2018 External Quality Review

EASTPOINTE

Submitted: December 14, 2018

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

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EXECUTIVE SUMMARY

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

EQR goals include the following:

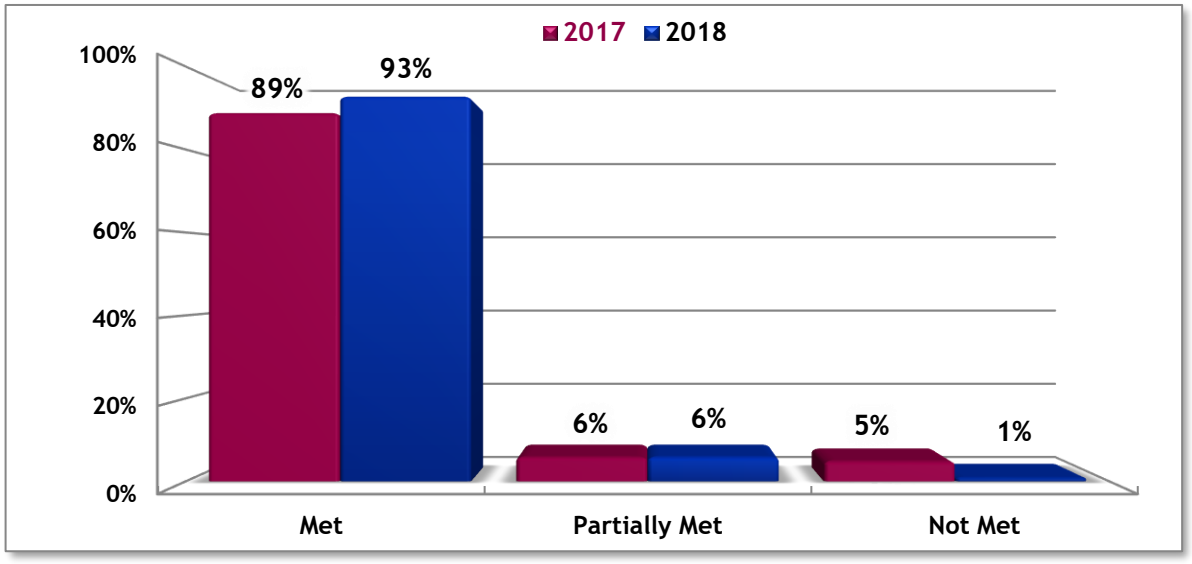
- Determine if Eastpointe complies with service delivery as mandated by their North Carolina Medicaid (NC Medicaid) contract
- Provide feedback for potential areas of further improvement
- Verify the delivery and determine the quality of contracted health care services

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

A. Overall Findings

The 2018 Annual EQR reflects that Eastpointe achieved a “Met” score for 93% of the standards reviewed, 6% of those standards were scored as “Partially Met,” and 1% of the standards scored “Not Met”. It should be noted that standards scored as “Not Applicable” equaled less than 1% and so are not captured in Figure 1, which demonstrates a comparative of the 2017 and 2018 EQR scores.

Figure 1: Annual EQR Review Comparative Results



B. Overall Recommendations

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

Administration

The Administration Review comprises required assessment and evaluation of the Eastpointe's policies, organizational staffing, management of protected health information (PHI) and information system capabilities using the Information Systems Capabilities Assessment (ISCA) tool.

CCME's review of Eastpointe's policies, organizational staffing, confidentiality practices, and ISCA resulted in seven recommendations and one item requiring corrective action. CCME's recommendations centered on reconciling the lists used to track Eastpointe policies, ensuring accurate representation of the Assistant Medical Director on the organizational chart and committee minutes, and updating the organizational chart consistently so that it captures staff degrees and licensure information.

The one item requiring Corrective Action is related to the submission of ICD-10 diagnosis codes. Even though Eastpointe captures 24 ICD-10 diagnosis codes in AlphaMCS, the PIHP submits no more than two diagnosis codes to NCTracks on both institutional and professional encounter data files. NCTracks can capture up to 25 diagnosis codes for institutional claims and 12 diagnosis codes for professional encounters.

Provider Services

The Provider Services review includes Network Adequacy and Credentialing and Recredentialing. The "Not Met" item for this review was due to missing evidence of Primary Source Verification (PSV) of the Drug Enforcement Agency (DEA) certificate in one of the two credentialing files for which it is required. The "Partially Met" items are in the areas of Credentialing/Recredentialing, and Practitioner Accessibility. Some files were missing documentation of PSVs or other items needed for the EQR. Other files contained the PSVs but the PSVs are either are illegible or do not contain the date of the query. In response to CCME's request, Eastpointe provided additional documents.

CCME recommends revising the Credentialing Committee meeting minutes to include needed documentation. CCME also recommends Eastpointe revise the *Provider Credentialing Operations Manual/Plan* and the *Credentialing Committee Bylaws* to eliminate conflicting information across documents.

Enrollee Services

The Enrollee Services review focuses on enrollee rights and responsibilities, enrollee PIHP program education, behavioral health and chronic disease management education, and the Call Center. Eastpointe's Call Center meets performance metrics, and the PIHP makes enrollee educational opportunities available on the website calendar which offers several enrollee and community trainings. CCME's recommendations and corrective actions center around the information in the *Provider Directory* and the *Enrollee/Member and Family Handbook*.

Quality Improvement

This section concentrates on the Quality Improvement (QI) Program, QI Committee, performance measures, Performance Improvement Projects (PIPs), provider participation in QI, and the annual evaluation of the QI Program. There were improvements over last EQR in the enrollee survey results analysis. CCME noted the effort made towards improving the lower scoring results. CCME also noted improvement in the Clinical Practice Guideline monitoring. Two standards scored a "Partially Met" and two scored a "Not Met." The "Partially Met" items were within the sections of the QI Committee and the PIPs. The "Not Met" items were related to over and underutilization, and the written annual summary and assessment of the QI Program's effectiveness.

Utilization Management

Utilization Management (UM) EQR includes UM, Care Coordination and Transition to Community Living (TCLI) programs. CCME offers four recommendations and two Corrective Actions. Recommendations include; documentation when an expedited authorization request is transferred to a standard request, adding the processes used for Over and Underutilization into the policy, including the Medical Director's participation in UM, adding information regarding the *Children's Assessment of Needs and Strengths (CANS) in the Policy Q-3.2.37*, and updating the TCLI Program description. The Corrective Actions are related to the application of the policies; ensuring that Care Coordination notes are timely, and that *Peer Support* and *Supported Employment* opportunities are provided to members as part of their transition process.

Grievances and Appeals

The Grievance EQR resulted in all standards being "Met" and six recommendations. The recommendations include: updating the definition of a Grievance, adding Adverse Benefits Determination to the grievance definitions, and updating "who can file a grievance" so that it is consistent with the *2017 DMA Contract and 42 CFR § 438.400*. Additional information is also needed in the grievance policy including; consistently use one term for grievance; include the process used for *Quality of Care Concern* referrals; and ensure all communication and notifications are documented in the grievance process notes.

Delegation

Eastpointe reported four current delegated entities. The delegation agreement with Access Nurse, Inc. dba TeamHealth Medical Call Center ended on February 14, 2018. Delegation Agreements with Business Associate Agreements (BAAs) are in place with the remaining delegates. Effective May 15, 2018, Eastpointe ended the Delegation Agreement with BHM for Medical Director services, but Eastpointe has a current contract with Dr. Doniparthi.

The only Corrective Action item from the last EQR was to develop monitoring tools and monitor the Medical Director delegates. Eastpointe did not develop monitoring tools nor monitor Dr. Doniparthi, per the Corrective Action from the previous EQR. This continues as a "Partially Met" item with Corrective Action for this EQR.

Program Integrity

Island Peer Review Organization (IPRO) conducted an offsite review of Eastpointe's documentation to assess the PIHP's compliance with federal and state regulations and the PIHP's contract with NC Medicaid. This information was reviewed under topic areas titled: General Requirements, Fraud and Abuse, and Provider Payment Suspensions & Overpayments. Overall, Eastpointe updated and provided all documentation including policies that meet contractual requirements. CCME recommends that Eastpointe include links to information on how providers can report overpayment to the PIHP on the provider webpage of Eastpointe's website, along with the refund check form. Currently, the website is limited to newsletter archives from 2015/2016 and the referral form. The links will ensure the information is up to date and readily accessible.

Financial Services

Eastpointe received all "Met" scores for the 2018 Financial Services EQR. CCME identified two areas to enhance the policy. CCME recommends adding language to *Policy B-2.2.25, Risk Reserve* that payment is due within five business days of receipt of capitation payment. CCME also recommends adding the requirement for 10-year retention for Medicaid records to *Policy B-2.1.12, Data Storage, Maintenance and Destruction*. Eastpointe should also ensure that all risk reserve payments are made within five business days of receipt of the capitation payment from the state.

