was being initiated (see *Attachment 1*). This notification included:

- Materials Requested for Desk Review
- ISCA Survey
- Draft Onsite Agenda
- PIHP EQR Standards

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

The review consisted of two segments. The first was a Desk Review of materials and documents received from Cardinal on December 19, 2018 and reviewed in the offices of CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the QI and Medical Management Programs. Also included in the Desk Review was a review of credentialing, grievance, utilization, care coordination, case management, and appeal files.

The second segment was a two-day, Onsite review conducted on January 23, 2019 and January 24, 2019, at Cardinal's corporate office in Charlotte, North Carolina. CCME's Onsite visit focused on areas not covered in the Desk Review and areas needing clarification. For a list of items requested for the Onsite visit, see *Attachment 2*. CCME's Onsite activities included:

- Entrance and Exit Conferences
- Interviews with Cardinal Administration and Staff

All interested parties were invited to the entrance and exit conferences.

FINDINGS

The EQR findings are summarized in the following pages of this report and are based on the regulations set forth in *42 CFR § 438.358* and the contract requirements between Cardinal and NC DHHS' NC Medicaid. Strengths, weaknesses, corrective action items, and recommendations are identified where applicable. Areas of review are identified as meeting a standard (Met), acceptable but needing improvement (Partially Met), failing a standard (Not Met), Not Applicable, or Not Evaluated, and are recorded on the tabular spreadsheet (*Attachment 4*).

A. Administration

The Administration review focused on the health plan's policies, procedures, staffing, confidentiality practices, information systems, and encounter data capture and reporting.

Policies and Procedures

Two hundred and twenty current policies and procedures along with an accompanying index were submitted for this year's EQR. Each policy and procedure contain a review and revision history, as well as upcoming dates for required annual reviews. These dates correspond to the dates captured in the *Policy & Procedure Index*. Cardinal demonstrated an active revision process and timely annual reviews. Cardinal maximizes the use of Compliance 360 and, as a result, their policy and procedure set is exceptionally organized.

Policy & Procedure 1000, Policy and Procedure Development, describes the process for creating, terminating, revising, and annually reviewing policies and procedures, but does not clearly indicate the final approval process. During the Onsite discussion, Cardinal explained that a designated attorney in Cardinal's Office of General Counsel (OGC) is responsible for final approval. CCME recommends adding this level of detail to this policy and procedure to better describe the final approval process. This also was a recommendation in last year's EQR.

Organizational Staffing/Management

CCME's EQR of Cardinal's overall organizational structure examined the Cardinal's *Organizational Chart*, job descriptions, policies and procedures, and Program Descriptions. Additional information was provided during the Onsite discussions with Cardinal staff.

The *Organizational Chart* submitted for this EQR period shows Cardinal was adequately staffed to oversee Cardinal's PIHP functions. At the time of the Onsite, staff reported

three key positions within the organization were vacant. Staff explained during the Onsite discussion that these positions, the Chief Operations Officer, Director of Information Technology (IT) and Utilization Management Director, have potential candidates and/or interim staff/coverage identified.

Cardinal's Medical Department is headed up by Dr. Terri Harpold. Dr. Harpold recently joined the PIHP and is serving as the Interim Medical Director. The Medical Department is staffed with clinicians with a variety of specialties including substance use, pharmacy, child and adolescent psychiatry, and neuropsychiatry. However, Medical Department staff functions and/or departmental oversight are not shown in the *Organizational Chart*. This was a recommendation in the 2017 EQR. For this EQR, Cardinal did add the statement, "The Medical Office provides clinical oversight to the following departments: Network Management, Quality Management and Clinical Operations." While this statement provides some clarification, a function of an organizational chart is to demonstrate the structure of an organization and the relationships of specific positions/jobs. During the Onsite, staff could readily identify each medical staff person's role and responsibilities. CCME again recommends adding additional detail that explains the roles and responsibilities of the Medical Department within the *Organizational Chart*.

In the previous year's EQR, the *Organizational Chart* did not include full and part-time status of staff or educational/clinical licensure information. Cardinal has since added this additional information to their *Organizational Chart*.

Confidentiality

As a Covered Entity under the Health Insurance Portability and Accountability Act (HIPAA), Cardinal's Policies & Procedures regarding the management and protection of enrollee confidentiality were reviewed by CCME. Cardinal has a robust complement of policies and procedures in place that fully address both state and federal requirements for preserving enrollee confidentiality and protecting health information.

Cardinal ensures all new staff are trained on confidentiality on the first day of their employment. During staff orientation, new staff also sign a non-disclosure statement prior to IT staff allowing access to member protected health information (PHI).

Information Systems Capabilities Assessment

As required by its contract with the CCME, IPRO conducted a review of Cardinal's information system capabilities using the *Information Systems Capabilities Assessment* (ISCA), as specified in the CMS protocol.

Upon receipt of the completed ISCA tool and supporting documentation from Cardinal, IPRO reviewed the responses and followed up on areas requiring clarification via

interviews and a systems walk through at the Cardinal office located in Charlotte, North Carolina, on January 24, 2019.

Enrollment Systems

Cardinal experienced growth in enrollment from 2015 to 2016 with the acquisition of Centerpoint. But there was very little change year to year from 2016 to 2017. The comparative end-of-year enrollment totals were reported are noted in *Table 1*.

Table 1: Enrollment Counts

2015	2016	2017
361,930	462,952	463,854

During the ISCA Onsite review, Cardinal provided a demonstration of the Cardinal Innovations Enterprise (CIE) claim system including enrollment screens. The system maintains a member's enrollment history. The enrollment import is an automated routine in which the Global Eligibility File (GEF) files are imported daily into the CIE system. The daily eligibility file is compared to existing eligibility in the CIE system. The following fields are used to determine if a member is new: Medicaid ID, Client ID, Social Security Number, and First Name, Last Name, Date of Birth. New members are added to the CIE system with their accompanying eligibility information. For existing members, any changes to eligibility information are updated in the enrollment system.

Cardinal stores the Medicaid identification number received on the GEF. Cardinal's eligibility system merges multiple member records and links the patient's historical claims. Instances where a member has multiple IDs are rare.

Cardinal demonstrated its Provider Direct provider web portal during the Onsite interview. Provider Direct allows Cardinal providers to confirm a member's eligibility and provides Cardinal with third party liability (TPL) information.

Once-a-month, Cardinal generates a GEF exception report and the Enrollment and Eligibility staff review and determine if any consumer information or eligibility changes/corrections exist and need to be addressed.

Cardinal reconciles the CIE enrollment records with the monthly 820 Capitation file. In addition, Cardinal began using the quarterly GEF file NC Medicaid provides for reconciliation.

Claims Systems

Cardinal's claims and encounters are processed in the CIE system. A review of Cardinal's processes for collecting, adjudicating, and reporting claims was conducted through an analysis of Cardinal's ISCA response and supporting documentation. A demonstration of Provider Direct claims entry portal and the CIE claims processing system was performed during the Onsite review.

Cardinal receives claims from three methods, as detailed in *Table 2*.

Table 2: Claim Method Percentages

Source	HIPAA File	Paper	Provider
Institutional	71%	0%	29%
Professional	76%	0%	24%

Note: Paper claims are received for out-of-state services.

If a required field is missing from the claim, Cardinal's Provider Direct will not allow the claim to be submitted to Cardinal. If the claim is being submitted electronically via an electronic 837 file and fields are missing, the claim will not be accepted. Cardinal claim processors do not add or change any information on the claims. Claims are processed during the nightly adjudication and assigned a CIE claim number.

Cardinal adjudicates claims nightly. Any claim that is missing information is pended and worked by a Claims Specialist.

Cardinal processes eligible paper claims within nine days of receipt. If a claim is approved, payment is made within 30 calendar days after receipt. Claims submitted through an electronic file are processed through a frontend editor - Optum Transaction Validation Manager (OTVM). This system will not process unvalidated files nor files that are not Health Insurance Portability and Accountability Act (HIPAA) compliant.

ICD-10 procedure codes are not loaded into the system and are not submitted to NCTracks. When providers use them, Diagnosis Related Group (DRG) codes are accepted by Cardinal if the values are included by the provider and included on an 837I. DRG codes are available for reporting purposes but are not submitted to NCTracks.

Cardinal indicated at the ISCA Onsite that the CIE claim system captures up to 12 ICD-10 diagnosis codes for Professional claims and up to 22 ICD-10 diagnosis codes for Institutional claims. Twenty-five ICD-10 diagnosis codes are the maximum number of diagnosis codes that may be submitted on an 837I and the maximum number that is

captured by NCTracks. Cardinal indicated that they submit to NCTracks all codes that they receive.

Cardinal staff provided a demonstration of their audit process. Cardinal audits at least 3% of all claims and high dollar claims. In addition, Cardinal performs focused audits based on, for example, high dollar or specific diagnosis codes. For new-hire Claim Examiners, there is a six- to eight-week training period. New hires will work side by side with an experienced Analyst. There is a "nesting" period 60 days, after which their claims are routinely audited for accuracy.

Reporting

Cardinal's data repository is a Structured Query Language (SQL) server and captures all the enrollment and claims information captured in CIE. All data from the CIE system is extracted into the SQL server. This relational database is used to create reports and data extracts. The current data warehouse is updated nightly.

Cardinal does not outsource any of their programming needs and uses internal staff for all programming. Cardinal reported that they employ four programmers who are trained and capable of modifying the reports and extracts.

Encounter Data Submissions

Cardinal's submission process to NCTracks is fully automated. Weekly, Cardinal submits claims to NCTracks using the 837I and 837P file formats. The 835 file from NCTracks is used to review denials. A total of 105,602 Institutional and 1,825,340 Professional encounters were submitted to NCTracks for 2017 dates of service. Cardinal identified 2,266 Institutional and 274,340 Professional encounters that have been denied and not yet accepted with 2017 dates of service.

Cardinal improved since the last ISCA audit in the area of encounter data submissions by reducing provider taxonomy related denials. Cardinal worked with NC Medicaid to reduce these errors. On average, it takes Cardinal 45 days to correct and resubmit an encounter to NCTracks.

Cardinal's encounter data submission and reconciliation information is maintained in a SQL database. When a claim denial is returned to Cardinal from NCTracks via the incoming 835 file, and if the provider data is missing in NCTracks, Cardinal sends a notification request to the provider to submit the proper data before the claim is resubmitted. Cardinal has a dedicated Encounter Data Reconciliation Team that is responsible for the resubmission process. Cardinal tracks the encounters via generated reports worked by the Team.

Cardinal noted that ICD-10 procedure codes and DRG codes are not submitted to NCTracks. NC Medicaid will discuss internally if these codes are required to be submitted to NCTracks.

Cardinal informed CCME that all ICD-10 diagnosis codes for Professional and Institutional claims are submitted to NCTracks.

The *Figure 2* shows the that Cardinal scored 90% "Met" on all of the Administrative standards in 2018 and compares this score to the percentage of standards "Met" in 2017.

Figure 2: Administration Comparative Findings

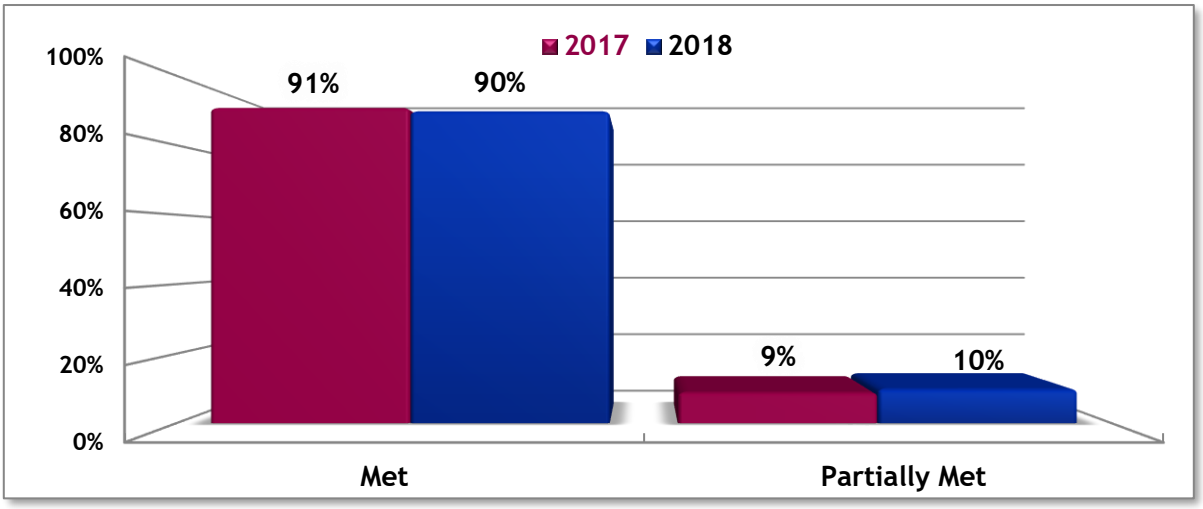


Table 3: Administration

Section	Standard	2018 Review
Management Information Systems	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.	**Partially Met**
	The MCO has the capabilities in place to submit the State required data elements to DMA on the encounter data.	**Partially Met**

Strengths

- Cardinal's policy and procedure set is exceptionally organized.
- Cardinal ensures all new staff are trained on confidentiality on the first day of their employment.
- Cardinal has comprehensive enrollment and claim processing transaction and reporting systems.
- The Provider Direct Module provides a platform for providers to submit and view claims, as well as enrollment history.
- Cardinal maximizes the quarterly GEF file from NC Medicaid to enhance their enrollment reconciliation process.
- Cardinal CIE system merges multiple member records and links the member's historical claims data to the merged member record.
- Cardinal's current NCTracks encounter acceptance rate improved since last year's EQR.
- Billing and IT staff are dedicated to improving encounter data submissions, reducing the number of encounter data denials, and the resubmission of denied encounters.
- Cardinal made significant improvements in the rate of denied encounter submissions to the state since the last EQR.

Weaknesses

- Cardinal's *Policy & Procedure 1000, Policy and Procedure Development* does not clearly explain the final step in approving new or revised policies and procedures.
- The *Organizational Chart* does not show functions and/or departmental oversight of each of the staff within the Medical Department.
- Cardinal does not receive and store ICD-10 procedure codes.
- Cardinal does not submit DRG or ICD-10 procedure codes to NCTracks.

Corrective Action

- Update the CIE claim system and provider web portal to allow for ICD-10 procedure codes to be accepted and be stored in their claims processing and reporting system.
- Update the encounter data submission process to allow for all ICD-10 procedure and DRG codes to be submitted to NCTracks.

Recommendations

- Add detail to *Policy & Procedure 1000, Policy and Procedure Development* to better describe the final approval process.
- Delineate functions and/or departmental oversight of each of the staff within the Medical Department.

B. Provider Services

The EQR of Cardinal's Provider Services is composed of Credentialing and Recredentialing, and Network Adequacy (including Provider Accessibility, Provider Education, Clinical Practice Guidelines for Behavioral Health Management, Continuity of Care, and Practitioner Medical Records). CCME reviewed relevant policies and procedures, the *Credentialing Committee Charter and Credentialing Program Operations Manual (Credentialing Manual)*, the *Provider Manual*, clinical practice guidelines, Resource Library materials, credentialing and recredentialing files, provider network information, the 2017 *Cardinal Innovations Community Mental Health, Substance Use and Developmental Disabilities Services Needs and Gaps Analysis (Gaps and Needs Analysis)* and *Exception Requests*, and the Cardinal website.

Dr. Terri Harpold, Interim Chief Medical Officer, a board-certified psychiatrist, is the current Chair of the Credentialing Committee. The *Credentialing Manual* outlines the structure of the credentialing program, including the Credentialing Committee composition and the Credentialing Committee roles and responsibilities.

Page 10 of the 2018-2019 *Annual Quality Strategy & Performance Improvement Plan* states the Credentialing Committee is "comprised of practicing practitioners from the Cardinal Innovations network as well as clinical staff from various Cardinal Innovations departments. This committee meets once a month and quorum consists of at least 50% of the voting members." Page 3 of the *Credentialing Manual* defines a quorum, as "at least 51% of the voting members". There were 16 committee meetings between December 2017 and November 2018, with a quorum present at all meetings. Attendance by voting members ranged from 56% at one meeting to 89% of voting members in attendance at two meetings.

The review of the practitioner credentialing and recredentialing files showed they were well-organized and contained appropriate documentation. The organizational credentialing and recredentialing files were missing items, as outlined in the Weaknesses section and in the Tabular Spreadsheet. Cardinal provided some items after CCME requested them but was unable to locate other items. The organizational files could benefit from checklists such as those used in the practitioner files, to ensure all PSVs are

conducted. Retain documentation, such as PSV print-outs, in the files, as dated evidence of the required queries.

Cardinal assesses network adequacy on an annual basis for the NC Division of Health Benefits (DHB)-required gaps and needs analysis. The *SFY 2018 LME-MCO Network Adequacy and Accessibility Analysis,* previously called the *Gaps and Needs Analysis*, was to be submitted to DHB by September 21, 2018. The Cardinal draft *2018 Network Adequacy and Accessibility Analysis* report had not been approved by DHB when Desk Materials were submitted for the EQR. Cardinal again submitted the *2017 Gaps and Needs Analysis* and accompanying documents, including *Exception Requests*. These documents were also reviewed for the last EQR.

Cardinal uses data from various reports, including the *Gaps and Needs Analysis,* to create the annual *Network Development Plan*. The *2017 Network Development Plan* was submitted for the last EQR and for the current EQR. During the Onsite discussion, Cardinal staff reported using Member Specific Agreements (MSAs) as needed, to ensure enrollees receive services. MSA trends are tracked to help determine if Cardinal should add contracted providers.

The *Provider Manual* has six-and-a-half pages of "Resources" that would likely be very helpful to providers. The Cardinal website has many helpful resources, including an "Events" calendar with information regarding upcoming training and other events. However, in general, the website was difficult to navigate, and specific items often could not be located. CCME recommends Cardinal provide clear information directing providers to available training and resources, and that Cardinal makes the website searches more intuitive.

Figure 3 shows 96% of the standards in the Provider Services section were scored as "Met". The "Partially Met" scores due to inconsistent practices in obtaining and retaining evidence of required queries for credentialing and recredentialing.

Figure 3: Provider Services Findings

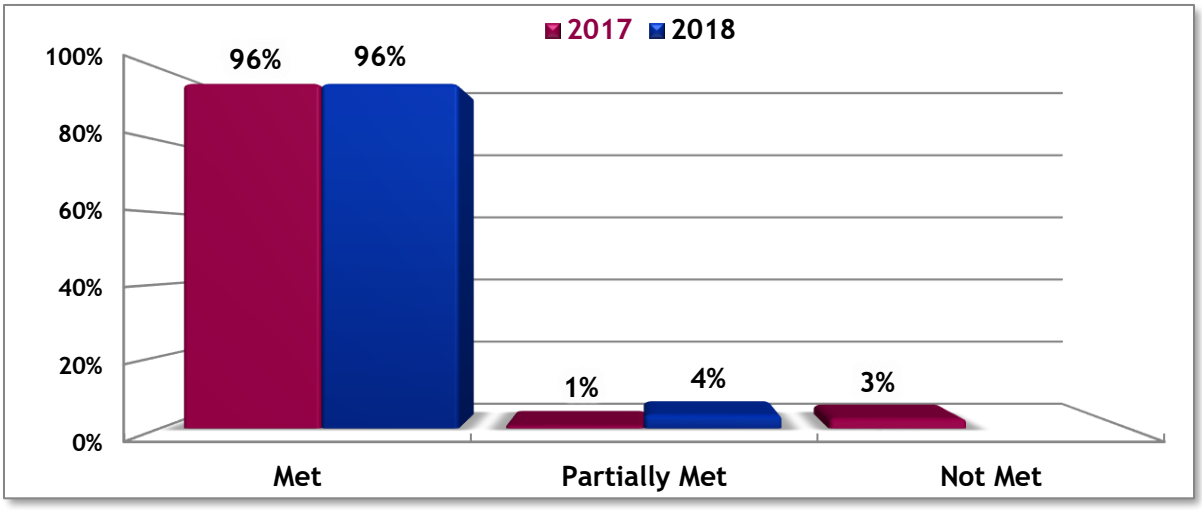


Table 4: Provider Services

Section	Standard	2017 Review
Credentialing	Verification of information on the applicant, including: Query of the National Plan and Provider Enumeration System (NPPES)	**Partially Met**
Recredentialing	Verification of information on the applicant, including: Query of the Social Security Administration's Death Master File;	**Partially Met**
	Query of the NPPES;	**Partially Met**

Strengths

- The practitioner credentialing and recredentialing files were well-organized and contained required information.
- The Cardinal website includes a Resource Library with filters for “Cardinal Innovations”, "Community”, “Members”, or “Providers”.
- The *Provider Manual* is detailed and provides information to assist providers in navigating the health plan.
- The *Provider Manual* has six-and-a-half pages of “Resources”.

Weaknesses

- The Annual Quality Strategy & Performance Improvement Plan 2017-2018 and the Annual Quality Strategy & Performance Improvement Plan 2018-2019 indicate a quorum consists of “at least 50% of voting members”. The *Credentialing Program Operations Manual* approved 04/10/18 states a quorum “will consist of at least 51% of the voting members”.
- Some of the credentialing and recredentialing files uploaded for Desk Review were missing items. CCME requested the items in the Onsite Document Request List. Cardinal provided some of the missing items but was unable to provide some items.
    - Reviews showed inconsistent practice when obtaining application attestation statements for organizational files. The organizational recredentialing files lacked Primary Source Verification (PSV) evidence of criminal background checks (which include the query of the Social Security Death Master file), and evidence of PSVs of the query of the OIG, the SAM, NPPES, and the *State Exclusion List*.
    - The organizational recredentialing files showed inconsistent documentation of the original credentialing approval dates and any recredentialing approval dates, including the most recent recredentialing date.
    - Two of the practitioner initial credentialing files were missing proof of insurance or a waiver/attestation for auto insurance and for Workers’ Comp/Employer’s Liability insurance. Cardinal submitted the attestations in response to CCME’s *Onsite Document Request*.
- The Cardinal attestation form regarding Workers’ Comp/Employer’s Liability insurance does not provide information defining the requirements for carrying the insurance. Neither the *Provider Manual* nor the website contains this information.
- Several of the topics listed in *Policy & Procedure 8600, Training Coordination by Network Management*, were not found via a “search” of the Resource Library or the website.

- The *Orientation Companion* references the 2015 *Provider Manual,* and includes a link, presumably to the *Provider Manual*.
- Though the website has an online Resource Library and an "Events" calendar, clear information about available training and training information is lacking on the website, in the *Provider Manual,* and in the *Orientation Companion*.

Corrective Actions

- Ensure all credentialing and recredentialing files include the PSV of the NPPES query and retain the documentation. See *DMA Contract, Attachment B, section 7.6.4.*
- Consistently conduct query of the Social Security Administration's Death Master File at recredentialing, as required by *DMA Contract, Attachment B, section 7.6.4,* and retain the documentation.

Recommendations

- Ensure the required percentage for a Credentialing Committee meeting quorum is the same across documents.
- Verify all credentialing files contain proof of all required insurance coverage, a statement that the practitioner is covered under all agency insurance, and an attestation/waiver for automobile insurance and Worker's Comp/Employer's Liability, if coverage is not required. Inform providers as to the requirements for Worker's Comp/Employer's Liability insurance.
- To comply with Cardinal *Policy & Procedure 8000, Agency Application and Enrollment, Section 1.a.*, ensure all applications include the signed Attestation Statement.
- Ensure all credentialing applications and materials are received and clearly dated prior to the credentialing decision, with no element older than 180 days.
- To comply with Cardinal's policies and procedures, ensure all recredentialing files include documentation of recredentialing approval dates, with recredentialing occurring within three years of the documented initial credentialing approval date.
- Verify the training topics listed in *Policy & Procedure 8600, Training Coordination by Network Management,* are available on the Cardinal website, or revise the policy and procedure to delete topics that are not available on the website.
- Revise the *Orientation Companion* to reference the current *Provider Manual*. Verify the link goes to the current *Provider Manual*.
- Include clear information on the website, in the *Provider Manual*, and in the *Orientation Companion* to direct providers to available training and resources for providers.

C. Enrollee Services

The Enrollee Services review focuses on member rights and responsibilities, member program education, behavioral health and chronic disease management education, and the Call Center.

CCME reviewed Cardinal's Member Services, including relevant policies and procedures, the *Member & Family Handbook*, Call Center training, orientation materials, new member correspondence and documentation, enrollee and community education offerings, and the website.

Within 14 days of the initial request for services, Cardinal provides new members with a letter called *Enrollee Mailer*. The letter directs members to the PIHP website for the *Member & Family Handbook*, *The Individual and Family Guide*, and *Notice of Privacy Practices*. For members without internet access, the Access Call Center telephone number is provided in the *Enrollee Mailer* so they may call to ask questions or request member materials, including a copy of the *Member & Family Handbook*. Instructions to call the Access to Care phone number for copies in other languages are printed on the *Enrollee Mailer* in English, Spanish, and one other language.

The *Member & Family Handbook*, which contains a list of member rights and responsibilities, is organized and easy to understand. Cardinal is using a reader-centered approach, gathering direct input from intended readers, and using readability formulas to get the target readability of fifth to sixth grade reading level if possible.

Cardinal completed a substantial amount of work on its website Provider Search since the last EQR. The print version available on the website is the *2018 Provider Directory* and it has an introduction in both Spanish and English. The printed and online versions of the Provider Search/Directory include all the NC Medicaid required fields. Provider education is listed in a field of the Provider Search which is an addition over the past year. The online search feature allows users to filter and customize their search for a contracted provider name or provider agency. In the provider agencies online search, fields for "Accommodation" and "Cultural Competency" display "Data is not available at the time." Cardinal continues to load these fields as the information becomes available.

Cardinal informs members about the educational services that are available to them and encourages them to use the benefits. The website's Events page has many activities listed that are held by Cardinal and within the community. Events vary from "Game Fun" and "Zumba" to Alcoholics Anonymous (AA) meetings and "Issues and Concerns for LGBTQ Individuals with Substance Use Disorder." The site is searchable by county, topic, type (community/ training/ meeting), and date. On the website, under Members/Wellness Centers, there is a full month calendar view of events at each wellness center, by

location. The *Member & Family Handbook* explains how to access these education and community occasions.

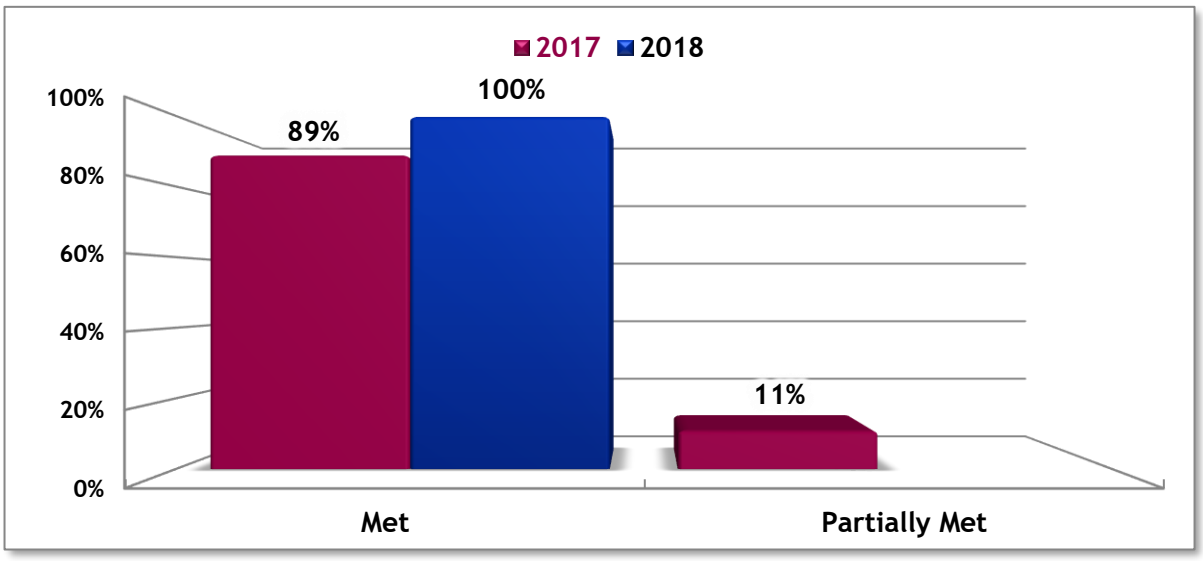
Cardinal Innovations Community is a newsletter that is written for members and family monthly. It was launched December 2017 and is "100% opt in". Members are encouraged to sign up at every consumer and community event including Consumer Family Advisory Committee meetings.

The Access Call Center is available 24/7 to respond to stakeholder calls. The management team is in the National Association for Stock Car Auto Racing, Inc. (NASCAR) building while the Access Coordinators (qualified professionals) and Access Clinicians (licensed) work remotely. There is no roll over call process and, if a caller calls when all Agents are on a call, the phone will ring for six seconds and the caller gets a message that the next available Agent will answer your call. When a crisis call occurs, the Access Clinician handling the call uses an internal chat feature with a co-worker. That co-worker will call 911 or dispatch mobile crisis services, whichever is needed, allowing the Access Clinician to remain on the phone with the caller.

The Access Call Center has two unique and newer areas of concentration. During the hours of 8:00 a.m. and 8:00 p.m., a Live Chat is available. Access Call Center staff rotate answering Live Chat with as many as five Agents at one time available to answer. This provides another level of customer service to engage members. Cardinal collects data on which screens the Live Chat originated from and if the caller was on a mobile device or desktop device. This data is exported to Communications once a month and used to improve the website and Access Call Center processes. The number of Live Chats has steadily increased with 115 Live Chats answered in December. The Access Call Center developed an enhanced process to assist Veterans in a partnership with America Serves. This includes a team of Access Coordinators trained in the America Serves system and a team of Access Clinicians trained in NC Serves. All Access Call Center reported statistics meet NC Medicaid standards.

Figure 4 indicates Cardinal received a score of "Met" for all of the Enrollee standards.

Figure 4: Enrollee Services Findings



Strengths

- Cardinal completed a substantial amount of work on its website Provider Search since the last EQR. Provider education is listed in a field of the Provider Search which is an addition to the past year.
- During the hours of 8:00 a.m. and 8:00 p.m., a Live Chat is available. Access Call Center staff rotate answering Live Chat with as many as five agents at one time who are available to answer.
- *Cardinal Innovations Community* is a newsletter that is written for members and family monthly. It was launched December 2017 and is "100% opt in". Members are encouraged to sign up at every consumer and community event including Consumer Family Advisory Committee.
- The Access Call Center developed an enhanced process to assist Veterans in a partnership with America Serves.

D. Quality Improvement

This section reviews the Quality Improvement (QI) Program, QI Committee, performance measures (PMs), performance improvement projects (PIPs), provider participation in QI, and the Annual Evaluation of the QI Program. Cardinal's 2018-2019 *Annual Quality Strategy & Performance Improvement Plan* outlines the program in place for measuring and improving the care and services received by members. Cardinal focused on three clinical practice guidelines: child residential, peer support services, and medication assisted treatment. These guidelines are reviewed during focused and routine Utilization

Management (UM) reviews. Results of these reviews are mailed to the providers, including any needed Corrective Action Plan.

Results of the enrollee surveys was discussed in the March 2018 Continuous Quality Improvement (CQI) meeting. The survey review identified five growth areas. In the March 2018 CQI Committee minutes, a workgroup to discuss interventions for "low scoring enrollee surveys" was formed. Cardinal conducted an environmental scan over the past several months to identify priorities for this workgroup. The workgroup plans to begin meeting in February 2019 and report to CQI in March 2019. Providers can view ECHO Survey results on the Cardinal website. The most recent *ECHO Survey* on the website was completed in 2016. CCME recommends posting the most recent *ECHO Survey* results and *Perception of Care Survey* results to the Cardinal website.

Page 32 of the 2018-2019 *Annual Quality Strategy & Performance Improvement Plan* has a section called CQI Work Plan 2018-2019. The work plan includes 14 clinical and non-clinical activities. It is updated annually with elements reviewed periodically throughout the year. CCME recommends adding a target time period to complete the activities and notes to explain the status of each activity listed on the work plan. The notes section could replace the interventions list. The interventions are also on the Quality Improvement Activities (QIAs). A work plan is a document that should be updated and changed, if needed, throughout the year.

The main QI Committee is the CQI Committee and it meets monthly, as stated in the CQI Committee Charter. CQI is made up of 23 positions and two of those are vacant. Twenty-two members are internal to Cardinal and one is a provider who represents Global Continuous Quality Improvement (GCQI) Committee. GCQI is made up of providers and Cardinal staff and meets quarterly. GCQI reports updates to CQI. Elaine Smith of the New Hope Treatment Centers is a provider member of CQI and GCQI. She shares information from each of these meetings with the other members in each committee.

Network providers participate in QI activities at Cardinal. The Barriers Workgroup project is an example of providers participating in QI activities. This workgroup meets every other month to identify and discuss barriers of Care Coordination. UM routine and focused reports are shared with the providers with a plan of correction for any areas that fall below 100%.

The 2017-2018 *Continuous Quality Improvement (CQI) Annual Work Plan Evaluation* was included in the 2018-2019 *Annual Quality Strategy & Performance Improvement Plan* document. This section lists bullet points for the overall program goals, highlights of interventions and accomplishments, continued occasions for improvement and planned intervention, and next steps. The analysis and evaluation portion would most likely be the "Continued Opportunities for Improvement" and "Next Steps" sections. Both sections

give vague statements. One bullet in the Continued Opportunities for Improvement section evaluates a portion of the program. The others are statements of action. CCME suggests that Cardinal create an annual program evaluation that contains an analysis and evaluation of the overall effectiveness of the goals in the QI program. Specific projects related to the goals can be documented and analyzed. If a goal is not met at the end of the year, identified barriers should be listed and the interventions planned for next year documented in this evaluation. If the goal is met, explain what interventions contributed to meeting the goal and how the goal will be maintained.

