CCME

2019 External Quality Review

CARDINAL INNOVATIONS HEALTHCARE

Submitted: February 28, 2020

Prepared on behalf of the
North Carolina Department of
Health and Human Services,
North Carolina Medicaid

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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*. 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 2019 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of North Carolina Medicaid (NC Medicaid).

Goals of the review are to:

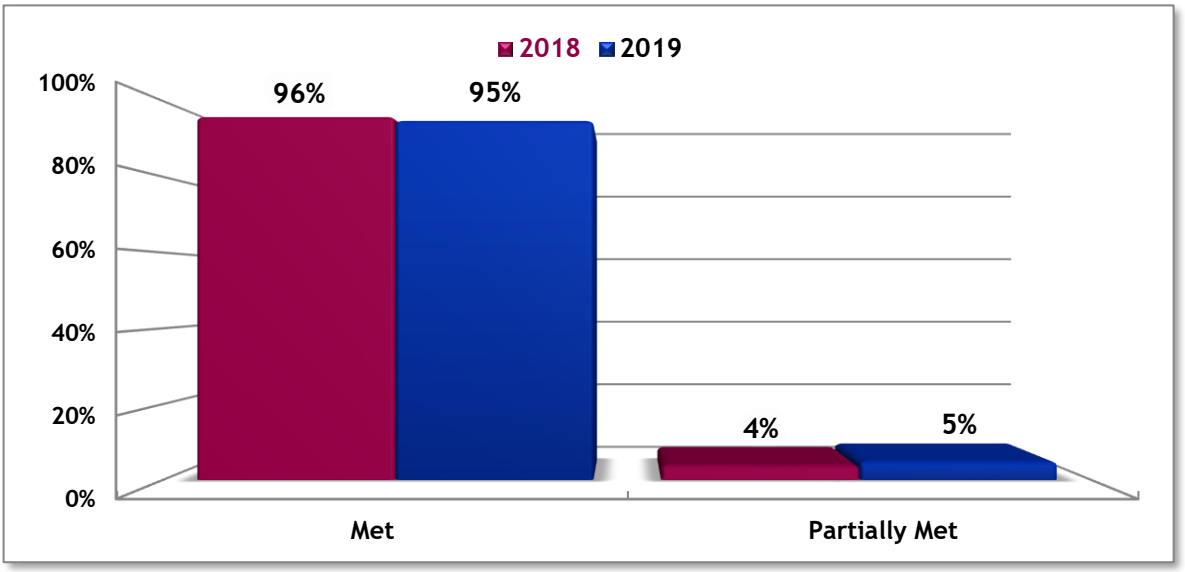
- Determine if Cardinal complies with service delivery as mandated by their *NC Medicaid Contract*
- Provide feedback for potential areas of further improvement
- Verify the delivery and determine the quality of contracted health care services

The process used for the EQR was based on the Centers for Medicare & 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, validation of performance measures, validation of encounter data, an Information System Capabilities Assessment (ISCA) Audit, and Medicaid program integrity review of the PIHP.

A. Overall Findings

The 2019 Annual EQR reflects that Cardinal achieved a “Met” score for 95% of the standards reviewed. As Figure 1 indicates, 5% of the standards were scored as “Partially Met.” None of the EQR standards were scored as “Not Met”. Figure 1 provides a comparison of Cardinal’s 2018 review results to 2019 results.

Figure 1: Annual EQR Review Comparative Findings



B. Overall Recommendations

Recommendations addressing each of the review findings are addressed in detail under each respectively labeled section of this report. The following global Recommendations were identified for improvement and should be implemented in conjunction with the detailed Recommendations in each section.

Administration

In the Administrative EQR, Cardinal met 90% of the standards. Issues noted were primarily related to the Information Systems Capabilities Assessment (ISCA).

There were no significant concerns noted in the EQR of Cardinal's policies and procedures, organizational staffing, or confidentiality practices. During the Onsite discussion, the departmental involvement of the Chief Medical Officer (CMO) and designated medical staff was explained. It was noted that Cardinal's Organizational Chart did not demonstrate any departmental oversight by the CMO and medical staff. This was a recommendation in last year's EQR. CCME again recommends Cardinal revise their Organizational Chart to clearly delineate the role of each of the medical staff with specific departments such as Credentialing, Utilization Management, Quality Assurance, Network, etc. This will demonstrate the "substantial involvement" of the CMO and designated medical staff required in *NC Medicaid Contract, Section 7.1.3*.

Cardinal's CIE claim system and encounter data submission process is able to process up to 12 ICD-10 Diagnosis codes for Professional claims and up to 22 ICD-10 Diagnosis codes for Institutional claims. Cardinal should update their Provider Portal and CIE system to allow the receipt of the maximum number of ICD-10 Diagnosis codes captured on 837

files. Cardinal updated the CIE claim system and provider web portal to allow for ICD-10 Procedure codes to be submitted and be stored in their claims processing and reporting system. In addition, they updated their submission process to NCTracks in order to submit ICD-10 procedure and Diagnosis Related Group (DRG) codes. Cardinal has consistently surpassed the 95% submission acceptance rate during the review period.

Provider Services

The Provider Services External Quality Review (EQR) is comprised of Credentialing and Recredentialing, and Provider Services, which includes Network Adequacy, Provider Accessibility, Provider Education, Clinical Practice Guidelines for Behavioral Health Management, Continuity of Care, and Practitioner Medical Records.

In the current EQR, Cardinal met 91% of the Provider Services standards. The "Partially Met" standards for this review are in the areas of Credentialing and Recredentialing and are related to Cardinal's process of approving credentialing or recredentialing before some required items are received. Specific issues, including Corrective Actions and Recommendations, are outlined in Attachment 4 of this report.

Enrollee Services

In the Enrollee Services EQR, Cardinal met 100% of the standards. This section includes enrollee rights/responsibilities, enrollee program education, and the call center. There were no Corrective Actions or Recommendations for the last EQR.

Member rights are addressed in policies and procedures, the *Member & Family Handbook*, in the Provider Manual, and on the Cardinal website. Cardinal sends all new members a notice advising where to find updated written materials within fourteen (14) days of enrollment, as well as an annual update. All contract required information was included in written materials. Enrollees are notified per contract time fames when their provider terminates from the network. Members have various training opportunities throughout the catchment area, including web-based. The call center's processes and statistics are in-line with contract requirements. There are no Corrective Actions or Recommendations for this EQR.

Quality Improvement

The EQR of the Quality Improvement (QI) section includes analysis of the quality program, QI committee minutes, provider participation in QI activities, the QI work plan, the annual evaluation of the QI work plan, Performance Improvement Projects, Performance Measures, and over/under utilized services. In this section, Cardinal met 94% of the standards.

There was one Corrective Action successfully implemented from the last EQR involving updates to the annual QI Work Plan evaluation. There were two recommendations from

the last EQR. One Recommendation was implemented and maintained in this EQR. One was not implemented and remains a Recommendation for this year's EQR. This Recommendation addresses the need for target time frames within the QI work plan.

There is one Corrective Action identified for this year's EQR. Cardinal needs to develop a Quality Improvement Activity to measure and improve lower scoring items identified in the Adult and Child Experience of Care and Health Outcomes (ECHO®) surveys.

Utilization Management

The EQR of Utilization Management (UM) includes review of UM, Care Coordination, and Transition to Community Living (TCLI) programs. Cardinal met 98% of the UM standards in this year's EQR. One Corrective Action and three Recommendations were issued in an effort to improve consistency within all three departments.

In the review of the treatment authorization files, 24% of the denied files reviewed did not contain the full signature and credentials of the Care Managers. This was a Corrective Action from last year's EQR. While some improvement was noted, CCME is recommending that Cardinal ensure full signatures and credentials are consistently documented within the TAR record and viewable in the electronic and paper formats. CCME also recommends Cardinal closely monitor the practice of extending the treatment authorization decision timeframe to prevent undue burden on providers and enrollees.

As a result of the file review for the Care Coordination Department, which included a file review of the TCLI Department, CCME is requiring Cardinal to enhance the current monitoring process. CCME is advocating that the monitoring of Care Coordination and TCLI files should be data-driven and focused on the timeliness of activities (e.g., enrollees discharging from Care Coordination, Home and Community Based Services monitoring, follow up activities), as well as the completeness, quality and timeliness of documentation of activities.

Grievances and Appeals

In the EQR of Cardinal's grievance and appeal functions, 90% of the standards were scored as "Met". All of the standards within the grievance section were scored as "Met" and two appeals standards were scored as "Partially Met."

Overall, the EQR of Cardinal's grievance functions resulted in four Recommendations. One Recommendations was aimed at adding information about the right of a Grievant to request an extension to the grievance resolution timeframe. The second Recommendation is that the *Provider Manual* and the *Member & Family Handbook* did not include details regarding the member's ability to request and extension. The third Recommendation is to enhance the monitoring process to ensure consultations with subject matter experts (e.g., medical, legal, and HR staff) are occurring and are captured within the grievance file. The fourth Recommendation is to monitor the

grievance resolution time frames and to use the extension process when the time frame exceeds 30 days. All of the grievance standards were scored as "Met" for this year's EQR.

This year's EQR of Cardinal's appeals showed that Cardinal addressed the majority of the Corrective Actions and Recommendations from last year's EQR. These Corrective Actions and Recommendations targeted missing or incorrect appeals information within Cardinal's primary appeal policy and procedure, the *Provider Manual*, Cardinal's website and the *Member & Family Handbook*. One minor correction is still needed within the *Member & Family Handbook* related to the timeframe to request an appeal.

The 2019 EQR of Cardinal's appeal functions resulted in three Corrective Actions and three Recommendations. These Corrective Actions and Recommendations are aimed at improving Cardinal's processes of determining invalid appeals, providing appeal notifications, and releasing the appeal record to enrollees or their representative.

Delegation

Cardinal met 100% of the Delegation standards for this year's EQR. Cardinal has fully executed Delegation Agreements with five delegated entities and has a Business Associates Agreement with the one delegate (BHM) for which it is needed. Cardinal conducted annual monitoring with all delegates.

At the last EQR, there were no Corrective Actions and one Recommendation. During the current EQR review period, Cardinal addressed the Recommendation.

Program Integrity

In the Program Integrity (PI) EQR, Cardinal met 98% of the standards. One standard was scored as "Partially Met."

Cardinal PI policies and procedures sufficiently address contractual requirements and case files were fully compliant. Cardinal has made good progress in utilizing data mining to identify potential case of fraud. In keeping with companywide initiatives in Quality Improvement, the PI function has implemented process improvements to more quickly identify cases for referral and render decisions on referrals. As a result, Cardinal has increased its level of referrals to NC Medicaid and reduced average length of investigations.

There were no Corrective Actions from the previous EQR. There was one Recommendation from the previous year's EQR. It was recommended that Cardinal add language to Policy & Procedure 1945, Employee Code of Conduct and the Work Environment that explicitly includes the False Claims Act in the list of protected whistleblower reporting. The current review found this Recommendation was fully implemented.

Only one area of concern was noted in this year's EQR. In Cardinal's PI Investigation Process Workflow there is no distinction between the process for investigating fraud and the process for investigating waste and abuse. This is a *NC Medicaid Contract* requirement and so a Corrective Action was issued to bring Cardinal into compliance.

Financial Services

This section includes a review of financial services, including financial statements, audit report, Medicaid monthly reports, and policies and procedures. Cardinal had one Recommendation from the prior EQR review regarding the length of record retention (10 years) for Medicaid records and the need for this to be documented in a policy and procedure. Policy & Procedure 2150 was revised by Cardinal to capture this retention timeframe.

In this year's EQR, Cardinal met 100% of the Financial Services standards. CCME recommends Cardinal increase its cash balance in order to increase its days of service expense in cash calculation. CCME also recommends further documentation of Cardinal's medical loss ratio process in Policy & Procedure 2212.

Encounter Data Validation

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

The two issues identified in the Encounter Data Validation process were only apparent in the Institutional claims submitted and are minimal, considering the volume of claims and the method for adjudication (Revenue code versus Procedure code). Cardinal should take corrective action to ensure they are capturing and reporting valid Procedure codes for Institutional claims when required for the reported Revenue code, and only submitting the expected 10-byte alphanumeric Recipient ID.

METHODOLOGY

The process used for the EQR was based on the CMS protocols for EQR 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 optional activity in the area of Encounter Data Validation, conducted by CCME's subcontractor, HMS. Additionally, as required by CCME's contract with NC Medicaid, a system capabilities audit and Medicaid program integrity (PI) review of the PIHP was conducted by CCME's subcontractor, IPRO.

On November 18, 2019 CCME sent notification to Cardinal that the annual EQR was being initiated (see *Attachment 1*). This notification included:

- Materials Requested for Desk Review
- Information Systems Capabilities Assessment (ISCA) Survey
- Draft Onsite Agenda
- PIHP EQR Standards

Further, an invitation was extended to the PIHP 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 requested by CCME.

The review consisted of two segments. The first was a Desk Review of materials and documents received from Cardinal on December 11, 2019 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 29, 2020 and January 30, 2020, 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 findings of the EQR are summarized in the following pages of this report and are based on the regulations set forth in *42 CFR § 438.358* and the *NC Medicaid Contract* requirements between Cardinal and NC DHHS' NC Medicaid. Strengths, weaknesses, corrective action items, and recommendations are identified where applicable. Areas of review were 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 Cardinal's policies, procedures, staffing, compliance, confidentiality, information systems, encounter data capture and reporting.

Policies & Procedures

For this years' review, 233 policies and procedures were submitted. Review of these policies showed that Cardinal has an active revision process and each policy and procedure is reviewed annually.

Policy & Procedure 1000, Policy and Procedure Development, adequately describes the process for creating, terminating, revising, and annually reviewing policies and procedures. It was recommended in last year's EQR that Cardinal add more detail describing the final policy and procedure approval process. Cardinal addressed this Recommendation and Policy & Procedure 1000 now explains the Office of General Counsel completes the final step of reviewing and publishing revised or new policies and procedures.

Organizational Staffing/ Management

The information submitted for this year's EQR did not clearly demonstrate oversight by the Chief Medical Officer (CMO) and designated medical staff. Review of committee meeting minutes showed membership by Medical Department staff was in flux in the past year. Also, the Organizational Chart did not contain information showing departmental or function oversight or correct credentials for the Chief Medical Officer. During the Onsite discussion, the departmental involvement of the Chief Medical Officer (CMO) and designated medical staff was described. The current CMO explained since assuming her CMO role in July 2019, she has thoroughly evaluated the current staffing of functions such as credentialing, Utilization Management oversight, etc. and is in the process of moving medical staff into specified roles. In last year's EQR, CCME recommended that Cardinal delineate on their Organizational Chart the departmental oversight of the CMO and medical staff. CCME again recommends Cardinal revise their Organizational Chart to clearly delineate the role of each of the medical staff to show oversight of specific

departments such as Credentialing, Utilization Management, Quality Assurance, Network, etc. This will demonstrate the "substantial involvement" of medical personnel required in *NC Medicaid Contract, Section 7.1.3*.

Confidentiality

Cardinal maintains policies and procedures that address their confidentiality practices. These policies and procedures sufficiently address *NC Medicaid Contract*, state and federal confidentiality requirements.

Cardinal continues to ensure new staff are trained on their HIPAA/confidentiality practices during new employee orientation and prior to their exposure to PHI.

Information Systems Capabilities Assessment (ISCA)

As specified in the CMS protocol, the EQR of Cardinal's system capabilities was conducted by using the Information Systems Capabilities Assessment (ISCA) and supporting documentation. Areas requiring clarification were addressed through interviews and a system walk through during the Onsite.

Enrollment Systems

Cardinal had experienced growth in enrollment from 2015 to 2016 with the acquisition of another Managed Care Organization. From 2016 to 2017 there was very little change year to year. The enrollment as of December 2018 decreased slightly from 2017. Table 1 provides a comparative of end of year enrollment totals.

Table 1: Enrollment Counts

2016	2017	2018
462,952	463,854	452,979

During the Onsite discussion, Cardinal provided a demonstration of the CI Enterprise (CIE) system. The system maintains a member's enrollment history. The enrollment import is an automated routine in which the Global Eligibility File (GEF) that is supplied by the NC Medicaid and is imported daily into the CIE system. The daily eligibility file is compared to existing eligibility in the CIE system to determine if the file is for a new member. New recipients are added to the CIE system with their accompanying eligibility information. For existing recipients, 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 is able to merge multiple member records and link the patient's

historical claims. Cardinal creates a daily report to address any line count discrepancies as well as any unmatched records. The Member Data Management Team utilizes the *Exceptions Report* weekly to correct any discrepancies.

Cardinal's provider web portal, Provider Direct, allows providers to confirm a member's eligibility and provide Cardinal with third party liability information.

On a monthly basis, 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 uses the quarterly GEF file provided by NC Medicaid 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 a review of its ISCA response and supporting documentation provided. A demonstration of Cardinal's Provider Direct claims entry portal and the CIE claims processing system was performed during the onsite review.

Table 2 shows the three sources of claims received by Cardinal and a breakdown of percentages of received claims for each of the sources.

Table 2: Claim Method Percentages

Source	HIPAA File	Paper	Provider Web Portal
Institutional	79%	0%	21 %
Professional	80%	0%	20%

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

The provider portal will allow a provider to submit a claim through manual entry or through an electronic file. Claims entered by direct entry into Cardinal's *Provider Directory* will not allow the claim to be submitted to Cardinal unless all fields are validated. 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. Any claim that is missing information will be pended and worked by a claims specialist.

Cardinal enters paper claims within five business days from receipt. If a claim is approved, payment will be made within 30 calendar days after receipt. Claims submitted through an electronic file are processed through a frontend editor OTVM (Optum Transaction Validation Manager). This system will not allow any files that are not validated to be processed and must be HIPAA compliant.

The Provider Direct web portal was updated to be able to capture receipt of ICD-10 Procedure codes. When providers use them, Diagnosis Related Groups (DRGs) are accepted by Cardinal when submitted by the provider and included on an 837I.

Cardinal indicated 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 captured by NCTracks. Cardinal indicated the standard Institutional claims form captures 22 Diagnosis codes and they submit all codes that are received to NCTracks. Cardinal does not have the capability to store all possible Diagnosis codes submitted on an 837I file.

Cardinal continues to audit at least 3% of all claims and high dollar claims. In addition, Cardinal performs focused audits based on high dollar or specific Diagnosis codes for example. Pre-payment audits are conducted weekly to review 100% of Emergency Department claims that are greater than $10,000.

Reporting

Cardinal's data repository is a Microsoft 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. Behavioral Health claims, encounters, membership and provider data are extracted from the CIE source system nightly. Historical membership and provider data is maintained in the Business Intelligence Warehouse (BIW). Cardinal maintains a fully accessible database of historical claims.

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. The breakdown of encounter data acceptance/denial rates was provided for the dates of service in 2018, Table 3 shows a comparison to the data acceptance/denial rates in 2017.

Table 3: Volume of Submitted Encounter Data with dates of service in 2018 and 2019

2018	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	114,238	2,879	21	117,138
Professional	1,999,406	51,914	3,309	2,054,629
2017	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	99,646	2,547	2,266	104,459
Professional	1,515,997	27,149	274,340	1,817,486

On a weekly basis 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 117,138 Institutional and 2,054,629 professional encounters were submitted to NCTracks for 2018 dates of service. Cardinal identified 21 Institutional and 3,309 professional encounters that have been denied and not yet accepted with 2018 dates of service.

Cardinal has maintained an acceptance rate over the 95% threshold, with the exception of one submission, during the review period.

Cardinal submits claims to NC Medicaid on average within 10 days from claim adjudication. Cardinals 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, they request the provider to submit the proper data before the claim is resubmitted. Cardinal has a dedicated Encounter Data Reconciliation team responsible for the resubmission process. Cardinal tracks the encounters via generated reports and worked by the team.

Cardinal noted that ICD-10 Procedure codes and DRG codes now submitted to NCTracks. While the systems were updated to accept DRG codes, it was noted by Cardinal they reimburse providers on a per-diem basis and DRG coding is not often used.

Figure 2 shows the percentage of standards scored as “Met” and “Partially Met” for this year’s Administrative EQR. A comparative of the previous year’s scores is also demonstrated in Figure 2.

Figure 2: Administration Comparative Findings

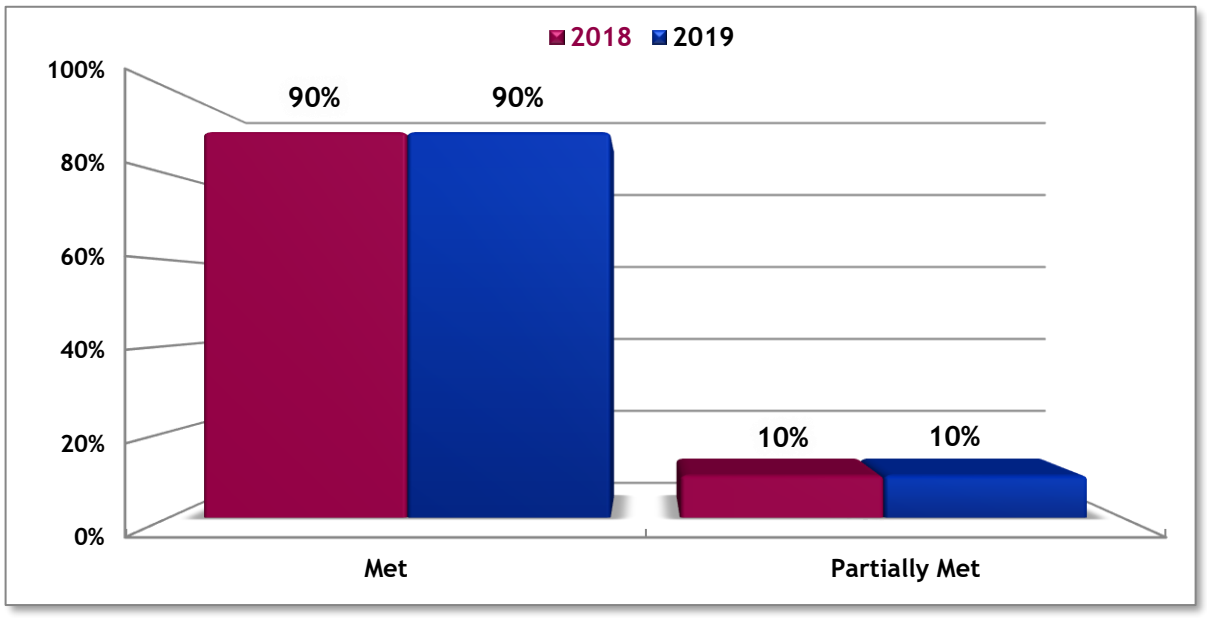


Table 4: Administration

Section	Standard	2019 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**
Reporting	The PIHP has the capabilities in place to submit the state required data elements to NC Medicaid on the encounter data submission.	**Partially Met**

Strengths

- The Medical Department is staffed by clinicians with a variety of specialties including pharmacy, addiction, child and adolescent psychiatry, forensic psychiatry, etc.
- Cardinal reconciles the CIE eligibility information to the 820 capitation payment on a monthly basis and uses the quarterly GEF file from NC Medicaid to enhance their enrollment reconciliation process.
- Cardinal's current NCTracks encounter acceptance rate continues to be above the 95% threshold.

- Claims and IT staff are knowledgeable about their processes and are dedicated to improving encounter data submissions and reducing the number of encounter data denials and the resubmission of denied encounters.

Weaknesses

- The documentation submitted for this year's EQR did not clearly demonstrate the roles and responsibilities of the medical staff nor the departmental and clinical oversight that, per the *NC Medicaid Contract*, should be "significant" in specific areas.
- Cardinal does not have the ability to receive and store all the ICD-10 Diagnosis codes for Institutional claims. Cardinal has the ability to store up to 22 ICD-10 Diagnosis codes for Institutional claims received electronically.
- Cardinal captures only up to 12 ICD-10 Diagnosis codes for Professional claims through the provider web portal and CIE System.
- Since Cardinal isn't able to accept all ICD-10 Professional and Institutional claims electronically, they are not submitting all possible codes to NCTracks.
- Providers are not properly submitting all required claims fields such as secondary diagnoses and are submitting the Revenue code data in the Procedure code field.

Corrective Action

- Update the Provider Direct Portal and the CIE system to be able to accept up to 25 ICD-10 Diagnosis codes for an 837I.
- Update the provider web portal to mirror the UB04 claim form for Institutional claims and capture up to 18 ICD-10 Diagnosis codes.
- Update Cardinal's encounter data submission process to allow all ICD-10 Diagnosis codes submitted on an Institutional and Professional 837 HIPAA file and provider web portal to be submitted to NCTracks. Twenty-five ICD-10 Diagnosis codes are the maximum number of Diagnosis codes that may be submitted on an 837I and the maximum number captured by NCTracks. NCTracks is capable of capturing up to 12 Diagnosis codes for Professional claims.

Recommendations

- On the Organizational Chart, delineate functions and/or departmental oversight of each of the staff within the Medical Department.
- Collaborate with providers to ensure they are submitting all required claims fields such as secondary diagnoses and making sure providers are not submitting the Revenue code data in the Procedure code field.

B. Provider Services

The Provider Services External Quality Review (EQR) is comprised of Credentialing and Recredentialing, and Provider Services, which includes Network Adequacy, 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, which was submitted as the Credentialing Program Description), credentialing/recredentialing files, provider orientation materials, the *Provider Manual*, Credentialing Committee meeting minutes, provider network information, the Clinical Practice Guidelines, the *Cardinal Innovations Healthcare Member & Family Handbook* (Member & Family Handbook), the *Cardinal Innovations Healthcare 2019 Network Adequacy and Accessibility Analysis (Gaps Analysis)*, and the Cardinal website. CCME also conducted an Onsite interview with relevant staff.

There were three items requiring Corrective Action in the Credentialing/Recredentialing section of Provider Services at the last EQR. Cardinal addressed all three of the Corrective Action items.

At the last EQR, three of the six Recommendations in the Credentialing/Recredentialing section were related to missing documentation in some files, including evidence of all types of required insurance or the relevant attestation, or the application attestation. Cardinal addressed three, partially addressed two, and did not address one of the six Recommendations. Cardinal's credentialing and recredentialing processes, which include approval by the M.D. (for "clean" files) or by the Credentialing Committee (for files with "issues") before some required items are received, resulted in Corrective Action items at this EQR. The Tabular Spreadsheet provides details.

There were no Corrective Actions or Recommendations at the last EQR in the "Adequacy of the Provider Network", "Clinical Practice Guidelines for Behavioral Health Management", "Continuity of Care", or "Practitioner Medical Record" sections. There were no Corrective Actions and three Recommendations in the "Provider Education" area at the last EQR. Cardinal addressed the Recommendations.

Dr. Saidat Kashimawo-Akande is the Interim Chair of the Credentialing Committee, a position she has held since April 2019. The *Credentialing Manual* outlines the structure of the credentialing program, including the Credentialing Committee composition and the Credentialing Committee roles and responsibilities. There were 13 committee meetings between November 2018 and October 2019, with a quorum present at all meetings.

Cardinal assesses network adequacy on an annual basis for the NC Medicaid-required gaps and needs analysis. The review of the *Cardinal Innovations Healthcare 2019 Network*

Adequacy and Accessibility Analysis (Gaps Analysis) revealed Cardinal failed to meet the choice and access standards for the same services as in the previous year. NC Medicaid approved the submitted *Exception Requests*, though the *Exception Requests* related to Substance Use Disorder were only approved through the end of January 2020, at which time NC Medicaid will determine whether the Exception Requests will continue to be approved. The annual *Access Plan*, which is now part of Gaps Analysis, serves as the *Network Development Plan*.

As Figure 3 indicates, 91% of the standards in the Provider Services section were scored as "Met", 9% were scored as "Partially Met". No standards were scored as "Not Met" in the current Provider Services EQR. Figure 3 provides a comparison of Cardinal's 2019 scores versus the 2018 scores.

Figure 3: Provider Services Comparative Findings

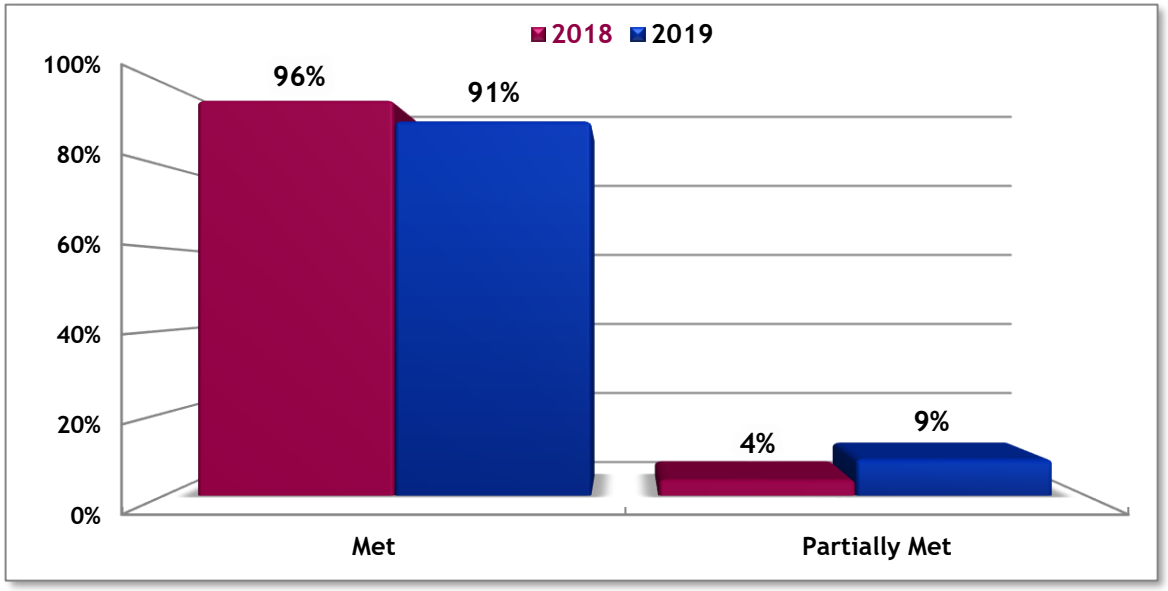


Table 5: Provider Services

Section	Standard	2019 Review
Credentialing	Verification of information on the applicant, including: Insurance requirements;	Partially Met
	Query of the Social Security Administration's Death Master File (SSADMF);	Partially Met

	Ownership Disclosure is addressed;	**Partially Met**
	Criminal background Check;	**Partially Met**
Recredentialing	Verification of information on the applicant, including: Insurance requirements;	**Partially Met**
	Ownership Disclosure is addressed;	**Partially Met**

Strengths

- The Cardinal website includes a Resource Library with filters for "Members", "Providers", "Community", and "Cardinal Innovations".
- The *Provider Manual* has six-and-a-half pages of "Resources".
- The *Provider Manual* is detailed and provides information to assist providers in navigating Cardinal's various functions and resources.
- The *Orientation Companion* is a comprehensive resource which is especially helpful for new providers.