Encounter Data Validation

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

HMS is recommending that the encounter data from NCTracks be reviewed to look at encounters that pass front-end edits and are adjudicated to either a paid or denied status. It is difficult to reconcile the various tracking reports with the data submitted by the PIHP. Reviewing an extract from NCTracks would provide insight into how the State's MMIS is handling the encounter claims and could be reconciled back to reports requested from Eastpointe. The goal is to ensure that Eastpointe 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 Encounter Data Validation, conducted by CCME's subcontractor, HMS. Additionally, as required by CCME's contract with NC DHHS, CCME's subcontractor, IPRO conducted an ISCA Audit and Medicaid Program Integrity Review of the health plan.

On September 26, 2018, CCME sent notification to Eastpointe that the annual EQR was being initiated (see *Attachment 1*). This notification included:

- Materials requested for Desk Review
- ISCA Survey
- Draft Onsite agenda
- PIHP EQR Standards

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

The review consisted of two segments. The first was a Desk Review of materials and documents received from Eastpointe on October 17, 2018 and reviewed in the offices of CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the QI and Medical Management programs. Also included in the Desk Review was a review of credentialing, grievance, Utilization Management, Care Coordination, program integrity and appeal files.

The second segment was a two-day, Onsite Review conducted on November 14, 2018 and November 15, 2018, at Eastpointe's corporate office in Beulaville, North Carolina. CCME's Onsite visit focused on areas not covered in the Desk Review and areas needing clarification. For a list of items requested for the Onsite visit, see *Attachment 2*. CCME's Onsite activities included:

- Entrance and Exit Conferences
- Interviews with Eastpointe 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 contract requirements between Eastpointe and North Carolina Medicaid. Strengths, weaknesses, Corrective Action items, and recommendations are identified where applicable. Areas of review were identified as meeting a standard "Met", acceptable but needing improvement "Partially Met," failing a standard "Not Met," "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheet (*Attachment 4*).

A. Administration

The Administration EQR comprises required assessment and evaluation of the health plan's policies, organizational staffing, management of protected health information (PHI) and information system capabilities using the Information Systems Capabilities Assessment (ISCA) tool. The following narrative highlights the Administration Review findings and is followed by a summary of strengths, weaknesses, and recommendations for ensuring compliance with standards.

Policies & Procedures

For this year's EQR, Eastpointe submitted 326 policies, a *Policy and Procedure List* and a *P&P Manual Table of Contents*. It was explained during the Onsite discussion that the *Policy and Procedure List* is maintained for EQR and/or audit purposes only, while staff use the *P&P Manual Table of Contents* as this document contains hyperlinks to individual policies.

CCME reviewed a sample of Eastpointe's policies along with the *Policy and Procedure List* and the *P&P Manual Table of Contents*. When comparing this sample of policies (63 policies, or 20%) to the *Policy and Procedure List* and the *P&P Manual Table of Contents*, 15 (or 24%) of the sample had incorrect information such as mis-numbered policies, missing policies and/or typos within the two tracking lists. Overall, Eastpointe has well organized policies, reviews them annually, and demonstrates an active policy revision process. However, CCME recommends that Eastpointe reconcile the two tracking lists to ensure all policies are accounted for and all dates (revised/review dates and original effective dates) and policy labels are accurate and consistent within these two tracking documents.

Organizational Staffing/ Management

Sarah Stroud continues in her role as Chief Executive Officer and provided a presentation during the Onsite visit regarding Eastpointe's response to hurricane Florence. During and after this hurricane, staff maintained contact with Eastpointe's enrollees and providers

and worked with local shelters and first responders to assist with hurricane recovery efforts. A nearby PIHP, Partners Behavioral Health, also assisted in contacting enrollees to ensure they were safe.

Dr. Sid Hosseini, DO joined Eastpointe as Chief Medical Officer in May 2018. Dr. Hosseini is licensed and board-certified in North Carolina and has over 25 years of experience in psychiatry.

Dr. Venkata Doniparthi continues in her consultant role with Eastpointe. During the Onsite Administrative discussion, Eastpointe staff reported she is working 13 hours per week to support Eastpointe's clinical functions. While staff could describe Dr. Doniparthi's responsibilities during the Onsite discussion, there was an overall lack of clarity regarding her official title as evidenced by committee minutes and Onsite discussion. Additionally, Dr. Doniparthi's responsibilities and oversight are also not represented on the organizational chart as outlined in her contractual job description or as staff described during the Onsite. CCME recommends the organizational chart and committee minutes come into alignment with Dr. Doniparthi's contractual responsibilities and title.

In last year's EQR, CCME documented concerns with Eastpointe's current Medical Director services contractual arrangements. BHM Healthcare Solutions was providing 20 hours of Medical Director services. As BHM is also completing the peer clinical reviews for Eastpointe, this duality of roles brought to light several potential conflicts of interests. Eastpointe has since secured a full-time Medical Director and terminated this contract provision in May of 2018.

Eastpointe's organizational chart adequately demonstrated the departmental structures within the PIHP, but staff education and licensure were not consistently reflected on the chart. During the Onsite discussion, CCME highlighted that, moving forward, including certifications (e.g., Peer Support Specialists, Data Analytics Certifications, etc.) on the organizational chart would better show how Eastpointe staff are credentialed for their positions.

Confidentiality

As a Covered Entity under the Health Insurance Portability and Accountability Act (HIPAA), Eastpointe's policies on the management and protection of enrollee confidentiality were reviewed by CCME. Eastpointe's complement of policies addresses both state and federal requirements for preserving enrollee confidentiality and protecting health information.

Additionally, Eastpointe ensures all new staff are apprised of Eastpointe's confidentiality practices prior to their exposure to PHI. *Policy H-5.3.2 Employee Orientation and*

Training states, "New employees will report to the Human Resources Department on their first day of employment to complete the New Employee Orientation Session that includes HIPAA/Confidentiality training upon hire and offered through Essential Learning platform."

Information Systems Capabilities Assessment

IPRO, in contract with CCME and as required by the CMS' Encounter Data Validation protocol, conducted the yearly review of Eastpointe's ISCA.

Like many other PIHPs in North Carolina, Eastpointe uses the AlphaMCS transactional system, a hosted system environment produced by Wellsky (formerly known as Mediware). Wellsky modifies the user interface and conducts backend programming updates to the system.

Prior to the Onsite, Eastpointe completed the 2018 ISCA tool and submitted supporting documentation, workflows, and policies. IPRO reviewed the responses and followed up on areas requiring clarification via interviews and a system walk through at Eastpointe office located in Beulaville, North Carolina, on November 15, 2018. This review was part of the annual compliance audit CCME conducted on November 14th and 15th, 2018.

Enrollment Systems

Eastpointe experienced a small decrease in enrollment over the past two years. The year-end enrollment was 195,379 in 2016 and 170,303 in 2017. During the Onsite, Eastpointe explained that the approximate 10% decrease in enrollment from 2016 to 2017 was due to Nash county moving from Eastpointe to Trillium on July 1, 2017. Eastpointe also explained that there was approximately 6% decrease in enrollment for 2018 due to Columbus county moving from Eastpointe to Trillium on July 1, 2018.

The ISCA tool and supporting documentation for enrollment systems loading processes clearly defined the process for enrollment data updates in AlphaMCS enrollment system. During the ISCA Onsite Review, Eastpointe provided a demonstration of the AlphaMCS enrollment system. The system maintains a member's enrollment history. Wellsky daily imports Global Eligibility File (GEF) files into a SQL database. The 834 file is loaded monthly and the quarterly GEF file is loaded when Wellsky receives it. The daily eligibility file is compared to existing eligibility in the AlphaMCS. The member enrollment records are processed and checked against the existing data in the database. An edit code that identifies if the member record needs to be added or changed or deleted is applied.

Eastpointe stores the Medicaid identification number received on the GEF. Eastpointe's eligibility system is able to merge multiple member records and link the patient's historical claims.

Eastpointe providers have the capability to confirm a member's eligibility in the AlphaMCS Provider Portal. Each monthly, Eastpointe uses the 820 Capitation file to reconcile with the payment received by member and categories of aid. Eastpointe also reconciles the 820 Capitation file with the member enrollment data in the AlphaMCS system to ensure accurate payment was received.

The AlphaMCS system is able to capture demographic data like race, ethnicity and language.

Claims Systems

Eastpointe's claims are processed in the AlphaMCS system. IPRO conducted a review of Eastpointe's processes for collecting, adjudicating and reporting claims by examining its ISCA response and supporting documentation. Eastpointe demonstrated its Provider Web Claims Entry Portal and the AlphaMCS claims processing system during the Onsite Review.

Table 1: Percent of claims with 2017 dates of service that were received via electronic (HIPAA, Provider Web Portal) or paper forms.