Performance Measure Validation

As part of the EQR, CCME conducted the independent validation of NC Medicaid-selected B and C Waiver performance measures.

Table 5: 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 6: C Waiver Measures

C WAIVER MEASURES	
Proportion of Level of Care evaluations completed at least annually for enrolled participants	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals
Proportion of Level of Care evaluations completed using approved processes and instrument	Proportion of Individual Support Plans that address identified health and safety risk factors
Proportion of New Level of Care evaluations completed using approved processes and instrument	Percentage of participants reporting that their Individual Support Plan has the services that they need

C WAIVER MEASURES	
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	Proportion of individuals for whom an annual ISP and/or needed updates took place
Proportion of monitored Innovations providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame	Proportion of new waiver participants who are receiving services according to their ISP within 45 days of ISP approval

CCME performed validations following the CMS developed protocol, *EQR Protocol 2: Validation of Performance Measures Reported by the Managed Care Organization (MCO) Version 2.0* (September 2012) which requires a review of the following for each measure:

- Performance measure documentation
- Denominator data quality
- Validity of denominator calculation
- Data collection procedures (if applicable)
- Numerator data quality
- Validity of numerator calculation
- Sampling methodology (if applicable)
- Measure reporting accuracy

This process assesses the production of these measures by the PIHP to verify what is submitted to NC Medicaid complies with the measure specifications as defined in the *North Carolina LME/MCO Performance Measurement and Reporting Guide*.

B Waiver Measures

Ten B Waiver measures were reviewed and validated in accordance with the October 2015 protocol developed by NC Medicaid and the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

Cardinal's reported results for these measures are included in the following tables. The percentage rates are shown for FY 2016 and FY 2017.

Table 7: A.1. Readmission Rates for Mental Health

30-day Readmission Rates for Mental Health	2016	2017	Change
Inpatient (Community Hospital Only)	11.0%	8.7%	-2.30%
Inpatient (State Hospital Only)	4.2%	11.4%	7.20%

Inpatient (Community and State Hospital Combined)	10.9%	8.8%	-2.10%
Facility Based Crisis	6.4%	8.0%	1.60%
Psychiatric Residential Treatment Facility (PRTF)	5.6%	4.0%	-1.60%
Combined (includes cross-overs between services)	11.6%	9.7%	-1.90%

Table 8: A.2. Readmission Rate for Substance Abuse

30-day Readmission Rates for Substance Abuse	2016	2017	Change
Inpatient (Community Hospital Only)	9.3%	8.3%	-1.00%
Inpatient (State Hospital Only)	0.0%	0.0%	0.00%
Inpatient (Community and State Hospital Combined)	9.3%	8.2%	-1.10%
Detox/Facility Based Crisis	12.2%	9.2%	-3.00%
Combined (includes cross-overs between services)	13.5%	11.7%	-1.80%

Table 9: A.3. Follow-Up after Hospitalization for Mental Illness

Follow-up after Hospitalization for Mental Illness	2016	2017	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	37.1%	36.7%	-0.40%
Percent Received Outpatient Visit Within 30 Days	58.1%	56.3%	-1.80%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	32.6%	30.6%	-2.00%
Percent Received Outpatient Visit Within 30 Days	52.3%	47.3%	-5.00%
PRTF			
Percent Received Outpatient Visit Within 7 Days	22.9%	23.3%	0.40%
Percent Received Outpatient Visit Within 30 Days	48.2%	45.8%	-2.40%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	36.2%	35.8%	-0.40%
Percent Received Outpatient Visit Within 30 Days	57.2%	55.3%	-1.90%

Table 10: A.4. Follow-Up After Hospitalization for Substance Abuse

Follow-up after Hospitalization for Substance Abuse	2016	2017	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	12.3%	14.8%	2.50%
Percent Received Outpatient Visit Within 30 Days	25.3%	25.3%	0.00%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	15.5%	11.8%	-3.70%
Percent Received Outpatient Visit Within 7 Days	21.0%	17.1%	-3.90%
Percent Received Outpatient Visit Within 30 Days	30.4%	27.6%	-2.80%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	17.0%	16.2%	-0.80%
Percent Received Outpatient Visit Within 30 Days	28.1%	26.7%	-1.40%

*NR = Denominator is equal to zero.

Table 11: B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	2016	2017	Change
Ages 13–17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	33.6%	35.7%	2.10%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	18.2%	18.4%	0.20%
Ages 18–20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	32.8%	31.8%	-1.00%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	16.2%	16.0%	-0.20%
Ages 21-34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	50.7%	47.6%	-3.10%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	35.3%	33.3%	-2.00%
Ages 35-64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	38.6%	36.6%	-2.00%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	23.9%	23.9%	0.00%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	26.1%	29.0%	2.90%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	11.8%	13.5%	1.70%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	41.5%	39.7%	-1.80%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	26.3%	25.6%	-0.70%

Table 12: D.1. Mental Health Utilization-Inpatient Discharges and Average Length of Stay

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		2016	2017	Change	2016	2017	Change
3–12	Male	0.3	0.2	-0.1	13.8	14.6	0.8
	Female	0.2	0.2	0.0	13.1	10.7	-2.4
	Total	0.2	0.2	0.0	13.5	12.9	-0.6
13–17	Male	1.1	0.9	-0.2	14.3	13.1	-1.2
	Female	1.9	1.8	-0.1	12.1	12.5	0.4
	Total	1.5	1.4	-0.1	12.9	12.7	-0.2
18–20	Male	1.6	1.2	-0.4	9.3	9.5	0.2
	Female	1.3	1.6	0.3	8.6	8.1	-0.5
	Total	1.5	1.4	-0.1	8.9	8.6	-0.3
21–34	Male	4.6	4.2	-0.4	9.1	9.2	0.1
	Female	1.3	1.2	-0.1	7.8	7.9	0.1
	Total	2.0	1.9	-0.1	8.4	8.5	0.1
35–64	Male	3.0	2.5	-0.5	8.9	9.5	0.6
	Female	2.1	2.0	-0.1	8.2	8.7	0.5
	Total	2.4	2.2	-0.2	8.5	9.0	0.5
65+	Male	0.3	0.4	0.1	20.3	22.6	2.3
	Female	0.4	0.4	0.0	17.7	16.7	-1.0
	Total	0.4	0.4	0.0	18.4	18.8	0.4
Unknown	Male	0.0	0.0	0.0	0.0	0.0	0.0
	Female	0.0	0.0	0.0	0.0	0.0	0.0
	Total	0.0	0.0	0.0	0.0	0.0	0.0
Total	**Male**	**1.2**	**1.0**	**-0.2**	**10.6**	**10.8**	**0.2**
	Female	**1.0**	**1.0**	**0.0**	**9.7**	**9.7**	**0.0**
	Total	**1.1**	**1.0**	**-0.1**	**10.2**	**10.2**	**0.0**

Table 13: D.2. Mental Health Utilization -% of Members that Received at Least 1 Mental Health Service in the Category Indicated during the Measurement Period

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
3-12	Male	11.15%	10.90%	-0.25%	0.25%	0.23%	-0.02%	0.30%	0.35%	0.05%	11.10%	10.84%	-0.26%
	Female	7.52%	7.18%	-0.34%	0.17%	0.17%	0.00%	0.08%	0.11%	0.03%	7.51%	7.16%	-0.35%
	Total	9.37%	9.08%	-0.29%	0.21%	0.20%	-0.01%	0.19%	0.23%	0.04%	9.34%	9.04%	-0.30%
13-17	Male	14.27%	13.69%	-0.58%	1.04%	0.97%	-0.07%	0.26%	0.30%	0.04%	14.19%	13.62%	-0.57%
	Female	16.02%	15.77%	-0.25%	1.80%	1.88%	0.08%	0.22%	0.27%	0.05%	15.92%	15.66%	-0.26%
	Total	15.14%	14.72%	-0.42%	1.42%	1.42%	0.00%	0.24%	0.28%	0.04%	15.05%	14.63%	-0.42%
18-20	Male	9.87%	8.63%	-1.24%	1.54%	1.25%	-0.29%	0.02%	0.05%	0.03%	9.68%	8.50%	-1.18%
	Female	11.20%	10.86%	-0.34%	1.29%	1.53%	0.24%	0.05%	0.11%	0.06%	11.06%	10.72%	-0.34%
	Total	10.60%	9.85%	-0.75%	1.40%	1.40%	0.00%	0.04%	0.08%	0.04%	10.44%	9.72%	-0.72%
21-34	Male	24.78%	23.78%	-1.00%	3.89%	3.89%	0.00%	0.21%	0.26%	0.05%	24.50%	23.60%	-0.90%
	Female	15.97%	15.39%	-0.58%	1.35%	1.33%	-0.02%	0.16%	0.26%	0.10%	15.83%	15.30%	-0.53%
	Total	17.83%	17.12%	-0.71%	1.88%	1.86%	-0.02%	0.17%	0.26%	0.09%	17.65%	17.02%	-0.63%
35-64	Male	21.07%	20.89%	-0.18%	2.76%	2.40%	-0.36%	0.10%	0.17%	0.07%	20.85%	20.73%	-0.12%
	Female	24.20%	23.72%	-0.48%	1.97%	1.92%	-0.05%	0.19%	0.26%	0.07%	24.05%	23.57%	-0.48%
	Total	23.05%	22.67%	-0.38%	2.26%	2.10%	-0.16%	0.16%	0.23%	0.07%	22.87%	22.51%	-0.36%

65+	Male	5.12%	6.07%	0.95%	0.46%	0.54%	0.08%	0.02%	0.01%	-0.01%	5.02%	5.98%	0.96%
	Female	5.42%	6.54%	1.12%	0.40%	0.43%	0.03%	0.00%	0.00%	0.00%	5.33%	6.47%	1.14%
	Total	5.33%	6.40%	1.07%	0.42%	0.47%	0.05%	0.01%	0.01%	0.00%	5.23%	6.32%	1.09%
Unknown	Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	**Male**	**13.64%**	**13.32%**	**-0.32%**	**1.08%**	**1.00%**	**-0.08%**	**0.23%**	**0.27%**	**0.04%**	**13.53%**	**13.23%**	**-0.30%**
	Female	**13.31%**	**13.13%**	**-0.18%**	**1.02%**	**1.05%**	**0.03%**	**0.13%**	**0.18%**	**0.05%**	**13.22%**	**13.05%**	**-0.17%**
	Total	**13.45%**	**13.21%**	**-0.24%**	**1.05%**	**1.03%**	**-0.02%**	**0.17%**	**0.22%**	**0.05%**	**13.35%**	**13.12%**	**-0.23%**

Table 14: D.3. Identification of Alcohol and Other Drug Services

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
3–12	Male	0.05%	0.03%	-0.02%	0.00%	0.00%	0.00%	0.01%	0.00%	-0.01%	0.05%	0.03%	-0.02%
	Female	0.02%	0.01%	-0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.01%	-0.01%
	Total	0.04%	0.02%	-0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.03%	0.02%	-0.01%
13–17	Male	1.99%	1.96%	-0.03%	0.10%	0.12%	0.02%	0.42%	0.29%	-0.13%	1.88%	1.83%	-0.05%
	Female	1.05%	1.15%	0.10%	0.15%	0.16%	0.01%	0.12%	0.15%	0.03%	0.93%	1.02%	0.09%
	Total	1.53%	1.56%	0.03%	0.13%	0.14%	0.01%	0.27%	0.22%	-0.05%	1.41%	1.43%	0.02%
18–20	Male	3.50%	3.08%	-0.42%	0.64%	0.48%	-0.16%	0.29%	0.29%	0.00%	3.19%	2.89%	-0.30%
	Female	2.54%	2.28%	-0.26%	0.35%	0.49%	0.14%	0.29%	0.22%	-0.07%	2.39%	2.12%	-0.27%
	Total	2.98%	2.64%	-0.34%	0.48%	0.48%	0.00%	0.29%	0.25%	-0.04%	2.75%	2.47%	-0.28%
21–34	Male	9.55%	9.27%	-0.28%	1.56%	1.39%	-0.17%	0.91%	0.83%	-0.08%	9.00%	8.98%	-0.02%
	Female	6.88%	6.45%	-0.43%	0.55%	0.56%	0.01%	1.08%	0.93%	-0.15%	6.52%	6.25%	-0.27%
	Total	7.44%	7.03%	-0.41%	0.76%	0.74%	-0.02%	1.05%	0.91%	-0.14%	7.04%	6.81%	-0.23%
35–64	Male	8.97%	8.32%	-0.65%	1.30%	1.03%	-0.27%	0.98%	0.90%	-0.08%	8.47%	8.01%	-0.46%
	Female	5.63%	5.68%	0.05%	0.68%	0.61%	-0.07%	0.75%	0.71%	-0.04%	5.30%	5.43%	0.13%
	Total	6.86%	6.66%	-0.20%	0.91%	0.76%	-0.15%	0.83%	0.78%	-0.05%	6.47%	6.39%	-0.08%
65+	Male	1.21%	1.27%	0.06%	0.17%	0.17%	0.00%	0.13%	0.12%	-0.01%	1.10%	1.12%	0.02%
	Female	0.32%	0.37%	0.05%	0.03%	0.05%	0.02%	0.01%	0.01%	0.00%	0.31%	0.36%	0.05%

2018 External Quality Review

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	Total	0.59%	0.65%	0.06%	0.07%	0.08%	0.01%	0.04%	0.05%	0.01%	0.54%	0.60%	0.06%
Unknown	Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	**Male**	**2.58%**	**2.47%**	**-0.11%**	**0.36%**	**0.30%**	**-0.06%**	**0.31%**	**0.27%**	**-0.04%**	**2.42%**	**2.36%**	**-0.06%**
	Female	**2.57%**	**2.55%**	**-0.02%**	**0.27%**	**0.27%**	**0.00%**	**0.36%**	**0.33%**	**-0.03%**	**2.42%**	**2.44%**	**0.02%**
	Total	**2.57%**	**2.52%**	**-0.05%**	**0.30%**	**0.28%**	**-0.02%**	**0.34%**	**0.31%**	**-0.03%**	**2.42%**	**2.41%**	**-0.01%**

Table 15: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	3-12			13-17			18-20			21-34		
Alamance	0.03%	0.02%	-0.01%	0.89%	1.15%	0.26%	1.79%	1.96%	0.17%	5.35%	5.33%	-0.02%
Cabarrus	0.07%	0.02%	-0.05%	1.17%	1.27%	0.10%	2.43%	1.95%	-0.48%	6.09%	5.99%	-0.10%
Caswell	0.00%	0.00%	0.00%	1.10%	1.38%	0.28%	0.74%	4.44%	3.70%	5.19%	6.84%	1.65%
Chatham	0.00%	0.00%	0.00%	1.13%	0.77%	-0.36%	2.77%	2.65%	-0.12%	7.22%	8.48%	1.26%
Davidson	0.02%	0.02%	0.00%	1.19%	0.92%	-0.27%	2.52%	2.86%	0.34%	6.97%	7.04%	0.07%
Davie	NA	0.04%	NA	NA	1.75%	NA	NA	3.28%	NA	NA	7.59%	NA
Forsyth	NA	0.01%	NA	NA	1.75%	NA	NA	2.02%	NA	NA	4.28%	NA
Franklin	0.00%	0.02%	0.02%	0.67%	0.86%	0.19%	1.60%	2.06%	0.46%	5.33%	5.83%	0.50%
Granville	0.05%	0.00%	-0.05%	0.75%	0.58%	-0.17%	2.81%	2.62%	-0.19%	5.51%	6.80%	1.29%
Halifax	0.03%	0.00%	-0.03%	0.31%	0.94%	0.63%	3.27%	2.48%	-0.79%	5.68%	6.16%	0.48%
Mecklenburg	0.00%	0.02%	0.02%	1.61%	1.74%	0.13%	2.43%	2.16%	-0.27%	4.05%	3.70%	-0.35%
Orange	0.03%	0.02%	-0.01%	1.64%	1.42%	-0.22%	2.87%	3.20%	0.33%	8.90%	9.37%	0.47%
Person	0.00%	0.00%	0.00%	1.20%	1.56%	0.36%	3.31%	3.31%	0.00%	7.69%	7.74%	0.05%
Rockingham	NA	0.01%	NA	NA	1.28%	NA	NA	2.39%	NA	NA	4.93%	NA
Rowan	0.04%	0.05%	0.01%	1.90%	1.77%	-0.13%	3.68%	2.76%	-0.92%	9.72%	9.79%	0.07%
Stanly	0.00%	0.02%	0.02%	2.21%	1.38%	-0.83%	3.74%	4.39%	0.65%	6.01%	6.52%	0.51%
Stokes	NA	0.00%	NA	NA	1.93%	NA	NA	3.45%	NA	NA	7.77%	NA

Union	0.02%	0.02%	0.00%	1.44%	1.45%	0.01%	2.48%	2.72%	0.24%	5.09%	5.06%	-0.03%
Vance	0.00%	0.04%	0.04%	0.95%	0.91%	-0.04%	3.27%	3.17%	-0.10%	6.83%	6.59%	-0.24%
Warren	0.00%	0.00%	0.00%	1.06%	0.45%	-0.61%	3.56%	2.12%	-1.44%	3.64%	4.52%	0.88%
	35-64			65+			Unknown			Total		
Alamance	7.43%	7.39%	-0.04%	0.71%	0.97%	0.26%	0.00%	0.00%	0.00%	2.27%	2.38%	0.11%
Cabarrus	5.74%	5.79%	0.05%	0.52%	0.35%	-0.17%	0.00%	0.00%	0.00%	2.13%	2.09%	-0.04%
Caswell	5.09%	3.83%	-1.26%	0.99%	0.67%	-0.32%	0.00%	0.00%	0.00%	2.08%	2.29%	0.21%
Chatham	5.94%	6.71%	0.77%	0.28%	0.14%	-0.14%	0.00%	0.00%	0.00%	2.12%	2.37%	0.25%
Davidson	4.46%	4.82%	0.36%	0.17%	0.47%	0.30%	0.00%	0.00%	0.00%	2.18%	2.27%	0.09%
Davie	NA	4.40%	NA	NA	0.00%	NA	NA	0.00%	NA	NA	2.32%	NA
Forsyth	NA	6.14%	NA	NA	0.84%	NA	NA	0.00%	NA	NA	2.09%	NA
Franklin	3.94%	4.28%	0.34%	0.19%	0.30%	0.11%	0.00%	0.00%	0.00%	1.65%	1.84%	0.19%
Granville	5.97%	5.84%	-0.13%	0.56%	0.35%	-0.21%	0.00%	0.00%	0.00%	2.21%	2.36%	0.15%
Halifax	7.44%	6.55%	-0.89%	1.43%	0.70%	-0.73%	0.00%	0.00%	0.00%	2.98%	2.82%	-0.16%
Mecklenburg	5.63%	5.42%	-0.21%	0.89%	0.75%	-0.14%	0.00%	0.00%	0.00%	1.87%	1.84%	-0.03%
Orange	8.66%	9.03%	0.37%	1.30%	1.63%	0.33%	0.00%	0.00%	0.00%	3.35%	3.54%	0.19%
Person	5.97%	6.03%	0.06%	1.23%	0.24%	-0.99%	0.00%	0.00%	0.00%	2.83%	2.81%	-0.02%
Rockingham	NA	5.53%	NA	NA	0.20%	NA	NA	0.00%	NA	NA	2.23%	NA
Rowan	7.33%	7.60%	0.27%	0.30%	0.79%	0.49%	0.00%	0.00%	0.00%	3.34%	3.39%	0.05%
Stanly	5.87%	5.83%	-0.04%	0.60%	0.68%	0.08%	0.00%	0.00%	0.00%	2.65%	2.63%	-0.02%
Stokes	NA	4.78%	NA	NA	0.50%	NA	NA	0.00%	NA	NA	2.62%	NA
Union	5.04%	4.60%	-0.44%	0.37%	0.40%	0.03%	0.00%	0.00%	0.00%	1.81%	1.77%	-0.04%

Vance	6.68%	7.63%	0.95%	0.48%	0.31%	-0.17%	0.00%	0.00%	0.00%	2.78%	2.97%	0.19%
Warren	3.94%	4.46%	0.52%	0.55%	0.69%	0.14%	0.00%	0.00%	0.00%	1.80%	1.85%	0.05%

Table 16: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	3-12			13-17			18-20			21-34		
Alamance	7.50%	7.94%	0.44%	13.50%	14.39%	0.89%	8.50%	8.73%	0.23%	15.30%	14.80%	-0.50%
Cabarrus	7.40%	8.17%	0.77%	13.90%	14.05%	0.15%	11.30%	9.12%	-2.18%	12.90%	12.82%	-0.08%
Caswell	8.00%	9.81%	1.81%	13.90%	13.97%	0.07%	8.60%	7.77%	-0.83%	17.90%	14.29%	-3.61%
Chatham	7.20%	8.88%	1.68%	15.30%	16.20%	0.90%	7.40%	7.91%	0.51%	15.30%	16.01%	0.71%
Davidson	7.40%	7.65%	0.25%	14.10%	12.98%	-1.12%	9.40%	9.09%	-0.31%	12.10%	11.30%	-0.80%
Davie	NA	8.08%	NA	NA	12.22%	NA	NA	8.54%	NA	NA	10.78%	NA
Forsyth	NA	6.18%	NA	NA	12.60%	NA	NA	8.35%	NA	NA	13.80%	NA
Franklin	8.40%	7.67%	-0.73%	12.90%	12.01%	-0.89%	7.70%	9.81%	2.11%	15.60%	15.39%	-0.21%
Granville	8.50%	8.62%	0.12%	13.10%	12.56%	-0.54%	11.20%	9.41%	-1.79%	14.10%	15.14%	1.04%
Halifax	9.10%	9.54%	0.44%	14.40%	14.98%	0.58%	12.20%	11.02%	-1.18%	15.80%	15.75%	-0.05%
Mecklenburg	6.80%	6.95%	0.15%	12.70%	12.69%	-0.01%	8.00%	7.73%	-0.27%	11.80%	11.03%	-0.77%
Orange	10.60%	9.21%	-1.39%	19.00%	17.99%	-1.01%	11.40%	11.72%	0.32%	21.10%	18.98%	-2.12%
Person	10.30%	10.09%	-0.21%	17.10%	16.80%	-0.30%	11.50%	12.55%	1.05%	18.60%	18.36%	-0.24%
Rockingham	NA	8.16%	NA	NA	15.42%	NA	NA	10.03%	NA	NA	13.98%	NA

Rowan	10.20%	9.43%	-0.77%	16.00%	14.86%	-1.14%	10.50%	10.04%	-0.46%	13.30%	14.18%	0.88%
Stanly	11.20%	9.97%	-1.23%	18.80%	16.79%	-2.01%	12.30%	11.62%	-0.68%	14.10%	13.95%	-0.15%
Stokes	NA	10.60%	NA	NA	16.54%	NA	NA	7.80%	NA	NA	13.92%	NA
Union	7.60%	8.42%	0.82%	13.70%	14.50%	0.80%	8.30%	8.98%	0.68%	11.10%	10.93%	-0.17%
Vance	7.70%	8.19%	0.49%	12.10%	12.94%	0.84%	10.90%	10.22%	-0.68%	17.90%	16.88%	-1.02%
Warren	8.70%	10.22%	1.52%	13.10%	12.18%	-0.92%	10.60%	8.80%	-1.80%	14.40%	15.50%	1.10%
	35-64			65+			Unknown			Total		
Alamance	24.80%	26.38%	1.58%	6.40%	9.01%	2.61%	0.00%	0.00%	0.00%	12.40%	13.12%	0.72%
Cabarrus	19.60%	19.83%	0.23%	8.90%	11.34%	2.44%	0.00%	0.00%	0.00%	11.40%	11.85%	0.45%
Caswell	20.30%	20.05%	-0.25%	6.40%	8.40%	2.00%	0.00%	0.00%	0.00%	12.60%	13.00%	0.40%
Chatham	19.20%	18.14%	-1.06%	3.30%	5.08%	1.78%	0.00%	0.00%	0.00%	11.00%	12.02%	1.02%
Davidson	17.20%	16.14%	-1.06%	7.20%	11.65%	4.45%	0.00%	0.00%	0.00%	11.00%	10.91%	-0.09%
Davie	NA	17.17%	NA	NA	10.57%	NA	NA	0.00%	NA	NA	10.90%	NA
Forsyth	NA	22.31%	NA	NA	12.15%	NA	NA	0.00%	NA	NA	11.49%	NA
Franklin	16.60%	16.72%	0.12%	4.10%	7.75%	3.65%	0.00%	0.00%	0.00%	11.10%	11.12%	0.02%
Granville	21.20%	21.66%	0.46%	5.00%	4.95%	-0.05%	0.00%	0.00%	0.00%	12.20%	12.27%	0.07%
Halifax	21.90%	22.41%	0.51%	7.10%	8.75%	1.65%	0.00%	0.00%	0.00%	13.80%	14.21%	0.41%
Mecklenburg	18.40%	17.67%	-0.73%	7.30%	8.29%	0.99%	0.00%	0.00%	0.00%	10.30%	10.23%	-0.07%
Orange	26.40%	28.55%	2.15%	7.60%	9.22%	1.62%	0.00%	0.00%	0.00%	16.00%	15.59%	-0.41%
Person	23.20%	24.05%	0.85%	8.10%	8.07%	-0.03%	0.00%	0.00%	0.00%	14.90%	15.00%	0.10%
Rockingham	NA	20.90%	NA	NA	7.69%	NA	NA	0.00%	NA	NA	12.78%	NA
Rowan	21.60%	21.84%	0.24%	8.20%	12.20%	4.00%	0.00%	0.00%	0.00%	13.40%	13.47%	0.07%

Stanly	25.10%	25.66%	0.56%	8.90%	14.63%	5.73%	0.00%	0.00%	0.00%	15.30%	15.07%	-0.23%
Stokes	NA	19.30%	NA	NA	10.86%	NA	NA	0.00%	NA	NA	13.60%	NA
Union	16.10%	16.20%	0.10%	8.70%	11.65%	2.95%	0.00%	0.00%	0.00%	10.40%	11.14%	0.74%
Vance	23.30%	23.97%	0.67%	4.80%	10.13%	5.33%	0.00%	0.00%	0.00%	13.00%	13.75%	0.75%
Warren	19.70%	20.58%	0.88%	7.30%	11.37%	4.07%	0.00%	0.00%	0.00%	12.50%	13.58%	1.08%

B Waiver Validation Results

The overall validation score was in the "Fully Compliant" range, with an average validation score of 100% across the ten measures. The following tables display the validation scores for each of Cardinal's ten measures, as well as the combined final validation for the ten measures that present an overall validation score (see *Performance Measure Validation Worksheets* for details).

Table 17: B Waiver Performance Measure Validation Scores 2017

Measure	Validation Score Received
A.1. Readmission Rates for Mental Health	100%
A.2. Readmission Rate for Substance Abuse	100%
A.3. Follow-Up After Hospitalization for Mental Illness	100%
A.4. Follow-Up After Hospitalization for Substance Abuse	100%
B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment	100%
D.1. Mental Health Utilization-Inpatient Discharges and Average Length of Stay	100%
D.2. Mental Health Utilization	100%
D.3. Identification of Alcohol and other Drug Services	100%
D.4. Substance Abuse Penetration Rate	100%
D.5. Mental Health Penetration Rate	100%
Average Validation Score & Audit Designation	**100% FULLY COMPLIANT**

C Waiver Measures

Changes made to the measures were validated for review of 2016-2017 *C Waiver* measures. Eight new measures were selected and two previously-validated measures were retained. Cardinal included documentation for all ten *C Waiver* measures. Cardinal's reported rates are displayed in the *Table 18*.

Table 18: C Waiver Measures Reported Rates

Measure	Data Collection	2017/2018*
Proportion of Level of Care evaluations completed at least annually for enrolled participants	Semi Annually	2519/2519 = 100%
Proportion of Level of Care evaluations completed using approved processes and instrument	Semi Annually	2519/2519 = 100%
Proportion of New Level of Care evaluations completed using approved processes and instrument	Semi Annually	157/157= 100%
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	Annually	85/85 = 100%
Proportion of monitored Innovations providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame	Annually	405/422 = 95.97%
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	Annually	8129/8129 = 100%
Proportion of Individual Support Plans that address identified health and safety risk factors	Semi Annually	4062/4062 = 100%
Percentage of participants reporting that their Individual Support Plan has the services that they need	Annually	8129/8129 = 100%
Proportion of individuals for whom an annual ISP and/or needed updates took place	Annually	941/946 = 99.47%
Proportion of new waiver participants who are receiving services according to their ISP within 45 days of ISP approval	Quarterly	20/25 = 80%

*Latest available calculated rates are reported as of November 2018

C Waiver Validation Results

Validation scores are "Fully Compliant" with an average validation score of 100% across the 10 measures. The validation scores are shown in *Table 19, C Waiver Performance Measure Validation Scores 2018.* Data validation methods were not included in the initial upload but were added to the portal prior to the Onsite interview. The Validation Worksheets offer detailed information on validation steps for C waiver measures.

Table 19: C Waiver Measures Validation Scores 2018

Measure	Percentages Reported
Proportion of Level of Care evaluations completed at least annually for enrolled participants	100%
Proportion of Level of Care evaluations completed using approved processes and instrument	100%
Proportion of New Level of Care evaluations completed using approved processes and instrument	100%
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	100%
Proportion of monitored Innovations providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame	100%
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	100%
Proportion of Individual Support Plans that address identified health and safety risk factors	100%
Percentage of participants reporting that their Individual Support Plan has the services that they need	100%
Proportion of individuals for whom an annual ISP and/or needed updates took place	100%
Proportion of new waiver participants who are receiving services according to their ISP within 45 days of ISP approval	100%
Average Validation Score & Audit Designation	**100% FULLY COMPLIANT**

Performance Improvement Project Validation

CCME conducted PIP validations following the CMS-developed protocol entitled, EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

- Study topic(s)
- Study question(s)
- Study indicator(s)
- Identified study population
- Sampling methodology, if used
- Data collection procedures
- Improvement strategies

Validation Results

For the 2017 review year, Cardinal submitted three new projects that were not validated in the previous year. All three projects were validated. The primary issue was lack of improvement in the rates. For 2018, three PIPs were validated. Two were the same as those submitted in 2017, and a new one regarding 7-day and 30-day follow-up for substance abuse (SA) related discharges was added. The Follow up after Emergency Department (ED) visit for substance use disorder PIP was not submitted to the Desk Materials. *Table 20* displays the project names and validation scores for 2017 and 2018 review years.

Table 20: Performance Improvement Project Validation Scores

Project Type	Project	2017 Validation Score	2018 Validation Score
Clinical	Follow Up After Emergency Department Visit for Substance Use Disorder	96/96 = 100%	Not Validated
	Improving the Percentage of Follow Up Appointments that Occur Within 7 and 30 Days of Mental Health Specific Community Hospital and Facility Based Crisis Discharges	95/96 = 99%	90/90 =100%
	Improving the Percentage of Follow Up Appointments that Occur Within 7 and 30 Days of SA Related Community Hospital and SA-related Facility Based Crisis Discharges	Not validated	90/90 = 100%
Non-Clinical	Increase Timely Submission of Quality of Life Surveys	95/96 = 99%	90/90 = 100%

During the Onsite, errors in the reports were noted, and Cardinal uploaded the revised PIPs to the Desk Materials. The revisions were approved, thus, there are no issues/recommendations for the current review year for the PIPs.

The *Figure 5* shows the that Cardinal scored 94% "Met" on the Quality standards in 2018 and compares this score to the percentage of standards "Met" in 2017.

Figure 5: Quality Improvement Findings

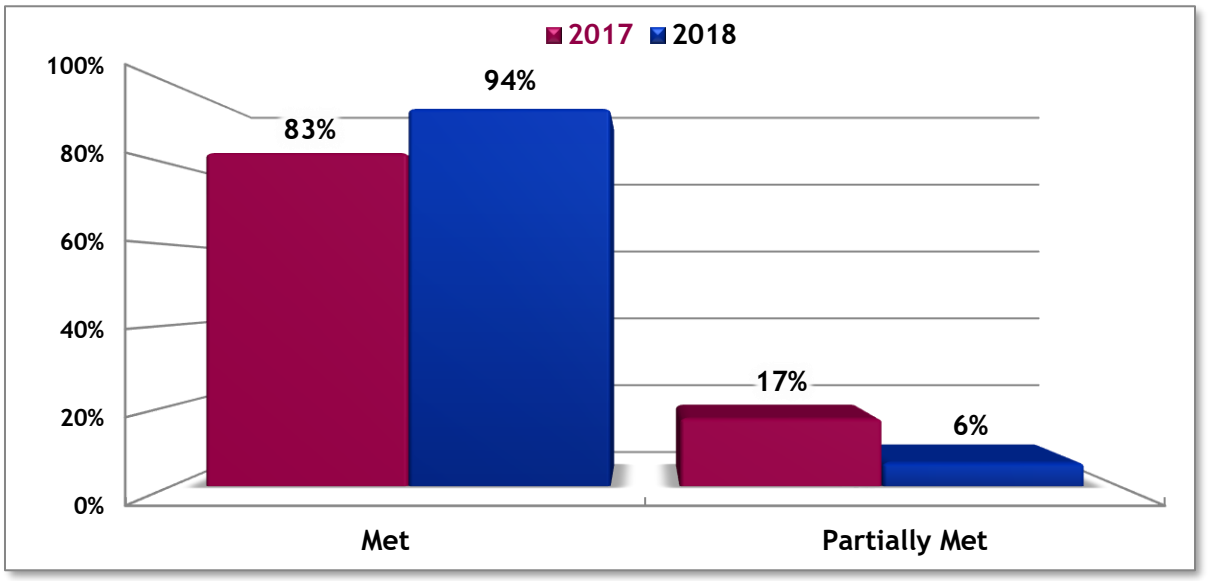


Table 21: Quality Improvement

Section	Standard	2018 Review
Annual Evaluation of the Quality Improvement Program	A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	**Partially Met**

Strengths

- Cardinal is focused on three clinical practice guidelines: child residential, peer support services, and medication assisted treatment. These guidelines are reviewed during focused and routine UM reviews.
- A workgroup to discuss interventions for low scoring enrollee surveys was formed.
- The Barriers Workgroup project is an example of providers participating in QI activities. This workgroup is meeting every other month to identify and discuss barriers of coordination in care.
- PIPs were based on analysis of comprehensive aspects of member needs and services, and rationale for each topic was documented. Implemented recommendations from last year's PIP reviews resulted in increased rates.
- Query for B waiver performance measures was accurate, and rates were presented accurately.
- Cardinal presented, discussed, and addressed over and underutilization issues.