Weaknesses

- The definition of a quorum for committee meetings in the *2019-2020 Annual Quality Strategy & Performance Improvement Plan* and the *2018-2019 Annual Quality Strategy & Performance Improvement Plan* differs from the quorum definition in other documents. See Tabular Spreadsheet for details.
- Cardinal's credentialing and recredentialing processes include approval by the M.D. (for "clean" files) or the Credentialing Committee (for files with "issues") before some required items are received. Specific issues, listed below, are addressed in the Tabular Spreadsheet, later in this report.

  a. Initial Credentialing issues: prior to credentialing approval,

  - Three of 14 reviewed files did not have proof of insurance or the insurance attestation for some of the insurance referenced in *NC Medicaid Contract Attachment B, section 7.7.4*.
  - Three of 14 reviewed files did not have Ownership Disclosure.

- Two of 14 reviewed files did not have the FirstPoint Background Screening Report, which addresses both the Social Security Death Master File query and the Criminal Background Check.

b. Recredentialing issues: prior to recredentialing approval,

- Five of 16 reviewed files did not have proof of insurance or the insurance attestation for some of the insurance referenced in *NC Medicaid Contract Attachment B, section 7.7.4*.
- Three of 16 reviewed files did not have Ownership Disclosure.

Corrective Actions

- Prior to approving credentialing or recredentialing, verify all 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. See *NC Medicaid Contract, Attachment B, section 7.7.4 and Attachment N*.
  - The required Social Security Administration's Death Master File query. See *NC Medicaid Contract Attachment B, Section 1.13* and *42 CFR § 455.436*.
  - Ownership Disclosure as required by *NC Medicaid Contract Attachment B, Section 1.13*.
  - The required Criminal Background Check query. See *NC Medicaid Contract Attachment B, Section 1.13* and *42 CFR § 455.434*.

Recommendations

- As recommended at the last EQR, ensure the required percentage for a Credentialing Committee meeting quorum is the same across documents.
- Ensure credentialing files contain the application and the attestation statement, as required by Cardinal Policy & Procedure 8000, Agency Application and Enrollment.
- For the EQR, submit the full credentialing file, "from the date of the application/ attestation, to the notification of approval of credentialing", as requested in the *External Quality Review Materials Requested for Desk Review* document.
- Ensure all credentialing/recredentialing applications and materials are clearly date stamped, with no element older than 180 days when the credentialing/recredentialing decision is made. If the applications are not going to be date stamped, revise Cardinal Policy & Procedure 8000, Agency Application and Enrollment, Section 1.a to reflect the process Cardinal will use for documenting the date of application receipt.

C. Enrollee Services

The Enrollee Services section covers Enrollee Rights and Responsibilities, Enrollee PIHP Program Education, Behavioral Health and Chronic Disease Management Education, and the Call Center. There were no Corrective Actions and no Recommendations issued in the last EQR.

Member rights and responsibilities are addressed in Policy & Procedure 1531, Enrollee Rights and Responsibilities, the *Cardinal Innovations Healthcare Member & Family Handbook (Member & Family Handbook)*, and the *Provider Manual* (revised January 2019). The Cardinal website has a Rights & Responsibilities page. There were no issues identified regarding the sub-standards for member rights.

Policy & Procedure 9515, Member Mailings states Cardinal will send all new members a notice advising where to find updated written materials concerning information required by their contract with NC Medicaid. This is completed within fourteen (14) days of enrollment. In addition, an annual notice is sent as a postcard with information and website links for the most recent written information. Staff adhere to this policy and procedure.

CCME reviewed information for five terminated providers. All examples given were voluntary terminations. Cardinal notified affected enrollees for all five providers within 15 calendar days of receiving notice of the request to terminate from the network. Cardinal follows the same process for providers terminated "with cause."

The *Member & Family Handbook* informs members of the availability of oral translation services. Policy & Procedure 9510, Content Development 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."

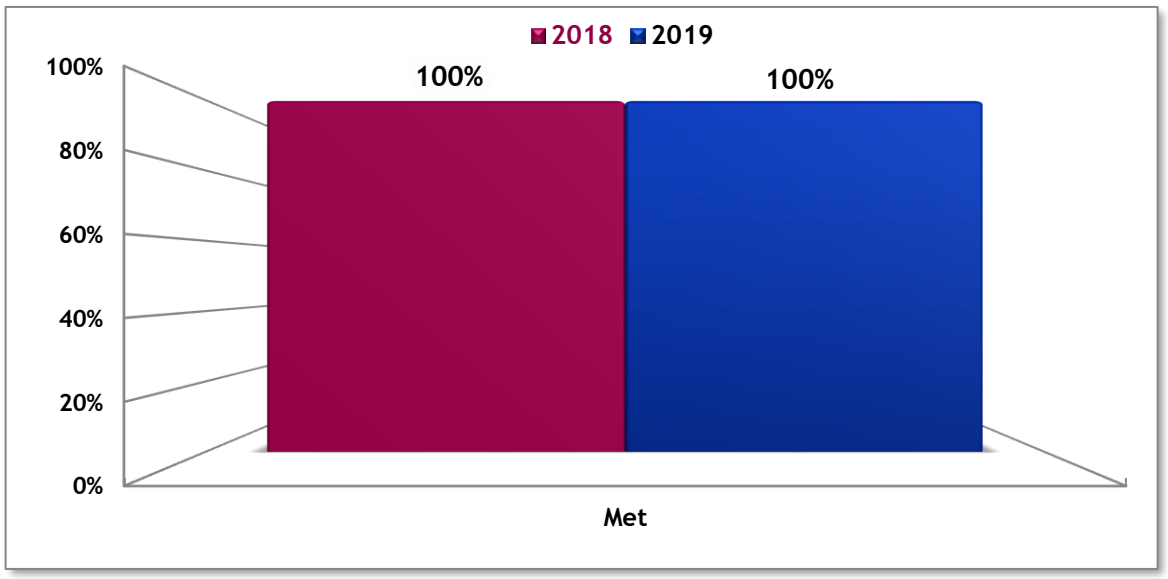
Policy & Procedure 1545, Community and Member Education & Outreach is in place to provide oversight of the *Cardinal Annual Education Plan*. The *Community Training Catalog* is available and explains offerings by Cardinal with instructions on how to request a training. The events page on the website has many activities listed that are held by Cardinal within the community.

Call Center phones are answered 24/7/365. Live Chat is available Monday – Friday from 8:00a.m. – 8:00p.m. Call Center statistics show a higher abandonment rate for Feb 2019, at 5.1%. This was explained at the Onsite interview as an outlier. Cardinal was piloting a new software called Whisper Tones which informs the qualified professional where the

call is coming from before accepting the call. Calls were staying in the que longer than wanted. They did not continue the pilot. If a call is screened as emergent, 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 instant message, to call the appropriate crisis service for them so there is no disruption in the live call.

Figure 4 shows that Cardinal scored a "Met" on all of the Enrollee standards in 2019 and compares this score to the percentage of standards that were met in 2018.

Figure 4: Enrollee Services Comparative Findings



Strengths

- Cardinal held several in-person events to answer questions from their community members about Medicaid Transformation.
- Cardinal created a Medicaid Transformation page on their website. Cardinal monitored their website with analytics for keywords used on the website searches which helped identify the most common questions from their community.
- Cardinal provides services to veterans through a partnership and coordinated platform of referrals. The veteran's request goes to one of several coordinating centers in NC to find providers that would be able to call those veterans with solutions or suggestions for their request.
- Cardinal has started providing information to assist specialized populations with needs they might have during weather emergencies, like hurricanes. They have put together emergency contact information by county that members will need.
- Cardinal has Live Chat functionality as part of the Access Call Center operations.

D. Quality Improvement

The Quality Improvement (QI) section reviews the QI Program, QI Committees, provider participation in QI, the QI work plan, the annual evaluation of the QI work plan, Performance Measures, and Performance Improvement Projects. The one Corrective Action from last EQR was corrected and maintained for this review. One Recommendation was not implemented from last EQR and is a Recommendation again in this year's EQR.

Cardinal's *2019-2020 Annual Quality Strategy & Performance Improvement Plan* outlines the program in place for measuring and improving the care and services received by members and providers.

The Annual Quality Strategy & Performance Improvement Plan Evaluation Fiscal Year 2018-2019 explains "Cardinal Innovations engaged providers in three pilots to explore the challenges involved in implementing CPGs across the network. The pilots focused on CPG for treating Childhood Autism Spectrum Disorders, Medication Assisted Treatment (MAT) for Opioid Use Disorders, and Metabolic Monitoring for Individuals with Schizophrenia on Antipsychotic Medications." Monitoring was completed for each chosen Clinical Practice Guideline.

The *Clinical Operations UM Program Evaluation FY18* document provides evidence of monitoring and addressing utilization issues. During the onsite, the top three over and underutilized services were discussed, in addition to the interventions that have been implemented to improve utilization.

The Adult and Child Experience of Health Outcomes (ECHO®) Surveys from 2016 to 2018 are posted on the Cardinal website. The 2018 results were shared with the Continuous Quality Improvement (CQI) Committee and the Global Continuous Quality Improvement (GCQI) Committee. During the previous EQR, it was noted in the March 2018 CQI Committee minutes, a workgroup was formed to discuss quality problems identified in the enrollee satisfaction surveys and interventions needed to improve survey results. Since then, there is no evidence of implementing measures that are directed at impacting the enrollee satisfaction survey results. CCME requested, and did not receive, additional information showing evidence that enrollee survey results were integrated and analyzed to identify potential areas needing improvements. CCME asked for minutes from the Survey Integration Project meetings. Cardinal responded that formal minutes were not kept for those meetings. When asked how many meetings have occurred in the past year, staff answered "a handful." Cardinal also explained that the QM Project Manager is the lead for the Survey Integration Project and that position experienced turnover in the past year. While Onsite, the document *Survey Impact Project Plan 2019.xlsx* was submitted. This document appeared incomplete. The second tab, labeled Survey Intervention Summary, lists interventions or services for existing quality improvement activities (QIAs) that are not focused on improving enrollee satisfaction survey results. This Excel

document does not include specifics regarding what barriers the interventions are intended to address, how the interventions are measured, nor the intended outcome. Survey items are not compared year to year to see if improvement is made. CCME is requiring Cardinal to develop a Quality Improvement Activity to improve lower scoring enrollee satisfaction survey items.

It was a 2018 EQR Recommendation to add target time frames for each of the activities included on the CQI work plan. The areas documented for each QIA includes objective, measurements, interventions, responsible department/staff, and Impact. A "Progress Towards QIA Goal Achievement in FY1819" was added to each Quality Improvement Activity (QIA) to meet this Recommendation. This is a look back at what happened and not a projection/goal for the implementation or completion at the beginning of the fiscal year. CCME is again recommending that Cardinal add a time frame for implementation and completion for each QIA on the *CQI Annual Work Plan*.

The CQI Committee meets monthly as stated in the CQI Committee Charter. There are 14 voting members of CQI, all internal to Cardinal except one GCQI provider member and one board/member representative. Currently, 13 positions are filled. The GCQI Committee is made up of providers, practitioners, and CFAC members. The GCQI meets quarterly and reports updates to CQI in the GCQI Update Section of each CQI meeting. The GCQI providers discuss, participate in, and disseminate information about the QI activities. Providers receive QI feedback during focused reviews from Provider Monitoring.

The *Annual Quality Strategy & Performance Improvement Plan Evaluation Fiscal Year 2018-2019* adequately summarizes the effectiveness of the QM program during FY 2018-2019.

Performance Measure Validation

As part of the EQR, CCME conducted the independent validation of NC Medicaid-selected (b) and (c) Waiver performance measures.

Table 6: (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

(b) WAIVER MEASURES	
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 7: (c) Waiver Measures

(c) WAIVER MEASURES	
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals. IW D1 ISP	Percentage of level 2 and 3 incidents reported within required timeframes. IW G2
Proportion of Individual Support Plans that address identified health and safety risk factors. IW D2 ISP	Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required. IW G3
Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need. IW D3 ISP	Percentage of medication errors resulting in medical treatment. IW G4
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Percentage of beneficiaries who received appropriate medication. IW G5
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8

CCME performed validations in compliance with 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 Reported Results

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

The measures' rates for FY2017 and FY2019 as reported by Cardinal are included in Table 8. The timing of the reviews last year and this year created a one-year skip in trending. Substantial increases based on this 2-year trend were reported for 30-day follow up after hospitalization for mental illness for the inpatient population; and 7 and 30-day rates for the Facility Based Crisis (FBC) population. Also, follow-up after hospitalization for substance abuse for Detox and FBC improved for 3, 7, and 30-day follow-up and for the Combined 7 and 30-day follow-up.

The current rate in comparison to last year's rate is presented in the following Tables 8 through 17.

Table 8: A.1. Readmission Rates for Mental Health

30-day Readmission Rates for Mental Health	FY 2017	FY 2019	Change
Inpatient (Community Hospital Only)	8.7%	10.6%	1.90%
Inpatient (State Hospital Only)	11.4%	4.9%	-6.50%
Inpatient (Community and State Hospital Combined)	8.8%	10.5%	1.70%
Facility Based Crisis	8.0%	11.0%	3.00%
PRTF	4.0%	2.4%	-1.60%
Combined (includes cross-overs between services)	9.7%	11.9%	2.20%

Table 9: A.2. Readmission Rate for Substance Abuse

30-day Readmission Rates for Substance Abuse	FY 2017	FY 2019	Change
Inpatient (Community Hospital Only)	8.3%	8.2%	-0.10%
Inpatient (State Hospital Only)	0.0%	0.9%	0.90%
Inpatient (Community and State Hospital Combined)	8.2%	6.9%	-1.30%
Detox/Facility Based Crisis	9.2%	9.4%	0.20%
Combined (includes cross-overs between services)	11.7%	11.5%	-0.20%

Table 10: A.3. Follow-Up after Hospitalization for Mental Illness

Follow-up after Hospitalization for Mental Illness	FY 2017	FY 2019	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	36.7%	36.7%	0.00%
Percent Received Outpatient Visit Within 30 Days	56.3%	54.2%	-2.10%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	30.6%	61.8%	31.20%
Percent Received Outpatient Visit Within 30 Days	47.3%	70.1%	22.80%
PRTF			
Percent Received Outpatient Visit Within 7 Days	23.3%	26.6%	3.30%
Percent Received Outpatient Visit Within 30 Days	45.8%	61.6%	15.80%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	35.8%	39.9%	4.10%
Percent Received Outpatient Visit Within 30 Days	55.3%	58.1%	2.80%

Table 11: A.4. Follow-Up After Hospitalization for Substance Abuse

Follow-up after Hospitalization for Substance Abuse	FY 2017	FY 2019	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NR
Percent Received Outpatient Visit Within 7 Days	14.8%	18.5%	3.70%
Percent Received Outpatient Visit Within 30 Days	25.3%	28.2%	2.90%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	11.8%	33.1%	21.30%
Percent Received Outpatient Visit Within 7 Days	17.1%	38.0%	20.90%
Percent Received Outpatient Visit Within 30 Days	27.6%	47.0%	19.40%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NR
Percent Received Outpatient Visit Within 7 Days	16.2%	29.9%	13.70%
Percent Received Outpatient Visit Within 30 Days	26.7%	38.6%	11.90%

*NR = Denominator is equal to zero.

Table 12: B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FY 2017	FY 2019	Change
Ages 13–17			
Percent With 2nd Service Or Visit Within 14 Days (Initiation)	35.7%	35.2%	-0.50%
Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)	18.4%	19.0%	0.60%
Ages 18–20			
Percent With 2nd Service Or Visit Within 14 Days (Initiation)	31.8%	30.1%	-1.70%
Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)	16.0%	13.2%	-2.80%
Ages 21–34			
Percent With 2nd Service Or Visit Within 14 Days (Initiation)	47.6%	45.1%	-2.50%
Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)	33.3%	28.3%	-5.00%
Ages 35-64			
Percent With 2nd Service Or Visit Within 14 Days (Initiation)	36.6%	39.1%	2.50%
Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)	23.9%	24.1%	0.20%
Ages 65+			
Percent With 2nd Service Or Visit Within 14 Days (Initiation)	29.0%	26.2%	-2.80%
Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)	13.5%	15.8%	2.30%
Total (13+)			
Percent With 2nd Service Or Visit Within 14 Days (Initiation)	39.7%	39.5%	-0.20%
Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)	26.6%	23.7%	-1.90%

Table 13: D.1. Mental Health Utilization-Inpatient Discharges and Average Length of Stay

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		FY2017	FY2019	Change	FY2017	FY2019	Change
3–12	Male	0.2	0.2	0.0	14.6	12.2	-2.4
	Female	0.2	0.2	0.0	10.7	13.0	2.3
	Total	0.2	0.2	0.0	12.9	12.6	-0.3
13–17	Male	0.9	0.8	-0.1	13.1	16.7	3.6
	Female	1.8	1.7	-0.1	12.5	13.5	1.0
	Total	1.4	1.2	-0.2	12.7	14.6	1.9
18–20	Male	1.2	1.7	0.5	9.5	7.9	-1.6
	Female	1.6	1.6	0.0	8.1	9.2	1.1
	Total	1.4	1.6	0.2	8.6	8.6	0.0
21–34	Male	4.2	5.0	0.8	9.2	9.9	0.7
	Female	1.2	1.4	0.2	7.9	8.6	0.7
	Total	1.9	2.1	0.2	8.5	9.3	0.8
35–64	Male	2.5	3.1	0.6	9.5	10.1	0.6
	Female	2.0	2.0	0.0	8.7	9.0	0.3
	Total	2.2	2.4	0.2	9.0	9.5	0.5
65+	Male	0.4	0.4	0.0	22.6	23.0	0.4
	Female	0.4	0.4	0.0	16.7	28.3	11.6
	Total	0.4	0.4	0.0	18.8	26.8	8.0
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**	**1.0**	**1.1**	**0.1**	**10.8**	**11.2**	**0.4**
	Female	**1.0**	**1.0**	**0.0**	**9.7**	**10.9**	**1.2**
	Total	**1.0**	**1.1**	**0.1**	**10.2**	**11.0**	**0.8**

Table 14: 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		
		FY2017	FY2019	Change	FY2017	FY2019	Change	FY2017	FY2019	Change	FY2017	FY2019	Change
3-12	Male	10.90%	11.65%	0.75%	0.23%	0.26%	0.03%	0.35%	0.31%	-0.04%	10.84%	11.59%	0.75%
	Female	7.18%	8.22%	1.04%	0.17%	0.23%	0.06%	0.11%	0.09%	-0.02%	7.16%	8.21%	1.05%
	Total	9.08%	9.97%	0.89%	0.20%	0.24%	0.04%	0.23%	0.20%	-0.03%	9.04%	9.93%	0.89%
13-17	Male	13.69%	14.34%	0.65%	0.97%	1.88%	0.91%	0.30%	0.37%	0.07%	13.62%	14.24%	0.62%
	Female	15.77%	17.04%	1.27%	1.88%	1.08%	-0.80%	0.27%	0.28%	0.01%	15.66%	16.92%	1.26%
	Total	14.72%	15.67%	0.95%	1.42%	1.49%	0.07%	0.28%	0.32%	0.04%	14.63%	15.56%	0.93%
18-20	Male	8.63%	9.69%	1.06%	1.25%	1.68%	0.43%	0.05%	0.12%	0.07%	8.50%	9.56%	1.06%
	Female	10.86%	12.11%	1.25%	1.53%	1.62%	0.09%	0.11%	0.15%	0.04%	10.72%	11.98%	1.26%
	Total	9.85%	11.00%	1.15%	1.40%	1.65%	0.25%	0.08%	0.14%	0.06%	9.72%	10.86%	1.14%
21-34	Male	23.78%	25.09%	1.31%	3.89%	4.06%	0.17%	0.26%	0.37%	0.11%	23.60%	24.82%	1.22%
	Female	15.39%	15.75%	0.36%	1.33%	1.45%	0.12%	0.26%	0.24%	-0.02%	15.30%	15.58%	0.28%
	Total	17.12%	17.74%	0.62%	1.86%	2.01%	0.15%	0.26%	0.27%	0.01%	17.02%	17.55%	0.53%

35-64	Male	20.89%	21.22%	0.33%	2.40%	2.68%	0.28%	0.17%	0.31%	0.14%	20.73%	20.95%	0.22%
	Female	23.72%	23.30%	-0.42%	1.92%	1.90%	-0.02%	0.26%	0.28%	0.02%	23.57%	23.13%	-0.44%
	Total	22.67%	22.51%	-0.16%	2.10%	2.19%	0.09%	0.23%	0.29%	0.06%	22.51%	22.31%	-0.20%
65+	Male	6.07%	6.66%	0.59%	0.54%	0.47%	-0.07%	0.01%	0.04%	0.03%	5.98%	6.51%	0.53%
	Female	6.54%	6.99%	0.45%	0.43%	0.42%	-0.01%	0.00%	0.02%	0.02%	6.47%	6.93%	0.46%
	Total	6.40%	6.89%	0.49%	0.47%	0.44%	-0.03%	0.01%	0.02%	0.01%	6.32%	6.80%	0.48%
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**	**13.32%**	**13.95%**	**0.63%**	**1.00%**	**1.26%**	**0.26%**	**0.27%**	**0.30%**	**0.03%**	**13.23%**	**13.83%**	**0.60%**
	Female	**13.13%**	**13.69%**	**0.56%**	**1.05%**	**0.97%**	**-0.08%**	**0.18%**	**0.17%**	**-0.01%**	**13.05%**	**13.59%**	**0.54%**
	Total	**13.21%**	**13.80%**	**0.59%**	**1.03%**	**1.09%**	**0.06%**	**0.22%**	**0.23%**	**0.01%**	**13.12%**	**13.70%**	**0.58%**

Table 15: 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		
		FY2017	FY2019	Change	FY2017	FY2019	Change	FY2017	FY2019	Change	FY2017	FY2019	Change
3–12	Male	0.03%	0.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.03%	0.03%	0.00%
	Female	0.01%	0.02%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.02%	0.01%
	Total	0.02%	0.03%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.02%	0.00%
13–17	Male	1.96%	1.78%	-0.18%	0.12%	0.13%	0.01%	0.29%	0.17%	-0.12%	1.83%	1.68%	-0.15%
	Female	1.15%	1.08%	-0.07%	0.16%	0.18%	0.02%	0.15%	0.04%	-0.11%	1.02%	0.99%	-0.03%
	Total	1.56%	1.43%	-0.13%	0.14%	0.15%	0.01%	0.22%	0.10%	-0.12%	1.43%	1.34%	-0.09%
18–20	Male	3.08%	2.70%	-0.38%	0.48%	0.74%	0.26%	0.29%	0.21%	-0.08%	2.89%	2.41%	-0.48%
	Female	2.28%	2.03%	-0.25%	0.49%	0.37%	-0.12%	0.22%	0.14%	-0.08%	2.12%	1.87%	-0.25%
	Total	2.64%	2.33%	-0.31%	0.48%	0.54%	0.06%	0.25%	0.17%	-0.08%	2.47%	2.12%	-0.35%
21-34	Male	9.27%	8.89%	-0.38%	1.39%	1.83%	0.44%	0.83%	0.66%	-0.17%	8.98%	8.48%	-0.50%
	Female	6.45%	6.30%	-0.15%	0.56%	0.65%	0.09%	0.93%	0.64%	-0.29%	6.25%	6.07%	-0.18%
	Total	7.03%	6.86%	-0.17%	0.74%	0.90%	0.16%	0.91%	0.65%	-0.26%	6.81%	6.58%	-0.23%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY2017	FY2019	Change	FY2017	FY2019	Change	FY2017	FY2019	Change	FY2017	FY2019	Change
35-64	Male	8.32%	8.93%	0.61%	1.03%	1.55%	0.52%	0.90%	1.02%	0.12%	8.01%	8.46%	0.45%
	Female	5.68%	6.10%	0.42%	0.61%	0.79%	0.18%	0.71%	0.56%	-0.15%	5.43%	5.84%	0.41%
	Total	6.66%	7.17%	0.51%	0.76%	1.08%	0.32%	0.78%	0.73%	-0.05%	6.39%	6.83%	0.44%
65+	Male	1.27%	1.49%	0.22%	0.17%	0.15%	-0.02%	0.12%	0.21%	0.09%	1.12%	1.36%	0.24%
	Female	0.37%	0.37%	0.00%	0.05%	0.02%	-0.03%	0.01%	0.02%	0.01%	0.36%	0.35%	-0.01%
	Total	0.65%	0.73%	0.08%	0.08%	0.06%	-0.02%	0.05%	0.08%	0.03%	0.60%	0.67%	0.07%
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**	**2.47%**	**2.47%**	**0.00%**	**0.30%**	**0.42%**	**0.12%**	**0.27%**	**0.25%**	**-0.02%**	**2.36%**	**2.33%**	-0.03%
	Female	**2.55%**	**2.50%**	**-0.05%**	**0.27%**	**0.31%**	**0.04%**	**0.33%**	**0.23%**	**-0.10%**	**2.44%**	**2.39%**	-0.05%
	Total	**2.52%**	**2.49%**	**-0.03%**	**0.28%**	**0.36%**	**0.08%**	**0.31%**	**0.24%**	**-0.07%**	**2.41%**	**2.36%**	-0.05%

Table 16: 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		
	FY2017	FY2019	Change	FY2017	FY2019	Change	FY2017	FY2019	Change	FY2017	FY2019	Change
	3-12			13-17			18-20			21-34		
Alamance	0.02%	0.04%	0.02%	1.15%	1.19%	0.04%	1.96%	1.47%	-0.49%	5.33%	4.89%	-0.44%
Cabarrus	0.02%	0.03%	0.01%	1.27%	1.07%	-0.20%	1.95%	1.86%	-0.09%	5.99%	5.66%	-0.33%
Caswell	0.00%	0.06%	0.06%	1.38%	0.71%	-0.67%	4.44%	1.64%	-2.80%	6.84%	6.08%	-0.76%
Chatham	0.00%	0.00%	0.00%	0.77%	1.29%	0.52%	2.65%	2.07%	-0.58%	8.48%	8.17%	-0.31%
Davidson	0.02%	0.05%	0.03%	0.92%	1.03%	0.11%	2.86%	2.91%	0.05%	7.04%	6.43%	-0.61%
Davie	0.04%	0.04%	0.00%	1.75%	1.85%	0.10%	3.28%	0.98%	-2.30%	7.59%	5.14%	-2.45%
Forsyth	0.01%	0.02%	0.01%	1.75%	1.32%	-0.43%	2.02%	1.80%	-0.22%	4.28%	4.20%	-0.08%
Franklin	0.02%	0.00%	-0.02%	0.86%	0.48%	-0.38%	2.06%	1.30%	-0.76%	5.83%	5.49%	-0.34%
Granville	0.00%	0.03%	0.03%	0.58%	0.60%	0.02%	2.62%	2.40%	-0.22%	6.80%	6.96%	0.16%
Halifax	0.00%	0.04%	0.04%	0.94%	0.82%	-0.12%	2.48%	1.38%	-1.10%	6.16%	5.55%	-0.61%
Mecklenburg	0.02%	0.01%	-0.01%	1.74%	1.54%	-0.20%	2.16%	2.11%	-0.05%	3.70%	3.67%	-0.03%
Orange	0.02%	0.00%	-0.02%	1.42%	1.38%	-0.04%	3.20%	2.27%	-0.93%	9.37%	8.16%	-1.21%
Person	0.00%	0.00%	0.00%	1.56%	1.75%	0.19%	3.31%	2.58%	-0.73%	7.74%	6.85%	-0.89%