Source	HIPAA File	Paper	Provider Web Portal
Institutional	92.5%	.5%	7%
Professional	73%	.5%	26.5%

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

If a required field is missing from the claim, Eastpointe's Provider Web Portal will not allow the claim to be submitted to Eastpointe. If the claim is submitted electronically via an electronic 837 file and one or more required fields are missing, the Web portal sends the provider a 999 response file advising the provider of the claim submission failure. Eastpointe Claim Processors do not change any information on the claims.

Eastpointe adjudicates claims nightly. Eastpointe auto-adjudicates approximately 20% of institutional claims and 80% of professional claims.

Eastpointe processes claims within 18 days of receipt of a claim and pays them within 30 calendar days after receipt. As stated in the ISCA, Eastpointe pays 90% of clean claims within 30 calendar days of the date of approval and 99% of clean claims within 180 days of date of receipt.

Eastpointe accepts ICD-10 procedure codes and DRGs if provider includes the values on an 837I. Eastpointe's Provider Web Portal can receive the DRG code. Eastpointe does not use DRGs for payment.

Eastpointe's AlphaMCS system can capture up to 12 ICD-10 diagnosis codes for professional claims and up to 24 ICD-10 diagnosis codes including the admitting diagnosis code for institutional claims. Eastpointe's Provider Web Portal can capture up to 12 diagnosis codes for professional claims and up to eighteen diagnosis codes for institutional claims. Twenty-five ICD-10 diagnosis codes are the maximum number of diagnosis codes that may be submitted on an 837I;12 ICD-10 diagnosis codes are the maximum number of diagnosis codes that may be submitted on an 837P.

Eastpointe conducts audits of claims processed monthly and quarterly. Eastpointe staff audits 3% of all claims processed during a one-month period and high dollar claims over $5,000 monthly. Eastpointe conducts quarterly audits of claims suspected to be duplicates.

Reporting

Eastpointe's data warehouse captures all the enrollment, provider, claims and authorization information in the AlphaMCS. AlphaMCS stores data in a Microsoft SQL Server database. Eastpointe maintains an internal database and data warehouse for reporting. The database is refreshed with data from the AlphaMCS daily through a backup copy of the database that Wellsky provides. Eastpointe compares the number of records in the AlphaMCS to the number of records loaded in Eastpointe's data warehouse to verify the completeness of data. Eastpointe's staff also runs queries against the data warehouse to ensure that correct and valid data is available for reporting. As confirmed during the Onsite, up to six years' worth of claims data is available in the online AlphaMCS system and Eastpointe's data warehouse for reporting.

Wellsky generates reports for Eastpointe within the AlphaMCS system. Eastpointe also creates reports internally from the reporting data warehouse. Eastpointe staff use rePortal, a third-party software, to create reports based on their requirements.

Eastpointe provided a business continuity and disaster recovery plan prior to the Onsite audit for review. Eastpointe was affected by the hurricane in September 2018. During the Onsite, Eastpointe clarified that the hurricane had very little impact to business and there was no disruption of business processes and services.

Encounter Data Submissions

Eastpointe uses a defined process for their encounter data submission, with 837 files submitted to NC Medicaid, and 835 files received back from NC Medicaid through the NCTracks system. Approved and paid encounters are submitted to NCTracks. The NCTracks 835 file from NCTracks is used to review denials. The extraction, submission and reconciliation of encounter data are fully automated. Eastpointe manually resubmits NCTracks-denied encounter data. During the Onsite, Eastpointe mentioned that Eastpointe developed a report to identify encounters that need to be resubmitted. Eastpointe is working with Wellsky to automate the reconciliation process.

Wellsky updates and maintains details on encounters that are extracted for encounter data submission on 837 files and the response 835 files. Eastpointe uses tracking spreadsheets to verify that a response 999 file was received for all files submitted to NCTracks. Eastpointe uses paid and denied reports to identify, research, and correct denied encounters for resubmission. Eastpointe also uses an internal report to identify claims not submitted to NCTracks or denied and not resubmitted. Eastpointe manually reviews and resubmits denied encounters weekly.

Table 2 shows the breakdown of encounter data acceptance/denial rates provided for the 2017 year compared with 2016.

Table 2: Volume of 2016 and 2017 Submitted Encounter Data

2017	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	98,319	18,114	2,458	118,891
Professional	1,558,893	161,105	165,957	1,885,955
2016	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	10,344	12	368	10,724
Professional	457,202	1,389,009	632,122	2,478,333

As of December 2017, Eastpointe had a 92% encounter acceptance rate. Eastpointe explained that the low encounter acceptance rate was mainly attributed to invalid taxonomy codes. Currently, Eastpointe has edits in place to check taxonomy codes prior to encounter submission. Eastpointe also advised providers to correct and resubmit claims. During the Onsite, Eastpointe explained that their efforts to identify and correct errors related to taxonomy codes resulted in removing invalid taxonomy codes from

among their top five denial reason codes. Eastpointe also advised that they improved their encounter acceptance rate to 98.5% in September 2018. The reduction in encounter denial rates was attributed to their effort to suspend claims from providers that were terminated in NCTracks. Eastpointe is also pending the claims of providers with incorrect billing/rendering NPI that would be denied by NCTracks and not submitted in encounter data extracts. Eastpointe indicated that the three top denial reason codes were:

1. Billing provider must be enrolled
2. Taxonomy of attending/rendering provider is missing or invalid
3. Possible duplicates

During the Onsite, Eastpointe explained that 25% of all encounters submitted in 2016 were denied and not resubmitted to NCTracks. This was due to NC Medicaid's advice to Eastpointe to not resubmit the encounters because of system edits in place would deny all the encounters. Eastpointe is working with NC Medicaid to resubmit the encounters.

On average, it takes Eastpointe 15 days to correct and resubmit an encounter to NCTracks. When a claim denial is returned to Eastpointe from NCTracks via the incoming 835 file, depending on the denial reason code the Eastpointe Encounters Team coordinates with other departments and the billing provider to correct and resubmit the encounters.

Currently, Eastpointe does not submit all the secondary diagnosis codes to NCTracks. For both institutional and professional encounters, Eastpointe submits no more than two diagnosis codes. Twenty-five ICD-10 diagnosis codes for institutional encounters and 12 ICD-10 diagnosis codes for professional encounters are the maximum number of diagnosis codes that may be submitted on an 837I and 837P, respectively and the maximum number that NCTracks captures. Eastpointe does not have the capability to submit to NCTracks with all the possible 837I and 837P diagnosis codes. During the Onsite, Eastpointe indicated that the health plan and Wellsky are testing additional secondary diagnosis codes, including physical health diagnosis codes, on encounter data extracts to NC Medicaid. After successfully testing the encounter data extracts, Eastpointe will apply the change to submit all secondary diagnosis codes.

Figure 2 provides an overview of 2017 scores compared to 2018 scores.

Figure 2: Administration Comparative Findings

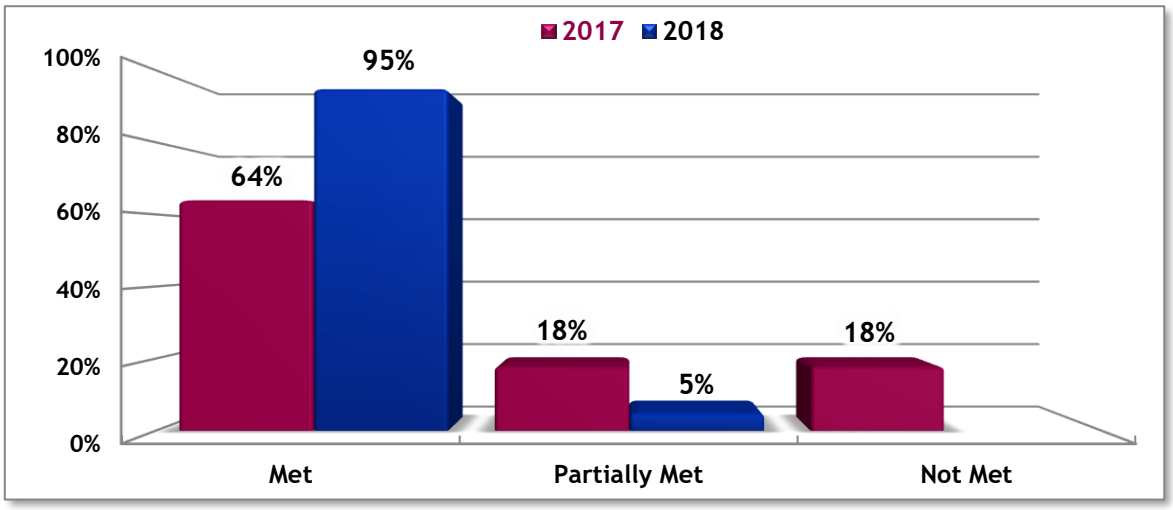


Table 3: Administration

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

Strengths

- Eastpointe described working with providers, shelter staff, first responders and a neighboring PIHP to support their enrollees and overall community during hurricane Florence and the ongoing recovery efforts.
- Dr. Sid Hosseini began as Eastpointe's full time Medical Director in May 2018. Dr. Hosseini brings over 25 years of psychiatry experience to Eastpointe.
- Eastpointe has a comprehensive enrollment, claim processing and reporting system.
- Eastpointe can merge multiple member records and link the member's historical claims data to the merged member record.
- Eastpointe reconciles the monthly payment received per member with the 820 Capitation file.
- Eastpointe's current NCTracks encounter acceptance rate is approximately 98.5%. The PIHP significantly improved the acceptance rate of encounter data submissions.
- Eastpointe can receive, store and report ICD-10 procedure and DRG codes.

