2020 External Quality Review

CARDINAL INNOVATIONS HEALTHCARE

Submitted: May 28, 2021

Prepared on behalf of the
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 (42 CFR § 438.358)*. This review determines the level of performance demonstrated by Cardinal Innovations Healthcare (Cardinal). This report contains a description of the process and the results of the 2020 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the North Carolina Medicaid (NC Medicaid).

Goals of the review are to:

- Determine if the PIHP 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

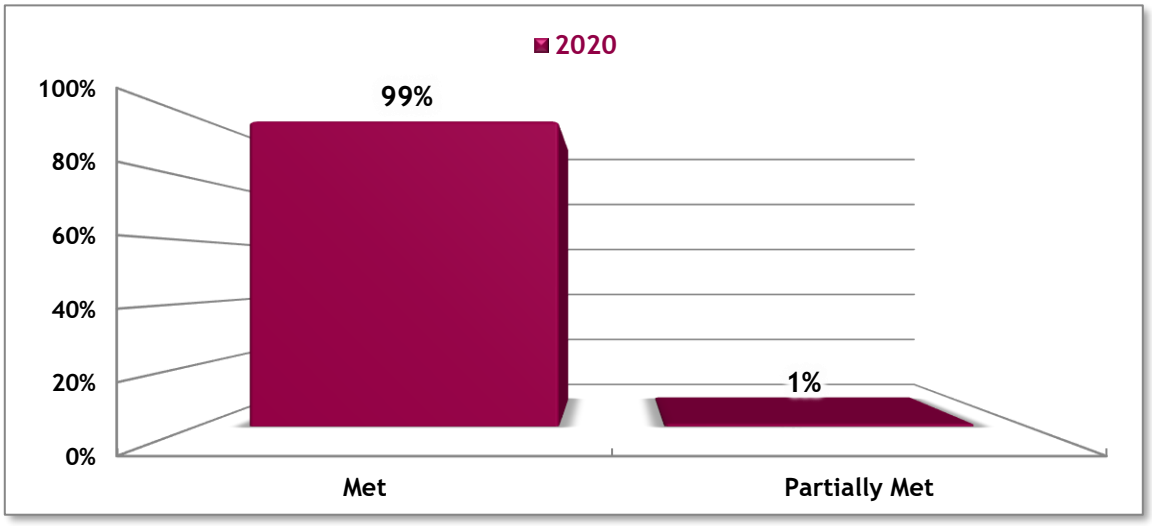
The process used for the EQR was based on the Centers for Medicare & Medicaid Services (CMS) protocols for EQR of Medicaid Managed Care Organizations (MCOs) and PIHPs. The review includes a Desk Review of documents, an Onsite visit, compliance review, validation of performance improvement projects (PIPs),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

Due to the COVID-19 pandemic, the 2020 EQR was delayed. CCME implemented a focused review and implemented the Onsite virtually.

A. Overall Score

The 2020 Annual EQR reflects that Cardinal achieved a “Met” score for 99% of the standards reviewed. As Figure 1 indicates, 1% of the standards were scored as “Partially Met”. None of the 2020 EQR standards were scored as “Not Met”.

Figure 1: 2020 EQR Results



B. Overall Findings

The following provides a global or high-level summary of the status of the Recommendations and Corrective Action items from the 2019 EQR and the findings of the 2020 EQR. Specific Recommendations and Corrective Actions are detailed in each section of this report.

Information Systems Capabilities Assessment (ISCA)

In the 2019 EQR, Cardinal partially met two of the ISCA standards and received three Corrective Actions. These Corrective Actions were related to the number of ICD-10 codes accepted in the CI system and submitted to NCTracks. One Recommendation was given to Cardinal to collaborate with their providers to ensure providers are submitting all required claims fields such as secondary diagnoses. This collaboration would also ensure providers are not submitting the Revenue code data in the Procedure code field.

In the 2020 EQR, it was evident that Cardinal addressed the three 2019 Corrective Actions. However, it is still recommended Cardinal continue to work with providers who are not submitting all secondary diagnoses and continue to submit the Revenue code in the procedure code field. Cardinal met all of the ISCA standards in this 2020 EQR.

Provider Services

In Cardinal's 2019 EQR, there were six items requiring Corrective Action and three Recommendations in the Credentialing/Recredentialing section of Provider Services. Cardinal addressed all six of the Corrective Action items and two of the three Recommendations. The Recommendation from the last two EQRs to "ensure the required percentage for a Credentialing Committee meeting quorum is the same across

documents" persists. In the current EQR, Cardinal met 100% of the Provider Services Credentialing/Recredentialing standards.

Quality Improvement

The Quality Improvement (QI) EQR included validation of Performance Measures (PMs) and Performance Improvement Projects (PIPs).

In the 2019 EQR, there were no Corrective Actions and one Recommendation given for the Routine Access to Care PIP regarding monitoring of interventions to improve appointment attendance. This will be a Recommendation again this year since no improvement was made with appointment attendance.

For the 2020 EQR, the Performance Measure Query was accurate for (b) Waiver Measures and those measures had no substantial rate increase or decreases from last year. All (c) Waiver Performance Measures were above benchmark rates. All PMs were validated at 100%. The five validated PIPs all scored in the High Confidence range, although two PIPs have Recommendations for improvement. In this 2020 EQR, 100% of the QI standards were met.

Care Coordination

In the 2019 EQR, Cardinal met 98% of Utilization Management (UM) standards, which included review of Cardinal's Care Coordination functions and documentation. CCME issued one Corrective Action and one Recommendation. The Corrective Action and Recommendation were aimed at improving the timeliness, completeness, and quality of staff documentation through an enhanced monitoring process. Cardinal addressed the Corrective Action item and the Recommendation.

The UM section covered Care Coordination and TCLI for this year's review. Cardinal met 100% of the UM standards. CCME offered one Recommendation to update Policy & Procedure 9720, NC Innovations Termination, to include exemptions listed in NC Joint Communication Bulletin #J362 regarding waiver cost limits.

Grievances and Appeals

In the 2019 EQR, Cardinal met 90% of the Grievance and Appeal standards. Three Corrective Actions and five Recommendations were issued to address concerns within Cardinal's appeal policy and procedure, the *Provider Manual*, *Member & Family Handbook*, and the Appeal and Grievance files reviewed. In the 2020 EQR, Cardinal met 95% of the Grievance and Appeals standards.

In the EQR of the Grievance processes, Cardinal met 100% of the Grievance Standards. Two Recommendations were offered. The Policy & Procedure Grievances and Formal Level of Appeal does not include information of the Grievance investigation process for

network providers and out-of-network providers. In Policy & Procedure 5050, providing a reference to Policy & Procedure 5200, Provider Investigation, will provide clarification about the Grievance process. The second Recommendation includes continued monitoring of the Grievance investigative steps to resolve the Grievance and ensure the details are included in Cardinals Grievance Form.

In the EQR of Appeal functions, one Corrective Action was issued to address errors in the appeal files reviewed. The file review showed five of the 11 Appeal files were out of compliance with the requirements found in the *NC Medicaid Contract* and federal regulations governing appeals. While compliance improved throughout the past year, there was still a pattern of missing required written and oral notifications, especially within expedited and invalid appeal files. Additionally, three Recommendations were issued targeting missing or incorrect contract language within Policy & Procedure 6020, the *Member & Family Handbook*, Appeals Brochure, and the *Provider Manual*.

Program Integrity

In the 2019 EQR, Cardinal met 100% of the Program Integrity (PI) EQR standards. Cardinal was issued one Recommendation in the 2019 EQR to revise their case workflow process to indicate a clear evaluation process for cases identified as fraud as opposed to cases identified as waste and or abuse. There was evidence in the 2020 EQR that Cardinal incorporated this Recommendation.

In the 2020 EQR, Cardinal met 100% of Program Integrity EQR standards. The review found that PI files were well documented and organized. The PIHP makes use of data mining and collaborates with IBM Partners to devise new algorithms and has increased its referral rate of potential fraud cases to NC Medicaid. Cardinal has undertaken an initiative during the COVID-19 pandemic to reduce their backlog and currently has no cases older than one year. During the Onsite, Cardinal highlighted efforts to tighten the integration of its compliance function with other departments such as Provider Network, Quality Management, and areas such as risk management and security.

Encounter Data Validation

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 of the three issues identified were only apparent in the Institutional claims and their impacts were minimal considering the volume of claims and the method for adjudication (Revenue code vs, Procedure code). Cardinal took a Corrective Action in 2019 to ensure they are capturing and reporting valid Procedure codes for Institutional claims. Cardinal is also closely monitoring Recipient Id to ensure that they are submitting the expected 10-byte alphanumeric Recipient ID.

The third issue involving Other Diagnosis code was mostly present in professional claims and appears to be driven by provider behavior – with some providers not reporting any additional Diagnosis codes while others do report at a high frequency. Similar to other two issues, this third issue did not appear to have impacted provider reimbursements. However, given the Other Diagnosis code is a required data element, Cardinal should identify providers who never code and submit Other Diagnosis codes and contact those providers to remind them of their obligation to submit claims that are complete and accurate.

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 Medicaid Management Information System (MMIS) is handling the encounter claims and could be reconciled back to reports requested from Cardinal. The goal is to ensure that Cardinal is reporting all paid claims as encounters to NC Medicaid.

METHODOLOGY

The process used for the EQR was based on the CMS protocols for 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, an ISCA Audit and Medicaid Program Integrity (PI) review of the health plan was conducted by CCME's subcontractor IPRO.

On November 2, 2020, CCME sent notification to Cardinal that the annual EQR was being initiated (see *Attachment 1*). This notification included:

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

Further, an invitation was extended to the 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 on November 23, 2020 and reviewed by 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. The Desk Review included a review of credentialing, Grievance, Program Integrity, Care Coordination, and Appeal files.

The second segment of the EQR is typically a two-day, Onsite review conducted at the PIHP's offices. However, due to COVID-19, this Onsite was conducted through a teleconference platform on April 29, 2021. This 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 PIHP 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 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. Information Systems Capabilities Assessment (ISCA)

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

In the 2019 EQR, Cardinal partially met two of the ISCA standards and received three Corrective Actions. These Corrective Actions were related to the number of ICD-10 codes accepted in the CI system and submitted to NCTracks. Cardinal implemented the three Corrective Actions. Cardinal now can accept up to 25 ICD-10 Diagnosis codes on an 837I; capture up to 18 Diagnosis codes on their Provider Web Portal; and submit all ICD-10 Diagnosis codes to NCTracks. Recommendation was given to Cardinal to collaborate with their providers to ensure they are submitting all required claims fields such as secondary diagnoses. This collaboration would also ensure providers are not submitting the Revenue code data in the Procedure code field. This Recommendation continues to be implemented by Cardinal and improvement in this 2020 EQR was noted. Further, Cardinal has implemented system edits to validate Procedure codes which will continue improve the accuracy and completeness of the claims data over time.

Cardinal uses the Cardinal Innovations Enterprise (CIE) system to process member enrollment, claims, submit encounters, and generate reports. The ISCA tool and supporting documentation for the enrollment systems loading processes clearly define the process for enrollment data updates in the CIE enrollment system. During the ISCA Onsite, it was confirmed the process had not changed from the prior EQR and that no system changes were made. The CIE systems maintains a member's enrollment history. The enrollment import is an automated routine in which the Global Eligibility File (GEF), supplied by NC Medicaid, is imported daily into the CIE system. The daily eligibility file is compared to existing eligibility in the CIE system. The following fields are used to determine if it is a new member by checking fields for Medicaid Identification number

(Medicaid ID), Client ID, Social Security Number, and First Name, Last Name, and Date of Birth. 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 ID received on the GEF. Cardinal's eligibility system can 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 uses the Exceptions Report weekly to correct any discrepancies.

Cardinal has experienced a small decrease in year-end enrollment numbers over the past three years.

Table 1: Enrollment Counts

2017	2018	2019
463,854.27	452,979.01	432,496.00

Within CIE, there is a module called Provider Direct (PD), which is a web portal that providers use to access Cardinal Innovations' system. Cardinal demonstrated the functions of Provider Direct during the Onsite. Providers can submit Treatment Authorization Requests (TARs) through Provider Direct and view enrollments and claims. Cardinal also has an application software used with CIE called Optum Transaction Validation Manager (OTVM). This software checks all incoming 837 files to ensure HIPAA compliance. Files that do not pass this check are not processed into CIE.

Cardinal's claims and authorizations are processed in the CIE claims processing system. An overview of Cardinal's processes for collecting, adjudicating and reporting claims was presented by Cardinal during the Onsite to confirm ISCA response and supporting documentation provided by Cardinal. During the demonstration of Cardinal's CIE claims processing system, both Institutional and Professional screens were displayed.

Cardinal receives claims from three methods, 837 electronic file, Provider Web Portal, and paper claims. During the Onsite, Cardinal confirmed the only paper claims they receive are from out-of-network providers, accounting for a very small percentage (less than 1%) of total claims. Table 2 details the percentage of 2019 claims received via the three methods.

Table 2: Percent of claims with 2019 dates of service that were received via Electronic (HIPAA, Provider Web Portal) or Paper forms.

Source	HIPAA File	Paper	Provider Web Portal
Institutional	80%	0%	20%
Professional	82%	0%	18%

Cardinal adjudicates claims on a nightly basis. Any claim that is missing information is pended and missing information addressed by a claims specialist. Cardinal no longer accepts paper claims from providers other than out-of-state hospitals. All other providers must submit claims electronically. Claims submitted through an electronic file are processed through a frontend editor. This system will not allow any files that are not validated to be processed and must be HIPAA compliant.

For Professional claims, Cardinal can receive and store up to 12 ICD-10 Diagnosis codes via the Provider Web Portal and 27 ICD-10 Diagnosis codes via HIPAA files. For Institutional claims, Cardinal can capture up to 29 ICD-10 Diagnosis codes if they are submitted on the claim via HIPAA files and up to 25 ICD-10 Diagnosis codes if they are submitted on the claim through the Provider Web Portal. Cardinal can capture ICD-10 Procedure codes and Diagnosis Related Groups (DRGs) on both the Provider Web Portal and via HIPAA files. During the Onsite, Cardinal stated that though they can capture ICD-10 Procedure codes, Cardinal does not receive many DRG or ICD-10 Procedure codes on Institutional claims. Enrollment and claims history is maintained in the CIE system. Cardinal's ISCA response indicated the reporting database is backed up on a nightly basis.

Cardinal has a defined process in place for their encounter data submission for approved claims, with 837 files submitted to NC Medicaid, and 999 and 835 response files received back from NC Medicaid through the NCTracks system. The process is automated with manual reconciling the exceptions, working of denials, and review of the reconciliation exceptions. 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. Cardinal has maintained an acceptance rate over the 95% threshold. Cardinal has a dedicated Encounter Data Reconciliation team that is responsible for the resubmission process. Cardinal tracks the encounters via generated reports and are worked by the team.

The breakdown of encounter data acceptance/denial rates by claim service detail counts was provided for encounters submitted in 2019. Table 3 provides a comparison of 2018 and 2019.

Table 3: Volume of 2018 and 2019 Submitted Encounter Data

2019	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	115,323	254	8	115,585
Professional	2,148,335	5,900	631	2,154,866
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

During the Onsite, Cardinal advised the two top denial reason codes for encounters in 2019:

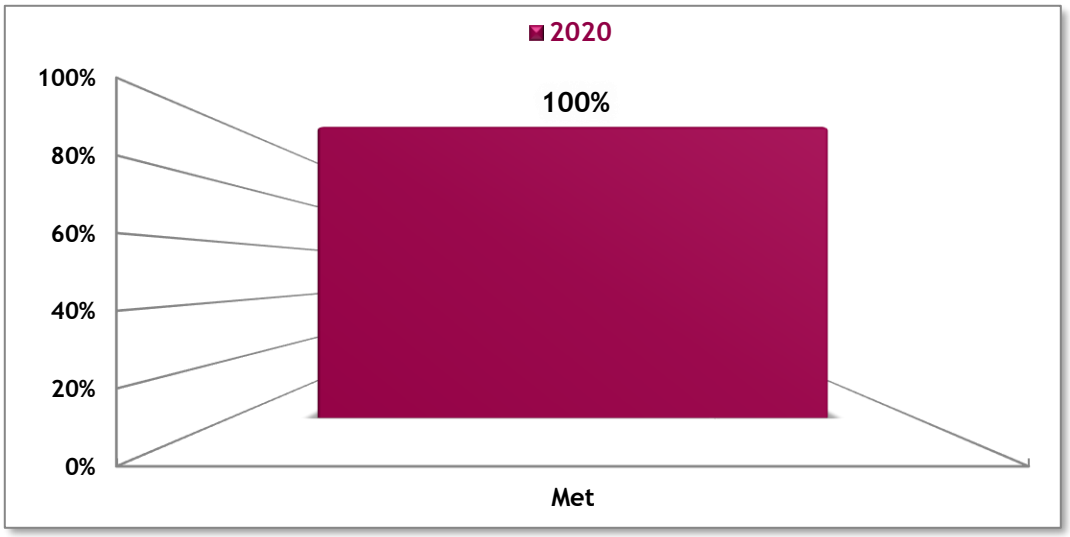
- Taxonomy code for attending provider missing or invalid
- Clinician no longer practicing

On average, Cardinal submits an encounter within nine days from the time of adjudication to NCTracks. It takes Cardinal approximately 56 days to correct and resubmit a denied encounter to NCTracks. Cardinal uses the 835 response file to identify encounters that were denied. Cardinal Innovations has a dedicated Encounter Data Reconciliation Team. This team consists of a Manager, Supervisor and five Encounter Reconciliation Analysts. As required, they do open work tickets to other departments as needed to resolve any issues.

Cardinal noted that ICD-10 Procedure codes and DRG codes are submitted to NCTracks. Cardinal also noted that they reimburse providers on a per-diem basis, and DRG coding is not often used. Additionally, they rarely receive ICD-10 Procedure codes from providers.

Figure 2 demonstrates that Cardinal met all the Standards in the 2020 ISCA EQR.

Figure 2: ISCA Findings



Strengths

- Cardinal can capture of up to 29 Diagnosis codes on Institutional claims and 27 Diagnosis codes on Professional claims.
- Cardinal can capture the DRG and ICD-10 Procedure codes on Institutional claims on the Provider Web Portal and via HIPAA files.
- Cardinal can submit all ICD-10 Diagnosis codes submitted by the provider on the encounter data extracts to NCTracks.
- Cardinal's current NCTracks encounter data acceptance rate is approximately 99% for the combined Professional and Institutional extracts.

Weaknesses

- Though Cardinal can capture ICD-10 Procedure codes, they rarely receive them from their providers on Institutional claims.

Recommendations

- Continue to work with Cardinal providers to ensure they are submitting ICD-10 Procedure codes on Institutional claims.

B. Provider Services

The Provider Services EQR for Cardinal included Credentialing and Recredentialing as well as a discussion of provider education and network adequacy. CCME reviewed relevant policies and procedures, the *Credentialing Committee Charter and Credentialing Program Operations Manual* (which was submitted as the Credentialing Program Description), credentialing and recredentialing files, a sample of Credentialing Committee meeting minutes, and select items on Cardinal's website. Cardinal staff provided additional information during an Onsite interview.

In Cardinal's 2019 EQR of Credentialing/Recredentialing, there were six items requiring Corrective Action and three Recommendations. Cardinal addressed all six of the Corrective Action items and two of the three Recommendations. The Recommendation from the last two EQRs to "ensure the required percentage for a Credentialing Committee meeting quorum is the same across documents" persists.

The *Credentialing Committee Charter and Operations Manual 12.10.2019* (*Credentialing Manual*) and several policies and procedures guide the credentialing and recredentialing processes. CCME's review of the credentialing/recredentialing files showed they were organized and contained appropriate information, with noted improvement over the last EQR.

CCME was unable to determine if recredentialing occurred within three years for the submitted agency file. The file contained evidence of the initial credentialing in 2011, but there was no evidence of the most recent recredentialing, which should have occurred in 2017. See Tabular Spreadsheet for more information.