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		
	FY2017	FY2019	Change	FY2017	FY2019	Change	FY2017	FY2019	Change	FY2017	FY2019	Change
	3-12			13-17			18-20			21-34		
Rockingham	0.01%	0.01%	0.00%	1.28%	0.81%	-0.47%	2.39%	1.68%	-0.71%	4.93%	6.24%	1.31%
Rowan	0.05%	0.04%	-0.01%	1.77%	2.26%	0.49%	2.76%	2.62%	-0.14%	9.79%	8.72%	-1.07%
Stanly	0.02%	0.02%	0.00%	1.38%	1.63%	0.25%	4.39%	1.85%	-2.54%	6.52%	6.88%	0.36%
Stokes	0.00%	0.00%	0.00%	1.93%	1.16%	-0.77%	3.45%	3.24%	-0.21%	7.77%	5.93%	-1.84%
Union	0.02%	0.03%	0.01%	1.45%	1.32%	-0.13%	2.72%	2.80%	0.08%	5.06%	4.27%	-0.79%
Vance	0.04%	0.02%	-0.02%	0.91%	1.46%	0.55%	3.17%	1.84%	-1.33%	6.59%	6.94%	0.35%
Warren	0.00%	0.13%	0.13%	0.45%	1.58%	1.13%	2.12%	3.25%	1.13%	4.52%	4.95%	0.43%
	35-64			65+			Unknown			Total		
Alamance	7.39%	7.99%	0.60%	0.97%	1.08%	0.11%	0.00%	0.00%	0.00%	2.38%	2.40%	0.02%
Cabarrus	5.79%	6.29%	0.50%	0.35%	0.59%	0.24%	0.00%	0.00%	0.00%	2.09%	2.04%	-0.05%
Caswell	3.83%	3.71%	-0.12%	0.67%	0.67%	0.00%	0.00%	0.00%	0.00%	2.29%	1.89%	-0.40%
Chatham	6.71%	7.71%	1.00%	0.14%	0.42%	0.28%	0.00%	0.00%	0.00%	2.37%	2.47%	0.10%
Davidson	4.82%	5.34%	0.52%	0.47%	0.42%	-0.05%	0.00%	0.00%	0.00%	2.27%	2.27%	0.00%
Davie	4.40%	6.10%	1.70%	0.00%	0.61%	0.61%	0.00%	0.00%	0.00%	2.32%	2.18%	-0.14%

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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		
	FY2017	FY2019	Change	FY2017	FY2019	Change	FY2017	FY2019	Change	FY2017	FY2019	Change
	3-12			13-17			18-20			21-34		
Forsyth	6.14%	5.89%	-0.25%	0.84%	0.90%	0.06%	0.00%	0.00%	0.00%	2.09%	1.95%	-0.14%
Franklin	4.28%	5.96%	1.68%	0.30%	0.70%	0.40%	0.00%	0.00%	0.00%	1.84%	1.99%	0.15%
Granville	5.84%	7.46%	1.62%	0.35%	0.74%	0.39%	0.00%	0.00%	0.00%	2.36%	2.69%	0.33%
Halifax	6.55%	6.87%	0.32%	0.70%	1.03%	0.33%	0.00%	0.00%	0.00%	2.82%	2.72%	-0.10%
Mecklenburg	5.42%	5.64%	0.22%	0.75%	0.86%	0.11%	0.00%	0.00%	0.00%	1.84%	1.78%	-0.06%
Orange	9.03%	9.36%	0.33%	1.63%	1.72%	0.09%	0.00%	0.00%	0.00%	3.54%	3.32%	-0.22%
Person	6.03%	6.96%	0.93%	0.24%	0.60%	0.36%	0.00%	0.00%	0.00%	2.81%	2.82%	0.01%
Rockingham	5.53%	6.02%	0.49%	0.20%	0.57%	0.37%	0.00%	0.00%	0.00%	2.23%	2.41%	0.18%
Rowan	7.60%	7.49%	-0.11%	0.79%	0.77%	-0.02%	0.00%	0.00%	0.00%	3.39%	3.19%	-0.20%
Stanly	5.83%	7.12%	1.29%	0.68%	0.80%	0.12%	0.00%	0.00%	0.00%	2.63%	2.72%	0.09%
Stokes	4.78%	6.11%	1.33%	0.50%	0.13%	-0.37%	0.00%	0.00%	0.00%	2.62%	2.45%	-0.17%
Union	4.60%	4.51%	-0.09%	0.40%	0.33%	-0.07%	0.00%	0.00%	0.00%	1.77%	1.59%	-0.18%
Vance	7.63%	9.29%	1.66%	0.31%	0.77%	0.46%	0.00%	0.00%	0.00%	2.97%	3.39%	0.42%
Warren	4.46%	6.89%	2.43%	0.69%	1.31%	0.62%	0.00%	0.00%	0.00%	1.85%	2.79%	0.94%

Table 17: 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		
	FY2017	FY2019	Change	FY2017	FY2019	Change	FY2017	FY2019	Change	FY2017	FY2019	Change
	3-12			13-17			18-20			21-34		
Alamance	7.94%	8.78%	0.84%	14.39%	15.41%	1.02%	8.73%	9.48%	0.75%	14.80%	14.03%	-0.77%
Cabarrus	8.17%	8.74%	0.57%	14.05%	15.26%	1.21%	9.12%	9.18%	0.06%	12.82%	13.57%	0.75%
Caswell	9.81%	9.85%	0.04%	13.97%	17.26%	3.29%	7.77%	8.55%	0.78%	14.29%	12.32%	-1.97%
Chatham	8.88%	9.62%	0.74%	16.20%	15.76%	-0.44%	7.91%	7.91%	0.00%	16.01%	16.13%	0.12%
Davidson	7.65%	8.03%	0.38%	12.98%	14.71%	1.73%	9.09%	9.50%	0.41%	11.30%	11.56%	0.26%
Davie	8.08%	10.32%	2.24%	12.22%	15.81%	3.59%	8.54%	5.87%	-2.67%	10.78%	10.74%	-0.04%
Forsyth	6.18%	7.44%	1.26%	12.60%	13.26%	0.66%	8.35%	8.06%	-0.29%	13.80%	13.19%	-0.61%
Franklin	7.67%	7.82%	0.15%	12.01%	13.32%	1.31%	9.81%	8.72%	-1.09%	15.39%	12.87%	-2.52%
Granville	8.62%	7.58%	-1.04%	12.56%	13.63%	1.07%	9.41%	9.46%	0.05%	15.14%	14.62%	-0.52%
Halifax	9.54%	9.14%	-0.40%	14.98%	13.05%	-1.93%	11.02%	10.71%	-0.31%	15.75%	16.64%	0.89%
Mecklenburg	6.95%	7.33%	0.38%	12.69%	13.62%	0.93%	7.73%	8.77%	1.04%	11.03%	11.58%	0.55%
Orange	9.21%	12.30%	3.09%	17.99%	20.11%	2.12%	11.72%	12.09%	0.37%	18.98%	20.83%	1.85%
Person	10.09%	8.73%	-1.36%	16.80%	17.15%	0.35%	12.55%	14.09%	1.54%	18.36%	19.84%	1.48%

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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		
	FY2017	FY2019	Change	FY2017	FY2019	Change	FY2017	FY2019	Change	FY2017	FY2019	Change
	3-12			13-17			18-20			21-34		
Rockingham	8.16%	8.91%	0.75%	15.42%	16.84%	1.42%	10.03%	10.98%	0.95%	13.98%	13.91%	-0.07%
Rowan	9.43%	10.80%	1.37%	14.86%	15.71%	0.85%	10.04%	9.92%	-0.12%	14.18%	15.02%	0.84%
Stanly	9.97%	10.16%	0.19%	16.79%	15.91%	-0.88%	11.62%	12.83%	1.21%	13.95%	14.07%	0.12%
Stokes	10.60%	11.98%	1.38%	16.54%	16.62%	0.08%	7.80%	10.67%	2.87%	13.92%	11.97%	-1.95%
Union	8.42%	9.04%	0.62%	14.50%	15.01%	0.51%	8.98%	10.93%	1.95%	10.93%	11.84%	0.91%
Vance	8.19%	8.38%	0.19%	12.94%	11.05%	-1.89%	10.22%	10.86%	0.64%	16.88%	17.26%	0.38%
Warren	10.22%	8.76%	-1.46%	12.18%	11.37%	-0.81%	8.80%	7.94%	-0.86%	15.50%	15.19%	-0.31%
	35-64			65+			Unknown			Total		
Alamance	26.38%	23.73%	-2.65%	9.01%	8.70%	-0.31%	0.00%	0.00%	0.00%	13.12%	13.08%	-0.04%
Cabarrus	19.83%	19.58%	-0.25%	11.34%	11.59%	0.25%	0.00%	0.00%	0.00%	11.85%	12.33%	0.48%
Caswell	20.05%	17.54%	-2.51%	8.40%	7.65%	-0.75%	0.00%	0.00%	0.00%	13.00%	12.57%	-0.43%
Chatham	18.14%	20.06%	1.92%	5.08%	6.72%	1.64%	0.00%	0.00%	0.00%	12.02%	12.64%	0.62%
Davidson	16.14%	16.58%	0.44%	11.65%	9.25%	-2.40%	0.00%	0.00%	0.00%	10.91%	11.29%	0.38%
Davie	17.17%	15.85%	-1.32%	10.57%	9.13%	-1.44%	0.00%	0.00%	0.00%	10.90%	11.82%	0.92%
Forsyth	22.31%	21.12%	-1.19%	12.15%	10.51%	-1.64%	0.00%	0.00%	0.00%	11.49%	11.69%	0.20%

2019 External Quality Review

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		
	FY2017	FY2019	Change	FY2017	FY2019	Change	FY2017	FY2019	Change	FY2017	FY2019	Change
	3-12			13-17			18-20			21-34		
Franklin	16.72%	19.43%	2.71%	7.75%	6.18%	-1.57%	0.00%	0.00%	0.00%	11.12%	11.34%	0.22%
Granville	21.66%	20.29%	-1.37%	4.95%	5.29%	0.34%	0.00%	0.00%	0.00%	12.27%	11.77%	-0.50%
Halifax	22.41%	23.13%	0.72%	8.75%	8.99%	0.24%	0.00%	0.00%	0.00%	14.21%	14.06%	-0.15%
Mecklenburg	17.67%	18.35%	0.68%	8.29%	7.85%	-0.44%	0.00%	0.00%	0.00%	10.23%	10.68%	0.45%
Orange	28.55%	27.42%	-1.13%	9.22%	9.34%	0.12%	0.00%	0.00%	0.00%	15.59%	17.23%	1.64%
Person	24.05%	25.66%	1.61%	8.07%	8.57%	0.50%	0.00%	0.00%	0.00%	15.00%	15.10%	0.10%
Rockingham	20.90%	20.17%	-0.73%	7.69%	7.94%	0.25%	0.00%	0.00%	0.00%	12.78%	13.13%	0.35%
Rowan	21.84%	20.35%	-1.49%	12.20%	12.95%	0.75%	0.00%	0.00%	0.00%	13.47%	13.98%	0.51%
Stanly	25.66%	24.29%	-1.37%	14.63%	15.98%	1.35%	0.00%	0.00%	0.00%	15.07%	14.82%	-0.25%
Stokes	19.30%	18.50%	-0.80%	10.86%	7.89%	-2.97%	0.00%	0.00%	0.00%	13.60%	13.54%	-0.06%
Union	16.20%	16.32%	0.12%	11.65%	9.45%	-2.20%	0.00%	0.00%	0.00%	11.14%	11.59%	0.45%
Vance	23.97%	23.49%	-0.48%	10.13%	7.82%	-2.31%	0.00%	0.00%	0.00%	13.75%	13.37%	-0.38%
Warren	20.58%	20.39%	-0.19%	11.37%	6.84%	-4.53%	0.00%	0.00%	0.00%	13.58%	12.20%	-1.38%

(b) Waiver Validation Results

The overall validation scores are "Fully Compliant" with an average validation score of 100% across the ten measures. The stored procedures have been updated to address NC Medicaid's most recent changes to the measures.

Table 18 contains validation scores for each of the ten (b) Waiver Performance Measures.

Table 18: (b) Waiver Performance Measure Validation Scores

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 Reported Results

For reviews of 2018-2019 (c) Waiver measures, there were changes made to the measures that were validated. Eight new measures were chosen, and two previously validated measures were retained. Documentation was included for all ten (c) Waiver measures. The rates reported by Cardinal are displayed in Table 19.

Table 19: (c) Waiver Measures Reported Results 2018-2019

Performance measure	Data Collection	Latest Reported Rate	State Benchmark
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals. IW D1 ISP	Annual	9490/9490 = 100%	85%
Proportion of Individual Support Plans that address identified health and safety risk factors. IW D2 ISP	Semi Annually	5042/5042 = 100%	85%
Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need. IW D3 ISP	Annually	9490/9490 = 100%	85%
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Annually	9490/9490 = 100%	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Annually	9490/9490 = 100%	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	42/47 = 89.36%	85%
Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required. IW G3	Quarterly	6/6 = 100%	85%
Percentage of medication errors resulting in medical treatment. IW G4	Quarterly	0/4 = 0%	15%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	43/47 = 91.49%	85%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	Quarterly	12/12 =100%	85%

(c) Waiver Validation

Validation scores are "Fully Compliant" with an average validation score of 100% across the ten measures. The validation scores are shown in *Table 20, (c) Waiver Performance Measure Validation Scores*. Documentation on data sources, data validation, source code, and calculated rate for the ten (c) Waiver measures was provided. Additionally, all rates met or exceeded state performance benchmarks. The validation worksheets offer detailed information on validation and calculation steps for (c) Waiver measure.

Table 20: C Waiver Performance Measures Validation Scores 2018-2019

Measure	Validation Score Received
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 instruments	100%
Proportion of New Level of Care evaluations completed using approved processes and instruments	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 (PIP) Validation

The validation of the PIPs was conducted in accordance with the protocol developed by *CMS titled, 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

PIP Validation Results

For the 2018 review year, three projects were submitted, and reports were found to contain sound methodology and adequate documentation. For 2019, eight PIPs were submitted and validated. Table 21 shows a summary of the validation scores and displays the project names and validation scores for 2018 and 2019 review years.

Table 21: PIP Summary of Validation Scores

Project Type	Project	2018 Validation Score	2019 Validation Score
Clinical	Improving the percentage of follow-up appointments that occurs within 7 and 30 days of mental health specific community hospital and facility-based crisis discharges	90/90=100% High Confidence in Reported Results	90/90=100% High Confidence in Reported Results
	Improving the percentage of follow-up appointment that occurs within 7 and30 days of SA-related community hospital and SA-related facility-based crisis discharges	90/90=100% High Confidence in Reported Results	90/90=100% High Confidence in Reported Results

Project Type	Project	2018 Validation Score	2019 Validation Score
	Diabetes screening for individuals with schizophrenia and bipolar disorder who are using anti-psychotic medications	Not Validated	79/79/100% High Confidence in Reported Results
	Adherence to antipsychotic medications for individuals with schizophrenia	Not Validated	79/79/100% High Confidence in Reported Results
	Metabolic monitoring for children and adolescents on antipsychotics	Not Validated	90/90=100% High Confidence in Reported Results
	Metabolic monitoring for adults on antipsychotics	Not Validated	90/90=100% High Confidence in Reported Results
Non-Clinical	Treatment authorization requests	Not Validated	90/90=100% High Confidence in Reported Results
	Improving timely access to care	Not Validated	84/85+99% High Confidence in Reported Results

There are no errors for projects that require Corrective Action. Table 22 list the specific errors for projects that have Recommendations.

Table 22: Performance Improvement Project Errors and Recommendations

Project	Section	Reason	Recommendation
Improving Timely Routine Access to Care	Was there any documented, quantitative improvement in processes or outcomes of care?	Medicaid and non-Medicaid rates decreased from Measurement 3 to 4.	Continue to address barriers of childcare and transportation for members, and mobile engagement.

Figure 5 provides a comparison of the 2018 scores versus the 2019 scores. The 2019 review shows 94% of the standards were scored as "Met," and 6% of the standards were scored as "Partially Met." No standards were scored "Not Met."

Figure 5: Quality Improvement Comparative Findings

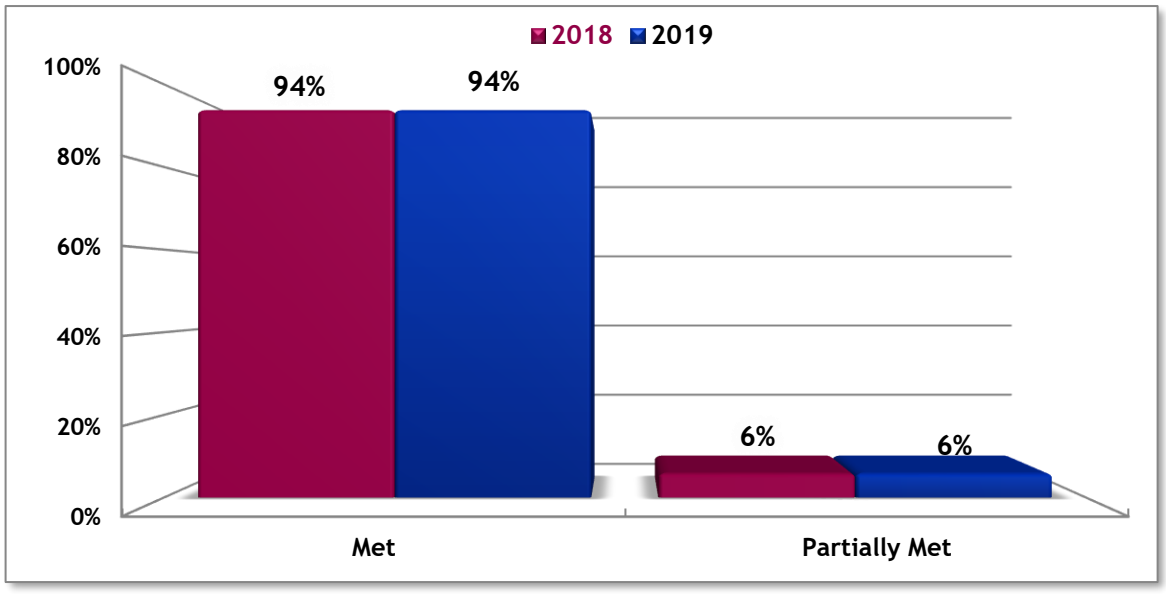


Table 23: Quality Improvement

Section	Standard	2019 Review
The Quality Improvement (QI) Program	The PIHP implements significant measures to address quality problems identified through the enrollees' satisfaction survey.	**Partially Met**

Strengths

- Cardinal provided more staff training on Inter-Rater Reliability (IRR) this year. IRR improved as a result of training and moving to monthly reviews of all staff within Mental Health, Intellectual Developmental Disability (I/DD), and Substance Use Disorder (SUD). Cardinal has talked about live IRRs in the future.
- Cardinal monitored three Clinical Practice Guidelines in a pilot over the past year and wants to broaden this work to expand into a large Health System. They are looking to do this in the next 90 days with implementation in the next 6 months.

Weaknesses

- There is no evidence of implementing measures directed at impacting the enrollee satisfaction survey results.
- Target time frames are not included in the *FY 2019-2020 Workplan*.

Corrective Action

- Develop a Quality Improvement Activity to improve lower scoring enrollee satisfaction survey items.

Recommendations

- CCME recommends that Cardinal add a time frame for implementation and completion for each QIA on the CQI work plan.

E. Utilization Management

The External Quality Review (EQR) of Utilization Management (UM) includes review of the *Utilization Management Plan (UM Plan)*, Cardinal's Organizational Chart, UM policies and procedures, and 50 treatment authorization files. Also included in the EQR of PIHP UM functions is review of the Care Coordination and Transition to Community Living (TCLI) programs. CCME reviewed relevant policies, procedures, staffing patterns, job descriptions, and 25 files of enrollees participating in mental health/substance use disorder (MH/SUD), Intellectual/Developmental Disability (I/DD), and TCLI Care Coordination. Onsite discussion with staff provided additional information. In this year's EQR, Cardinal met 98% of UM standards and CCME has issued one Corrective Action and three Recommendations.

In last year's EQR, a Corrective Action was issued to ensure that Cardinal's UM Treatment Authorization Requests (TARs) capture UM Care Manager and Peer Reviewer credentials. In response, Cardinal stated "Reviewers' credentials have been added to CIE, and IT is working to pull this information into the review documentation." In this year's file review, improvement was noted. However, the TARs again did not consistently reflect the credentials of the UM Care Managers. The UM files reviewed showed no evidence of an automated staff signature and credentials built into the CIE system. Staff are still manually entering their name and credentials in their TAR review and doing so inconsistently. The files showed 24% of TARs did not contain the credentials of the UM Care Manager and one contained a partial signature. CCME again recommends Cardinal ensure staff are signing their UM reviews with their full name and credentials or that the CIE system creates an electronic signature that includes reviewer credentials. To demonstrate compliance with UM staffing requirements outlined in the *NC Medicaid Contract, Section 8.2.2.1*, the staff signature and credentials must be evident in both the electronic record and any printed TAR documentation.

Extensions to the required TAR processing timeframe of 14 days are a common practice among UM Care Managers. During last year's EQR, CCME recommended that staff document justification for the extension within the treatment authorization record, to satisfy the contractual requirements in *NC Medicaid Contract, Section 7.4.13* and *Attachment M, D.1.b*. CCME also recommended that Cardinal describe this process in Policy & Procedure, 6010, Pre-Service Authorization a Reauthorization of Services. Both of these recommendations were addressed, implemented, and maintained by UM staff over the past year.

In the file review for this year's EQR, TAR processing time frames were extended in 26% of all of the files reviewed, and in 44% of submitted files in which services were denied or reduced. Within each file, the Care Manager justified the reason for the extension and sent a written notification explaining the reason for the extension. In this year's EQR, CCME recommends Cardinal monitor this TAR extension process to ensure this practice is being implemented by staff judiciously and with no undue burden placed on the provider or enrollee. Monitoring could include analysis of TAR extension data such as monthly percentage of extended TARs, extensions to initial versus concurrent requests, patterns of extensions per service or provider, etc.

Concerns noted within the I/DD, MH/SUD and TCLI Care Coordination files resulted in one Corrective Action and one Recommendation in this year's EQR of Cardinal's Care Coordination and TCLI programs. The documentation within the reviewed files lacked consistent compliance with the requirements set forth in Cardinal's policies and procedures. For example, Cardinal's policies and procedures require Care Coordinators to enter progress notes into the electronic record within two business days of the date of contact. If a progress note is entered beyond two days, it should be labeled "late entry". However, in the files submitted for review, 99% of progress notes created after two business days were not labeled "late entry". In another example, Care Coordinators also did not consistently follow the required steps prior to discharging an enrollee from the Innovations Waiver, as outlined in *NC Clinical Coverage Policy 8P, Attachment B, Section L*. It was also noted that seven % of progress notes were incomplete based on the requirements within Cardinal's policies and procedures, and that monitoring by Care Coordinators was not occurring at the required frequencies.

CCME asserts that a thorough, data-driven monitoring plan needs to be developed and implemented to increase file compliance by MH/SUD, I/DD, and TCLI Care Coordination staff. The monitoring plan should identify the frequency of monitoring, departmental benchmarks for compliance, and how and when outcomes of monitoring are captured, reviewed, and reported. The monitoring plan should target Care Coordination activities and documentation (e.g., discharges from Care Coordination, late progress notes, frequency of Care Coordination monitoring, follow up activities, HCBS monitoring, timeliness of progress notes, case transfers, etc.) to improve consistency by staff. This

monitoring plan is required through a Corrective Action in the Care Coordination section and is also recommended for TCLI.

During last year's EQR, Cardinal received two Recommendations for the Transitions to Community Living Initiative (TCLI) program. The first Recommendation was to update Policy & Procedure 7000, Transition Year Stability Resource (TYSR), to describe the monitoring of TYSR funds and reference the DOJ-TYSR Expenses Form within the policy and procedure. CCME also recommended that Cardinal continue to address barriers to referrals for Supported Employment and to ensure that TCLI enrollees who voice a desire for employment are referred and linked to this service. Both Recommendations were addressed over the past year.

Figure 6 shows 98% of the Utilization Management standards were scored as "Met" in both the 2018 and 2019 EQRs.

Figure 6: Utilization Management Comparative Findings

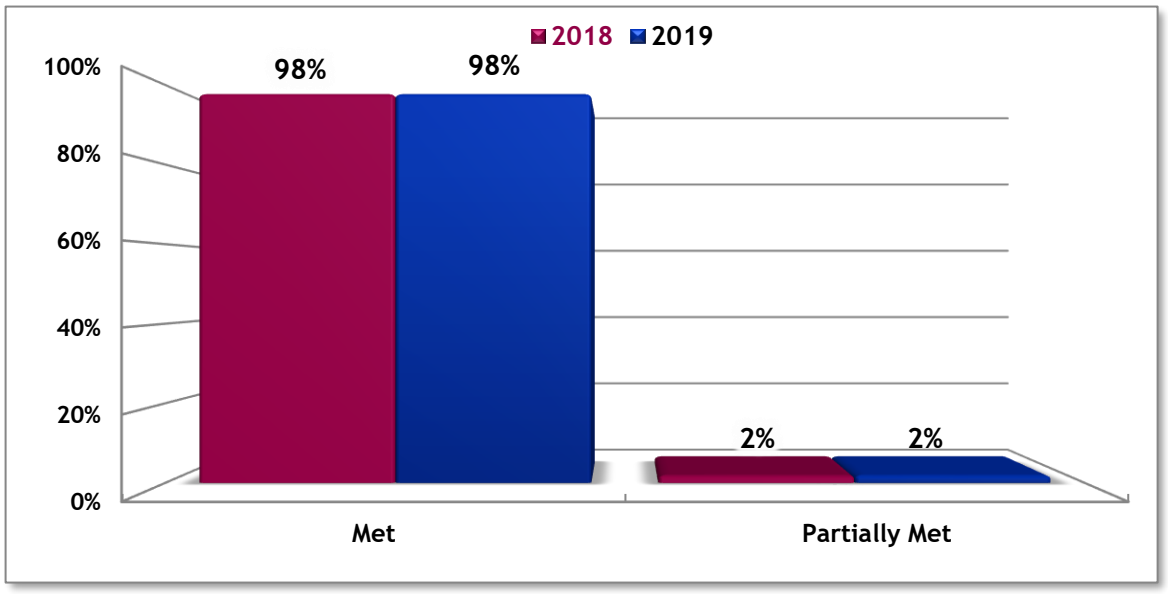


Table 24: Utilization Management

Section	Standard	2019 Review
Care Coordination	The PIHP applies the Care Coordination policies and procedures as formulated.	Partially Met

Strengths

- Cardinal reported a recent 73% reduction of crisis utilization and 63% reduction in complex care.
- Cardinal's reported the Bridge Transitional Housing program resulted in a 96% success rate for diverting enrollees recently discharged from the hospital to the community versus admission to an Adult Care Home.

Weaknesses

- There is no monitoring or data analysis regarding TAR extensions that would ensure this practice is being implemented judiciously and with no undue burden placed on the provider or enrollee.
- 24% of the UM files reviewed did not contain the full signature (including credentials) of the UM Care Manager.
- Documentation requirements, as outlined in Cardinal's Care Coordination and TCLI policies and procedures, are not consistently followed by MH/SUD, I/DD Care Coordinators and TCLI staff.

Corrective Action

- Develop, document, and implement a data-driven monitoring plan that routinely reviews Care Coordination documentation. The monitoring plan should identify the frequency of monitoring, departmental benchmarks for compliance, and how and when outcomes of monitoring are captured, reviewed, and reported. The monitoring plan should include review of timeliness of activities (e.g., discharges from Care Coordination, documentation of late progress notes, follow up activities, HCBS monitoring, etc.), as well as the quality and completeness of Care Coordination documentation.

Recommendations

- Ensure signatures within the TAR, electronic health records (EHR) and printed files, reflect the full signature (including credentials) of the Care Manager, as required by *NC Medicaid Contract, Section 8.2.2.1.*
- Develop, document, and implement a monitoring plan to analyze TAR extension data (e.g., monthly percentage of extended TARs, extensions to initial versus concurrent requests, patterns of extensions per service or provider, etc.) to this practice is being implemented by staff judiciously and with no undue burden placed on the provider or enrollee.
- Develop, document, and implement a data-driven monitoring plan that routinely reviews TCLI documentation. The monitoring plan should identify the frequency of

monitoring, departmental benchmarks for compliance, and how and when outcomes of monitoring are captured, reviewed, and reported. The monitoring plan should include review of timeliness and completeness of activities (e.g., transfer of cases, documentation of late progress notes, follow up activities, etc.), as well as the quality and completeness of TCLI documentation.

F. Grievances and Appeals

The EQR of grievances and appeals includes a thorough review of Cardinal's grievance and appeal policies and procedures, grievance and appeal logs, 25 grievance files, 25 appeal files, the *Member & Family Handbook*, Cardinal's website, and the *Provider Manual*.

Grievances

Policy & Procedure 5050, Grievances and Formal Levels of Review is the primary policy and procedure that governs Cardinal's grievance processes. There were two Recommendations in last year's EQR aimed at correcting or adding information in this policy and procedure. Cardinal implemented both Recommendations over the past year.

The *Provider Manual* and *Member & Family Handbook* provide an easy to read description of the grievance process. These documents, however, do not offer information on the right of the grievant to request an extension to the grievance resolution timeframe. On average, Cardinal resolves grievances in less than 20 days. It would be helpful for providers, members, and their representatives to know that they can request more time to gather and submit additional information regarding their grievance. CCME is recommending that additional information about the right to request an extension to a grievance is explained in the *Provider Manual* and *Member & Family Handbook*.

During the Onsite, Cardinal staff explained they have access to a variety of subject matter experts for grievance consultation. There is also a clinician on call 24/7/365 available to staff handling grievances. Cardinal staff described an active grievance consultation process that involves input from subject matter experts, when appropriate. However, within the files reviewed there were situations that warranted consultation with medical staff, but no consultations were evident. Staff explained that some consultations are conducted through email and may not be captured within the grievance record. CCME is recommending that Cardinal enhance their current monitoring process to ensure all consultations occur, when appropriate. Documentation of the consultations and their outcomes should also be captured within the grievance file.