- Enrollment, claims and IT staff are knowledgeable about their processes and are dedicated to improving encounter data submissions and reducing the number of denials.
- Eastpointe has effective business continuity and disaster recovery plans. Though the hurricane in September 2018 affected Eastpointe, there was no disruption of business processes and services.

Weaknesses

- When comparing this sample of policies (63 policies or 20%) to the *Policy and Procedure List* and the *P&P Manual Table of Contents*, 15 (or 24%) of the sample had incorrect information such as mis-numbered policies, missing policies and/or typos within the two tracking lists.
- Dr. Doniparthi is not represented on the organizational chart as outlined in her job description and described during the Onsite. Her title is also inconsistent across the organizational chart and within committee minutes.
- The organizational chart did not consistently reflect all staff degrees and licensure.
- Eastpointe submits only up to two diagnosis codes on both institutional and professional encounter data extracts.
- Eastpointe captures up to 24 ICD-10 diagnosis codes on institutional claims submitted on an 837I. 25 ICD-10 diagnosis codes are the maximum number of diagnosis codes that may be submitted on an 837I.
- Eastpointe does not submit physical health secondary diagnosis codes to NCTracks.
- Eastpointe is manually resubmitting corrected encounters to NCTracks. This may cause delays in resubmission of encounters.
- Approximately 25% of encounters submitted in 2016 were denied and not resubmitted to NCTracks.

Corrective Action

- Update Eastpointe's encounter data submission process to allow for all ICD-10 diagnosis codes submitted on an institutional and professional 837 HIPAA file and Provider Web Portal to be submitted to NCTracks. Twenty-five ICD-10 diagnosis codes are the maximum number of diagnosis codes that may be submitted on an 837I and the maximum number that is captured by NCTracks. NCTracks can capture up to 12 diagnosis codes for professional claims.

Recommendations

- Reconcile the two tracking lists to ensure all policies are accounted for and all dates (revised/review dates and original effective dates) and policy labels are accurate and consistent within these two tracking documents.
- Ensure Dr. Doniparthi's title and departmental oversight are consistent with her job description within the organizational chart and committee minutes.
- Ensure the organizational chart reflects staff degrees and licensure consistently throughout the chart.
- Capture all ICD-10 diagnosis codes submitted by the provider on a claim.
- Submit all secondary ICD-10 diagnosis codes providers include on their submitted claims to NCTracks.
- Develop a process that would allow the batch resubmission of specific denial reasons.
- Work with NC Medicaid to resubmit the 2016 encounters previously denied, to the degree that is possible.

B. Provider Services

Eastpointe's Provider Services External Quality Review (EQR) is comprised of Credentialing and Recredentialing, and Network Adequacy (including Provider Accessibility, Provider Education, Clinical Practice Guidelines for Behavioral Health Management, Continuity of Care, and Practitioner Medical Records). CCME reviewed relevant policies, the *Provider Credentialing Operations Manual/Plan* (submitted as the Credentialing Program Description), credentialing/recredentialing files, provider orientation materials, the *Provider Operations Manual*, Credentialing Committee meeting minutes, provider network information, the Clinical Practice Guidelines, the *2018 Eastpointe LME-MCO Community Mental Health, Substance Use and Developmental Disabilities Services Needs and Gaps Analysis* (*Gaps Analysis*) and the Eastpointe website.

The *Provider Credentialing Operations Manual/Plan* (the *Credentialing Manual*), the *Credentialing Committee Bylaws,* and several policies guide the credentialing and recredentialing processes. Eastpointe delegates pre-screens, criminal record checks, primary source verification (PSV), and continuous monitoring, including the monthly checks, to Medversant Technologies, a Credentials Verification Organization (CVO). CCME's review of the credentialing/recredentialing files showed they were organized and contained appropriate information. Details regarding identified issues are contained in the Tabular Spreadsheet.

Dr. Venkata Doniparthi, a board-certified psychiatrist, is listed as a "Consultant" on the "Clinical Operations" chart on the organization chart. Onsite discussion confirmed she lives in Texas and is under contract for "Medical Director Consultant services."

The *Credentialing Manual* indicates the voting membership of the Credentialing Committee includes representation from the PIHP as well as external representatives. External membership of the committee includes an "Active Participating I/DD Network member, Three Active Participating Network Practitioners, representing the PIHP Provider Network from the following types: Psychiatrist, Licensed Clinical Social Worker, PhD or PsyD Psychologist, Licensed Substance Abuse professional, Licensed Professional Counselor, and any other qualified North Carolina licensed professional." Current Eastpointe voting members of the committee are Dr. Doniparthi, the Chief of External Operations, the Director of Network Operations, and the Provider Monitoring Director. Two Eastpointe Credentialing Specialists are non-voting members.

No chair for the Credentialing Committee is listed on the *Committee Membership Matrix*, but the *Credentialing Manual* states the Credentialing Committee is chaired by the Associate Medical Director. There is no "Associate Medical Director" on the organization chart. The Credentialing Committee meeting minutes indicate meetings are called to order by the Chief of External Operations (Karen Salacki, LCSW, until her retirement at the end of June 2018, when she was replaced by Victoria Jackson, LCSW, who was the Chief of Clinical Operations). Onsite discussion confirmed Dr. Doniparthi chairs the committee meetings.

Page 7 of the *Credentialing Manual* states "A quorum shall consist of 50% of the identified voting members of the Committee. At least one external member must be present at each meeting. The meeting will not occur if the Medical Director is not present at the meeting." However, the Medical Director is not a member of the Credentialing Committee and does not attend the meetings.

The *Credentialing Manual* indicates the committee meets at least quarterly or more frequently at the discretion of the Chair. A review of the minutes shows the committee met monthly from September 2017 through August 2018, except for October 2017, when there was no meeting. The *Credentialing Manual* states meetings can be conducted face-to-face, telephonically, or by webinar. All 11 meetings from September 2017 through August 2018 were held by webinar, and staff confirmed during Onsite discussion that all meetings are held by webinar.

A quorum of voting members was present for ten of the eleven meetings. Votes for that meeting (June 22, 2018) were taken electronically, after the meeting. Attendance of the Eastpointe employees who are voting members ranged from 72% to 100% of the meetings

at which they were a member. Attendance of the provider representative members ranged from 45% to 91% of the meetings at which they were a member.

The minutes of the August 24, 2018 committee meeting note "Victoria Jackson stated the By-Laws has an error on Page 2, instead of a Quorum shall consist of 50% it should be 50% plus one. The change was asked to be made and send (*sic)* to the Committee for Electronic Vote." The definition of quorum also needs to be changed in the *Provider Credentialing Operations Manual/Plan*.

Credentialing Committee meeting minutes have several issues, including that items listed as "Pended" at one meeting are often never mentioned again. During Onsite discussion, Victoria Jackson reported that, when the relevant information is received, it is sent to committee members for a vote and the case would be included in the *Approval of Electronic Votes since the Last Meeting* list presented at the next committee meeting. The lists of *Approval of Electronic Votes since the Last Meeting* were not submitted for the EQR.

Additional issues with the meeting minutes include that they often don't reflect details of why the file is brought to the Credentialing Committee, and they frequently include no evidence of discussion of the applications. In at least one case, the "Comments" on the meeting minutes appeared to indicate the final decision would be made by Dr. Doniparthi, and in at least one other case, nothing in the minutes indicated why the file was pended. The minutes of the June 22, 2018 meeting reference votes that occurred on June 26, 2018, four days after the meeting occurred.

The *2018 Eastpointe Gaps Analysis* indicates Eastpointe met all choice and location standards, and no Exception Requests were filed. The Executive Summary of the *2018 Gaps Analysis* states "100% of Medicaid members have access to a single Opioid Treatment provider and 89.8% of all Medicaid members have choice of a second provider." Medicaid members with only a single Opioid Treatment provider reside in Wayne, Robeson or Columbus counties. Columbus county disengaged from Eastpointe and joined another PIHP. Efforts to expand Opioid Treatment are underway in Wayne and Robeson counties. The *2018 Gaps Analysis* reports "Achievement highlights", including continued progress on the community kiosk program, providing Crisis Intervention Team (CIT) trainings in all counties, and expansion of providers for key services.