Dr. Pamela Wright-Etter, Deputy Chief Medical Officer and a Board-Certified Psychiatrist, replaced Dr. Kashimawo-Akande as Chair of the Credentialing Committee in July 2020. At the Onsite, Cardinal staff indicated that, in the event Dr. Wright-Etter is unavailable to chair, the meeting would be rescheduled, or the Chief Medical Officer (CMO) would chair or appoint someone else to chair. The *Credentialing Manual* outlines the structure of the credentialing program, including the Credentialing Committee composition, roles, and responsibilities. Voting committee members include seven Cardinal staff members and two licensed providers, with one additional Provider Representative spot that was vacant. At the Onsite, Cardinal staff confirmed that the Provider Representative vacancy has been filled, and there are now three licensed providers on the committee. The Committee Chair is non-voting, except in the case of a tie vote.

The sample of Credentialing Committee meeting minutes reviewed for this EQR indicated a quorum was present. The Credentialing Committee section of the *2019-2020 Annual Quality Strategy & Performance Improvement Plan* states a "quorum consists of at least 50% of the voting members." This definition, also listed in the *2018-2019 Annual Quality*

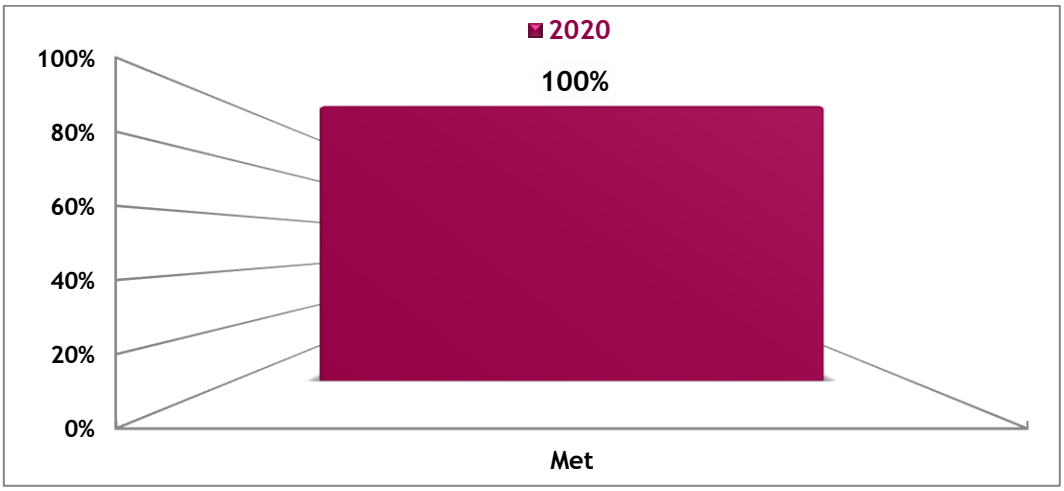
Strategy & Performance Improvement Plan, was not revised in response to the Recommendation from the last two EQRs and differs from the definition in the *Credentialing Manual* and in Policy & Procedure 1210, Cross Functional Committee Development, both of which indicate a quorum is "50% + 1 of the voting members."

A Resource Library on the Cardinal website includes resources for members, providers, and community members. New providers receive the *Provider Orientation Companion* document, which includes links to the Resource Library, Communication Bulletins, Training and Education materials, and other items on the Cardinal website, as well as links to relevant external resources such as the NC DHHS NCTracks website and HEDIS information on the National Committee for Quality Assurance (NCQA) website. A Network Relations staff member contacts new providers to schedule the New Provider Orientation, which is to be completed within 30 days.

Under the COVID-19 flexibilities as outlined in *NC Medicaid Contract Amendment #9*, the annual *Network Adequacy and Accessibility Analysis* (Gaps Analysis) will be submitted "no later than ninety (90) calendar days after termination of the Amendment." The 2019 Gaps Analysis indicated Cardinal did not meet all choice and location standards for five Medicaid-funded services. Cardinal did not meet access and choice standards for these same services in the previous year. Cardinal filed, and, in October 2019, NC Medicaid approved, *Exception Requests* for all five services, though the *Exception Requests* related to Substance Use Disorder were only approved through the end of January 2020. During the Onsite review for this EQR, Cardinal staff reported the previously identified gaps have been filled, with the exception of Child and Adolescent Day Treatment. Cardinal's efforts resulted in a five % improvement in access for Child and Adolescent Day Treatment, but a gap still exists in meeting the standards, and Cardinal is still working to improve access.

As Figure 3 indicates, 100% of the standards in the Provider Services review were scored as "Met".

Figure 3: Provider Services Findings



Strengths

- Cardinal has a dedicated toll-free Provider Line to assist providers.
- In April 2020, Network Management began hosting 45-minute webinars called Provider Huddles, to update providers on developments related to providing care during the COVID-19 pandemic. The Provider Huddles occurred four days per week for four consecutive weeks.
- The Cardinal website includes a Resource Library with filters for “Members”, “Providers”, "Community", and “Cardinal Innovations”.
- The *Orientation Companion* is a comprehensive resource which is especially helpful for new providers.

Weaknesses

- As was the case at the last EQR, the definition of a quorum for Credentialing Committee meetings in the *2019-2020 Annual Quality Strategy & Performance Improvement Plan* differs from the quorum definition in other documents. See Tabular Spreadsheet for details.

Recommendations

- As recommended at the last two EQRs, ensure the required percentage for a Credentialing Committee meeting quorum is the same across documents.

C. Quality Improvement

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

In the 2019 EQR, there were no Corrective Actions and one Recommendation given for the Routine Access to Care PIP regarding monitoring of interventions to improve appointment attendance. This will be a Recommendation again this year for the Routine Access to Care PIP since no improvement was made with appointment attendance. There were no Recommendations given for the 2019 EQR for the PMs. The 2019 EQR validation scores for (b) Waiver and (c) Waiver Performance Measures were fully compliant with an average validation score of 100%.

For the 2020 EQR, five PIPs were validated, and all PIPS scored in the High Confidence range. The 2020 EQR has no Corrective Action items, although two PIPs have one Recommendation each. The Performance Measure Query was accurate for (b) Waiver Measures and all measures were validated at 100%, Fully Compliant, and did not have significant rate increases or decreases when compared to last year's rates.

Performance Measure Validation

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

Table 4: (b) Waiver Measures

(b) WAIVER MEASURES	
A.1. Readmission Rates for Mental Health	D.1. Mental Health Utilization - Inpatient Discharges and Average Length of Stay
A.2. Readmission Rates for Substance Abuse	D.2. Mental Health Utilization
A.3. Follow-up After Hospitalization for Mental Illness	D.3. Identification of Alcohol and other Drug Services
A.4. Follow-up After Hospitalization for Substance Abuse	D.4. Substance Abuse Penetration Rates
B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment	D.5. Mental Health Penetration Rates

Table 5: (c) Waiver Measures

(c) WAIVER MEASURES
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.
Proportion of beneficiaries reporting they have a choice between providers.
Percentage of level 2 and 3 incidents reported within required timeframes.
Percentage of beneficiaries who received appropriate medication.
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.

CCME performed validations in compliance with the CMS developed protocol, *EQR Protocol 2: Validation of Performance Measures*, 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

There were no substantial increases or declines in any of the (b) Waiver Measures from EQR 2019 to EQR 2020. The current rate, in comparison to last year's rate is presented in the *Tables 6* through *15*. Rates were reported by Cardinal.

Table 6: A.1. Readmission Rates for Mental Health

30-day Readmission Rates for Mental Health	FY2019	FY2020	Change
Inpatient (Community Hospital Only)	10.6%	13.4%	2.8%
Inpatient (State Hospital Only)	4.9%	3.9%	-1.0%
Inpatient (Community and State Hospital Combined)	10.5%	13.1%	2.6%
Facility Based Crisis	11.0%	6.9%	-4.1%
Psychiatric Residential Treatment Facility (PRTF)	2.4%	0.9%	-1.5%
Combined (includes cross-overs between services)	11.9%	11.9%	0.0%

Table 7: A.2. Readmission Rate for Substance Abuse

30-day Readmission Rates for Substance Abuse	FY2019	FY2020	Change
Inpatient (Community Hospital Only)	8.2%	14.5%	6.3%
Inpatient (State Hospital Only)	0.9%	2.4%	1.5%
Inpatient (Community and State Hospital Combined)	6.9%	7.5%	0.6%
Detox/Facility Based Crisis	9.4%	10.3%	0.9%
Combined (includes cross-overs between services)	11.5%	13.8%	2.3%

Table 8: A.3. Follow-Up after Hospitalization for Mental Illness

Follow-up after Hospitalization for Mental Illness	FY2019	FY2020	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	36.7%	35.7%	-1.0%

Follow-up after Hospitalization for Mental Illness	FY2019	FY2020	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 30 Days	54.2%	54.5%	0.3%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	61.8%	66.8%	5.0%
Percent Received Outpatient Visit Within 30 Days	70.1%	77.9%	7.8%
PRTF			
Percent Received Outpatient Visit Within 7 Days	26.6%	29.7%	3.1%
Percent Received Outpatient Visit Within 30 Days	61.6%	60.2%	-1.4%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	39.9%	36.6%	-3.3%
Percent Received Outpatient Visit Within 30 Days	58.1%	55.4%	-2.7%

Table 9: A.4. Follow-Up After Hospitalization for Substance Abuse

Follow-up after Hospitalization for Substance Abuse	FY2019	FY2020	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	18.5%	22.5%	4.0%
Percent Received Outpatient Visit Within 30 Days	28.2%	32.8%	4.6%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	33.1%	35.0%	1.9%
Percent Received Outpatient Visit Within 7 Days	38.0%	40.7%	2.7%

Follow-up after Hospitalization for Substance Abuse	FY2019	FY2020	Change
Percent Received Outpatient Visit Within 30 Days	47.0%	47.9%	0.9%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	29.9%	33.6%	3.7%
Percent Received Outpatient Visit Within 30 Days	38.6%	41.8%	3.2%

Table 10: B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FY2019	FY2020	Change
Ages 13-17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	35.2%	35.05%	-0.2%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	19.0%	17.7%	-1.3%
Ages 18-20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	30.1%	31.4%	1.3%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	13.2%	14.9%	1.7%
Ages 21-34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	45.1%	37.4%	-7.7%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	28.3%	23.7%	-4.6%

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FY2019	FY2020	Change
Ages 35-64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	39.1%	30.9%	-8.2%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	24.1%	17.4%	-6.7%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	26.2%	28.1%	1.9%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	15.8%	14.6%	-1.2%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	39.5%	33.1%	-6.4%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	23.7%	18.9%	-4.8%

Table 11: D.1. Mental Health Utilization-Inpatient Discharges and Average Length of Stay

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		FY2019	FY2020	Change	FY2019	FY2020	Change
3-12	Male	0.2	0.2	0.0	12.2	14.7	2.5
	Female	0.2	0.2	0.0	13.0	9.9	-3.1
	Total	0.2	0.2	0.0	12.6	12.2	-0.4
13-17	Male	0.8	0.9	0.1	16.7	13.7	-3.0
	Female	1.7	1.7	0.0	13.5	10.9	-2.6
	Total	1.2	1.3	0.1	14.6	11.9	-2.7
18-20	Male	1.7	1.9	0.2	7.9	9.9	2.0
	Female	1.6	1.6	0.0	9.2	12.1	2.9
	Total	1.6	1.8	0.2	8.6	11.0	2.4

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		FY2019	FY2020	Change	FY2019	FY2020	Change
21-34	Male	5.0	5.5	0.5	9.9	16.3	6.4
	Female	1.4	1.5	0.1	8.6	13.1	4.5
	Total	2.1	2.4	0.3	9.3	14.7	5.4
35-64	Male	3.1	3.3	0.2	10.1	11.4	1.3
	Female	2.0	2.2	0.2	9.0	11.8	2.8
	Total	2.4	2.6	0.2	9.5	11.6	2.1
65+	Male	0.4	0.5	0.1	23.0	67.7	44.7
	Female	0.4	0.4	0.0	28.3	25.0	-3.3
	Total	0.4	0.4	0.0	26.8	41.8	15.0
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**	**1.1**	**1.2**	**0.1**	**11.2**	**14.4**	**3.2**
	Female	**1.0**	**1.1**	**0.1**	**10.9**	**12.2**	**1.3**
	Total	**1.1**	**1.2**	**0.1**	**11.0**	**13.2**	**2.2**

Table 12: 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		
		FY2019	FY2020	Change	FY2019	FY2020	Change	FY2019	FY2020	Change	FY2019	FY2020	Change
3-12	Male	11.65%	10.96%	-0.69%	0.26%	0.23%	-0.03%	0.31%	0.31%	0.00%	11.59%	11.58%	-0.01%
	Female	8.22%	8.11%	-0.11%	0.23%	0.24%	0.01%	0.09%	0.13%	0.04%	8.21%	8.47%	0.26%
	Total	9.97%	9.56%	-0.41%	0.24%	0.23%	-0.01%	0.20%	0.22%	0.02%	9.93%	10.06%	0.13%
13-17	Male	14.34%	13.78%	-0.56%	1.88%	1.09%	-0.79%	0.37%	0.42%	0.05%	14.24%	15.45%	1.21%
	Female	17.04%	16.48%	-0.56%	1.08%	1.90%	0.82%	0.28%	0.44%	0.16%	16.92%	18.82%	1.90%
	Total	15.67%	15.11%	-0.56%	1.49%	1.49%	0.00%	0.32%	0.43%	0.11%	15.56%	17.11%	1.55%
18-20	Male	9.69%	10.15%	0.46%	1.68%	0.76%	-0.92%	0.12%	0.28%	0.16%	9.56%	11.68%	2.12%
	Female	12.11%	12.00%	-0.11%	1.62%	1.57%	-0.05%	0.15%	0.15%	0.00%	11.98%	13.27%	1.29%
	Total	11.00%	11.14%	0.14%	1.65%	1.61%	-0.04%	0.14%	0.21%	0.07%	10.86%	12.53%	1.67%
21-34	Male	25.09%	24.14%	-0.95%	4.06%	4.17%	0.11%	0.37%	0.47%	0.10%	24.82%	28.99%	4.17%
	Female	15.75%	14.16%	-1.59%	1.45%	1.47%	0.02%	0.24%	0.20%	-0.04%	15.58%	15.55%	-0.03%

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY2019	FY2020	Change	FY2019	FY2020	Change	FY2019	FY2020	Change	FY2019	FY2020	Change
	Total	17.74%	16.35%	-1.39%	2.01%	2.06%	0.05%	0.27%	0.26%	-0.01%	17.55%	18.51%	0.96%
35-64	Male	21.22%	18.39%	-2.83%	2.68%	2.62%	-0.06%	0.31%	0.30%	-0.01%	20.95%	20.87%	-0.08%
	Female	23.30%	20.37%	-2.93%	1.90%	1.87%	-0.03%	0.28%	0.23%	-0.05%	23.13%	22.15%	-0.98%
	Total	22.51%	19.61%	-2.90%	2.19%	2.16%	-0.03%	0.29%	0.26%	-0.03%	22.31%	21.66%	-0.65%
65+	Male	6.66%	5.24%	-1.42%	0.47%	0.46%	-0.01%	0.04%	0.02%	-0.02%	6.51%	5.53%	-0.98%
	Female	6.99%	5.01%	-1.98%	0.42%	0.39%	-0.03%	0.02%	0.03%	0.01%	6.93%	5.21%	-1.72%
	Total	6.89%	5.09%	-1.80%	0.44%	0.41%	-0.03%	0.02%	0.03%	0.01%	6.80%	5.31%	-1.49%
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**	**13.95%**	**13.01%**	**-0.94%**	**1.26%**	**1.10%**	**-0.16%**	**0.30%**	**0.32%**	**0.02%**	**13.83%**	**14.40%**	**0.57%**
	Female	**13.69%**	**12.57%**	**-1.12%**	**0.97%**	**1.08%**	**0.11%**	**0.17%**	**0.20%**	**0.03%**	**13.59%**	**13.69%**	**0.10%**
	Total	**13.80%**	**12.76%**	**-1.04%**	**1.09%**	**1.09%**	**0.00%**	**0.23%**	**0.25%**	**0.02%**	**13.70%**	**14.00%**	**0.30%**

Table 13: 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		
		FY2019	FY2020	Change	FY2019	FY2020	Change	FY2019	FY2020	Change	FY2019	FY2020	Change
3-12	Male	0.03%	0.02%	-0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.03%	0.02%	-0.01%
	Female	0.02%	0.01%	-0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.01%	-0.01%
	Total	0.03%	0.02%	-0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.02%	0.00%
13-17	Male	1.78%	1.55%	-0.23%	0.13%	0.16%	0.03%	0.17%	0.09%	-0.08%	1.68%	1.47%	-0.21%
	Female	1.08%	0.94%	-0.14%	0.18%	0.12%	-0.06%	0.04%	0.02%	-0.02%	0.99%	0.90%	-0.09%
	Total	1.43%	1.25%	-0.18%	0.15%	0.14%	-0.01%	0.10%	0.05%	-0.05%	1.34%	1.19%	-0.15%
18-20	Male	2.70%	2.75%	0.05%	0.74%	0.73%	-0.01%	0.21%	0.15%	-0.06%	2.41%	2.51%	0.10%
	Female	2.03%	2.24%	0.21%	0.37%	0.44%	0.07%	0.14%	0.09%	-0.05%	1.87%	2.09%	0.22%
	Total	2.33%	2.48%	0.15%	0.54%	0.58%	0.04%	0.17%	0.12%	-0.05%	2.12%	2.29%	0.17%
21-34	Male	8.89%	8.43%	-0.46%	1.83%	2.17%	0.34%	0.66%	0.49%	-0.17%	8.48%	8.05%	-0.43%
	Female	6.30%	6.27%	-0.03%	0.65%	0.65%	0.00%	0.64%	0.54%	-0.10%	6.07%	6.10%	0.03%
	Total	6.86%	6.74%	-0.12%	0.90%	0.98%	0.08%	0.65%	0.53%	-0.12%	6.58%	6.53%	-0.05%
35-64	Male	8.93%	8.86%	-0.07%	1.55%	1.59%	0.04%	1.02%	0.91%	-0.11%	8.46%	8.50%	0.04%
	Female	6.10%	6.09%	-0.01%	0.79%	0.88%	0.09%	0.56%	0.56%	0.00%	5.84%	5.86%	0.02%
	Total	7.17%	7.15%	-0.02%	1.08%	1.15%	0.07%	0.73%	0.69%	-0.04%	6.83%	6.87%	0.04%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY2019	FY2020	Change	FY2019	FY2020	Change	FY2019	FY2020	Change	FY2019	FY2020	Change
65+	Male	1.49%	1.88%	0.39%	0.15%	0.20%	0.05%	0.21%	0.25%	0.04%	1.36%	1.73%	0.37%
	Female	0.37%	0.51%	0.14%	0.02%	0.05%	0.03%	0.02%	0.02%	0.00%	0.35%	0.47%	0.12%
	Total	0.73%	0.95%	0.22%	0.06%	0.10%	0.04%	0.08%	0.10%	0.02%	0.67%	0.88%	0.21%
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%	2.45%	-0.02%	0.42%	0.46%	0.04%	0.25%	0.21%	-0.04%	2.33%	2.34%	0.01%
	Female	2.50%	2.50%	0.00%	0.31%	0.32%	0.01%	0.23%	0.20%	-0.03%	2.39%	2.40%	0.01%
	Total	2.49%	2.48%	-0.01%	0.36%	0.38%	0.02%	0.24%	0.21%	-0.03%	2.36%	2.37%	0.01%