Review of the grievance log showed less than 1% of the grievances were resolved outside of the 30-day timeframe. Cardinal monitors the percentage of timely resolution of grievances and reports those percentages to the Global Quality Improvement Committee (GQIC). The GQIC also reviews grievances by several categories such as type, service,

disability, provider, and rate of grievances per 1,000 members served. This information is also used as a part of the provider monitoring process.

Overall, the EQR of Cardinal's grievance functions resulted in only two Recommendations and all of the grievance standards were scored as "Met".

Appeals

Policy & Procedure 6020, Adverse Benefit Determination Notice and Appeal Process for Medicaid-Funded Services is Cardinal's primary policy and procedure for governing the processing of appeals. In the last EQR, several Corrective Actions and Recommendations were issued to address incorrect or missing information within this policy and procedure. Cardinal addressed all of these Corrective Actions and Recommendations over the past year.

It was also recommended last year that Cardinal correct information in the *Member & Family Handbook* that explained the timeframe for filing appeals. While this information was corrected in two places within the handbook, page 38 of the handbook still incorrectly states enrollees have 30 days to request an expedited, Reconsideration Review.

Cardinal reported one invalid appeal during the period in review. Review of this file showed that Cardinal determined this appeal was invalid as it was submitted 16 days outside of the allowable 60 days for filing an appeal. However, per the appeal log, there were 27 appeals that were processed despite being as many as 120 days beyond the timeframe for filing an appeal. Per Cardinal's Policy & Procedure 6020, if an appeal is received beyond the 60-day timeframe, staff "should immediately forward the request to the Office of General Counsel (OGC), who will respond to the request appropriately."

Guidelines or criteria are needed to ensure consistency and fairness in decisions by the OGC around whether to process an appeal received outside of the 60-day timeframe.

Cardinal enhanced their internal process for generating and mailing appeal resolution notifications over the past year. As a result, all of the appeals since the last EQR showed timely written notification of appeal resolution.

Within the expedited appeal files reviewed for this year's EQR, several notifications were not provided to enrollees as required by Cardinal's Policy & Procedure 6020, *NC Medicaid Contract, Attachment M*, and *42 CFR § 438*. The issues noted in the files this year were also targeted by two corrective actions in last year's EQR. The 2018 EQR corrective actions were to provide training to staff around expedited and extended appeal requirements and to enhance the current monitoring process for the purpose of increasing compliance. Staff were unable to demonstrate during the Onsite that either of

these occurred and, as a result, similar concerns were noted in the files reviewed this year. These concerns and their corresponding Recommendations and Corrective Actions are detailed within the Tabular Spreadsheet, located in Attachment 4 of this report.

In addition to these concerns, it was highlighted during the Onsite that the Appeal log contained some errors. The Appeal Log contained incorrect information regarding enrollee names, appeal extensions, and information about expedited appeals. One file, selected from the appeal log and reviewed for this EQR was not, in fact, an appeal. Staff explained during the Onsite that the process followed for resolving this inpatient denial was external to and separate from the appeal process. However, this resolution was captured on the appeal log and an appeal resolution notification sent to the enrollee. The appeal log should be routinely monitored for accuracy as it is the primary data source for the tracking, monitoring, and reporting of appeal data.

There were no files reviewed this year that showed Cardinal extended the appeal resolution timeframe. The appeal log also showed none were extended by Cardinal during the year in review. However, given the concerns from the previous EQR and that the required notifications around extended appeals parallel those of expedited appeals, CCME recommends Cardinal include appeal extensions in the development of the training and monitoring plans described in the Corrective Actions on this standard.

During the Onsite discussion, staff acknowledged that, when requested, the appeal record is provided to the appellant. In this discussion, however, there was no reference to Cardinal's policies and procedures that outline the required internal steps that must be followed prior to releasing an enrollee's record. There is also no reference to this process noted in Policy & Procedure 6020. CCME is recommending that Cardinal revise Policy & Procedure 6020 to describe the requirement of releasing the appeal record, when requested, and ensure this process is congruent with the policies and procedures that govern releasing PHI (e.g., Policy & Procedure 1920, Requests for Access to Member Records, Policy & Procedure 1924, Accounting of PHI Disclosures, etc.) It is also recommended that staff capture each step of releasing the appeal record within the appeal clinical documentation notes.

Figure 7 shows the percentage of standards scored as "Met" and "Partially Met" for this year's grievance and appeal EQR. A comparative of the previous year's scores is also demonstrated in Figure 7.

Figure 7: Grievances and Appeals Comparative Findings

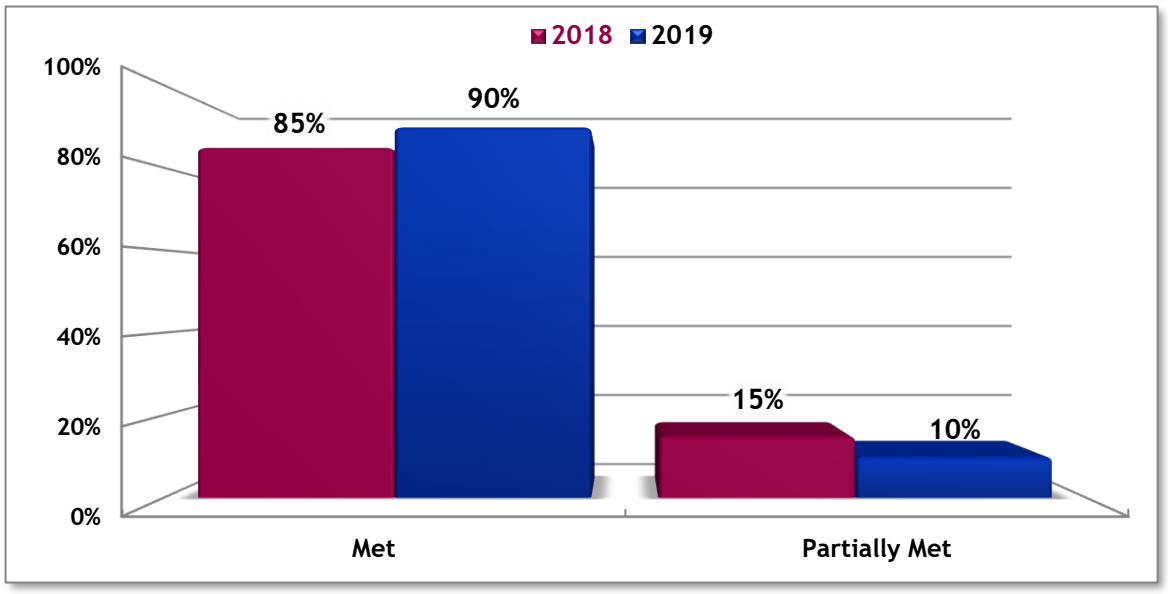


Table 25: Grievances and Appeals

Section	Standard	2019 Review
Appeals	The procedure for filing an appeal;	Partially Met
	The PIHP applies the appeal policies and procedures as formulated.	Partially Met

Strengths

- Cardinal enhanced their internal process for generating and mailing appeal resolution notifications over the past year. As a result, all of the appeals since the last EQR showed timely written notification of appeal resolution.

Weaknesses

- The *Provider Manual* and *Member & Family Handbook* do not offer information on the right of the grievant to request an extension to the grievance resolution timeframe.
- Within the grievance files reviewed there were situations that warranted consultation with medical staff or other subject matter experts, but no consultations were evident in the file.

- Page 37 of the *Member & Family Handbook* correctly states in two places that the enrollee has 60 days to request an appeal. Page 38, however, incorrectly states enrollees have 30 days to request an expedited appeal.
- Guidelines or criteria are needed to ensure consistency and fairness in decisions by the OGC around whether to process an appeal received outside of the 60 day timeframe.
- Within the expedited appeal files reviewed for this year's EQR, several notifications were not provided to enrollees as required by Cardinal's Policy & Procedure 6020, *NC Medicaid Contract*, *Attachment M*, and *42 CFR § 438*. This was a concern noted in Cardinal's previous EQR.
- While no appeal resolution timeframes were extended in the past year, the required notifications when Cardinal extends the resolution timeframe parallel those of expedited appeals. Staff should be trained on and appeal files monitored to ensure the required notifications occur.
- There is no reference to the process of releasing the enrollee's appeal record within Policy & Procedure 6020. There was also no evidence within the appeal clinical documentation notes that appeal staff were following the internal steps required by compliance policies and procedures governing the protection of PHI and the release of an enrollee's record.

Corrective Action

- The Appeals Department and the Office of General Counsel (OGC) should work together to develop guidelines or criteria for deciding when to process an appeal that has been received by Cardinal outside of the 60-day timeframe enrollees are given for filing appeals. Include those guidelines within Policy & Procedure 6020.
- Develop and implement a training plan to include a timeline for the training specific staff that will participate, how effectiveness of training will be evaluated, and a training agenda to include requirements listed in Attachment 4 of this report. This training would primarily focus on the required notifications related to expedited appeals.
- Develop, document, and implement a monitoring plan to increase compliance with required appeal notifications. See the required details of this monitoring plan outlined in Attachment 4 of this report. This monitoring plan would also focus on the required notifications related to expedited appeals.

Recommendations

- Add to the *Provider Manual* and the *Member & Family Handbook* information that a member, someone on the behalf of a member, or the PIHP can request to extend the grievance time frame to meet member rights requirements.

- Enhance that monitoring process to ensure any consultations with subject matter experts (medical, legal, HR staff, etc.) and the outcomes of these consultations are captured within the grievance investigation notes. Monitoring should also identify whether appropriate consultations are actually occurring.
- Revise page 38 of the *Member & Family Handbook* to say enrollees have 60 days to request an expedited appeal.
- Include in the training and monitoring plans above the required notifications and their timelines when Cardinal extends the appeal resolution timeframe.
- Revise Policy & Procedure 6020 to describe the requirement of releasing the appeal record, when requested, and ensure this process is congruent with the policies and procedures that govern releasing PHI (e.g., Policy & Procedure 1920, Requests for Access to Member Records, Policy & Procedure 1924, Accounting of PHI Disclosures, etc.) Ensure staff capture each step of releasing the appeal record within the appeal clinical documentation notes.
- Revise Policy & Procedure 6020 to describe the requirement of releasing the appeal record, when requested, and ensure this process is congruent with the policies and procedures that govern releasing PHI (e.g., Policy & Procedure 1920, Requests for Access to Member Records, Policy & Procedure 1924, Accounting of PHI Disclosures, etc.). Ensure staff capture each step of releasing the appeal record within the appeal clinical documentation notes.

G. Delegation

CCME's EQR of Delegation functions included a review of the relevant policies and procedures, and the submitted Delegate List, Delegation Contracts, and the Delegation Monitoring materials. CCME also conducted an Onsite interview with relevant staff.

At the last EQR, there were no Corrective Action items and one Recommendation. During the current EQR review period, Cardinal addressed the Recommendation item.

Cardinal's Policy & Procedure 1200, Delegation establishes the "standardized process for the delegation of NCQA-required activities to another business entity, instead of the activities being performed by Cardinal Innovations." Policy & Procedure 8345, Delegated Credentialing establishes, "a standardized process for the delegation of credentialing functions that would otherwise be performed by Cardinal Innovations."

As at the last EQR, Cardinal reported delegation agreements with five entities, as evidenced in *Table 26: Delegated Entities*. 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

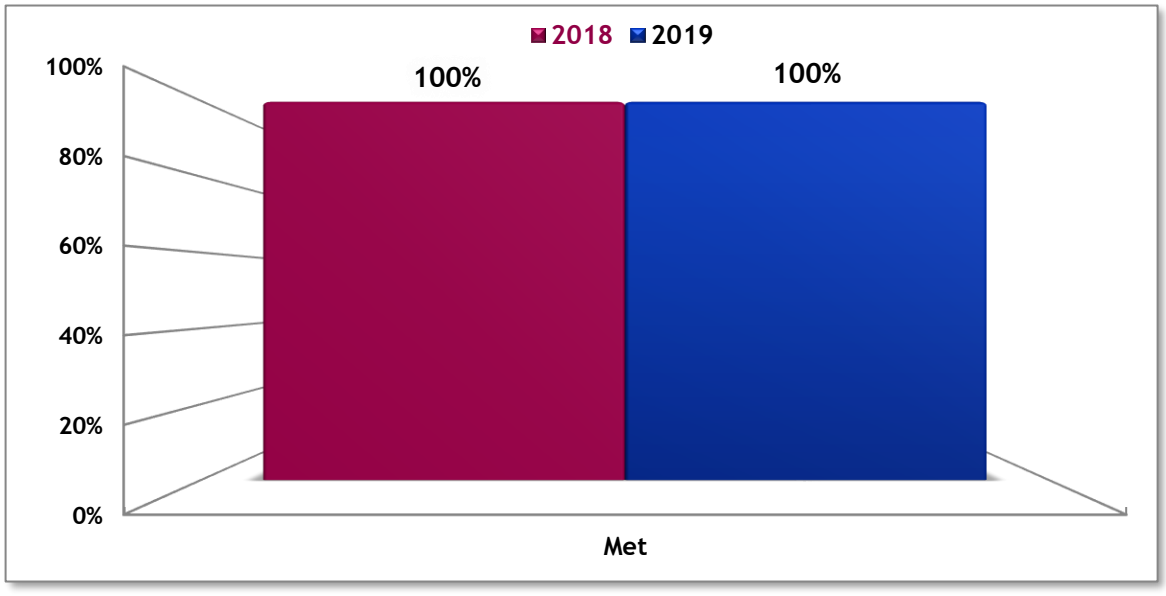
(PHI) is gathered or disclosed. The Delegation Agreement with Behavioral Healthcare Management (BHM) includes a BAA.

Table 26: 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
Atrium Health {formerly known as Carolinas Healthcare System (CHS) through Managed Health Resources, Inc.}	Delegated Credentialing

Figure 8 shows that Cardinal scored 100% "Met" on all of the Delegation standards in 2019 and the previous EQR in 2018.

Figure 8: Delegation Comparative Findings



Strengths

- Cardinal has current delegation contracts with all delegates, and a BAA for the delegate with access to PHI.

- BHM submits monthly reports, on a rolling quarter basis.
- The credentialing delegates submit a quarterly roster, and provider change reports on a monthly basis.
- Cardinal staff, including Dr. Wright-Etter, have biweekly meetings with BHM.
- Delegation reports are taken to the appropriate committees for review, discussion, and recommendations.

H. Program Integrity

The EQR of the Program Integrity (PI) involves assessing PIHP compliance with federal and state regulations regarding program integrity functions. This is accomplished through a review of a 15 PI files, Cardinal's *Compliance Plan*, training materials, organizational charts, job descriptions, committee meeting minutes and reports, provider agreements, enrollment application, workflows, *Provider Manual*, employee handbook, newsletters, and conflict of interest forms. Onsite interviews provided additional information around the Desk Review findings.

IPRO requested the universe of program integrity files from Cardinal for the review period and from there selected a random sample of 15 files with a two file oversample for a total of 17 files. These files were reviewed to ensure Cardinal provides required information to NC Medicaid on the approved PI template, and no concerns were noted.

In review of the PI documentation, one concern was noted related to Cardinal's Program Integrity Investigation Process Workflow. While this document provides an overview of the investigation process, it does not distinguish between the processes for investigation of fraud versus waste and abuse. The *NC Medicaid Contract*, *Section 14.2.6 (b)* requires each PIHP to have a detailed workflow, and it "differentiate the steps taken for fraud versus abuse." This is a *NC Medicaid Contract* requirement and so a Corrective Action is issued to bring Cardinal into compliance.

Figure 9 shows that Cardinal scored 98% "Met" and 2% "Partially Met" on Program Integrity standards in 2019 and compares this score to the percentage of standards scored as "Met" in 2018.

Figure 9: Program Integrity Comparative Findings

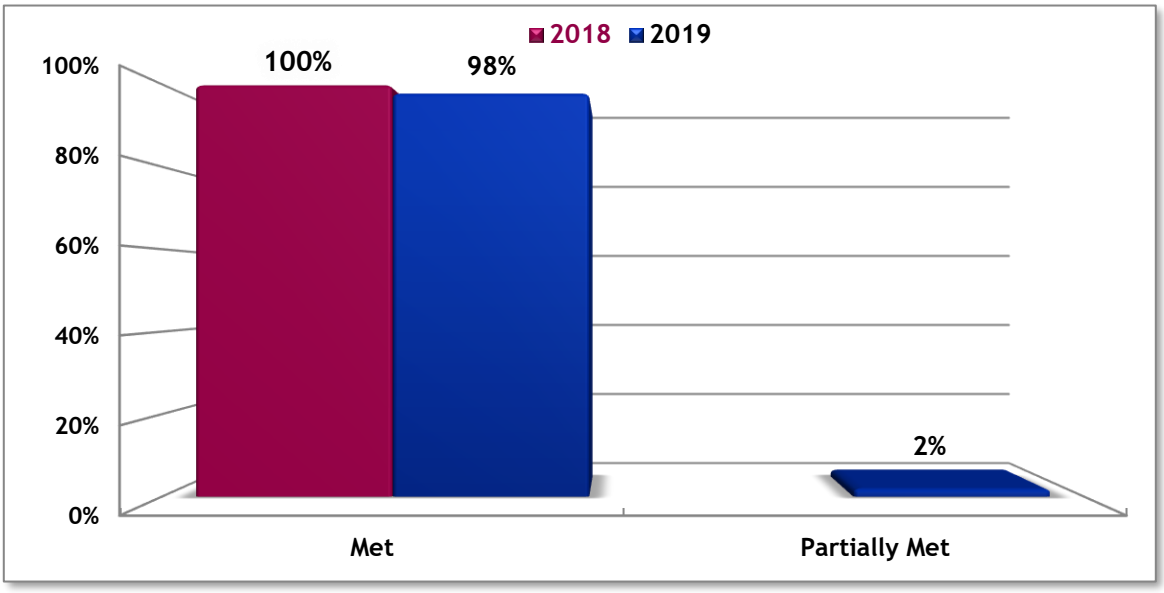


Table 27: Program Integrity

Section	Standard	2019 Review
Fraud and Abuse	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.	Partially Met

Strengths

- Cardinal uses a provider maturity model which takes a multi-functional view of their provider monitoring process, including compliance and Program Integrity functions.
- Cardinal implemented several successful data mining initiatives during the review period and has begun the migration to the FAMS tool set.

Weaknesses

- Cardinal's PI Investigation Process Workflow does not distinguish between the processes for investigation of fraud versus waste and abuse.

Corrective Actions

- Update the PI Investigation Process Workflow to differentiate the internal processes for investigating fraud versus investigating waste and abuse.

I. Financial Services

In reviewing Cardinal's financial operations, CCME used a standardized EQR Finance Desk Review and an Onsite Administrative Interview guide. CCME also reviewed deficiencies from prior EQRs to determine if they were corrected.

CCME implemented a Desk Review of the following documentation:

- Financial policies and procedures
- Audited financial statements and footnotes dated June 30, 2019
- Balance sheet and income statements dated July 31, 2019, and August 31, 2019
- Medicaid monthly financial reports for July 2019 and August 2019
- Claims processing aging reports for July and August, as well as claims processing policies
- Accounting Department staffing structure
- Fiscal year budget for 2019-2020
- Risk reserve account reporting and bank statements

In addition to the standardized Desk Review inquiries, CCME asked additional interview questions in the following areas:

- Policies and procedures
- Staffing changes in the Finance Department
- Accounting system

- Budget variances and development
- IBNR calculation
- Medical loss ratio calculation and reporting

The 2019 EQR of Cardinal's Financial Services identified one policy and procedure enhancement that was needed. The policy and procedure change related to adding language to Policy & Procedure 2150, Fiscal Records Retention to reflect 10 years retention for all Medicaid records. This recommendation was followed, and the policy and procedure was revised in January 2019.

Per the EQR of Cardinal's financial records, Cardinal demonstrates ongoing financial stability through their audit report, net asset balance, and financial ratios. Cardinal's audit report for June 30, 2019, received an overall unqualified audit opinion on financial statements, which indicates auditors believe that their audited financial statements present fairly, in all material respects the financial position of Cardinal. Their independent auditors did report one federal award finding over block grants for Prevention and Treatment of Substance Abuse. This finding was related to Cardinal not obtaining subrecipient audit reports as required. This finding was discussed at the interview; finance staff identifies providers and the network staff obtains the necessary audit reports for grant pass through dollars.

Cardinal exceeded the contract benchmarks for current ratio and Medical Loss Ratio (MLR). Cardinal's Medicaid current ratio is 2.12 total with a total current ratio of 1.99 in September 2019. The Medicaid current ratio is 2.0 total, with a total current ratio of 2.14 for October 2019. The benchmark is 1.00. Cardinal's year-to-date MLR is 93.65% year-to-date as of September 30, 2019, and 95.15% year-to-date as of October 31,2019. The benchmark is 85%. Medicaid total assets as of September 30, 2019, are $239,754,504 and $234,368,656 for October 31, 2019. Cardinal's net assets position was $190,935,093 as of June 30, 2019.

Cardinal meets the requirement in *42 CFR § 433.32(a)* for maintaining an appropriate accounting system (Great Plains). Cardinal uses Microsoft Dynamics Great Plains version 2018 and uses purchasing, financial, bank reconciliation, fixed assets, general ledger, and accounts payable. Cardinal uses CI for claims processing.

Cardinal meets the requirement of retaining financial records for ten years, as required by their *NC Medicaid Contract, Section 8.3.2*. The PIHP is retaining Medicaid financial records for ten years from the last date of service, date of activity, or end of reporting period, as applicable. Within Great Plains, records are not purged and remain accessible. The PIHP's Policy & Procedure, 2150 Fiscal Records Retention, states that Cardinal will keep all financial records for review by authorized federal and state personnel and their

contractors during the entire term of the contract and ten years thereafter, unless an audit is in progress.

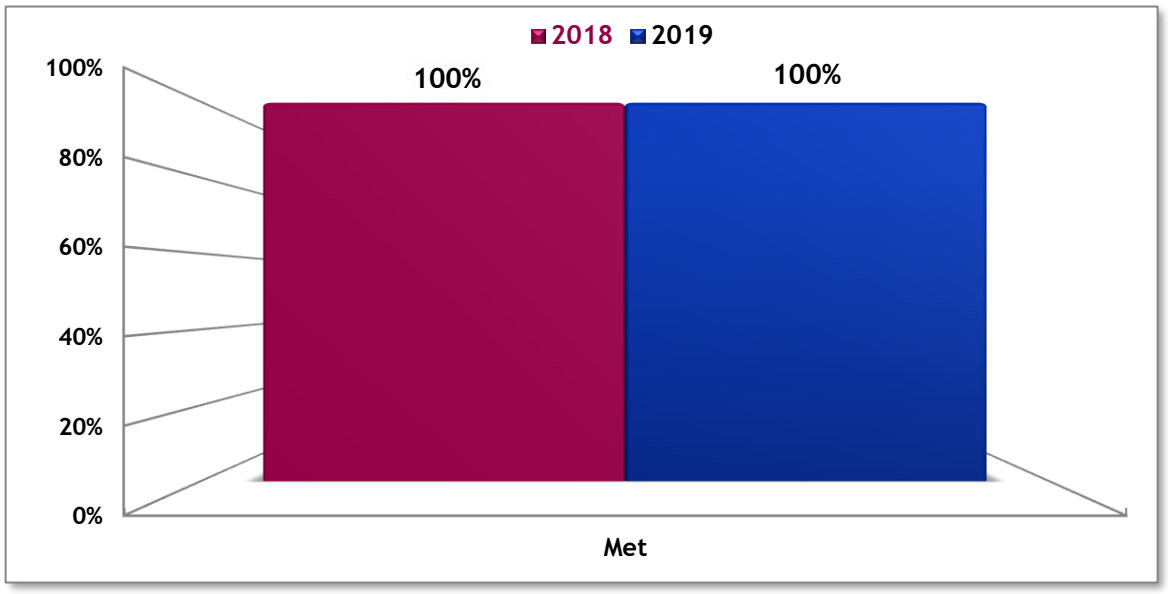
Cardinal's *Cost Allocation Plan* meets the requirements for allocating the administrative costs between federal, state, and local jurisdictions based on revenue as required by *42 CFR § 433.34.* Cardinal submits a *Cost Allocation Plan* to NC Medicaid annually to determine the percentage of Medicaid's share of administrative costs. Cardinal's Medicaid percentage for the current fiscal year is 89%. The administrative expenses are recorded by expense type in the general ledger, and then allocated to the different funding sources based on a percentage of total year-to-date service revenues received. Cardinal's Medicaid funds are properly segregated through the chart of accounts in the general ledger.

Cardinal's Medicaid Risk Reserve account meets the minimum requirement of contributing 1.6% of the capitation payment per month required by the *NC Medicaid Contract, Section 1.9.* During the period in review, Cardinal reached 12.7% of their required percentage of annualized capitation maximum (15%), with a balance of $95,801,681. Once Cardinal receives the NC Medicaid capitation payment, the payment is broken down by Category of Aid, and the Finance Director reviews and pays the risk reserve contribution electronically to the risk reserve account. All deposits are timely and there are no unauthorized withdrawals. Cardinal provided CCME with bank statements demonstrating the risk reserve deposit and balances. The risk reserve accounts are housed at Wells Fargo Bank and Uwharrie Bank, where they are invested in Certificates of Deposit. Cardinal indicated that it kept the risk reserve housed in multiple banks to lower risk.

Although Cardinal exceeds the requirements for minimum Medicaid and total current ratio, their cash on hand is low in terms of days of service expenses (6.3 days). This poses a potential risk to Cardinal's solvency and liquidity. A best practice Recommendation would be for Cardinal to keep 30 days of service expenses in cash on hand.

Figure 10 shows Cardinal scored a "Met" on 100% of the Finance standards in 2018 and 2019.

Figure 10: Financial Services Comparative Findings



Strengths

- Cardinal has changed auditors in order to gain certification on the accuracy of the Incurred but Not Reported (IBNR) liability.
- Cardinal utilizes a medical economics team to review and analyze revenue and the changes in IBNR process.
- Cardinal's policies have Medicaid contract and statutory references, as well as cross-references to other Cardinal policies.

Weaknesses

- Although Cardinal exceeds the requirements for minimum Medicaid and total current ratio, it is low in days of service expenses in cash (6.3 days) as compared with the other PIHPs, which typically average 30 days of service expenses in cash.
- Policy & Procedure 2212, Management of Financial Risk is missing details around the Medical Loss Ratio process.

Recommendations

- Keep 30 days of service expenses in cash on hand. Policy & Procedure 2212, Management of Financial Risk should be revised to include monthly monitoring of days service expenses.

- Enhance the information related to the Medical Loss Ratio process in Policy & Procedure 2212, Management of Financial Risk to include the 85% minimum, the process for MLR monitoring, and HCQI expenses.

J. Encounter Data Validation

CCME subcontractor, HMS, has completed a review of the encounter data submitted by Cardinal to NC Medicaid, as specified in the CCME agreement with NC Medicaid.

The scope of the review, guided by the CMS EDV Protocol, was focused on measuring the data quality and completeness of claims paid by Cardinal for the period of January 2018 through December 2018. 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 Information Systems Capability Assessment (ISCA)
- Analysis of Cardinal's converted 837 encounter files
- A review of NC Medicaid's encounter data acceptance report

Results and Recommendations

Issue: Procedure Code

The Procedure code for Institutional claims should be populated 99% of the time. In the encounter data provided, only 67% of claims contained a value in the Procedure code field and 1 % values were populated with a Revenue code instead of a valid Procedure code.

Resolution:

This issue was present in the review of 2017 encounters, but at a much higher error rate. Cardinal should ensure that the appropriate data validation checks are in place in their provider portal to prevent Revenue codes being submitted in the Procedure code fields. Claims submitted through the portal or an 837 should be denied by Cardinal without the proper Revenue code and Procedure code combination. Cardinal should review their 837 encounter creation and encounter data extract process to ensure that an invalid Procedure code is not transmitted to NC Medicaid, even when the data is invalid based on the provider claim submission.

Issue: Recipient ID

The Recipient ID should be populated 100% of the time with valid values. NC Medicaid is expecting a 10-byte alphanumeric value, specifically 9 digits following by and alpha character. Of the encounters submitted, 553 records were invalid. There was a mix of SSN values with the hyphen included and values less than 10 bytes in length.

Resolution:

Cardinal's eligibility data is driven by the 834 and Global Eligibility File (GEF) provided by NC Medicaid. Cardinal should ensure that each encounter being submitted matches to the state-provided eligibility prior to submission. They already validate that the member is eligible prior to claim payment, so the correct Recipient or Medicaid Id should be captured and available for submission. If the claim being submitted by the provider does not contain a valid Recipient ID, the claim should be denied. If the claim is being submitted through the provider portal, the provider should be limited to only select or enter a valid Id on record with the PIHP.

Conclusion:

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

The two issues identified were only apparent in the Institutional claims submitted and are minimal considering the volume of claims and the method for adjudication (Revenue code vs Procedure code). Cardinal should take corrective action to ensure they are capturing and reporting valid Procedure codes for Institutional claims when required for the reported Revenue code, and only submitting the expected 10-byte alphanumeric Recipient ID.

For the next review period, 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 PIHP. Reviewing an extract from NCTracks would provide insight into how the state's MMIS is handling the encounter claims and could be reconciled back to reports requested from Cardinal. The goal is to ensure that Cardinal is reporting all paid claims as encounters to NC Medicaid.

The full Encounter Data Validation report can be found in *Attachment 5* of this report.