- The submitted C waiver measure query was accurate and consistent with NC Medicaid requirements.

Weaknesses

- The *Continuous Quality Improvement (CQI) Annual Work Plan* does not include the target time frames for the actives or documented updates that are made periodically throughout the year.
- The most recent *ECHO Surveys* on the website was completed in 2016. The 2017 *ECHO Survey Results* are not posted on the website.
- The 2017-2018 *Continuous Quality Improvement (CQI) Annual Work Plan Evaluation* should analyze how the overall program goals were accomplished or partially accomplished. If a goal is not met at the end of the year, identified barriers should be listed and the specific interventions planned for next year documented in this evaluation. Input from CQI and other committees should happen prior to completing the annual evaluation.

Corrective Action

- Create an annual QI program evaluation that contains an analysis and evaluation of the overall effectiveness of the QI program goals. Specific projects related to the goals can be documented and analyzed. If a goal is not met at the end of the year, identified barriers should be listed and the interventions planned for next year documented in this evaluation. If the goal is met, explain what interventions contributed to meeting the goal and how the goal will be maintained. See *42 CFR § 438.330*.

Recommendations

- Add target time frames for each of the activities included on the *Continuous Quality Improvement (CQI) Annual Work Plan*. A notes column should be added to track progress throughout the year. A work plan is a document that is intended to be updated and change, if needed, throughout the year.
- Post the most recent *ECHO Surveys* to the Cardinal website.

E. Utilization Management

The External Quality Review (EQR) of the Cardinal Utilization Management (UM) Program includes; review of the *Utilization Management Plan (UM Plan*), *Organizational Chart*, UM policies and procedures, and 50 UM files. Onsite discussion with staff provided additional information.

Christine Beck, LPC, LCAS, Vice President of Clinical Operations is currently providing program oversight for the UM Department due the recent vacancy of the UM Director

position. There are two UM manager positions; Chantay Cooper, LCSW, is Manager of Mental Health/Substance Use (MH/SU) Care Management and Tony Martin, QP, is Manager of Intellectual/Developmental Disorder (I/DD) Care Management. Per the Onsite discussion, Dr. Terri Harpold, Interim Chief Medical Officer (CMO) oversees medical decision-making and provides clinical supervision and guidance to the UM Program Management staff.

The *UM Plan* describes the program's purpose, scope, structure components and staffing qualifications. The *UM Plan* includes an overview of the processes and criteria and is reviewed annually. The *Organizational Chart* delineates organizational and supervisory structure; however, medical oversight of the UM Program is not represented. During the Onsite interview, Dr. Harpold provided an overview of the medical staff changes, restructuring and the medical oversight since the last EQR.

Policy & Procedure 6010, Pre-Service Authorization and Re-Authorization of Services includes the procedural steps to process a *Treatment Authorization Request* (TAR) and information on extensions to the TAR processing time frame. Criteria for extensions within the policy and procedure do not reference the requirement that Cardinal "demonstrates to DMA" or "justifies" the need for the extensions (see *DMA Contract Section 7.4.13* and *Attachment M, D.1.b*) or how staff demonstrate and/or justify extensions to the TAR processing time frame.

In the UM files where staff applied an extension, there was inconsistent documentation justifying the need for additional information or how the extension was in the enrollee's best interest. Eight of the 25 files where a denial was issued showed extensions to the TAR processing time frame, but did not have evidence that could justify or "demonstrate to DMA", that extension criteria were considered and met. CCME recommends UM staff document the consideration of the required criteria outlined in the *DMA Contract* and justify the decision to extend the TAR processing time frame within the TAR. Monitoring TARs with extended time frames would also ensure justifications are adequately and consistently documented. It should be noted that all UM files reviewed (standard, expedited and extended) were made and notification provided within the required time frames.

Policy & Procedure 6010, includes a mechanism to process an appeal and notes; "Any decisions to deny a request for authorization of services, or authorize the requested services in a limited manner, shall be done in accordance with *Policy & Procedure #6020.*" *Policy & Procedure 6020, Adverse Benefits Determination, Notice, and Appeal Process for Medicaid-Funded Services* describes the procedure for processing appeals.

The review of the UM files noted that the Cardinal's electronic TAR system includes an electronic signature of the Reviewer or Peer Reviewer, however the credentials are not present. Per *DMA Contract, 8.2 Clinical Records, Section 8.2.2.1. e and f…* the "name,

signature and credentials of the individual who conduct the review" and who "made the decision to deny, reduce or terminate authorization for the requested service..." are required as a part of the clinical record.

Twenty Care Coordination member files and all Care Coordination policies and procedures were reviewed for Cardinal's Care Coordination Program.

The Onsite discussion included an overview of the program and the process used in the assignment of Care Coordinators. There are several factors that are taken into consideration when members are assigned to a Care Coordinator. Care Coordination policies and procedures describe the roles and responsibilities of Care Coordinators, including coordination with internal and external stakeholders around referrals and transition of care.

The Transition to Community Living (TCLI) Program includes several policies and procedures that provide educational requirements and staff functions for the following: Qualified Professionals (QP), Certified Peer Support Specialists (PSS), Supported Employment (SE), Transition Care Coordinator, and Transitional Health Care Coordinator where included in policies and procedures.

The TCLI file review also included the review of Person-Centered Plans to ensure that community-based services are provided. The review of the Person Centered Plans found that Assertive Community Treatment (ACT) was regularly provided as community supports but rarely linked with TCLI members with Supported Employment, even when members identified seeking employment as a goal. During the Onsite interview, potential barriers with this service were discussed along with efforts to educate the community and Supported Employment providers to increase linkage of TCLI members with this service.

Policy and Procedure 7000, TYSR includes what the Transition Year Stability Resource (TYSR) funds can be used for and the eligibility criteria for members to access these funds. However, it does not describe the monitoring process of these funds or the use of the *DOJ-TYSR Expenses Form* which was described as a component of the cross-department monitoring process. CCME recommends the use of this form and the process by which funds are monitored are detailed in *Policy & Procedure 7000*.

Figure 6, Utilization Management Findings, Cardinal has achieved the score of "Met" for 98% of the standards for the Utilization Management section of the EQR review.

Figure 6: Utilization Management Findings

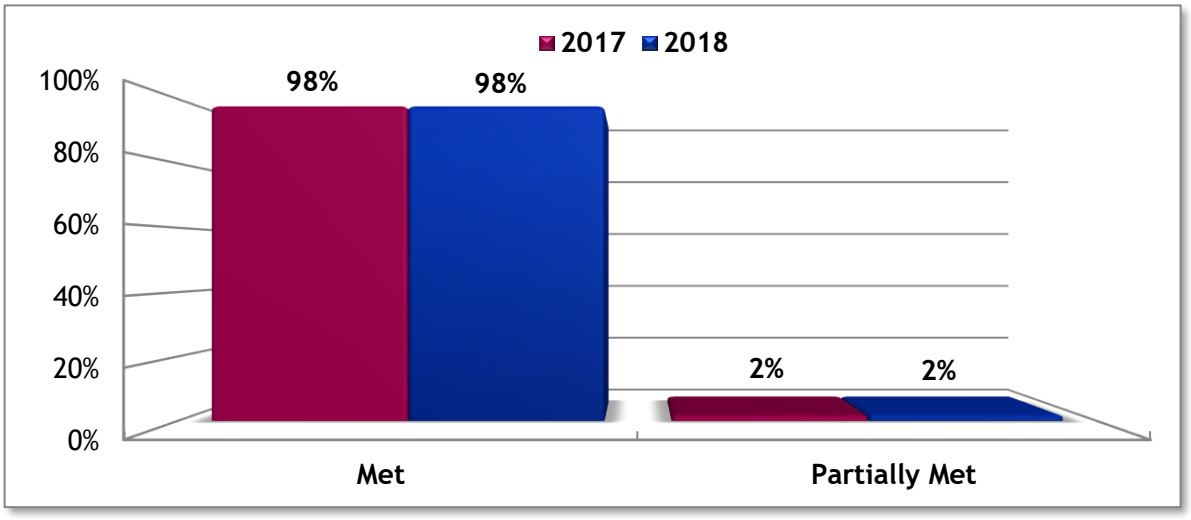


Table 22: Utilization Management

Section	Standard	2018 Review
Medical Necessity Determinations	Utilization management decisions are made by appropriately trained reviewers	**Partially Met**

Strengths

- During the Onsite discussion, Dr. Terri Harpold, Interim Chief Medical Officer, described changes implemented during the past year that provide additional layers of clinical oversight by the Medical Department.
- A Behavioral Health Nurse Director position was developed to assist coordination of "rounds" and provide additional, clinical support.
- Care Coordination caseloads are determined by the member's need within a specified population.

Weaknesses

- Criteria for extensions within Policy & Procedure 6010, Pre-Service Authorization and Re-Authorization of Services do not reference the requirement that Cardinal "demonstrates to DMA" or justifies extensions (see DMA Contract Section 7.4.13 and Attachment M, D.1.b) or how staff demonstrate and/or justify in documentation extensions to the TAR processing time frame.

- Cardinal extended the TAR processing time frame in eight of the 25 files where services were denied or reduced and files did not have consistent documentation to "demonstrate" or "justify" that criteria for extensions were considered and the extension justified.
- Within the electronic TAR system, there was no evidence of reviewer credentials as is required by DMA Contract, Section 8.2.2.1.
- Within the TCLI files reviewed, members were rarely linked with Supported Employment, even when they identified seeking employment as a goal.
- Policy and Procedure 7000, TYSR does not describe how Cardinal monitors the TYSR funds.

Recommendations

- Add detail to Policy & Procedure 6010, Pre-Service Authorization and Re-Authorization of Services regarding the requirement that Cardinal "demonstrates to DMA" or "justifies" extensions (see DMA Contract Section 7.4.13 and Attachment M, D.1.b) and how staff demonstrate and/or justify extensions to the TAR processing time frame.
- Add detail to Policy & Procedure 6010, Pre-Service Authorization and Re-Authorization of Services explaining how staff document the consideration of extension criteria and the justification for implementing an extension to the TAR processing time frame.
- Monitor Pre-Service and Re-Authorization requests where the TAR processing time frame was extended to ensure extension justifications are adequately and consistently documented by staff.
- Continue to address barriers to referrals for Supported Employment and ensure those TCLI enrollees that voice a desire for employment are referred and linked to this service.
- Add detail to Policy & Procedure 7000, describing the monitoring of the TYSR funds and reference the DOJ-TYSR Expenses Form that was described as an essential form used with Cardinal's cross agency monitoring process.

Corrective Action

- Ensure electronic signatures within the UM files reflect the reviewer and peer reviewer credentials, as is required by *DMA Contract, Section 8.2.2.1.*

F. Grievances and Appeals

Grievances

The Grievances Section of the External Quality Review (EQR) includes a thorough examination of Cardinal's Grievance policies and procedures, Grievance Logs, 25 Grievance files, and information presented during the Onsite interview.

Cardinal's Grievance functions are in the Quality Management (QM) Department. The Director of QM is Onika Wilson and the Grievance Manager is Jennifer Greene, LCSW. Ms. Greene is a Licensed Social Worker and provides clinical supervision over the Grievance Team. The Grievance Team is comprised of three Grievance Specialists who have experience in the areas of Intellectual and Developmental Disabilities, Mental Health and Substance Use services. There was a change in the management and processing of grievances, which includes the Grievance Specialist remaining as the primary contact throughout the Grievance process. Cardinal staff suggests that this change appears to be an effective procedural change as grievances processed over the past year decreased. During the year reviewed for this EQR, 591 grievances were processed compared to 654 in the previous year.

The EQR of grievance files noted that files were well organized and contained required documentation. The practice by staff to confirm guardianship, secure releases of information, and keep disclosures to the minimal amount of information necessary to achieve resolution of the grievance was documented. The procedural steps to file a grievance are included in *Policy & Procedure 5050, Grievance and Formal Level of Review*.

Cardinal states in *Policy & Procedure 5050,* they resolve grievances within 30 days, although the *DMA Contract, Attachment M,* and *42 CFR § 438.408* provide a ninety (90)-day time frame to complete the Grievance process. The file review concluded that there were three files where the Grievance process was completed on the thirtieth (30) day and three files where the process was completed on the twenty-ninth (29) day. Cardinal's average time frame to complete a grievance is 19 days. However, the time frames vary by regions between 17.7 to 21.2 days as provided in the *Central Office Quality Management Dashboard, Grievances- FYTD June 2018.*

Policy & Procedure 5050, incudes the time frames for filing an extension. The steps are clear; however, some details are missing. Cardinal needs to add detail and clarification to the extension process in *Policy & Procedure 5050*. Page 3 of *Policy & Procedure 5050*, on page 3, Section III, Grievance Investigation and Resolution states, "…A fourteen (14) calendar day extension may be granted if more time is needed to resolve the grievance. This extension can be granted by the Grievance Team Manager or designee if requested by the member or justified by Cardinal Innovations." Per *DMA Contract Attachment M, Sections C and D,* and *42 CFR § 438.408*, this policy and procedure should include the details regarding the need for additional information and that Cardinal must demonstrate "to the satisfaction of DMA" how the delay is in the best interests of the enrollee.

In addition to *Policy & Procedure 5050*, Cardinal will also need to add the required details to the extension process per *42 CFR § 438.408* "(2) Requirements following an extension, If MCO, PIHP extends, It must complete the following: (i) Make reasonable efforts to give the enrollee prompt oral notice of the delay, (ii) Within 2 calendar days give the enrollee

written notice of the reason for the decision to extend the time frame and inform the enrollee of the right to file a grievance."

The Onsite interview included clarifications of the Chief Medical Officer's (CMO's) or designee's access or involvement in the Grievance process. During the Onsite interview, Grievance Manager Jennifer Greene explained, that the Grievance Team has access to medical staff for consultation when there are complex cases beyond the scope of their expertise or practice. When there is an expedited grievance, Ms. Greene can access Medical Department staff and assign the case to a Grievance Specialist concurrently. Grievance Specialists can schedule case consultations with medical staff to "round" grievances on a regular basis.

Appeals

The EQR of Cardinal's Appeal functions involved a thorough examination of Cardinal's appeals policies and procedures, files containing first and second level appeals, and appeal information provided to stakeholders through the *Provider Manual*, the *Member & Family Handbook*, and Cardinal's website.

Information regarding appeals and the appeals processes are made available to the public through Cardinal's website. This information is easy to understand and provides contact numbers for members to obtain additional assistance and appeal information. While this information is easy to understand, it is difficult to locate on the website. Entering the word "appeals" into the search engine pulls up multiple links that are not intuitive in locating appeals information. Providing a direct link to appeals information would better assist members. Additionally, within the member appeal information on the website is a link to the provider Reconsideration process, which is a separate process not related to the appeal of service authorizations.

The *Provider Manual* also provides easy-to-understand appeal information but does not provide clear information regarding who can file an appeal. The manual states "The member/guardian has 30 days after the date of notice on the action to request a Reconsideration Review. With the member or guardian's written consent, the provider may file an appeal on behalf of the member." This information does not explain that anyone may file an appeal on the member's behalf, not just the guardian or provider, if written consent is given.

Similarly, the *Provider Manual* contained incorrect information about appeals for an extended period. The time frame for filing an appeal was changed from 30 to 60 days, effective July 1, 2017. It was reported during the Onsite discussion that the *Provider Manual* was corrected in January of 2019. However, this erroneous information regarding the time frame to file an appeal existed within that document for over 18 months and as of the date of this report, has still not been uploaded to Cardinal's website.

Files submitted for this EQR included 22 first level appeal files and five State fair hearing files. Of the 22 first level appeals, four were requested to be expedited. Concerns noted within these files are discussed in the following paragraph.

Timeliness of standard resolution

Three of 18 standard appeal files (or 16%) showed late notification of appeal resolution. These notifications were sent only one to two days beyond the 30-day time frame for resolution. Further review and Onsite discussion revealed that appeal resolution notifications are thoroughly vetted through the Office of General Counsel (OGC) but can delay timely notification of appeal resolutions. Appeal staff stated they are aware of this issue and are working to come into compliance.

All of the expedited appeals were decided, and notice provided within the required 72-hour time frame. However, outside of the written notifications of resolution, other requirements were not consistently met.

Expedited Appeals

Four expedited appeal files were provided for this EQR. Two of these files showed Cardinal denied the request to expedite the appeal resolution time frame. One of these two files showed compliance with required notifications and documentation and the other lacked enough documentation to show Cardinal processed this appeal in compliance with expedited appeal requirements. This one file lacked:

- Oral notification to the appellant of the decision by Cardinal to deny the request to expedite the appeal resolution time frame. This is required by Cardinal's appeal *Policy & Procedure 6020 (Section VIII.c.5)*.
- Evidence of a written acknowledgement notice. Cardinal's appeal policy and procedure requires that an "Acknowledgement of a Request for a Reconsideration Review" is used to acknowledge all appeals. (See *Policy & Procedure 6020 Section VIII.b.4.)*
- Documentation of the rationale to support the decision by Cardinal to deny the request to expedite the appeal. The "rationale" field within the CI documentation was left blank.

Two of the four expedited appeals provided for this EQR showed Cardinal processed the appeal as expedited, as requested by the appellant. Of these two expedited appeal files, showed compliance with required notifications and documentation. The second file lacked enough documentation to show Cardinal processed this appeal in compliance with expedited appeal requirements. This file lacked:

- Clear documentation of the oral notification of the expedited appeal resolution

Extended Appeals

One standard appeal file was submitted for this EQR that showed the appeal resolution time frame was extended by Cardinal. This file lacked:

- Evidence that the appellant was informed of their right to file a grievance against Cardinal for extending the appeal resolution time frame. Staff acknowledged during the Onsite that the wrong template was sent. See Cardinal's *Policy & Procedure 6020, Section VII.B.9.a.*
- Documentation of oral notification of the decision by Cardinal to extend the appeal resolution time frame.
- Evidence that staff provided to the appellant how the extension is in the best interest of the appellant. Cardinal's appeals policy and procedure requires this, but neither the extension notice in this file nor the blank notice provided for this EQR give the explanation to the appellant. See Cardinal's *Policy & Procedure 6020, Section VII.B.9.a.*

There was evidence within the appeal files reviewed of staff making efforts to obtain proof of guardianship prior to releasing protected health information (PHI). This was a recommendation from last year's EQR that was addressed.

Cardinal generates appeal notifications in Spanish. One file reviewed for this EQR reflected the appeal resolution notification was in Spanish and sent within the resolution time frame to the appellant. Several appeal notification templates Cardinal provided for this EQR were also translated into Spanish.

Review of the appeal files show Cardinal does review each file to determine how "expeditiously" an appeal should be processed. There was evidence that Cardinal expedites appeals even though an expedited resolution was not requested.

Considering the inconsistencies within the appeal files, Cardinal's policy and procedure was also reviewed to determine if missing information within the policy and procedure was impacting staff's ability to be compliant with *DMA Contract* and federal regulation requirements. Overall, this did appear to be the case.

Cardinal's *Policy & Procedure 6020, Adverse Benefit Determination, Notice, and Appeal Process for Medicaid-Funded Services*, guides staff on processing appeals. This policy and procedure references overarching general statutes (e.g., *42 CFR § 438.400*) that govern appeal processes, but does not point staff to specific appeal requirements within the *DMA Contract* (*DMA Contract, Attachment M, Section H 9.b.*) and federal regulations (e.g., *42 CFR § 438.4406(b)(2)(i)*. Specifying *DMA Contract* and federal regulations will help staff quickly access language and specific requirements to help navigate the

complicated appeals process, especially when processing expedited and extended appeals.

Policy & Procedure 6020, Adverse Benefit Determination, Notice, and Appeal Process for Medicaid-Funded Services is missing information regarding the following requirements of processing expedited appeals;

- Acknowledgment of expedited appeals (see *DMA Contract, Attachment M, Section A. 1.B*)
- The appellant's right to file a grievance if Cardinal denies the request to expedite an appeal (See *42 CFR § 438.410 (c) 2*)
- Oral and written notifications of the resolution of expedited appeals and the time frames for both notifications see (see *DMA Contract, Attachment M, Section H.5 and H.6*). The policy and procedure only notes that a written notice will be given and gives no timeline for that written notice of resolution.

Policy & Procedure 6020, Adverse Benefit Determination, Notice, and Appeal Process for Medicaid-Funded Services is missing information regarding required notifications and their timelines pertaining to the resolution of appeals;

- A written notification of a standard appeal resolution is required to be sent within the standard, 30-day appeal time frame. Throughout this policy and procedure only the time frame for making decisions is noted and not the requirement that notice must also be provided during this appeal time frame. See *DMA Contract, Attachment M, Section G.4.*
- Oral and written notifications are required within specific time frames when Cardinal extends the standard, appeal resolution time frame. Only a written notice is noted in the policy and procedure, and no time frame for that written notice is given. See *DMA Contract, Attachment M, Section G.6* and *42 CFR § 438.408 (c) 2.*
- Oral and written notifications are required within specific time frames when Cardinal extends the expedited appeal resolution time frame. Only a written notice is noted in the policy and procedure, and no time frame for that written notice is given. See *DMA Contract, Attachment M, Section G.6* and *42 CFR § 438.408 (c) 2.*
- The right of the appellant to file a grievance when Cardinal extends the standard appeal time frame is noted in this policy and procedure but is not included within the policy and procedure section that discusses extensions to expedited appeal resolution time frames.

Lastly, while staff could articulate the consideration of subordinate relationships when assigning appeal Peer Reviewers, *Policy & Procedure 6020, Adverse Benefit Determination, Notice, and Appeal Process for Medicaid-Funded Services* does not clarify

that appeal Peer Reviewers cannot be a subordinate of the clinician that made the initial, UM decision.

Cardinal's appeal policy and procedure, *Policy & Procedure 6020, Adverse Benefit Determination, Notice, and Appeal Process for Medicaid-Funded Services* does correctly define an appeal as "a request for review of an Adverse Benefit Determination, as defined by 42 CFR 438.400."

This policy and procedure also asserts that Cardinal takes no punitive actions against providers for assisting with appeals and that each appeal is clinically reviewed to determine how expeditiously the appeal be resolved.

Enhancing Cardinal's current appeals policy and procedure, including referencing *DMA Contract* requirements and federal regulations, training staff on appeal requirements, and increasing the monitoring of specific categories of appeals (i.e., expedited and extended appeals) will help Cardinal become more consistently compliant with appeal requirements.

While appeal data presented for this EQR showed appeals are tallied, categorization of appeals is lacking to the degree that staff struggled to accurately identify and provide expedited appeals that were requested for this EQR. The Appeal Log reviewed for this EQR also did not identify key appeal categories such as extended appeals, requests for expedited appeals that were denied by Cardinal, etc.

Further, analysis of appeals data was also absent. The CQI Committee minutes showed overall numbers of appeals and numbers of appeal outcomes were reported to this committee, but no discussion or analysis of appeal trends were discussed per these minutes. Review of the *UM Plan* also provided no clarification on any appeal data analysis, trends or targeted interventions.

Inclusion of information such as expedited appeals (both accepted as expedited and denied), extended appeals, etc. would help staff accurately identify appeals by category, identify appeal trends, and provide meaningful analysis of trends within appeals.

The *Figure 7* indicates the scoring for Grievances and Appeals for 2018 compared to the scores received in the 2017 EQR.

Figure 7: Grievances and Appeals Comparative Findings

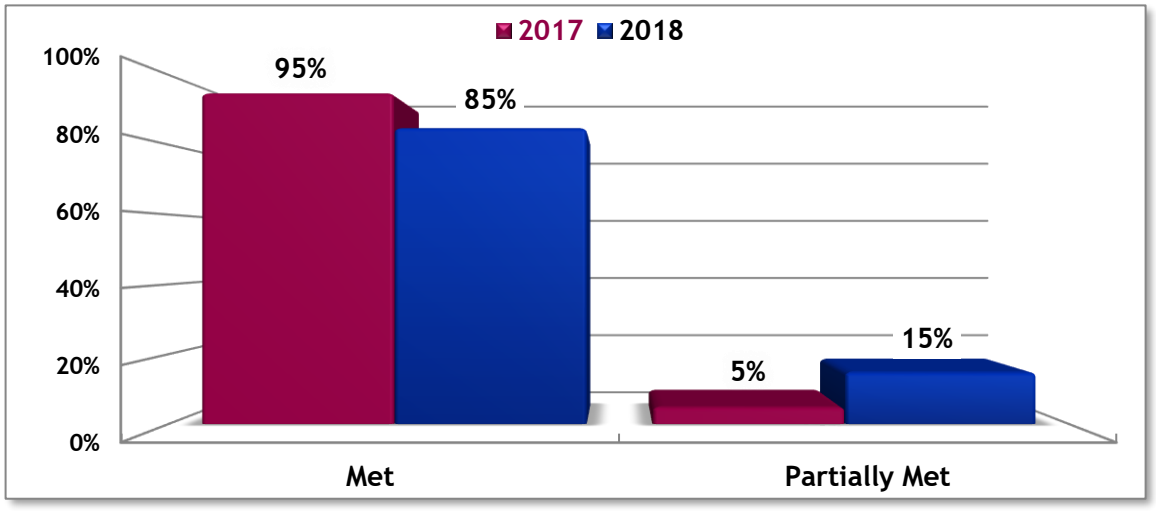


Table 23: Grievances and Appeals

Section	Standard	2018 Review
Appeals	A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	Partially Met
	Timeliness guidelines for resolution of the appeal as specified in the contract;	Partially Met
	The PIHP applies the appeal policies and procedures as formulated.	Partially Met

Strengths

- There was a consistent application of the confidentiality processes in the grievance and appeal files reviewed. Documentation of the verification and the presence of guardianship documents were noted throughout the review files, when appropriate.
- Staff articulated the requirements for assigning Peer Reviewers based on the reviewers areas of expertise.
- Cardinal generates appeal notifications in Spanish. One file reviewed for this EQR reflected the appeal resolution notification was transferred to the Spanish notification template and sent within the resolution time frame to the appellant.

- Review of the appeal file shows Cardinal reviews each file to determine how "expeditiously" an appeal should be processed. There was evidence that Cardinal would "expedite' an appeal even though an expedited resolution was not requested.

Weaknesses

- *In Policy & Procedure 5050,* there is a lack of detail describing required justification when Cardinal extends the grievance time frame decision. The procedure is missing the following detail; "PIHP demonstrates to DMA that there is a need for additional information and demonstrates how the delay is in the best interest of the Enrollee." Per *DMA Contract Attachment M, Sections C* and *42 CFR § 438.408."*
- There are additional details missing regarding Cardinal's notifications of an extension of a grievance in *Policy & Procedure 5050*. Cardinal needs to include details to the extension process, per *42 CFR § 438.408,* "(2) Requirements following and extension: If MCO, PIHP extends it must: (i) Make reasonable efforts to give the enrollee prompt oral notice of the delay, (ii) Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the time frame and inform the enrollee of the right to file a grievance."
- While the appeal information provided through Cardinal's website is easy to understand, the information is difficult to locate. Additionally, within the member appeal information on the website is a link to the provider Reconsideration process, which is a separate process not related to the appeal of service authorizations.
- *Policy & Procedure 6020, Adverse Benefit Determination, Notice, and Appeal Process for Medicaid-Funded Services* provides reference to overarching general statutes but does not point staff to specific appeal requirements within the *DMA Contract* and federal regulations.
- The *Provider Manual* states, "The member/guardian has 30 days after the date of notice on the action to request a Reconsideration Review. With the member or guardian's written consent, the provider may file an appeal on behalf of the member." This information does not clarify that anyone may file an appeal on the members behalf, not just the guardian or provider, if written consent is given.
- The time frame for filing an appeal was changed from 30 to 60 days, effective July 1, 2017. It was reported during the Onsite discussion that the *Provider Manual* was corrected in January of 2019. However, this erroneous information regarding the time frame to file an appeal existed within that document for over eighteen months.
- While staff could articulate the consideration of subordinate relationships when assigning appeal Peer Reviewers, *Policy & Procedure 6020, Adverse Benefit Determination, Notice, and Appeal Process for Medicaid-Funded Services* does not clarify that appeal Peer Reviewers cannot be a subordinate of the clinician that made the initial, UM decision.

- *Policy & Procedure 6020, Adverse Benefit Determination, Notice, and Appeal Process for Medicaid-Funded Services* is missing information regarding some requirements of processing expedited appeals. This missing information is detailed in Standard 1.4 of the Appeals section of the tabular spreadsheet.
- *Policy & Procedure 6020, Adverse Benefit Determination, Notice, and Appeal Process for Medicaid-Funded Services* is missing information regarding some requirements regarding required resolution notifications and when Cardinal decides to extend appeal time frames. This missing information is detailed in Standard 1.5 within the Appeals section of the tabular spreadsheet.
- The EQR of the appeal files revealed inconsistencies in providing timely notifications of standard appeal resolutions, adequate documentation and notifications (oral and written) around expedited and extended appeals. Details regarding the file review results are provided in Standard 2.0 in the tabular spreadsheet.
- While appeal data presented for this EQR showed appeals are tallied, categorization of appeals is lacking to the degree that staff struggled to accurately identify and provide expedited appeals that were requested for this EQR.
- The Appeal Log provided for this EQR also did not identify key appeal categories such as extended appeals, requests for expedited appeals that were denied by Cardinal, etc.
- Analysis of appeals data was also absent. The CQI Committee minutes showed overall numbers of appeals and numbers of appeal outcomes were reported to this committee, but no discussion or analysis of appeal trends were discussed per these minutes.

Corrective Actions

- Add the missing procedural elements delineated on the Appeals section of the tabular spreadsheet, Standard 1.4 to *Policy & Procedure 6020, Adverse Benefit Determination, Notice, and Appeal Process for Medicaid-Funded Services*.
- Add the missing procedural elements delineated in the Appeals section of the tabular spreadsheet (Standard 1.4) to *Policy & Procedure 6020, Adverse Benefit Determination, Notice, and Appeal Process for Medicaid-Funded Services*.
- Continue to hone the internal process that Cardinal implements to generate appeal resolution notifications with a focus on mailing these notifications within the required appeal resolution time frames.
- Ensure staff are trained on the requirements for processing expedited appeals and extending standard and expedited appeals, with a focus on requirements for providing oral and written notifications.
- Increase monitoring of expedited and extended appeals to ensure the following:

- Required notifications (oral and written) occur, are adequately documented, and are provided within the required time frames
- Rationale for denying expedited appeals is clearly documented within the appeal record
- Extension notifications to appellants include the reason for the delay and how it is in the enrollee's best interest to be compliant with Cardinal's *Policy & Procedure 6020, Adverse Benefit Determination, Notice, and Appeal Process for Medicaid-Funded Services.*

Recommendations

- In *Policy & Procedure 5050*, add missing details to the extension process; "PIHP demonstrates that there is a need for additional information and demonstrates how the delay is in the best interest of the Enrollee." Per *DMA Contract Attachment M, Sections C and D and 42 CFR § 438.408.*"
- Include within *procedure 5050*, add missing detail to the extension process per *42 CFR § 438.408,* "(2) Requirements following and extension, If MCO, PIHP extends, It must complete the following: (if) Make reasonable efforts to give the enrollee prompt oral notice of the delay, (ii) Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the time frame and inform the enrollee of the right to file a grievance."
- When the words "appeal" or "reconsideration" are entered into the website search engine, ensure users are sent directly to the appropriate and accurate appeal information.
- Note specific CFRs and *DMA Contract* requirements (e.g., *42 CFR § 438.406 (b)(2)(i), DMA Contract Attachment M, Section H 9 (b)*, etc.) within the appeals policy and procedure. This will provide staff with quick reference to specific language and appeal requirements when processing appeals.
- Clarify in the *Provider Manual* that appeals can be filed by "the Enrollee, legally responsible person, or a Provider or other designated personal representative, acting on behalf of the Enrollee and with the Enrollee's signed consent." See *DMA Contract, Attachment M, Section G.1.*
- Ensure the appeals information within the *Provider Manual* is updated timely as changes occur within the federal regulations governing appeals. See *DMA Contract, Attachment M, Section G.2.*
- Add to *Policy & Procedure 6020, Adverse Benefit Determination, Notice, and Appeal Process for Medicaid-Funded Services* the requirement that appeal Peer Reviewers cannot be subordinates of the Peer Reviewer that made the initial UM decision. See *DMA Contract, Attachment M, Section A c.* and *42 CFR § 438.406 (b)(2)(i).*

- Ensure key information is captured on the Appeal Log. Inclusion of information such as expedited appeals (both accepted as expedited and denied), extended appeals, etc. would help staff accurately identify appeals by category, identify appeal trends, and develop potential quality improvement opportunities.
- Ensure the expectation of appeal data analysis is captured in the *UM Plan* and that discussion related to analysis of appeal trends are documented in committee minutes.

G. Delegation

CCME's External Quality Review (EQR) of Delegation functions includes a review of the submitted Delegate List, Delegation Contracts, and Delegation Monitoring materials. CCME also conducted an Onsite interview with relevant staff.

Cardinal's *Policy & Procedure 1200, Delegation*, guides the process for delegation, except for delegated credentialing, which is directed by *Policy & Procedure 8345, Delegated Credentialing*.