Table 14: 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		
	FY2019	FY2020	Change	FY2019	FY2020	Change	FY2019	FY2020	Change	FY2019	FY2020	Change
	3-12			13-17			18-20			21-34		
Alamance	0.04%	0.00%	-0.04%	1.19%	1.03%	-0.16%	1.47%	1.44%	-0.03%	4.89%	4.29%	-0.60%
Cabarrus	0.03%	0.02%	-0.01%	1.07%	1.01%	-0.06%	1.86%	2.16%	0.30%	5.66%	5.38%	-0.28%
Caswell	0.06%	0.04%	-0.02%	0.71%	0.60%	-0.11%	1.64%	0.69%	-0.95%	6.08%	5.79%	-0.29%
Chatham	0.00%	0.01%	0.01%	1.29%	1.05%	-0.24%	2.07%	2.34%	0.27%	8.17%	7.57%	-0.60%
Davidson	0.05%	0.00%	-0.05%	1.03%	0.75%	-0.28%	2.91%	2.96%	0.05%	6.43%	5.82%	-0.61%
Davie	0.04%	0.03%	-0.01%	1.85%	1.31%	-0.54%	0.98%	0.98%	0.00%	5.14%	4.40%	-0.74%
Forsyth	0.02%	0.02%	0.00%	1.32%	1.25%	-0.07%	1.80%	1.85%	0.05%	4.20%	4.02%	-0.18%
Franklin	0.00%	0.02%	0.02%	0.48%	1.07%	0.59%	1.30%	2.17%	0.87%	5.49%	5.73%	0.24%
Granville	0.03%	0.00%	-0.03%	0.60%	0.80%	0.20%	2.40%	1.19%	-1.21%	6.96%	6.47%	-0.49%
Halifax	0.04%	0.00%	-0.04%	0.82%	0.63%	-0.19%	1.38%	1.86%	0.48%	5.55%	6.69%	1.14%
Mecklenburg	0.01%	0.00%	-0.01%	1.54%	1.39%	-0.15%	2.11%	2.25%	0.14%	3.67%	3.74%	0.07%
Orange	0.00%	0.04%	0.04%	1.38%	1.25%	-0.13%	2.27%	2.68%	0.41%	8.16%	9.75%	1.59%
Person	0.00%	0.05%	0.05%	1.75%	0.91%	-0.84%	2.58%	2.49%	-0.09%	6.85%	7.67%	0.82%
Rockingham	0.01%	0.04%	0.03%	0.81%	0.89%	0.08%	1.68%	2.02%	0.34%	6.24%	5.62%	-0.62%
Rowan	0.04%	0.02%	-0.02%	2.26%	1.90%	-0.36%	2.62%	2.62%	0.00%	8.72%	8.50%	-0.22%
Stanly	0.02%	0.00%	-0.02%	1.63%	1.84%	0.21%	1.85%	2.80%	0.95%	6.88%	7.56%	0.68%
Stokes	0.00%	0.07%	0.07%	1.16%	0.74%	-0.42%	3.24%	2.41%	-0.83%	5.93%	6.47%	0.54%
Union	0.03%	0.00%	-0.03%	1.32%	1.10%	-0.22%	2.80%	2.46%	-0.34%	4.27%	3.95%	-0.32%
Vance	0.02%	0.02%	0.00%	1.46%	1.48%	0.02%	1.84%	1.44%	-0.40%	6.94%	6.58%	-0.36%
Warren	0.13%	0.04%	-0.09%	1.58%	1.30%	-0.28%	3.25%	2.16%	-1.09%	4.95%	5.78%	0.83%

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		
	FY2019	FY2020	Change	FY2019	FY2020	Change	FY2019	FY2020	Change	FY2019	FY2020	Change
	35-64			65+			Unknown			Total		
Alamance	7.99%	7.25%	-0.74%	1.08%	1.34%	0.26%	0.00%	0.00%	0.00%	2.40%	2.12%	-0.28%
Cabarrus	6.29%	6.47%	0.18%	0.59%	0.87%	0.28%	0.00%	0.00%	0.00%	2.04%	2.00%	-0.04%
Caswell	3.71%	3.68%	-0.03%	0.67%	0.52%	-0.15%	0.00%	0.00%	0.00%	1.89%	1.60%	-0.29%
Chatham	7.71%	7.06%	-0.65%	0.42%	0.44%	0.02%	0.00%	0.00%	0.00%	2.47%	2.17%	-0.30%
Davidson	5.34%	5.11%	-0.23%	0.42%	0.71%	0.29%	0.00%	0.00%	0.00%	2.27%	2.01%	-0.26%
Davie	6.10%	6.45%	0.35%	0.61%	0.40%	-0.21%	0.00%	0.00%	0.00%	2.18%	1.91%	-0.27%
Forsyth	5.89%	6.37%	0.48%	0.90%	1.23%	0.33%	0.00%	0.00%	0.00%	1.95%	2.00%	0.05%
Franklin	5.96%	5.85%	-0.11%	0.70%	0.50%	-0.20%	0.00%	0.00%	0.00%	1.99%	2.02%	0.03%
Granville	7.46%	7.35%	-0.11%	0.74%	0.71%	-0.03%	0.00%	0.00%	0.00%	2.69%	2.39%	-0.30%
Halifax	6.87%	7.20%	0.33%	1.03%	0.95%	-0.08%	0.00%	0.00%	0.00%	2.72%	2.70%	-0.02%
Mecklenburg	5.64%	5.74%	0.10%	0.86%	1.15%	0.29%	0.00%	0.00%	0.00%	1.78%	1.79%	0.01%
Orange	9.36%	9.55%	0.19%	1.72%	2.23%	0.51%	0.00%	0.00%	0.00%	3.32%	3.50%	0.18%
Person	6.96%	7.56%	0.60%	0.60%	1.53%	0.93%	0.00%	0.00%	0.00%	2.82%	2.88%	0.06%
Rockingham	6.02%	5.99%	-0.03%	0.57%	0.67%	0.10%	0.00%	0.00%	0.00%	2.41%	2.21%	-0.20%
Rowan	7.49%	7.41%	-0.08%	0.77%	0.74%	-0.03%	0.00%	0.00%	0.00%	3.19%	2.94%	-0.25%
Stanly	7.12%	7.46%	0.34%	0.80%	0.70%	-0.10%	0.00%	0.00%	0.00%	2.72%	2.73%	0.01%
Stokes	6.11%	5.11%	-1.00%	0.13%	0.52%	0.39%	0.00%	0.00%	0.00%	2.45%	2.08%	-0.37%
Union	4.51%	4.55%	0.04%	0.33%	0.46%	0.13%	0.00%	0.00%	0.00%	1.59%	1.46%	-0.13%
Vance	9.29%	8.91%	-0.38%	0.77%	0.82%	0.05%	0.00%	0.00%	0.00%	3.39%	3.05%	-0.34%
Warren	6.89%	7.36%	0.47%	1.31%	1.69%	0.38%	0.00%	0.00%	0.00%	2.79%	2.73%	-0.06%

Table 15: 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	8.78%	8.81%	0.03%	15.41%	15.41%	0.00%	9.48%	9.83%	0.35%	14.03%	15.10%	1.07%
Cabarrus	8.74%	8.90%	0.16%	15.26%	14.29%	-0.97%	9.18%	10.56%	1.38%	13.57%	13.89%	0.32%
Caswell	9.85%	8.77%	-1.08%	17.26%	16.16%	-1.10%	8.55%	8.68%	0.13%	12.32%	13.80%	1.48%
Chatham	9.62%	10.01%	0.39%	15.76%	15.76%	0.00%	7.91%	9.57%	1.66%	16.13%	15.25%	-0.88%
Davidson	8.03%	8.30%	0.27%	14.71%	15.32%	0.61%	9.50%	10.11%	0.61%	11.56%	11.26%	-0.30%
Davie	10.32%	8.78%	-1.54%	15.81%	15.76%	-0.05%	5.87%	7.13%	1.26%	10.74%	11.37%	0.63%
Forsyth	7.44%	7.49%	0.05%	13.26%	12.98%	-0.28%	8.06%	8.65%	0.59%	13.19%	12.78%	-0.41%
Franklin	7.82%	7.37%	-0.45%	13.32%	14.48%	1.16%	8.72%	8.04%	-0.68%	12.87%	14.25%	1.38%
Granville	7.58%	8.76%	1.18%	13.63%	16.33%	2.70%	9.46%	6.95%	-2.51%	14.62%	15.17%	0.55%
Halifax	9.14%	8.00%	-1.14%	13.05%	12.57%	-0.48%	10.71%	10.83%	0.12%	16.64%	16.84%	0.20%
Mecklenburg	7.33%	7.32%	-0.01%	13.62%	14.01%	0.39%	8.77%	9.30%	0.53%	11.58%	12.65%	1.07%
Orange	12.30%	11.74%	-0.56%	20.11%	22.68%	2.57%	12.09%	13.25%	1.16%	20.83%	20.12%	-0.71%
Person	8.73%	8.36%	-0.37%	17.15%	14.30%	-2.85%	14.09%	12.24%	-1.85%	19.84%	17.67%	-2.17%
Rockingham	8.91%	10.68%	1.77%	16.84%	16.10%	-0.74%	10.98%	11.34%	0.36%	13.91%	13.03%	-0.88%
Rowan	10.80%	11.30%	0.50%	15.71%	16.35%	0.64%	9.92%	10.82%	0.90%	15.02%	16.27%	1.25%
Stanly	10.16%	10.89%	0.73%	15.91%	19.00%	3.09%	12.83%	12.27%	-0.56%	14.07%	13.99%	-0.08%
Stokes	11.98%	13.32%	1.34%	16.62%	15.60%	-1.02%	10.67%	12.45%	1.78%	11.97%	13.85%	1.88%
Union	9.04%	8.57%	-0.47%	15.01%	15.93%	0.92%	10.93%	9.63%	-1.30%	11.84%	11.73%	-0.11%
Vance	8.38%	8.15%	-0.23%	11.05%	11.11%	0.06%	10.86%	10.49%	-0.37%	17.26%	14.97%	-2.29%
Warren	8.76%	8.32%	-0.44%	11.37%	11.69%	0.32%	7.94%	8.99%	1.05%	15.19%	17.91%	2.72%

2020 External Quality Review

	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
	35-64			65+			Unknown			Total		
Alamance	23.73%	23.37%	-0.36%	8.70%	10.24%	1.54%	0.00%	0.00%	0.00%	13.08%	13.32%	0.24%
Cabarrus	19.58%	19.83%	0.25%	11.59%	10.03%	-1.56%	0.00%	0.00%	0.00%	12.33%	12.32%	-0.01%
Caswell	17.54%	17.85%	0.31%	7.65%	6.03%	-1.62%	0.00%	0.00%	0.00%	12.57%	12.13%	-0.44%
Chatham	20.06%	18.86%	-1.20%	6.72%	5.46%	-1.26%	0.00%	0.00%	0.00%	12.64%	12.57%	-0.07%
Davidson	16.58%	16.67%	0.09%	9.25%	8.77%	-0.48%	0.00%	0.00%	0.00%	11.29%	11.48%	0.19%
Davie	15.85%	16.98%	1.13%	9.13%	7.24%	-1.89%	0.00%	0.00%	0.00%	11.82%	11.44%	-0.38%
Forsyth	21.12%	20.66%	-0.46%	10.51%	9.17%	-1.34%	0.00%	0.00%	0.00%	11.69%	11.52%	-0.17%
Franklin	19.43%	19.10%	-0.33%	6.18%	6.82%	0.64%	0.00%	0.00%	0.00%	11.34%	11.47%	0.13%
Granville	20.29%	20.90%	0.61%	5.29%	5.30%	0.01%	0.00%	0.00%	0.00%	11.77%	12.68%	0.91%
Halifax	23.13%	23.19%	0.06%	8.99%	9.74%	0.75%	0.00%	0.00%	0.00%	14.06%	13.81%	-0.25%
Mecklenburg	18.35%	18.82%	0.47%	7.85%	7.71%	-0.14%	0.00%	0.00%	0.00%	10.68%	10.99%	0.31%
Orange	27.42%	28.18%	0.76%	9.34%	10.78%	1.44%	0.00%	0.00%	0.00%	17.23%	17.64%	0.41%
Person	25.66%	24.62%	-1.04%	8.57%	10.49%	1.92%	0.00%	0.00%	0.00%	15.10%	14.18%	-0.92%
Rockingham	20.17%	18.47%	-1.70%	7.94%	8.09%	0.15%	0.00%	0.00%	0.00%	13.13%	13.20%	0.07%
Rowan	20.35%	21.06%	0.71%	12.95%	11.87%	-1.08%	0.00%	0.00%	0.00%	13.98%	14.57%	0.59%
Stanly	24.29%	23.85%	-0.44%	15.98%	14.53%	-1.45%	0.00%	0.00%	0.00%	14.82%	15.28%	0.46%
Stokes	18.50%	17.02%	-1.48%	7.89%	6.11%	-1.78%	0.00%	0.00%	0.00%	13.54%	13.71%	0.17%
Union	16.32%	16.42%	0.10%	9.45%	6.49%	-2.96%	0.00%	0.00%	0.00%	11.59%	11.29%	-0.30%
Vance	23.49%	22.49%	-1.00%	7.82%	7.26%	-0.56%	0.00%	0.00%	0.00%	13.37%	12.68%	-0.69%
Warren	20.39%	20.58%	0.19%	6.84%	8.45%	1.61%	0.00%	0.00%	0.00%	12.20%	12.67%	0.47%

(b) Waiver Validation Results

All measures received a validation score of 100% and were found Fully Compliant. The stored procedures have been updated to address NC Medicaid's most recent changes to the measures. Table 16 contains validation scores for each of the 10 (b) Waiver Performance Measures.

Table 16: (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

Five (c) Waiver Measures were chosen for validation. The rates reported by Cardinal and the State benchmarks are displayed in *Table 17: (c) Waiver Measures Reported Results 2019 - 2020*.

Table 17: (c) Waiver Measures Reported Results 2019-2020

Performance measure	Data Collection	Latest Reported Rate	State Benchmark
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Annually	9,215/9,215 = 100%	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Annually	9,215/9,215 = 100%	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	119/132 = 90.15%	85%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	124/124 = 100%	85%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	Quarterly	22/22 = 100%	85%

Note. Rates reported using Waiver Performance Measures Q4 2020 Excel file

Documentation on data sources, data validation, source code, and calculated rate for the five measures was provided. Additionally, all rates met or exceeded the State Performance Benchmarks.

(c) Waiver Validation

All (c) Waiver Measures met the validation requirements and were Fully Compliant as shown in *Table 18, (c) Waiver Performance Measure Validation Scores*. The validation worksheets offer detailed information on validation and calculation steps for (c) Waiver Measures.

Table 18: C Waiver Performance Measures Validation Scores 2020-2012 Focused Review

Measure	Validation Score Received
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	100%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	100%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	100%
Percentage of beneficiaries who received appropriate medication. IW G5	100%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	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 1: Validating Performance Improvement Projects. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology. 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

Cardinal submitted ten projects for this 2020 EQR. Five were validated: Diabetes Screening for Individuals with Schizophrenia and Bipolar Disorder Who Are Using Anti-psychotic Medications, Metabolic Monitoring for Children and Adolescents on Anti-psychotics, Metabolic Monitoring for Adults on Anti-psychotics, TCLI Supported Employment, and Improving Timely Routine Access to Care. *Table 19: PIP Summary of Validation Scores* provides an overview of the previous year's validation scores with the previous scores.

Table 19: PIP Summary of Validation Scores

Project Type	Project	2019 Validation Score	2020 Validation Score
Clinical	Diabetes Screening for Individuals with Schizophrenia and Bipolar Disorder Who Are Using Anti-psychotic Medications	79/79 = 100% High Confidence in Reported Results	79/79 = 100% High Confidence in Reported Results
	Metabolic Monitoring for Children and Adolescents on Anti-psychotics	90/90 = 100% High Confidence in Reported Results	79/79 = 100% High Confidence in Reported Results
	Metabolic Monitoring for Adults on Anti-psychotics	90/90 = 100% High Confidence in Reported Results	79/79 = 100% High Confidence in Reported Results
Non-clinical	TCLI Supported Employment	Not submitted or validated.	68/73 = 93% High Confidence in Reported Results
	Improving Timely Routine Access to Care	84/85 = 99% High Confidence in Reported Results	78/79 = 99% High Confidence in Reported Results

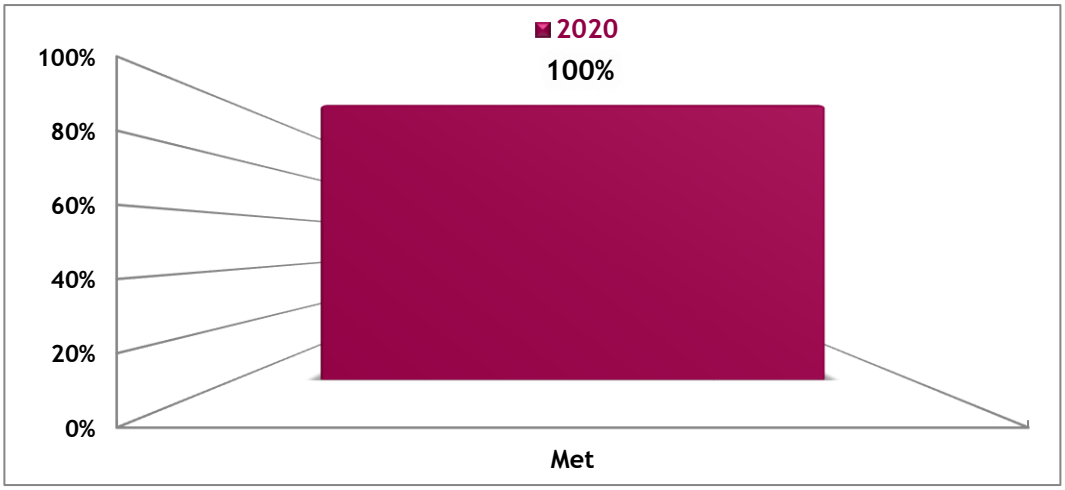
All validated PIPs received a validation score within the High Confidence range and met the validation requirements. Four of the five PIPs validated for the 2020 EQR were also validated in the 2019 EQR. In the 2019 EQR, one PIP, Improving Timely Routine Access to Care, had a Recommendation regarding interventions to improve the outcome rates. The outcome rates have not improved for the 2020 EQR. They declined from 67% to 50% with a goal of 75% in the Medicaid population. The same Recommendation is given again in 2020 for this PIP. There is also a Recommendation for the TCLI Supported Employment PIP to remove the numerator and denominator labels and call them "number per quarter" and "number per year". This displays the results in the correct format, a numeric value instead of a percentage. These Recommendations are displayed in *Table 20: Performance Improvement Project Recommendations*.

Table 20: Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Improving Timely Routine Access to Care	Was there any documented, quantitative improvement in processes or outcomes of care?	The routine access measure for Medicaid declined from 67% to 50% with a goal of 75%; the non-Medicaid rate improved from 58% to 71% with a goal of 75%.	Continue to monitor the mobile engagement for members, use of Cal Calendars with providers, provider cancellation processes, confirming member information, outreach to new providers. Continue to evaluate for Medicaid-specific member reasons for lack of attendance.
TCLI Supported Employment	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	Results are presented using tables. The values are difficult to interpret since they are labeled as numerator and denominator although the indicator is not a rate.	Remove the numerator and denominator labels and call them "number per quarter" and "number per year" and then create to goal columns with quarterly goal and yearly goal and add the goal values to those columns. Since you are not using rates, the numerator and denominator labels can be omitted.

Details of the validation activities for the PMs and PIPs and specific outcomes related to each activity may be found in *Attachment 3, CCME EQR Validation Worksheets*. As demonstrated in Figure 4, Cardinal met all of the Quality Improvement standards in the 2020 EQR.

Figure 4: Quality Improvement Findings



Strengths

- (b) Waiver Measures included all necessary documentation and measures were reported according to specifications.
- (c) Waiver Measures met or exceeded State benchmark rates.
- All PIPs were in the High Confidence range.

Weaknesses

- The Improving Timely Routine Access to Care PIP did not show improvement last EQR or this 2020 EQR for the Medicaid population, and declined from 67% to 50% with a goal of 75%.
- For the TCLI Supported Employment PIP, the results are presented using tables. The values are difficult to interpret since they are labeled as numerator and denominator yielding a percentage rate. This result is not a rate but a numerical value.

Recommendations

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

D. Utilization Management

The EQR of Utilization Management (UM) included a review of the Care Coordination and Transition to Community Living (TCLI) programs. CCME reviewed relevant policies, procedures, the *Member & Family Handbook*, the *Provider Manual*, the Organizational Chart, and 11 files of enrollees participating in Mental Health/Substance Use Disorder (MH/SUD), Intellectual/Developmental Disability (I/DD), and TCLI Care Coordination.