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet
- Attachment 5: Encounter Data Validation Report

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

November 18, 2019

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

Dear Mr. Sutten,

At the request of the North Carolina Medicaid (NC Medicaid), this letter serves as notification that the 2019 External Quality Review (EQR) of Cardinal Innovations Healthcare (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 29, 2020** through **January 30, 2020**. 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 11, 2019**. As indicated in item 40 of the Desk Materials 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 42 of the Desk Materials 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 the NC 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: Greg Daniels, NC Medicaid Contract Manager
Deb Goda, NC Medicaid Behavioral Health Unit Manager

External Quality Review 2019

MATERIALS REQUESTED FOR DESK REVIEW

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

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

3. Current Medical Director and Medical Staff job descriptions.

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

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

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

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

8. List of new services added to the provider network in the past 12 months (November 2018 through October 2019) by provider.

9. Network turnover rate for the past 12 months (November 2018 through October 2019) including a list of providers that were terminated for cause and list of providers that did not have their contracts renewed. For five providers termed in the last 12 months (November 2018 through October 2019), who were providing service to enrollees at the time of the termination notice, submit the termination letter sent to or from the provider, and the notification (of provider termination) letters sent to three consumers who were seeing the provider at the time of the provider termination notice.

10. List of providers credentialed/recredentialed in the last 12 months (November 2018 through October 2019). Include the date of approval of initial credentialing and the date of approval of recredentialing.

11. A current provider manual and provider directory.

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

13. The Quality Improvement work plans for 2018 and 2019.

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

15. Minutes of committee meetings for the months of November 2018 through October 2019 for all committees reviewing or taking action on enrollee-related activities. For example, quality committees, quality subcommittees, credentialing committees, compliance committee, etc.

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

16. 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.

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

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

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

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

21. 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.

22. A copy of the complete Appeals log for the months of November 2018 through October 2019. Please indicate on the log appeal type (standard or expedited), the service appealed, the date the appeal was received, the resolution date, and if the resolution timeframe was extended, who requested the extension. Also include on the log those appeals that were withdrawn or deemed invalid.

23. A copy of the complete Grievances log for the months of November 2018 through October 2019. Please indicate on the log the nature of the grievance, the date received, and the date resolved. If the grievance resolution timeframe was extended, please include who requested the extension.

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

25. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal PIHP compliance with these standards.
26. Clinical Practice Guidelines developed for use by practitioners, including references used in their development, when they were last updated and how they are disseminated. Also, policies and procedures for researching, selecting, adopting, reviewing, updating, and disseminating practice guidelines. Results of the most recent monitoring of provider compliance with Clinical Practices Guidelines.

27. All information supplied at orientation to new providers, including, for example, the Welcome letter and any orientation materials. If the new provider orientation is provided via the PIHP website, provide a link to the location of the orientation materials. Please also provide the location of ongoing provider training materials and/or calendar of training events.

28. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the PIHP, and any reports of activities submitted by the subcontractor to the PIHP. Include pre-delegation assessments conducted for any delegates added/contracted during the timeframe covered by the current EQR.

29. Contracts and relevant amendments for all delegated entities, including Business Associate Agreements for delegates handling PHI.

30. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used. Include annual evaluations, if applicable, and indicate to which committees delegate monitoring is reported.

31. Please provide an excel spreadsheet with a list of enrollees that have been placed in care coordination since April 2016. Please indicate the disability type (MH/SU, I/DD).
32. Please provide an excel spreadsheet with a list of enrollees that have been placed in the TCLI program since April 2016. Please indicate on that list the individuals transitioned to the community, the individuals currently receiving Care Coordination, the individuals connected to services and list the services they are receiving, the individuals choosing to remain in ACH and the services they are receiving.
33. Information regarding the following selected Performance Measures:

B WAIVER MEASURES	
A.1. Readmission Rates for Mental Health	D.1. Mental Health Utilization - Inpatient Discharges and Average Length of Stay
A.2. Readmission Rate for Substance Abuse	D.2. Mental Health Utilization
A.3. Follow-up After Hospitalization for Mental Illness	D.3. Identification of Alcohol and other Drug Services
A.4. Follow-up After Hospitalization for Substance Abuse	D.4. Substance Abuse Penetration Rate
B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment	D.5. Mental Health Penetration Rate
C WAIVER MEASURES	
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals
Proportion of beneficiaries reporting they have a choice between providers.	Proportion of Individual Support Plans that address identified health and safety risk factors
Percentage of level 2 and 3 incidents reported within required timeframes.	Percentage of participants reporting that their Individual Support Plan has the services that they need
Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.	Percentage of beneficiaries who received appropriate medication.
Percentage of medication errors resulting in medical treatment.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.

Required information includes the following for each measure:

a. Data collection methodology used (administrative, medical record review, or hybrid) including a full description of those procedures;

b. Data validation methods/ systems in place to check accuracy of data entry and calculation;

c. Reporting frequency and format;

d. Complete exports of any lookup / electronic reference tables that the stored procedure / source code uses to complete its process;

e. Complete calculations methodology for numerators and denominators for each measure, including:

   i. The actual stored procedure and / or computer source code that takes raw data, manipulates it, and calculates the measure as required in the measure specifications;

ii. All data sources used to calculate the numerator and denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);

iii. All specifications for all components used to identify the population for the numerator and denominator;

f. The latest calculated and reported rates provided to the State.

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

34. 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.)

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

36. Data, Dashboards and/or reports for the Transition to Community Living Initiative (e.g., numbers of in-reach completed, housing slots filled, completed transitions, numbers of enrollees in supported employment, numbers of enrollees receiving ACT, Supported Employment, Peer Support Services, Community Support Team, Psychosocial Rehabilitation, etc. for the period November 2018 through October 2019.

37. Call performance statistics for the period of November 2018 through October 2019, including average speed of answer, abandoned calls, and average call/handle time for customer service representatives (CSRs).

38. Provide copies of the following files:

a. Credentialing files for the 12 most recently credentialed practitioners (should include 6 licensed practitioners who work at agencies and 6 Licensed Independent Practitioners; include at least two physicians). Please also include 4 files for network provider agencies and/or hospitals and/or psychiatric facilities, in any combination. Please submit the full credentialing file, from the date of the application/attestation, to the notification of approval of credentialing. In addition to the application and notification of credentialing approval, the credentialing files should include all of the following:

i. Insurance:

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

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

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

iii. Ownership disclosure information/form.

b. Recredentialing files for the 12 most recently recredentialed practitioners (should include 6 licensed practitioners who work at agencies and 6 Licensed Independent Practitioners, include the files of at least two MDs). Also, please include 4 files of network provider agencies and/or hospitals and/or psychiatric facilities, in any combination.
Please submit the full recredentialing file, from the date of the application/attestation, to the notification of approval of recredentialing. In addition to the recredentialing application, the recredentialing files should include all of the following:

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

ii. Insurance:

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

B.

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

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

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

v. Ownership disclosure information/form.

c. Ten MH/SU, ten I/DD and five TCLI files medical necessity approvals made from November 2018 through October 2019, including any medical information and approval criteria used in the decision. Please select MEDICAID ONLY files and submit the entire file.

d. Ten MH/SU, ten I/DD and five TCLI files medical necessity denial files for any denial decisions made from November 2018 through October 2019. 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.

39. Provide the following for Program Integrity:
    a. File Review: Please produce a listing of all active files during the review period (November 2018 through October 2019) including:
        i. Date case opened
        ii. Source of referral
        iii. Category of case (enrollee, provider, subcontractor)
        iv. Current status of the case (opened, closed)
    b. Program Integrity Plan and/or Compliance Plan.
    c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.
    d. Workflow of process of taking complaint from inception through closure.
    e. All 'Attachment Y' reports collected during the review period.
    f. All 'Attachment Z' reports collected during the review period.
    g. Provider Manual and Provider Application.
    h. Enrollee Handbook.
    i. Subcontractor Agreement/Contract Template.
    j. Training and educational materials for the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse and the False Claims Act.
    k. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse.
    l. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors and employees.
    m. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to NC Medicaid or any other state or federal agency.
    n. Code of Ethics and Business Conduct.
    o. Internal and/or external monitoring and auditing materials.
    p. Materials pertaining to how the PIHP captures and tracks complaints.
    q. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
        i. NC Medicaid approved reporting templates.
    r. Sample Data Mining Reports.

s. NC Medicaid Monthly Meeting Minutes for entire review period, including agendas and attendance lists.
t. Monthly reports of NCID holders/FAMS-users in PIHP.
u. Any program or initiatives the plan is undertaking related to Program Integrity including documentation of implementation and outcomes, if appropriate.
v. Corrective Action Plans including any relevant follow-up documentation.
w. Policies/Procedures for:
    i. Program Integrity
    ii. HIPAA and Compliance
    iii. Internal and external monitoring and auditing
    iv. Annual ownership and financial disclosures
    v. Investigative Process
    vi. Detecting and preventing fraud
    vii. Employee Training
    viii. Collecting overpayments
    ix. Corrective Actions
    x. Reporting Requirements
    xi. Credentialing and Recredentialing Policies
    xii. Disciplinary Guidelines

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

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

NC Medicaid Submissions	2b	Workflow for NC Medicaid denials
NC Medicaid Submissions	2e	NC Medicaid outstanding claims report

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

41. 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. 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.
    l. Copy of the last two program integrity reports sent to NC Medicaid's Program Integrity Department.
    m. 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.
    n. 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.
    o. List of the internal and external program integrity trainings delivered by PIHP in the past year.
    p. Description and procedures used to allocate direct and overhead expenses to Medicaid and state funded programs, if changed during the review period.
    q. Claims still pending after 30 days.
    r. Bank statements for the restricted reserve account for the most recent two months.

s. A copy of the most recent administrative cost allocation plan.
t. A copy of the PIHP's accounting manual.
u. A copy of the PIHP's general ledger chart of accounts.
v. Any finance Corrective Action Plan
w. 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
x. A copy of the PIHP's annual MLR report.

42. Provide the following for Encounter Data Validation (EDV):
    a. Include all adjudicated claims (paid and denied) from January 1, 2018 – December 31, 2018. Follow the format used to submit encounter data to NC Medicaid (i.e., 837I and 837P). If you archive your outbound files to NC Medicaid, you can forward those to HMS for the specified time period. In addition, please convert each 837I and 837P to a pipe delimited text file or excel sheet using an EDI translator. If your EDI translator does not support this functionality, please reach out immediately to HMS.
    b. Provide a report of all paid claims by service type from January 1, 2018 – December 31, 2018. Report should be broken out by month and include service type, month and year of payment, count, and sum of paid amount.

NOTE: EDV information should be submitted via the secure FTP to HMS. This site was previously set up during the first round of Semi-Annual audits with HMS. If you have any questions, please contact James Finley of HMS at (770) 933-5829.

B. Attachment 2: Materials Requested for Onsite Review

Cardinal Pre Onsite Request List

External Quality Review 2019

MATERIALS REQUESTED FOR REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were uploaded 12/11/19. Please submit in Folder 15 and label subfolder “Recent committee minutes”.

2. Please submit items missing from credentialing/recredentialing files, for providers identified on the separate list (titled “Cardinal Cred.Recred Supplemental Documentation list”), for information obtained during the credentialing/ recredentialing process. Please upload into Folder 38 (into subfolder 38a. for Credentialing or 38b. for Recredentialing).

3. For the I/DD Care Coordination files submitted, any evidence of HCBS monitoring. Please submit into Folder 31, within the I/DD subfolder.

4. Meeting minutes over the past year from the workgroup discussing interventions for low scoring enrollee survey items. Please upload into Folder 15.

5. CQI Charter. Please upload to Folder 15, CQI Committee Folder.

6. Any care notes related to appeals for appeal files #11, #14, and #18. Please upload into Folder 22.

7. The appeal request that was submitted by appellant for appeal file #18. Please upload into Folder 22.

8. Documentation of the clinician that made the initial UM denial for appeal files #5, #7, #8 and #18.

9. Please provide any documentation of the investigation and investigation outcome for PI file #876. Please upload into Folder 39.

10. Please provide the resolution notifications to the grievant from Cardinal for grievance #6695 and # 6748. Please upload into Folder 23.

11. Any existing Desk Reference, Operations Manual, etc. that describes in detail the credentialing and recredentialing workflows. Please do not create a new document for this request. Please upload into Folder 38.

C. Attachment 3: EQR Validation Worksheets

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

- Performance Improvement Project Validation Worksheet
  - Improving the percentage of follow-up appointments that occurs within 7 and 30 days of mental health specific community hospital and facility-based crisis discharges
  - Improving the percentage of follow-up appointment that occurs within 7 and30 days of SA-related community hospital and SA-related facility-based crisis discharges Increase Rate of Routine Access to Care Calls Receiving Service Within 14 Days
  - Diabetes screening for individuals with schizophrenia and bipolar disorder who are using anti-psychotic medications
  - Adherence to antipsychotic medications for individuals with schizophrenia
  - Metabolic monitoring for children and adolescents on antipsychotics
  - Metabolic monitoring for adults on antipsychotics
  - Treatment authorization requests
  - Improving timely access to care

CCME EQR PM Validation Worksheet

PIHP Name:	**CARDINAL**
Name of PM:	**READMISSION RATES FOR MENTAL HEALTH**
Reporting Year:	7/1/2018-6/30/2019
Review Performed:	01/20

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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**
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 were complete.
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**
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 were complete.
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.
Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
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**
Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
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**
Name of PM:	**READMISSION RATES FOR SUBSTANCE ABUSE**
Reporting Year:	7/1/2018-6/30/2019
Review Performed:	01/20

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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**
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.
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**
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 were complete.
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.
Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
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**
Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
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**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS**
Reporting Year:	7/1/2018-6/30/2019
Review Performed:	01/20

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
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GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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**
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 were complete.
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**
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 were complete.
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.
Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
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**
Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
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**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR SUBSTANCE ABUSE**
Reporting Year:	7/1/2018-6/30/2019
Review Performed:	01/20

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
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GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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**
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 were complete.
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**
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 were complete.
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.
Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
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**
Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
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.

CME EQR PM Validation Worksheet

PIHP Name:	**CARDINAL**
Name of PM:	**INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT**
Reporting Year:	7/1/2018-6/30/2019
Review Performed:	01/20

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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**
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 were complete.
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**
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 were complete.
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.
Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
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**
Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
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**
Name of PM:	**MENTAL HEALTH UTILIZATION- INPATIENT DISCHARGES AND AVERAGE LENGTH OF STAY**
Reporting Year:	7/1/2018-6/30/2019
Review Performed:	01/20

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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**
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 were complete.
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**
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 were complete.
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.
Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
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**
Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
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**
Name of PM:	**MENTAL HEALTH UTILIZATION**
Reporting Year:	7/1/2018-6/30/2019
Review Performed:	01/20

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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**
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 were complete.
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**
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 were complete.
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.
Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
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**
Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
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**
Name of PM:	**IDENTIFICATION OF ALCOHOL AND OTHER DRUG SERVICES**
Reporting Year:	7/1/2018-6/30/2019
Review Performed:	01/20

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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**
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 were complete.
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**
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 were complete.
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.
Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
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**
Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
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**
Name of PM:	**SUBSTANCE ABUSE PENETRATION RATE**
Reporting Year:	7/1/2018-6/30/2019
Review Performed:	01/20

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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**
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 were complete.
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**
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 were complete.
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.
Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
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**
Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
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**
Name of PM:	**MENTAL HEALTH PENETRATION RATE**
Reporting Year:	7/1/2018-6/30/2019
Review Performed:	01/20

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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**
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 were complete.
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**
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 were complete.
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.
Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
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**
Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
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 PM Validation Worksheet

PIHP Name	**CARDINAL**
Name of PM	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals.
Reporting Year	2018-2019
Review Performed	01/20

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications, and sources were documented.
Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods were noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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.
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**
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.
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**
Reporting (10)	Was the measure reported accurately?	**MET**	Rate reported in Waiver Excel file.
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**
Name of PM	Proportion of Individual Support Plans that address identified health and safety risk factors
Reporting Year	2018-2019
Review Performed	01/20

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications, and sources were documented.
Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods were noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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.
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**
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.
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**
Reporting (10)	Was the measure reported accurately?	**MET**	Rate reported in Excel file.
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**
Name of PM	Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need.
Reporting Year	2018-2019
Review Performed	01/20

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications, and sources were documented.
Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods were noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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.
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**
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.
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**
Reporting (10)	Was the measure reported accurately?	**MET**	Rate reported in Excel file.
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**
Name of PM	Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available
Reporting Year	2018-2019
Review Performed	01/20

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications, and sources were documented.
Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods were noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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.
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**
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.
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**
Reporting (10)	Was the measure reported accurately?	**MET**	Rate reported in Excel file.
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**
Name of PM	Proportion of beneficiaries reporting they have a choice between providers
Reporting Year	2018-2019
Review Performed	01/20

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications, and sources were documented.
Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods were noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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.
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**
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.
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**
Reporting (10)	Was the measure reported accurately?	**MET**	Rate reported in Excel file
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**
Name of PM	Percentage of level 2 and 3 incidents reported within required timeframes
Reporting Year	2018-2019
Review Performed	01/20

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications, and sources were documented.
Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods were noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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.
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**
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.
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**
Reporting (10)	Was the measure reported accurately?	**MET**	Rate reported in Excel file.
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**
Name of PM	Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.
Reporting Year	2018-2019
Review Performed	01/20

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications, and sources were documented.
Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods were noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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.
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**
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.
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**
Reporting (10)	Was the measure reported accurately?	**MET**	Rate reported in Excel file.
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**
Name of PM	Percentage of medication errors resulting in medical treatment
Reporting Year	2018-2019
Review Performed	01/20

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications, and sources were documented.
Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods were noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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.
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**
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.
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**
Reporting (10)	Was the measure reported accurately?	**MET**	Rate reported in Excel file
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**
Name of PM	Percentage of beneficiaries who received appropriate medication
Reporting Year	2018-2019
Review Performed	01/20

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications, and sources were documented.
Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods were noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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.
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**
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.
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**
Reporting (10)	Was the measure reported accurately?	**MET**	Rate reported in Excel file.
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**
Name of PM	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required
Reporting Year	2018-2019
Review Performed	01/20

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications, and sources were documented.
Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods were noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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.
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**
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.
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**
Reporting (10)	Was the measure reported accurately?	**MET**	Rate reported in Excel file.
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%**

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.

CCME EQR PIP Validation Worksheet

PIHP Name:	**CARDINAL**
Name of PIP:	**IMPROVING 7- AND 30-DAY FOLLOW-UP FOR MH-RELATED DISCHARGES**
Reporting Year:	**2019**
Review Performed:	**01/2020**

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 addressed 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 was 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 were 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 were 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 relevant to study question were 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 was documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data were 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 was 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 provided consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Personnel collecting the data were 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 addressed 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 were presented in table format.
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 or sustainment of rate 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 was the result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Sampling was not used, thus, statistical testing was 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

Steps	Possible Score	Score		Steps	Possible Score	Score
Step 1				**Step 6**		
1.1	5	5		6.4	5	5
1.2	1	1		6.5	1	1
1.3	1	1		6.6	5	5
Step 2				**Step 7**		
2.1	10	10		7.1	10	10
Step 3				**Step 8**		
3.1	10	10		8.1	5	5
3.2	1	1		8.2	10	10
Step 4				8.3	1	1
4.1	5	5		8.4	1	1
4.2	1	1		**Step 9**		
Step 5				9.1	5	5
5.1	NA	NA		9.2	1	1
5.2	NA	NA		9.3	5	5
5.3	NA	NA		9.4	NA	NA
Step 6				**Step 10**		
6.1	5	5		10.1	NA	NA
6.2	1	1		**Verify**		
6.3	1	1			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 PIHP 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	PIHP 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**
Name of PIP:	**IMPROVING 7- AND 30-DAY FOLLOW-UP FOR SA-RELATED DISCHARGES**
Reporting Year:	**2019**
Review Performed:	**01/2020**

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 addressed 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 was 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 were 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 were 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 relevant to study question were 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 was documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data were 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 was 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 provided consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Personnel collecting the data were 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 addressed 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 were presented in tables.
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 was the result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Sampling was not used, thus statistical testing was 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 PIHP 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	PIHP 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**
Name of PIP:	**DIABETES SCREENING FOR PEOPLE WITH SCHIZOPHRENIA OR BIPOLAR DISORDER WHO ARE USING ANTIPSYCHOTIC MEDICATIONS**
Reporting Year:	**2019**
Review Performed:	**01/2020**

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 addressed 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 was 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 were related to functional and health 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 were 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 relevant to the study question were 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 was documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data were 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 was 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 provided consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Personnel collecting the data were 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 addressed 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 were presented in table format showing benchmark rate of 81% was met at baseline.
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 baseline measurement.
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)**	**NA**	Baseline data only.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Baseline data only.
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)**	**NA**	Baseline data only.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Baseline data only.

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**	Baseline data only.

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	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify	NA	NA

Project Score	**79**
Project Possible Score	**79**
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 PIHP 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	PIHP 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**
Name of PIP:	**ADHERENCE TO ANTIPSYCHOTIC MEDICATIONS FOR INDIVIDUALS WITH SCHIZOPHRENIA**
Reporting Year:	**2019**
Review Performed:	**01/2020**

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 addressed 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 was 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 were related to functional and health 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 were 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 relevant to the study question were 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 was documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data were 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 was 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 provided consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Personnel collecting the data were 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 addressed 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 were presented in table format showing benchmark rate of 63% was met at baseline.
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 baseline measurement.
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)**	**NA**	Baseline data only.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Baseline data only.
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)**	**NA**	Baseline data only.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Baseline data only.

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**	Baseline data only.

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	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify	**NA**	**NA**

Project Score	**79**
Project Possible Score	**79**
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 PIHP 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	PIHP 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**
Name of PIP:	**METABOLIC MONITORING FOR CHILDREN AND ADOLESCENTS ON ANTI-PSYCHOTICS**
Reporting Year:	**2019**
Review Performed:	**01/2020**

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 addressed 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 was 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 were related to health 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 were 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 relevant to the study question were 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 was documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data were 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 was 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 provided 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 were 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 addressed 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 were presented in table format. Numerator and denominator rates were unable to be accessed for baseline, as per onsite discussion.
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 measurement.
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 or maintenance of rates occurred, with the exception of Lipid/LDL-C panel testing that decreased by 1%.
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 was the result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Sampling was 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 PIHP 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	PIHP 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**
Name of PIP:	**METABOLIC MONITORING FOR ADULTS ON ANTI-PSYCHOTICS**
Reporting Year:	**2019**
Review Performed:	**01/2020**

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 addressed 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 was 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 were related to health 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 were 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 relevant to the study question were 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 was documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data were 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 was 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 provided consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Personnel collecting the data were 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 addressed 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 were presented in table format. Numerator and denominator rates were unable to be accessed for baseline, as per onsite discussion.
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 measurement.
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 by 1% for all three quantifiable measures.
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 was the result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Sampling was 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 PIHP 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	PIHP 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**
Name of PIP:	**METABOLIC MONITORING FOR ADULTS ON ANTI-PSYCHOTICS**
Reporting Year:	**2019**
Review Performed:	**01/2020**

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 addressed 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 was 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 were related to health 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 were 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 relevant to the study question were 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 was documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data were 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 was 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 provided consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Personnel collecting the data were 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 addressed 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 were presented in table format. Numerator and denominator rates were unable to be accessed for baseline, as per onsite discussion.
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 measurement.
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 by 1% for all three quantifiable measures.
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 was the result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Sampling was 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 PIHP 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	PIHP 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**
Name of PIP:	**TREATMENT AUTHORIZATION REQUESTS**
Reporting Year:	**2019**
Review Performed:	**01/2020**

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 addressed 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 was 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 were related to health status and processes of care.
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 were 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 relevant to the study question were 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 was documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data were 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 was 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 provided consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Personnel collecting the data were 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 addressed 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 were presented in table format.
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 remeasurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Of the six measures, the majority (four) improved and two did not improve.
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 was related to training and reviews.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Sampling was 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 PIHP 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	PIHP 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**
Name of PIP:	**IMPROVING TIMELY ROUTINE ACCESS TO CARE**
Reporting Year:	**2019**
Review Performed:	**01/2020**

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 addressed 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 was 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 were related to health status and processes of care.
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 were 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 relevant to the study question were 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 was documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data were 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 was 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 provided consistent data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Personnel collecting the data were 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 addressed 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 were presented in table format.
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 remeasurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	Medicaid and non-Medicaid rates decreased from Measurement 3 to 4. ***Recommendation: Continue to address barriers of childcare, transportation for members, and mobile engagement.***
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)**	**NA**	No reported improvement.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Sampling was 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	0
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify		
	NA	NA

Project Score	**84**
Project Possible Score	**85**
Validation Findings	**99%**

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 PIHP 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	PIHP 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.*

D. Attachment 4: Tabular Spreadsheet

CCME PIHP Data Collection Tool

PIHP Name:	Cardinal
Collection Date:	2019

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 Enrollees, both directly and indirectly.	X					For this year's review, 233 policies and procedures were submitted. Review of these policies showed Cardinal has an active revision process and each policy and procedure is reviewed annually. Policy & Procedure 1000, Policy and Procedure Development, adequately describes the process for creating, terminating, revising, and annually reviewing policies and procedures. It was recommended in last year's EQR that Cardinal add more detail describing the final policy and procedure approval process. Cardinal addressed this Recommendation and now Policy & Procedure 1000 explains the Office of General Counsel completes the final step of reviewing and publishing revised or new policies and procedures.
I. B. Organizational Chart / Staffing						
1. The PIHP's resources are sufficient to ensure that all health care products and services required by the State of North Carolina are provided to enrollees. At a minimum, this includes designated staff performing in the following roles:						

STANDARD	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					The information submitted for this year's EQR did not clearly demonstrate oversight by the Medical Department. Review of committee minutes showed membership by medical staff was in flux in the past year. Also, the *Organizational Chart* did not contain information showing departmental or function oversight or correct credentials for the Chief Medical Officer (CMO). During the Onsite, the current CMO explained that, since assuming her CMO role in July 2019, she has thoroughly evaluated the current staffing of functions such as credentialing, Utilization Management oversight, etc. and is in the process of moving medical staff into specified roles. CCME recommends again this year that Medical Director oversight by the CMO or designees are delineated on the *Organizational Chart*. The *Organizational Chart* is the only document that can capture the various functions of the Medical Department staff and is essential to demonstrating "substantial oversight" over functions specified in the *NC Medicaid Contract* is occurring. ***Recommendation: On the Organizational Chart, delineate functions and/or departmental oversight of staff within the Medical Department.***
2. Operational relationships of PIHP staff are clearly delineated.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all PIHP staff positions, including those that are required by NC Medicaid.	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					Cardinal continues to ensure new staff are trained on their HIPAA/confidentiality practices during new employee orientation and prior to their exposure to PHI.
I D. Management Information Systems						
1. Enrollment Systems						
1.1 The PIHP capabilities of processing the state enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					The 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 is able to examine 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.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.2 The PIHP is able to identify and review any errors identified during, or as a result, of the state enrollment file load process.	X					Cardinal generates a GEF exception report and the Member Data Management Team review on a weekly basis and correct exceptions based on established business rules. Eligibility records are reconciled with the monthly 820 Capitation file and also use the quarterly GEF full file received from NC Medicaid as additional reconciliation.
1.3 The PIHP'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 PIHP processes provider claims in an accurate and timely fashion.	X					Cardinal processes paper claims within five days of receipt. Only out of area providers are allowed to submit paper claims. All others submit electronically. If a claim is approved, payment will be made within 30 calendar days after receipt. Electronic claims are processed on a nightly basis.
2.2 The PIHP 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, for example.
2.3 The PIHP has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 diagnosis codes received on an 837 Institutional and 837 Professional file. The PIHP has the capability of receiving and storing ICD-10 Procedure codes on an 837 Institutional file.		X				Cardinal captures all primary and secondary diagnosis codes submitted by providers. All codes are stored in the CIE system. Cardinal updated the Provider Direct Portal and CIE system in order to accept, store, and submit IC-10 Procedure codes. ***Corrective Action: Update Cardinal's system to accept up to 25 ICD-10 diagnosis codes for an 837I.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Update the Provider Web Portal to mirror UB04 claim form for Institutional claims and allow for up to 18 ICD-10 diagnosis codes. ***Recommendation: Cardinal should work with their provides to ensure they are submitting all required claims fields such as secondary diagnoses and making sure providers are not submitting the Revenue code data in the Procedure code field.***
2.4 The PIHP'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 PIHP's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					The enrollment reporting system is stored in an SQL DBMS and is updated nightly from the production system. All information within CIE is readily available and reportable with just a one day delay from production data. Cardinal does not outsource any of their programming needs and uses internal staff for all programming. Cardinal reported they employ four programmers who are trained and capable of modifying the reports and extracts.
3.2 The PIHP 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 as part of their Disaster Recovery Plan.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Encounter Data Submission						
4.1 The PIHP has the capabilities in place to submit the state required data elements to NC Medicaid on the encounter data submission.		X				Cardinal's NC Medicaid submission process is fully automated. On a weekly basis Cardinal submits claims/encounters to NCTracks using 837I and 837P files. Cardinal updated it's Provider Direct Portal and CIE system in order to accept, store, and submit IC-10 Procedure codes. ***Corrective Action: Update Cardinal's encounter data submission process to be able to submit all ICD-10 diagnosis codes present on an 837I and 837P.***
4.2 The PIHP has the capability to identify, reconcile and track the encounter data submitted to NC Medicaid.	X					Cardinal has tracking and reconciliation processes in place 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 PIHP has policies and procedures in place to reconcile and resubmit encounter data denied by NC Medicaid.	X					Cardinal provided several policies and procedures, as well as workflows regarding the reconciliation and resubmittal process. A total of 117,138 Institutional and 2,054,629 professional encounters were submitted to NCTracks with 2018 service dates. Cardinal identified 21 Institutional and 3,309 professional encounters that have been denied and not yet accepted with 2018 dates of service.
4.4 The PIHP has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to NC Medicaid.	X					Cardinal has a dedicated Encounter Data Reconciliation Team. This team consists of a Manager, Supervisor, and four Encounter Reconciliation Analysts.