Cardinal reported delegation agreements with five entities, as evidenced in *Table 24*. The Delegation Agreements continue with four hospital systems for the credentialing of hospital employees. No Business Associates Agreement (BAA) is needed for these agreements, as no Protected Health Information (PHI) is gathered or disclosed.

In April of 2013, Cardinal entered into a contract with Behavioral Healthcare Management (BHM) for Peer Reviewer/Physician Advisor Services. During discussion at the Onsite Review, Cardinal staff indicated that this was an evergreen contract, but Cardinal was not using their services. In 2018, it was decided to start using BHM. A *Predelegation Evaluation* was completed in April 2018, and an amendment was fully executed as of May 2, 2018, for services beginning in May 2018. Though the contract amendment executed in May 2018 references replacing *Exhibit A*, *Business Associate Agreement*, no replacement *Exhibit A* was submitted for the EQR. When asked at the Onsite Review, Cardinal was unable to locate a replacement *Attachment A, Business Associate Agreement*). Because the contract from 2013 is an evergreen contract that was never cancelled, the original BAA is still in effect.

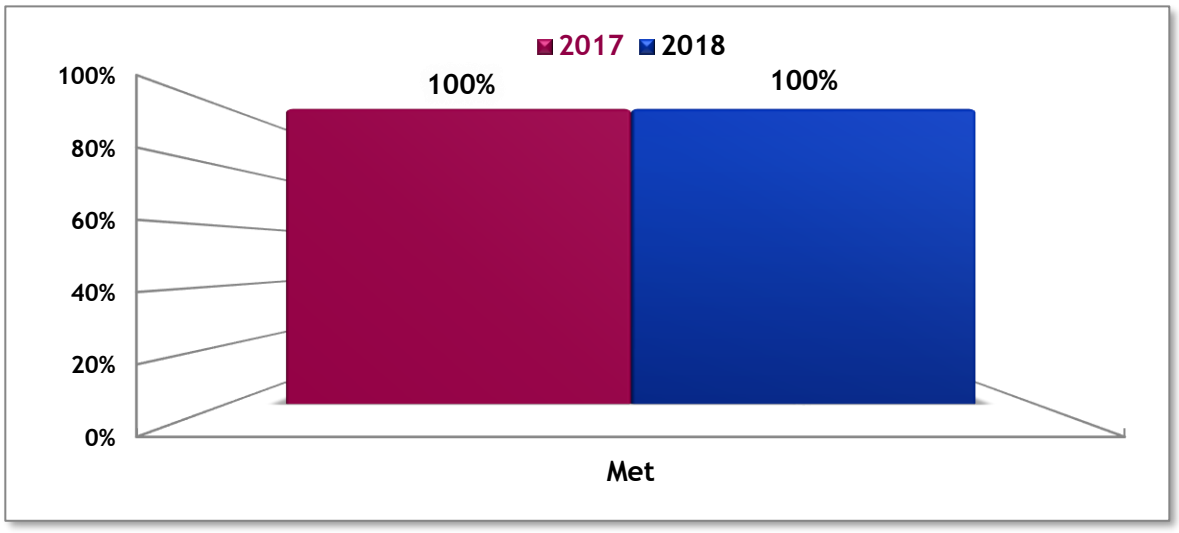
Policy & Procedure 1200, Delegation, outlines the standardized process for delegation, including predelegation evaluations, written delegation agreements, and on-going monitoring of delegates, except for delegated credentialing. *Policy & Procedure 8345, Delegated Credentialing,* establishes, "a standardized process for the delegation of credentialing functions." Cardinal conducts annual oversight and on-going monitoring of its delegates.

Table 24: Delegated Entities

Delegated Entities	Service
Behavioral Healthcare Management (BHM)	Peer Reviewer/Physician Advisor Services
Duke University Health System, Inc.	Delegated Credentialing
ChoiceHealth/Novant	Delegated Credentialing
UNC Hospitals at Chapel Hill	Delegated Credentialing
Managed Health Resources, Inc./Carolinas Physician Network	Delegated Credentialing

As noted in *Figure 8*, 100% of the standards in the 2018 Delegation review received a "Met" score. *Figure 8* also provides a comparison of the 2017 scores versus the 2018 scores.

Figure 8: Delegation Comparative Findings



Strengths

- Cardinal has current delegation contracts with all delegates, and a BAA for the delegate with access to PHI.
- Cardinal receives quarterly performance reviews from BHM, quarterly reports from Duke and UNC, and monthly reports from CHS and Novant.
- Cardinal conducted a *Predelegation Evaluation* before executing the current contract delegating Peer Review/Physician Advisor Services to BHM.

Weaknesses

- The replacement *Attachment A, Business Associates Agreement* with BHM, referenced in the contract amendment executed in May 2018, was not submitted and Cardinal was unable to provide it.

Recommendations

- If the Delegation Agreement or any amendment references replacement documents, ensure the documents are replaced, fully executed, and retained in the file.

H. Program Integrity

As required by its contract with CCME, IPRO is tasked with Cardinal's compliance with federal and state regulations regarding program integrity functions.

IPRO's review of Cardinal began in December 2018 with an offsite review of Cardinal's program integrity files and documentation. IPRO analyzed the files and documentation and Onsite interviews were conducted on January 24, 2019 with the Compliance and Program Integrity staff to review the offsite documentation and file review findings. The period of review is October 1, 2017 through September 30, 2018.

File Review

IPRO requested the universe of Program Integrity files from Cardinal for the October 1, 2017 through September 30, 2018 review period and from there selected a random sample of fifteen (15) files with a two (2) file oversample for a total of seventeen (17) files.

Contract Requirement: In each case where the PIHP investigates a credible allegation of fraud, the PIHP shall provide DMA (now NC Medicaid) Program Integrity with the following information on a DMA approved template:

- Subject (name, Medicaid provider ID, address, provider type)
- Source/origin of complaint
- Date reported to the PIHP or, if developed by the PIHP, the date the PIHP initiated the investigation
- Description of the 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 conduct
- Amount paid to the provider for the last three years or during the period of the alleged misconduct, whichever is greater

- All communications between the PIHP and the provider concerning the conduct at issue, when available
- Contact information for PIHP staff persons with practical knowledge of the workings of the relevant programs
- Sample/exposed dollar amount, when available

Findings: Fifteen (15) of fifteen (15) files contained the requirements (or were non applicable).

Contract Requirement: in each case of suspected enrollee fraud, the PIHP shall provide DMA program integrity with the following:

- The enrollee's name, birth date, and Medicaid number;
- The source of the allegation;
- The nature of the allegation;
- Copies of all communications between the PIHP and the provider concerning the conduct at issue;
- Contact information for PIHP staff persons with practical knowledge of the allegation;
- The date reported to the State; and
- The legal and administrative status of the case.

Findings: No cases under review involved suspected enrollee fraud.

Documentation

IPRO conducted a Desk Review of Cardinal's documentation to assess the PIHP's compliance with federal and state regulations and the PIHP's contract with NC Medicaid. The documentation review included Cardinal's policies, procedures, training materials, organizational charts, job descriptions, committee meeting minutes and reports, provider agreements, enrollment application, workflows, *Provider Manual*, *Employee Handbook*, newsletters, conflict of interest forms and *Compliance Plan*. This information was reviewed under three topic areas: General Requirements, Fraud and Abuse and Provider Payment Suspensions. Onsite interviews were conducted on January 24, 2019 with the Compliance and Program Integrity Managers to review the offsite documentation and file review findings.

General Requirements

Findings: All documentation required under *DMA Contract, Section VIII A. General Requirements* was addressed in Cardinal's documentation.

Recommendations: None

Fraud and Abuse

Findings: All documentation required under DMA Contract, Section VIII B. Fraud and Abuse was addressed in Cardinal's documentation.

Recommendations: *Policy & Procedure 1945, Employee Code of Conduct and the Work Environment* could be enhanced by explicitly including the False Claims Act in the list of protected whistleblower reporting.

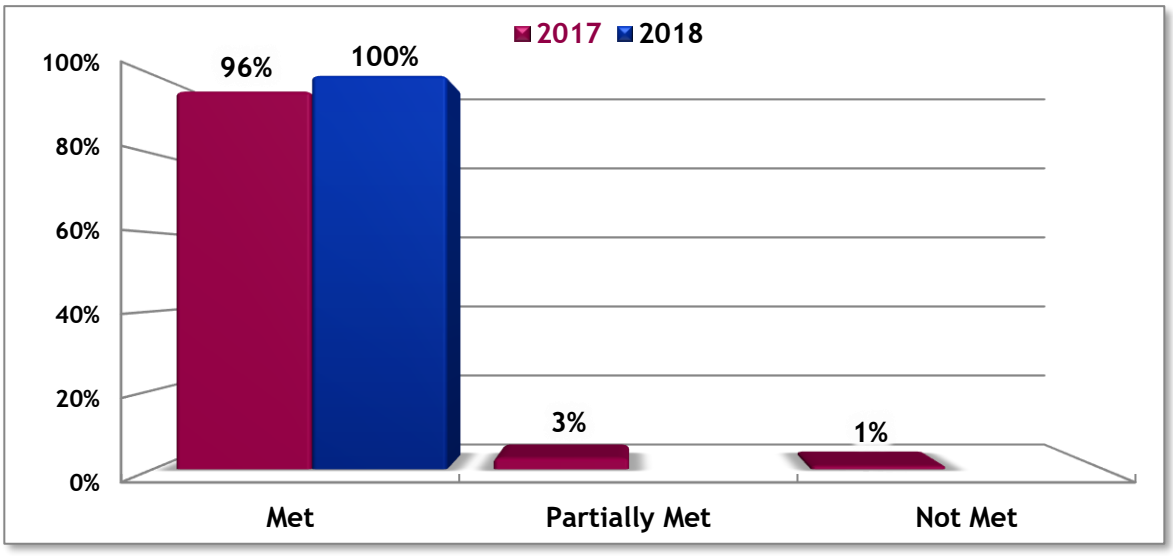
Provider Payment Suspensions

Findings: All documentation required under *DMA Contract, Section VIII C Provider Payment Suspensions and Overpayments* was addressed in Cardinal's documentation.

Recommendations: None

The *Figure 9* indicates the scoring for Program Integrity standards in 2018 compared to the scores received in the 2017 Program Integrity EQR.

Figure 9: Program Integrity Findings



Strengths

- Cardinal's Program Integrity Unit is well versed in the contractual language that governs their work.
- Cardinal has an integrated Program Integrity process with appropriate interfaces to compliance, quality management, provider relations, utilization management and other areas.

- The Program Integrity files were organized, thorough and contained all contractual requirements. In particular, the Investigation Summary form is comprehensive.
- Cardinal implemented several successful data mining initiatives.

Weaknesses

- *Policy & Procedure 1945, Employee Code of Conduct and the Work Environment* could be enhanced by explicitly including the Federal False Claims Acts in the list of protected whistleblower reporting.

Recommendation

- Add detail to *Policy & Procedure 1945, Employee Code of Conduct and the Work Environment* to explicitly include the Federal False Claims Acts in the list of protected whistleblower reporting.

I. Financial Services

The EQR of Cardinal's financial services includes an examination of the following Cardinal Desk Review materials prior to the Onsite visit:

- Financial policies and procedures
- Audited financial statements dated June 30, 2018
- Balance sheet and income statements dated September 30, 2018 and October 31, 2018
- Medicaid monthly financial reports for September and October 2018
- Reconciliation process for claims system with accounting system and data warehouse
- Fiscal year budget for 2018-2019
- Budget to actual expenses report for September 2018 and October 2018

After examining Cardinal's Desk Review materials, an Onsite visit and interview were held at Cardinal's office on January 24, 2019. In reviewing Cardinal's financial operations, CCME used a Standardized EQR Finance Desk Review and Onsite Administrative Interview Guide. CCME reviewed whether deficiencies noted in prior EQRs were corrected. In addition to the standardized Desk Review inquiries, CCME asked interview questions in the following areas:

- Policies and procedures
- Staffing changes in Finance
- Budget variances and development
- Board of Directors' financial role
- Cardinal's *Reinvestment Plan*

The EQR of Cardinal's financial services identified a need to change *Policy & Procedure 2150, Fiscal Records Retention* to reflect retention for ten (10) years of all Medicaid records, in accordance with *DMA Contract, Section 8.3.2*.

Cardinal demonstrates overall financial stability. Cardinal's audit report dated June 30, 2018 received an unqualified audit opinion. There were two findings on the auditor's report regarding internal control over financial reporting and compliance. These were corrected and satisfactorily discussed during the Onsite interview. During fiscal year 2018, Cardinal's total net position decreased by $33 million from the prior fiscal year.

Cardinal exceeded NC Medicaid benchmarks for current ratio and medical loss ratio. Cardinal's Medicaid current ratio was 3.34 with a total current ratio of 2.97 for September 2018. The Medicaid current ratio was 3.20 with a total current ratio of 2.99 for October 2018 (benchmark is 1.00). Cardinal's Medicaid Medical Loss Ratio (MLR) was 88.4% fiscal year to date at October 31, 2018 before Health Care Quality Improvement (HCQI) activities, and 92.7% including these activities (benchmark is 85%). Cardinal's Medicaid total assets on September 30, 2018, were $178,524,338, and overall total assets were $191,367,308. At October 31, 2018, Cardinal's Medicaid total assets were $167,935,833, and overall total assets were $189,224,497. Cardinal is monitoring their MLR monthly to ensure it exceeds the 85% benchmark.

Cardinal meets standard *42 CFR § 433.32(a)* for maintaining an appropriate accounting system (Great Plains Dynamics). Cardinal uses Great Plains 2018 purchasing, general ledger, accounts payable, and fixed assets modules. Cardinal uses their own proprietary software for claims processing.

Cardinal meets the minimum record retention of ten years that is required by standard *DMA Contract Section 8.3.2*. Cardinal's *Policy & Procedure 2150, Fiscal Records Retention* addresses Cardinal's plan for record storage, and Cardinal stated during the interview that they are following the North Carolina Department of Health and Human Services' (DHHS) records retention schedule. Cardinal should change *Policy & Procedure 2150* to reflect ten (10) years for all Medicaid records, in accordance with *DMA Contract, Section 8.3.2*.

Cardinal's *Cost Allocation Plan* meets the requirements for allocating the administrative costs between Medicaid, non-Medicaid, federal, state, and local entities based on revenue as required by *42 CFR § 433.34*. There were no costs disallowed per the audit report and Onsite interview. Annually, Cardinal submits a *Cost Allocation Plan* to NC Medicaid to determine the percentage of Medicaid's share of administrative costs. Currently this percentage is 89%. The allocation is a three-factor calculation that includes the budgeted revenue dollars, expense dollars, and claims count for the prior year. The administrative expenses are recoded by expense type in the general ledger and are then allocated to the different funding sources based on a percentage of total revenues

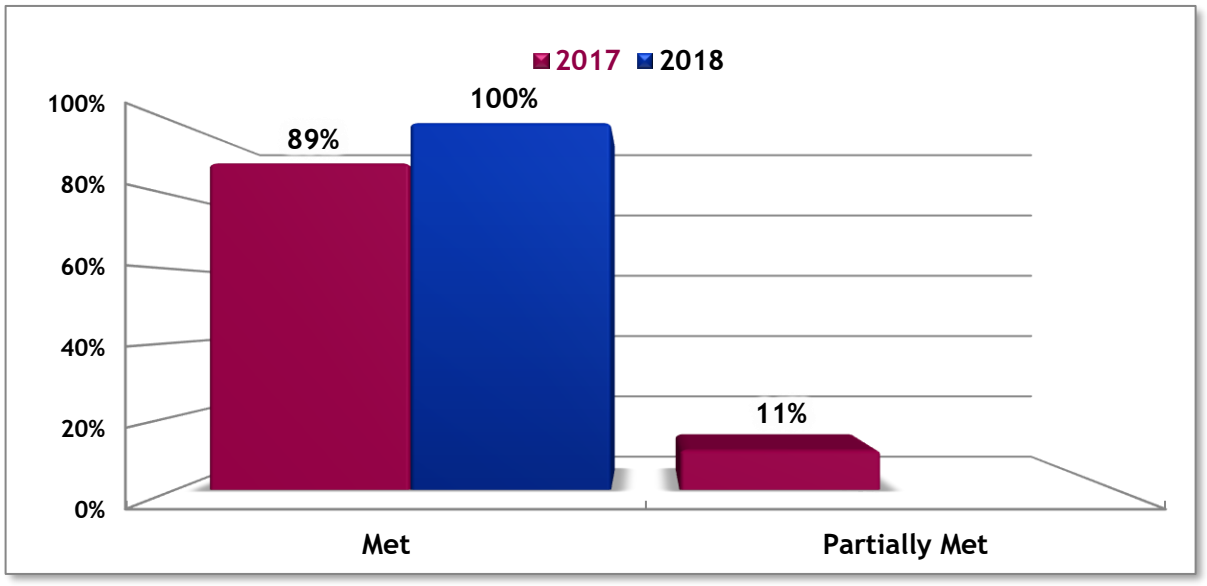
received (minus county funding). The cost allocation is calculated by the Accounting Manager, Jill Bost. Cardinal's Medicaid funds are properly segregated through the chart of accounts in the general ledger of Great Plains and Cardinal's *Policy & Procedure 2219, Accounting for Funding Source*, addresses the segregation of funds.

Cardinal's Medicaid risk reserve account meets the minimum requirement of 1.6% of the capitation payment per month required by *DMA Contract, Section 1.9*. Cardinal has reached 11.1% of their required percentage of annualized capitation maximum (15%) at October 31, 2018, with a balance of $82,665,274. Once the capitation payment is received from NC Medicaid, the Director of Accounting calculates the risk reserve payment, which is reviewed and paid electronically to Uwharrie Bank by Finance staff within five business days of the capitation payment. All deposits were timely and there were no unauthorized withdrawals. Cardinal provided CCME with bank statements demonstrating the risk reserve balance and deposits, which were made timely. Cardinal documents their risk reserve process in *Policy & Procedure 2218, Restricted Risk Reserve Account*.

The prior EQR recommended Cardinal ensure that all risk reserve account payments be made within five business days of the capitation payment. Cardinal complied by adding the due date to their monthly financial close checklist and to several employees' Outlook reminders.

The *Figure 10* shows the that Cardinal scored 100% "Met" on all of the Finance standards in 2018 and compares this score to the percentage of standards "Met" in 2017.

Figure 10: Financial Findings



Strengths

- Cardinal has a strong financial position, as demonstrated by its key Medicaid financial ratios and balances.
- Medicaid reports are filed timely.
- All risk reserve payments were made timely and reminders were put into place.

Weaknesses

- *Policy & Procedure 2150, Fiscal Records Retention*, does not reflect all Medicaid records are retained for ten years.

Recommendations

- Revise *Policy & Procedure 2150, Fiscal Records Retention*, to reflect all Medicaid records are retained for ten years. See *DMA Contract, Section 8.3.2*.

A. Attachment 1: Initial Notice and Materials Requested for Desk Review

The Carolinas Center *for* Medical Excellence
12040 Regency Parkway, Suite 100, Cary, NC 27518-8597 • 919.461.5500 • 800.682.2650 • www.thecarolinascenter.org

November 28, 2018

Mr. Trey Sutten
Chief Executive Officer
Cardinal Innovations Healthcare Solutions
550 S. Caldwell Street, Suite 2000
Charlotte, NC 28202

Dear Mr. Sutten,

At the request of the Department of Health and Human Services and North Carolina Medicaid (formerly the Division of Medical Assistance or DMA), this letter serves as notification that the 2018 External Quality Review (EQR) of Cardinal Innovations Healthcare Solutions (Cardinal) is being initiated. The review will be conducted by us, The Carolinas Center for Medical Excellence (CCME), and is a contractual requirement. The review will include both a desk review (at CCME) and a two-day onsite visit at Cardinal's office in Charlotte, North Carolina that will address all contractually required services.

CCME's review methodology will include all of the EQR protocols required by the Centers for Medicare and Medicaid Services (CMS) for Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans.

The CMS EQR protocols can be found at:

https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html

The CCME EQR review team plans to conduct the onsite visit at Cardinal on **January 23, 2019** through **January 24, 2019**. For your convenience, a tentative agenda for the two-day review is enclosed.

In preparation for the desk review, the items on the enclosed **Materials Requested for Desk Review** list are to be submitted electronically, and are due no later than **December 19, 2018**. As indicated in item 42 of the review list, a completed Information Systems Capabilities Assessment (ISCA) for Behavioral Health Managed Care Organizations is required. The enclosed ISCA document is to be completed electronically and submitted by the aforementioned deadline.

Further, as indicated on item 44 of the list, Encounter Data Validation (EDV) will also be part of this review. Our subcontractor, Health Management Systems (HMS) will be evaluating this component. Please read the documentation requirements for this section carefully and make note of the submission instructions, as they differ from the other requested materials.

Submission of all other materials should be submitted to CCME electronically through our secure file transfer website.

The location for the file transfer site is:

https://eqro.thecarolinascenter.org

Upon registering with a username and password, you will receive an email with a link to confirm the creation of your account. After you have confirmed the account, CCME will simultaneously be notified and will send an automated email once the security access has been set up. Please bear in mind that while you will be able to log in to the website after the confirmation of your account, you will see a message indicating that your registration is pending until CCME grants you the appropriate security clearance.

We are encouraging all health plans to schedule an education session (via webinar) on how to utilize the file transfer site. At that time, we will conduct a walk-through of the written desk instructions provided as an enclosure. Ensuring successful upload of desk materials is our priority and we value the opportunity to provide support. Of course, additional information and technical assistance will be provided as needed.

An opportunity for a pre-onsite conference call with your management staff, in conjunction with North Carolina Medicaid, to describe the review process and answer any questions prior to the onsite visit, is being offered as well.

Please contact me directly at 919-461-5618 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

Katherine Niblock, MS, LMFT
Project Manager, External Quality Review

Enclosure(s) – 5
Cc: Andrea Misenheimer, Cardinal Contract Manager
Renee Rader, NC Medicaid Quality Manager
Deb Goda, NC Medicaid Behavioral Health Unit Manager

External Quality Review 2018

MATERIALS REQUESTED FOR DESK REVIEW

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

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

3. Current Medical Director, medical staff job descriptions.

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

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

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

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

8. List of new services added to the provider network in the past 12 months (November 2017 – October 2018) by provider.

9. List of executed single case agreements by provider and level of care during the past 12 months (November 2017 – October 2018).

10. Network turnover rate for the past 12 months (November 2017 – October 2018) including a list of providers that were terminated by cause and list of providers that did not have their contracts renewed. For five providers termed in the last 12 months (November 2017 – October 2018), who were providing service to enrollees at the time of the termination notice, submit the termination letter to or from the provider, and the notification (of provider termination) letters sent to three consumers who were seeing the provider at the time of the termination notice.

11. List of providers credentialed/recredentialed in the last 12 months (November 2017 – October 2018).

12. A current provider manual and provider directory.

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

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

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

16. Minutes of committee meetings for the months of November 2017 – October 2018 for **all** committees reviewing or taking action on enrollee-related activities. For example, quality committees, quality subcommittees, credentialing committees, compliance committee, etc.

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

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

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

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

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

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

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

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

24. A copy of the Grievance, Complaint and Appeal logs for the months of November 2017 – October 2018. Please indicate the disability type (MH/SA, I/DD) and whether the enrollee is in the TCLI program for each entry.

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

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

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

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

29. A copy of the provider contract/application.

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

31. Contracts for all delegated entities.

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

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

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

35. Information regarding the following selected Performance Measures:

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

1.

2. C WAIVER MEASURES	
k. Proportion of Level of Care evaluations completed at least annually for enrolled participants	l. Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals
m. Proportion of Level of Care evaluations completed using approved processes and instrument	n. Proportion of Individual Support Plans that address identified health and safety risk factors

2. C WAIVER MEASURES	
o. Proportion of New Level of Care evaluations completed using approved processes and instrument	p. Percentage of participants reporting that their Individual Support Plan has the services that they need
q. Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	r. Proportion of individuals for whom an annual plan and/or needed update took place
s. Proportion of monitored Innovations providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame	t. Proportion of new waiver participants who are receiving services according to their ISP within 45 days of ISP approval

u.

Required information includes the following for each measure:

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

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

36. Documentation of all Performance Improvement Projects (PIPs) completed or planned in the last year, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. research question (s), analytic plans, reasons for choosing the topic including how the topic impacts the Medicaid population overall, measurement definitions, qualifications of personnel collecting/abstracting the data, barriers to improvement and interventions planned or implemented to address each barrier, calculated result, results, etc.)
37. Summary description of quality oversight of the Transition to Community Living Initiative, including monitoring activities, performance metrics, and results.

38. Data and/or reports for the Transition to Community Living Initiative (e.g., numbers of in-reach completed, housing slots filled, completed transitions, numbers of enrollees in supported employment, numbers of enrollees assigned to assertive community treatment [ACT], etc.) for the period November 2017 – October 2018.
39. Call performance statistics for the period of November 2017 – October 2018, including average speed of answer, abandoned calls, and average call/handle time for customer service representatives (CSRs).
40. Provide electronic copies of the following files:
    a. Credentialing files for 12 most recently credentialed practitioners (should include 6 licensed practitioners who work at agencies and 6 Licensed Independent Practitioners, include at least two physicians). Please also include four files for network provider agencies and/or hospitals and/or psychiatric facilities, in any combination. The credentialing files should include all of the following:

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

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

The Recredentialing files should include all of the following:

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

The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.	

c. Ten MH/SA, ten I/DD and five TCLI files medical necessity approvals made from November 2017 – October 2018, including any medical information and approval criteria used in the decision. Please select MEDICAID ONLY files and submit the entire file.

d. Ten MH/SA, ten I/DD and five TCLI files medical necessity denial files for any denial decisions made from November 2017 – October 2018. Include any medical information and physician review documentations used in making the denial determination. Please include all correspondence or notifications sent to providers and enrollees. Please select MEDICAID ONLY files and submit the entire file.

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

41. Provide the following for Program Integrity:
    a. File Review: Please produce a listing of all active files during the review period (November 2017 – October 2018) including:
        i. Date case opened
        ii. Source of referral
        iii. Category of case (enrollee, provider, subcontractor)
        iv. Current status of the case (opened, closed)
    b. Program Integrity Plan and/or Compliance Plan.
    c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.
    d. Workflow of process of taking complaint from inception through closure.
    e. All 'Attachment Y' reports collected during the review period.
    f. Provider Manual and Provider Application.
    g. Enrollee Handbook.
    h. Subcontractor Agreement/Contract Template.
    i. Training and educational materials for the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse and the False Claims Act.
    j. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse.
    k. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors and employees.
    l. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to NC Medicaid or any other State or Federal agency.
    m. Code of Ethics and Business Conduct.
    n. Internal and/or external monitoring and auditing materials.
    o. Materials pertaining to how the PIHP captures and tracks complaints.

p. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
    i. NC Medicaid approved reporting templates.
q. Sample Data Mining Reports.
r. NC Medicaid Monthly Meeting Minutes for entire review period, including agendas and attendance lists.
s. Monthly reports of NCID holders/FAMS-users in PIHP.
t. Any program or initiatives the plan is undertaking related to Program Integrity including documentation of implementation and outcomes, if appropriate.
u. Corrective action plans including any relevant follow-up documentation.
v. Policies/Procedures for:

    i. Program Integrity
    ii. HIPAA and Compliance
    iii. Internal and external monitoring and auditing
    iv. Annual ownership and financial disclosures
    v. Investigative Process
    vi. Detecting and preventing fraud
    vii. Employee Training
    viii. Collecting overpayments
    ix. Corrective Actions
    x. Reporting Requirements
    xi. Credentialing and Recredentialing Policies
    xii. Disciplinary Guidelines

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

Section	Question Number	Attachment
Enrollment Systems	1b	Enrollment system loading process
Enrollment Systems	1e	Enrollment loading error process
Enrollment Systems	1f	Enrollment loading completeness reports
Enrollment Systems	2c	Enrollment reporting system load process
Enrollment Systems	2e	Enrollment reporting system completeness reports
Claims Systems	2	Claim process flowchart
Claims Systems	2t	Claim exception report.
Claims Systems	3e	Claim reporting system completeness process / reports.
Claims Systems	3h	Physician and institutional lag triangles.
Reporting	1a	Overview of information systems
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.

43. Provide the following for Financial Reporting:

a. Most recent annual audited financial statements.

b. Most recent annual compliance report

c. Most recent two months' State-required NC Medicaid financial reports.

d. Most recent two months' balance sheets and income statements including associated balance sheet and income statement reconciliations.

e. Most recent months' capitation/revenue reconciliations.

f. Most recent reconciliation of claims processing system, general ledger, and the reports data warehouse. Provide full year reconciliation if completed.

g. Most recent incurred but not reported claims medical expense and liability estimation. Include the process, work papers, and any supporting schedules.

h. Any other most recent month-end financial/operational management reports used by PIHP to monitor its business. Most recent two months' claims aging reports.

i. Most recent two months' receivable/payable balances by provider. Include a detailed list of all receivables/payables that ties to the two monthly balance sheets.

j. Any P&Ps for finance that were changed during the review period.

k. PIHP approved annual budget for fiscal year in review.

l. P&Ps regarding program integrity (fraud, waste, and abuse) including a copy of PIHP's compliance plan and work plan for the last twelve months.

m. Copy of the last two program integrity reports sent to NC Medicaid's Program Integrity Department.

n. An Excel spreadsheet listing all of the internal and external fraud, waste, and abuse referrals, referral agent, case activity, case status, case outcome (such as provider education, termination, recoupment and recoupment amount, recoupment reason) for the last twelve months.

o. A copy of PIHP's Special Investigation Unit or Program Integrity Unit Organization chart, each staff member's role, and each staff member's credentials.

p. List of the internal and external program integrity trainings delivered by PIHP in the past year.

q. Description and procedures used to allocate direct and overhead expenses to Medicaid and State funded programs, if changed during the review period.

r. Claims still pending after 30 days.

s. Bank statements for the restricted reserve account for the most recent two months.

t. A copy of the most recent cost allocation plan.

u. A copy of the PIHP's accounting manual.

v. A copy of the PIHP's general ledger chart of accounts.

w. Any finance Corrective Action Plan

x. Detailed medical loss ratio calculation, including the following requirements under CFR § 438.8:

   i. Total incurred claims
   ii. Expenditures on quality improvement activities
   iii. Expenditures related to PI requirements under §438.608
   iv. Non-claims costs
   v. Premium revenue
   vi. Federal, state and local taxes, and licensing and regulatory fees
   vii. Methodology for allocation of expenditures
   viii. Any credibility adjustment applied
   ix. The calculated MLR
   x. Any remittance owed to State, if applicable
   xi. A comparison of the information reported with the audited financial report required under §438.3 (m)
   xii. The number of member months
   xiii. Provide the following for Encounter Data Validation (EDV):

a. Include all adjudicated claims (paid and denied) from January 1, 2017 – December 31, 2017. Follow the format used to submit encounter data to 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, 2017 – December 31, 2017. Report should be broken out by month and include service type, month and year of payment, count, and sum of paid amount.

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

B. Attachment 2: Materials Requested for Onsite Review

Cardinal

External Quality Review 2018

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were uploaded.

2. Credentialing or recredentialing items for providers identified on the supplemental ***Cardinal Credentialing/Recredentialing/Care Coordination Documentation list***, for information obtained during the credentialing/ recredentialing process.

3. *Credentialing Committee Charter* referenced in item 6a on the "2017 EQR Recommendations" document.
4. Invalid appeal template.

5. Care Coordination Progress Notes or correspondence for the files listed on accompanying list; ***Cardinal Credentialing/Recredentialing/Care Coordination Documentation list***.

6. A sample provider agreement demonstrating that Program Integrity and/or fraud, waste and abuse requirements are incorporated.