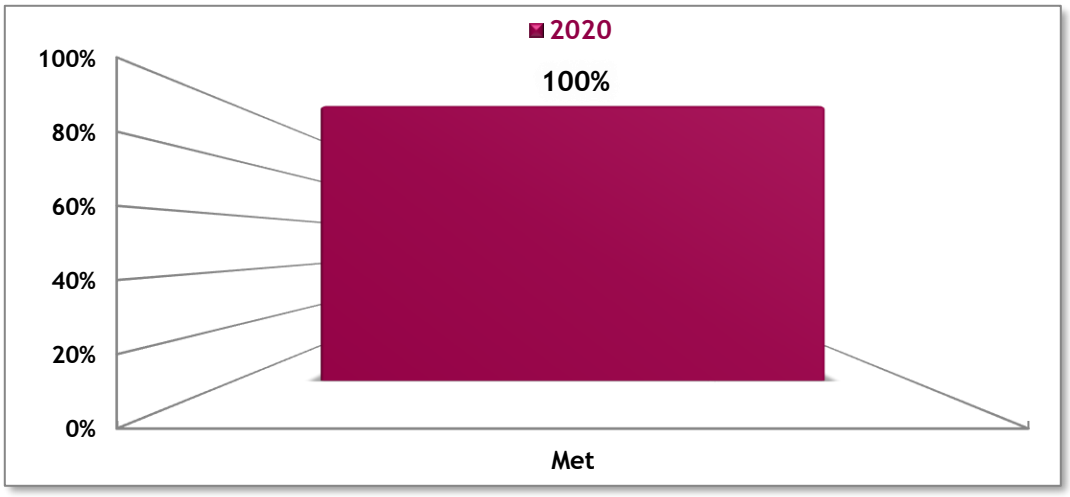
During the 2019 EQR, Cardinal met 98% of UM standards. CCME issued one Corrective Action and one Recommendation for concerns noted within the Care Coordination and TCLI programs. The review found that documentation within the member files did not align with compliance requirements set forth in Cardinal's policies and procedures and the *NC Medicaid Contract*. CCME emphasized that, through a data-driven monitoring plan, Cardinal would increase file compliance within the MH/SUD, I/DD, and TCLI Care Coordination files. Cardinal addressed the Corrective Action and the Recommendation.

For this 2020 EQR, CCME has issued no Corrective Action and one Recommendation. Cardinal's Policy & Procedure 9720, NC Innovations Terminations, states, "Base and Non-Base services cannot exceed the waiver cost limit of $135,000." This does not align with *NC Joint Communication Bulletin #J362*, that allows enrollees to exceed the waiver cost limit when three criteria are met. CCME recommends Cardinal update Policy & Procedure 9720 to include the exemptions to the waiver cost limits listed in *NC Joint Communication Bulletin #J362*.

The review of the Care Coordination and TCLI files found consistent patterns of compliance with Cardinal's policies and procedures and the *NC Medicaid Contract*. Targeted activities such as discharge, follow up activities, and submission of progress notes were timely and met standard requirements. Care Coordination contacts with enrollees and Home and Community Based Services (HCBS) activities were complete and documented appropriately according to the *NC Medicaid Contract* and *NC Clinical Coverage Policy 8P*.

Figure 5 shows 100% of the UM standards were scored as "Met".

Figure 5: Utilization Management Findings



Strengths

- Cardinal implemented a thorough Care Coordination/TCLI monitoring plan that reinforces the duties of frontline staff and increases accountability for effective monitoring conducted by Supervisors and Managers.
- Cardinal increased Care Coordination member contacts to weekly during the NC COVID-19 Stay-at-Home Order to provide additional outreach and support to enrollees.
- TCLI continued to maintain a high percentage of housing placements throughout the COVID-19 Pandemic.

Weaknesses

- Cardinal's Policy & Procedure 9720, NC Innovations Termination does not reflect the exemptions listed in *NC Joint Communication Bulletin #J362*.

Recommendation

- Update Policy & Procedure 9720, NC Innovations Termination, to include the exemptions to waiver cost limits as listed in *NC Joint Communication Bulletin #J362*.

E. Grievances and Appeals

The Grievances and Appeals External Quality Review (EQR) for Cardinal included a Desk Review of policies and procedures, ten Grievance and eleven Appeal files, the Grievances and Appeals Logs, Cardinal's *Provider Manual* and *Member & Family Handbook*, and information about Grievances and Appeals available on the Cardinal website. An Onsite discussion with Grievance and Appeal staff occurred to further clarify Cardinal's documentation and processes.

In the 2019 EQR, Cardinal met 90% of the Grievance and Appeal standards. Three Corrective Actions and five Recommendations were issued to address concerns within Cardinal's Appeal policy and procedure, the *Provider Manual*, *Member & Family Handbook*, and the Appeal and Grievance files reviewed.

In the 2020 EQR, Cardinal met 95% of the Grievance and Appeals standards. One Corrective Action was issued to improve upon the compliance issues noted in the Appeal files and CCME made five Recommendations to improve upon the Grievance and Appeals documentation and processes.

Grievances

In the 2019 EQR of Grievances, CCME issued two Recommendations. CCME recommended Cardinal add information to the *Provider Manual* and *Member & Family Handbook* explaining a grievant can request an extension to the Grievance resolution timeframe. Cardinal implemented this Recommendation and added extension information to the *Provider Manual* and the current revision of The *Member & Family Handbook*. The second Recommendation was to include the documentation regarding subject matter experts (SMEs) within the Grievance Investigation notes. Cardinal implemented these two Recommendations over the past review year.

Policy & Procedure 5050, Grievances and Formal Levels of Review is the primary policy and procedure that governs Cardinal's Grievance processes. It does not provide information about the Grievance steps related to network provider or out-of-network providers. The network provider and out-of-network provider Grievances are addressed in Policy & Procedure 5200, Provider Investigations. In Policy & Procedure 5050, Grievances and Formal Levels of Review, Cardinal needs to add a reference of Policy & Procedure 5200, Provider Investigations, to provide clarification of the network provider and out-of-network provider Grievance process Cardinal uses when it is warranted.

Within the 10 files reviewed for this EQR, two Grievances were resolved outside of the 30 days. An extension was provided for the two Grievances, and the steps were well documented, following Policy & Procedure 5050. The review for 10 Grievances files shows that 100% of the files were completed within the Policy & Procedure 5050 timeframe.

In the 2019 EQR, CCME recommended Cardinal enhance the Grievance monitoring process to ensure any consultations with subject matter experts (SMEs), such as medical, legal, HR staff, etc. and to ensure the documentation of the outcomes of these consultations. The files reviewed in the 2020 EQR showed these consultations are occurring, when appropriate and documented within the files. The Grievance Investigation notes captured documentation by the consultant or the SME with exception of one file. This file lacked details of the investigative steps taken within Cardinal's Grievance Form. During the Onsite interview, this file was reviewed, Cardinal acknowledged the lack of information within the files Grievance Form.

During the Onsite, a discussion regarding the Grievance monitoring process included staff explaining the recently-implemented process for monitoring Grievance files to ensure compliance. An overview of the QA Summary Plan-Grievances process implemented in September 2020 was provided. The process includes quarterly monitoring review of Grievances starting with the July -September 2020 quarter. The process ensures verification of documentation and data elements within the Grievance file are accurate and complete. CCME recommends continued monitoring of Grievance files with use of the QA Summary Plan-Grievances process to ensure documentation within the Grievance form is complete.

Additional discussion during the Onsite interview included Cardinal providing an overview of the Grievance data and trends analysis using the recently developed and implemented QA Summary Plan-Grievances process. The analysis revealed an increased number of Grievances and further data analysis informed Cardinal the increased number of Grievances were related to unused Service Authorizations for the Intellectual and Developmental Disabilities (I/DD) members. As a result of this finding, a Quality Improvement (QI) Project to address the increased Grievances was developed.

The 2020 EQR of Cardinal's Grievance functions resulted in two Recommendations and all the Grievance standards were scored as "Met".

Appeals

In the 2019 EQR, CCME issued three Corrective Actions and three Recommendations aimed at improving Cardinal's Appeal functions. The Corrective Actions targeted concerns noted in the review of the Appeal files and Appeal Log. The first Corrective Action addressed inconsistent practices around invalid Appeals. There were 27 Appeals that were processed by Cardinal despite being as many as 120 days beyond the timeframe for filing an Appeal. However, one Appeal was deemed invalid despite being 16 days beyond the Appeal timeframe. CCME required Cardinal develop guidelines for processing invalid Appeals to ensure a more consistent and fair practice. Cardinal addressed this Corrective Action and added clarifying language to their Appeal procedure. The second Corrective Action targeted a lack of compliance by Cardinal staff when providing Appeal acknowledgements and verbal and written notifications related to expedited Appeals. CCME required Cardinal to provide training to staff to ensure, moving forward, staff consistently provided required expedited Appeal notifications. The third Corrective Action issued in the 2019 EQR further addressed issues noted in the Appeal file review. CCME required Cardinal to enhance their current monitoring process to include routine compliance review of the Appeal log and required expedited Appeal notifications.

Two Recommendations issued in the 2019 EQR addressed missing or incorrect information in Cardinal's *Member & Family Handbook* and Appeals policy and procedure. The third and final Recommendation from the 2019 EQR was to train Appeals staff on the required steps and notifications around extended Appeals. There was evidence in the 2020 EQR

that all Corrective Actions and Recommendations from the 2019 EQR of Appeals were addressed by Cardinal.

In the 2020 EQR, CCME has issued one Corrective Action and three Recommendations. The concerns identified that resulted in this Corrective Action and Recommendations focused primarily on compliance issues within the Appeal files and incorrect or inconsistent information within the Appeal policy and procedure, the *Provider Manual*, *Member & Family Handbook*, and Cardinal's Appeal Brochure.

An explanation of who can file an Appeal and participate in the process is described inconsistently throughout the Policy & Procedure 6020. *NC Medicaid Contract, Attachment M and 42 CFR § 438.402 (b*) allow "the enrollee, legally responsible person, or a provider or other designated personal representative, acting on behalf of the enrollee and with the enrollee's signed consent, may file a PIHP internal Appeal." As an example of the inconsistencies within the Appeal procedure, page 10 of Procedure 6020 states, "A member, legally responsible person, or authorized representative (in making the request on the member's behalf or supporting the member's request), acting on behalf of the member and with the member's signed consent…" This description is consistent with the *NC Medicaid Contract* and federal regulations. However, on page 9 its stated, "The member's first step in the Appeal process is requesting a Reconsideration Review". Further, on page 10 it is stated, "A member or legally responsible person may submit any additional information." Additionally, on page 13 it is stated, "A member or provider, with signed consent from the member that they are acting on the member's behalf, may request an expedited Reconsideration Review." These inconsistencies confuse the procedures and the participants outlined in the Appeal policy and procedure.

As a result of the Appeal file review, it was evident staff need additional guidance to process all types of invalid Appeals consistently and in compliance with Policy & Procedure 6020. CCME recommends that Cardinal revise Policy & Procedure 6020, Section b.1, to ensure staff identify and resolve all types of invalid Appeals consistently, and not just Appeals filed outside of the required 60-day timeframe. Examples of other types of Appeals include; Appeals deemed invalid due to a subsequent approved authorization covering all dates and units appealed or Appeals submitted by providers without consent from the enrollee or legal guardian (*NC Medicaid Contract, Attachment M, Section G.1*).

Cardinal's *Provider Manual*, *Appeals Brochure*, *Member & Family Handbook*, and Procedure 6020 contain the requirement that appellants must use Cardinal's Reconsideration Review Request for to initiate an Appeal. This is a more restrictive practice than the process outlined in *NC Medicaid, Attachment M* and *42 CFR § 438.406*. It is recommended Cardinal revise the *Provider Manual*, *Cardinal Appeals Brochure*, the *Member & Family Handbook,* and Policy and Procedure 6020 to clearly and consistently state that any written Appeal request will initiate the Appeal process, so long as there is enough information to know who and what is being appealed.

In the 2020 EQR of Cardinal's Appeal files, five of the eleven Appeals files reviewed showed required notifications and documentation were out of compliance.

- Two of the three standard Appeal files reviewed showed no written Appeal acknowledgement and/or written resolution was sent.
- Three of the five expedited Appeal files reviewed showed required written and oral notifications were not issued.
- One of the five expedited Appeal files reviewed showed the Appeal was filed by the Day treatment provider, without written consent by the enrollee.

CCME has issued a Corrective Action to Cardinal in this year's EQR for Cardinal document and implement an enhanced Appeals monitoring process that includes:

- Targeting expedited, invalid, extended, and withdrawn Appeals;
- Ensuring all Appeals, including invalid and withdrawn Appeals, are acknowledged and written resolution sent within the required resolution timeframes, per *NC Medicaid Contract, Attachment M, Sections A.1.b* and *G.4, 42 CFR § 438.406 (b)(1)*, and *42 CFR § 438.408 (b)*;
- Ensuring all written and oral notifications are provided within the required timeframes for expedited and extended Appeals, per *NC Medicaid Contract, Attachment M, Sections G.5* and *G.6, Section H, 42 CFR § 438.410* and *42 CFR § 438.408 (c)(2)*;
- Ensuring consent from the enrollee or legal guardian is obtained and documented in the Appeal file if an Appeal is filed by a provider or any other representative, per *NC Medicaid Contract, Attachment M, Section G.1.*

In this 2020 EQR, Cardinal met 95% of the Grievance and Appeal standards. One Appeal Standard was scored as "Partially Met". Figure 6 demonstrates the outcome of the 2020 EQR of Grievance and Appeals standards.

Figure 6: Grievances and Appeals Findings

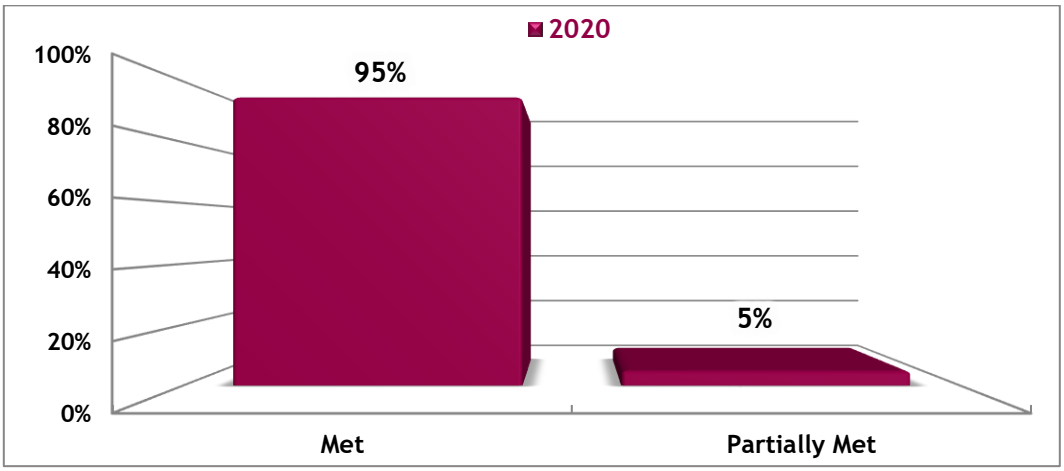


Table 21: Grievances and Appeals

Section	Standard	2020 Review
Appeals	The PIHP applies the Appeal policies and procedures as formulated.	Partially Met

Strengths

- There was no interruption in Cardinal Grievance investigations during the COVID-19 pandemic.
- Cardinal implemented a quarterly monitoring of Grievances in September 2020 to ensure compliance and improve the quality of the Grievance process.
- In the past year, Cardinal Appeal staff implemented a bi-weekly staff huddle to review Appeal files and the Appeal Log and discuss potential compliance issues or concerns.

Weaknesses

- Policy & Procedure 5050, Grievances and Formal Levels of Review does not address Grievances related to network providers and out-of-network providers. The network provider and out-of-network provider Grievances are addressed in Policy & Procedure 5200, Provider Investigations. Within Policy & Procedure 5050, include a reference of the Grievance steps related to network provider and out-of-network Grievance process provided in Policy & Procedure 5200 to provide clarification about the process and steps when warranted.
- One of the 10 Grievance files reviewed showed the Grievance investigation steps lacked the details of the investigative steps taken within Cardinals Grievance Form.
- An explanation of who can file an Appeal and participate in the Appeal process is described inconsistently throughout the Policy & Procedure 6020.
- Based on the Appeal file review, it is evident staff need additional guidance to process all types of invalid Appeals consistently and in compliance with Policy & Procedure 6020.
- Requiring Cardinal's Reconsideration Review Request Form to initiate an Appeal, as documented in the *Provider Manual*, Appeals brochure, *Member & Family Handbook*, and in Procedure 6020 is a more restrictive practice than what is outlined in *NC Medicaid, Attachment M* and *42 CFR § 438.406*.

- Five of the eleven Appeals files reviewed in this year's EQR showed required notifications and documentation were out of compliance.
    - Two of the three standard Appeal files reviewed showed no written Appeal acknowledgement and/or written resolution was sent.
    - Three of the five expedited Appeals files reviewed showed required written and oral notifications were not issued.
    - One of the five expedited Appeals files reviewed showed the Appeal was filed by the Day treatment provider, without written consent by the enrollee.

Corrective Action

- Document and implement an enhanced Appeals monitoring process that includes:
    - Targeting expedited, invalid, extended, and withdrawn Appeals;
    - Ensuring all Appeals, including invalid and withdrawn Appeals, are acknowledged and written resolution sent within the required resolution timeframes, per *NC Medicaid Contract, Attachment M, Sections A.1.b* and *G.4*, *42 CFR § 438.406 (b)(1)*, and *42 CFR § 438.408 (b);*
    - Ensuring all written and oral notifications are provided within the required timeframes for expedited and extended Appeals, per *NC Medicaid Contract*, *Attachment M*, *Sections G.5* and *G.6*, *Section H, 42 CFR § 438.410* and *42 CFR § 438.408 (c)(2)*;
    - Ensuring consent from the enrollee or legal guardian is obtained and documented in the Appeal file if an Appeal is filed by a provider or any other representative, per *NC Medicaid Contract, Attachment M, Section G.1.*

Recommendations

- In Policy & Procedure 5050, Grievances and Formal Levels of Review, add a reference of Policy and Procedure 5200, Provider Investigations, to provide clarification about the network provider and out-of-network provider Grievance investigation process Cardinal uses with network providers and out-of-network providers when it is warranted.
- Continue to use current monitoring process to ensure Grievance investigative steps taken by Cardinal to resolve the Grievance are documented within Cardinals Grievance Form.

- Define who can file an Appeal and participate throughout the Appeal process in the definitions section of Policy & Procedure 6020. Use the full definition provided in *NC Medicaid Contract, Attachment M, Section G.1*. Subsequently use the term "appellant" throughout the body of the policy and procedure to identify clearly and consistently who can file and Appeal and participate in the Appeal process.

- Revise Policy & Procedure 6020, Section b.1, to ensure staff identify and resolve all types of invalid Appeals consistently, and not just Appeals filed outside of the required 60-day timeframe. For example, Appeals deemed invalid due to a subsequent approved authorization covering all dates and units appealed or Appeals submitted by providers without consent from the enrollee or legal guardian (*NC Medicaid Contract, Attachment M, Section G.1*).

- Revise the *Provider Manual*, Cardinal Appeals brochure, Policy & Procedure 6020, and *Member & Family Handbook* to clearly and consistently state that any written Appeal request will initiate the Appeal process, so long as there is enough information to know who and what is being appealed.