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 Committee Charter and Credentialing Program Operations Manual* (*Credentialing Manual*) and several policies and procedures guide 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					Dr. Saidat Kashimawo-Akande is the Interim Chair of the Credentialing Committee, a position she has held since April 2019. During Onsite discussion, Dr. Welch, CMO, indicated she will soon evaluate this arrangement to determine the permanent Chair. The *Credentialing Manual Updated/Approved 10/8/2019* describes roles and responsibilities of the Credentialing Committee, and indicates the committee meets "at least monthly unless otherwise directed by the Chair". In response to a Recommendation at the last EQR, Cardinal revised the definition of a quorum in the *Credentialing Manual*. The revised definition complies with Policy & Procedure 1210, Cross Functional Committee Development. The 2019-2020 *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 a "quorum consists of at least 50% of the voting members." This definition was not revised in response to the *Recommendation* from the last EQR, and differs from the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						definition in the *Credentialing Manual*, and in Policy & Procedure 1210, Cross Functional Committee Development. The *EQR Recommendations* document submitted for the current EQR states, "The Director of the Quality Management Department, which owns the Annual Quality Strategy & Performance Improvement Plan, has indicated that its document will be changed to reflect that information at the time its next due for revision and update." Credentialing Committee meeting minutes contain information about each applicant for which background incidents were identified during the credentialing process. Meeting minutes document the votes taken for those files, and for "Clean Approvals" (applications approved by the CMO). Cardinal staff who are voting members attended between 0% (one member) and 100% (three members) of the meetings at which they were a member. Attendance of the three provider representative members was 85% (one member), 92% (one member), and 100% (one member) of the meetings at which they were a member. ***Recommendation: As recommended at the last EQR, 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 the PIHP's internal policies as applicable to type of Provider.	X					CCME identified the following issues in the file review:
3.1 Verification of information on the applicant, including:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.1 Insurance requirements;		X				The *Provider Manual* provides details regarding insurance requirements and attestation forms, and provides the email address for providers to submit questions regarding the required coverages. Some of the reviewed credentialing files did not include the proof of all required insurance (or relevant insurance attestation) dated before the credentialing approval date (based on the date of the M.D. approval or the Credentialing Committee approval, as indicated on the *Independent Practitioner Sign Off Sheet* in the files). When CCME asked for the information, Cardinal resubmitted the same information and, during Onsite discussion, indicated it was obtained later in the credentialing process. Verifying insurance should be resolved before provider credentialing is approved. ***Corrective Action: Prior to approving credentialing, verify all credentialing files contain proof of all required insurance coverage, a statement confirming the practitioner is covered under all agency insurance, and an attestation/waiver for automobile insurance and/or Worker's Comp/Employer's Liability, if coverage is not required. See NC Medicaid Contract section 7.7, section 7.7.4.***
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.3 Valid DEA certificate; and/or CDS certificate;	X					
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."
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 organizational initial credentialing files submitted for the EQR did not include an application at all, and three of the four organizational initial credentialing files did not include an Attestation. Cardinal submitted them in response to a Pre-Onsite Request from CCME. This was an issue for which Cardinal received a Recommendation at the last EQR. ***Recommendations: Ensure credentialing files contain the application and attestation statement, as required by Cardinal Policy & Procedure 8000, Agency Application and Enrollment.*** ***For the EQR, submit the full credentialing file, "from the date of the application/attestation, to the notification of approval of credentialing", as requested in the External Quality Review Materials Requested for Desk Review document.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.8 Query of the National Practitioner Data Bank (NPDB);	X					Cardinal staff reported they had not been conducting a query of the NPDB for organizations, but are doing so now, and submitted supporting evidence.
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); and query of the State Exclusion List;	X					For practitioners, Cardinal documents the query of the *State Excluded Provider List* on the *Cardinal Innovations Primary Source Verification Form - Initial Credentialing* form. For organizations, Cardinal documents the query of the *State Excluded Provider List* on the *Cardinal Innovations Organizational Provider Contracting - Credentialing PSV Checklist*.
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 conducted as part of the Criminal Background Check at Cardinal. In some reviewed files, the Social Security Death Master File query was not completed, and/or was not dated, until after the credentialing approval date (based on the date of the M.D. approval or the Credentialing Committee approval, as indicated on the *Independent Practitioner Sign Off Sheet* in the files). ***Corrective Action: Prior to approving credentialing, ensure credentialing files contain the required Social security Administration's Death Master File query. See NC Medicaid Contract Attachment B, Section 1.13 and 42 CFR § 455.436.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 Names of hospitals at which the physician has admitting privileges, if any;	X					
3.1.15 Ownership Disclosure is addressed;		X				In some reviewed files, the Ownership Disclosure was not received, and/or was not dated, until after the credentialing approval date (based on the date of the M.D. approval or the Credentialing Committee approval, as indicated on the *Independent Practitioner Sign Off Sheet* in the files). *NC Medicaid Contract Attachment B, Section 1.13* states "PIHP shall require all Providers to disclose names, social security numbers, dates of birth, addresses and any other information necessary to complete a criminal background check as outlined in Section 1.13.2 for each managing employee and persons with an ownership and control interest in the Provider at the time they apply or renew their applications for participation in the PIHP Closed Network or at any time upon request by the PIHP." Ownership Disclosure should be obtained before the provider is credentialed/before credentialing is approved. ***Corrective Action: Prior to approving credentialing, verify all credentialing files contain the Ownership Disclosure. See NC Medicaid Contract Attachment B, Section 1.13.***
3.1.16 Criminal background Check;		X				In some reviewed files, the Criminal Background Check was not completed, and/or was not dated, until after the credentialing approval date (based on the date of the M.D. approval or the Credentialing Committee approval, as indicated on the *Independent Practitioner Sign Off Sheet* in the files).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Corrective Action: Prior to approving credentialing, ensure credentialing files contain the required Criminal Background Check query. See NC Medicaid Contract Attachment B, Section 1.13 and 42 CFR § 455.434.
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					The review of credentialing files submitted for this EQR showed inconsistencies of credentialing approval dates, with some files containing three credentialing "approval" letters, with at least two "credentialing approval" dates. Checklists were added for the organizational applications. However, as was the case at the last EQR, some of the 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/recredentialing applications and materials are clearly date stamped, with no element older than 180 days when the credentialing/ recredentialing decision is made. If the applications are not going to be date stamped, revise Cardinal Policy & Procedure 8000, Agency Application and Enrollment, Section 1.a to reflect the process Cardinal will use for documenting the date of application receipt.***
4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.	X					CCME identified the following issues in the file review:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.
4.2 Verification of information on the applicant, including:						
4.2.1 Insurance Requirements;		X				The *Provider Manual* provides details regarding insurance requirements and attestation forms, and provides the email address for providers to submit questions regarding the required coverages. Some of the reviewed recredentialing files did not include the proof of all required insurance (or relevant insurance attestation) dated before the recredentialing approval date (based on the date of the M.D. approval or the Credentialing Committee approval, as indicated on the *Re-Credentialing Verification Form* in the files).Verifying insurance should be resolved before recredentialing is approved. ***Corrective Action: Prior to approving recredentialing, verify all recredentialing files contain proof of all required insurance coverage, a statement confirming the practitioner is covered under all agency insurance, and an attestation/waiver for automobile insurance and/or Worker's Comp/Employer's Liability, if coverage is not required. See NC Medicaid Contract section 7.7, section 7.7.4 and Attachment N.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
4.2.7 Requery of the National Practitioner Data Bank (NPDB);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.8 Requery for state sanctions and/or license limitations (State Board of Examiners for specific discipline) since the previous credentialing event; and query of the State Exclusion List;	X					For practitioners, Cardinal documents the query of the *State Excluded Provider List* on the *Cardinal Innovations Re-Credentialing Verification Form*. For organizations, Cardinal documents the query of the *State Excluded Provider List* on the *Cardinal Innovations Primary Source Verification Form-Organizational Provider Re-Credentialing*. In one of the four organizational recredentialing files, the "Date Verified" column was blank for all nine items in the "Verification Checks" section of the *Primary Source Verification Form*. Therefore, there is no date for the query of the *State Exclusion List* for that file.
4.2.9 Requery of the SAM;	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (OIG LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File;	X					
4.2.12 Query of the NPPES;	X					
4.2.13 Names of hospitals at which the physician has admitting privileges, if any;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.14 Ownership Disclosure is addressed.		X				In some reviewed files, the Ownership Disclosure was not received, and/or was not dated, until after the recredentialing approval date (based on the date of the M.D. approval or the Credentialing Committee approval, as indicated on the *Re-Credentialing Verification Form in* in the files). *NC Medicaid Contract Attachment B, Section 1.13* states "PIHP shall require all Providers to disclose names, social security numbers, dates of birth, addresses and any other information necessary to complete a criminal background check as outlined in Section 1.13.2 for each managing employee and persons with an ownership and control interest in the Provider at the time they apply or renew their applications for participation in the PIHP Closed Network or at any time upon request by the PIHP." Ownership Disclosure should be obtained before recredentialing is approved. ***Corrective Action: Prior to approving recredentialing, verify all recredentialing files contain the Ownership Disclosure. See NC Medicaid Contract Attachment B, Section 1.13.***
4.3 Site reassessment if the provider has had quality issues.	X					
4.4 Review of provider profiling activities.	X					During Onsite discussion, Cardinal staff reported that the Compliance Department recently developed a database that pulls together quality of care issues "that have become serious enough to result in a termination or sanction. Checking that database is now part of our verification process."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					Policy & Procedure 8375, Provider Sanctions "outlines the process by which Network Providers may be sanctioned and the related responsibilities of various business units." The Network Management Cross Departmental Managerial Workgroup (NMCDMW) determines "certain Network Provider sanctions." Policy & Procedure 8025, Contract Terminations delineates the process for provider contract terminations. Policy & Procedure 8380, Alteration of Practitioner's Credentialed Status provides the "mechanism for sanctioning, suspending, or terminating the credentialed status of a Practitioner credentialed to participate in Cardinal Innovations' closed network of providers" and provides "an appeal process for a Practitioner sanctioned under that mechanism." The minutes of the April 11, 2019 Credentialing Committee meeting and the minutes of the October 8, 2019 Credentialing Committee Meeting include a review of the *Bi-Annual Reporting Clinician Sanctions* for the preceding six months.
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					
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 30 mile/30 minute criteria for urban/suburban areas and 45 mile/45 minute criteria for rural areas. Policy & Procedure 8500, Network Adequacy and Accessibility Analysis, and Network Development describes the annual gaps and needs analysis process and reports Cardinal uses the results to inform the annual *Network Development Plan*.

1.1 Enrollees have a Provider location within a 30 – mile distance of 30 minutes' drive time of their residence. Rural areas are 45 miles and 45 minutes. Longer distances as approved by NC Medicaid are allowed for facility based or specialty providers.	X					The *Cardinal Innovations Healthcare 2019 Network Adequacy and Accessibility Analysis* (Gaps Analysis) reported: 1. Less than 100% of enrollees had a choice of two providers within 30/45 miles/minutes of their residences for the following location-based, Medicaid-funded services: • Child and Adolescent Day Treatment • Substance Abuse Comprehensive Outpatient Treatment Program (SACOT) • Opioid Treatment 2. Cardinal did not meet the access and choice standard of at least one provider within the Cardinal Innovations service area for the following Medicaid-funded services: • Residential Treatment Level • Substance Abuse non-Medical Community Residential Treatment 3. Cardinal did not meet access and choice standards for these same services in the previous year. 4. Cardinal submitted an *Exception Request* for these services for 2019 and for 2018. The *Network Development Plan* addresses Cardinal's plans for meeting enrollee needs for the services that do not meet access standards. The submitted *Exception Requests* were approved by NC Medicaid, though the Exception Requests related to Substance Use were approved only through the end of January 2020. During the Onsite review, Cardinal staff outlined current efforts to meet choice and access standards. At the next IMT meeting with NC Medicaid, Cardinal will present updates to their efforts. NC Medicaid will then determine whether the *Exception Request* approval will be extended. Policy & Procedure 8046, Member-Specific Agreements reports Cardinal uses Member-Specific Agreements when needed "in order to secure access to services and/or continuity of care for its members."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					Information is provided in the *Member & Family Handbook*.
1.3 The sufficiency of the provider network in meeting enrollee demand is formally assessed at least annually.	X					The required *Network Adequacy and Accessibility Analysis Report* is completed on an annual basis.
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					Cardinal's *Cultural Competency Provider Network Plan 2016-2020* is posted in the Resource Library on the website, along with a variety of other resources related to cultural competence. The annual *Gaps and Needs Analysis* includes information focused on "Geographic, Cultural and Special Populations". The report provides information on ten specific areas such as "People Who Are Blind or Visually Impaired", "People Who Are Deaf or Hard of Hearing", and "Racial and Ethnic Groups". Each report includes the number of members within the specific area, broken down by county. Each of the focus area reports also includes a summary of the specific issue, a "Supports" section that highlights "how Cardinal Innovations supports people" with the specific focus area (e.g. "People with Traumatic Brain Injuries", "People with Physical Disabilities", etc.), and identified Obstacles, Barriers and Gaps. Member-Specific Agreements are used, if needed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.5 The PIHP demonstrates significant efforts to increase the provider network when it is identified as not meeting enrollee demand.	X					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." The Corporate Network Management Cross Departmental Managerial Workgroup evaluates various reports and makes recommendations concerning opportunities for improvement and network development. The *Network Development Plan* addresses "plans for how the LME/MCO will meet an individual's need for access to the service" for services for which Cardinal is not meeting Provider Access and Choice Standards. A Service Needs List is posted on the Cardinal website. Member-Specific Agreements are used if needed.
2. Provider Accessibility						
2.1 The PIHP formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	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.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 states, "In addition to the training materials available on our website, Cardinal Innovations will provide the following trainings on a routine basis: • Incident Reporting • Person-Centered Thinking • Mental Health First Aid"
2. Initial provider education includes:						The *Orientation Companion* is a three page document detailing a variety of helpful information. Among information included: links to the *Provider Manual*, the Resource Library, the Clinical Practice Guidelines, the Provider Direct portal (for claims and authorizations), the NCTracks website, the Member Appeal Rights brochure, and additional information including how to report Fraud/Waste/Abuse, Tips for Submission of Authorization Requests, and other resources for providers.
2.1 PIHP purpose and mission;	X					Page 7 of the *Provider Manual* includes Cardinal's vision and values for the provider network.
2.2 Clinical Practice Standards;	X					The *Provider Manual* references the Clinical Practice Guidelines and provides several links to the guidelines.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
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." *Provider Request for Reconsideration of an Action Forms* are posted on the Cardinal website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 the statement of Member Rights and Responsibilities inside the *Member & Family Handbook*. Section V of the *Provider Manual* addresses Member Rights and Empowerment and includes a list of member rights.
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 website includes a "Report fraud & abuse" page, which provides information about what Medicaid fraud and abuse is, and provides information on "How to report fraud or abuse," with a tollfree phone number, a mailing address, and a link to an online reporting form. The *Provider Manual* includes information about 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. The Resource Library section of the website has a section specific to providers. The *Orientation Companion* provides a link to the Training & Education section of the Resource Library on the Cardinal website. The *Provider Manual* provides information about available training and opportunities. There are links to the Resource Library in several sections of the *Provider Manual*. *Section IX: Resources for Providers*, starting on page 93 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." The "Provider" tab on the website provides a link to the "Learning Center." There is also a link to Announcement and Bulletins.
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 CPGs are selected and approved by the Chief Medical Officer (CMO) or designee and approved by the Clinical Advisory Committee (CAC) which is comprised of licensed providers and Cardinal Innovations' clinicians." The policy and procedure also notes "guidelines will be reviewed and updated, if appropriate, every two (2) years." Discussion and approval of Clinical Practice Guidelines is documented in the Clinical Advisory Committee meeting minutes.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					The *Provider Manual* informs providers of their responsibility to "Comply with all applicable service definitions and practice guidelines", and notes, "Providers are expected to be familiar with the guidelines and to use them to inform their behavioral healthcare activities."
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.
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." The "General Medical Records Requirements/Treatment Records Standards" section of the *Provider Manual* includes links to relevant manuals and requirements on the NC DHHS website.
2. The PIHP monitors compliance with medical record documentation standards through formal periodic medical record audit and addresses any deficiencies with the providers.	X					
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 *NC Medicaid 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 the member rights and responsibilities and how members are notified of their rights and responsibilities.
2. Enrollee rights include, but are not limited to, the right:	X					Member rights are addressed in Policy & Procedure 1531, the *Cardinal Innovations Healthcare Member & Family Handbook* (*Member & Family Handbook*), and the *Provider Manual* (revised January 2019). The Cardinal website has a Rights & Responsibilities page. There were no issues identified regarding the sub-standards for 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 CFR. § 164.524* and in *NCGS § 122C-53(d)*, and to request that the medical						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
record be amended or corrected in accordance with *45 CFR § 164*.						
2.7 Of enrollees who live in Adult Care Homes to report any suspected violation of 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*.
1.3 Updates regarding program changes;						This information is included in Policy & Procedure 9515 and on page 12 of the *Member & Family Handbook*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.4 A description of the procedures for obtaining benefits, including authorizations and EPSDT criteria;						EPSDT benefit information is explained on page 17 of the *Member & Family Handbook*. Page 34 of the *Member & Family Handbook* explains other services requiring prior approval and not requiring prior approval.
1.5 An explanation of the Enrollee's responsibilities and rights and protection as set forth in *42 CFR § 438.100*;						
1.6 An explanation of the Enrollee's rights to select and change Network Providers						Page 28 of the *Member & Family Handbook* explains the process of changing Network Providers.
1.7 The restrictions, if any, on the enrollee's right to select and change Network Providers						Chapter 5 "Our Providers", starting on page 27 of the *Member & Family Handbook* explains the member's right to select and change Network Providers, including any restrictions.
1.8 The procedure for selecting and changing Network Providers						This procedure is outlined for the members in Chapter 5, "Our Providers", in the *Member & Family Handbook*.
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);						The online Provider Search allows for searching by provider agencies and provider names. All required information is available including name, address, telephone number, license held, and if new patients are accepted. Cardinal provides a written copy of the *Provider Directory* when requested. Anyone with access to the website can open a PDF version and print specific pages. A spot check was performed for the field Accommodations for Physically Disabled. All of the spot checks display "Unavailable at this time. Please contact provider."
1.10 The non-English languages, if any, spoken by each Network Provider;						The PDF version accessible online has a field for "Non-English Language Spoken onsite." The online provider search has a field for "Languages."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.11 The extent to which, and how, after-hours and emergency coverage are provided, including:						
1.11.1 What constitutes an Emergency Behavioral Health Condition, Emergency Services, and Post Stabilization Services in accordance with *42 CFR § 438.114* and EMTALA;						Page 22-26 of the *Member & Family Handbook*, "Getting Help in My Community," explains services and displays charts of locations for: Comprehensive Community Clinics/Open Access Clinics, Crisis Recovery Centers, Post stabilization for Emergency Medical Conditions, Facility Based Treatment, and Mobile Crisis Services.
1.11.2 The fact that prior authorization is not required for emergency services;						Page 9 of the *Member & Family Handbook* states, "You can use emergency or crisis services without prior approval." And on page 19, "Treatment for mental health emergencies does not require prior approval from Cardinal Innovations."
1.11.3 The process and procedures for obtaining Emergency Services, the use of 911 telephone services or the equivalent;						Page 21 of the *Member & Family Handbook*, "You will receive immediate face-to-face care for life-threatening emergencies using 911."
1.11.4 The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under the contract;						Emergency Services and Post Stabilization services locations are featured on page 24 of the *Member & Family Handbook* in the Crisis Recovery Centers chart.
1.11.5 A statement that, subject to the provisions of the *NC Medicaid Contract*, the Enrollee has a right to use any hospital or other setting for Emergency care;						Page 27 of the *Member & Family Handbook*, states, "if it is a behavioral health emergency, you do not have to have prior approval and may go to any hospital or acute care/urgent care setting, such as a Facility-Based Crisis Center."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.12 The PIHP's policy on referrals for Specialty Care to include cost sharing, if any, and how to access Medicaid benefits that are not covered under the *NC Medicaid Contract;*						
1.13 Any limitations that may apply to services obtained from Out-of Network Providers, including disclosures of the Enrollee's responsibility to pay for unauthorized behavioral health care services obtained from Out-of Network Providers, and the procedures for obtaining authorization for such services.						Page 28 of the *Member & Family Handbook* states, "You may be responsible for payment of services if you go to an out-of-network or out-of-area provider for non-emergency services that have not been pre-authorized by Cardinal Innovations. If you have questions about prior authorization for non-emergency services, talk with your provider or contact the Utilization Management Department at 704.939.7700."
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;						Some members are required to pay a co-payment each month to be eligible for Medicaid. Cardinal does not require additional co-payments, deductibles, or other forms of cost sharing. They do not charge members for missed appointments.
1.15 Procedures for obtaining out-of-area or out-of-state coverage of services, if special procedures exist;						On page 27 of the *Member & Family Handbook* it states, "In certain cases, you may be able to receive services from providers located outside of our 20 counties. These are called out-of-area providers. They are providers who are not located in our coverage area but with whom we have contracts for specific services…The service provider must contact Cardinal Innovations for provider enrollment help for authorization, provision and payment of these services."
1.16 Information about medically necessary transportation services by the Department of Social Services in each county;						This is detailed for members on page 26 of the *Member & Family Handbook*.
1.17 Identification and explanation of state laws and rules Policies regarding the treatment of minors;						The rights of minors are covered on page 13 in the *Member & Family Handbook*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.18 The enrollee's right to recommend changes in the PIHP's policies and services						On page 12 of the *Member & Family Handbook*, there is a chart to guide members on how to make a suggestion about Cardinal's policies and services.
1.19 The procedure for recommending changes in the PIHP's policies and services;						On page 12 of the *Member & Family Handbook*, there is a chart to guide members on how to make a suggestion about Cardinal's policies and services.
1.20 The Enrollee's right to formulate Advance Directives;						
1.21 The Enrollee's right to file a grievance concerning non-actions, and the Enrollee's right to file an appeal if PIHP takes an action against an Enrollee;						
1.22 The accommodations made for non-English speakers, as specified in *42 CFR § 438.10(c)(5)*;						The *Member & Family Handbook* and several brochures are available in Spanish and 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. 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.						
1.24 The availability of oral interpretation service for non-English languages and how to access the service;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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)*.						
2. Enrollees are notified annually of their right to request and obtain written materials produced for Enrollee use.	X					The annual notice is sent as a postcard with information and website links for the most recent written information.
3. Enrollees are informed promptly in writing of (1) any "significant change" in the information specified in *42 CFR § 438.10(f)(61)* and *438.10(g)* at least 30 days before calendar days before the intended effective date of the change; and (2) termination of their provider within fifteen (15) calendar days after PIHP receives notice that NC Medicaid or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider.	X					All five terminated provider examples given to CCME were voluntary terminations. Cardinal notified affected enrollees for all five providers within 15 calendar days of receiving notice of the request to terminate from the network. Cardinal follows the same process for providers terminated "with cause." Cardinal didn't submit "with cause" terminations because those providers were not seeing members.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
. 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					
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					Policy & Procedure 1545, Community and Member Education & Outreach is in place to provide oversight of the Cardinal Annual Education Plan. *The Community Training Catalog* is available and explains offerings by Cardinal with instructions on how to request a training.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The Events page on the website has many activities listed that are held by Cardinal within the community. The site is searchable by County, Topic, Type (community/ training/ meeting), and Date. Events can only be seen 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. Events vary and examples of event categories are social events, health/wellness, financial information, self-care, art/crafts, and light exercise.
3. The PIHP tracks the participation of enrollees in the behavioral health education services.	X					Cardinal uses sign-in sheets to track and gather enrollee participation in health education services.
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					Cardinal has the following policies for the call center: Policy & Procedure 6508, Providing Callers with Information on Community Resource; Policy & Procedure 6512, Call Center Documentation Required; Policy & Procedure 6506, Enrollment Through Access Call Center; and, 6501, Policy & Procedure Overview of Access Call Center.
1.1 Respond appropriately to inquiries by enrollees and their family members (including those with limited English proficiency);	X					Pages 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, 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 instant message, to call the appropriate

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						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					
1.5 Answer phones and respond to inquiries from 8:30 a.m. until 5:00 p.m. weekdays;	X					Call Center phones are answered 24/7/365. Live Chat is available Monday – Friday from 8:00a.m. – 8:00p.m. Call Center statistics show a higher abandonment rate for Feb 2019, at 5.1%. This was explained at the Onsite interview as an outlier. Cardinal was piloting a new software called Whisper Tones which informs the qualified professional where the call was coming from before accepting the call. Calls were staying in the que longer than wanted. They did not continue the pilot.
1.6 Process referrals twenty-four (24) hours per day, seven (7) days per week; 365 days per year; and	X					
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 *Annual Quality Strategy & Performance Improvement Plan FY 2019-2020 o*utlines 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 November 2019, 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." The *Annual Quality Strategy & Performance Improvement Plan Evaluation Fiscal Year 2018-2019* explains "Cardinal Innovations engaged providers in three pilots to explore the challenges involved in implementing CPGs across the network. The pilots focused on CPGs for treating Childhood Autism Spectrum Disorders, Medication Assisted Treatment (MAT) for Opioid Use Disorders, and Metabolic Monitoring for Individuals with Schizophrenia on Antipsychotic Medications." Monitoring was completed for each chosen Clinical Practice Guideline.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						• Childhood Autism Spectrum Disorders: Cardinal did record reviews for the two providers involved. The providers looked at their own documentation of how children were assessed and diagnosed. They used pharmacy claims data internally to see if medications were appropriately prescribed. • MAT: Cardinal looked at prescriptions given for naloxone and if psychosocial treatment was also given for one provider and ten randomly selected cases. Data was gathered on Naloxone kit, prescriptions, patient education, family education, and types of treatment given. • Metabolic Monitoring: One hospital provided 187 records for schizophrenia. Data was collected on lipid testing and metabolic screening. The hospital created a report specifically for this pilot. For next steps, Cardinal stated they would like to broaden this and work to expand into a large Health System. They are looking to do this in the next 90 days with implementation in the next 6 months.
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					Policy & Procedure 6100 refers to Utilization Review and covers a range of utilization aspects including over and underutilization. Regarding utilization, several reports were submitted for desk material review including monitoring of: (1) Mental Health Admissions, Readmissions, and Length Of Stay (2) Substance Abuse Admissions, Readmissions, and Length Of Stay (3) B3 services and others.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The Clinical Operations UM Program Evaluation FY 18 document provides evidence of monitoring and addressing utilization issues. During the Onsite, the top three over and underutilized services were discussed, in addition to the interventions that have been implemented to improve utilization.
4. The PIHP implements significant measures to address quality problems identified through the enrollees' satisfaction survey.		X				CCME requested, and did not receive, additional information showing evidence that Adult and Child Experience of Care and Health Outcomes (ECHO®) surveys were integrated and analyzed to identify potential areas needing improvements. CCME asked for minutes from the Survey Integration Project meetings. Cardinal responded that formal minutes were not kept for those meetings. When asked how many meetings have occurred in the past year, staff answered "a handful." Cardinal also explained that the QM Project Manager is the lead for the Survey Integration Project and that position had experienced turnover in the past year. While Onsite, the document *Survey Impact Project Plan 2019.xlsx* was submitted. This document appeared incomplete. The second tab, labeled Survey Intervention Summary, lists interventions or services for existing QIAs that are not focused on improving enrollee satisfaction survey results. This Excel document does not include specifics regarding what barriers the interventions are intended to address, how the interventions are measured, nor the intended outcome. Survey items are not compared year-to-year to see if improvement is made. During the previous EQR, it was noted in the March 2018 CQI Committee minutes, a workgroup was formed to discuss quality problems identified in the enrollee satisfaction survey and interventions needed to improve survey results. Since then, there is no evidence of implementing measures

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						directed at impacting the enrollee satisfaction survey results. ***Corrective Action: Develop a Quality Improvement Activity to measure and improve lower scoring Adult and Child Experience of Care and Health Outcomes (ECHO®) surveys items.***
5. The PIHP reports the results of the enrollee satisfaction survey to providers.	X					The Adult and Child ECHO® Surveys from 2016 to 2018 are posted on the Cardinal website. Results are discussed in GCQI and CQI.
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					Documentation was submitted to folder 15 called "Survey Outcomes Review.pdf". This was helpful to point out committee discussions about surveys. Survey results were shared with CQI and GCQI.
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					Target time frames are not included in Cardinal's annual work plan. It was a 2018 EQR Recommendation to add target time frames for each of the activities included in the work plan. The areas documented for each QIA include objective, measurements, interventions, responsible department/staff, and Impact. A "Progress Towards QIA Goal Achievement in FY1819" was added to each Quality Improvement Activity (QIA). This is a look back at what happened and not a projection/goal for the implementation or completion at the beginning of the fiscal year. ***Recommendation: CCME recommends, again in this EQR, that Cardinal add a time frame for implementation and completion for each QIA on the CQI work plan.***