7. Documentation of DHB/NC Medicaid's approval of Cardinal's Compliance Plan.

8. ISCA document 42b II. 1e, *EnrollmentLoadingErrorProcess_docx_aspx*. We are not able to open this document.

9. Data validation methods/steps for C waiver performance measures (submitted as a PDF last year).

All items can be uploaded on the CCME File Transfer Site (folder 49, Other Info):
https://eqro.thecarolinascenter.org

C. Attachment 3: EQR Validation Worksheets

- Performance Improvement Project Validation Worksheet
  - Improving the Percentage of Follow-up Appointments That Occur Within 7 and 30 Days Of Mental Health Specific Community Hospital and Facility Based Crisis Discharges
  - Improving the Percentage of Follow-up Appointments That Occur Within 7 and 30 Days Of SA Related Community Hospital and SA Related Facility Based Crisis Discharges
  - Increase Timely Submission of Quality of Life (QOL) Surveys

- Mental Health (B Waiver) Performance Measures Validation Worksheet
  - Readmission Rates for Mental Health
  - Readmission Rates for Substance Abuse
  - Follow-up after Hospitalization for Mental Illness
  - Follow-up after Hospitalization for Substance Abuse
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
  - Mental Health Utilization –Inpatient Discharge and Average Length of Stay
  - Mental Health Utilization
  - Identification of Alcohol and Other Drug Services
  - Substance Abuse Penetration Rate
  - Mental Health Penetration Rate

- Innovations (C Waiver) Performance Measures Validation Worksheet
  - Innovations Measure: Level of Care Evaluation
  - Innovations Measure: Level of Care Evaluations Completed Using Approved Processes and Instruments
  - Innovations Measure: New Level of Care Evaluations Completed Using Approved Processes and Instruments
  - Innovations Measure: Proportion of Providers That Implemented an Approved Corrective Action Plan
  - Innovations Measure: Proportion of Providers Wherein All Staff Completed Mandated Training
  - Innovations Measure: Proportion of ISPs in which Services and Supports Reflect Participant Assessed Needs and Life Goals
  - Innovations Measure: ISPs Address Identified Health and Safety Risk Factors
  - Innovations Measure: Participants Reporting That ISP Has Services They Need
  - Innovations Measure: Individuals for Whom an Annual ISP and/or Needed Updates Took Place
  - Innovations Measure: New Waiver Participants are Receiving Services According to ISP within 45 Days of Approval

CCME EQR PIP Validation Worksheet

PIHP Name:	**Cardinal Innovations Healthcare**
Name of PIP:	**Improving the Percentage of Follow-Up Appointments that Occur Within 7 and 30 of Mental Health-Specific Community Hospital and Facility-Based Crisis Discharges**
Reporting Year:	**2018**
Review Performed:	**01/2019**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected based on data and analysis of enrollee care/ services.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	The project addresses key aspects of enrollee care.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIPs did not exclude enrollees.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Study question is stated clearly in writing.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures were clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Measures are related to functional status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	All relevant enrollees are documented.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	All members that are relevant to study question are captured in data.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected is documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are specified.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Method of collecting data is valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments provide consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Personnel collecting the data are documented.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions address barriers identified.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Findings are presented in Table and Graph format. The graph values initially did not match the rates in the Table for the 7 nor 30-day results. Updated PIP report was uploaded after the onsite and revisions were appropriate.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Analysis identified initial and repeat measurements.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis included an interpretation of extent of success for PIP.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	The same methodology was used at baseline and remeasurement.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Improvement occurred for 7 and 30 day follow up.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be results of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Sampling not used, thus, statistical testing is not required.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Not enough rates to show sustainment.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	NA

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify		
	NA	NA

Project Score	**90**
Project Possible Score	**90**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

PIHP Name:	**Cardinal Innovations Healthcare**
Name of PIP:	**IMPROVING THE PERCENTAGE OF FOLLOW-UP APPOINTMENTS THAT OCCURS WITHIN 7 AND 30 DAYS OF SA-RELATED COMMUNITY HOSPITAL AND SA-RELATED FACILITY BASED CRISIS DISCHARGES**
Reporting Year:	**2018**
Review Performed:	**01/2019**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected based on data and analysis of enrollee care/ services.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	The project addresses key aspects of enrollee care.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIPs did not exclude enrollees.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Study question is stated clearly in writing.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures were clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Measures are related to functional status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	All relevant enrollees are documented.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	All members that are relevant to study question are captured in data.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected is documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are specified.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Method of collecting data is valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments provide consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Personnel collecting the data are documented.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions address barriers identified.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Findings are presented in Table and Graph format. The graph values initially did not match the rates in the Table with results. Updated PIP report was uploaded after the onsite and revisions were appropriate.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Analysis identified initial and repeat measurements.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis included an interpretation of extent of success for PIP.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	The same methodology was used at baseline and remeasurement.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Improvement occurred for 7 and 30 day follow up.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be results of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Sampling not used, thus, statistical testing is not required.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Not enough rates to show sustainment.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	NA

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify		
	NA	NA

Project Score	**90**
Project Possible Score	**90**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

PIHP Name:	**Cardinal Innovations Healthcare**
Name of PIP:	**INCREASE TIMELY SUBMISSION OF QUALITY OF LIFE (QOL) SURVEYS**
Reporting Year:	**2018**
Review Performed:	**01/2019**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected based on data and analysis of enrollee care/ services.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	The project addresses key aspects of enrollee care.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIPs did not exclude enrollees.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Study question is stated clearly in writing.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures were clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Measures are related to functional status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	All relevant enrollees are documented.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	All members that are relevant to study question are captured in data.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected is documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are specified.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Method of collecting data is valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments provide consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Personnel collecting the data are documented.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions address barriers identified.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Findings are presented clearly and accurately.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Analysis identified initial and repeat measurements.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis included an interpretation of extent of success for PIP.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	The same methodology was used at baseline and remeasurement.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Improvement occurred for initial, 11 month QoL surveys, and 24 month QoL surveys for most recent remeasurement.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be a result of the interventions that have been implemented.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Sampling not used, thus, statistical testing is not required.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	There is not enough time periods at goal to show sustainment.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	NA.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify		
	NA	NA

Project Score	**90**
Project Possible Score	**90**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PM Validation Worksheet

PIHP Name:	**Cardinal Innovations Healthcare**
Name of PM:	**READMISSION RATES FOR MENTAL HEALTH**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**01/19**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
S2. Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
S3. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R2. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

VALIDATION SUMMARY		
Element	**Standard Weight**	**Validation Result**
G1	10	10
D1	10	10
D2	5	5
N1	10	10
N2	5	5
N3	5	NA
N4	5	NA
N5	5	NA
S1	5	NA
S2	5	NA
S3	5	NA
R1	10	10
R2	5	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

PIHP's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

PIHP Name:	**Cardinal Innovations Healthcare**
Name of PM:	**READMISSION RATES FOR SUBSTANCE ABUSE**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**01/19**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculation was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N6. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N7. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N8. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N9. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N10. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
S2. Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
S3. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R3. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R4. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

VALIDATION SUMMARY		
Element	**Standard Weight**	**Validation Result**
G1	10	10
D1	10	10
D2	5	5
N1	10	10
N2	5	5
N3	5	NA
N4	5	NA
N5	5	NA
S1	5	NA
S2	5	NA
S3	5	NA
R1	10	10
R2	5	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

PIHP's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

PIHP Name:	**Cardinal Innovations Healthcare**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**01/19**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
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GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
S2. Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
S3. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R2. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

VALIDATION SUMMARY		
Element	**Standard Weight**	**Validation Result**
G1	10	10
D1	10	10
D2	5	5
N1	10	10
N2	5	5
N3	5	NA
N4	5	NA
N5	5	NA
S1	5	NA
S2	5	NA
S3	5	NA
R1	10	10
R2	5	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

PIHP's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

PIHP Name:	**Cardinal Innovations Healthcare**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR SUBSTANCE ABUSE**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**01/19**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
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GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
S2. Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
S3. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R2. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

VALIDATION SUMMARY

Element	Standard Weight	Validation Result
G1	10	10
D1	10	10
D2	5	5
N1	10	10
N2	5	5
N3	5	NA
N4	5	NA
N5	5	NA
S1	5	NA
S2	5	NA
S3	5	NA
R1	10	10
R2	5	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

PIHP's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

PIHP Name:	**Cardinal Innovations Healthcare**
Name of PM:	**INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**01/19**

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GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
S2. Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
S3. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R2. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

VALIDATION SUMMARY

Element	Standard Weight	Validation Result
G1	10	10
D1	10	10
D2	5	5
N1	10	10
N2	5	5
N3	5	NA
N4	5	NA
N5	5	NA
S1	5	NA
S2	5	NA
S3	5	NA
R1	10	10
R2	5	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

PIHP's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

PIHP Name:	**Cardinal Innovations Healthcare**
Name of PM:	**MENTAL HEALTH UTILIZATION- INPATIENT DISCHARGES AND AVERAGE LENGTH OF STAY**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**01/19**

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GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
S2. Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
S3. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R2. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

VALIDATION SUMMARY

Element	Standard Weight	Validation Result
G1	10	10
D1	10	10
D2	5	5
N1	10	10
N2	5	5
N3	5	NA
N4	5	NA
N5	5	NA
S1	5	NA
S2	5	NA
S3	5	NA
R1	10	10
R2	5	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

PIHP's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

PIHP Name:	**Cardinal Innovations Healthcare**
Name of PM:	**MENTAL HEALTH UTILIZATION**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**01/19**

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GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
S2. Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
S3. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R2. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

VALIDATION SUMMARY		
Element	**Standard Weight**	**Validation Result**
G1	10	10
D1	10	10
D2	5	5
N1	10	10
N2	5	5
N3	5	NA
N4	5	NA
N5	5	NA
S1	5	NA
S2	5	NA
S3	5	NA
R1	10	10
R2	5	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

PIHP's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

PIHP Name:	**Cardinal Innovations Healthcare**
Name of PM:	**IDENTIFICATION OF ALCOHOL AND OTHER DRUG SERVICES**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**01/19**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
S2. Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
S3. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R2. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

VALIDATION SUMMARY		
Element	**Standard Weight**	**Validation Result**
G1	10	10
D1	10	10
D2	5	5
N1	10	10
N2	5	5
N3	5	NA
N4	5	NA
N5	5	NA
S1	5	NA
S2	5	NA
S3	5	NA
R1	10	10
R2	5	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

PIHP's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

PIHP Name:	**Cardinal Innovations Healthcare**
Name of PM:	**SUBSTANCE ABUSE PENETRATION RATE**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**01/19**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
S2. Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
S3. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R2. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

VALIDATION SUMMARY		
Element	**Standard Weight**	**Validation Result**
G1	10	10
D1	10	10
D2	5	5
N1	10	10
N2	5	5
N3	5	NA
N4	5	NA
N5	5	NA
S1	5	NA
S2	5	NA
S3	5	NA
R1	10	10
R2	5	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

PIHP's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

PIHP Name:	**Cardinal Innovations Healthcare**
Name of PM:	**MENTAL HEALTH PENETRATION RATE**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**01/19**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
S2. Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
S3. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R2. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

VALIDATION SUMMARY		
Element	**Standard Weight**	**Validation Result**
G1	10	10
D1	10	10
D2	5	5
N1	10	10
N2	5	5
N3	5	NA
N4	5	NA
N5	5	NA
S1	5	NA
S2	5	NA
S3	5	NA
R1	10	10
R2	5	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

PIHP's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Cardinal Innovations Healthcare**
Name of PM	**INNOVATIONS MEASURE: LEVEL OF CARE EVALUATION**
Reporting Year	**2017-2018**
Review Performed	**01/19**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
State PIHP Reporting Schedule- Innovations Measures

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G2. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in Innovations Waiver Excel file
R2. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

Element	Standard Weight	Validation Result
G1	**10**	**10**
G2	**2**	**2**
D1	**10**	**10**
D2	**5**	**5**
N1	**10**	**10**
N2	**5**	**5**
R1	**10**	**10**
R2	**3**	**3**

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and / or accuracy.

PIHP's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Cardinal Innovations Healthcare**
Name of PM	**INNOVATIONS MEASURE: LEVEL OF CARE EVALUATIONS COMPLETED USING APPROVED PROCESSES AND INSTRUMENTS**
Reporting Year	**2017-2018**
Review Performed	**01/19**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
State PIHP Reporting Schedule- Innovations Measures

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G2. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in Innovations Waiver Excel file
R2. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

Element	Standard Weight	Validation Result
G1	**10**	**10**
G2	**2**	**2**
D1	**10**	**10**
D2	**5**	**5**
N1	**10**	**10**
N2	**5**	**5**
R1	**10**	**10**
R2	**3**	**3**

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and / or accuracy.

PIHP's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Cardinal Innovations Healthcare**
Name of PM	**INNOVATIONS MEASURE: NEW LEVEL OF CARE EVALUATIONS COMPLETED USING APPROVED PROCESSES AND INSTRUMENTS**
Reporting Year	**2017-2018**
Review Performed	**01/19**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
State PIHP Reporting Schedule- Innovations Measures

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G2. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in Innovations Waiver Excel file
R2. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

Element	Standard Weight	Validation Result
G1	**10**	**10**
G2	**2**	**2**
D1	**10**	**10**
D2	**5**	**5**
N1	**10**	**10**
N2	**5**	**5**
R1	**10**	**10**
R2	**3**	**3**

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and / or accuracy.

PIHP's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Cardinal Innovations Healthcare**
Name of PM	**INNOVATIONS MEASURE: PROPORTION OF PROVIDERS THAT IMPLEMENTED AN APPROVED CORRECTIVE ACTION PLAN**
Reporting Year	**2017-2018**
Review Performed	**01/19**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
State PIHP Reporting Schedule- Innovations Measures

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G2. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in Innovations Waiver Excel file
R2. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

Element	Standard Weight	Validation Result
G1	**10**	**10**
G2	**2**	**2**
D1	**10**	**10**
D2	**5**	**5**
N1	**10**	**10**
N2	**5**	**5**
R1	**10**	**10**
R2	**3**	**3**

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and / or accuracy.

PIHP's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Cardinal Innovations Healthcare**
Name of PM	**INNOVATIONS MEASURE: PROPORTION OF PROVIDERS WHEREIN ALL STAFF COMPLETED MANDATED TRAINING**
Reporting Year	**2017-2018**
Review Performed	**01/19**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
State PIHP Reporting Schedule- Innovations Measures

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G2. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in Innovations Waiver Excel file
R2. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

Element	Standard Weight	Validation Result
G1	**10**	**10**
G2	**2**	**2**
D1	**10**	**10**
D2	**5**	**5**
N1	**10**	**10**
N2	**5**	**5**
R1	**10**	**10**
R2	**3**	**3**

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and / or accuracy.

PIHP's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Cardinal Innovations Healthcare**
Name of PM	**INNOVATIONS MEASURE: PROPORTION OF ISPS IN WHICH SERVICES AND SUPPORTS REFLECT PARTICIPANT ASSESSED NEEDS AND LIFE GOALS**
Reporting Year	**2017-2018**
Review Performed	**01/19**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
State PIHP Reporting Schedule- Innovations Measures

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G2. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

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REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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R2. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

Element	Standard Weight	Validation Result
G1	**10**	**10**
G2	**2**	**2**
D1	**10**	**10**
D2	**5**	**5**
N1	**10**	**10**
N2	**5**	**5**
R1	**10**	**10**
R2	**3**	**3**

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and / or accuracy.

PIHP's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Cardinal Innovations Healthcare**
Name of PM	**INNOVATIONS MEASURE: ISPS ADDRESS IDENTIFIED HEALTH AND SAFETY RISK FACTORS**
Reporting Year	**2017-2018**
Review Performed	**01/19**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
State PIHP Reporting Schedule- Innovations Measures

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
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Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

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REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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N2	**5**	**5**
R1	**10**	**10**
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Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and / or accuracy.

PIHP's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Cardinal Innovations Healthcare**
Name of PM	**INNOVATIONS MEASURE: PARTICIPANTS REPORTING THAT ISP HAS SERVICES THEY NEED**
Reporting Year	**2017-2018**
Review Performed	**01/19**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
State PIHP Reporting Schedule- Innovations Measures

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
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DENOMINATOR ELEMENTS			
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Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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N2	**5**	**5**
R1	**10**	**10**
R2	**3**	**3**

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and / or accuracy.

PIHP's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Cardinal Innovations Healthcare**
Name of PM	**INNOVATIONS MEASURE: INDIVIDUALS FOR WHOM AN ANNUAL ISP AND/OR NEEDED UPDATES TOOK PLACE**
Reporting Year	**2017-2018**
Review Performed	**01/19**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
State PIHP Reporting Schedule- Innovations Measures

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
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Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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R1	**10**	**10**
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Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and / or accuracy.

PIHP's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Cardinal Innovations**
Name of PM	**INNOVATIONS MEASURE: NEW WAIVER PARTICIPANTS RECEIVING SERVICES ACCORDING TO ISP WITHIN 45 DAYS OF APPROVAL**
Reporting Year	**2017-2018**
Review Performed	**01/19**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
State PIHP Reporting Schedule- Innovations Measures

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
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REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in Innovations Waiver Excel file
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VALIDATION SUMMARY

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N2	**5**	**5**
R1	**10**	**10**
R2	**3**	**3**

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and / or accuracy.

PIHP's Measure Score	**55**
Measure Weight Score	**55**
Validation Findings	**100%**

VALIDATION PERCENTAGE FOR MEASURES									
MEASURE 1	MEASURE 2	MEASURE 3	MEASURE 4	MEASURE 5	MEASURE 6	MEASURE 7	MEASURE 8	MEASURE 9	MEASURE 10
100%	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

AVERAGE VALIDATION PERCENTAGE & AUDIT DESIGNATION
100% FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

D. Attachment 4: Tabular Spreadsheet

CCME PIHP Data Collection Tool

PIHP Name:	Cardinal Innovation Healthcare
Collection Date:	2018

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. A. General Approach to Policies and Procedures						
1. The PIHP has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					*Policy & Procedure 1000, Policy and Procedure Development*, adequately describes the process for creating, terminating, revising, and annually reviewing policies and procedures, but does not clearly indicate the final approval process. During the Onsite discussion, Cardinal explained that a designated attorney in Cardinal's OGC is responsible for final approval. ***Recommendation: Add detail to Policy & Procedure 1000, Policy and Procedure Development to better describe the final approval process.***
I. B. Organizational Chart / Staffing						
1. The PIHP's resources are sufficient to ensure that all health care products and services required by the State of North Carolina are provided to enrollees. At a minimum, this includes designated staff performing in the following roles:						The Medical Department is staffed with clinicians with a variety of specialties including substance use, pharmacy, child and adolescent psychiatry, neuropsychiatry, etc. However, staff functions and/or departmental oversight are not shown in the *Organizational Chart*. This was a recommendation in the 2017 EQR. ***Recommendation: Delineate functions and/or departmental oversight of each of the staff within the Medical Department.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 A full time administrator of day-to-day business activities;	X					
1.2 A physician licensed in the state where operations are based who serves as Medical Director, providing substantial oversight of the medical aspects of operation, including quality assurance activities.	X					
2. Operational relationships of PIHP staff are clearly delineated.	X					
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all PIHP staff positions, including those that are required by DMA contract.	X					
I. C. Confidentiality						
1. The PIHP formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					
2. The PIHP provides HIPAA/confidentiality training to new employees and existing staff.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I D. Management Information Systems						
1. Enrollment Systems						
1.1 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					The Global Eligibility File (GEF) file is imported daily into the Cardinal Innovations Enterprise (CIE) system. The daily eligibility file is compared to existing eligibility in the CIE system and add/changes/delete records are updated in the CIE system. A new Medicaid ID# and a former Medicaid ID# is stored in CIE enrollment system and Cardinal sees the claims history for the prior member record since the data is merged. Cardinal has demographic information stored in the CIE system. Historical member information is stored.
1.2 The MCO is able to identify and review any errors identified during or as a result of the State enrollment file load process.	X					Cardinal generates a GEF exception report and the Member Data Management Team review and correct exceptions based on established business rules weekly. Eligibility records are reconciled with the monthly 820 Capitation file and also by using the quarterly GEF full file NC Medicaid sends.
1.3 The MCO's enrollment system member screens store and track enrollment and demographic information.	X					During the Onsite, Cardinal staff provided a demonstration of the CIE enrollment screens and the Provider Direct (provider web portal). All members' enrollment history is retained in the CIE system.
2. Claims System						
2.1 The MCO processes provider claims in an accurate and timely fashion.	X					Cardinal processes paper claims within 5 days of receipt. If a claim is approved, payment is made within 30 calendar days after receipt. Electronic claims are processed nightly.
2.2 The MCO has processes and procedures in place to monitor review and audit claims staff.	X					Cardinal staff provided a demonstration of their audit process. Cardinal audits at least 3% of all claims and high dollar claims. In addition, Cardinal performs focused audits based on high dollar, specific diagnosis codes, as an example. For new-hire Claim Examiners there is a 6- to 8-week training period. The new-hire works

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						side by side with an experienced Analyst. There is a nesting period 60 days, after which their claims are routinely audited for accuracy.
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.		X				Cardinal captures all primary and secondary diagnosis codes that providers submit. All codes are stored in the CIE system. While the screen doesn't show all codes, staff can drill down to see all submitted codes. Cardinal indicated it receives and stores any Diagnosis Related Group (DRG) codes that are submitted but does not require or store ICD-10 procedure codes. ***Corrective Action: Update the CIE claim system and provider web portal to allow for ICD-10 procedure codes to be accepted and be stored in their claims processing and reporting system.***
2.4 The MCO's claim system screens store and track claim information and claim adjudication/payment information.	X					During the Onsite, Cardinal demonstrated the CIE claim screens (for Institutional and Professional) and the Provider Direct (provider web portal) claim entry interface. The system captured all necessary claim information.
3. Reporting						
3.1 The MCO's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					The enrollment reporting system is stored in a Structured Query Language (SQL) database management system and is updated nightly from the production system. All information within CIE is readily available and reportable with just a 1-day delay from production data. Cardinal does not outsource any of their programming needs and uses internal staff for all programming. Cardinal reported that they employ 4 programmers who are trained and capable of modifying the reports and extracts.
3.2 The MCO has processes in place to back up the enrollment and claims data repositories.	X					Cardinal has processes in place that back up the CIE enrollment, claims and reporting systems on a nightly basis. Separate backups are stored at offsite locations, according to their *Disaster Recovery Plan*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Encounter Data Submission						
4.1 The MCO has the capabilities in place to submit the State required data elements to DMA on the encounter data submission.		X				Cardinal's submission process to NC Medicaid is fully automated by IT. Weekly, Cardinal submits claims/encounters to NCTracks using 837I and 837P files. Cardinal indicated it receives and stores any DRG codes that are submitted but does not require or store ICD-10 procedure codes. ***Corrective Action: Update the encounter data submission process to allow for all ICD-10 diagnosis codes submitted on an Institutional and Professional 837 HIPAA file to be submitted to NCTracks.***
4.2 The MCO has the capability to identify, reconcile and track the encounter data submitted to DMA.	X					Cardinal uses tracking and reconciliation processes to identify encounter status. Outgoing 837 files are logged into the SQL database for tracking purposes. The system generates a unique ID to each claim/encounter submitted to NCTracks. Each record receives a time stamp.
4.3 MCO has policies and procedures in place to reconcile and resubmit encounter data denied by DMA.	X					Cardinal provided several policies and procedures as well as workflows regarding the reconciliation and resubmittal process. Cardinal submitted a total of 105,602 Institutional and 1,825,340 Professional encounters to NCTracks with 2017 service dates. Cardinal identified 2,266 Institutional and 274,340 Professional encounters that have been denied and not yet accepted with 2017 dates of service. Based on discussions at the Onsite, Cardinal worked with NC Medicaid to resubmit as many historical claims as possible, but due to multiple factors cannot resubmit the entire batch.
4.4 The MCO has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to DMA	X					Cardinal's dedicated Encounter Data Reconciliation Team consists of a Manager, Supervisor and 4 Encounter Reconciliation Analyst.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II. 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 manner consistent with contractual requirements.	X					The *Credentialing Operations Manual* and several policies and procedures address credentialing and recredentialing processes.
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.	X					The 2017-2018 *Annual Quality Strategy & Performance Improvement Plan* and the 2018-2019 *Annual Quality Strategy & Performance Improvement Plan* indicate the Credentialing Committee is "comprised of practicing practitioners from the Cardinal Innovations network as well as clinical staff from various Cardinal Innovations departments." Both documents state the Credentialing Committee meets once a month and "quorum consists of at least 50% of the voting members." The *Credentialing Manual* describes roles and responsibilities of the Credentialing Committee, indicates the committee meets "at least monthly unless otherwise directed by the Chair", and states a "quorum will consist of at least 51% of the voting members." The Credentialing Committee met at least monthly between December 2017 and November 2018, with a quorum of voting members present at each meeting. Credentialing Committee meeting minutes contain information about each applicant for which background incidents were identified during the credentialing process, as well as the vote taken. ***Recommendations: Ensure the required percentage for a Credentialing Committee meeting quorum is the same across documents.***
3. The credentialing process includes all elements required by the contract and by	X					Practitioner credentialing files reviewed were organized and contained appropriate information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
the PIHP's internal policies as applicable to type of provider.						Organizational credentialing files lacked evidence of Primary Source Verification (PSV) of some items, and generally lacked clear documentation of the credentialing process. Most missing information was provided after CCME specifically requested it. The following issues were identified in the file review:
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					Two practitioner initial credentialing files did not contain proof of insurance or a waiver/attestation for auto and Worker's Comp/Employer's Liability insurance. Cardinal submitted these items in response to the *Onsite Document Request List*. The *Attestation No.2 - Workers' Compensation and Employer Liability insurance* form provides an opportunity for providers to attest that the provider "is not required under North Carolina law to secure and maintain Workers' Compensation and Employer Liability Insurance". No information is provided, on the form or in the *Provider Manual* or on the website, regarding what the law requires. ***Recommendations: Verify all credentialing files contain proof of all required insurance coverage, a statement that the practitioner is covered under all agency insurance, and an attestation/waiver for automobile insurance and Worker's Comp/Employer's Liability, if coverage is not required. Inform providers as to the NC Department of Labor requirements for Worker's Comp/Employer's Liability insurance.***
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
3.1.3 Valid DEA certificate; and/or CDS certificate	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					*Policy & Procedure 8350, Primary Source Verification, Section II, PSV Requirements for Initial Credentialing Only*, states "At least annually, the Credentialing Manager or designee should either obtain a letter from each licensure board confirming educational PSV, or verify via an alternative source of NCQA documentation, that the board conducts PSV of practitioner education and training." During the Onsite visit, Cardinal staff indicated these verifications are done each February.
3.1.5 Work History	X					
3.1.6 Malpractice claims history;	X					
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;	X					The review of the credentialing files showed inconsistent practice when obtaining attestation statements for organizational initial credentialing files. ***Recommendations: To comply with Cardinal Policy & Procedure 8000, Agency Application and Enrollment, section 1.a., ensure all files include the signed Attestation Statement.***
3.1.8 Query of the National Practitioner Data Bank (NPDB) ;	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of	X					The practitioner credentialing files include the query of the State Exclusion List (SEL) on the *Cardinal Innovations Primary Source Verification Form-Initial Credentialing*. The organizational credentialing files do not include a similar checklist. Two of the four

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
Examiners for the specific discipline);						organizational initial credentialing files include a screen shot of the SEL. One of the two screen shots was illegible. The other two organizational credentialing files did not include evidence of a query of the SEL. In response to CCME's *Onsite Request List*, Cardinal provided the contracting cover sheet on which the Primary Source Verification (PSV) of the SEL is now documented.
3.1.10 Query for the System for Awards Management (SAM);	X					
3.1.11 Query for Medicare and/or Medicaid sanctions Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of the Social Security Administration's Death Master File (SSADMF);	X					The Social Security Death Master File query is part of the Criminal Background Check.
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES)		X				The practitioner initial credentialing files included the PSV of the NPPES. None of the organizational initial credentialing files included evidence of an NPPES query. When asked, Cardinal was unable to produce the PSV evidence of the NPPES query. ***Corrective Action: Ensure all credentialing files include the PSV of the NPPES query. See DMA Contract, Attachment B, section 7.6.4.***
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					.
3.1.15 Ownership Disclosure is addressed.	X					Three of the 12 practitioner initial credentialing files and one of the organizational initial credentialing files did not include ownership disclosure. Cardinal provided information in response to CCME's *Onsite Request List*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.16 Criminal background Check	X					
3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.	X					
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					The review of credentialing files showed inconsistent documentation of credentialing approval dates. Submitted organizational applications are not clearly date stamped, as indicated in *Cardinal Policy & Procedure 8000, Agency Application and Enrollment, Section 1.a.* ***Recommendation: Ensure all credentialing applications and materials are received and clearly dated 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.	X					The reviewed practitioner recredentialing files were organized and contained mostly appropriate information. The organizational recredentialing files lacked some information such as PSVs or other documentation. The following issues were identified in the file review.
4.1 Recredentialing every three years;	X					*Policy & Procedure 8005, Licensed Practitioner Credentialing Re-Credentialing and Network Enrollment, Policy & Procedure 8320, Criteria for Licensed Practitioner Participation and Ongoing Responsibilities, Policy & Procedure 8009, Organizational Provider Re-Credentialing for Active Contracted Network Providers*, and the *Credentialing Operations Manual* include the requirement that practitioners be re-credentialed every thirty-six (36) months. Review of the recredentialing files showed inconsistent documentation of initial credentialing and recredentialing approval

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						dates. These dates would be required order to determine if recredentialing occurred within 36 months of credentialing or the most recent recredentialing. ***Recommendation: To comply with Cardinal's policies and procedures, ensure all recredentialing files include documentation of recredentialing approval dates, with recredentialing occurring within three years of the documented initial credentialing approval date.***
4.2 Verification of information on the applicant, including:						
4.2.1 Insurance Requirements	X					
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
4.2.3 Valid DEA certificate; and/or CDS certificate	X					
4.2.4 Board certification if claimed by the applicant;	X					
4.2.5 Malpractice claims since the previous credentialing event;	X					
4.2.6 Practitioner attestation statement;	X					Reviews showed inconsistent practice when obtaining application attestation statements. Cardinal provided attestation statements in response to CCME's *Onsite Request List*. ***Recommendation: Obtain and retain attestation statements for all recredentialing applications.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.7 Requery of the National Practitioner Data Bank (NPDB);	X					
4.2.8 Requery for state sanctions and/or license limitations (State Board of Examiners for specific discipline) since the previous credentialing event;	X					Organizational recredentialing files did not contain evidence of query of the *State Exclusion List*. Cardinal provided documentation in response to CCME's *Onsite Request List*.
4.2.9 Requery of the SAM.	X					Organizational recredentialing files did not contain evidence of query of the SAM. Cardinal provided documentation in response to CCME's *Onsite Request List*.
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event;	X					Organizational recredentialing files did not contain evidence of query of the OIG. Cardinal provided documentation in response to CCME's *Onsite Request List*.
4.2.11 Query of the Social Security Administration's Death Master File		X				Organizational recredentialing files did not contain evidence of query of the criminal background checks (which include the query of the SSDMF), conducted for recredentialing. Cardinal was unable to produce the PSV evidence of the criminal background checks/Social Security Death Master file queries conducted for organizational providers at recredentialing. ***Corrective Action: Conduct query of the Social Security Administration's Death Master File at recredentialing, as required by DMA Contract, Attachment B, section 7.6.4, and retain the documentation.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.12 Query of the NPPES;		X				Organizational recredentialing files did not contain evidence of query of the NPPES. Cardinal was unable to produce the PSV evidence of the NPPES query at recredentialing. ***Corrective Action: Ensure all credentialing files include the PSV of the NPPES query. See DMA Contract, Attachment B, section 7.6.4, and retain the documentation.***
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
4.2.14 Ownership Disclosure is addressed.	X					Two of the 4 organizational recredentialing files did not contain ownership disclosure. Cardinal provided documentation in response to CCME's *Onsite Request List*.
4.3 Site reassessment if the provider has had quality issues.	X					
4.4 Review of provider profiling activities.	X					During the Onsite Review, Cardinal staff reported this is coordinated through the Quality Management Department and quality of care issues are brought to the Credentialing Committee for consideration.
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.	X					
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II B. Adequacy of the Provider Network						
1. The PIHP maintains a network of providers that is sufficient to meet the health care needs of enrollees and is consistent with contract requirements.	X					*Policy & Procedure 8015, Availability of Providers and Practitioners*, defines the "standards and provisions by which Network Management will monitor its Provider Network to ensure that its Members have adequate geographic access and availability to care and services." The policy and procedure also notes that the results of annual reports of the practitioner-to-member ratios are used to develop the annual *Network Development Plan*. "The Network Development Plan shall guide the overall process of limiting or recruiting additional practitioners and/or providers within the Provider Network. However, the NMCDMW and the Care Management Committee may use the results to recommend the immediate recruitment of additional practitioners and/or providers to meet the needs of Cardinal Innovations' Members and the Provider Network." *Policy & Procedure 8500, Network Adequacy and Accessibility Analysis, and Network Development*, reports the annual NAAA is used to "assess Cardinal Innovations' service areas or catchment are to determine needs for services and/or providers deliver services; Inform the development of the Annual Network Development Plan created by Network Management and other strategic initiatives developed by Cardinal Innovations."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 Enrollees have a Provider location within a 30 – mile distance of 30 minutes' drive time of their residence. Rural areas are 45 miles and 45 minutes. Longer distances as approved by DMA are allowed for facility based or specialty providers.	X					*Procedure 8015, Availability of Providers and* Practitioners defines the 30 mile/30 minute criteria for urban/suburban areas and 45 mile/45 minute criteria for rural areas. Cardinal did not submit for review the *2018 Network Adequacy and Accessibility Analysis Report*, as the Division of Health Benefits (DHB) had not yet approved the report at the time the materials were submitted for Desk Review. The *2017 Needs and Gaps Analysis* indicates access and choice gaps for standards for Medicaid-funded services were not met for the following services: • Psychosocial Rehabilitation • Child and Adolescent Day Treatment • Substance Abuse Comprehensive Outpatient Treatment Program (SACOT) • Opioid Treatment • Day Supports *Exception Requests* were submitted for the Medicaid-funded services that do not meet choice and access standards.
1.2 Enrollees have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the enrollee may utilize an out-of-network specialist with no benefit penalty.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 The sufficiency of the provider network in meeting enrollee demand is formally assessed at least annually.	X					The *Network Adequacy and Accessibility Analysis Report (NAAA)* is completed on an annual basis. For fiscal year 2017, Cardinal completed a separate *Needs and Gaps Analysis* for the Triad Region due to the consolidation with CenterPoint Human Services on July 1, 2016. Cardinal did not submit for review the *2018 NAAA*, as the Division of Health Benefits (DHB) had not yet approved the report at the time the materials were submitted for Desk Review.
1.4 Providers are available who can serve enrollees with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					The annual *Gaps and Needs Analysis* includes needs by members, family members, and stakeholders. Cardinal also identifies needs from reports made by providers. *Member-Specific Agreements* are used if needed.
1.5 The PIHP demonstrates significant efforts to increase the provider network when it is identified as not meeting enrollee demand.	X					Per *Policy & Procedure 8015, Availability of Providers and Practitioners*, the Corporate Network Management Cross Departmental Managerial Workgroup evaluates various reports and makes recommendations concerning opportunities for improvement and network development. *Member Specific Agreements* are used as needed, to ensure services are delivered. *Policy & Procedure 8046, Member-Specific Agreements*, outlines "how Cardinal Innovations establishes Member-Specific Agreements in order to secure access to services and/or continuity of care for its members." *Policy & Procedure 8090, Request for Proposals*, outlines the "standardized process when Cardinal Innovations uses Requests for Proposals or Requests for Information to add providers or services."
2. Provider Accessibility						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.1 The PIHP formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Accessibility standards for appointment availability are listed in the *Provider Manual*, in the *Member & Family Handbook*, and in *Policy & Procedure 6512, Screening, Triage & Referral*.
II C. Provider Education						
1. The PIHP formulates and acts within policies and procedures related to initial education of providers.	X					*Policy & Procedure 8600, Training Coordination by Network Management*, outlines the types of trainings and educational resources offered by Cardinal and coordinated through Network Management. *Section II* of the policy and procedure includes a list of specific topics with the statement, "In addition, Cardinal Innovations maintains numerous training resources on its external website, at: https://www.cardinalinnovations.org/Resources/Resource-Library." Several of the topics listed in *Policy & Procedure 8600, Training Coordination by Network Management*, were not found via a "search" of the Resource Library or the website. At the Onsite Review, Cardinal staff reported they are exploring ways to make web-based training available to providers, including possibly expanding Cardinal's internal *Learning Management* (training) *System* to add provider-specific training and a log-in for providers. ***Recommendation: Verify the training topics listed in Policy & Procedure 8600 are available on the Cardinal website, or revise the policy and procedure to delete topics that are not available on the website.***
2. Initial provider education includes:						With their initial contract, new providers receive the *Orientation Companion*, a document providing a summary of, and contact information for, the departments at Cardinal. The second paragraph of the first page of the *Orientation Companion* references the *2015 Provider Manual* and includes a link, presumably to the *Provider Manual*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Revise the Orientation Companion to reference the current Provider Manual. Verify the link goes to the current Provider Manual.
2.1 PIHP purpose and mission;	X					Page 6 of the *Provider Manual* includes Cardinal's vision and values for the provider network.
2.2 Clinical Practice Standards;	X					Page 11 of the *Provider Manual* provides a link to the Resource Library on the Cardinal website. The *Provider Manual* refers to "Clinical Practice Guidelines". On the website, they are in a document named "Practice Guidelines Overview". It would be helpful to add a sentence advising providers to conduct a "search" of the Resource Library, searching for "Practice Guidelines Overview".
2.3 Provider responsibilities;	X					"Provider Responsibilities" are referenced throughout the *Provider Manual*.
2.4 PIHP closed network requirements, including nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability.	X					
2.5 Access standards related to both appointments and wait times;	X					Access standards for appointments and wait times are in Section VII: "Access, Enrollment and Authorization of Services" of the *Provider Manual*.
2.6 Authorization, utilization review, and care management requirements;	X					
2.7 Care Coordination and discharge planning requirements;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.8 PIHP dispute resolution process;	X					Section XII of the *Provider Manual*, *Reconsideration Process for Providers*, explains the process by which providers can "request reconsideration of certain actions taken by Cardinal Innovations." *Reconsideration Request Forms* are posted on the Cardinal website and are accessible via the Network Providers page.
2.9 Complaint investigation and resolution procedures;	X					
2.10 Compensation and claims processing requirements, including required electronic formats, mandated timelines, and coordination of benefits requirements;	X					
2.11 Enrollee rights and responsibilities	X					The *Orientation Companion* includes information about member rights and responsibilities, and refers providers to Section V of the *Provider Manual*, which addresses Member Rights and Empowerment.
2.12 Provider program integrity requirements that include how to report suspected fraud, waste and abuse, training requirements as outlined in the False Claims Act, and other State and Federal requirements.	X					The home page of the Cardinal website lists a toll-free number for reporting fraud, waste, and abuse. The *Provider Manual* includes information specifically addressing reporting fraud, waste, and abuse.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The PIHP provides ongoing education to providers regarding changes and/or additions to its programs, practices, enrollee benefits, standards, policies and procedures.	X					Cardinal uses the website, emails, a weekly electronic newsletter (*InfoSource*), and communication bulletins to communicate information to providers. An "Events" calendar on the website provides information on training events. Neither the *Provider Manual* nor the *Orientation Companion* provides clear information about available training and opportunities. The Resource Library section of the website has a section specific to providers. There are links to the Resource Library in several sections of the *Provider Manual*, but no clear information about training. Page 97 of the *Provider Manual* has a section titled "Training and Technical Assistance", but it only provides information about *Provider Direct* (the Cardinal provider portal for enrolling member, creating treatment authorization requests, submitting claims, etc.). *Section IX: Resources for Providers*, starting on page 99 of the *Provider Manual*, provides 6 ½ pages of resources, in sections by topics. The page notes "The Network Management Department will coordinate the trainings offered by internal departments and post it on www.cardinalinnovations.org." However, there is nothing on the home page of the website about training or training opportunities. Neither the "Provider" tab nor the "Provider Overview" on the website lists anything about the resource library or training opportunities. That information can be accessed via links on the "Working with Us" tab or the "Resources" tab, but providers might not find this, since the provided link just goes to the home page of the website. ***Recommendation: Include clear information on the website, in the Provider Manual, and in the Orientation Companion to direct providers to available training and resources for providers.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II D. Clinical Practice Guidelines for Behavioral Health Management						
1. The PIHP develops clinical practice guidelines for behavioral health management of its enrollees that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					*Policy & Procedure 6400, Clinical Practice Guidelines,* states "the development of CPGs is the responsibility of the CMO or designee." Clinical Practice Guidelines (CPGs) "must be approved by the Clinical Advisory Committee (CAC). Approval of the Guidelines will be obtained by consensus." The policy and procedure also notes, "guidelines will be reviewed and updated, if appropriate, every two (2) years."
2. The PIHP communicates the clinical practice guidelines for behavioral health management and the expectation that they will be followed for PIHP enrollees to providers.	X					*Policy & Procedure 6030, Clinical Practice Guidelines*, outlines the development, approval, dissemination, and ongoing review of Cardinal's Clinical Practice Guidelines (CPGs) and states "both providers and members may obtain hard copies of the CPGs by contacting the assistant to the CMO or designee." The *Provider Manual* informs providers of their responsibility to "Comply with all applicable service definitions and practice guidelines."
II E. Continuity of Care						
1. The PIHP monitors continuity and coordination of care between providers.	X					Monitoring of provider medical records and audits include confirming providers are making appropriate referrals and are coordinating care for enrollees. Page 41 of the *Provider Manual* informs providers of their responsibility to, "Ensure a smooth transition for any member desiring to change providers and for any member being discharged because your agency or practice cannot meet his/her special needs, and provide timely notice of all such events to Cardinal Innovations."
II F. Practitioner Medical Records						
1. The PIHP formulates policies and procedures outlining standards for acceptable documentation in the Enrollee medical records maintained by providers.	X					*Policy & Procedure 5100, Initial Reviews and On-Going Provider Monitoring,* includes the" Minimum Standards for Acceptable Provider Documentation."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP monitors compliance with medical record documentation standards through formal periodic medical record audit and addresses any deficiencies with the providers.	X					During the Onsite Interview, Cardinal staff reported this process is handled through the Cardinal Quality Management Department.
3. The PIHP has a process for handling abandoned records, as required by the contract.	X					*Policy & Procedure 5500, Submission of Provider Records to Cardinal Innovations*, includes the abandoned records process required by *DMA Contract 8.2.1.*