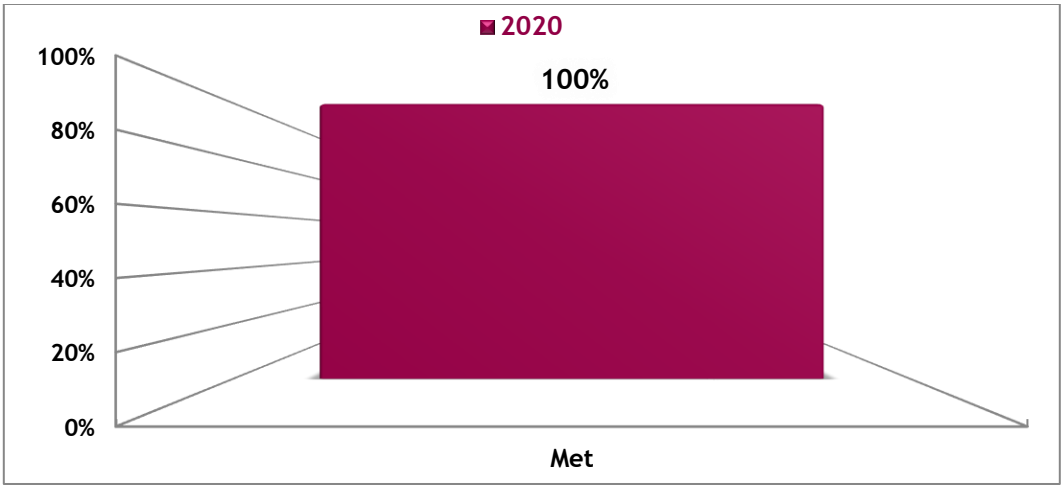
F. Program Integrity

The Program Integrity (PI) EQR involves an assessment of Cardinal's compliance with federal and state regulations regarding PI functions. A Desk Review of Cardinal's documentation was conducted, and included review of Cardinal's policies, procedures, training materials, Organizational Charts, job descriptions, committee meeting minutes and reports, provider agreements, enrollment application, PI workflows, *Provider Manual*, conflict of interest forms, and Cardinal's *Compliance Plan*. Additionally, 15 PI files were selected from the period of October 1, 2019 through September 30, 2020. The Onsite interviews were conducted to discuss the findings within the Desk Materials and PI files.

In the 2019 EQR, Cardinal met 100% of the PI EQR standards and one Recommendation was issued. Based on the 2019 PI policy and procedure review, it was recommended Cardinal update the workflow documentation to indicate a clear differentiation in the workflow based on an evaluation of fraud, as opposed to those cases in which no valid determination of fraud was encountered. This Recommendation was addressed by Cardinal. In the 2020 EQR, Cardinal provided an updated PI workflow with a clear differentiation between cases of fraud and cases of abuse. Additionally, the review of Program Integrity investigative files found that Cardinal's files contained all of the elements required within the EQR standards.

Figure 7 shows that Cardinal met 100% of the Program Integrity EQR standards.

Figure 7: Program Integrity Findings



Strengths

- Cardinal has made a successful transition to the FAMs system and is implementing data mining initiatives as part of their regular processes.
- Cardinal has transitioned their Data Analyst to a more strategic role in customizing their PI initiatives.

G. 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 2019 through December 2019. 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 should be populated 99% of the time. In the encounter data provided by Cardinal, 96.8% of claims contained a valid value in the Procedure code field and among those flagged for issues 220 of those claims contained a Revenue code instead of a Procedure code.

Recommendation:

This issue was also highlighted during the 2017 and 2018 encounter data validation reviews. The error rate did drop in 2019, but still there were 220 claims that contained a Revenue code in the Procedure code field. However, these errors did not appear to have affected provider reimbursements as the Institutional claims in question were paid a set rate such as per diem. In latter part of 2019, Cardinal adopted system edits to validate Procedure codes and we expect this issue to be not present moving forward.

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, 170 records were invalid. This is a smaller number than what was seen in 2018. There was a mix of SSN values with the hyphen included and values less than 10 bytes in length.

Recommendation:

Cardinal's eligibility data is driven by the 834 and Global Eligibility File (GEF) provided by NC Medicaid. Cardinal should ensure each encounter being submitted matches to the state provided eligibility prior to submission. In some instances, the issue could be caused due to timing issues as enrollees move from the state program to Medicaid. In such cases, Cardinal should ensure that the claim is paid under the correct program and make sure the proper identification number is submitted to NC Medicaid.

Cardinal already validates that the member is eligible prior to claim payment, so the correct Recipient or Medicaid ID should be captured and available for submission. If the claim being submitted by the provider does not contain a valid Recipient Id, the claim should be denied. If the claim is being submitted through the provider portal, the provider should be limited to only select or enter a valid Id on record with the LME.

Issue: Additional Diagnosis Codes

Other Diagnosis codes were populated less than 14% of the time for professional claims. The absence of Other Diagnosis codes does not appear to be a mapping issue within Cardinal, but likely driven by some providers' not coding beyond the Primary Diagnosis code. This value is not required by Cardinal when adjudicating the claim, therefore, certain providers may not be submitting Other Diagnosis codes even in cases where they are present when submitting claims via Provider Web Portal or 837P.

Recommendation:

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

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 of the three issues identified were only apparent in the Institutional claims and their impacts were minimal considering the volume of claims and the method for adjudication (Revenue code vs, Procedure code). Cardinal took a corrective action in 2019 to ensure they are capturing and reporting valid Procedure codes for Institutional claims. Cardinal is also closely monitoring Recipient Id to ensure that they are submitting the expected 10-byte alphanumeric Recipient ID.

The third issue involving Other Diagnosis code was mostly present in professional claims and appears to be driven by provider behavior – with some providers not reporting any additional Diagnosis codes while others do report at a high frequency. Similar to other two issues, this third issue did not appear to have impacted provider reimbursements. However, given that Other Diagnosis code is a required data element, Cardinal should identify providers who never code and submit Other Diagnosis codes and contact those providers to remind them of their obligation to submit claims that are complete and accurate.

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

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 2, 2020

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

Dear Mr. Sutten,

At the request of the North Carolina Medicaid (NC Medicaid) this letter serves as notification that the 2020 External Quality Review (EQR) of Cardinal Innovations Healthcare Solutions (Cardinal) is being initiated. The review will be conducted by us, The Carolinas Center for Medical Excellence (CCME), and is a contractual requirement. The review will include both a Desk Review (at CCME) and a one-day, virtual Onsite that will address 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

Due to COVID-19 and the issuance of the contractual flexibilities issued by the State outlined in Contract Amendment #9, the 2020 EQR will be a focused review. The focus of this review will be on the Corrective Actions from the previous EQR and Cardinal functions that impact enrollee health and safety. Similarly, for the 2020 EQR, the two day Onsite previously performed at PIHP offices will conducted during a one day, virtual Onsite. The CCME EQR review team plans to conduct the virtual Onsite on **April 29, 2021**. For your convenience, a tentative agenda for this one-day, virtual review is enclosed.

In preparation for the Desk Review, the items on the enclosed **Desk Materials List** are to be submitted electronically. **Please note that, to facilitate a timely review, there are three lists on the Desk Materials List (items 9, 10, and 19.a) that should be submitted by no later than November 6, 2020.** The remaining items are due by no later than **November 23, 2020**. Also, as indicated in item 20 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 with the other Desk Materials on **November 23, 2020**.

Further, as indicated on item 21 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.

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. Additional information and technical assistance will be provided as needed, or upon request.

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: Emily Bridgers, Cardinal Innovations Healthcare Solutions Contract Manager
Deb Goda, NC Medicaid Behavioral Health Unit Manager
Hope Newsome, NC Medicaid Quality Management Specialist

Focused External Quality Review 2020

MATERIALS REQUESTED FOR DESK REVIEW

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

1. Copies of all current policies and procedures, as well as a complete index which includes policy and procedure name, number, and department owner. The date of the addition/review/revision should be identifiable on each policy/procedure. *(Please do not embed files within word documents.)*
2. Organizational Chart of all staff members including names of individuals in each position including their degrees, licensure, and any certifications required for their position. Include any current vacancies. In addition, please include any positions currently filled by outside consultants/vendors.
3. Description of major changes in operations such as expansions, new technology systems implemented, etc. Include any major changes to PIHP functions related to COVID-19.
4. A summary of the status of all Corrective Action items from the previous External Quality Review. Please include evidence of Corrective Action implementation.
5. List of providers credentialed/recredentialed in the last 12 months (October 2019 through September 2020). Include the date of approval of initial credentialing and the date of approval of recredentialing.
6. A description of the Quality Improvement, Utilization Management, and Care Coordination Programs. Include a Credentialing Program Description and/or Plan, if applicable.
7. Minutes of committee meetings for the following committees:
    a. Credentialing (for the three, most recent committee meetings)
    b. UM (for the three, most recent committee meetings)
    c. Any clinical committee meeting minutes showing discussion of Clinical Practice Guidelines impacted by COVID-19.
8. Membership lists and a committee matrix for all committees, including the professional specialty of any non-staff members. Please indicate which members are voting members. Include the required quorum for each committee.
9. By November 6, 2020, submit a copy of the complete Appeal log for the months of October 2019 through September 2020. Please indicate on the log: the appeal type (standard, expedited, extended, withdrawn, or invalid), the service appealed, the date the appeal was received, and the date of appeal resolution.
10. By November 6, 2020, submit a copy of the complete Grievances log for the months of October 2019 through September 2020. Please indicate on the log: the nature of the Grievance, the date received, and the date of Grievance resolution.

11. Copies of all appeal notification templates used for expedited, invalid, extended, and withdrawn appeals.
12. For appeals and Grievances, please submit a description of your monitoring process that reviews compliance of oral and written notifications, completeness of documentation within the appeal and Grievance records, accuracy of appeal and Grievance logs, etc. Provide details regarding frequency of monitoring and any benchmarks, performance metrics, and reporting of monitoring outcomes.
13. Please submit a summary of new provider orientation processes and include a list of materials and training provided to new providers.
14. For MH/SU, I/DD, and TCLI Care Coordination, please submit a description of your monitoring plan that reviews compliance of Care Coordinator documentation. Include in the description the elements reviewed (timeliness of progress notes, timeliness of Innovations monitoring, timeliness of Quality of Life surveys, review of quality, completeness of discharge notes, accuracy of documentation, etc.). Provide details regarding frequency of monitoring, and any benchmarks, performance metrics, and reporting of monitoring outcomes.
15. For Care Coordination enrollees files, please provide:
    a. three MH/SU Care Coordination enrollee files (two active since 2018 and one recently discharged)
    b. three I/DD Care Coordination enrollee files (two active since 2018 and one recently discharged)
    c. four TCLI Care Coordination enrollee files (one active since 2018, one who received In-Reach, one who transitioned to the community and one recently discharged).

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

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

C WAIVER MEASURES
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.
Proportion of beneficiaries reporting they have a choice between providers.
Percentage of level 2 and 3 incidents reported within required timeframes.
Percentage of beneficiaries who received appropriate medication.
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.

Required information includes the following for each measure:

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

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

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

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

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

        A. Insurance:
            1. Proof of all required insurance, or a signed and dated statement/waiver/attestation from the practitioner/agency indicating why specific insurance coverage is not required
            2. For practitioners joining already-contracted agencies, include copies of the proof of insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.

        B. Other:
            1. All PSVs conducted during the current process, including current supervision contracts for all LPAs and all provisionally-licensed practitioners (*i.e.*, LCAS-A, LCSW-A).
            2. Ownership disclosure information/form (For practitioners joining an already-contracted agency, this may be in the agency file, but should be included in the submitted practitioner file).
    b. Recredentialing files for the five most recently recredentialed practitioners/agency (as listed below)
        i. One licensed practitioner who is joining an already contracted agency
        ii. One non-MD, Licensed Independent Practitioner (i.e., clinician who will have their own contract)
        iii. One physician
        iv. One practitioner with an associate licensure (e.g., LCSW-A, LMFT-A, etc.)
        v. One file for a network provider agency

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

A. Insurance:

1. Proof of all required insurance, or a signed and dated statement/waiver/attestation from the practitioner/agency indicating why specific insurance coverage is not required.
2. For practitioners joining already-contracted agencies, include copies of the proof of insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.

B. Other:

1. Proof of original credentialing date and all recredentialing dates, including the current recredentialing (this is usually a letter to the provider, indicating the effective date).
2. All PSVs conducted during the current process, including current supervision contracts for all LPAs and all provisionally-licensed practitioners (*i.e.*, LCAS-A, LCSW-A).
3. Site visit/assessment reports if the provider has had a quality issue or a change of address.
4. Ownership disclosure information/form (For practitioners joining an already-contracted agency, this may be in the agency file, but should be included in the submitted practitioner file).

19. a. By November 6, 2020, submit a copy of the complete listing of Program Integrity case files active during October 2019 through September 2020. On this list, provide the following for each case file:
    i. Date case opened
    ii. Source of referral
    iii. Category of case (enrollee, provider, subcontractor)
    iv. Current status of the case (opened, closed)

    b. Program Integrity Plan and/or Compliance Plan.
    c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.
    d. Workflow of process of taking complaint from inception through closure.
    e. All 'Attachment Y' reports collected during the review period.
    f. All 'Attachment Z' reports collected during the review period.
    g. Provider Manual and Provider Application.
    h. Enrollee Handbook
    i. Subcontractor Agreement/Contract Template.
    j. Training and educational materials for the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse and the False Claims Act.
    k. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse.
    l. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors, and employees.

m. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to NC Medicaid or any other State or Federal agency.
n. Code of Ethics and Business Conduct.
o. Internal and/or external monitoring and auditing materials.
p. Materials pertaining to how the PIHP captures and tracks complaints.
q. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
    i. NC Medicaid approved reporting templates.
r. Sample Data Mining Reports.
s. NC Medicaid Monthly Meeting Minutes for entire review period, including agendas and attendance lists.
t. Monthly reports of NCID holders/FAMS-users in PIHP.
u. Any program or initiatives the plan is undertaking related to Program Integrity including documentation of implementation and outcomes, if appropriate.
v. Corrective action plans including any relevant follow-up documentation.
w. Policies/Procedures for:

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

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

a. A completed ISCA.
b. See the last page of the ISCA for additional requested materials related to the ISCA.

Section	Question Number	Attachment
Enrollment Systems	1b	Enrollment system loading process
Enrollment Systems	1f	Enrollment loading error process reports
Enrollment Systems	1g	Enrollment loading completeness reports
Enrollment Systems	2c	Enrollment reporting system load process
Enrollment Systems	2e	Enrollment reporting system completeness reports
Claims Systems	2	Claim process flowchart
Claims Systems	2p	Claim exception report.

Claims Systems	3e	Claim reporting system completeness process / reports.
Claims Systems	3h	Physician and institutional lag triangles.
Reporting	1a	Overview of information systems
NC Medicaid Submissions	1d	Workflow for NC Medicaid submissions
NC Medicaid Submissions	2b	Workflow for NC Medicaid denials
NC Medicaid Submissions	2e	NC Medicaid outstanding claims report

c. A copy of the IT Disaster Recovery Plan.

d. A copy of the most recent disaster recovery or business continuity plan test results.

e. An organizational chart for the IT/IS staff and a corporate organizational chart that shows the location of the IT organization within the corporation.

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

a. Include all adjudicated claims (paid and denied) from January 1, 2019 – December 31, 2019. Follow the format used to submit encounter data to NC Medicaid (i.e., 837I and 837P). If you archive your outbound files to NC Medicaid, you can forward those to HMS for the specified time period. In addition, please convert each 837I and 837P to a pipe delimited text file or excel sheet using an EDI translator. If your EDI translator does not support this functionality, please reach out immediately to HMS.

b. Provide a report of all paid claims by service type from January 1, 2019 – December 31, 2019. Report should be broken out by month and include service type, month and year of payment, count, and sum of paid amount.

NOTE: EDV information should be submitted via the secure FTP to HMS. This site was previously set up during the first round of Semi-Annual audits with HMS. If you have any questions, please contact Kyung Lee of HMS at (978) 902-0031.

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2020

Please note: If any of the documentation requested on this list or the supplemental list does not currently exist, please submit into the indicated folders a statement to that effect.

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Two expedited Appeals processed between October 2020 and March 2021. If available, one of these Appeals should be requested and accepted for expedited resolution and one should be an Appeal that was requested to be expedited, but that request was denied by Cardinal.

2. Two Appeals deemed invalid between October 2020 and March 2021.

3. The complete Appeal log showing appeals processed between October 2020 and March 2021.

4. For the MH/SU and TCLI discharged files, please provide the letter(s) sent to members of the treatment team regarding the enrollees' discharge from Care Coordination, if available.

C. Attachment 3: EQR Validation Worksheets

- Mental Health (b Waiver) Performance Measures Validation Worksheets
  - 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 Worksheets
  - Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available
  - Proportion of beneficiaries reporting they have a choice between providers
  - Percentage of Level 2 and 3 incidents reported within required timeframes
  - Percentage of beneficiaries who received appropriate medication
  - Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required

- Performance Improvement Project Validation Worksheets
  - Diabetes Screening for Individuals with Schizophrenia and Bipolar Disorder Who Are Using Anti-psychotic Medications
  - Metabolic Monitoring for Children and Adolescents on Anti-psychotics
  - Metabolic Monitoring for Adults on Anti-psychotics
  - TCLI Supported Employment
  - Improving Timely Routine Access to Care

CCME EQR PM Validation Worksheet

PIHP Name:	**Cardinal**
Name of PM:	**Readmission Rates for Mental Health**
Reporting Year:	**2019/2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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	**50**
Measure Weight Score	**50**
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:	**2019/2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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	**50**
Measure Weight Score	**50**
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:	**2019/2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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	**50**
Measure Weight Score	**50**
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:	**2019/2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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	**50**
Measure Weight Score	**50**
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:	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**
Reporting Year:	**2019/2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

VALIDATION SUMMARY

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

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	50
Measure Weight Score	50
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 Discharged and Average Length of Stay**
Reporting Year:	**2019/2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

VALIDATION SUMMARY

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

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	50
Measure Weight Score	50
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:	**2019/2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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	**50**
Measure Weight Score	**50**
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:	**2019/2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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	**50**
Measure Weight Score	**50**
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:	**2019/2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

VALIDATION SUMMARY

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

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	50
Measure Weight Score	50
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:	**2019/2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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	**50**
Measure Weight Score	**50**
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 beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC
Reporting Year:	**2019/2020**
Review Performed:	**2021**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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	**50**
Measure Weight Score	**50**
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:	Proportion of beneficiaries reporting they have a choice between providers. IW D10
Reporting Year:	**2019/2020**
Review Performed:	**2021**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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	**50**
Measure Weight Score	**50**
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:	Percentage of level 2 and 3 incidents reported within required timeframes. IW G2
Reporting Year:	**2019/2020**
Review Performed:	**2021**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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	**50**
Measure Weight Score	**50**
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:	Percentage of beneficiaries who received appropriate medication. IW G5
Reporting Year:	**2019/2020**
Review Performed:	**2021**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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	**50**
Measure Weight Score	**50**
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:	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8
Reporting Year:	**2019/2020**
Review Performed:	**2021**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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	**50**
Measure Weight Score	**50**
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 PIP Validation Worksheet

PIHP Name:	**Cardinal**
Name of PIP:	**DIABETES SCREENING**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP 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**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 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.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined.
5.2 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**	Indicators are related to processes of care and functional status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collection methods are documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are documented.

Component / Standard (Total Points)	Score	Comments
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**	Data is collected using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan noted as annually.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Annual rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 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**	Baseline and subsequent rates are presented.
7.4 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 of data included rate evaluation over several years.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Rate was 81.1% at baseline; Remeasurement 3 was 72.7% and remeasurement 4 was 77.2%, so there is improvement although the 82% goal has not yet been met.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to the planned interventions.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	1
9.2	5	5
9.3	NA	NA
9.4	NA	NA

Project Score	**79**
Project Possible Score	**79**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Cardinal**
Name of PIP:	**METABOLIC MONITORING FOR CHILDREN AND ADOLESCENTS ON ANTIPSYCHOTICS**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP 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**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 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.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are defined.
5.2 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**	Indicators are related to health status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collection methods are documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are documented.

Component / Standard (Total Points)	Score	Comments
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**	Data is collected using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan noted as quarterly and interim.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Annual and quarterly/interim rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 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**	Baseline and several remeasurement periods are presented.
7.4 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 of data included rate evaluation over several periods/ years.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Indicator 1 improved from 34 % to 39.5% with a goal of 37%. Indicator 2 improved from 24% to 28% with a goal of 37%. Indicator 3 improved from 22% to 25% with a goal of 37%. All three indicators showed improvement.
9.2 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 in monitoring appears to be related to interventions for access to services, drill down analyses, and outreach.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Sampling not utilized.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	1
9.2	5	5
9.3	NA	NA
9.4	NA	NA

Project Score	**79**
Project Possible Score	**79**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Cardinal**
Name of PIP:	**METABOLIC MONITORING FOR ADULTS ON ANTI-PSYCHOTICS**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP 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**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 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.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are defined.
5.2 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**	Indicators are related to processes of care and functional status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collection methods are documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are documented.