Figure 3 shows 1% of the standards in the Provider Services section were scored as "Not Met", while 6% were scored as "Partially Met". The "Not Met" item was in Credentialing. The "Partially Met" scores were in the areas of Credentialing/ Recredentialing, and Practitioner Accessibility.

Figure 3: Provider Services Findings

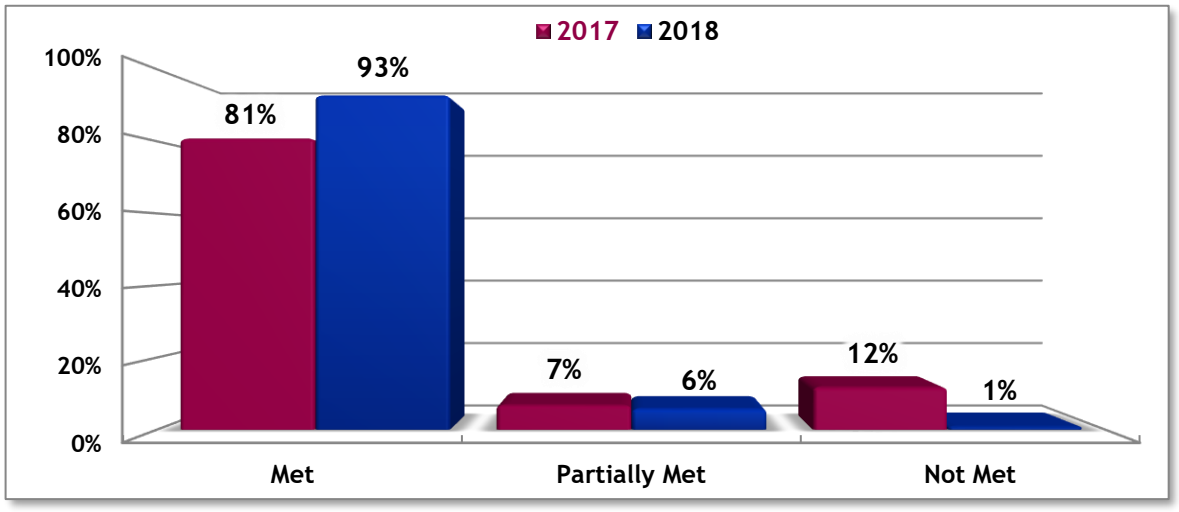


Table 4: Provider Services

Section	Standard	2017 Review
Credentialing and Recredentialing	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.	Partially Met
	Verification of information on the applicant, including: • Valid DEA certificate	Not Met
	• Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	Partially Met
Recredentialing	Verification of information on the applicant, including: • Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	Partially Met
Practitioner Accessibility	The PIHP formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	Partially Met

Strengths

- Eastpointe provides a Network Operations Call Center with a dedicated toll-free number to assist providers with questions. Network Operations also has a designated email address.
- Credentialing/recredentialing files are organized and contain appropriate documentation.
- The *2018 Eastpointe LME-MCO Community Mental Health, Substance Use and Developmental Disabilities Services Needs and Gaps Analysis* reports choice and access standards are met for 100% of Eastpointe's members, though 10.2% of Medicaid members only had access to one Opioid Treatment provider.

Weaknesses

- There is conflicting information in the *Provider Credentialing Operations Manual/Plan* and the *Credentialing Committee Bylaws*. See information in the Tabular Spreadsheet.
- Credentialing Committee meeting minutes lack documentation of needed elements, as outlined in the Tabular Spreadsheet.
- Some of the submitted credentialing/recredentialing files did not contain current PSVs of licensure, a Drug Enforcement Agency (DEA) certificate, accreditation, NC Department of Health Service Regulation (DHSR) licensure or were missing proof of some types of insurance or other items. Items were submitted in response to the *Onsite Request List*. Some of the PSVs submitted for the Desk Review were illegible or did not include the date of the query.
- No evidence of a query of *The North Carolina Medicaid Provider Termination and Exclusion list* (known as the *State Exclusion List*) was found in any practitioner credentialing or recredentialing files. During the Onsite Review, Eastpointe staff confirmed they have not been completing this query for credentialing, recredentialing or as part of the monthly checks and have now added it to the *Credentialing and Credentialing Checklists*.
- The previous recredentialing of one practitioner was approved for only one year. The current recredentialing of this practitioner was approved about three weeks after the one-year timeframe expired. Another file out of twelve recredentialing files was recredentialed almost three months late.
- Organizational credentialing and recredentialing files do not include PSV of NC DHSR licensure and/or accreditation.
- The *October 17, 2018 Provider Meeting PowerPoint* presentation has incorrect information regarding the timeframe for provision of emergency care and regarding the timeframe for delivery of routine care.

- There are several incorrect links in the *Getting Started* document that is posted on the Eastpointe website and was submitted in Desk Materials, in folder *28, New Provider Information*.
- The link in the *Provider Operations Manual* to the *Claims Manual* goes to an error page.
- As was the case at the last EQR, the October 7, 2015 letter titled *Eastpointe Adopted Clinical Practice Guidelines,* posted on the Eastpointe website provides incorrect information about the location of the Clinical Practice Guidelines on the Eastpointe website. The letter states the guidelines "can be found in the center of the page on the Eastpointe website under Provider Community/Medicaid Utilization Review." The referenced location does not exist on the Eastpointe website.
- The *Provider Operations Manual* and *Policy Q-6.3.27, Enrollee Medical Record Maintained by Providers*, reference the *Basic Medicaid Billing Guide*, as defined in the *DMA Contract Attachment B, Section 8.2*. However, *The Basic Medicaid Billing Guide* has now been replaced by the *NCMMIS Provider Claims and Billing Assistance Guide*.

Corrective Actions

- Ensure Credentialing Committee meeting minutes and documentation include evidence of discussion prior to votes, and that minutes reflect closure of items that are "pending" for information. Revise the *Credentialing Committee Bylaws*, the *Provider Credentialing Operations Manual/Plan* and any other documents that detail credentialing processes to accurately reflect the Chair of the committee and committee processes, and to eliminate conflicting information across documents. If meeting minutes are changed, mark them as "Amended".
- Ensure recredentialing files contain all items, including the PSV of the DEA certificates. See *DMA Contract Attachment O*.
- Revise the *Credentialing Manual*, *Policy E-4.4.17* (and any other documents that list queries to be conducted) to include the query of the *State Exclusion List*.
- Verify all credentialing and recredentialing files include documentation of the query of the *State Exclusion List*. See *DMA Contract Attachment B, Sections 1.14.4 and 7.6.4*.
- Correct the *October 17, 2018 Provider Meeting PowerPoint* (and any other documents that list the timeframes for access to care) to reflect the standards listed in the *DMA Contract Attachment S*, including 2 hours for emergency care, 1 hour for life-threatening emergencies, and 14 calendar days (not 10 business days) for routine appointments.

Recommendations

- Verify credentialing and recredentialing files contain all required information and PSVs. Specific recommendations are included in Attachment 4, the Tabular Spreadsheet.
- If Eastpointe does not keep a copy of the relevant Certificate of Insurance (COI) or waiver in the individual credentialing file, copies must be made available for the credentialing file review. If the practitioner is not named on the COI, a letter from the agency provider or insurance company indicating that the practitioner is covered under the policy is acceptable. See *DMA Contract, Attachment B, Section 7.7*.
- If a location is licensed by NC DHSR and/or if accreditation is required, conduct (or ensure the CVO conducts) the relevant PSV(s) and retain dated documentation (screenshot of the website or web posting) of the accreditation and of the licensure. See *DMA Contract Attachment B, Section 7.9*.
- Check the links in the *Getting Started* document and correct the links that are incorrect.
- Ensure links in the *Provider Operations Manual* to the *Eastpointe Claims and Billing Manual FY 18/19* on Eastpointe's website are accurate and operable. Include a statement in the *Provider Operations Manual* that providers can download a copy from the website or request a copy from Eastpointe.
- Correct the reference in the October 7, 2015 letter (titled *Eastpointe Adopted Clinical Practice Guidelines) on* the Eastpointe website to direct providers to the correct section of the Eastpointe website to access the Clinical Practice Guidelines. See *DMA Contract Attachment B, Section 7.4*.
- Update/replace all references to *The Basic Medicaid Billing Guide*, which was replaced by the *NCMMIS Provider Claims and Billing Assistance Guide*.

C. Enrollee Services

The Enrollee Services Review included policies, the *Member Call Center Manual,* the *Enrollee/Member and Family Handbook*, enrollee educational materials, information on enrollee rights, the *Provider Operations Manual*, and the Eastpointe website.