III. ENROLLEE SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III A. Enrollee Rights and Responsibilities						
1. The PIHP formulates policies outlining enrollee rights and procedures for informing enrollees of these rights.	X					*Policy & Procedure 1531, Member Rights and Responsibilities* describes member rights and responsibilities and how members are notified of their rights and responsibilities. Member rights are also addressed in *the 2018 Member & Family Handbook,* in the *2018 Provider Manual,* and on the Cardinal website.
2. Enrollee rights include, but are not limited to, the right:	X					Member rights are addressed in *Policy & Procedure 1531, Enrollee Rights and Responsibilities*, the *2018 Member & Family Handbook*, and the *Provider Manual* (revised January 2019). The Cardinal website has a Rights & Responsibilities page. There were no issues identified regarding member rights.
2.1 To be treated with respect and due consideration of dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand;						
2.3 To participate in decisions regarding health care;						
2.4 To refuse treatment;						
2.5 To be free from any form of restraint of seclusion used as a means of coercion, discipline, convenience or retaliation;						
2.6 To request and receive a copy of his or her medical record, except as set forth in 45 C.F.R. §164.524 and in						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
N.C.G.S. § 122C-53(d), and to request that the medical record be amended or corrected in accordance with 45 CFR Part 164.						
2.7 Of enrollees who live in Adult Care Homes to report any suspected violation of their enrollee rights, to the appropriate regulatory authority as outlined in NCGS§ 131-D21.						
III B. Enrollee PIHP Program Education						
1. Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid waiver managed care program which they are contractually entitled, including:	X					*Policy & Procedure 9515, Member Mailings,* states Cardinal will send all new members a notice advising where to find updated written materials concerning required member notifications within fourteen (14) days of enrollment. Staff adhere to this policy and procedure.
1.1 A description of the benefits and services provided by the PIHP and of any limitations or exclusions applicable to covered services. These descriptions must have sufficient detail to ensure the Enrollees understand the benefits to which they are entitled and may include a web link to the PIHP Benefit Plan. This includes a descriptions of all Innovations Waiver services and supports;						
1.2 Benefits include access to a 2nd opinion from a qualified health care professional within the network, or arranges for the enrollees to obtain one outside the network, at no cost to the enrollee;						This information is available for members in the Rights and Responsibilities section of the *Member & Family Handbook*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 Updates regarding program changes;						This information is included in *Policy & Procedure 9515* and on page 11 of the *Member & Family Handbook*.
1.4 A description of the procedures for obtaining benefits, including authorizations and EPSDT criteria;						
1.5 An explanation of the Enrollee's responsibilities and rights and protection;						
1.6 An explanation of the Enrollee's rights to select and change Network Providers						
1.7 The restrictions, if any, on the enrollee's right to select and change Network Providers						
1.8 The procedure for selecting and changing Network Providers						
1.9 Where to find a list or directory of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients (a written list of current Network Providers shall be provided by PIHP to any Enrollee upon request);						Cardinal completed a substantial amount of work on its website Provider Search since the last EQR The print version available for downloading from the website is "*2018 Provider Directory*" and it has introductions in English and Spanish. Provider education is listed in a field of the online Provider Search which is an addition made over the past year. On the online Provider Search both Accommodations and Cultural Competency fields display "Data is not available at this time." This is being loaded as the information becomes available.
1.10 The non-English languages, if any, spoken by each Network Provider;						"Non-English Languages Spoken Onsite" is a field included in the print version of the *Provider Directory* and in the online Provider Search. Spot checks revealed several providers who have other languages listed in this field.
1.11 The extent to which, and how, after-hours and emergency coverage are provided, including:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.11.1 What constitutes an Emergency Behavioral Health Condition, Emergency Services, and Post Stabilization Services in accordance with 42 CFR§ 438.114 and EMTALA;						Page 24 of the *Member & Family Handbook,* states: "You are entitled to post stabilization services after treatment for an emergency medical condition. Post stabilization services are services intended to keep your condition from getting worse and requiring further emergency treatment. Requests for post-stabilization services may be made to our Access Call Center on our 24-hour, toll-free Crisis and Referral Line: 1.800.939.5911."
1.11.2 The fact that prior authorization is not required for emergency services;						
1.11.3 The process and procedures for obtaining Emergency Services, the use of 911 telephone services or the equivalent;						
1.11.4 The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under the contract;						Page 24 of the *Member & Family Handbook* states: "Requests for post-stabilization services may be made to our Access Call Center on our 24-hour, toll-free Crisis and Referral Line: 1.800.939.5911." Under the "Provider Agencies" search on the website, there are several service categories for Emergency Department services (Speech Therapy, PT, OT, Supplies), Enhanced Crisis Response, and Mobile Crisis Management. There are also service categories for every type of Outpatient Treatment listed.
1.11.5 A statement that, subject to the provisions of the DMA this contract, the Enrollee has a right to use any hospital or other setting for Emergency care;						
1.12 The PIHP's policy on referrals for Specialty Care to include cost sharing, if any, and how to access Medicaid benefits that are not covered under this Contract;						Page 27 of the *Member & Family Handbook* provides information regarding specialty care.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Page 28 of the *Member & Family Handbook* states, "Some members are required to pay a co-payment each month to be eligible for Medicaid. Cardinal Innovations does not require additional co-payments, deductibles or other forms of cost sharing. Cardinal Innovations also does not charge members for missed appointments." When asked about some members required to pay a co-payment, this was explained Onsite as a "spend down". Some members are not eligible for Medicaid until they meet a deductible, potentially each month.
1.13 Any limitations that may apply to services obtained from Out-of Network Providers, including disclosures of the Enrollee's responsibility to pay for unauthorized behavioral health care services obtained from Out-of Network Providers, and the procedures for obtaining authorization for such services.						
1.14 How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost-sharing;						There is a webpage dedicated to explaining State-funded coverage with additional resource links including "State-funded Services Guide."
1.15 Procedures for obtaining out-of-area or out-of-state coverage of or services, if special procedures exist;						Page 27 of the *Member & Family Handbook* states, "Unless it is an emergency, you must receive prior approval to receive services from an out-of-network or out-of-area provider." Onsite, the question was asked, "Would you indeed require prior approval for a member to see an out-of-area provider who was in-network?" Cardinal staff answered that it depends on the service. If it's a passthrough service, no. Authorization would be needed for some providers that are member specific to protect the member. That provider may not be fully contracted. Members would need prior approval for some out-of-area providers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.16 Information about medically necessary transportation services by the department of Social Services in each country;						Transportation information is found on page 26 of the *Member & Family Handbook*.
1.17 Identification and explanation of State laws and rules Policies regarding the treatment of minors;						
1.18 The enrollee's right to recommend changes in the PIHP's policies and procedures						This is covered on page 12 in the *Member & Family Handbook*, under "Your Rights" section.
1.19 The procedure for recommending changes in the PHIP's policies and procedures;						This is covered on page 12 of the *Member & Family Handbook*.
1.20 The Enrollee's right to formulate Advance Directives;						
1.21 The Enrollee's right to file a grievance concerning non-actions, and the Enrollee's right to file an appeal if PIHP takes an action against an Enrollee;						
1.22 The accommodations made for non-English speakers, as specified in 42 CFR §438.10(c)(5);						The *Member & Family Handbook* and several brochures are available in Spanish and are posted on the website. The *Member & Family Handbook* states a large-print version is available. Several webpages have a Spanish translation option by clicking the Español button on the screen. Not all screens have a Spanish translation option.
1.23 Written information shall be made available in the non-English languages prevalent in the PIHP's services area.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.24 The availability of oral interpretation service for non-English languages and how to access the service;						
1.25 The availability of interpretation of written information in prevalent languages and how to access those services						
1.26 Information on how to report fraud and abuse; and						
1.27 Upon an Enrollee's request, the PIHP shall provide information on the structure and operation of the agency and any physician incentive plans.						
1.28 Information on grievance, appeal and fair hearing procedures and information specified in CFR §438.10 (g) and CFR §438.10 (f) (6).						
2. Enrollees are notified annually of their right to request and obtain written materials produced for Enrollee use.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Enrollees are informed promptly in writing of (1) any "significant change" in the information specified in CFR 438.10 (f) (61) and 438.10 (g) at least 30 days before calendar days before the intended effective date of the change; and (2) . termination of their provider within fifteen (15) calendar days after PIHP receives notice that DMA or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider.	X					The 5 terminated provider files CCME reviewed all had letters sent to members within 15 calendar days, except for 1 that included a sick leave prior to the provider passing away. Onsite interview revealed that this provider was not seeing any Medicaid enrollees at the time of the sick leave.
4. Enrollee program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation of prevalent non-English languages as required by the contract.	X					The *Member & Family Handbook* informs members of the availability of oral translation services. *Policy & Procedure 9510* states, "Communications & Marketing will use multiple methods and tools as outlined in the Centers for Medicare and Medicaid Services (CMS) health literacy resource, *Toolkit for Making Written Material Clear and Effective* to ensure enrollee comprehension. These include the use of the reader-centered approach, gathering direct input from intended readers, and the use of readability formulas (with target readability of 5th-6th grade levels if possible)."
5. The PIHP maintains and informs Enrollees of how to access a toll-free vehicle for 24-hours Enrollee access to coverage information from the PIHP, including the availability of free oral translation services for all languages and care management services such as crisis interventions.	X					Information regarding 24-hour access is covered throughout the *Member & Family Handbook*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III C. Behavioral Health and Chronic Disease Management Education						
1. The PIHP enables each enrollee to choose a Provider upon enrollment and provides assistance as needed.	X					
2. The PIHP informs enrollees about the behavioral health education services that are available to them and encourages them to utilize these benefits.	X					The Events page on the website has many activities listed that are held by Cardinal and within the community. Events vary from "Game Fun" and "Zumba" to Alcoholics Anonymous (AA) meetings and "Issues and Concerns for LGBTQ Individuals with Substance Use Disorder". The site is searchable by County, Topic, Type (community/ training/ meeting), and Date. Events can be seen for one day at a time. On the website under Members/Wellness Centers, there is a full month calendar view of events at each wellness center, by location. Page 30 of the *Member & Family Handbook* states: "Cardinal Innovations' has Wellness Centers in Davie, Forsyth, Rockingham and Stokes counties that offer a variety of programs to help in whole-person wellness. The centers host educational training and workshops on mental health, substance use recovery and intellectual disabilities/developmental disabilities." There is a link for more information that is directed to the website page Members/ Wellness Centers. *Cardinal Innovations Community* is a newsletter that is written for members and family. It was launched December 2017 and is 100% opt in. Members are encouraged to sign up at every consumer and community event including Consumer Family Advisory Committee.
3. The PIHP tracks the participation of enrollees in the behavioral health education services.	X					Per *Policy & Procedure 1545, Community and Member Education & Outreach,* the Member Engagement and Community Engagement Departments track attendance at educational events via electronic log or sign-in sheet. Onsite interview confirmed that attendance is tracked.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III D. Call Center						
1. The PIHP provides customer services that are responsible to the needs of the Enrollees and their families. Services include:	X					
1.1 Respond appropriately to inquiries by enrollees and their family members (including those with limited English proficiency);	X					Page 2 and 19 of the *Member & Family Handbook*, indicate translation services are available in 150 languages at no cost to enrollees.
1.2 Connect enrollees, family members and stakeholders to crisis services when clinically appropriate;	X					If a call is screened as emergent, or urgent, or emergent and not life threatening, suitable services are initiated. If the call is emergent, the Access Call Center staff asks a colleague, using an internal chat software, to call the appropriate crisis service for them so there is no disruption in the live call. That colleague will dispatch for service.
1.3 Provide information to enrollees and their family members on where and how to access behavioral health services;	X					
1.4 Train its staff to recognize third-party insurance issues, recipient appeals, and grievances and to route these issues to the appropriate individual;	X					This information is included in the *Access Electronic Operations Manual*.
1.5 Answer phones and respond to inquiries from 8:30 a.m. until 5:00 p.m. weekdays;	X					This occurs 24/7/365. Live Chat is available Monday – Friday from 8:00a.m. – 8:00p.m.
1.6 Process referrals twenty-four (24) hours per day, seven (7) days per week; 365 days per year; and	X					The *Member & Family Handbook* and *Policy & Procedure 6501 and 6504*, indicate the Access Line is available 24 hours a day, every day. This was confirmed during the Onsite review. Call Center metrics were "Met." There was a higher than average abandonment rate in December 2017. December 2017 abandonment Rate was 2.9%. This was the highest of the reporting period, but still

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						within contract standards. This was attributed to staffing difficulties and availability related to holiday scheduling.
1.7 Process Call Center linkage and referral requests for services twenty-four (24) hours per day, seven (7) days per week, 365 days per year.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV A. The Quality Improvement (QI) Program						
1. The PIHP formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to enrollees.	X					Cardinal's 2018-2019 *Annual Quality Strategy & Performance Improvement Plan* outlines the program in place for measuring and improving the care and services received by members and providers.
2. The scope of the QI program includes monitoring of provider compliance with PIHP practice guidelines.	X					*Policy & Procedure 6400 Clinical Practice Guidelines*, effective 10/2018 and contains this detail: "e. On an annual basis Cardinal Innovations will measure provider adherence on at least three (3) CPGs by measuring two (2) important points of care on each of the three (3) chosen CPGs. f. Cardinal Innovations will compile data obtained from the annual measurement of adherence and will look for opportunities of improvement of care if appropriate. g. Cardinal Innovations will share the results of the annual measurement with the providers evaluated and with appropriate committees or stakeholder groups." Cardinal is focused on 3 clinical practice guidelines: child residential, peer support services, and medication assisted treatment. These guidelines are reviewed during focused and routine Utilization

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Management (UM) reviews. Results of these reviews are mailed to the providers with any Corrective Action Plan that is needed.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					
4. The PIHP implements significant measures to address quality problems identified through the enrollees' satisfaction survey.	X					In the March 2018 CQI Committee minutes, a workgroup to discuss interventions for low scoring enrollee surveys was formed. Cardinal went through an environmental scan over the past several months. Katheryn Thomas presented at the December CQI meeting to begin the project. The workgroup plans to begin meeting in February 2019 and report out in March 2019.
5. The PIHP reports the results of the enrollee satisfaction survey to providers.	X					Providers can view enrollee surveys on the Cardinal website. The most recent *ECHO Survey* on the website was completed in 2016. The *2017 ECHO Survey* results are not posted on the website. ***Recommendation: Post the most recent ECHO Surveys results to the Cardinal website.***
6. The PIHP reports to the Quality Improvement Committee on the results of the enrollee satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					Results of the enrollee surveys were discussed in the March 2018 CQI meeting. There are 5 areas of opportunities for growth identified in reviewing surveys.
7. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, time frame for implementation and completion, and the person(s) responsible for the project(s).	X					The *2018-2019 Annual Quality Strategy & Performance Improvement Plan* has a section called Continuous Quality Improvement (CQI) Work Plan 2018-2019 on page 32. The work plan includes 14 clinical and non-clinical activities. It is updated annually with elements reviewed periodically throughout the year. ***Recommendation: Add to the CQI Annual Work Plan target time frames for completing activities throughout the year. Adding a notes column would be helpful to explain the status for each element. A work plan is a document that is intended to be frequently updated and changed, if needed, throughout the year.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV B. Quality Improvement Committee						
1. The PIHP has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The main QIC is the Continuous Quality Improvement (CQI) Committee and it meets monthly as stated in the *CQI Committee Charter*. The GCQI Committee is made up of providers and Cardinal staff and meets quarterly. GCQI reports updates to CQI.
2. The composition of the QI Committee reflects the membership required by the contract.	X					CQI is made up of 23 positions and 2 of those are vacant. 22 members are internal to Cardinal and one is a provider who represents Global Continuous Quality Improvement Committee.
3. The QI Committee meets at regular intervals.	X					CQI and GCQI committees meet regularly.
4. Minutes are maintained that document proceedings of the QI Committee.	X					
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV E. Provider Participation in Quality Improvement Activities						
1. The PIHP requires its providers to actively participate in QI activities.	X					The Barriers Workgroup project is an example of providers participating in QI activities. This workgroup is meeting every other month to identify and discuss barriers of coordination in care. Elaine Smith will report findings to CQI at the next meeting (February 2019).
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Elaine Smith of New Hope Treatment Centers is a member of CQI and GCQI. She shares information from each of these meetings with the other members in each committee. UM routine and focused reports are shared with the providers with a Corrective Action Plan for any areas that fall below 100%.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.		X				The 2017-2018 *Continuous Quality Improvement (CQI) Annual Work Plan Evaluation* was included in the 2018-2019 *Annual Quality Strategy & Performance Improvement Plan* document. This section list bullet points for the overall goals of the program, highlights of interventions and accomplishments, continued occasions for improvement and planned intervention, and Next Steps. The Evaluation portion in this section would most likely be the "Continued Opportunities for Improvement" and "Next Steps" sections. Both sections give vague statements. There is one bullet in the Continued Opportunities for Improvement section that evaluates a portion of the program. The others are statement of action. This evaluation should analyze how the goals listed on page 14 were accomplished or partially accomplished. If a goal is not met at the end of the year, identified barriers should be listed and the specific interventions planned for next year documented in this evaluation.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Input from CQI and other committees should happen prior to completing the annual evaluation. ***Corrective Action: Create an annual QI program evaluation that contains an analysis and evaluation of the overall effectiveness of the goals for the QI program. Specific projects related to that goal can be documented and analyzed. If a goal is not met at the end of the year, identified barriers should be listed and the interventions planned for next year documented in this evaluation. If the goal is met, explain what interventions contributed to meeting the goal and how the goal will be maintained.***
2. The annual report of the QI program is submitted to the QI Committee and to the PIHP Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V A. The Utilization Management (UM) Program						
1. The PIHP formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					
1.1 structure of the program;	X					
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;	X					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					*Policy & Procedure 6010, Pre-Service Authorization and Re-Authorization of Services* includes the procedural steps to process a treatment authorization and information on extensions of the Treatment Authorization Request (TAR) processing time frame. Criteria for extensions within the policy and procedure do not reference the requirement that Cardinal "demonstrates to DMA" or "justifies" the need for the extensions (see *DMA Contract Section 7.4.13* and *Attachment M, D.1.b*) or how staff demonstrate and/or justify extensions to the TAR processing time frame. ***Recommendation: Add detail to Policy & Procedure 6010, Pre-Service Authorization and Re-Authorization of Services regarding the requirement that Cardinal "demonstrates to DMA" or "justifies" extensions (see DMA Contract Section 7.4.13 and Attachment M, D.1.b) and how staff demonstrate and/or justify extensions to the TAR processing time frame.***
1.5 consideration of new technology;	X					*Policy & Procedure 6420, Technology Assessment, Implement New BH Technology or Medical Procedure* provides the process used by Cardinal to consider technology or treatment.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.6 the appeal process, including a mechanism for expedited appeal;	X					*Policy & Procedure 6010, Preservice Authorization and Reauthorization of Services* includes a mechanism to process an appeal and notes within the policy and procedures; "Any decisions to deny a request for authorization of services, or authorize the requested services in a limited manner, shall be done in accordance with *Policy & Procedure* 6020." *Policy & Procedure 6020, Adverse Benefits Determination, Notice, and Appeal Process for Medicaid-Funded Services* includes the process to file an appeal and the mechanism for expedited appeal.
1.7 the absence of direct financial incentives to provider or UM staff for denials of coverage or services;	X					
1.8 mechanisms to detect underutilization and overutilization of services.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					During the Onsite interview Dr. Terri Harpold, Interim CMO, provided an overview of her involvement in the UM Program and the changes made to the medical oversight structure during the past year. A Behavioral Health Nurse Director was hired to assist in the coordination of "rounds" and to assist Peer Reviewers.
3. The UM program design is reevaluated annually, including Provider input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The UM Program design is re-evaluated annually and includes an overview of the program, operational structure and overall program effectiveness. The *Clinical Operations Program Evaluation* included the UM goals and progress toward the goals.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					*Policy & Procedure 6007, Medically Necessary Treatment Determination* provides the criteria used by UM staff to determine medical necessity for covered services.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
4. Utilization management standards/criteria are consistently applied to all enrollees across all reviewers.	X					*Policy & Procedure 6024, Inter-Rater Reliability (IRR)*, outlines Cardinal's IRR process. The scores are tracked and monitored. It was also noted that BHM, contracted to provide peer review services, will be monitored for their consistency of UM decisions through this year's IRR process.
5. Emergency and post stabilization care are provided in a manner consistent with contract and federal regulations.	X					
6. Utilization management standards/criteria are available for Providers.	X					
7. Utilization management decisions are made by appropriately trained reviewers		X				Within the UM files reviewed, there was no evidence of reviewer credentials as is required by *DMA Contract, Section 8.2.2.1, "e.* the name and Credentials of the individual conducting the review, *f.* the name, signature and credentials of the individual who made the decision to deny, reduce or terminate authorization for the requested service;"

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Corrective Actions: Ensure signatures within the UM files reflect the reviewer and peer reviewer credentials, as is required by DMA Contract, Section 8.2.2.1.
8. Initial utilization decisions are made promptly after all necessary information is received	X					Cardinal extended the TAR processing time frame in eight of the 25 files where services were denied or reduced. Files did not have consistent documentation to "demonstrate" or "justify" that criteria for extensions were considered and the extension justified. ***Recommendation: Monitor Pre-Service and Re-Authorization requests where the TAR processing time frame was extended to ensure extension justifications are adequately and consistently documented by staff.***
9. Denials						
9.1 A reasonable effort that is not burdensome on the enrollee or the provider is made to obtain all pertinent information prior to making the decisions to deny services	X					
9.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
9.3 Denial decisions are promptly communicated to the provider and enrollee and include the basis for the denials of service and the procedure for appeal	X					In the files submitted for this EQR, all (standard, expedited, extended) showed timely decisions and notifications.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V C. Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					Care Coordination caseloads are determined by population and the needs of each member within the specified population.
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;	X					
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	X					*Policy & Procedure 7205, Complex Care Coordination* includes details about the roles and responsibility of the Care Coordinator and the face-to-face Follow up process. The file review of the Care Coordination Progress Notes indicated face-to-face assessments in the "Primary Reason" line of the electronic progress note.
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					
2.4 Develop treatment plans for enrollees that meet all requirements;	X					
2.5 Quality monitoring and continuous quality improvement;	X					*Policy & Procedure 7212, IDD Support Planning* includes in the time frames in which monitoring occurs. *Policy & Procedure 7205, Complex Case Management* provides the procedures for members identified as receiving Complex Care Coordination and time frame requirement for monitoring.
2.6 Determine of which Behavioral Health Services are medically necessary;	X					*Policy & Procedure 6512, Screening, Triage and Referrals*, includes the requirements for assessment of urgent, emergent and Immerging needs/interventions/ assessment referral process. Time frame requirements for the referral process are included in this policy and procedure.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					
2.8 Coordinate care with each Enrollee's provider;	X					
2.9 Provide follow-up activities for Enrollees;	X					
2.10 Ensure privacy for each Enrollee is protected.	X					
3. The PIHP applies the Care Coordination policies and procedures as formulated.	X					
V. D Transition to Community Living Initiative						
1. Transition to Community Living functions are performed by appropriately licensed, or certified, and trained staff.	X					*Policy & Procedure, 7005, In-Reach*, specifies educational requirements for Qualified Professionals and Certified Peer Support Specialists. *Policy & Procedure 7010, Transition to the Community* specifies educational requirements of Transition Care Coordinator, Transitional Health Care Coordinator and *Policy & Procedure 7020, Post Transition* specifies the requirements for Transition Team members.
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements includes all required elements.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.1 Care Coordination activities occur as required.	X					
2.2 Person Centered Plans are developed as required.	X					*Policy & Procedure 7010, Transition to Care Coordination* in the procedure, provides details regarding time frames for the completion of the Person-Centered Plan and the process to the development of the plan. Transition tool and clinical assessments where included in the TCLI files reviewed.
2.3 Assertive Community Treatment, Peer Support Services, and Supported Employment services are included in the individual's transition, if applicable.	X					Within the TCLI files reviewed, members were rarely linked with Supported Employment, even when they identified seeking employment as a goal. During the Onsite interview, potential barriers with this service were discussed, along with efforts to educate the community and Supported Employment providers to increase linkage of TCLI members with this service. ***Recommendation: Continue to address barriers to referrals for Supported Employment and ensure those TCLI enrollees that voice a desire for employment are referred and linked to this service.***
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					*Policy and Procedure 7000, TYSR does not describe how Cardinal monitors the TYSR funds.* ***Recommendation: Add detail to Policy & Procedure 7000, describing the monitoring of the TYSR funds and reference the DOJ-TYSR Expenses Form that was described as an essential form used with Cardinal's cross agency monitoring process.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.5 QOL Surveys are administered timely.	X					QOL surveys were present in the files reviewed and notes verified the completion of the survey with members.
3. A diversion process is in place for individuals considering admissions into an Adult Care Home (ACH).	X					
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to DMA within the timeframes determined by DMA.	X					
5. The PIHP will develop a TCLI communication plan that includes materials and training about crisis hotline, services for enrollees with limited English proficiency and also to for external and internal stakeholders providing information on the TCL initiative, resources, and system navigation tools, etc.	X					TCLI information is provided to internal and external stakeholders. TCLI staff participate in local and regional meetings and in community housing organization meetings. Cardinal is developing a TCLI web-based, four (4) modules, training for stakeholders. During the Onsite interview, it was stated that the TCLI Program received a significant increase of referrals for the Diversion and Transition services.
6. A review of files demonstrates the PIHP is following appropriate TCL policies, procedures and processes, as required by NC DMA, and developed by the PIHP.	X					