Component / Standard (Total Points)	Score	Comments
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**	Data is collected using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan noted as quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Annual rates and interim rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 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**	Baseline and subsequent rates are presented.
7.4 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 of data included rate evaluation over several years.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Indicator 1 improved from 67% to 73% with a goal of 79%. Indicator 2 improved from 33 % to 44% with a goal of 51%. Indicator 3 improved from 37% to 43% with a goal of 50%. Thus, all measures improved from Remeasurement 4 to Remeasurement 5.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to the planned interventions based on barrier analysis.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	1
9.2	5	5
9.3	NA	NA
9.4	NA	NA

Project Score	**79**
Project Possible Score	**79**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Cardinal**
Name of PIP:	**TCLI SUPPORTED EMPLOYMENT**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP 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**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 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.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are defined.
5.2 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**	Indicators are related to functional status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collection methods are documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are documented (claims and IPSE Report)
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**	Data is collected using programming logic.

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan noted as quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**PARTIALLY MET**	Results are presented using tables. The values are difficult to interpret since they are labeled as numerator and denominator although the indicator is not a rate. ***Recommendation: Remove the numerator and denominator labels and call them "number per quarter" and "number per year" and then create goal columns with quarterly goal and yearly goal and add the goal values to those columns. Since the results are not rates, the numerator and denominator labels can be omitted.***
7.3 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)**	**NA**	Only 1 timepoint is presented.
7.4 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 of data included rate evaluation over several years.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	No remeasurements.
9.2 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**	Unable to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Unable to assess/rates not utilized as the indicator.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	5
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	**68**
Project Possible Score	**73**
Validation Findings	**93%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Cardinal**
Name of PIP:	**ROUTINE ACCESS TO CARE**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP 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**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 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.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are defined.
5.2 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**	Indicators are related to functional status and processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collection methods are documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are documented (appointment access data)
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**	Data is collected using programming logic.

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan noted as quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 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**	Baseline and several repeat measurements are presented.
7.4 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 of data included rate evaluation over several quarters/years.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**PARTIALLY MET**	The routine access measure for Medicaid declined from 67% to 50% with a goal of 75%; the non-Medicaid rate improved from 58% to 71% with a goal of 75%. ***Recommendation: Continue to monitor the mobile engagement for members, use of calendars with providers, provider cancellation processes, confirming member information, and outreach to new providers. Continue to evaluate for Medicaid-specific member reasons for lack of attendance***.
9.2 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 for non-Medicaid members appears to be related to provider and system interventions.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analysis not presented or necessary as sampling was not utilized.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	0
9.2	5	5
9.3	NA	NA
9.4	NA	NA

Project Score	78
Project Possible Score	79
Validation Findings	99%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

D. Attachment 4: Tabular Spreadsheet

I. Information Systems Capabilities Assessment (ISCA)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I A. Management Information Systems						
1. Enrollment Systems						
1.1 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Cardinal has standard processes in place for enrollment data updates and uploads the daily and quarterly Global Eligibility files (GEF) to the CIE enrollment system. Cardinal uses the monthly 820 capitation file to reconcile the Medicaid eligibility with payment received every month. A new Medicaid Identification Number (Medicaid ID) and a former Medicaid ID is stored in CIE enrollment system and Cardinal can see 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 also available.
1.2 The MCO is able to identify and review any errors identified during, or as a result, of the State enrollment file load process.	X					Cardinal generates a GEF exception report and the Member Data Management Team reviews the data on a weekly basis in order to correct exceptions based on established business rules.
1.3 The MCO's enrollment system member screens store and track enrollment and demographic information.	X					The enrollment system stores all historical data for members is stores and merges all data under one member ID.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Claims System						
2.1 The MCO processes provider claims in an accurate and timely fashion.	X					Cardinal noted that approximately 100% of the Institutional and Professional claims are auto adjudicated. All Cardinal claims are processed through CIE claims adjudication system. If a required field is missing from a claim, Provider Web Portal will not allow the claim to be submitted to Cardinal. If the claim is being submitted electronically via an electronic 837 file and one or more required fields are missing, the provider will receive a HIPAA 999 response file advising the provider of the claim submission failure. Cardinal claims processors do not change any information on the claims.
2.2 The MCO has processes and procedures in place to monitor review and audit claims staff.	X					Quality Audits are conducted on a weekly basis for 10% of work completed by Claims Specialists. 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. Cardinal met their quality targets for the 2020 EQR.
2.3 The MCO has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 Diagnosis codes received on an 837 Institutional and 837 Professional file, capabilities of receiving and storing ICD-10 Procedure codes on an 837 Institutional file.	X					Cardinal indicated in their ISCA response that 25 Institutional ICD-10 Diagnosis codes and 12 ICD-10 Diagnosis codes are captured for Professional on the Provider Web Portal. Cardinal indicated that 29 Institutional ICD-10 Diagnosis codes and 27 ICD-10 Diagnosis codes are captured for Professional through the EDI files. ICD-10 Procedure codes and Diagnosis Related Group (DRG) codes received from the provider are captured. Currently, Cardinal does not receive ICD-10 Procedure codes on Institutional claims from providers. ***Recommendation: Continue to work with Cardinal providers to ensure they are submitting ICD-10 Procedure codes on Institutional claims.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 The MCO's claim system screens store and track claim information and claim adjudication/payment information.	X					A review of the claims system screens identified the capture of all adjudication/payment information for the claims.
3. Reporting						
3.1 The MCO's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					Cardinal captures all necessary data elements required for enrollment and claims reporting. ICD-10 Procedure and DRG codes are also captured when submitted on a claim by the provider.
3.2 The MCO has processes in place to back up the enrollment and claims data repositories.	X					Cardinal has processes in place that back up the CIE enrollment, claims and reporting systems on a nightly basis. Separate backups are stored at offsite locations as part of their disaster recovery plan.
4. Encounter Data Submission						
4.1 The MCO has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission.	X					Cardinal's encounter data submission process allows all ICD-10 Diagnosis codes for Institutional and Professional encounters to be submitted to NCTracks. Cardinal's encounter data submission process allows for the ICD-10 Procedure codes received on an Institutional claim to be submitted to NCTracks, although many providers do not bill with these codes. DRG codes are captured in the CIE system but are not typically used for payments

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2 The MCO has the capability to identify, reconcile and track the encounter data submitted to NC Medicaid.	X					Cardinal has tracking and reconciliation processes in place reports to identify encounter status. Outgoing 837 files are logged into the SQL database for tracking purposes. The system generates a unique ID to each claim/encounter submitted to NCTracks. Each record receives a time stamp.
4.3 MCO has policies and procedures in place to reconcile and resubmit encounter data denied by NC Medicaid.	X					Cardinal provided several policies and procedures as well as workflows regarding the reconciliation and resubmittal process. Cardinal has an encounter data acceptance rate of over 99%.
4.4 The MCO 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 five 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 Updated/Approved 12/10/2019* (*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					The *Credentialing Committee Membership List* submitted in Desk Materials indicates Dr. Saidat Kashimawo-Akande was the Interim Chair of the Credentialing Committee from April 2019 to June 2020, and Dr. Pamela Wright-Etter became Chair of the committee in July 2020. The *Credentialing Manual* describes the composition, roles, and responsibilities of the Credentialing Committee, indicates the Chief Medical Officer (CMO)/designee chairs the committee, and states the committee meets "at least monthly unless otherwise directed by the Chair." The *Credentialing Manual* defines "clean" files as "credentialing files that meet Cardinal Innovations' criteria for participation", and indicates approval of "clean" credentialing files is delegated to the CMO/designee. The lists of CMO/designee-approved "clean" applications are shared with the Credentialing Committee for review. Files that have "one or more criteria for participation not met" are presented to the Credentialing Committee for "review and recommendation." As was the case at the last EQR, the *2019-2020 Annual Quality Strategy & Performance Improvement Plan*, section 7, regarding the Credentialing Committee states a "quorum consists of at least 50% of the voting members."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						This definition was not revised in response to the *Recommendation* from the last two EQRs, and differs from the definition in the *Credentialing Manual*, and in Policy & Procedure 1210, Cross Functional Committee Development, both of which indicate a quorum is "50% + 1 of the voting members." Credentialing Committee meeting minutes contain information about each applicant for which background incidents were identified during the credentialing process. Meeting minutes document discussions by the committee, and the votes taken for those files, and for "Clean Approvals" (applications approved by the CMO/designee). ***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					Credentialing files reviewed for the EQR were organized and contained appropriate information.
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.8 Query of the National Practitioner Data Bank (NPDB) ;	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of 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					

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					
3.1.16 Criminal background Check	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.	X					Recredentialing files reviewed for the EQR were organized and contained appropriate information. CCME identified the following in the file review:
4.1 Recredentialing every three years;	X					The organizational (agency) recredentialing file submitted for this EQR included the letter reflecting initial credentialing approval in 2011. The most recent recredentialing of the agency would have been in 2017, and the submitted file does not include verification of that recredentialing. When asked for documentation of the 2017 recredentialing, Cardinal submitted a statement that indicated they did not complete the recredentialing of this agency in 2017, though they conducted the required monthly exclusion screens, and "providers were subject to routine, focused and post payment reviews by the Quality Management department pursuant to P & Ps 5100 and 5300." Based on the presumed immediate prior recredentialing date of 2017, the submitted agency file reflects recredentialing within three years. Practitioner files submitted for the current review also reflect recredentialing within three years. 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 for recredentialing every three years/thirty-six (36) months.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2 Verification of information on the applicant, including:						
4.2.1 Insurance Requirements	X					
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
4.2.3 Valid DEA certificate; and/or CDS certificate	X					
4.2.4 Board certification if claimed by the applicant;	X					
4.2.5 Malpractice claims since the previous credentialing event;	X					
4.2.6 Practitioner attestation statement;	X					
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*.
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 Requery of the Social Security Administration's Death Master File	X					
4.2.12 Requery of the NPPES;	X					
4.2.13 Names of hospitals at which the physician has admitting privileges, if any.	X					
4.2.14 Ownership Disclosure is addressed.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.3 Site reassessment if the provider has had quality issues.	X					
4.4 Review of provider profiling activities.	X					During Onsite discussion at the last EQR, Cardinal's staff reported the Compliance Department had 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." The *Cardinal Innovations Re-Credentialing Verification Form* in the practitioner recredentialing files submitted for the current EQR includes the date the "Network Compliance Check" was verified via the Network SharePoint database. Credentialing Committee meeting minutes reflect discussion of quality of care issues for providers.
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."
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					

III. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III. Quality Improvement						
III. A Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					There were no substantial increases or declines in any of the (b) Waiver Measures from FY2019 to FY2020. All (c) Waiver Measures were above the State benchmark rates. The overall validation score for all Performance Measures were in the Fully Compliant range, with an average validation score of 100% across the ten measures (b) Waiver Measures and the five (c) Waiver Measures.
III. B Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					Cardinal submitted ten projects for this 2020 EQR. Five were validated: Diabetes Screening for Individuals with Schizophrenia and Bipolar Disorder Who Are Using Anti-psychotic Medications, Metabolic Monitoring for Children and Adolescents on Anti-psychotics, Metabolic Monitoring for Adults on Anti-psychotics, TCLI Supported Employment, and Improving Timely Routine Access to Care.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					All five validated PIPs scored in the High Confidence range. Although, two PIPs had one error each and CCME provided Recommendations that included: The Improving Timely Routine Access to Care PIP did not show improvement last EQR or this 2020 EQR for the Medicaid population and declined from 67% to 50% with a goal of 75%. ***Recommendation: Continue to monitor the mobile engagement for members, use of calendars with providers, provider cancellation processes, confirming member information, and outreach to new providers. Continue to evaluate for Medicaid-specific member reasons for lack of attendance.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						For the TCLI Supported Employment PIP, the results are presented using tables. The values are difficult to interpret since they are labeled as numerator and denominator yielding a percentage rate. This result is not a rate, but a numerical value. ***Recommendation: Remove the numerator and denominator labels and call them "number per quarter" and "number per year". Create goal columns with quarterly goal and yearly goal and add the goal values to those columns. Since the results are not rates, the numerator and denominator labels can be omitted.***

IV. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV. A Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					Cardinal Innovations has a comprehensive *Care Coordination Program Description* in place that provides an overview of its MH/SUD/I/DD/TCLI programs.
2. The case coordination program includes:						
2.1 Staff available 24 hours per day, seven days per week to perform telephone assessments and crisis interventions;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	X					
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's *Care Coordination Monitoring Plan* supports Policy & Procedure 7202, Monitoring of Plan Implementation.
2.6 Determination of which Behavioral Health Services are medically necessary;	X					Cardinal's Policy & Procedure 9720, NC Innovations Termination, addresses the cost limits for enrollees participating in the Innovations Waiver. The procedure states, "Base Budget and Non-Base Budget services combined may not total more than the waiver cost limit of $135,000." On April 29, 2020, NC Medicaid issued *Joint Communication Bulletin #J362*, allowing the waiver limits to exceed $135,000 cost limits when: • The individual lives independently • The individual receives Supported Living Level III, and • The individual requires 24-hour support. ***Recommendation: Update Policy & Procedure 9720, NC Innovations Termination, to include the exemption to the waiver cost limits as listed in NC Joint Communication Bulletin #J362.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					
2.8 Coordinate care with each Enrollee's provider;	X					
2.9 Provide follow-up activities for Enrollees;	X					
2.10 Ensure privacy for each Enrollee is protected.	X					
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					During last year's EQR, CCME issued a Corrective Action to Cardinal to develop and implement a data-driven monitoring plan to be used for routine review of Care Coordination documentation. The goal for the monitoring plan was for Cardinal to identify the frequency of monitoring, departmental benchmarks for compliance, and how and when outcomes of monitoring are captured, reviewed, and reported. Additionally, the monitoring plan would address 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 the Care Coordinator documentation. The Corrective Action was implemented. The review of Care Coordination files for the 2020 EQR showed compliance with Cardinal policies and procedures and *NC Medicaid Contract*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV. B 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					Cardinal has the *Care Coordination Monitoring Plan* in place that supports Policy & Procedure 7025, TCL Quality Assurance.
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					
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					
2.5 QOL Surveys are administered timely.	X					All Quality of Life surveys and In-Reach Transition Tools were completed timely.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 timeframes 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					
6. A review of files demonstrates the PIHP is following appropriate TCL policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.	X					During last year's EQR, CCME issued a Recommendation to Cardinal Innovations to develop and implement a data-driven monitoring plan that includes routinely reviews of TCLI documentation, (case transfer, progress notes, follow up activities, etc.). The plan would ensure ongoing monitoring for timeliness, completeness of activities, and quality. The Recommendation was accepted. The review of TCLI files for the 2020 EQR showed compliance with Cardinal Innovations policies and procedures and *NC Medicaid Contract*.