The Call Center is led by Victoria Jackson, LCSW, Chief of External Operations. Katina Dial-Scott, LPC, is the Director of the Call Center, which is in Lumberton, NC. Unlicensed Call Center Referral Coordinators answer calls, complete enrollment information, and conference in a licensed Call Center Clinician when clinically applicable. Call Center Referral Coordinators offer provider choice and schedule appointments via the Slot Scheduler, which displays provider availability. A detailed *Member Call Center Manual* and several policies provide direction for Call Center functions.

Call Center metrics are being met. During the Onsite discussion, Call Center staff reported the Call Center is adequately staffed to ensure enrollees never have to leave a message. Eastpointe's vendor, Cardinal Innovations, handles call coverage when Eastpointe is offline and for roll-over call coverage, if needed. CCME's review of the *Enrollee/Member and Family Handbook* and the *Member Call Center Manual* reveals several different titles/references for the "Call Center," "Access to Care Call Center," "The Access Care Center, and "Member Call Center." CCME recommends using one standard name for the Call Center.

Eastpointe sends a letter to all new Medicaid enrollees in their catchment area, advising them to contact Eastpointe for any behavioral health needs. The letter includes the Call Center toll-free telephone number and the website address, and it informs enrollees about the *Enrollee/Member and Family Handbook*, including how to obtain a copy.

Enrollees who contact the Call Center with an initial service request receive a welcome packet, available in English or Spanish, within 14 days of the request. The packet includes the *Welcome Letter*, *the Enrollee/Member Rights and Responsibilities* brochure, several additional brochures about available behavioral health services, and information about advance directives. The *Welcome Letter* references the *Enrollee/Member and Family Handbook* and the Eastpointe website.

The *Provider Directory*, the *Enrollee/Member and Family Handbook*, and a variety of brochures, including materials in Spanish, are available on the Eastpointe website. Review and Onsite discussion around the *Provider Directory* and the *Enrollee/Member and Family Handbook* resulted in CCME recommendations and corrective actions. The website offers a calendar with several enrollee and community trainings available.

During the Onsite discussion, staff described available trainings and verified that training attendance is tracked and kept via a sign-in sheet.

Figure 4 shows 89% of the standards in the Enrollee Services section were scored as "Met." 11% of the standards were scored as "Partially Met" which related to enrollee program education within the *Provider Directory* and the *Enrollee/Member and Family Handbook*. There were no standards which scored a "Not Met."

Figure 4: Enrollee Services Findings

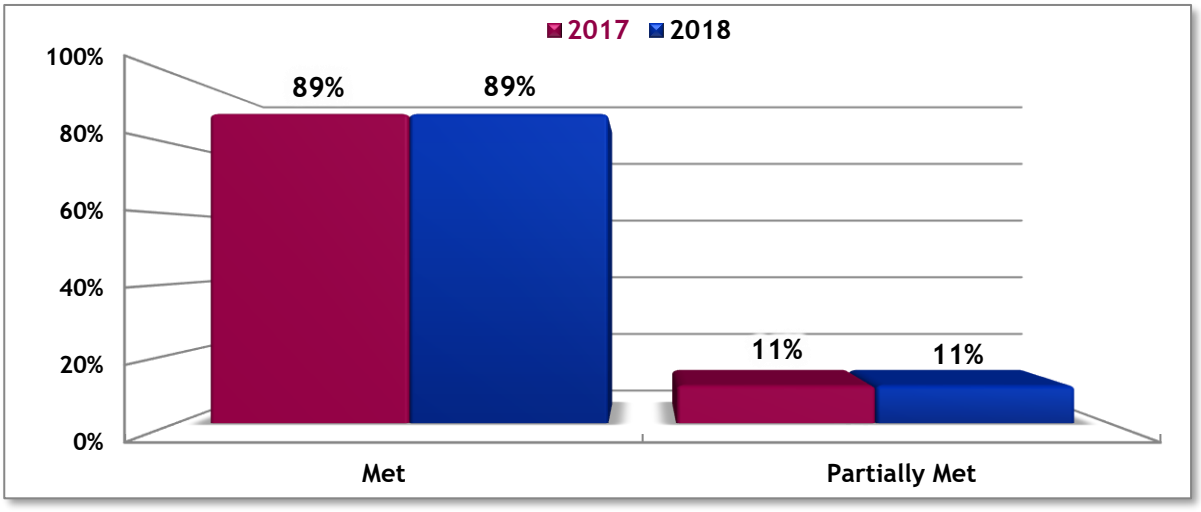


Table 5: Enrollee Services

Section	Standard	2018 Review
Enrollee PIHP Program Education	Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid waiver managed care program which they are contractually entitled, including: • Where to find a list or directory of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients (a written list of current Network Providers shall be provided by PIHP to any Enrollee upon request); • The fact that prior authorization is not required for emergency services; • The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under the contract; • Procedures for obtaining out-of-area or out-of-state coverage or services, if special procedures exist;	**Partially Met**
	Enrollee program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation of prevalent non-English languages as required by the contract.	**Partially Met**

Strengths

- All enrollee rights were clearly documented in enrollee educational materials.
- "Whole Person Model and Integrated Care" initiative is on the website listing providers currently participating in this initiative.
- The website offers a calendar with several enrollee and community trainings available. Onsite, staff described the enrollee offerings and verified that training attendance is tracked and kept via a sign-in sheet.

Weaknesses

- The online Provider Directory has a statement that all providers are accepting new patients in a banner at the top. But the printed Provider Directory has several "NO" indications in the field of "Accepting New Patients." The providers with NO's in the printed document are also in the online version. Onsite discussion revealed that the printed Provider Directory is generated from the online version and fields can be added depending on the amount of information that is requested. A printed copy is generated at the time of the enrollee request. At last EQR, only the providers accepting new patients were to be in the online version.
- A hard copy of Provider Directory in Desk Materials does not have non-English language, if any, spoken by providers. The online Provider Directory has fields for "Cultures Served" and "Languages Served." This doesn't indicate the non-English language spoken by the provider.
- Page 19 of the Enrollee/Member and Family Handbook under "Crisis Services," states "In cases where the care that is needed is emergent, a quick request for authorization, if necessary, is available 24 hours a day, 7 days a week. Medical necessity criteria must be established by the provider along with other clinical information. Eastpointe has created an environment that supports rapid access for many crisis services to prevent unnecessary inpatient hospitalization."
- Post Stabilization is defined on page 25 of the Enrollee/Member and Family Handbook. No locations are mentioned where Post Stabilization services are available.
- The Enrollee/Member and Family Handbook and other enrollee materials do not contain information on obtaining out-of-area or out-of-state coverage of services. Page 28 of the Enrollee/Member and Family Handbook provides information about receiving services from out-of-network providers.
- There are three ways to file a grievance about privacy practices documented on page 52 of the Enrollee/Member and Family Handbook. None of the three ways tells the enrollee to call the Access to Care Line. There is another section telling enrollees

about Grievance and Appeals on pages 28 – 30 of the *Enrollee/Member and Family Handbook*.

- Documentation from Eastpointe to providers and enrollees was reviewed on five terminated providers. Three of the providers have letters that were sent to enrollees. The other two providers didn't have patients currently being served. None of the enrollee letters tell the enrollee the date when the provider's service ends. They all say "(provider name) is, at this time, unable to provide the service you receive in our area. You will need to choose another provider." Page 20 of the *Enrollee/Member and Family Handbook* addresses both items in this standard.
- The light grey type on the website is hard to see.
- The *Enrollee/Member and Family Handbook* is written in a complex manner and some topic areas are spread out in different sections of the document making is hard to find all information on a specific topic.

Examples of information spread out in different sections include:

- Grievances/Appeals is in one section and how to report a Grievance on privacy issues is in a different section.
- Information on Emergency Care / Crisis is in several different sections. Some examples include:
  - What is a Crisis Plan? (page 35)
  - Crisis Services (page 19 – this is the area with the incorrect reference to needing authorization in an emergency.)
  - What do I do in an Emergency? (page 25)
  - Mobile Crisis Services (pages 25-26)

Examples of information written in a complex manner include:

- What is an Advanced Access Agency? To become an Advanced Access Agency, a Critical Access Behavioral Health Agency (CABHA) must serve at least two disability groups and provide five different services, including emergency services. (pages 26-27)
- When receiving substance use services, Federal law allows disclosure in the following situations, (page 49)
- When receiving services other than substance use, State law requires disclosure in specific situations that include, but are not limited to… (page 50)

Corrective Action

- Update the online *Provider Directory* in a way that all enrollees can see which providers are "Accepting New Patients." Include this indication as a field on the printed *Provider Directory* when it is generated.
- Emergent care for a member cannot require "a quick request for authorization." Remove this documentation from page 19 of the *Enrollee/Member and Family Handbook*.
- Within enrollee written materials, add examples of where post stabilization services are available.
- In the *Enrollee/Member and Family Handbook* add how members obtain out-of-area and out-of-state coverage of services. This is different from out-of-network coverage.
- More discussion at Eastpointe is needed to decide the best way to make improvements in the *Enrollee/Member and Family Handbook regarding information* written in a complex manner and some topic areas spread out in different sections of the document making is hard to find all information on a specific topic. This may be an internal workgroup that looks at all the documentation that needs to be included and consolidates that information based on information enrollees need. Please provide the plan you will initiate as part of the Corrective Action Plan (CAP) process.