VI. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee grievances in a manner consistent with contract requirements, including, but not limited to:	X					*Policy & Procedure 5050, Grievance and Formal Level of Review* contains all elements for registration to grievances and most elements in and responding to and enrollee grievances.
1.1 Definition of a grievance and who may file a grievance;	X					The definitions were consistent with the NC Medicaid contract.
1.2 The procedure for filing and handling a grievance;	X					
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	X					On page 3, *Policy & Procedure 5050*, Section III. Grievance Investigation and Resolution states "…A fourteen (14) calendar day extension may be granted if more time is needed to resolve the grievance. This extension can be granted by the Grievance Team Manager or designee if requested by the member or justified by Cardinal Innovations." Cardinal needs to clarify that the "PIHP demonstrates to DMA that there is a need for additional information and demonstrates how the delay is in the best interest of the Enrollee", per *DMA Contract Attachment M, Sections C* and *42 CFR § 438.408*. ***Recommendations: In Policy & Procedure 5050 lacks detail describing required justification when Cardinal extends the grievance time frame decision. The procedure is missing the following detail; "PIHP demonstrates to DMA that there is a need for additional information and demonstrates how the delay is in the best interest of the Enrollee" per DMA Contract Attachment M, Sections C and 42 CFR § 438.408.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						There are additional details missing in *Policy & Procedure 5050* regarding notifications of a grievance extension by Cardinal. This policy and procedure lacks the details outlined in *42 CFR § 438.408* "(2) Requirements following and extension, If MCO, PIHP extends, it must complete the following: (i) Make reasonable efforts to give the enrollee prompt oral notice of the delay, (ii) (ii) Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the time frame and inform the enrollee of the right to file a grievance." Cardinal will need to add this detail to complete *Policy & Procedure 5050*. ***Recommendations: Include in Policy & Procedure 5050, the required notifications when Cardinal extends a grievance resolution time frame. Per 42 CFR § 438.408 "(2) Requirements following and extension, If MCO, PIHP extends, It must complete the following:*** ***(iii) Make reasonable efforts to give the enrollee prompt oral notice of the delay,*** ***(iv) (ii) Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the time frame and inform the enrollee of the right to file a grievance."***
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;	X					
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.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP applies the grievance policies and procedure as formulated.	X					
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Grievances are tallied and analyzed for patterns that include population types of service and top 10 Grievance types on a monthly and quarterly basis.
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					There was a consistent application of the confidentiality processes in the files review. Documentation of the verification and the presence of documents were noted throughout the review files. Acknowledgement Letters were all sent within 5 days from receiving the grievance per *Policy & Procedure 5050*.
VI. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to enrollee and/or provider appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					While the appeal information provided through Cardinal's website is easy to understand, the information is difficult to locate. Additionally, within the member appeal information on the website is a link to the provider Reconsideration process, which is a separate process not related to the appeal of service authorizations. ***Recommendation: When the words "appeal" or "reconsideration" are entered into the website search engine, ensure users are sent directly to the appropriate and accurate appeal information.*** *Policy & Procedure 6020, Adverse Benefit Determination, Notice, and Appeal Process for Medicaid-Funded Services* provides reference to overarching general statutes but does not point staff to specific appeal requirements within the *DMA Contract* and federal regulations. ***Recommendation: Note specific CFRs and DMA Contract requirements (e.g., 42 CFR § 438.406 (b)(2)(i), DMA Contract Attachment M, section H 9 (b), etc.) within the appeals policy and procedure. This will provide staff with quick reference to***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						specific language and appeal requirements when processing appeals.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					*Policy & Procedure 6020, Adverse Benefit Determination, Notice, and Appeal Process for Medicaid-Funded Services* correctly defines an appeal as "a request for review of an Adverse Benefit Determination, as defined by 42 CFR 438.400."
1.2 The procedure for filing an appeal;	X					The *Provider Manual* states, "The member/guardian has 30 days after the date of notice on the action to request a Reconsideration Review. With the member or guardian's written consent, the provider may file an appeal on behalf of the member." This information does not clarify that anyone may file an appeal on the members behalf, not just the guardian or provider, if written consent is given. The time frame for filing an appeal was changed from 30 to 60 days, effective July 1, 2017. It was reported during the Onsite discussion that the *Provider Manual* was corrected in January of 2019. However, this erroneous information regarding the time frame to file an appeal existed within that document for more than 18 months. ***Recommendations: Clarify in the Provider Manual that appeals can be filed by "the Enrollee, legally responsible person, or a Provider or other designated personal representative, acting on behalf of the Enrollee and with the Enrollee's signed consent." See DMA Contract, Attachment M, Section G.1.*** ***Ensure the appeals information within the Provider Manual is updated timely as changes occur within the federal regulations governing appeals. See DMA Contract, Attachment M, Section G.2.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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;	X					While staff could articulate the consideration of subordinate relationships when assigning appeal Peer Reviewers, *Policy & Procedure 6020, Adverse Benefit Determination, Notice, and Appeal Process for Medicaid-Funded Services* does not clarify that appeal Peer Reviewers cannot be a subordinate of the clinician that made the initial, UM decision. ***Recommendation: Add to Policy & Procedure 6020, Adverse Benefit Determination, Notice, and Appeal Process for Medicaid-Funded Services the requirement that appeal Peer Reviewer s cannot be subordinates of the Peer Reviewer that made the initial UM decision. See DMA Contract, Attachment M, Section A c. and 42 CFR § 438.406 (b)(2)(i).***
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;		X				*Policy & Procedure 6020, Adverse Benefit Determination, Notice, and Appeal Process for Medicaid-Funded Services* is missing information regarding the following requirements of processing expedited appeals; • Acknowledgment of expedited appeals. See *DMA Contract, Attachment M, Section A.1.b* • The appellant's right to file a grievance if Cardinal denies the request to expedite an appeal. See *42 CFR § 438.410 (c)(2)* • Oral and written notifications of the resolution of expedited appeals and the time frames for both notifications see (see *DMA Contract, Attachment M, Section H.5 and H.6*). The policy and procedure only notes that a written notice will be given and gives no timeline for that written notice of resolution. ***Corrective Action: Add the above requirements to Policy & Procedure 6020, Adverse Benefit Determination, Notice, and Appeal Process for Medicaid-Funded Services.***
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;		X				*Policy & Procedure 6020, Adverse Benefit Determination, Notice, and Appeal Process for Medicaid-Funded Services* is missing information regarding required notifications and their timelines pertaining to the resolution of appeals:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						• A written notification of a standard appeal resolution is required to be sent within the standard, 30-day appeal time frame. Throughout this policy and procedure only the time frame for making decisions is noted and not the requirement that notice must also be provided during this appeal time frame. See *DMA Contract, Attachment M, Section G.4.* • Oral notification and written notifications are required within specific time frames when Cardinal extends the standard, appeal resolution time frame. Only written notice is noted in the policy and procedure, and no time frame for that written notice given. See *DMA Contract, Attachment M, Section G.6* and *42 CFR § 438.408 (c) 2.* • Oral notification and written notifications are required within specific time frames when Cardinal extends the expedited appeal resolution time frame. Only written notice is noted in the policy and procedure, and no time frame for that written notice given. See *DMA Contract, Attachment M, Section G.6* and *42 CFR § 438.408 (c) 2.* • The right of the appellant to file a grievance when Cardinal extends the standard appeal time frame is noted in this policy and procedure, but is not included within the policy and procedure section that discusses extensions to expedited appeal resolution time frames. ***Corrective Action: Add the above requirements to Policy & Procedure 6020, Adverse Benefit Determination, Notice, and Appeal Process for Medicaid-Funded Services.***
1.6 Written notice of the appeal resolution as required by the contract;	X					Cardinal generates appeal notifications in Spanish. One file reviewed for this EQR reflected the appeal resolution notification was transferred to the Spanish notification template and sent within the resolution time frame to the appellant.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.7 Other requirements as specified in the contract.	X					Review of the appeal file shows Cardinal does review each file to determine how "expeditiously" an appeal should be processed. There was evidence that Cardinal would "expedite' an appeal even though an expedited resolution was not requested.
2. The PIHP applies the appeal policies and procedures as formulated.		X				22 first level appeal files and 5 State fair hearing files were provided for this EQR. Concerns noted within these files are described below. <u>Timeliness of standard resolution;</u> 3 of 18 standard appeal files (or 17%) showed late notification of appeal resolution. These notifications were sent only 1-2 days beyond the 30-day time frame for resolution. Further review and Onsite discussion revealed that appeal resolution notifications are thoroughly vetted through the Office of General Counsel (OGC) but can delay timely notification of appeal resolutions. Appeal staff stated they are aware of this issue and are working to come into compliance. <u>Expedited appeals;</u> 4 expedited appeal files were provided for this EQR. 2 of these files showed Cardinal denied the request to expedite the appeal resolution time frame. 1 of these 2 files showed compliance with required notifications and documentation and the other lacked enough documentation to show Cardinal processed this appeal following expedited appeal requirements. This 1 file lacked: • Oral notification to the appellant of the decision by Cardinal to deny the request to expedite the appeal resolution time frame. This is required by Cardinal's appeal policy and procedure *(Section VIII.c.5)*. • Evidence of a written acknowledgement notice. Cardinal's appeal policy and procedure requires that an "Acknowledgement of a Request for a Reconsideration Review" is used to acknowledge all appeals in Section VIII.b.4). • Documentation of the rationale to support the decision by Cardinal to deny the request to expedite the appeal. The "rationale" field within the CI documentation was left blank.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						2 of the 4 expedited appeals provided for this EQR showed Cardinal processed the appeal as expedited, as requested by the appellant. Of these 2 expedited appeal files, 1 file showed compliance with required notifications and documentation and the other lacked enough documentation to show Cardinal processed this appeal following expedited appeal requirements. This file lacked: • Clear documentation of the oral notification of the expedited appeal resolution. <u>Extended appeals;</u> 1 standard appeal file was submitted for this EQR that showed the appeal resolution time frame was extended by Cardinal. This file lacked: • Evidence that the appellant was informed of their right to file a grievance against Cardinal for extending the appeal resolution time frame. Staff acknowledged during the Onsite that the wrong template was sent. See Cardinal's appeals *Policy & Procedure 6020*, Section VII.B.9.a. • Documentation of oral notification of the decision by Cardinal to extend the appeal resolution time frame. • Evidence that staff provided to the appellant how the extension is in the best interest of the appellant. Cardinal's appeals policy and procedure requires this but neither the extension notice in this file nor the blank notice provided for this EQR prompt this explanation to the appellant. See *Policy & Procedure 6020, Section VII.B.9.a.* ***Corrective Action: Continue to hone the internal process that Cardinal implements to generate appeal resolution notifications with a focus on mailing these notifications within the required appeal resolution time frames.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Ensure staff are trained on the requirements for processing expedited appeals and extending standard and expedited appeals, with a focus on the requirements for providing oral and written notifications. ***Increase monitoring of expedited and extended appeals to ensure;*** • ***The required notifications (oral and written) occur, are adequately documented, and are provided within the required time frames.*** • ***The rationale for denying expedited appeals are clearly documented within the appeal record.*** • ***Extension notifications to appellants include the reason for the delay and how it is in the enrollee's best interest, to be compliant with Cardinal's Policy & Procedure 6020, Adverse Benefit Determination, Notice, and Appeal Process for Medicaid-Funded Services.***
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					While appeal data presented for this EQR showed appeals are tallied, categorization of appeals is lacking to the degree that staff struggled to accurately identify and provide expedited appeals that were requested for this EQR. The Appeal Log provided for this EQR also did not identify key appeal categories such as extended appeals, requests for expedited appeals that were denied by Cardinal, etc. Further, analysis of appeals data was also absent. The CQI Committee minutes showed overall numbers of appeals and numbers of appeal outcomes were reported to this committee, but no discussion or analysis of appeal trends were discussed per these minutes.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Ensure key information is captured on the Appeal Log. Inclusion of information such as expedited appeals (both accepted as expedited and denied), extended appeals, etc. would help staff accurately identify appeals by category, identify appeal trends, and develop potential quality improvement opportunities. ***Ensure the expectation of appeal data analysis is captured in the UM Plan and that discussion related to analysis of appeal trends are documented in committee minutes.***
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	X					There was evidence within the appeal files reviewed of staff making efforts to obtain proof of guardianship prior to releasing protected health information (PHI).

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. Delegation						
1. The PIHP has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Written agreements are in place and current with all delegated entities. Cardinal completed the *Predelegation Evaluation* of BHM before executing a contract amendment for services beginning in May 2018. The replacement *Attachment A, Business Associates Agreement* with BHM, referenced in the contract amendment executed in May 2018, was not submitted for the EQR and Cardinal was unable to provide it. ***Recommendation: If the Delegation Agreement or any amendment references replacement documents, ensure the documents are replaced, fully executed, and retained in the file.***
2. The PIHP conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the PIHP if the PIHP were directly performing the delegated functions.	X					Cardinal conducts oversight of its delegates, with regular meetings with BHM and annual audits of all delegates. Routine reports are received from the delegates, and delegation reports are taken to the appropriate committees for review, discussion, and recommendations. Plans of correction are used when needed.

VIII. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VIII A. General Requirements						
1. PIHP shall be familiar and comply with Section 1902(a)(68) of the Social Security Act, 42 C.F.R. Parts 438,455 and 1000 through 1008, as applicable, including proper payments to Providers and methods for detection of fraud and abuse.	X					This requirement is addressed in Cardinal *Policy & Procedure 1930 Fraud, Waste and/or Abuse Detection, Investigation and Reporting*.
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.	X					This requirement is addressed in Cardinal *Policy & Procedure 1930 Fraud, Waste and/or Abuse Detection, Investigation and Reporting*.
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					Cardinal provided a subcontractor agreement template which incorporates, by reference, the *Provider Manual*, which is referenced as a part of the contract, and contains the required language.
4. PIHP shall investigate all grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	X					This requirement is addressed in Cardinal *Policy & Procedure 1930 Fraud, Waste and/or Abuse Detection, Investigation and Reporting*.
VIII B. Fraud and Abuse						
1. PIHP shall establish and maintain a written Compliance Plan consistent with 42 C.F.R. 438.608 that is designed to guard against fraud and abuse. The Compliance Plan shall be submitted to the DMA Contract Administrator on an annual basis.	X					This requirement is addressed in *Compliance Plan* dated 8/2/2018. Cardinal also provided an email transmittal of the *Compliance Plan* with an acknowledgement reply from NC Medicaid.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. PIHP shall designate, however named, a Compliance Officer who meets the requirements of 42 C.F.R. 438.608 and who retains authority to report directly to the CEO and the Board of Directors as needed irrespective of administrative organization. PIHP shall also establish a regulatory compliance committee on the PIHP board of directors and at the PIHP senior management level that is charged with overseeing PIHP's compliance program and compliance with requirements under this Contract. PIHP shall establish and implement policies outlining a system for training and education for PIHP's Compliance Officer, senior management, and employees in regard to the Federal and State standards and requirements under DMA Contract in accordance with 42 CFR 438.608(a)(1)(iv).	X					This requirement is addressed in the *Compliance Plan* dated 8/2/2018. Cardinal also supplied an *Organizational Chart* depicting the reporting lines of the Compliance Officer to the General Counsel.
3. PIHP shall establish and implement a special investigations or program integrity unit, however named, that is responsible for PIHP program integrity activities, including identification, detection, and prevention of fraud, waste and abuse in the PIHP Closed Provider Network. PIHP shall identify an appropriately qualified contact for Program Integrity and Regulatory Compliance issues as mutually agreed upon by PIHP and DMA. This person may or may not be the PIHP Compliance Officer or the PIHP Contract Administrator.	X					This requirement is addressed in Cardinal *Policy & Procedure 1930 Fraud, Waste and/or Abuse Detection, Investigation and Reporting.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. PIHP shall participate in quarterly Program Integrity meetings with DMA Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the N.C. Department of Justice ("MFCU/ MID').	X					This requirement is addressed in Cardinal *Policy & Procedure 1930 Fraud, Waste and/or Abuse Detection, Investigation and Reporting.*
5. PIHP shall participate in monthly meetings with DMA Program Integrity, in the most productive setting, either telephonically or in person at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.	X					This requirement is addressed in Cardinal *Policy & Procedure 1930 Fraud, Waste and/or Abuse Detection, Investigation and Reporting.* Cardinal also supplied copies of monthly meeting minutes.
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	X					This requirement is addressed in Cardinal *Policy & Procedure 1930 Fraud, Waste and/or Abuse Detection, Investigation and Reporting.*
7. PIHP shall also make Regulatory Compliance minutes and Program Integrity minutes, redacted as deemed appropriate by PIHP, available for review upon request by DMA.	X					This requirement is addressed in Cardinal *Policy & Procedure 1930 Fraud, Waste and/or Abuse Detection, Investigation and Reporting.* Cardinal also supplied copies of monthly meeting minutes. Cardinal states that internal communications regarding Internal risk reviews were highly confidential and that particular meeting in September 2018 was very unusual.
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	X					This requirement is addressed in the *Compliance Plan* dated 8/2/2018.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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;	X					This requirement is addressed in the *Compliance Plan* dated 8/2/2018.
8.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					This requirement is addressed in the *Compliance Plan* dated 8/2/2018.
8.4 Provision for full cooperation by PIHP and PIHP's employees, contractors, and Providers with any investigation conducted by Federal or State authorities, including DMA or MFCU/MID, and including promptly supplying all data and information requested for their respective investigations.	X					This requirement is addressed in the *Compliance Plan* dated 8/2/2018.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9. In accordance with 42 CFR 436.606(a)(vii), PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under DMA Contract, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under DMA Contract; and making documentation of investigations and compliance available as requested by the State.	X					This requirement is addressed in the *Compliance Plan* dated 8/2/2018. Cardinal also supplied an *Organizational Chart* depicting the dedicated program integrity staff as well as job descriptions.
10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse.	X					This requirement is addressed in Cardinal *Policy & Procedure 1930 Fraud, Waste and/or Abuse Detection, Investigation and Reporting.*
10.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse;	X					This requirement is addressed in Cardinal *Policy & Procedure 1930 Fraud, Waste and/or Abuse Detection, Investigation and Reporting.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.	X					This requirement is addressed in Cardinal *Policy & Procedure 1930 Attachment I – SIU process flow*. Recovery and overpayment processes, time frames and documentation requirements are addressed in *Policy & Procedure 2300-Paybacks*.
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	X					This requirement is addressed in Cardinal *Policy & Procedure 2300-Paybacks*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.						
10.4 Process for tracking overpayments and collections, and reporting on Attachment Y – Audits/Self-Audits/Investigations;	X					This requirement is addressed in Cardinal *Policy & Procedure 2300-Paybacks*.
10.5 Process for handling self-audits and challenge audits;	X					This requirement is addressed in Cardinal *Policy & Procedure 5300 - Provider Post-Payment Reviews*.
10.6 Process for using data mining to determine leads;	X					This requirement is addressed in *Cardinal Policy & Procedure 1930 Fraud, Waste and/or Abuse Detection, Investigation and Reporting*. Cardinal provided a sample data mining report. Cardinal provided a summary of data mining initiatives and results during the period. Excellent examples of using data for investigation were provided.
10.7 Process for informing PIHP employees, subcontractors and providers regarding the False Claims Act;	X					This requirement is addressed in *Cardinal Policy & Procedure 1930 Fraud, Waste and/or Abuse Detection, Investigation and Reporting*. This is also addressed in the *Compliance Plan*. Cardinal supplied examples of training materials delivered to employees, providers and contractors.
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	X					This requirement is addressed in *Cardinal Policy & Procedure 1945 - Employee Code of Conduct and the Work Environment*. This policy and procedure also addresses whistleblowers, corporate ethics and policy violations. However, there is no verbatim wording on the Federal False Claims Acts was included in this policy and procedure.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
laws as described in the Social Security Act 1902(a)(66), including information about rights of employees to be protected as whistleblowers.						***Recommendation: Add detail to Policy & Procedure 1945 - Employee Code of Conduct and the Work Environment to explicitly include the Federal False Claims Acts in the list of protected whistleblower reporting.***
10.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains DMA-standardized elements or a DMA-approved template;	X					This requirement is addressed in *Cardinal Policy & Procedure 1990 - Verification of Services Survey*. This was also evident in the reviewed PI files.
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.	X					This requirement is addressed *in Cardinal Policy & Procedure 8350- Primary Source of Verification* and *8370 - Ongoing Monitoring of Practitioners and Providers*.
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.	X					This requirement is addressed in Cardinal *Policy & Procedure 2300- Paybacks*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
12. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to DMA within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					This requirement is addressed in Cardinal *Policy & Procedure 1930 Fraud, Waste and/or Abuse Detection, Investigation and Reporting.* This item was partially met last review with a Corrective Action Plan. Fifteen (15) of Fifteen (15) files reviewed demonstrated that the preliminary investigation was initiated within ten days. The prior finding has been remediated.
13. In each case where PIHP refers to DMA an allegation of fraud involving a Provider, PIHP shall provide DMA Program Integrity with the following information on the DMA approved template:						The policy and procedure requirement for all of section 13 is addressed in *Cardinal Policy & Procedure 1930 Fraud, Waste and/or Abuse Detection, Investigation and Reporting.*
13.1 Subject (name, Medicaid provider ID, address, provider type);	X					15 of 15 files reviewed contained the required elements.
13.2 Source/origin of complaint;	X					15 of 15 files reviewed contained the required elements.
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					15 of 15 files reviewed contained the required elements.
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;	X					15 of 15 files reviewed contained the required elements.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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;	X					1 of the reviewed case files (case #4) was closed based on preliminary investigation and no claims data was required. Of the remaining files: 14 of 14 files reviewed contained the required elements.
13.6 All communications between PIHP and the Provider concerning the conduct at issues, when available.	X					One of the reviewed case files (case #15) was opened based on a data mining initiative and closed by the PI Supervisor due to low dollar value and lack of documentation. No communication was exchanged with the provider. Of the remaining files: 14 of 14 files reviewed contained the required elements
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					15 of 15 files reviewed contained the required elements.
13.8 Sample/exposed dollar amount, when available.	X					2 of the reviewed case files (#5 and #15) were closed based on initial evidence and before sample/exposed dollar values would have been calculated. Of the remaining files: 13 of 13 files reviewed contained the required elements.
14. In each case where PIHP refers suspected Enrollee fraud to DMA, PIHP shall provide DMA Program Integrity with the following information on the DMA approved template:						The policy and procedure requirement for Section 14 is addressed in *Cardinal Policy & Procedure 1930 Fraud, Waste and/or Abuse Detection, Investigation and Reporting*. There were no cases of Enrollee fraud reported during the review period.
14.1 The Enrollee's name, birth date, and Medicaid number;	X					
14.2 The source of the allegation;	X					
14.3 The nature of the allegation, including the timeframe of the allegation in question;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;	X					
14.5 Contact information for PIHP staff persons with practical knowledge of the allegation;	X					
14.6 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation; and	X					
14.7 The legal and administrative status of the case.	X					
15. PIHP and DMA shall mutually agree on program integrity and monitoring forms, tools, and letters that meet the requirements of State and Federal law, rules, and regulations, and are consistent with the forms, tools and letters utilized by other PIHPs.	X					
16. PIHP shall use the DMA Fraud and Abuse Management System (FAMS) or a DMA approved alternative data mining technology solution to detect and prevent fraud, waste and abuse in managed care.	X					Cardinal provided an email dated 6/24/15 from Katherine Nichols of DHHS approving the use of STARS instead of Fraud and Abuse Management System (FAMS).
17. If PIHP uses FAMS, PIHP shall work with the DMA designated Administrator to submit appropriate claims data to load into the DMA Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. If PIHP uses FAMS, PIHP shall notify the DMA designated Administrator within forty-eight (48) hours of FAMS-user changing roles				X		Cardinal says they are looking at moving to FAMS and are expected to decide within the November time frame.

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
19. On a quarterly basis, DMA shall review a sample of cases where the PIHP's Special Investigation Unit has identified overpayments, investigated or audited a provider. The results of these reviews will be discussed during the PIHP monthly Program Integrity meetings to assure that DMA is providing consistent guidance on expectations with regard to referrals for potential cases of fraud. DMA shall also determine what additional technical assistance may be available to PIHP to support PIHP's efforts in making referrals.	X					Cardinal provided monthly NC Medicaid meeting minutes.
VIII C. Provider Payment Suspensions and Overpayments						
1. Within thirty (30) business days of receipt from PIHP of referral of a potential credible allegation of fraud, DMA Program Integrity shall complete a preliminary investigation to determine whether there is sufficient evidence to warrant a full investigation. If DMA determines that a full investigation is warranted, DMA shall make a referral within five (5) business days of such determination to the MFCU/ MID and will suspend payments in accordance with 42 CFR § 455.23. At least monthly, DMA shall provide written notification to PIHP of the status of each such referral. If MFCU/ MID indicates that suspension will not impact their investigation, DMA may send a payment suspension notice to the Provider and notify PIHP. If the MFCU/ MID indicates that payment suspension will impact the investigation, DMA shall temporarily						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.	X					This requirement is addressed in Cardinal *Policy & Procedure 1930 Fraud, Waste and/or Abuse Detection, Investigation and Reporting.*
2. Upon receipt of a payment suspension notice from DMA Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of DMA Program Integrity's suspension and lasting until PIHP is notified by DMA Program Integrity in writing that the suspension has been lifted.	X					This requirement is addressed in Cardinal *Policy & Procedure 1930 Fraud, Waste and/or Abuse Detection, Investigation and Reporting.*
3. PIHP shall provide to DMA all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.	X					This requirement is addressed in Cardinal *Policy & Procedure 1930 Fraud, Waste and/or Abuse Detection, Investigation and Reporting.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to DMA Program Integrity due to allegations of suspected fraud without prior written approval from DMA Program Integrity or the MFCU/MID.	X					This requirement is addressed in Cardinal *Policy & Procedure 1930 Fraud, Waste and/or Abuse Detection, Investigation and Reporting.*
5. Notwithstanding the foregoing, nothing herein shall be construed as prohibiting PIHP from taking any action against a Network Provider in accordance with the terms and conditions of any written agreement with a Network Provider, including but not limited to prepayment review, identification and collection of overpayments, suspension of referrals, de-credentialing, contract nonrenewal, suspension or termination or other sanction, remedial or preventive efforts necessary to ensure continuous, quality care to Enrollees, regardless of any ongoing investigation being conducted by DMA, MFCU/MID or other oversight agency, to the extent that such action shall not interfere with Enrollee access to care or with any such ongoing investigation being conducted by DMA, MFCU/MID or other oversight agency.	X					This requirement is addressed in Cardinal *Policy & Procedure 1930 Fraud, Waste and/or Abuse Detection, Investigation and Reporting.*
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	X					This requirement is addressed in Cardinal *Policy & Procedure 2300-Paybacks.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery.						
7. The MFCU/MID reserves the right to prosecute or seek civil damages regardless of payments made by the Provider to PIHP. The Parties shall work collaboratively to develop a plan for the disbursement of the share of monies that are recovered and returned to the state by the MFCU/MID for fraudulent claims paid by PIHP. DMA will examine options to refund returned funds to PIHP and/or to appropriately account for these recoveries in the rate setting process.						

IX. FINANCIAL SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IX. Financial						
1. The PIHP has policies and systems in-place for submitting and reporting financial data.	X					Cardinal *Policy & Procedure 2208, Financial Reports to NC Medicaid*, documents reporting of monthly NC Medicaid reports. Cardinal's policies and procedures are reviewed annually. All reports were submitted timely to NC Medicaid.
2. The PIHP has and adheres to a cost allocation plan that meets the requirements of 42 CFR 433.34.	X					Per the Onsite interview, the *Cost Allocation Plan* is calculated and submitted to NC Medicaid in April. The calculation is reviewed monthly. Cardinal's Medicaid percentage was 89%.
3. PIHP maintains detailed records of the administrative costs and expenses incurred as required by the DMA contract. (DMA Contract, Section 8.3).	X					The administrative costs are allocated by funding source according to the *Cost Allocation Plan*. All administrative costs are easily identifiable within the general ledger structure of Great Plains.
4. Maintains an accounting system in accordance with 42 CFR 433.32 (a).	X					Cardinal uses Great Plains version 2018 for its accounting system and their own proprietary software for claims processing.
5. The PIHP follows a record retention policy of retaining records for ten years.	X					Cardinal *Policy & Procedure 2150, Fiscal Records Retention*, documents their record retention. Cardinal stated during the interview that they are following the North Carolina Department of Health and Human Services' (DHHS) records retention schedule of ten years but this is not reflected in Cardinal's record retention policy and procedure. ***Recommendation: Change Policy & Procedure 2150 to reflect the retention for ten (10) years of all Medicaid records. See DMA Contract, Section 8.3.2.***
6. The PIHP maintains a restricted risk reserve account with a federally guaranteed financial institution.	X					Cardinal maintains their Risk Reserve Account at Uwharrie Bank and it is federally guaranteed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
7. The required minimum balance of the Risk Reserve Account meets the requirements of the DMA contract. (DMA Contract, Section 1.8 Restricted Risk Reserve Account)	X					Cardinal's *Policy & Procedure 2218* documents the risk reserve monthly payments. These are monitored by the Manager, General Ledger. At the Onsite interview, Cardinal stated all deposits were made within 5 business days of capitation payment.
8. All funds received by PIHP are accounted for by tracking Title XIX Medicaid expenditures separately from services provided using other funding, as required by the DMA contract (DMA Contract, Section 1.9).	X					The segregation of Title XIX (Medicaid) funds is done by funding source. All reports and systems separately identify Title XIX funds, as well as the NC Medicaid reports separating Medicaid funds. There is a separate account segment within the Great Plains general ledger structure for Medicaid revenue and expenses.
9. The Medical Loss Ratio (MLR) meets the requirements of 42 CFR 438.8 and the DMA contract (Amendment 2, Section 12.3 Item k).	X					The Medical Loss Ratio (MLR) is calculated monthly within the NC Medicaid report. The year to date MLR percentage is 92.7%, which exceeds the 85% requirement. Cardinal monitors the MLR monthly.

E. Attachment 5: Encounter Data Validation Report

Cardinal Innovations Healthcare

Encounter Data Validation Report

performed on behalf of

North Carolina Department of Health and Human Services, Division of Health Benefits

February 13, 2019

Prepared By:

hms

4601 Six Forks Road / Suite 306 / Raleigh, NC 27609

Table of Contents

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Background

Health Management Systems (HMS) has completed a review of the encounter data submitted by Cardinal to North Carolina Medicaid, as specified in The Carolinas Center for Medical Excellence (CCME) agreement with NC Medicaid. CCME contracted with HMS to perform encounter data validation for each LME/MCO. North Carolina Senate Bill 371 requires that each LME/MCO submit encounter data "for payments made to providers for Medicaid and State-funded mental health, intellectual and developmental disabilities, and substance abuse disorder services. NC Medicaid may use encounter data for purposes including, but not limited to, setting LME/MCO capitation rates, measuring the quality of services managed by LME/MCOs, assuring compliance with State and federal regulations, and for oversight and audit functions."

In order to utilize the encounter data as intended and provide proper oversight, NC Medicaid must be able to deem the data complete and accurate.

Overview

The scope of our review, guided by the CMS Encounter Data Validation Protocol, was focused on measuring the data quality and completeness of claims paid by Cardinal for the period of January 2017 through December 2017. All claims paid by Cardinal should be submitted and accepted as a valid encounter to NC Medicaid. Our approach to the review included:

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

Review of Cardinal's ISCA response

The review of Cardinal's ISCA response was focused on section V. Encounter Data Submission.

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

The 837 files are transmitted securely to CSRA and parsed using an EDI validator to check for errors and produce a 999 response to confirm receipt and any compliance errors. The behavioral health encounter claims are then validated by applying a list of edits provided by the state (See Appendix 1) and adjudicated accordingly by MMIS. Utilizing existing Medicaid pricing methodology, using the billing or rendering provider accordingly, the appropriate Medicaid allowed amount is calculated for each encounter claim in order to shadow price what was paid by the MCO.

The LME/MCO is required to resubmit encounters for claims that may be rejected due to compliance errors or NC Medicaid edits marked as "DENY" in Appendix 1.

Looking at claims with dates of service in 2017, Cardinal submitted 1,921,945 unique encounters to the state. To date, 14% of all encounters submitted have not been corrected and accepted by NC Medicaid.

2017	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	104,459	99,646	2,547	2,266	2%
Professional	1,817,486	1,515,997	27,149	274,340	15%
Total	1,921,945	1,615,643	29,696	276,606	14%

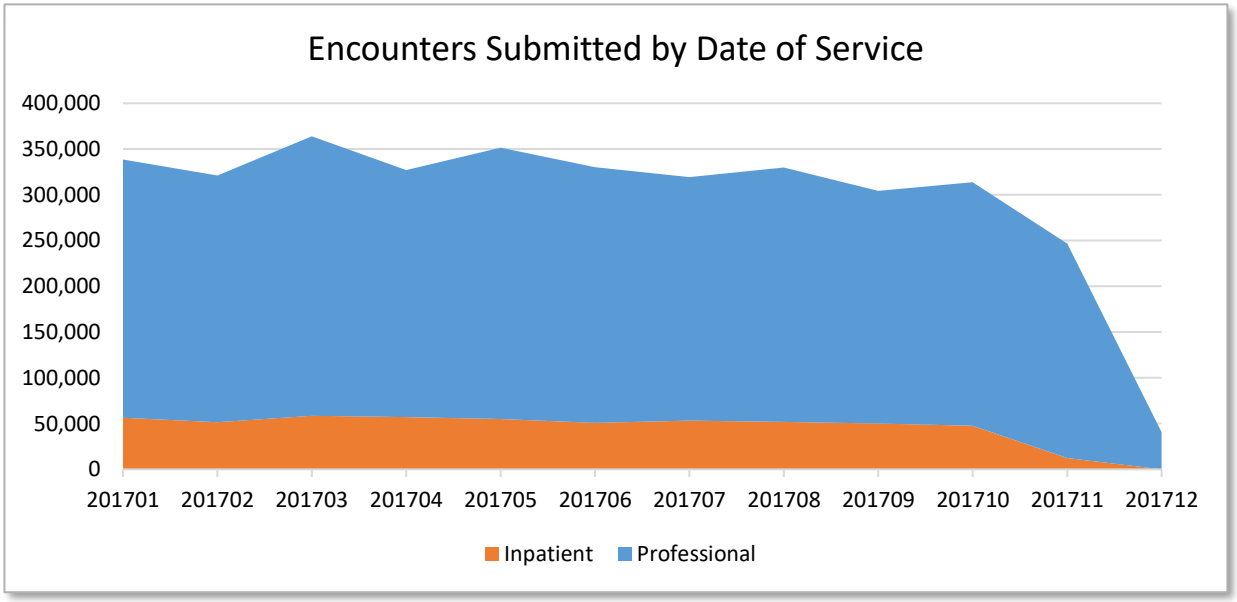
Compared to claims submitted in 2016, Cardinal has decreased the number of initial denials and total number of outstanding denials for claims submitted in 2017. Looking at denials month over month, Cardinal showed significant improvements in the number of claims initially accepted starting in November of 2017.

According to Cardinal's response and review of NC Medicaid's acceptance report, 69% of all outstanding and ongoing denials are still related to invalid taxonomy codes for the billing and rendering provider or invalid combination of procedure code and taxonomy. Taxonomy errors are the main denials for all of the MCOs, although Cardinal is experiencing more denials for invalid taxonomy than the other PIHPs. As noted above, the denials improved in the latter part of the year. Cardinal's strategy to continue to reduce, correct and resubmit encounter denials includes the following steps:

- Provider education guidelines
- Rebilling corrected encounter denials
- Rewriting 837 to update formatting issues
- Adding additional edits to ensure providers are submitting valid taxonomy codes

Analysis of Encounters

The analysis of encounter data evaluated whether Cardinal submitted complete, accurate, and valid data to NC Medicaid for all claims paid between January 1, 2017 through December 31, 2017. Cardinal pulled all claims adjudicated and submitted to NC Medicaid during 2017 and sent to HMS via SFTP. This included more than 3.45 million Professional claims and just over 621,000 Institutional claims. Data transmitted included voids and resubmissions for previously denied claims, so the numbers do not reconcile back to the metrics reported in the ISCA response.