VI. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee Grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy & Procedure 5050, Grievances and Formal Levels of Review is the primary policy and procedure that governs Cardinal's Grievance processes. There were two (2) Recommendations in last year's EQR. Cardinal implemented the three (3) Recommendations from the 2019 EQR
1.1 Definition of a Grievance and who may file a Grievance;	X					
1.2 The procedure for filing and handling a Grievance;	X					Policy & Procedure 5050, Grievances and Formal Levels of Review is the primary policy and procedure that governs Cardinal's Grievance processes. However, it does not address Grievance steps related to network providers and out-of-network providers. The network provider and out-of-network provider Grievances are addressed in Policy & Procedure 5200, Provider Investigations. The Procedure section outlines the Grievance process used to investigate network providers and out-of-network providers. Add a reference of Policy & Procedure 5200, Provider Investigations, to Policy & Procedure 5050, Grievances and Formal Levels of Review, to provide clarification of the network provider and out-of-network provider Grievance investigation process Cardinal uses when it is warranted. ***Recommendations: Add to Policy & Procedure 5050, Grievances and Formal Levels of Review, a reference of Policy & Procedure 5200, Provider Investigations, to provide clarification of the network provider and out-of-network Grievance investigation process when it is warranted.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 Timeliness guidelines for resolution of the Grievance as specified in the contract;	X					In the 2019 EQR, CCME recommended Cardinal add to the *Provider Manual* and the *Member & Family Handbook* information that a grievant can request to extend the Grievance time frame. In the 2020 EQR, it was evident Cardinal revised the *Provider Manual* and the *Member & Family Handbook* to include this information.
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					Grievance staff have access to a variety of subject matter experts (SMEs) at Cardinal for Grievance consultation. Also, there is always a clinician on call to assist staff in handling Grievances. Staff capture SME consultations and the outcomes of those consultations in Cardinal's Grievance Investigation Form.
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					In the 2020 EQR of Grievance files, it was noted that 100% of Grievances, two Grievances included the extension process including all steps documented and process completed, were resolved within the 30-day timeframe required by Cardinal's Policy & Procedure 5050, Grievances and Formal Level of Review. The Grievance Resolution letters identified the steps taken to resolve the Grievance.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						In the 2019 EQR, CCME recommended Cardinal to enhance the Grievance monitoring process to ensure any consultations with Cardinal SMEs such as medical, legal, and HR staff, are documented in the Grievance file. In the 2020 EQR of the Grievance files, it was noted that SME consultation are documented by staff in the Grievance Investigation notes. In one of the files reviewed, Grievance investigation details were not documented in the Grievance Form. During the Onsite, staff reviewed this file and agreed there was a lack of information within the Grievance Form. During the 2020 Onsite, a discussion regarding the process used to monitor Grievances files, Cardinal provided information about the implementation of a Grievance monitoring plan in September 2020. This plan includes a quarterly review of Grievances to ensure documentation within the Grievance files are complete and accurate. CCME recommends Cardinal to continue to monitor the details of the Grievance investigative steps taken by Cardinal to resolve the Grievance and ensure the details are included in Cardinals Grievance Form. ***Recommendation: Continue to monitor the details of the investigative steps taken by Cardinal to resolve the Grievance and ensure the details are included in Cardinals Grievance Form.***
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					During the Onsite interview, Cardinal explained how analysis of the Grievance data revealed a trend of increased Grievances related to unused service authorizations for the Intellectual Disability Disorder (I/DD) members. As a result of this finding, a Quality Improvement (QI) Project to address the increased Grievances was developed.
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider Appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	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.
1.1 The definitions an Appeal and who may file an Appeal;	X					An explanation of who can file an Appeal and participate in the Appeal process is described inconsistently throughout the Policy & Procedure 6020. *NC Medicaid Contract, Attachment M and 42 CFR § 438.402 (b*) allow "the enrollee, legally responsible person, or a provider or other designated personal representative, acting on behalf of the Enrollee and with the enrollee's signed consent, may file a PIHP internal Appeal." As an example of the inconsistencies within the Appeal procedure, page 10 of Procedure 6020 states, "A member, legally responsible person, or authorized representative (in making the request on the member's behalf or supporting the member's request), acting on behalf of the member and with the member's signed consent…" This description is consistent with the *NC Medicaid Contract* and federal regulations. However, on page 9 its stated, "The member's first step in the Appeal process is requesting a Reconsideration Review". Further, on page 10 it is stated, "A member or legally responsible person may submit any additional information." Additionally, on page 13 it is stated, "A member or provider, with signed consent from the member that they are acting on the member's behalf, may request an expedited Reconsideration Review." These inconsistencies confuse the procedures and the participants outlined in the Appeal policy and procedure.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Define who can file an Appeal and participate throughout the Appeal process in the definitions section of Policy & Procedure 6020. Use the full definition provided in NC Medicaid Contract, Attachment M, Section G.1. Subsequently use the term "Appellant" throughout the body of the policy and procedure to identify clearly and consistently who can file and Appeal and participate in the Appeal process.
1.2 The procedure for filing an Appeal;	X					In the 2019 EQR, it was noted that 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 stated enrollees have 30 days to request an expedited Appeal. This 2019 Recommendation was not implemented by Cardinal until December 2020, seven months after Cardinal received this Recommendation. It was incorrect in the *Member & Family Handbook 13th Edition* which was the version uploaded to the Desk Materials. This was later corrected in a subsequent version of the *Member & Family Handbook*. Also, in the 2019 EQR of Appeals a Corrective Action was issued to address inconsistent practices around invalid Appeals. In the 2019 EQR, there were 27 Appeals that were processed by Cardinal despite being as many as 120 days beyond the required timeframe for filing an Appeal. One Appeal file that was reviewed in the 2019 EQR was deemed invalid after being 16 days beyond the Appeal timeframe. CCME required Cardinal to develop guidelines for processing invalid Appeals to ensure a more consistent and fair practice. It was evident in the 2020 EQR that Cardinal addressed this Corrective Action and added language to the Appeal procedure that the Office of General Counsel should be consulted to determine whether an Appeal should be processed when it is submitted beyond the required 60-day timeframe. There was also clarifying language added to the Appeal procedure regarding invalid Appeals, including the requirement that a "Non-Acceptance Letter" is sent "within 2 business days if the decision was not to accept the Reconsideration review." However,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						based on the Appeal file review, it is evident staff need additional guidance to process all types of invalid Appeals to remain consistent with the timeframe for providing the "Non-Acceptance Letter" outlined in Policy & Procedure 6020. ***Recommendation: Revise Policy & Procedure 6020, Section b.1, to ensure staff identify and resolve all types of invalid Appeals consistently, and not just Appeals filed outside of the required 60 day timeframe. For example, Appeals deemed invalid due to a subsequent approved authorization covering all dates and units appealed or Appeals submitted by providers without consent from the enrollee or legal guardian (NC Medicaid Contract, Attachment M, Section G.1).***
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's Appeal policy and procedure outlines the notifications required by Cardinal when Cardinal denies an enrollee's request to expedite an Appeal.
1.5 Timeliness guidelines for resolution of the Appeal as specified in the contract;	X					
1.6 Written notice of the Appeal resolution as required by the contract;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.7 Other requirements as specified in the contract.	X					In the 2020 EQR, it was noted that the Cardinal's *Provider Manual* (pg. 62) states, "To request a Reconsideration Review, the member/guardian must complete and return the Reconsideration request for…". Also on page 63, the manual states, the member "must complete and return the Cardinal Innovations Reconsideration Review Request Form…". Similarly, the Appeals brochure also states the enrollee "must complete and return the Reconsideration Review Request Form to Cardinal Innovations." Cardinal's *Member & Family Handbook* explains that enrollees "may" submit the Reconsideration Review Request form to initiate the Appeal process but should also be revised to clearly state that any written request for Appeal can initiate the Appeal process. Page 10 of Procedure 6020 states, "A member, legally responsible person, … must complete and return the Reconsideration Review request form by fax, mail, electronic mail, or in person. If an authorized representative is utilized, there must be written documentation from the member indicating that the representative is authorized to file the Appeal, which should be submitted when the request for reconsideration is made." Requiring Cardinal's Reconsideration Review Request Form to initiate an Appeal, as documented in the *Provider Manual*, Appeals brochure, *Member & Family Handbook*, and in Procedure 6020 is a more restrictive practice than the process outlined in *NC Medicaid, Attachment M* and *42 CFR § 438.406*. ***Recommendation: Revise the Provider Manual, Cardinal Appeals brochure, Policy & Procedure 6020, and Member & Family Handbook to clearly and consistently state that any written Appeal request will initiate the Appeal process, so long as there is enough information to know who and what is being appealed.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP applies the Appeal policies and procedures as formulated.		X				In the 2019 EQR, Cardinal was issued two Corrective Actions centered around late or missing acknowledgements and expedited Appeal notifications found in the Appeal files reviewed. It was evident additional training was needed for Appeal staff and that a more intensive monitoring process was needed to ensure the accuracy and timeliness throughout the Appeal process. In the 2020 EQR, Cardinal provided evidence these Corrective Actions were addressed. An enhanced monitoring process was implemented by Cardinal in June of 2020 and Appeals staff were trained by September of 2020. This training included explanation of the required notifications for standard, expedited and extended Appeals. The Appeals process was moved into the Quality Management Department in September of 2020 and additional Appeal staff were also added in January of 2021. In the 2020 EQR of Appeals, compliance improvements with the standard Appeal processes and notifications was noted as a result of Cardinal's adjustments. However, compliance issues were again noted. Review of the Appeal Log (October 2019 through September 2020) showed 17 of the 819 Appeals (or 2%) were resolved outside of the required 30-day timeframe. Additionally, five of the eleven files reviewed in this year's EQR showed required notifications and documentation were out of compliance. • Two of the three standard Appeal files reviewed showed no written Appeal acknowledgement and/or written resolution was sent. • Three of the five expedited Appeals files reviewed showed required written and oral notifications were not issued. • One of the five expedited Appeals files reviewed showed the Appeal was filed by the Day treatment provider, without written consent by the enrollee.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						While compliance issues gradually improved throughout the year, issues were still noted in Appeal files processed as late as March of 2021. Review of Cardinal's Appeal monitoring process, monitoring tools and discussion with staff revealed concerns that the monitoring process is not adequately identifying issues related to compliance with the *NC Medicaid Contract*, *Attachment M* and *42 CFR § 438.408*. For example, Cardinal is choosing a random sample of Appeals and not targeting those Appeals posing the biggest compliance challenges, such as expedited, invalid, and withdrawn Appeals. CCME is again issuing a Corrective Action to ensure Cardinal improves compliance with requirements outlined in Cardinal's *NC Medicaid Contract* and federal regulations. ***Corrective Action: Document and implement an enhanced Appeals monitoring process that includes:*** • ***Targeting expedited, invalid, extended, and withdrawn Appeals;*** • ***Ensuring all Appeals, including invalid and withdrawn Appeals, are acknowledged and written resolution sent within the required resolution timeframes, per NC Medicaid Contract, Attachment M, Sections A.1.b and G.4, 42 CFR § 438.406 (b)(1), and 42 CFR § 438.408 (b);*** • ***Ensuring all written and oral notifications are provided within the required timeframes for expedited and extended Appeals, per NC Medicaid Contract, Attachment M, Sections G.5 and G.6, Section H, 42 CFR § 438.410 and 42 CFR § 438.408 (c)(2);*** • ***Ensuring consent from the enrollee or legal guardian is obtained and documented in the Appeal file if an Appeal is filed by a provider or any other representative, per NC Medicaid Contract, Attachment M, Section G.1.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	X					In the 2020 EQR, it was noted that Cardinal's Quality Management Department started the management of Appeals in September of 2020. This department implemented a comprehensive Appeals monitoring process that involves monthly review of a sample of Appeal files and routine review of the Appeal Log. Trends of compliance and quality findings are tracked and used to identify opportunities for improvement and potential efficiencies.
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	X					As a result of a 2019 EQR Recommendation, Cardinal revised Policy & Procedure 6020 to point to the requirements of releasing the Appeal record, when requested. Policy & Procedure 6020 now references Policy & Procedure 1920, Requests for Access to Member Records, Policy & Procedure 1921, Authorized Access, Uses and Disclosure of PHI, and Policy & Procedure 1924, Accounting of PHI Disclosures.

VI. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI A. General Requirements						
1. PIHP shall be familiar and comply with *Section 1902 (a)(68)* of the *Social Security Act*, *42 CFR § 438.455* and *1000* through *1008*, as applicable, including proper payments to providers and methods for detection of fraud and abuse.	X					General Requirements are found 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					Guidance is found in the Cardinal Policy & Procedure 1900, Corporate Compliance.
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					Cardinal provided a template of the Provider Agreement that contained the required language on Fraud, Wase and Abuse (FWA).
4. PIHP shall investigate all Grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	X					The *Provider Manual* has FWA requirements detailed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI B. Fraud and Abuse						
1. PIHP shall establish and maintain a written Compliance Plan consistent with *42 CFR 438.608* that is designed to guard against fraud and abuse. The Compliance Plan shall be submitted to the *NC Medicaid Contract* Administrator on an annual basis.	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. PIHP shall establish and implement a special investigations or program integrity unit, however named, that is responsible for PIHP program integrity activities, including identification, detection, and prevention of fraud, waste, and abuse in the PIHP Closed Provider Network. PIHP shall identify an appropriately qualified contact for Program Integrity and Regulatory Compliance issues as mutually agreed upon by PIHP and NC Medicaid. This person may or may not be the PIHP Compliance Officer or the PIHP Contract Administrator. In addition, PIHP shall identify a primary point of contact within the Special Investigations Unit to receive and respond to data requests from MFCU/MID. The MFCU/ MID will copy the PIHP Contract Administrator on all such requests.	X					The investigation process and point of contact are found in Cardinal's Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting.
4. PIHP shall participate in quarterly Program Integrity meetings with NC Medicaid Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the N.C. Department of Justice ("MFCU/ MID').	X					Participation in meetings is addressed in Cardinal Policy & Procedure 1900, Corporate Compliance. PIHP provided monthly meeting minutes with NC Medicaid.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. PIHP shall send staff to participate in monthly meetings with NC Medicaid Program Integrity staff either telephonically or in person, at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.	X					
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					Cardinal provided internal minutes for monthly meetings.
7. Within seven (7) business days of a request by the Division, PIHP shall also make portions of the PIHP's Regulatory Compliance and Program Integrity minutes relating to Program Integrity issues available for review, but the PIHP may, redact other portions of the minutes not relating to Regulatory Compliance or Program Integrity issues.	X					Providing minutes on request is addressed in Cardinal's Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting.
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	X					Training is addressed in the Cardinal 2019 *Compliance Plan*. Examples of FWA training for providers and employees were provided.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
Claims Act as identified in *Section 1902(a)(66)* of the *Social Security Act;*						
8.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing, and development of corrective action initiatives;	X					Prompt responses are covered in the Cardinal *Compliance Plan*.
8.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					Disciplinary actions are covered 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 supplying all data in a uniform format provided by NC Medicaid and information requested for their respective investigations within seven (7) business days or within an extended timeframe determined by the Division as provided in *NC Medicaid Contract Section 13.2-Monetary Penalties.*	X					Cooperation with investigations 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					Implementation of systems, monitoring, and reporting are all addressed in Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting.
10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse	X					Policies and procedures are 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					Detecting FWA is addressed in 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					In the 2019 EQR, it was recommended that Cardinal update the workflow documentation to indicate a clear differentiation in the workflow based on an evaluation of fraud as opposed to those cases in which no valid determination of fraud is encountered. Cardinal addressed the Recommendation.

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					Reporting overpayments 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					Tracking overpayments is addressed in Policy & Procedure 2300, Paybacks.
10.5 Process for handling self-audits and challenge audits.	X					Audits are addressed in Policy & Procedure 2300, Paybacks.
10.6 Process for using data mining to determine leads.	X					
10.7 Process for informing PIHP employees, subcontractors, and providers regarding the *False Claims Act.*	X					Notifications are 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					False Claims and whistleblower protection are covered in Policy & Procedure 1945, Employee Code of Conduct and the Work Environment.
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					Use of Explanation of Benefits (EOB) to verify services 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					Obtaining financial information is addressed in Policy & Procedure 8000, Agency Application and Enrollment and Policy & Procedure 8370, Ongoing Monitoring off Practitioners and Providers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
11. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements. Nothing in this Contract is intended to address any requirement for PIHP to offer Providers written notice of the process for appealing to the NC Office of Administrative Hearings or any other forum.	X					Overpayment dispute is addressed in Policy & Procedure 2300, Paybacks.
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					Investigation timeframes are addressed in Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting. The review of files for this EQR found that all preliminary investigations were initiated within the required timeframe.
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:						All elements required in the case files for credible allegations of Fraud are found in Cardinals' Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting. All 15 PI files reviewed in this 2020 EQR contained the required elements.
13.1 Subject (name, Medicaid provider ID, address, provider type);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.2 Source/origin of complaint;	X					
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					
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					
13.6 All communications between PIHP and the Provider concerning the conduct at issue, when available.	X					
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					
13.8 Total Sample Amount of Funds Investigated per Service Type	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 included in this review. However, a thorough review of Cardinal's policies and procedures governing Enrollee fraud processes was conducted and all required elements were included within the policies and procedures.
14.1 The Enrollee's name, birth date, and Medicaid number;	X					
14.2 The source of the allegation;	X					
14.3 The nature of the allegation, including the timeframe of the allegation in question;	X					
14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;	X					
14.5 Contact information for PIHP staff persons with practical knowledge of the allegation;	X					
14.6 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation; and	X					
14.7 The legal and administrative status of the case.	X					
14.8 Any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers;	X					
14.9 Details that relate to the original allegation that PIHP received which triggered the investigation;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.10 Period of Service Investigated – PIHP shall include the timeframe of the investigation and/or timeframe of the audit, as applicable.;	X					
14.11 Information on Biller/Owner;	X					
14.12 Additional Provider Locations that are related to the allegations;	X					
14.13 Legal and Administrative Status of Case.	X					
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 provided samples of FAMS reports and list of data mining initiatives undertaken during the review period.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 provided a list of FAMS users. NC Medicaid confirmed submission of required claims and user updates.
18. PIHP shall submit to the NC Medicaid Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month or the next business day if the 10th day is a non-business day (i.e., weekend or State or PIHP holiday). In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to NC Medicaid Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not limited to overpayments and self-audits. The monthly report shall be due by 11:59 p.m. on the tenth (10th) of each month in the format as identified in Attachment Y. PIHP shall also report to NC Medicaid Program Integrity all	X					The contractual requirements for submitting FAMS user changes and cases is addressed in Cardinal Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting. Cardinal also provided samples of Attachment Y and Z.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
Network Provider contract terminations and non-renewals initiated by PIHP, including the reason for the termination or non-renewal and the effective date. The only report shall be due by 11:59p.m. on the tenth (10th) day of each month in the format as identified in attachment Z – Terminations, Provider Enrollment Denials, Other Actions. Compliance with the reporting requirements of Attachments X, Y and Z and any mutually approved template shall be considered compliance with the reporting requirements of this Section.						
VIII C. Provider Payment Suspensions and Overpayments						
1. Within thirty (30) business days of receipt from PIHP of referral of a potential credible allegation of fraud, NC Medicaid Program Integrity shall complete a preliminary investigation to determine whether there is sufficient evidence to warrant a full investigation. If NC Medicaid determines that a full investigation is warranted, NC Medicaid 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						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
suspension notice to the Provider and notify PIHP. If the MFCU/ MID indicates that payment suspension will impact the investigation, NC Medicaid shall temporarily withhold the suspension notice and notify PIHP. Suspension of payment actions under this *Section 14.3* shall be temporary and shall not continue if either of the following occur: PIHP or the prosecuting authorities determine that there is insufficient evidence of fraud by the Provider; or Legal proceedings related to the Provider's alleged fraud are completed and the Provider is cleared of any wrongdoing.						
1.1 In the circumstances described in *Section 14.3 (c)* above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.	X					Payment suspension and notification are addressed in Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					Support of NC Medicaid in defense of an investigation 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 payment in the amount of the original overpayment identified or One Thousand Dollars ($1,000) per case, whichever amount is greater.	X					Written authorization for sanctions 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	
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					Authority to execute sanctions is addressed in Policy & Procedure 1930, Fraud, Waste and/or Abuse Detection, Investigation and Reporting.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with *NCGS 108C-5*, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery.	X					Collection of overpayments is addressed in Policy & Procedure 2300, Paybacks.

E. Attachment 5: Encounter Data Validation Report

Cardinal Innovations Healthcare

Encounter Data Validation Report

performed on behalf of

North Carolina Medicaid

May 12, 2021

Prepared By:

hms

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

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Background

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

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

Overview

The scope of our review, guided by the CMS Encounter Data Validation Protocol, focused on measuring the data quality and completeness of claims paid and submitted to NC Medicaid by Cardinal for the period of January 1, 2019 through December 31, 2019. 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 encounter data elements
- A review of NC Medicaid's encounter data acceptance report

Review of Cardinal's ISCA response

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

The 837 files are transmitted securely to CSRA and parsed using an EDI validator to check for errors and produce a 999 response to confirm receipt and any compliance errors. The behavioral health encounter claims are then validated by applying a list of edits provided by the state (See Appendix 1) and adjudicated accordingly by the Medicaid Management Information System (MMIS). Using existing Medicaid pricing methodology and 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 LME/MCO.

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

Looking at claims with dates of service in 2019, 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.

2019	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
Institutional	115,585	115,323	254	8	0.01%
Professional	2,154,866	2,148,335	5,900	631	0.03%
Total	2,270,451	2,263,658	6,154	639	0.03%

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 99.9%, well above NC Medicaid's expectations.

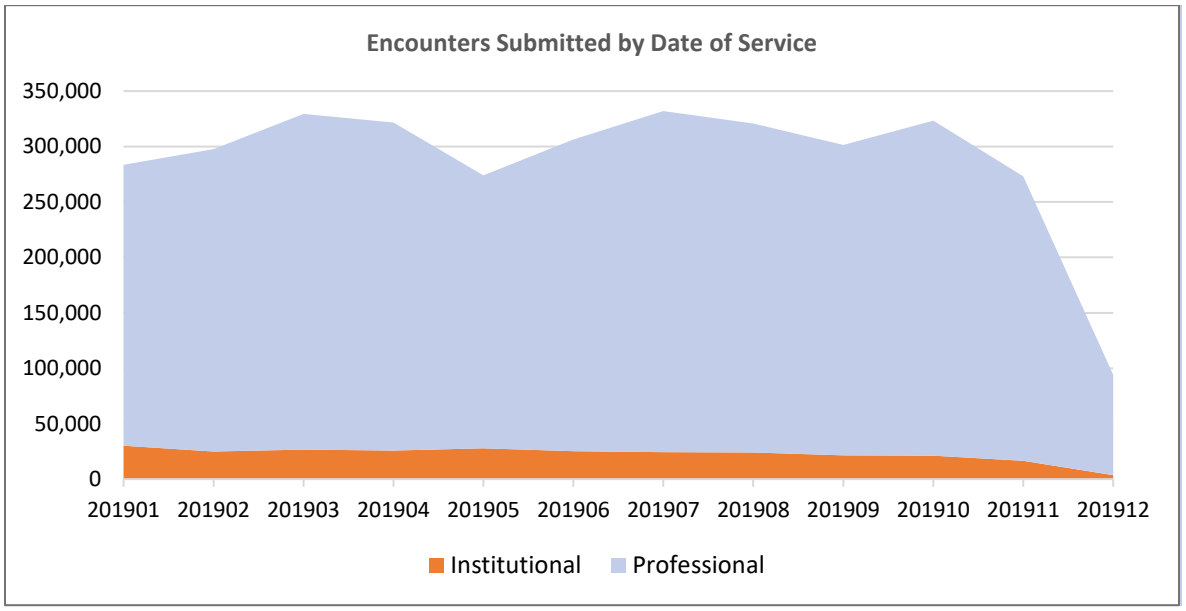
Year of Service	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
2016	1,441,643	822,674	109,268	509,701	35%
2017	1,921,945	1,615,643	29,696	276,606	14%
2018	2,171,767	2,113,644	54,793	3,330	0.15%
2019	2,270,451	2,263,658	6,154	3,330	0.03%

Cardinal has a dedicated Encounter Data Reconciliation Team which follows a detailed reconciliation and correction process in place to ensure that all denials are reviewed, corrected, and resubmitted to NC Medicaid. This team consists of a Manager, Supervisor and five Encounter Reconciliation Analyst responsible for monitoring 835 response files, investigating all denied encounters, correcting the errors, and resubmitting the denied encounters. Cardinal is determining the denial reason by using the EOB code and description found on the 835 response 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, 2019 and December 31, 2019. Cardinal pulled all claims adjudicated and submitted to NC Medicaid during this period and sent to HMS via SFTP. This included more than three million professional claim lines and nearly three hundred thousand Institutional claim lines with 2019 dates of services. A small number of these records 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, HMS processed and combined all batch encounter files and loaded them to a consolidated database. After data onboarding was completed, HMS applied proprietary, internally designed data analysis logic within SAS to review each data element, focusing on the data elements defined as required. Our logic evaluates the presence of data in each field within a record as well as whether the value for the field is within accepted standards. Results of these checks were compared with general expectations for each data field and to the CMS standards adopted for encounter data. The table below depicts the specific data expectations and validity criteria applied.