Recommendations

- Clearly indicate the non-English languages spoken by providers in all versions of the Provider Directory.
- Consolidate documentation on Grievances and appeals for the enrollee in the Enrollee/Member and Family Handbook.
- Inform the enrollees, in written communication, of the date when the provider will no longer be in the network.
- Consider changing the light grey type on the website to an easier to read, darker color.

D. Quality Improvement

Eastpointe's *FY 2019 Quality Improvement Plan and Program Description* outlines a plan for measuring and improving the care and services received by enrollees and providers. Sid Hosseini, DO, serves as the Medical Director and provides support for the Quality Management (QM) program.

Jeanette Jordan-Huffam is the Chief of Quality Management. Cordelia Chavis and Anna North report to Ms. Jordan-Huffam. Ms. Chavis serves as the Director of Quality Improvement (QI). Four positions report to Ms. Chavis: three QI Specialists and one

Administrative Assistant. Ms. North serves as the Data Analytics Director/Waiver Contract Manager and has three QM Data Analyst reporting to her, although, one Data Analyst position is vacant.

During this review period a Cross Functional Workgroup started to develop a process to implement and monitor Clinical Practice Guidelines. The workgroup completed data analysis on the highest utilized diagnosis among two enhanced services: Intensive In Home (IIH) and Community Support Team (CST). Analysis revealed Conduct Disorder and PTSD was highest utilized for IIH. Bipolar Disorder and Depressive Disorders was highest utilized for CST. Clinical Tags were added to the Service Authorization Request (SAR) to capture providers who adhere to Clinical Practice Guidelines Information was shared to providers at the August 2018 Provider Meeting.

Providers are not currently required to complete individual performance improvement projects (PIPs). CCME recommends Eastpointe Develop and implement a written plan and process that will hold providers accountable for individual quality improvement projects (QIPs). Add provider QIP monitoring to that process and include feedback to providers on individual QIPs they will be doing.

Eastpointe has mechanisms to detect and document under and over utilization of medical services as required by the contract. Although, there is no evidence of monitoring or analysis of utilization data for over/underutilization. Documentation from meeting minutes and program evaluations should include evidence of monitoring rates, reasons/causes for over or underutilization, and the interventions or action steps that demonstrate how Eastpointe is addressing those reasons/causes of over or underutilization. The next step is to keep a file with each service, the monthly and quarterly reports, and updates on action steps being taken to address over and under-utilization, as applicable.

Eastpointe developed a *QI Work Plan FY19* which includes fields for Initiative, purpose, Goal/strategy, responsible department, responsible party, target date, status, completion data, quarterly review date, and date/actions taken. Ms. Chavis manages and updates the work plan quarterly. The QI Work Plan FY19 has several items with "mark throughs." Onsite interview defined the mark throughs as completed items.

The Global Quality Improvement Committee (GQIC) is granted authority by Eastpointe's executive team and is chaired by Dr. Hosseini. The committee did not meet at regular intervals. GQIC meetings reviewed occurred on these dates: 10/13/17, 11/3/17, 2/16/18, 6/15/18. Eastpointe changed the GQIC meeting interval to every other month starting with the August 2018 meeting. The committee includes members of the provider community and the Consumer and Family Advisory Committee (CFAC). A quorum was present for all meetings. Eastpointe is following their committee bylaws and holding

members accountable for attendance and replacing provider members when they are not able to consistently attend meetings. Meeting minutes are completed for the GQIC; discussion points are not documented on many of the meeting topics. CCME recommends Eastpointe capture GQIC Committee meeting discussions in the meeting minutes.

The June 2018 GQIC meeting included a discussion of completed child and adult surveys. The Power Point named, Eastpointe Composites 2017 ECHO Report Adult and Children, provided comprehensive results by comparing 2016 results to 2017 and Eastpointe to the state average. Results were also shared with providers.

No annual evaluation that covered July 2017 – June 2018 was uploaded at the time the Desk Materials were due. The document titled, *Strengthening our Communities 2018 Annual Report*, was presented Onsite and uploaded to the Desk Material at that time. This document was lacking many of the report features expected for an Annual Evaluation of the Quality Program. This is a different format from what was submitted for the last EQR. For the last EQR, the Annual Report FY 2016 was submitted. *Strengthening our Communities 2018 Annual Report* contains general and overall happenings at Eastpointe during the 2018 FY. The document is well done and highlights some positive outcomes from Eastpointe in FY 2018. It does not contain the following information:

- Analysis of the quality projects for FY 2018
- FY 2019 Strategy
- Information about what was implemented in 2018, if those implementation efforts were successful or not, what barriers still exist, and what will be changed with each project for the 2019 FY to effect change.
- Information about over and underutilization
- Overall summary of the Enrollee Surveys

Also, Eastpointe did not submit an annual evaluation of the QI program for FY 2017 this year or for last year's EQR.

Performance Measure Validation

As part of the EQR for Eastpointe, CCME conducted the independent validation of NC Medicaid-selected B and C waiver performance measures. The measures are listed in the tables that follow.

Table 6: B Waiver Measures

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

Table 7: C Waiver Measures

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

B Waiver Performance Measures

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

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

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

The reported results for these measures are included in the following tables. The percentage rate covers a time period of July 1, 2016 through June 30, 2017. As shown, there was a large decrease (10%) in FBC 30-day readmissions, which is a substantial improvement. There was also a strong improvement in Alcohol and Other Drug Dependence Treatment initiation rates for 13-17 year olds at 11.2%. Rates decreased for 30-day F/U after SA treatment for inpatient subgroup. Validation worksheets based on the CMS protocol for validating performance measures for each of the B waiver measures are provided in Attachment 3.

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

30-day Readmission Rates for Mental Health	2016	2017	Change
Inpatient (Community Hospital Only)	10.8%	9.3%	-1.50%
Inpatient (State Hospital Only)	3.7%	0.0%	-3.70%
Inpatient (Community and State Hospital Combined)	11.0%	9.5%	-1.50%
Facility Based Crisis	14.7%	4.3%	-10.40%
Psychiatric Residential Treatment Facility (PRTF)	9.4%	5.7%	-3.70%
Combined (includes cross-overs between services)	11.7%	10.2%	-1.50%

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

30-day Readmission Rates for Substance Abuse	2016	2017	Change
Inpatient (Community Hospital Only)	9.5%	11.5%	2.00%
Inpatient (State Hospital Only)	0.0%	0.0%	0.00%
Inpatient (Community and State Hospital Combined)	9.4%	11.3%	1.90%
Detox/Facility Based Crisis	6.2%	2.6%	-3.60%
Combined (includes cross-overs between services)	8.6%	9.3%	0.70%

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

Follow-up after Hospitalization for Mental Illness	2016	2017	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	35.2%	31.1%	-4.10%
Percent Received Outpatient Visit Within 30 Days	56.8%	52.4%	-4.40%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	30.0%	36.4%	6.40%
Percent Received Outpatient Visit Within 30 Days	45.0%	36.4%	-8.60%
PRTF			
Percent Received Outpatient Visit Within 7 Days	27.9%	21.5%	-6.40%
Percent Received Outpatient Visit Within 30 Days	52.9%	49.2%	-3.70%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	12.8%	8.9%	-3.90%
Percent Received Outpatient Visit Within 30 Days	30.1%	25.4%	-4.70%

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

Follow-up after Hospitalization for Substance Abuse	2016	2017	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NR
Percent Received Outpatient Visit Within 7 Days	16.9%	9.1%	-7.8%
Percent Received Outpatient Visit Within 30 Days	28.1%	17.6%	-10.5%

Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	33.0%	24.6%	-8.4%
Percent Received Outpatient Visit Within 7 Days	36.2%	30.8%	-5.4%
Percent Received Outpatient Visit Within 30 Days	48.9%	42.1%	-6.8%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NR
Percent Received Outpatient Visit Within 7 Days	21.6%	11.7%	-9.9%
Percent Received Outpatient Visit Within 30 Days	16.1%	20.6%	4.5%

*NR = *Denominator* is equal to zero.