In order to evaluate the data, HMS ingested the 837I and 837P data extracts, and loaded them to a consolidated database. After data onboarding was completed, HMS applied proprietary, internally designed data analysis logic within SAS to review each data element, focusing on the data elements defined as required. Our logic evaluates the presence of data in each field within a record as well as whether the value for the field is within accepted standards. Results of these checks were compared with general expectations for each data field and to the CMS standards adopted for encounter data. The table below depicts the specific data expectations and validity criteria applied.

Data Quality Standards for Evaluation of Submitted Encounter Data Fields Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
Recipient ID	Should be valid ID as found in the State's eligibility file. Can use State's ID unless State also accepts Social Security Number.	100% valid
Recipient Name	Should be captured in such a way that makes separating pieces of name easy. Expect data to be present and of good quality	85% present. Lengths should vary, but there should be at least some last names of >8 digits and some first names of < 8 digits, validating that fields have not been truncated. Also, a high percentage of names should have at least a middle initial.

Data Quality Standards for Evaluation of Submitted Encounter Data Fields
Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
Recipient Date of Birth	Should not be missing and should be a valid date.	< 2% missing or invalid
MCO/PIHP ID	Critical Data Element	100% valid
Provider ID	Should be an enrolled provider listed in the provider enrollment file.	95% valid
Attending Provider ID	Should be an enrolled provider listed in the provider enrollment file (will accept the MD license number if it is listed in the provider enrollment file).	> 85% match with provider file using either provider ID or MD license number
Provider Location	Minimal requirement is county code, but zip code is strongly advised.	> 95% with valid county code > 95% with valid zip code (if available)
Place of Service	Should be routinely coded, especially for physicians.	> 95% valid for physicians > 80% valid across all providers
Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% nonmissing and valid on physician or other applicable provider type claims (e.g., other practitioners)
Principal Diagnosis	Well-coded except by ancillary type providers.	> 90% non-missing and valid codes (using International Statistical Classifications of Diseases, Ninth Revision, Clinical Modification [ICD-10-CM] lookup tables) for practitioner providers (not including transportation, lab, and other ancillary providers)
Other Diagnosis	This is not expected to be coded on all claims even with applicable	90% valid when present

Data Quality Standards for Evaluation of Submitted Encounter Data Fields
Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
	provider types, but should be coded with a high frequency.	
Dates of Service	Dates should be evenly distributed across time.	If looking at a full year of data, 5%–7% of the records should be distributed across each month.
Unit of Service (Quantity)	The number should be routinely coded.	98% nonzero <70% should have one if Current Procedural Terminology (CPT) code is in 99200–99215 or 99241–99291 range.
Procedure Code	Critical Data Element	99% present (not zero, blank, or 8- or 9-filled). 100% should be valid, State-approved codes. There should be a wide range of procedures with the same frequency as previously encountered.
Procedure Code Modifier	Important to separate out surgical procedures/ anesthesia/assistant surgeon, not applicable for all procedure codes.	> 20% non-missing. Expect a variety of modifiers both numeric (CPT) and Alpha (Healthcare Common Procedure Coding System [HCPCS]).
Patient Discharge Status Code (Hospital)	Should be valid codes for inpatient claims, with the most common code being “Discharged to Home.” For outpatient claims, the code can be “not applicable.”	For inpatient claims, expect >90% “Discharged to Home.” Expect 1%–5% for all other values (except “not applicable” or “unknown”).
Revenue Code	If the facility uses a UB04 claim form, this should always be present	100% valid

Encounter Accuracy and Completeness

The table below outlines the key fields that were reviewed to determine if information was present, whether the information was the correct type and size, and whether or not the data populated was valid. Although we looked at the complete data set and validated all data values, the fields below are key to properly pricing for the services paid by Cardinal.

Table: Evaluation of Key Fields

Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	4,079,006	100.00%	4,079,006	100.00%	4,079,000	100.00%	4,079,000	100.00%
Recipient Name	4,079,006	100.00%	4,079,006	100.00%	4,079,006	100.00%	4,079,006	100.00%
Recipient Date of Birth	4,079,006	100.00%	4,079,006	100.00%	4,079,006	100.00%	4,079,006	100.00%
MCO/PIHP ID	4,079,006	100.00%	4,079,006	100.00%	4,079,006	100.00%	4,079,006	100.00%
Provider ID	4,078,175	99.98%	4,078,175	99.98%	4,078,175	99.98%	4,078,175	99.98%
Attending/Renderring Provider ID	926,543	22.71%	926,543	22.71%	926,543	22.71%	926,543	22.71%
Provider Location	4,079,006	100.00%	4,079,006	100.00%	4,079,006	100.00%	4,079,006	100.00%
Place of Service	4,067,728	99.72%	4,067,728	99.72%	4,067,728	99.72%	4,067,728	99.72%
Specialty Code / Taxonomy - Billing	4,079,006	100.00%	4,078,657	99.99%	4,078,657	99.99%	4,078,657	99.99%
Specialty Code / Taxonomy - Rendering / Attending	1,513,709	37.11%	1,513,709	37.11%	1,513,709	37.11%	1,513,709	37.11%
Principal Diagnosis	4,079,006	100.00%	4,079,006	100.00%	4,079,006	100.00%	4,079,006	100.00%
Other Diagnosis	727,247	17.83%	727,247	17.83%	727,247	17.83%	727,247	17.83%
Dates of Service	4,079,006	100.00%	4,079,006	100.00%	4,079,006	100.00%	4,079,006	100.00%
Unit of Service (Quantity)	4,079,006	100.00%	4,079,006	100.00%	4,079,006	100.00%	4,078,959	100.00%
Procedure Code	3,994,490	97.93%	3,994,487	97.93%	3,850,179	94.39%	3,850,179	94.39%
Procedure Code Modifier	1,105,052	27.09%	1,105,052	27.09%	1,105,052	27.09%	1,105,052	27.09%
Patient Discharge Status Code Inpatient	-	0.00%	-	0.00%	-	0.00%	-	0.00%
Revenue Code	621,747	100.00%	621,747	100.00%	621,747	100.00%	621,747	100.00%

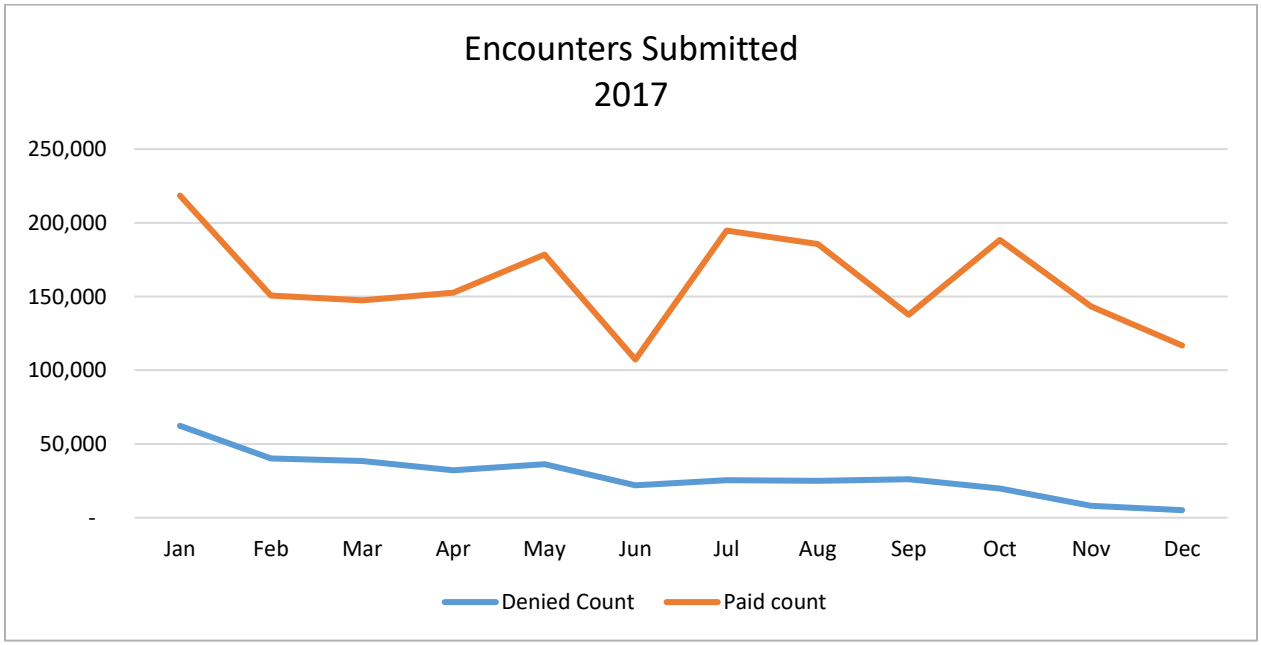
Cardinal has put effort into improving the accuracy of their encounter data; however, significant improvements in quality and accuracy were not apparent in the review of the 2017 claims data. Improvements were noted for claims submitted in the fourth quarter of 2017, but claims submitted prior to that contained a lot of the same inconsistencies that were noted in last year's EDV review.

Institutional claims contained complete and valid data in 14 of the 18 key fields (78%) with noted issues for procedure code, discharge codes, rendering provider, and taxonomy values. The procedure code was populated with revenue code values or null for 37% of the claims. Given the services provided and revenue codes submitted, the procedure code should have been more consistently populated with valid values. Taxonomy values were not populated consistently for the billing or rendering providers in the extract Cardinal provided and is a significant driver in NCTracks to adjudicate a claim properly. Rendering provider and patient discharge status were null for all records.

Professional encounter claims submitted contained complete and accurate data in 12 of the 15 key Professional fields (93%). Only 12% of the encounters had the secondary diagnosis code populated. The taxonomy code and rendering provider was not populated for over 73% of the Professional claims, similar to the Institutional data feed. Taxonomy codes are required.

Encounter Acceptance Report

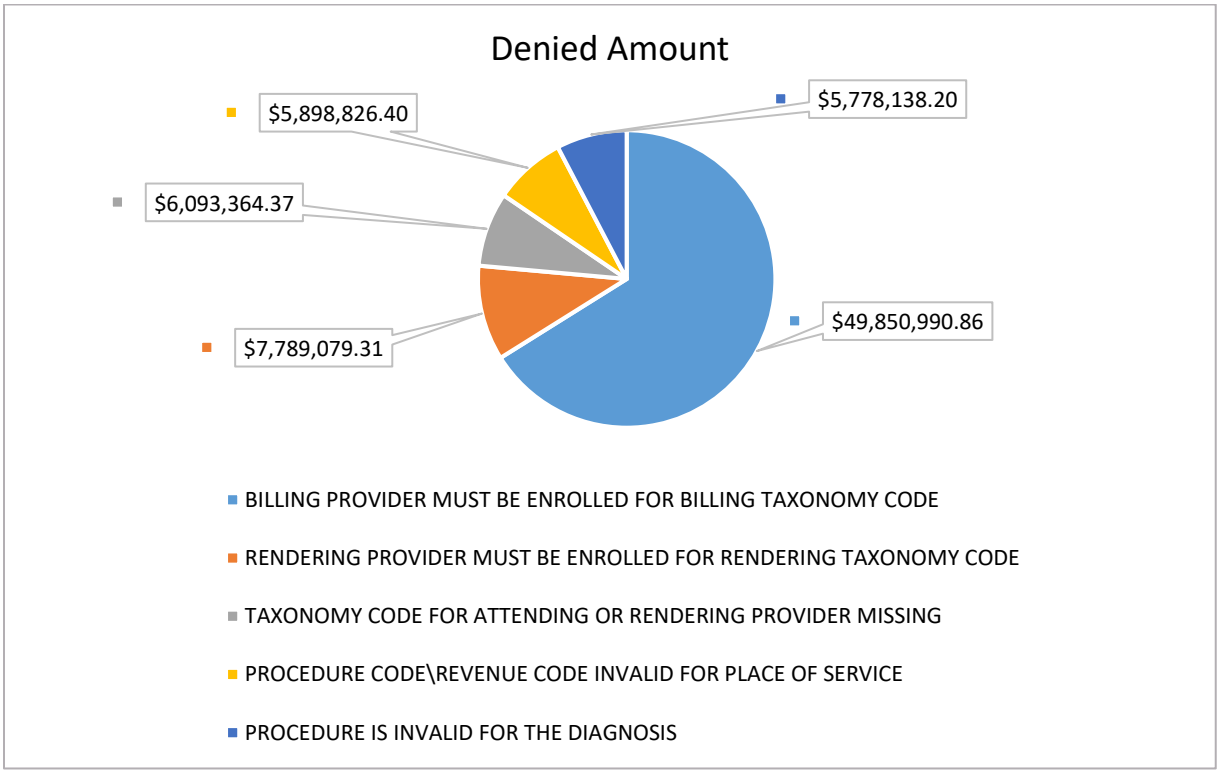
In addition to performing evaluation of the encounter data submitted, the HMS analyst reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each LME/MCO. The report is tracked by check write, which made it difficult to tie back to the ISCA response and the submitted encounter files since only the Date of Service for each is available. During the 2017 weekly check write schedule, Cardinal submitted 1,921,234 encounters to NC Medicaid. On average, 18% of all encounters submitted were initially denied. Approximately 14% of claims denied are still outstanding -- the rest have been reviewed, resubmitted, and accepted by NC Medicaid.

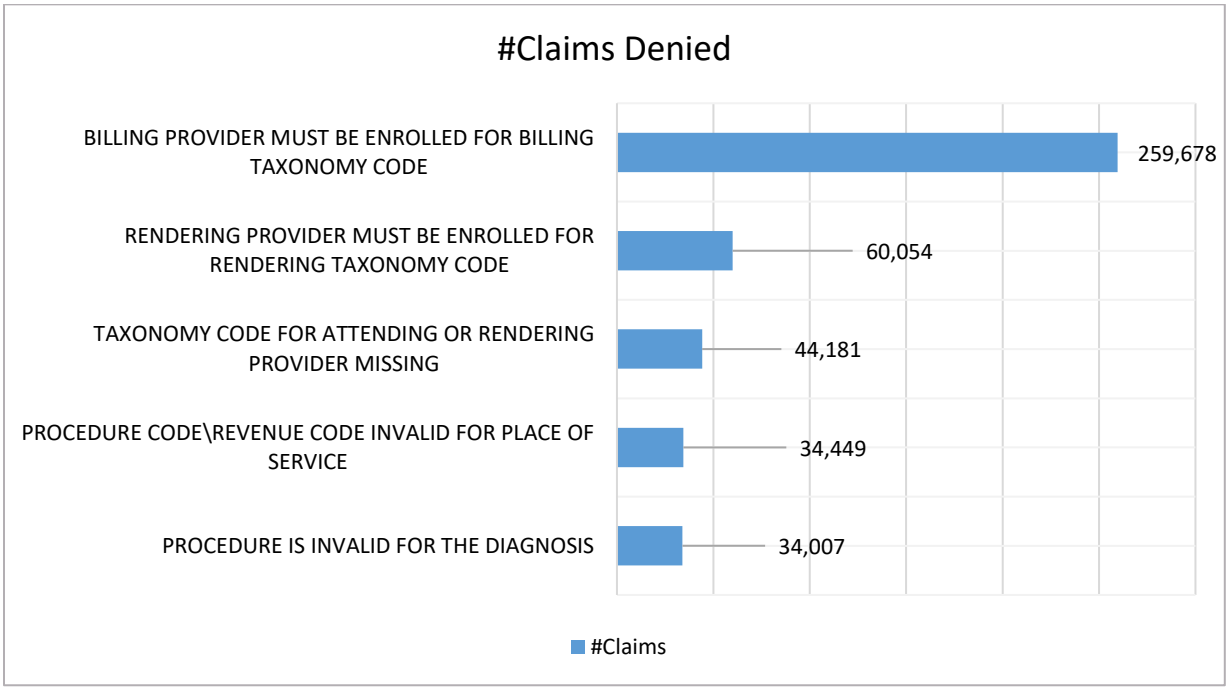


Evaluation of the top denials for Cardinal encounters correlates with the some of the data deficiencies identified by the HMS analyst in the Key Field analysis above. Encounters were denied primarily for:

- Billing provider must be enrolled for billing taxonomy code
- Rendering provider must be enrolled for rendering taxonomy code
- Taxonomy code for attending or rendering provider missing
- Procedure code / Revenue Code invalid for place of service
- Procedure is invalid for the diagnosis

The charts below reflect the top five denials by paid amount and the number of claims impacted by each denial reason.





Results and Recommendations

Issue: Procedure Code

The procedure code for Institutional claims should populated 99% of the time. In the encounter data provided, HMS found that the field was populated 37% of the time with invalid values. Screenshots provided by Cardinal reflected that the provider was submitting the revenue code for both the revenue code field and procedure code field. Valid procedure codes are required to adjudicate the claim appropriately and should be provided by the provider given the types of services being billed and supporting revenue codes provided.

Resolution:

Cardinal should ensure that the appropriate data validation checks are in place in their provider portal to prevent revenue codes being submitted in the procedure code fields. Claims submitted through the portal or an 837 should be denied by Cardinal without the proper revenue code and procedure code combination. Cardinal should review their 837 encounter creation and encounter data extract process to ensure that an invalid procedure code is not transmitted to DHB, even when the data is invalid based on the provider claim submission.

Issue: Diagnosis Codes

The secondary diagnosis was populated less than 12% for Professional claims. This value is not required by Caridinal when adjudicating the claim, therefore, not a requirement of the provider when submitting via Provider Portal or 837.

Resolution:

Cardinal should work closely with their provider community and encourage them to submit all applicable diagnosis codes, behavioral and medical. This information is key for measuring member health, identifying areas of risk, and evaluating quality of care.

Issue: Patient Discharge Status not populated

Patient Discharge Status is not populated for any of the Institutional claims. This is a required field and should be captured more than 90% of the time for Inpatient claims. During the ISCA review, Cardinal revealed that this field is captured during claim submission.

Resolution:

Cardinal should update their process to ensure the provider is submitting discharge statuses for the appropriate inpatient services and capture and carry through the discharge status for claims to their data warehouse. This will enable Cardinal to report the value going forward in their encounters to DHB. The PIHP should review and update their 837 formatting process as well to insure the field is submitted to DHB moving forward.

Issue: Taxonomy code and Attending/Rendering providers

Rendering provider id and taxonomy values were not consistently populated. This information is key for passing the front end edits put in place by the State and to effectively price the claim. This impacts pricing since NCTracks is expecting the correct combination of NPI, taxonomy and procedure code. When values were populated, the taxonomy code did not always match up with the Taxonomy values enrolled in NCTracks for the Billing and/or Rendering Provider. These errors result in denials by DHB that must be corrected and resubmitted.

Resolution:

As outlined in their ISCA response, Cardinal has a process in place to review denials and correctly resubmit encounters to the State that were denied due to invalid or missing taxonomy. Cardinal should continue to follow their current process as well as monitor the front end edits that were implemented in 2017 and 2018 to prevent these errors at the point of claim submission to ensure they are working as intended. The encounter data reviewed and NC Medicaid check write report reflects significant improvement over the last few months of 2017, so we know the process in place is making a positive impact.

Conclusion

Based on the analysis of Cardinal's encounter data, we have concluded that the data submitted to NC Medicaid is not complete and accurate. Minor issues were noted with both Institutional and Professional encounters. Cardinal should take corrective action to resolve the issues identified with procedure code and diagnosis codes, as well as continue work on improving taxonomy denials.

For the next review period, HMS is recommending that the encounter data from NCTracks be reviewed to look at encounters that pass front-end edits and are adjudicated to either a paid or denied status. It is difficult to reconcile the various tracking reports with the data submitted by the LME/MCO. Reviewing an extract from NCTracks would provide insight into how the State's MMIS is handling the encounter claims and could be reconciled back to reports requested from Cardinal. The goal is to ensure that Cardinal is reporting all paid claims as encounters to NC Medicaid.

Appendix 1

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
00001	HDR BEG DOS INVLD/ > TCN DATE	DENY
00002	ADMISSION DATE INVALID	DENY
00003	HDR END DOS INVLD/ > TCN DATE	DENY
00006	DISCHARGE DATE INVALID	PAY AND REPORT
00007	TOT DAYS CLM GTR THAN BILL PER	PAY AND REPORT
00023	SICK VISIT BILLED ON HC CLAIM	IGNORE
00030	ADMIT SRC CD INVALID	PAY AND REPORT
00031	VALUE CODE/AMT MISS OR INVLD	PAY AND REPORT
00036	HEALTH CHECK IMMUNIZATION EDIT	IGNORE
00038	MULTI DOS ON HEALTH CHECK CLM	IGNORE
00040	TO DOS INVALID	DENY
00041	INVALID FIRST TREATMENT DATE	IGNORE
00044	REQ DIAG FOR VITROCERT	IGNORE
00051	PATIENT STATUS CODE INVALID	PAY AND REPORT
00055	TOTAL BILLED INVALID	PAY AND REPORT
00062	REVIEW LAB PATHOLOGY	IGNORE
00073	PROC CODE/MOD END-DTE ON FILE	PAY AND REPORT
00076	OCC DTE INVLD FOR SUB OCC CODE	PAY AND REPORT
00097	INCARCERATED - INPAT SVCS ONLY	DENY
00100	LINE FDOS/HDR FDOS INVALID	DENY
00101	LN TDOS BEFORE FDOS	IGNORE
00105	INVLD TOOTH SURF ON RSTR PROC	IGNORE
00106	UNABLE TO DETERMINE MEDICARE	PAY AND REPORT

00117	ONLY ONE DOS ALLOWED/LINE	PAY AND REPORT
00126	TOOTH SURFACE MISSING/INVALID	IGNORE
00127	QUAD CODE MISSING/INVALID	IGNORE
00128	PROC CDE DOESNT MATCH TOOTH #	IGNORE
00132	HCPCS CODE REQ FOR REV CODE	IGNORE
00133	HCPCS CODE REQ BILLING RC 0636	IGNORE
00135	INVL POS INDEP MENT HLTH PROV	PAY AND REPORT
00136	INVLD POS FOR IDTF PROV	PAY AND REPORT
00140	BILL TYPE/ADMIT DATE/FDOS	DENY
00141	MEDICAID DAYS CONFLICT	IGNORE
00142	UNITS NOT EQUAL TO DOS	PAY AND REPORT
00143	REVIEW FOR MEDICAL NECESSITY	IGNORE
00144	FDOS AND TDOS MUST BE THE SAME	IGNORE
00146	PROC INVLD - BILL PROV TAXON	PAY AND REPORT
00148	PROC\REV CODE INVLD FOR POS	PAY AND REPORT
00149	PROC\REV CD INVLD FOR AGE	IGNORE
00150	PROC CODE INVLD FOR RECIP SEX	IGNORE
00151	PROC CD/RATE INVALID FOR DOS	PAY AND REPORT
00152	M/I ACC/ANC PROC CD	PAY AND REPORT
00153	PROC INVLD FOR DIAG	PAY AND REPORT
00154	REIMB RATE NOT ON FILE	PAY AND REPORT
00157	VIS FLD EXAM REQ MED JUST	IGNORE
00158	CPT LAB CODE REQ FOR REV CD	IGNORE
00164	IMMUNIZATION REVIEW	IGNORE
00166	INVALID VISUAL PROC CODE	IGNORE

00174	VACCINE FOR AGE 00-18	IGNORE
00175	CPT CODE REQUIRED FOR RC 0391	IGNORE
00176	MULT LINES SAME PROC, SAME TCN	IGNORE
00177	HCPCS CODE REQ W/ RC 0250	IGNORE
00179	MULT LINES SAME PROC, SAME TCN	IGNORE
00180	INVALID DIAGNOSIS FOR LAB CODE	IGNORE
00184	REV CODE NOT ALLOW OUTPAT CLM	IGNORE
00190	DIAGNOSIS NOT VALID	DENY
00192	DIAG INVALID RECIP AGE	IGNORE
00194	DIAG INVLD FOR RECIP SEX	IGNORE
00202	HEALTH CHECK SHADOW BILLING	IGNORE
00205	SPECIAL ANESTHESIA SERVICE	IGNORE
00217	ADMISSION TYPE CODE INVALID	PAY AND REPORT
00250	RECIP NOT ON ELIG DATABASE	DENY
00252	RECIPIENT NAME/NUMBER MISMATCH	PAY AND REPORT
00253	RECIP DECEASED BEFORE HDR TDOS	DENY
00254	PART ELIG FOR HEADER DOS	PAY AND REPORT
00259	TPL SUSPECT	PAY AND REPORT
00260	M/I RECIPIENT ID NUMBER	DENY
00261	RECIP DECEASED BEFORE TDOS	DENY
00262	RECIP NOT ELIG ON DOS	DENY
00263	PART ELIG FOR LINE DOS	PAY AND REPORT
00267	DOS PRIOR TO RECIP BIRTH	DENY
00295	ENC PRV NOT ENRL TAX	IGNORE
00296	ENC PRV INV FOR DOS	IGNORE

00297	ENC PRV NOT ON FILE	IGNORE
00298	RECIP NOT ENRL W/ THIS ENC PRV	IGNORE
00299	ENCOUNTER HMO ENROLLMENT CHECK	PAY AND REPORT
00300	BILL PROV INVALID/ NOT ON FILE	DENY
00301	ATTEND PROV M/I	PAY AND REPORT
00308	BILLING PROV INVALID FOR DOS	DENY
00313	M/I TYPE BILL	PAY AND REPORT
00320	VENT CARE NO PAY TO PRV TAXON	IGNORE
00322	REND PROV NUM CHECK	IGNORE
00326	REND PROV NUM CHECK	PAY AND REPORT
00328	PEND PER NC MEDICAID REQ FOR FIN REV	IGNORE
00334	ENCOUNTER TAXON M/I	PAY AND REPORT
00335	ENCOUNTER PROV NUM MISSING	DENY
00337	ENC PROC CODE NOT ON FILE	PAY AND REPORT
00339	PRCNG REC NOT FND FOR ENC CLM	PAY AND REPORT
00349	SERV DENIED FOR BEHAV HLTH LM	IGNORE
00353	NO FEE ON FILE	PAY AND REPORT
00355	MANUAL PRICING REQUIRED	PAY AND REPORT
00358	FACTOR CD IND PROC NON-CVRD	PAY AND REPORT
00359	PROV CHRGS ON PER DIEM	PAY AND REPORT
00361	NO CHARGES BILLED	DENY
00365	DRG - DIAG CANT BE PRIN DIAG	DENY
00366	DRG - DOES NOT MEET MCE CRIT.	PAY AND REPORT
00370	DRG - ILLOGICAL PRIN DIAG	PAY AND REPORT
00371	DRG - INVLD ICD-9-CM PRIN DIAG	DENY

00374	DRG PAY ON FIRST ACCOM LINE	DENY
00375	DRG CODE NOT ON PRICING FILE	PAY AND REPORT
00378	DRG RCC CODE NOT ON FILE DOS	PAY AND REPORT
00439	PROC\REV CD INVLD FOR AGE	IGNORE
00441	PROC INVLD FOR DIAG	IGNORE
00442	PROC INVLD FOR DIAG	IGNORE
00613	PRIM DIAG MISSING	DENY
00628	BILLING PROV ID REQUIRED	IGNORE
00686	ADJ/VOID REPLC TCN INVALID	DENY
00689	UNDEFINED CLAIM TYPE	IGNORE
00701	MISSING BILL PROV TAXON CODE	DENY
00800	PROC CODE/TAXON REQ PSYCH DX	PAY AND REPORT
00810	PRICING DTE INVALID	IGNORE
00811	PRICING CODE MOD REC M/I	IGNORE
00812	PRICING FACTOR CODE SEG M/I	IGNORE
00813	PRICING MOD PROC CODE DTE M/I	IGNORE
00814	SEC FACT CDE X & % SEG DTE M/I	IGNORE
00815	SEC FCT CDE Y PSTOP SEG DT M/I	IGNORE
01005	ANTHES PROC REQ ANTHES MODS	IGNORE
01060	ADMISSION HOUR INVALID	IGNORE
01061	ONLY ONE DOS PER CLAIM	IGNORE
01102	PRV TAXON CHCK - RAD PROF SRV	IGNORE
01200	INPAT CLM BILL ACCOM REV CDE	DENY
01201	MCE - ADMIT DTE = DISCH DTE	DENY
01202	M/I ADMIT AND DISCH HRS	DENY

01205	MCE: PAT STAT INVLD FOR TOB	DENY
01207	MCE - INVALID AGE	PAY AND REPORT
01208	MCE - INVALID SEX	PAY AND REPORT
01209	MCE - INVALID PATIENT STATUS	DENY
01705	PA REQD FOR CAPCH/DA/CO RECIP	PAY AND REPORT
01792	DME SUPPLIES INCLD IN PR DIEM	DENY
02101	INVALID MODIFIER COMB	IGNORE
02102	INVALID MODIFIERS	PAY AND REPORT
02104	TAXON NOT ALLOWED WITH MOD	PAY AND REPORT
02105	POST-OP DATES M/I WITH MOD 55	IGNORE
02106	LN W/ MOD 55 MST BE SAME DOS	IGNORE
02107	XOVER CLAIM FOR CAP PROVIDER	IGNORE
02111	MODIFIER CC INTERNAL USE ONLY	IGNORE
02143	CIRCUMCISION REQ MED RECS	IGNORE
03001	REV/HCPCS CD M/I COMBO	IGNORE
03010	M/I MOD FOR PROF XOVER	IGNORE
03012	HOME HLTH RECIP NOT ELG MCARE	IGNORE
03100	CARDIO CODE REQ LC LD LM RC RI	IGNORE
03101	MODIFIER Q7, Q8 OR Q9 REQ	IGNORE
03200	MCE - INVALID ICD-9 CM PROC	DENY
03201	MCE INVLD FOR SEX PRIN PROC	PAY AND REPORT
03224	MCE-PROC INCONSISTENT WITH LOS	PAY AND REPORT
03405	HIST CLM CANNOT BE ADJ/VOIDED	DENY
03406	HIST REC NOT FND FOR ADJ/VOID	DENY
03407	ADJ/VOID - PRV NOT ON HIST REC	DENY

04200	MCE - ADMITTING DIAG MISSING	DENY
04201	MCE - PRIN DIAG CODE MISSING	DENY
04202	MCE DIAG CD - ADMIT DIAG	DENY
04203	MCE DIAG CODE INVLD RECIP SEX	PAY AND REPORT
04206	MCE MANIFEST CODE AS PRIN DIAG	DENY
04207	MCE E-CODE AS PRIN DIAG	DENY
04208	MCE - UNACCEPTABLE PRIN DIAG	DENY
04209	MCE - PRIN DIAG REQ SEC DIAG	PAY AND REPORT
04210	MCE - DUPE OF PRIN DIAG	DENY
04506	PROC INVLD FOR DIAG	IGNORE
04507	PROC INVLD FOR DIAG	IGNORE
04508	PROC INVLD FOR DIAG	IGNORE
04509	PROC INVLD FOR DIAG	IGNORE
04510	PROC INVLD FOR DIAG	IGNORE
04511	PROC INVLD FOR DIAG	IGNORE
07001	TAXON FOR ATTND/REND PROV M/I	DENY
07011	INVLD BILLING PROV TAXON CODE	DENY
07012	INVLD REND PROV TAXONOMY CODE	DENY
07013	INVLD ATTEND PROV TAXON CODE	PAY AND REPORT
07100	ANESTH MUST BILL BY APPR PROV	IGNORE
07101	ASC MODIFIER REQUIREMENTS	IGNORE
13320	DUP-SAME PROV/AMT/DOS/PX	DENY
13420	SUSPECT DUPLICATE-OVERLAP DOS	PAY AND REPORT
13460	POSSIBLE DUP-SAME PROV/PX/DOS	PAY AND REPORT
13470	LESS SEV DUPLICATE OUTPATIENT	PAY AND REPORT

13480	POSSIBLE DUP SAME PROV/OVRLAP	PAY AND REPORT
13490	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13500	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13510	POSSIBLE DUP/SME PRV/OVRLP DOS	PAY AND REPORT
13580	DUPLICATE SAME PROV/AMT/DOS	PAY AND REPORT
13590	DUPLICATE-SAME PROV/AMT/DOS	PAY AND REPORT
25980	EXACT DUPE. SAME DOS/ADMT/NDC	PAY AND REPORT
34420	EXACT DUP SAME DOS/PX/MOD/AMT	PAY AND REPORT
34460	SEV DUP-SAME PX/PRV/IM/DOS/MOD	DENY
34490	DUP-PX/IM/DOS/MOD/$$/PRV/TCN	PAY AND REPORT
34550	SEV DUP-SAME PX/IM/MOD/DOS/TCN	PAY AND REPORT
39360	SUSPECT DUPLICATE-OVERLAP DOS	PAY AND REPORT
39380	EXACT/LESS SEVERE DUPLICATE	PAY AND REPORT
49450	PROCDURE CODE UNIT LIMIT	PAY AND REPORT
53800	Dupe service or procedure	PAY AND REPORT
53810	Dupe service or procedure	PAY AND REPORT
53820	Dupe service or procedure	PAY AND REPORT
53830	Dupe service or procedure	PAY AND REPORT
53840	Limit of one unit per day	PAY AND REPORT
53850	Limit of one unit per day	PAY AND REPORT
53860	Limit of one unit per month	PAY AND REPORT
53870	Limit of one unit per day	PAY AND REPORT
53880	Limit of 24 units per day	DENY
53890	Limit of 96 units per day	DENY
53900	Limit of 96 units per day	DENY