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

Data Element	*Expectation*	*Validity Criteria*
Recipient ID	Should be valid ID as found in the State's eligibility file. Can use State's ID unless State also accepts Social Security Number.	100% valid
Recipient Name	Should be captured in such a way that makes separating pieces of name easy. Expect data to be present and of good quality	85% present. Lengths should vary, but there should be at least some last names of >8 digits and some first names of < 8 digits, validating that fields have not been truncated. Also, a high percentage of names should have at least a middle initial.
Recipient Date of Birth	Should not be missing and should be a valid date.	< 2% missing or invalid

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

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

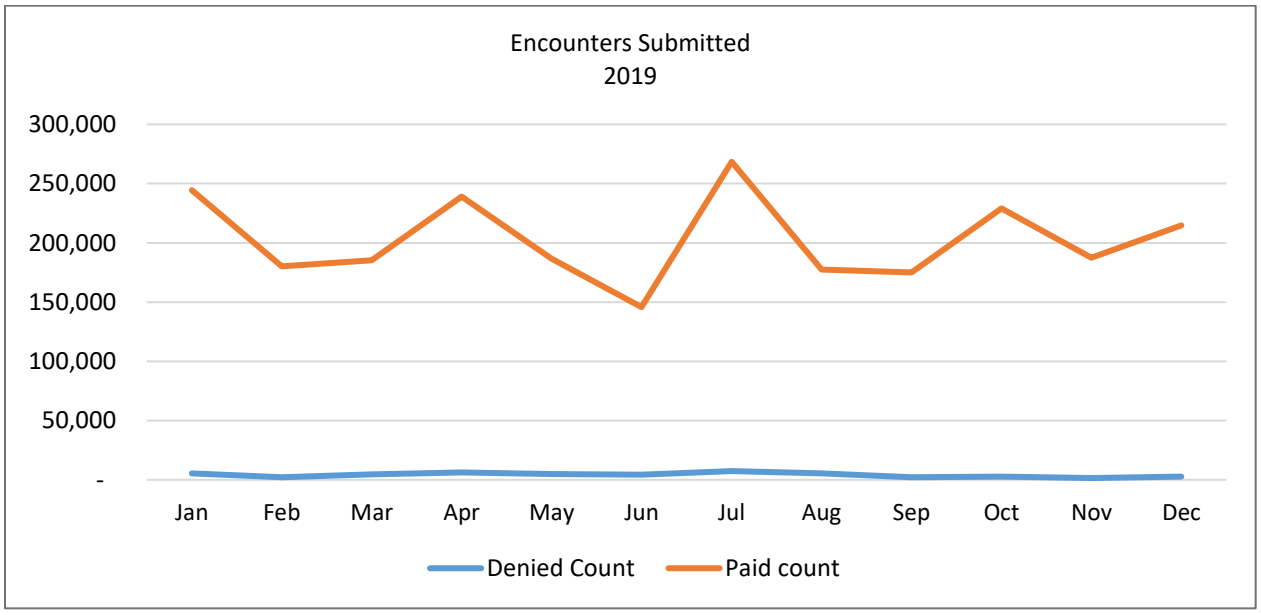
Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	3,817,378	100.00%	3,817,378	100.00%	3,817,378	100.00%	3,817,378	100.00%
Recipient Name	3,817,548	100.00%	3,817,548	100.00%	3,817,548	100.00%	3,817,548	100.00%
Recipient Date of Birth	3,817,548	100.00%	3,817,548	100.00%	3,817,548	100.00%	3,817,548	100.00%
MCO/PIHP ID	3,817,548	100.00%	3,817,548	100.00%	3,817,548	100.00%	3,817,548	100.00%
Provider ID	3,817,548	100.00%	3,817,548	100.00%	3,817,548	100.00%	3,817,548	100.00%
Attending/Rendering Provider ID	3,817,435	100.00%	3,817,435	100.00%	3,817,435	100.00%	3,817,435	100.00%
Provider Location	3,817,548	100.00%	3,817,548	100.00%	3,817,548	100.00%	3,817,548	100.00%
Place of Service	3,817,544	100.00%	3,817,548	100.00%	3,817,548	100.00%	3,817,548	100.00%
Specialty Code / Taxonomy - Billing	3,817,548	100.00%	3,817,548	100.00%	3,817,548	100.00%	3,817,548	100.00%
Specialty Code / Taxonomy - Rendering / Attending	3,817,435	100.00%	3,817,435	100.00%	3,817,435	100.00%	3,817,435	100.00%
Principal Diagnosis	3,817,548	100.00%	3,817,548	100.00%	3,817,548	100.00%	3,817,548	100.00%
Other Diagnosis	703,246	18.42%	703,246	18.42%	703,246	18.42%	703,246	18.42%
Dates of Service	3,817,548	100.00%	3,817,548	100.00%	3,817,548	100.00%	3,817,548	100.00%
Unit of Service (Quantity)	3,817,548	100.00%	3,817,548	100.00%	3,817,548	100.00%	3,817,548	100.00%
Procedure Code	3,695,419	96.80%	3,695,419	96.80%	3,695,419	96.80%	3,695,419	96.80%
Procedure Code Modifier	1,635,415	42.84%	1,635,415	42.84%	1,635,415	42.84%	1,635,415	42.84%
Patient Discharge Status Code Inpatient	331,824	100.00%	331,824	100.00%	331,824	100.00%	331,824	100.00%
Revenue Code	331,824	100.00%	331,824	100.00%	331,824	100.00%	331,824	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 codes. In a small number of cases, Cardinal submitted encounters without the 10 byte State Medicaid ID, including claims where the SSN is used or other unexpected values. Also, issues were identified with Procedure codes, which was an issue identified in the 2017 and 2018 encounter data reviews.

Professional encounter claims submitted contained complete and valid data in 14 of the 15 key Professional fields (93%). The primary issue is the infrequent reporting of Other Diagnosis on professional services. The Principal Diagnosis code was populated 100% of the time, however, we found inconsistency in Other Diagnosis codes being present. Specifically, some providers never reported Other Diagnosis codes. Separately, we noted a couple of minor issues involving Rendering Provider Id and Rendering Taxonomy codes were identified. However, the issues did not exceed the thresholds identified in the data quality standards table above.

Encounter Acceptance Report

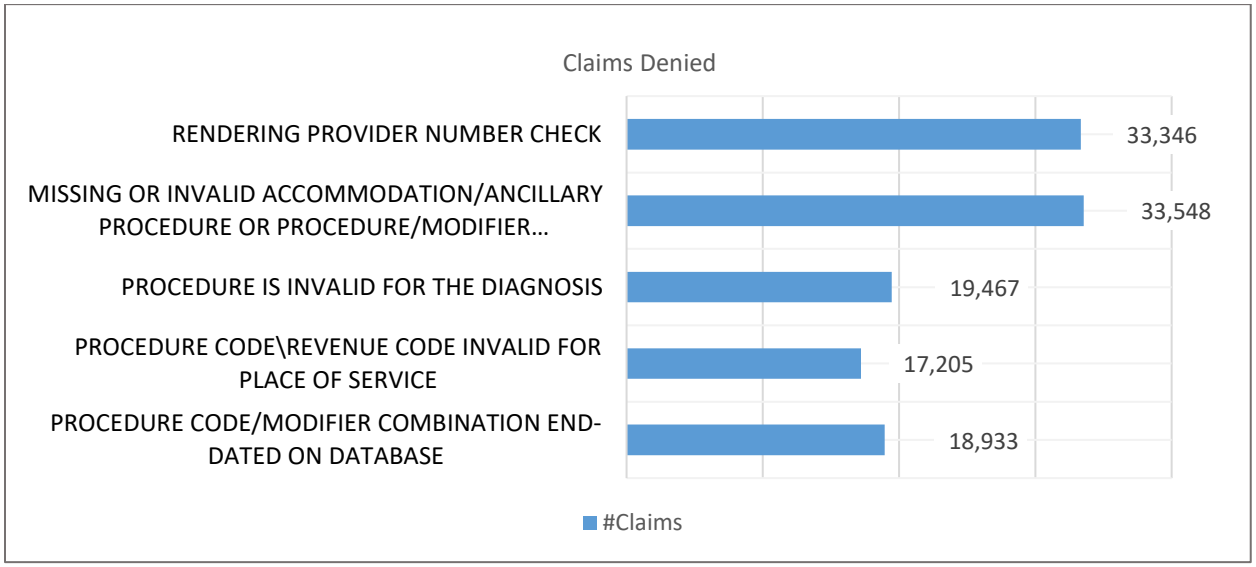
In addition to performing evaluation of the encounter data submitted, the HMS analyst reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each LME/MCO. The report is tracked by check write and excludes duplicates or resubmission which made it difficult to tie back to the ISCA response and converted encounter files. Data provided by LME.MCO's reports for our review includes all submission and resubmissions during 2019 which may include older dates of service. During the 2019 weekly check write schedule, Cardinal submitted a total of 2,270,451 encounters to NC Medicaid. Overall, 0.3% of all encounters submitted in 2019 were initially denied, which represents a marked improvement compared to 2017 when that figure stood at 16%. Approximately 0.03% of claims denied in 2019 are still outstanding -- the rest have been reviewed, resubmitted, and accepted by NC Medicaid.



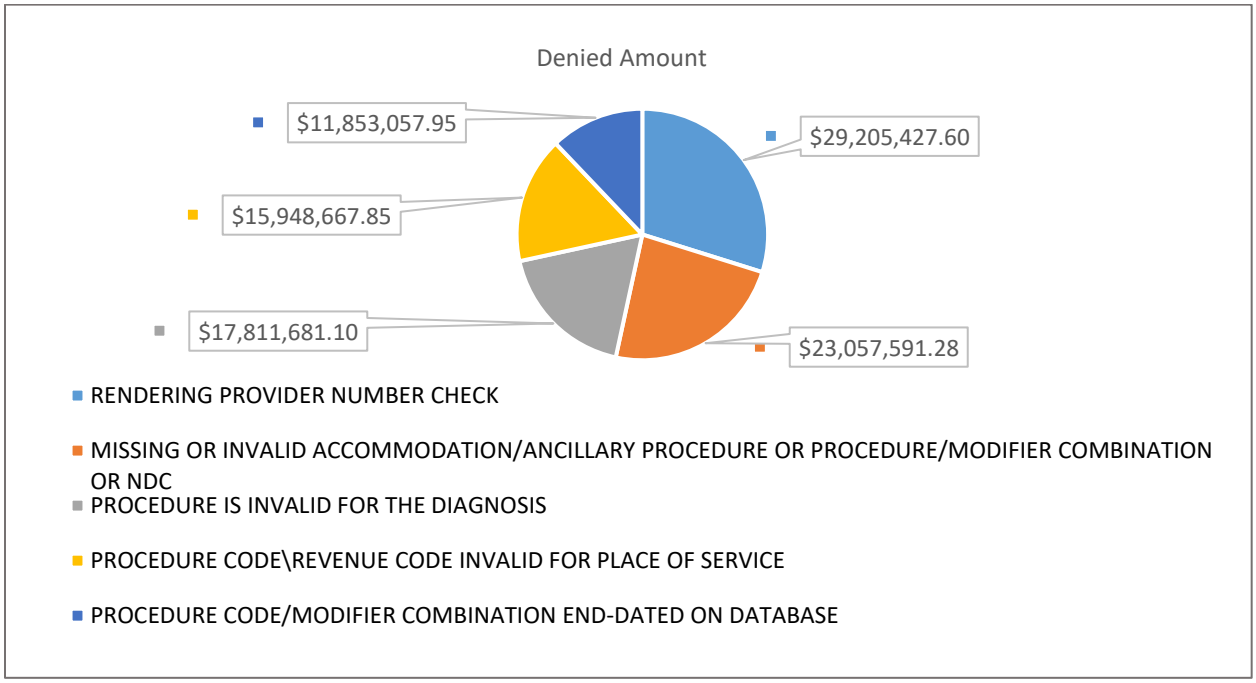
Evaluation of the top denials for Cardinal encounters correlates with the data deficiencies identified by the HMS analyst in the Key Field analysis an ISCA review above. Encounters were denied primarily for:

- Rendering provider number check
- Missing or invalid accommodation/ancillary procedure or procedure/modifier
- Procedure is invalid for the diagnosis
- Procedure code/Revenue code invalid for place of service
- Procedure code/modifier combination end-dated on database

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 should be populated 99% of the time. In the encounter data provided by Cardinal, 96.8% of claims contained a valid value in the Procedure code field and among those flagged for issues 220 of those claims contained a Revenue code instead of a Procedure code.

Recommendation:

This issue was also highlighted during the 2017 and 2018 encounter data validation reviews. The error rate did drop in 2019, but still there were 220 claims that contained a Revenue code in the Procedure code field. However, these errors did not appear to have affected provider reimbursements as the Institutional claims in question were paid a set rate such as per diem. In latter part of 2019, Cardinal adopted system edits to validate Procedure codes and we expect this issue to be not present moving forward.

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 nine digits following by and alpha character. Of the encounters submitted, 170 records were invalid. This is a smaller number than what was seen in 2018. There was a mix of SSN values with the hyphen included and values less than 10 bytes in length.

Recommendation:

Cardinal's eligibility data is driven by the 834 and Global Eligibility File (GEF) provided by NC Medicaid. Cardinal should ensure each encounter being submitted matches to the state provided eligibility prior to submission. In some instances, the issue could be caused due to timing issues as enrollees move from the state program to Medicaid. In such cases, Cardinal should ensure that the claim is paid under the correct program and make sure the proper identification number is submitted to NC Medicaid.

Cardinal already validates that the member is eligible prior to claim payment, so the correct Recipient or Medicaid ID should be captured and available for submission. If the claim being submitted by the provider does not contain a valid Recipient Id, the claim should be denied. If the claim is being submitted through the provider portal, the provider should be limited to only select or enter a valid Id on record with the LME.

Issue: Additional Diagnosis Codes

Other Diagnosis codes were populated less than 14% of the time for Professional claims. The absence of Other Diagnosis codes does not appear to be a mapping issue within Cardinal, but likely driven by some providers not coding beyond the Primary Diagnosis code. This value is not required by Cardinal when adjudicating the claim. Therefore, certain providers may not be submitting Other Diagnosis codes even in cases where they are present when submitting claims via Provider Web Portal or 837P.

Recommendation:

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

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 of the three issues identified were only apparent in the Institutional claims and their impacts were minimal considering the volume of claims and the method for adjudication (Revenue code vs, Procedure code). Cardinal took a corrective action in 2019 to ensure they are capturing and reporting valid Procedure codes for Institutional claims. Cardinal is also closely monitoring Recipient Id to ensure that they are submitting the expected 10-byte alphanumeric Recipient Id.

The third issue involving Other Diagnosis code was mostly present in professional claims and appears to be driven by provider behavior – with some providers not reporting any additional Diagnosis codes while others do report at a high frequency. Similar to other two issues, this third issue did not appear to have impacted provider reimbursements. However, given that Other Diagnosis code is a required data element, Cardinal should identify providers who never code and submit Other Diagnosis codes and contact those providers to remind them of their obligation to submit claims that are complete and accurate.

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

Appendix 1

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
00001	HDR BEG DOS INVLD/ > TCN DATE	DENY
00002	ADMISSION DATE INVALID	DENY
00003	HDR END DOS INVLD/ > TCN DATE	DENY
00006	DISCHARGE DATE INVALID	PAY AND REPORT
00007	TOT DAYS CLM GTR THAN BILL PER	PAY AND REPORT
00023	SICK VISIT BILLED ON HC CLAIM	IGNORE
00030	ADMIT SRC CD INVALID	PAY AND REPORT
00031	VALUE CODE/AMT MISS OR INVLD	PAY AND REPORT
00036	HEALTH CHECK IMMUNIZATION EDIT	IGNORE
00038	MULTI DOS ON HEALTH CHECK CLM	IGNORE
00040	TO DOS INVALID	DENY
00041	INVALID FIRST TREATMENT DATE	IGNORE
00044	REQ DIAG FOR VITROCERT	IGNORE
00051	PATIENT STATUS CODE INVALID	PAY AND REPORT
00055	TOTAL BILLED INVALID	PAY AND REPORT
00062	REVIEW LAB PATHOLOGY	IGNORE
00073	PROC CODE/MOD END-DTE ON FILE	PAY AND REPORT
00076	OCC DTE INVLD FOR SUB OCC CODE	PAY AND REPORT
00097	INCARCERATED - INPAT SVCS ONLY	DENY
00100	LINE FDOS/HDR FDOS INVALID	DENY
00101	LN TDOS BEFORE FDOS	IGNORE
00105	INVLD TOOTH SURF ON RSTR PROC	IGNORE
00106	UNABLE TO DETERMINE MEDICARE	PAY AND REPORT
00117	ONLY ONE DOS ALLOWED/LINE	PAY AND REPORT
00126	TOOTH SURFACE MISSING/INVALID	IGNORE
00127	QUAD CODE MISSING/INVALID	IGNORE
00128	PROC CDE DOESNT MATCH TOOTH #	IGNORE
00132	HCPCS CODE REQ FOR REV CODE	IGNORE
00133	HCPCS CODE REQ BILLING RC 0636	IGNORE
00135	INVL POS INDEP MENT HLTH PROV	PAY AND REPORT
00136	INVLD POS FOR IDTF PROV	PAY AND REPORT
00140	BILL TYPE/ADMIT DATE/FDOS	DENY
00141	MEDICAID DAYS CONFLICT	IGNORE
00142	UNITS NOT EQUAL TO DOS	PAY AND REPORT
00143	REVIEW FOR MEDICAL NECESSITY	IGNORE
00144	FDOS AND TDOS MUST BE THE SAME	IGNORE
00146	PROC INVLD - BILL PROV TAXON	PAY AND REPORT
00148	PROC\REV CODE INVLD FOR POS	PAY AND REPORT
00149	PROC\REV CD INVLD FOR AGE	IGNORE
00150	PROC CODE INVLD FOR RECIP SEX	IGNORE
00151	PROC CD/RATE INVALID FOR DOS	PAY AND REPORT

00152	M/I ACC/ANC PROC CD	PAY AND REPORT
00153	PROC INVLD FOR DIAG	PAY AND REPORT
00154	REIMB RATE NOT ON FILE	PAY AND REPORT
00157	VIS FLD EXAM REQ MED JUST	IGNORE
00158	CPT LAB CODE REQ FOR REV CD	IGNORE
00164	IMMUNIZATION REVIEW	IGNORE
00166	INVALID VISUAL PROC CODE	IGNORE
00174	VACCINE FOR AGE 00-18	IGNORE
00175	CPT CODE REQUIRED FOR RC 0391	IGNORE
00176	MULT LINES SAME PROC, SAME TCN	IGNORE
00177	HCPCS CODE REQ W/ RC 0250	IGNORE
00179	MULT LINES SAME PROC, SAME TCN	IGNORE
00180	INVALID DIAGNOSIS FOR LAB CODE	IGNORE
00184	REV CODE NOT ALLOW OUTPAT CLM	IGNORE
00190	DIAGNOSIS NOT VALID	DENY
00192	DIAG INVALID RECIP AGE	IGNORE
00194	DIAG INVLD FOR RECIP SEX	IGNORE
00202	HEALTH CHECK SHADOW BILLING	IGNORE
00205	SPECIAL ANESTHESIA SERVICE	IGNORE
00217	ADMISSION TYPE CODE INVALID	PAY AND REPORT
00250	RECIP NOT ON ELIG DATABASE	DENY
00252	RECIPIENT NAME/NUMBER MISMATCH	PAY AND REPORT
00253	RECIP DECEASED BEFORE HDR TDOS	DENY
00254	PART ELIG FOR HEADER DOS	PAY AND REPORT
00259	TPL SUSPECT	PAY AND REPORT
00260	M/I RECIPIENT ID NUMBER	DENY
00261	RECIP DECEASED BEFORE TDOS	DENY
00262	RECIP NOT ELIG ON DOS	DENY
00263	PART ELIG FOR LINE DOS	PAY AND REPORT
00267	DOS PRIOR TO RECIP BIRTH	DENY
00295	ENC PRV NOT ENRL TAX	IGNORE
00296	ENC PRV INV FOR DOS	IGNORE
00297	ENC PRV NOT ON FILE	IGNORE
00298	RECIP NOT ENRL W/ THIS ENC PRV	IGNORE
00299	ENCOUNTER HMO ENROLLMENT CHECK	PAY AND REPORT
00300	BILL PROV INVALID/ NOT ON FILE	DENY
00301	ATTEND PROV M/I	PAY AND REPORT
00308	BILLING PROV INVALID FOR DOS	DENY
00313	M/I TYPE BILL	PAY AND REPORT
00320	VENT CARE NO PAY TO PRV TAXON	IGNORE

00322	REND PROV NUM CHECK	IGNORE
00326	REND PROV NUM CHECK	PAY AND REPORT
00328	PEND PER 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