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					Continuous Quality Improvement (CQI) Committee meets monthly as stated in the CQI Committee Charter. The GCQI Committee is made up of providers, practitioners, and CFAC members. and Cardinal staff. The GCQI meets quarterly and reports updates to CQI in the GCQI Update Section of each CQI meeting.
2. The composition of the QI Committee reflects the membership required by the contract.	X					There are 14 voting members of CQI. Currently, 13 positions are filled. The one vacant position is in the Advanced Analytics Department. Twelve of the members are internal to Cardinal. One is a Board/Member representative, and one is a GCQI representative.
3. The QI Committee meets at regular intervals.	X					CQI meetings are held monthly with a minimum of 10 meetings per year. The quorum is set at 50% + 1. GCQI meetings are quarterly and a quorum consists of at least 50% of voting members.
4. Minutes are maintained that document proceedings of the QI Committee.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					(b) and (c) Waiver measures are 100% compliant.
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					There are no Corrective Actions for the PIPs. There is one Recommendation for the Improving Timely Access to Care PIP. That recommendation is detailed in *Table 22 Performance Improvement Project Errors and Recommendations* of this Quality section and on the PIP worksheet showing validation of this project.
IV E. Provider Participation in Quality Improvement Activities						
1. The PIHP requires its providers to actively participate in QI activities.	X					The GCQI providers discuss, participate in, and disseminate information regarding QI activities.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Providers receive feedback during focused reviews from Provider Monitoring.
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					Cardinal has implemented and maintained the following fields as a result of the Corrective Action in the 2018 EQR: Section 1 – Executive Summary/Description of the QI Program and Program Structure Section 2 – Overview of Program Goals/QI Program's Overall Goals Section 3 – Overall Major accomplishments achieved for the evaluation year Section 4 – Description of QI Activities/Each Activity to includes: a. Activities conducted b. Results trended overtime (to include yearly trends as applicable) c. Analysis of results d. Goal of the Activity e. Outcome of Goal (met/not met) f. Barrier Analysis (for goals not met) g. Plans/recommendations/new or continued interventions needed to meet the goal h. Continuation or discontinuation in upcoming year Section 5 – Conclusion and Recommendations Section 6 – Priorities for the upcoming year
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					Cardinal has a *Utilization Program Description* in place.
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;	X					Cardinal has Policy & Procedure 6007, Medically Necessary Treatment Determination that outlines the standards that will be used by Care Managers when making a treatment authorization decision.
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					During last year's EQR review, CCME recommended that Cardinal, "Add detail to Policy & Procedure 6010, Pre-Service Authorization and Re-Authorization of Services regarding the requirement that Cardinal "justify to DMA, upon request" extensions (see *NC Medicaid 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." Policy & Procedure 6010 now requires Care Managers to document justification in the TAR.
1.5 consideration of new technology;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.6 the appeal process, including a mechanism for expedited appeal;	X					
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					Cardinal's Chief Medical Officer (CMO) is Dr. Wendy Welch. Responsibilities related to the UM Department are listed in the *UM Program Description*. According to the submitted Organizational chart, the CMO has three staff with direct contact, including Dr, Pamela Wright-Etter, Vice President of Medical Services. Dr. Pamela Wright-Etter provides direct clinical oversite to the UM Department.
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 Description* is re-evaluated annually and updated as needed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					Cardinal's Policy & Procedure 6007, Medically Necessary Treatment Determination provides the criteria used by UM staff to determine medical necessity.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					The review of UM files showed that all approvals were made based on predetermined standards and criteria.
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 the IRR process. IRR is administered monthly to all UM reviewers and reviewed annually.
5. Emergency and post stabilization care is provided in a manner consistent with contract and federal regulations.	X					
6. Utilization management standards/criteria are available for Providers.	X					The "*Orientation Companion*" available on Cardinal's website, includes UM Tips for Submission of Authorization requests. Cardinal's policies and procedures and *Provider Manual* also explain the standards and criteria used in determining medical necessity.
7. Utilization management decisions are made by appropriately trained reviewers	X					During last year's EQR, Cardinal received a Corrective Action to ensure that signatures within the UM files reflect the reviewer and peer reviewer credentials, as is required by *NC Medicaid Contract, 8.2.2.1.* In response, Cardinal stated "Reviewers' credentials have been added to CIE, and IT is working to pull this information into the review documentation." In this year's file review, improvement was noted. However, the TARs again did not consistently reflect the credentials of the UM Care Managers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The review of Desk Materials for this year's EQR found that 24% of the denied files reviewed did not contain the full signature and credentials of the Care Managers. While this is an increase from last year's EQR, CCME is again recommending that Cardinal ensure signatures and credentials are consistently documented within the TAR record. ***Recommendations: Ensure signatures within the TAR, electronic health records (EHR) and printed files, reflect the full signature (including credentials) of the Care Manager, as required by NC Medicaid Contract, Section 8.2.2.1.***
8. Initial utilization decisions are made promptly after all necessary information is received	X					During last year's EQR, extensions to the required TAR processing timeframe of 14 days were a common practice among UM Care Managers. CCME recommended that staff document justification for the extension within the UM record, to satisfy the contractual requirements in *NC Medicaid Contract*, *Section 7.4.13* and *Attachment M, D.1.b*. CCME also recommended that Cardinal describe this process in Policy & Procedure, 6010, Pre-Service Authorization a Reauthorization of Services. Both of these recommendations were addressed, implemented, and maintained by UM staff over the past year. In the file review for this year's EQR, TAR processing time frames were extended in 26% of all of the files reviewed, and in 44% of submitted files in which services were denied or reduced. Within each file, the Care Manager justified the reason for the extension and sent a written notification explaining the reason for the extension. In this year's EQR, CCME recommends Cardinal monitor this TAR extension process to ensure this practice is being implemented by staff judiciously and with no undue burden placed on the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						provider or enrollee. Monitoring could include analysis of TAR extension data such as monthly percentage of extended TARs, extensions to initial versus concurrent requests, patterns of extensions per service or provider, etc. ***Recommendation: Develop, document, and implement a monitoring plan to analyze TAR extension data (e.g., monthly percentage of extended TARs, extensions to initial versus concurrent requests, patterns of extensions per service or provider, etc.) to this practice is being implemented by staff judiciously and with no undue burden placed on the provider or enrollee.***
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					Cardinal has Policy & Procedure, 6010 Pre-Service Authorization and Reauthorization of Services which outlines the process for Care Managers to request additional information from the requestor in an effort to render a decision. This process includes making a notation in the TAR and sending a letter to the requestor regarding the need for additional information. There was evidence within the UM files reviewed that Care Managers followed this policy and procedure.
9.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					The review of 25 TARs denied by Cardinal found that all decisions were made by appropriate peer reviewers, as was evidenced by the peer reviewer's signature and credentials within each file.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					The review of 25 TARs denied by Cardinal found that all decisions and notifications were timely.
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. According to the Care Coordination Program Description, the I/DD Care Team includes Community Care Coordinators, Monitoring Specialists, Olmstead Specialists, and Assessment Specialists. Similarly, the MH/SUD Care Team includes Acute Transition Nurses, Community Care Coordinators, Complex Care Coordinators, Child Residential Care Coordinators, State Hospital Care Coordinators, Population Health Specialist and Clinicians, and Residential Treatment Specialists.
2. The care coordination program includes:						
2.1 Staff available 24 hours per day, seven days per week to perform telephone assessments and crisis interventions;	X					
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					
2.4 Guide the develop treatment plans for enrollees that meet all requirements;	X					
2.5 Quality monitoring and continuous quality improvement;	X					Cardinal has Policy & Procedure, 7202 I/DD Care Coordination Monitoring of Plan Implementation, which outlines the monitoring requirements for Innovations' members. Policy & Procedure 7205, Complex Case Management describes the monitoring process for enrollees identified as having complex needs.
2.6 Determination of which Behavioral Health Services are medically necessary;	X					
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.8 Coordinate care with each Enrollee's provider;	X					Involvement by Care Coordinators in treatment planning was evident in treatment plans and progress notes.
2.9 Provide follow-up activities for Enrollees;	X					
2.10 Ensure privacy for each Enrollee is protected.	X					
2.11 NC Innovations' Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	X					
3. The PIHP applies the Care Coordination policies and procedures as formulated.		X				The review of Cardinals I/DD Care Coordination files found three enrollees who did not receive monthly monitoring during the first six months of engagement in the Innovation's waiver. *NC Medicaid Contract Section 6.11.3* and Policy & Procedure 7202, I/DD Care Coordination Monitoring of Plan Implementation requires monitoring to occur face-to-face on a monthly basis for enrollees who are new to the Innovation's Waiver for the first six (6) months. One enrollee's monitoring plan within the treatment plan did not match the occurrence of face-to-face visits by the Care Coordinator or Monitoring Specialist. The monitoring

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						plan stated that the enrollee would receive monthly monitoring, however monitoring was occurring quarterly. Policy & Procedure, 7202 I/DD Care Coordination Monitoring of Plan Implementation, requires monitoring to occur as outlined in the Individual Support Plan (ISP). The review of I/DD Care Coordination files found that Cardinal did not provide adequate follow-up to one enrollee who voluntarily terminated their enrollment in the Innovation's Waiver by relocating to Virginia. The case record lacked the discharge form mentioned in the progress note and the process outlined in *NC Clinical Coverage Policy 8P, Attachment B, L.* Additionally, the review also found 7% of all progress notes from MH/SUD, I/DD, and TCLI were submitted three or more days after the date of Care Coordinator contact, yet only one progress note was labelled as "late entry". This showed inconsistency by staff in following the documentation procedures outlined in Cardinal's policies and procedures. ***Corrective Action: Develop, document, and implement a data-driven monitoring plan that routinely reviews Care Coordination documentation. The monitoring plan should identify the frequency of monitoring, departmental benchmarks for compliance, and how and when outcomes of monitoring are captured, reviewed, and reported. The monitoring plan should include review of timeliness of activities (e.g., cases targeted for discharge, documentation of late progress notes, follow up activities, HCBS monitoring, etc.), as well as the quality and completeness of Care Coordinator documentation.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V. D Transition to Community Living Initiative						
1. Transition to Community Living Initiative (TCLI) functions are performed by appropriately licensed, or certified, and trained staff.	X					
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements.	X					
2.1 Care Coordination activities occur as required.	X					
2.2 Person Centered Plans are developed as required.	X					
2.3 Assertive Community Treatment, Peer Support, Supported Employment, Community Support Team, Psychosocial Rehabilitation, and other services as set forth in the DOJ Settlement are included in the individual's transition, if applicable.	X					During last year's EQR it was recommended that Cardinal, "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." The review of TCLI found enrollees engaged in a mixture of services to include ACTT, community support, PSR and peer support. While no enrollees were directly engaged in Supported Employment, those receiving ACTT did have goals in the treatment plan that were employment related.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					During last year's EQR it was recommended that Cardinal , "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." This Recommendation was implemented.
2.5 QOL Surveys are administered timely.	X					All Quality of Life surveys were thoroughly completed and timely.
3. Transition, diversion and discharge processes are in place for TCLI members as outlined in the DOJ Settlement and DHHS Contract.	X					
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to NC Medicaid within the time frames determined by NC Medicaid.	X					
5. The PIHP will develop a TCLI communication plan for external and internal stakeholders providing information on the TCLI initiative, resources, and system navigation tools, etc. This plan should include materials and training about the PIHP's crisis hotline and services for enrollees with limited English proficiency.	X					On June 5, 2019, Cardinal offered a provider training regarding TCLI. TCLI training is a continuous process that is offered throughout the year. Information about the TCLI program is also available to providers, enrollees and stakeholders on Cardinal's website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. A review of files demonstrates the PIHP is following appropriate TCLI policies, procedures and processes, as required by NC Medicaid, and developed by the PIHP.	X					The TCLI file review showed inconsistencies in staff documentation, but to a lesser degree than the MH/SUD and I/DD file review. TCLI staff were inconsistent with following policies and procedures regarding progress note documentation, discharge and transfers of enrollees from TCLI, completion of In-Reach tools, etc. Inconsistencies were noted in at least three of the 15 TCLI files reviewed. Since CCME is requiring a monitoring plan to increase MH/SUD and I/DD Care Coordination compliance with policies and procedures, CCME is also recommending that the TCLI program be included in the development and implementation of a monitoring plan to improve compliance with TCLI activities and documentation. ***Recommendation: Develop, document, and implement a data-driven monitoring plan that routinely reviews TCLI documentation. The monitoring plan should identify the frequency of monitoring, departmental benchmarks for compliance, and how and when outcomes of monitoring are captured, reviewed, and reported. The monitoring plan should include review of timeliness and completeness of activities (e.g., transfer of cases, documentation of late progress notes, follow up activities, etc.), as well as the quality and completeness of TCLI documentation.***

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, Grievances and Formal Levels of Review is the primary policy that governs Cardinal's grievance processes. There were two Recommendations in last year's EQR aimed at correcting or adding information to this policy and procedure. Cardinal implemented both Recommendations over the past year.
1.1 Definition of a grievance and who may file a grievance;	X					
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					The *Provider Manual* and *Member & Family Handbook* provide an easy to read description of the grievance process. These documents, however, do not offer information on the right of the grievant to request an extension to the grievance resolution timeframe. On average, Cardinal resolves grievances in less than 20 days. It would be helpful for providers, members, and their representatives to know that they can request more time to gather and submit additional information regarding their grievance. CCME is recommending that additional information about the right to request an extension to a grievance is explained in the *Provider Manual* and *Member & Family Handbook*. ***Recommendations: Add to the Provider Manual and the Member & Family Handbook information that a member, someone on the behalf of a member, or the PIHP can request to extend the grievance time frame to meet member rights requirements.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					Cardinal staff have access to a variety of subject matter experts for grievance consultation. There is also a clinician on call 24/7/365 available to staff handling grievances.
1.5 Maintenance of a grievance log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					
2. The PIHP applies the grievance policy and procedure as formulated.	X					Within the files reviewed for this EQR, there were two grievances resolved outside of the 30 days required by Cardinal's Policy & Procedure 5050. Review of the grievance log also shows less than 1% of the grievances were resolved outside of the 30 day timeframe. Cardinal staff described a monitoring process that includes review of staff documentation (timeliness of resolutions, completeness of staff notes, quality of resolution notices, etc.). Staff reported a high level of compliance with Cardinal's monitoring benchmarks. Cardinal staff described an active grievance consultation process that involves input from subject matter experts, when appropriate. However, within the files reviewed there were situations that warranted consultation with medical staff or other subject matter experts, but no consultations were evident. Staff explained that some consultations are conducted through email and may not be captured within the grievance record. ***Recommendation: Enhance the monitoring process to ensure any consultations with subject matter experts (medical, legal, HR staff, etc.) and the outcomes of these consultations are captured within the grievance investigation notes. Monitoring should also identify whether appropriate consultations are actually occurring.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					
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					Policy & Procedure 6020, Adverse Benefit Determination Notice and Appeal Process for Medicaid-Funded Services is Cardinal's primary policy and procedure for governing the processing of appeals. In the last EQR, several Corrective Actions and Recommendations were issued to address incorrect or missing information within this policy and procedure. Cardinal addressed all of these Corrective Actions and Recommendations over the past year.
1.1 The definitions an appeal and who may file an appeal;	X					
1.2 The procedure for filing an appeal;		X				Page 37 of the *Member & Family Handbook* correctly states in two places that the enrollee has 60 days to request an appeal. Page 38, however, incorrectly states enrollees have 30 days to request an expedited, Reconsideration Review. ***Recommendation: Revise page 38 of the Member & Family Handbook to say enrollees have 60 days to request an expedited appeal.*** Invalid appeals Cardinal reported one invalid appeal during the period in review. Review of this file showed that Cardinal determined this appeal was invalid as it was submitted 16 days outside of the allowable 60 days

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						for filing an appeal. However, per the appeal log, there were 27 appeals that were processed despite being as many as 120 days beyond the timeframe for filing an appeal. Per Cardinal's Policy & Procedure 6020, if an appeal is received beyond the 60-day timeframe, staff "should immediately forward the request to the Office of General Counsel (OGC), who will respond to the request appropriately." Guidelines or criteria are needed to ensure consistency and fairness in decisions by the OGC around whether to process an appeal received outside of the 60-day timeframe. ***Corrective Action: The Appeals Department and the OGC should work together to develop guidelines or criteria for deciding when to process an appeal that has been received by Cardinal outside of the 60-day timeframe enrollees are given for filing appeals. Include those guidelines within Policy & Procedure 6020.***
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					
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	X					Cardinal addressed several Corrective Actions and Recommendations that resulted in a revision of Policy & Procedure 6020. These revisions resolved the incorrect or missing information around processing of expedited appeals.
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Cardinal addressed several Corrective Actions and Recommendations that resulted in a revision of Policy & Procedure 6020. These revisions resolved the incorrect or missing information around extensions by Cardinal to the appeal resolution timeframe.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The PIHP applies the appeal policies and procedures as formulated.		X				Within the expedited appeal files reviewed for this year's EQR, several notifications were not provided to enrollees as required by Cardinal's Policy & Procedure 6020, *NC Medicaid Contract, Attachment M*, and *42 CFR § 438*. The issues noted in the files this year were also targeted by two corrective actions in last year's EQR. The 2018 EQR corrective actions were to provide training to staff around expedited and extended appeal requirements and to enhance the current monitoring process for the purpose of increasing compliance. Staff were unable to demonstrate during the Onsite that either of these occurred and, as a result, similar concerns were noted in the files reviewed this year. <u>Acknowledging appeals</u> Cardinal staff did not consistently, verbally acknowledge or send written acknowledgement of the receipt of appeals. Staff noted in at least one appeal file that the resolution notice sent to the appellant served as the acknowledgement notice. However, Cardinal's Policy & Procedure 6020 requires the Appeals Specialist to "send the member a written acknowledgement of the request receipt using the Acknowledgement of Request for a Reconsideration Review template." This template was not sent in any of the appeals that were resolved in three or less days. Similarly, Cardinal's Policy & Procedure 6020 requires staff to "verbally notify submitter that the expedited request has been received on the day of the receipt, or the next business day if received past 5:00 pm or on a weekend." However, none of the expedited appeal files showed staff verbally notified the submitter that the expedited appeal had been received by Cardinal.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						<u>Verbal and written notifications related to expedited appeals</u> There was no evidence of staff providing the verbal and written notifications related to expedited appeals as required by Policy & Procedure 6020, *42 CFR § 438* and the *NC Medicaid Contract, Attachment M*. In the files reviewed, there was no documentation by appeal staff of: ○ The verbal notification of Cardinal's decision to deny the request to expedite the appeal; ○ The written notification of Cardinal's decision to deny the request to expedite the appeal; ○ The verbal or written notification informing the appellant of their right to file a grievance against Cardinal for denying the request to expedite the appeal; ○ The verbal notification of the resolution of the expedited appeal. <u>Appeal log</u> In addition to these concerns, it was highlighted during the Onsite that the Appeal log contained some errors. The appeal log contained incorrect information regarding enrollee names, appeal extensions, and information about expedited appeals. One file, selected from the appeal log and reviewed for this EQR was not, in fact, an appeal. Staff explained during the Onsite that the process followed for resolving this inpatient denial was external to and separate from the appeal process. However, this resolution was captured on the appeal log and an appeal resolution notification sent to the enrollee. The appeal log should be routinely monitored for accuracy as it is the primary data source for the tracking, monitoring, and reporting of appeal data. Lastly, there were no files reviewed this year that showed Cardinal extended the appeal resolution timeframe. The appeal log also showed none were extended by Cardinal during the year in review.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						However, given the concerns from the previous EQR and that the required notifications around extended appeals parallel those of expedited appeals, CCME recommends Cardinal include appeal extensions in the development of the training and monitoring plans described in the Corrective Actions on this standard. *Corrective Action: Develop and implement a training plan to include a timeline for the training, specific staff that will participate, how effectiveness of training will be evaluated, and a training agenda to include the following requirements:* • *The required written and verbal acknowledgements for all appeals (standard and expedited) and the required timeframes for these acknowledgements;* • *The required written and verbal notifications when Cardinal denies a request to expedite an appeal and the required timeframes for these notifications;* • *How and when appellants are notified of their right to file a grievance when Cardinal denies a request to expedite an appeal; and* • *The required written and verbal notifications of the resolution of expedited appeals.* *See Policy & Procedure 6020, 42 CFR § 438 and the NC Medicaid Contract, Attachment M.* *Develop, document, and implement a monitoring plan to increase compliance with required appeal notifications. This monitoring plan should include the timeline for implementation, frequency of monitoring, staff that will implement the monitoring, benchmarks, and how and when outcomes of monitoring are captured, reviewed, and reported. The monitoring plan should include monitoring of:* • *Accuracy of data within the appeal log, including that only appeals are captured on the log;*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						• *The required written and verbal acknowledgements for all appeals (standard and expedited) and the required timeframes for these acknowledgements;* • *The required written and verbal notifications when Cardinal denies a request to expedite an appeal and the required timeframes for these notifications;* • *How and when appellants are notified of their right to file a grievance when Cardinal denies a request to expedite an appeal; and* • *The required written and verbal notifications of the resolution of expedited appeals.* ***Recommendation: Include in the training and monitoring plans above the required notifications and their timelines when Cardinal extends the appeal resolution timeframe.***
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	X					Appeals are analyzed by type, disability, age, and service and reported in the Quality Improvement Committee.
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	X					During the Onsite discussion, staff explained that, when requested, the appeal record is provided to the appellant. In this discussion there was no reference to Cardinal's policies and procedures that outline the required internal steps that must be followed when releasing an enrollee's record. There is also no reference to this process within Policy & Procedure 6020. ***Recommendation: Revise Policy & Procedure 6020 to describe the requirement of releasing the appeal record, when requested, and ensure this process is congruent with the polices and procedures that govern releasing PHI (e.g., Policy & Procedure 1920, Requests for Access to Member Records, Policy & Procedure 1924, Accounting of PHI Disclosures, etc.). Ensure staff capture each step of releasing the appeal record within the appeal clinical documentation notes.***

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. There is a *Business Associates Agreement* with BHM.
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 and ongoing monitoring of its delegates, including annual audits of all delegates. Routine reports are received from the delegates and are presented in the appropriate committees for review, discussion, and recommendations. Plans of correction are used when needed. Credentialing Committee Meeting Minutes include the review of the *2019 Annual Delegation Evaluation and Credentialing File Review* for credentialing delegates. During Onsite discussion, Cardinal staff indicated reports regarding BHM are presented in the "Continuous Quality Improvement (CQI) Committee, and are also reported through the medical area" at Cardinal. Cardinal staff, including Dr. Wright-Etter, have biweekly meetings with BHM, in which they discuss reviews completed by BHM, and any concerns, problems, issues, and any new authorization guidelines or Clinical Coverage Policies.

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 CFR § 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* of the *NC Medicaid Contract.*	X					This requirement is addressed in the Cardinal's 2019 Compliance Plan.
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					This requirement was addressed in the Provider Services Agreement.
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 CFR § 438.608* that is designed to guard against fraud and abuse. The Compliance Plan shall be submitted to the *NC Medicaid Contract* Administrator on an annual basis.	X					This requirement is addressed in the Cardinal's 2019 Compliance Plan.

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 CFR § 438.608* and who retains authority to report directly to the CEO and the Board of Directors as needed irrespective of administrative organization. PIHP shall also establish a regulatory compliance committee on the PIHP board of directors and at the PIHP senior management level that is charged with overseeing PIHP's compliance program and compliance with requirements under this Contract. PIHP shall establish and implement policies outlining a system for training and education for PIHP's Compliance Officer, senior management, and employees in regard to the federal and state standards and requirements under *NC Medicaid Contract* in accordance with *42 CFR § 438.608(a)(1)(iv).*	X					This requirement is addressed in the Cardinal 2019 Compliance Plan.
3. PIHP shall establish and implement a special investigations or program integrity unit, however named, that is responsible for PIHP program integrity activities, including identification, detection, and prevention of fraud, waste and abuse in the PIHP Closed Provider Network. PIHP shall identify an appropriately qualified contact for Program Integrity and Regulatory Compliance issues as mutually agreed upon by PIHP and NC Medicaid. This person may or may not be the PIHP Compliance Officer or the PIHP Contract Administrator. In addition, PIHP shall identify a primary point of contact within the Special Investigations Unit to receive and respond to	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	
data requests from MFCU/MID. The MFCU/ MID will copy the PIHP Contract Administrator on all such requests.						
4. PIHP shall participate in quarterly Program Integrity meetings with NC Medicaid Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the NC Department of Justice ("MFCU/ MID').	X					Cardinal provided copies of quarterly agendas and minutes.
5. PIHP shall send staff to participate in monthly meetings with Division Program Integrity staff, either telephonically or in person at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.						
6. PIHP shall designate appropriately qualified staff to attend the monthly meetings, and the parties shall work collaboratively to minimize duplicative or unproductive meetings and information	X					This requirement is addressed in Cardinal Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting. Cardinal provided internal minutes for monthly meetings.
7. The Division recognizes that the scope of the PIHP's Regulatory Compliance Committee includes issues beyond those related to Program Integrity. Within seven (7) business days of a request by the Division, PIHP shall also make portions of the PIHP's Regulatory Compliance and Program Integrity minutes relating to Program Integrity issues available for review, but the PIHP may, redact other portions of the minutes not relating to Regulatory Compliance or Program Integrity issues.	X					This requirement is addressed in Cardinal Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting. In the onsite interview it was confirmed that Cardinal provides minutes as requested.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
8. PIHP's written Compliance Plan shall, at a minimum include:						
8.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(66) of the Social Security Act;	X					This requirement is addressed in the Cardinal 2019 Compliance Plan. Cardinal provided examples of training delivered to employees and separately to providers.
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 Cardinal 2019 Compliance Plan. Cardinal provided a sample corrective action initiative undertaken after a completed SIU investigation.
8.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					This requirement is addressed in the Cardinal 2019 Compliance Plan.
8.4 Provision for full cooperation by PIHP and PIHP's employees, contractors, and Providers with any investigation conducted by federal or state authorities, including NC Medicaid or MFCU/MID, and including promptly supplying all data in a uniform format provided by NC Medicaid and information requested for their respective investigations within seven (7) business days or within an extended timeframe determined by Division as provided in Section 13.2 – Monetary Penalties.	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	
9. In accordance with *42 CFR § 436.606(a)(vii),* PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under *NC Medicaid Contract*, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under *NC Medicaid Contract*; and making documentation of investigations and compliance available as requested by the State. PIHP shall include in each monthly Attachment Y Report, all overpayments based on fraud or abuse identified by PIHP during the prior month. PIHP shall be penalized One Hundred Dollars ($100) for each overpayment that is not specified in an Attachment Y Report within the applicable month. In addition, PIHP shall have and implement written policies and procedures to guard against fraud and abuse	X					This requirement is addressed in Cardinal Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting. The PIHP experienced turnover in senior compliance PI positions during the review period, however it is currently fully-staffed. The compliance officer has changed the structure of committees and meeting schedules which pushes the onus for monitoring entirely onto the PI Director.
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.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.
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 partially addressed in the PI Investigation Process Workflow that shows the internal steps followed by staff when investigating complaints. This workflow does not differentiate the internal processes for investigating fraud versus investigating waste and abuse. ***Corrective Action: Update the PI Investigation Process Workflow to differentiate the internal processes for investigating fraud versus investigating waste and abuse.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.3 In accordance with Attachment Y – Audits/Self-Audits/Investigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.	X					This requirement is addressed in Policy & Procedure 2300, Paybacks. Cardinal provided quarterly schedule K reports with overpayment details.
10.4 Process for tracking overpayments and collections, based on fraud or abuse, including Program Integrity and Provider Monitoring activities initiated by PIHP and reporting on Attachment Y – Audits/Self- Audits/Investigations;	X					This requirement is addressed in Policy & Procedure 2300, Paybacks.
10.5 Process for handling self-audits and challenge audits;	X					
10.6 Process for using data mining to determine leads;	X					Cardinal provided sample data mining reports. Cardinal has made a transition from the existing STARS toolset to FAMS after review period. They have purchased 12 packages for FAMS including Recipient Fraud, Member as provider, and Geographic anomalies.
10.7 Process for informing PIHP employees, subcontractors and providers regarding the False Claims Act;	X					This requirement is addressed in Policy & Procedure 1945, Employee Code of Conduct and the Work Environment.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.8 If PIHP makes or receives annual payments of at least $5,000,000, PIHP shall establish and maintain written policies for all employees, contractors or agents that detail information about the False Claims Act and other federal and State laws as described in the Social Security Act 1902(a)(66), including information about rights of employees to be protected as whistleblowers.	X					This requirement is addressed in Policy & Procedure 1945, Employee Code of Conduct and the Work Environment. There was one Recommendation from the previous year's EQR. It was recommended that Cardinal add language to Policy & Procedure 1945, Employee Code of Conduct and the Work Environment that explicitly includes the False Claims Act in the list of protected whistleblower reporting. The current review found that this recommendation was fully implemented.
10.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains NC Medicaid-standardized elements or a NC Medicaid-approved template;	X					This requirement is addressed in Policy & Procedure 1990, Verifications of Services Survey
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 Policy & Procedure 8000, Agency Application and Enrollment and Policy & Procedure 8370, Ongoing Monitoring off 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	X					This requirement is addressed in Policy & Procedure 2300, Paybacks.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
notice of the process for appealing to the NC Office of Administrative Hearings or any other forum.						
12. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to NC Medicaid within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					This requirement is addressed in Cardinal Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting.
13. In each case where PIHP refers to NC Medicaid an allegation of fraud involving a Provider, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						
13.1 Subject (name, Medicaid provider ID, address, provider type);	X					This requirement is addressed in Cardinal Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting. Fifteen of 15 files reviewed met the requirement.
13.2 Source/origin of complaint;	X					This requirement is addressed in Cardinal Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting. Fifteen of 15 files reviewed met the requirement.
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					This requirement is addressed in Cardinal Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting. Fifteen of 15 files reviewed met the requirement.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
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					This requirement is addressed in Cardinal Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting. Four of 15 files reviewed were not applicable for this requirement because the case was determined not to be a credible allegation of fraud before the claims history was pulled. Eleven of 11 remaining files reviewed met the requirement.
13.6 All communications between PIHP and the Provider concerning the conduct at issues, when available.	X					This requirement is addressed in Cardinal Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting. Nine of 15 files reviewed were not applicable for this requirement because the case was determined not to be a credible allegation of fraud and required no communication with the provider. Six of 6 remaining files reviewed met the requirement.
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					This requirement is addressed in Cardinal Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting. Fifteen of the 15 files reviewed met the requirement.
13.8 Total Sample Amount of Funds Investigated per Service Type.	X					This requirement is addressed in Cardinal Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting. Fifteen of 15 files reviewed met the requirement.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.8.1 Any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers;	X					This requirement is addressed in Cardinal Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting. No files met this criterion.
13.8.2 Details that relate to the original allegation that PIHP received which triggered the investigation;	X					This requirement is addressed in Cardinal Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting. Fifteen of 15 files reviewed met the requirement.
13.8.3 Period of Service Investigated – PIHP shall include the timeframe of the investigation and/or timeframe of the audit, as applicable.;	X					
13.8.4 Information on Biller/Owner;	X					
13.8.5 Additional Provider Locations that are related to the allegations;	X					This requirement is addressed in Cardinal Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting. No files met this criterion.
13.8.6 Legal and Administrative Status of Case.	X					This requirement is addressed in Cardinal Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting. Fifteen of 15 files reviewed met the requirement.
14. In each case where PIHP refers suspected Enrollee fraud to NC Medicaid, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						There were no enrollee fraud cases to review.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.1 The Enrollee's name, birth date, and Medicaid number;	X					This requirement is addressed in Cardinal Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting.
14.2 The source of the allegation;	X					
14.3 The nature of the allegation, including the timeframe of the allegation in question;	X					
14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;	X					This requirement is addressed in Cardinal Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
15. PIHP and NC Medicaid shall mutually agree on program integrity and monitoring forms, tools, and letters that meet the requirements of state and federal law, rules, and regulations, and are consistent with the forms, tools and letters utilized by other PIHPs.	X					
16. PIHP shall use the NC Medicaid Fraud and Abuse Management System (FAMS) or a NC Medicaid approved alternative data mining technology solution to detect and prevent fraud, waste and abuse in managed care.	X					Cardinal showed reports generated from STAR Sentinel. Cardinal reported on three targeted initiatives related to data mining. Cardinal has a concurrency workgroup which identified 2.1 million in suspect claims.
17. If PIHP uses FAMS, PIHP shall work with the NC Medicaid designated Administrator to submit appropriate claims data to load into the NC Medicaid Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. If PIHP uses FAMS, PIHP shall notify the NC Medicaid designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.				X		Cardinal reports that it is implementing FAMS in December 2019.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
18. PIHP shall submit to the NC Medicaid Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month or the next business day if the 10th day is a non-business day (i.e. weekend, state or PIHP holiday). Section 9.8 Fraud and Abuse Reports. In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to NC Medicaid Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not limited to overpayments and self-audits. The monthly report shall be due by 11:59p.m. on the tenth (10th) of each month in the format as identified in Attachment Y. PIHP shall also report to NC Medicaid Program Integrity all Network Provider contract terminations and non-renewals initiated by PIHP, including the reason for the termination or non-renewal and the effective date. The only report shall be due by 11:59p.m. on the tenth (10th) day of each month in the format as identified in attachment Z – Terminations, Provider Enrollment Denials, Other Actions. Compliance with the reporting requirements of Attachments X, Y and Z and any mutually approved template shall be considered compliance with the reporting requirements of this Section.	X					This requirement is addressed in Cardinal Policy 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting. Cardinal provided samples of Attachment Y and Z.

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 NC Medicaid Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of NC Medicaid Program Integrity's suspension and lasting until PIHP is notified by NC Medicaid Program Integrity in writing that the suspension has been lifted.	X					
3. PIHP shall provide to NC Medicaid all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.	X					This requirement is addressed in Cardinal Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting.
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to NC Medicaid Program Integrity due to allegations of suspected fraud without prior written approval from NC Medicaid Program Integrity or the MFCU/MID. . If PIHP takes administrative action, including issuing a Notice of Overpayment based on such fraud that precedes the submission date of a Division referral, the State will adjust the PIHP capitated	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
payment in the amount of the original overpayment identified or One Thousand Dollars ($1,000) per case, whichever amount is greater.						
5. Notwithstanding the foregoing, nothing herein shall be construed as prohibiting PIHP from taking any action against a Network Provider in accordance with the terms and conditions of any written agreement with a Network Provider, including but not limited to prepayment review, identification and collection of overpayments, suspension of referrals, de-credentialing, contract nonrenewal, suspension or termination or other sanction, remedial or preventive efforts necessary to ensure continuous, quality care to Enrollees, regardless of any ongoing investigation being conducted by NC Medicaid, MFCU/MID or other oversight agency, to the extent that such action shall not interfere with Enrollee access to care or with any such ongoing investigation being conducted by NC Medicaid, MFCU/MID or other oversight agency.	X					
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	X					This requirement is addressed in Policy & Procedure 2300, Paybacks.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery.						
7. Recovery Audit Contactors (RACs) for the Medicaid program may audit Providers in the PIHP Network and may work collaboratively with PIHP on identification of overpayments. NC Medicaid shall require RACs to give PIHP prior written notice of such audits and the results of any audits as permitted by law.						
8. 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. NC Medicaid 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. Although Cardinal exceeds the requirements for minimum Medicaid and total current ratio, their cash on hand is low in terms of days of service expenses (6.3 days). This poses a potential risk to Cardinal's solvency and liquidity. ***Recommendation: Keep 30 days of service expenses in cash on hand. Policy & Procedure 2212, Management of Financial Risk should be revised to include monthly monitoring of days service expenses.***
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 *NC Medicaid Contract*.	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. (*NC Medicaid Contract, Section 8.3.2* and *Amendment 4, Section 31).*	X					Cardinal Policy & Procedure 2150, Fiscal Records Retention, documents their record retention, which documents ten years of financial record retention.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. The PIHP maintains a restricted risk reserve account with a federally guaranteed financial institution in accordance with *NC Medicaid Contract*.	X					Cardinal maintains their Risk Reserve Account at Uwharrie and Wells Fargo Bank and both are federally-guaranteed.
7. The required minimum balance of the Risk Reserve Account meets the requirements of the *NC Medicaid Contract*.	X					Cardinal's Policy & Procedure 2218 documents the risk reserve monthly payments. These are monitored by the Director of Finance. 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 *NC Medicaid Contract*.	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 *NC Medicaid Contract*.	X					The Medical Loss Ratio (MLR) is calculated monthly within the NC Medicaid report. The year to date MLR percentage is 95.15%, which exceeds the 85% requirement. Cardinal monitors the MLR monthly. ***Recommendation: Cardinal should further document their Medical Loss Ratio process in Policy & Procedure 2212, Management of Financial Risk, including the 85% minimum, process for monitoring, and HCQI expenses.***

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, NC Medicaid

February 19, 2020

Prepared By:

hms

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

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Background

Health Management Systems (HMS) has completed a review of the encounter data submitted by Cardinal to North Carolina Medicaid (NC 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 Prepaid Inpatient Health Plan (PIHP). North Carolina Senate Bill 371 requires that each PIHP submit encounter data "for payments made to providers for Medicaid and state-funded mental health, intellectual and developmental disabilities, and substance abuse disorder services. NC Medicaid may use encounter data for purposes including, but not limited to, setting PIHP capitation rates, measuring the quality of services managed by PIHPs, assuring compliance with state and federal regulations, and for oversight and audit functions."

In order to utilize the encounter data as intended and provide proper oversight, NC Medicaid must be able to confirm the data is 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 and submitted to NC Medicaid by Cardinal Innovations (Cardinal) for the period of January 2018 through December 2018. All claims paid by Cardinal should be submitted and accepted as a valid encounters 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 2018 encounter data provided as a data extract
- Analysis of Cardinal's 837 encounter files
- 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 PIHP 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 PIHP 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 Electronic Data Interchange (EDI) validator to check for errors and produce a 999 response. The 999 response is used to confirm receipt and communicate any compliance or layout errors to the PIHP. 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 Medicaid Management Information System (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 PIHP.

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

Looking at claims with dates of service in 2018, Cardinal submitted 2,171,767 unique encounters to the State. To date, less than 1% of all 2018 encounters submitted have not been corrected and accepted by NC Medicaid.

2018	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
Institutional	117,138	114,238	2,879	21	0.02%
Professional	2,054,629	1,999,406	51,914	3,309	0.16%
Total	2,171,767	2,113,644	54,793	3,330	0.15%

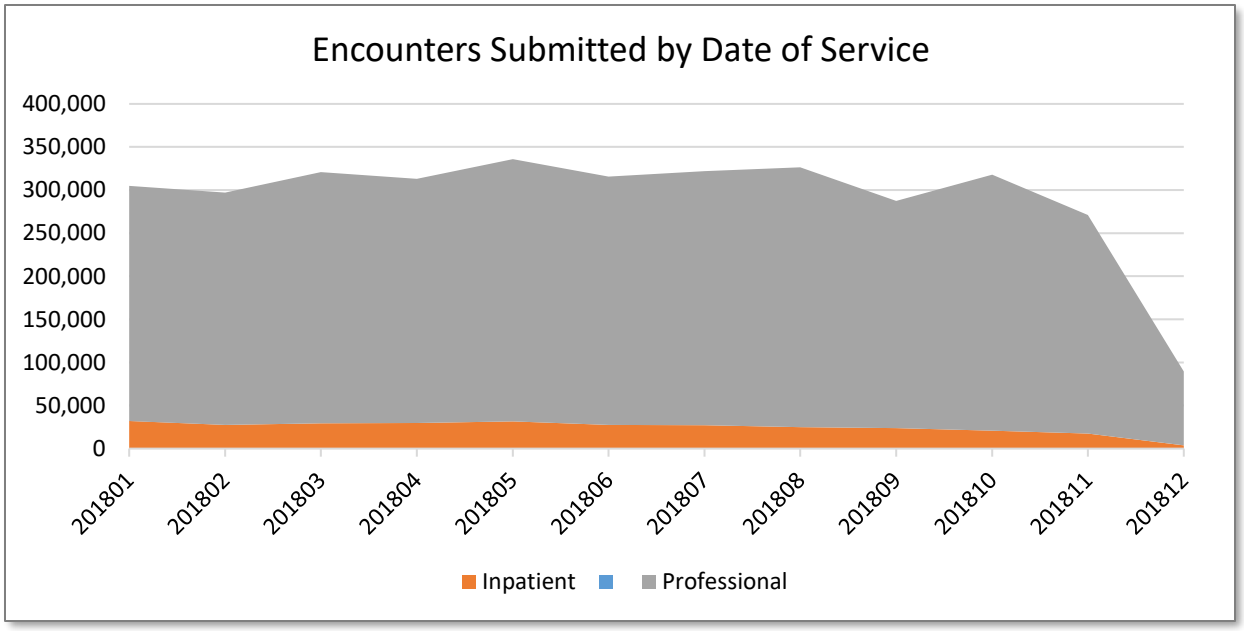
Each year Cardinal has made significant improvements to their encounter submission process, increasing their acceptance rate and quality of encounter data year over year. The table below reflects the increase in acceptance rate from 65% to 99%, well above NC Medicaid's expectations.

Year of Service	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
2016	1,441,643	822,674	109,268	509,701	35%
2017	1,921,945	1,615,643	29,696	276,606	14%
2018	2,171,767	2,113,644	54,793	3,330	0.15%

The PIHP has a detailed reconciliation and correction process in place to ensure that all denials are reviewed, corrected and resubmitted to NC Medicaid. Cardinal has a dedicated Encounter Data Reconciliation Team. This team consists of a Manager, Supervisor and 5 Encounter Reconciliation Analyst responsible for investigating all denied encounters. Cardinal is determining the denial reason by using the EOB code and description found on the 835 file. If the provider data is missing in NCTracks, they request the provider to submit a Manage Change Request to add that data prior to resubmission of denied Encounter claim. If the denied Encounter claim was caused by provider billing error, the team works with the front line claims team to educate the provider on how to bill a correct claim. In addition to the dedicated encounter staff, Cardinal has implemented various system enhancements including rewriting the 837 to update formatting issues and adding additional edits to ensure appropriate claim values are being submitted by providers.

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, 2018 and December 31, 2018. Cardinal pulled all claims adjudicated and submitted to NC Medicaid during 2018 and sent to HMS via Secured File Transfer Portal. This included more than three million Professional claims and just over three hundred thousand Institutional claims. Some may have been resubmissions for denials or adjustments, however, there was not an easy way to identify a subsequent adjustment looking at the data elements provided.



In order to evaluate the data, Cardinal provided HMS with a data extract of all encounters submitted. Other PIHPs typically convert their 837 files to a delimited file using an EDI translator; however, Cardinal does not have a tool to perform this function. 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

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
Recipient Name	Should be captured in such a way that makes separating pieces of name easy. Expect data to be present and of good quality	85% present. Lengths should vary, but there should be at least some last names of >8 digits and some first names of < 8 digits, validating that fields have not been truncated. Also, a high percentage of names should have at least a middle initial.
Recipient Date of Birth	Should not be missing and should be a valid date.	< 2% missing or invalid
MCO/PIHP ID	Critical Data Element	100% valid
Provider ID	Should be an enrolled provider listed in the provider enrollment file.	95% valid
Attending Provider ID	Should be an enrolled provider listed in the provider enrollment file (will accept the MD license number if it is listed in the provider enrollment file).	> 85% match with provider file using either provider ID or MD license number
Provider Location	Minimal requirement is county code, but zip code is strongly advised.	> 95% with valid county code > 95% with valid zip code (if available)
Place of Service	Should be routinely coded, especially for physicians.	> 95% valid for physicians > 80% valid across all providers
Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% non-missing and valid on physician or other applicable provider type claims (e.g., other practitioners)
Principal Diagnosis	Well-coded except by ancillary type providers.	> 90% non-missing and valid codes (using International Statistical Classifications of Diseases, Ninth Revision, Clinical

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
		Modification [ICD-9-CM] lookup tables) for practitioner providers (not including transportation, lab, and other ancillary providers)
Other Diagnosis	This is not expected to be coded on all claims even with applicable provider types, but should be coded with a fairly high frequency.	90% valid when present
Dates of Service	Dates should be evenly distributed across time.	If looking at a full year of data, 5%–7% of the records should be distributed across each month.
Unit of Service (Quantity)	The number should be routinely coded.	98% nonzero <70% should have one if Current Procedural Terminology (CPT) code is in 99200–99215 or 99241–99291 range.
Procedure Code	Critical Data Element	99% present (not zero, blank, or 8- or 9-filled). 100% should be valid, state-approved codes. There should be a wide range of procedures with the same frequency as previously encountered.
Procedure Code Modifier	Important to separate out surgical procedures/ anesthesia/assistant surgeon, not applicable for all Procedure codes.	> 20% non-missing. Expect a variety of modifiers both numeric (CPT) and Alpha (Healthcare Common Procedure Coding System [HCPCS]).
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 shadow pricing for the services paid by Cardinal.

Table: Evaluation of Key Fields

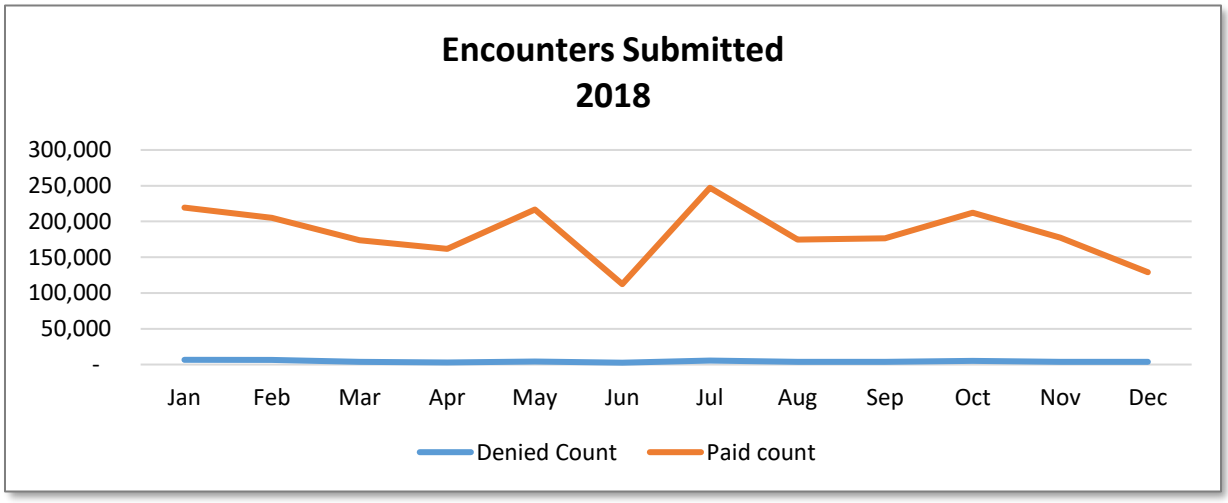
Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	4,015,227	100.00%	4,015,227	100.00%	4,014,774	99.99%	4,014,774	99.99%
Recipient Name	4,015,227	100.00%	4,015,227	100.00%	4,015,227	100.00%	4,015,227	100.00%
Recipient Date of Birth	4,015,227	100.00%	4,015,227	100.00%	4,015,227	100.00%	4,015,227	100.00%
MCO/PIHP ID	4,015,227	100.00%	4,015,227	100.00%	4,015,227	100.00%	4,015,227	100.00%
Provider ID	4,015,227	100.00%	4,015,227	100.00%	4,015,227	100.00%	4,015,227	100.00%
Attending/Rendering Provider ID	4,004,148	99.72%	4,004,148	99.72%	4,004,148	99.72%	4,004,148	99.72%
Provider Location	4,015,227	100.00%	4,015,227	100.00%	4,015,227	100.00%	4,015,227	100.00%
Place of Service	4,015,227	100.00%	4,015,227	100.00%	4,015,227	100.00%	4,015,227	100.00%
Specialty Code / Taxonomy - Billing	4,015,227	100.00%	4,015,227	100.00%	4,015,227	100.00%	4,015,227	100.00%
Specialty Code / Taxonomy - Rendering / Attending	4,004,148	99.72%	4,004,148	99.72%	4,004,148	99.72%	4,004,148	99.72%
Principal Diagnosis	4,015,227	100.00%	4,015,227	100.00%	4,015,227	100.00%	4,015,227	100.00%
Other Diagnosis	786,251	19.58%	786,251	19.58%	786,251	19.58%	786,251	19.58%
Dates of Service	4,015,227	100.00%	4,015,227	100.00%	4,015,227	100.00%	4,015,227	100.00%
Unit of Service (Quantity)	4,015,227	100.00%	4,015,227	100.00%	4,015,227	100.00%	4,015,227	100.00%
Procedure Code	3,889,209	96.86%	3,889,209	96.86%	3,887,995	96.83%	3,887,995	96.83%
Procedure Code Modifier	1,784,148	44.43%	1,784,148	44.43%	1,784,148	44.43%	1,784,148	44.43%
Patient Discharge Status Code Inpatient	374,030	100.00%	374,030	100.00%	374,030	100.00%	374,030	100.00%
Revenue Code	374,030	100.00%	374,030	100.00%	374,030	100.00%	374,030	100.00%

Overall, there were very few inconsistencies in the data. Institutional claims contained complete and valid data in 16 of the 18 key fields (94%) with minor issues identified with Recipient ID and Procedure code. Cardinal is submitting encounters without the 10 byte state Medicaid Id – including claims where the SSN is used or other unexpected values. Also, Cardinal is not consistently populating the Procedure code, which was an issue identified in the 2017 and 2018 encounter data reviews.

Professional encounter claims submitted contained complete and valid data in 15 of the 15 key Professional fields (100%). Minor issues with additional Diagnosis code, rendering provider, and rendering specialty/taxonomy were identified; however, the issues did not exceed the thresholds identified in the data quality standards table above.

Encounter Acceptance Report

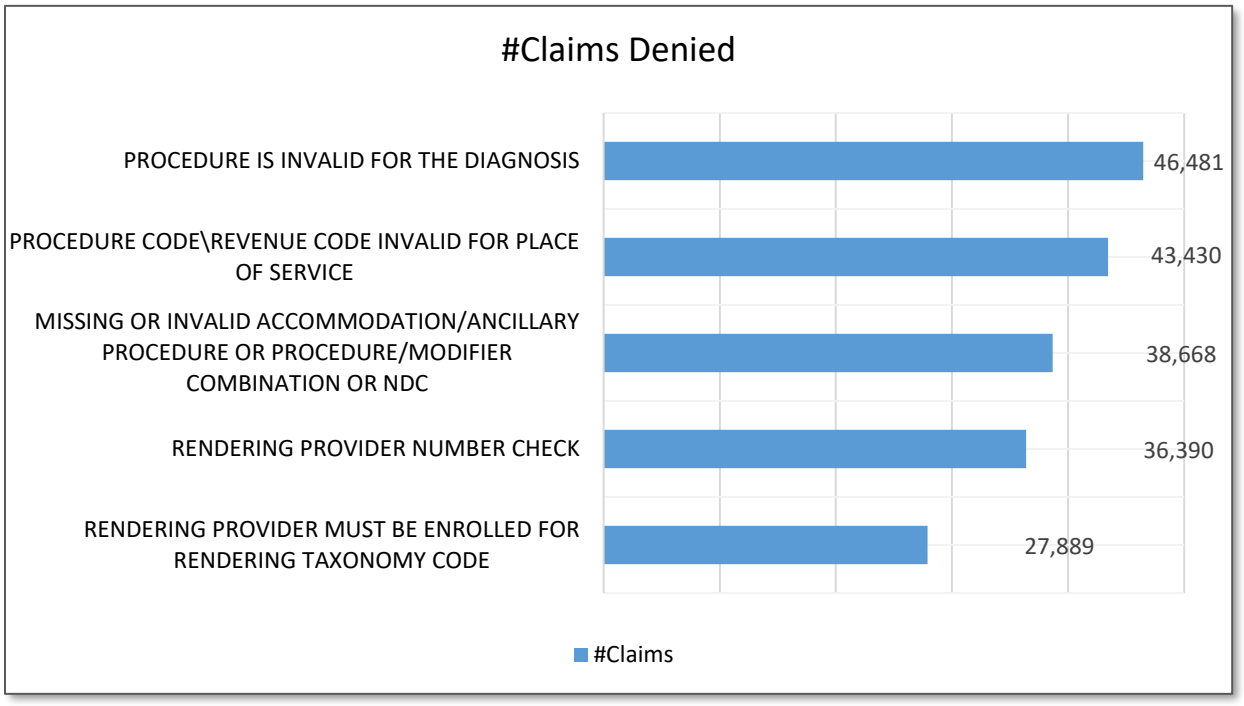
In addition to performing evaluation of the encounter data submitted, the HMS analyst reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by check write and excludes duplicates or resubmission which made it difficult to tie back to the ISCA response and converted encounter files. Data provided by PIHP's reports for our review includes all submission and resubmissions during 2018 which may include older dates of service. During the 2018 weekly check write schedule, Cardinal submitted a total of 2,171,767 encounters to NC Medicaid. On average, 16% of all encounters submitted were initially denied. Approximately less than 1% of claims denied are still outstanding - the rest have been reviewed, resubmitted, and accepted by NC Medicaid.



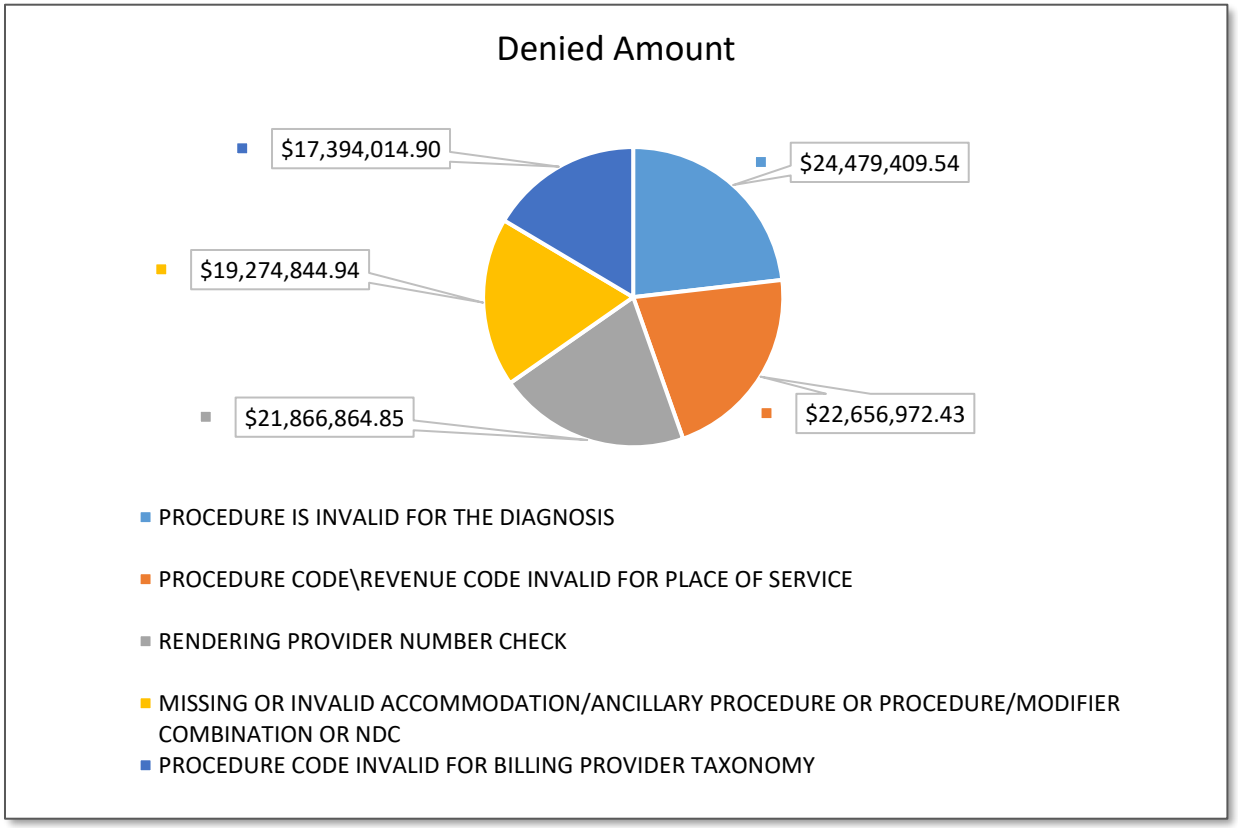
Evaluation of the top denials for Cardinal encounters correlates with the data deficiencies identified by the HMS analyst in the Key Field analysis an ISCA review above. Encounters were denied primarily for:

- Procedure is invalid for the diagnosis
- Procedure code/Revenue code invalid for Place of Service
- Missing or invalid accommodation/ancillary procedure or procedure/modifier
- Rendering provider number check
- Rendering provider number must be enrolled for rendering Taxonomy code

The graph below reflects the top 5 denials by claim volume.



The pie chart below reflects the top 5 denials by claim dollar amount.



Results and Recommendations

Issue: Procedure Code

The Procedure code for Institutional claims should be populated 99% of the time. In the encounter data provided, only 67% of claims contained a value in the Procedure code field and 1 % values were populated with a Revenue code instead of a valid Procedure code.

Resolution:

This issue was present in the review of 2017 encounters, but at a much higher error rate. Cardinal should ensure that the appropriate data validation checks are in place in their provider portal to prevent Revenue codes being submitted in the Procedure code fields. Claims submitted through the portal or an 837 should be denied by Cardinal without the proper Revenue code and Procedure code combination. Cardinal should review their 837 encounter creation and encounter data extract process to ensure that an invalid Procedure code is not transmitted to NC Medicaid, even when the data is invalid based on the provider claim submission.

Issue: Recipient ID

The Recipient ID should be populated 100% of the time with valid values. NC Medicaid is expecting a 10-byte alphanumeric value, specifically 9 digits following by and alpha character. Of the encounters submitted, 553 records were invalid. There was a mix of SSN values with the hyphen included and values less than 10 bytes in length.

Resolution:

Cardinal's eligibility data is driven by the 834 and Global Eligibility File (GEF) provided by NC Medicaid. Cardinal should ensure that each encounter being submitted matches to the state-provided eligibility prior to submission. They already validate that the member is eligible prior to claim payment, so the correct Recipient or Medicaid ID should be captured and available for submission. If the claim being submitted by the provider does not contain a valid Recipient ID, the claim should be denied. If the claim is being submitted through the provider portal, the provider should be limited to only select or enter a valid Id on record with the PIHP.

Conclusion

Based on the analysis of Cardinal's encounter data, we have concluded that the data submitted to NC Medicaid is complete and accurate as defined by NC Medicaid standards.

The two issues identified were only apparent in the Institutional claims submitted and are minimal considering the volume of claims and the method for adjudication (Revenue code vs Procedure code). Cardinal should take corrective action to ensure they are capturing and reporting valid Procedure codes for Institutional claims when required for the reported Revenue code, and only submitting the expected 10-byte alphanumeric Recipient ID.

For the next review period, 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 PIHP. Reviewing an extract from NCTracks would provide insight into how the state's MMIS is handling the encounter claims and could be reconciled back to reports requested from Cardinal. The goal is to ensure that Cardinal is reporting all paid claims as encounters to NC Medicaid.

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 DHB 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