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	2016	2017	Change
Ages 13–17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	49.2%	60.4%	11.20%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	47.2%	49.4%	2.20%
Ages 18–20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	46.8%	53.7%	6.90%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	31.7%	40.1%	8.40%
Ages 21–34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	58.3%	57.5%	-0.80%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	52.4%	51.4%	-1.00%
Ages 35–64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	62.4%	61.9%	-0.50%

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	2016	2017	Change
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	54.4%	52.6%	-1.80%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	74.1%	72.3%	-1.80%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	68.5%	59.5%	-9.00%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	59.4%	60.2%	0.80%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	52.2%	51.5%	-0.70%

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

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		2016	2017	Change	2016	2017	Change
3–12	Male	0.3	0.3	0.0	30.5	35.2	4.7
	Female	0.2	0.2	0.0	22.2	24.4	2.2
	Total	0.2	0.2	0.0	27.8	31.4	3.6
13–17	Male	1.3	1.1	-0.2	37.5	53.4	15.9
	Female	1.7	1.3	-0.4	24.5	33.2	8.7
	Total	1.5	1.2	-0.3	30.4	42.7	12.3
18–20	Male	1.9	1.5	-0.4	8.3	9.0	0.7
	Female	1.3	1.3	0.0	8.4	11.3	2.9
	Total	1.6	1.4	-0.2	8.3	10.1	1.8
21–34	Male	4.3	4.3	0.0	9.5	7.7	-1.8
	Female	1.6	1.5	-0.1	7.0	7.2	0.2
	Total	2.2	2.1	-0.1	8.1	7.4	-0.7
35–64	Male	3.0	2.9	-0.1	9.0	8.4	-0.6
	Female	2.1	2.3	0.2	8.7	7.8	-0.9
	Total	2.5	2.5	0.0	8.8	8.0	-0.8
65+	Male	0.3	0.4	0.1	8.8	22.2	13.4
	Female	0.2	0.4	0.2	11.6	15.9	4.3
	Total	0.3	0.4	0.1	10.6	17.9	7.3
Unknown	Male	0.0	0.0	0.0	0.0	0.0	0
	Female	0.0	0.0	0.0	0.0	0.0	0
	Total	0.0	0.0	0.0	0.0	0.0	0
Total	**Male**	**1.4**	**1.3**	**-0.1**	**16.1**	**18.0**	**1.9**
	Female	**1.1**	**1.1**	**0.0**	**12.0**	**12.7**	**0.7**
	Total	**1.2**	**1.2**	**0.0**	**14.0**	**15.1**	**1.1**

Table 14: D.2. Mental Health Utilization -% of Members that Received at Least 1 Mental Health Service in the Category Indicated during the Measurement Period

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
3-12	Male	13.40%	12.43%	-0.97%	0.24%	0.24%	0.00%	0.67%	0.68%	0.01%	13.24%	12.26%	-0.98%
	Female	9.05%	8.39%	-0.66%	0.14%	0.15%	0.01%	0.15%	0.15%	0.00%	9.02%	8.36%	-0.66%
	Total	11.27%	10.45%	-0.82%	0.19%	0.20%	0.01%	0.42%	0.42%	0.00%	11.17%	10.35%	-0.82%
13-17	Male	15.18%	13.78%	-1.40%	1.19%	1.05%	-0.14%	0.69%	0.59%	-0.10%	14.96%	13.61%	-1.35%
	Female	14.63%	13.66%	-0.97%	1.41%	1.22%	-0.19%	0.16%	0.15%	-0.01%	14.48%	13.52%	-0.96%
	Total	14.91%	13.72%	-1.19%	1.30%	1.13%	-0.17%	0.43%	0.38%	-0.05%	14.73%	13.57%	-1.16%
18-20	Male	10.13%	9.63%	-0.50%	1.46%	1.09%	-0.37%	0.02%	0.00%	-0.02%	9.85%	9.47%	-0.38%
	Female	11.23%	10.62%	-0.61%	1.02%	1.14%	0.12%	0.00%	0.03%	0.03%	11.05%	10.31%	-0.74%
	Total	10.72%	10.16%	-0.56%	1.23%	1.12%	-0.11%	0.01%	0.01%	0.00%	10.49%	9.91%	-0.58%
21-34	Male	22.67%	23.00%	0.33%	3.24%	3.40%	0.16%	0.02%	0.05%	0.03%	22.38%	22.64%	0.26%
	Female	17.51%	17.02%	-0.49%	1.33%	1.22%	-0.11%	0.00%	0.01%	0.01%	17.36%	16.82%	-0.54%
	Total	18.69%	18.34%	-0.35%	1.77%	1.70%	-0.07%	0.00%	0.02%	0.02%	18.51%	18.10%	-0.41%
35-64	Male	18.91%	19.12%	0.21%	2.13%	2.28%	0.15%	0.01%	0.02%	0.01%	18.58%	18.76%	0.18%

	Female	22.27%	22.41%	0.14%	1.80%	1.96%	0.16%	0.02%	0.04%	0.02%	22.12%	22.10%	-0.02%
	Total	20.98%	21.16%	0.18%	1.93%	2.08%	0.15%	0.01%	0.03%	0.02%	20.75%	20.83%	0.08%
65+	**Male**	4.12%	5.35%	1.23%	0.27%	0.35%	0.08%	0.00%	0.00%	0.00%	3.95%	5.31%	1.36%
	Female	4.19%	5.36%	1.17%	0.23%	0.38%	0.15%	0.01%	0.01%	0.00%	4.11%	5.19%	1.08%
	Total	4.17%	5.36%	1.19%	0.24%	0.37%	0.13%	0.01%	0.01%	0.00%	4.06%	5.22%	1.16%
Unknown	**Male**	66.67%	1.18%	-65.5%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	66.67%	1.18%	-65.49%
	Female	76.60%	0.00%	-76.6%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	76.60%	0.00%	-76.60%
	Total	72.29%	0.59%	-71.7%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	72.29%	0.59%	-71.70%
Total	**Male**	**14.53%**	**13.87%**	**-0.66%**	**1.06%**	**1.04%**	**-0.02%**	**0.41%**	**0.40%**	**-0.01%**	**14.30%**	**13.67%**	**-0.63%**
	Female	**13.65%**	**13.38%**	**-0.27%**	**0.93%**	**0.95%**	**0.02%**	**0.07%**	**0.08%**	**0.01%**	**13.54%**	**13.21%**	**-0.33%**
	Total	**14.02%**	**13.59%**	**-0.43%**	**0.99%**	**0.99%**	**0.00%**	**0.22%**	**0.22%**	**0.00%**	**13.86%**	**13.40%**	**-0.46%**

Table 15: D.3. Identification of Alcohol and Other Drug Services

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
3–12	Male	0.10%	0.05%	-0.05%	0.00%	0.00%	0.00%	0.02%	0.02%	0.00%	0.09%	0.04%	-0.05%
	Female	0.07%	0.04%	-0.03%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%	0.06%	0.04%	-0.02%
	Total	0.08%	0.05%	-0.03%	0.00%	0.00%	0.00%	0.01%	0.02%	0.01%	0.07%	0.04%	-0.03%
13–17	Male	2.05%	2.52%	0.47%	0.05%	0.01%	-0.04%	1.31%	1.80%	0.49%	1.12%	0.99%	-0.13%
	Female	1.02%	1.39%	0.37%	0.01%	0.01%	0.00%	0.57%	1.01%	0.44%	0.61%	0.43%	-0.18%
	Total	1.55%	1.97%	0.42%	0.03%	0.01%	-0.02%	0.95%	1.42%	0.47%	0.87%	0.72%	-0.15%
18–20	Male	4.99%	3.74%	-1.25%	0.34%	0.28%	-0.06%	1.26%	1.81%	0.55%	2.20%	2.42%	0.22%
	Female	2.08%	2.99%	0.91%	0.21%	0.23%	0.02%	0.77%	1.45%	0.68%	1.81%	1.76%	-0.05%
	Total	3.44%	3.34%	-0.10%	0.27%	0.25%	-0.02%	1.00%	1.62%	0.62%	1.99%	2.07%	0.08%
21–34	Male	7.19%	8.63%	1.44%	0.63%	0.87%	0.24%	1.74%	1.95%	0.21%	6.43%	8.07%	1.64%
	Female	6.47%	7.10%	0.63%	0.43%	0.49%	0.06%	1.97%	1.98%	0.01%	5.99%	6.62%	0.63%
	Total	6.63%	7.43%	0.80%	0.48%	0.58%	0.10%	1.92%	1.97%	0.05%	6.09%	6.94%	0.85%
35–64	Male	6.92%	8.32%	1.40%	0.64%	0.83%	0.19%	2.00%	2.69%	0.69%	6.27%	7.54%	1.27%
	Female	5.07%	5.98%	0.91%	0.36%	0.33%	-0.03%	1.60%	1.92%	0.32%	4.57%	5.51%	0.94%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	Total	5.78%	6.87%	1.09%	0.47%	0.52%	0.05%	1.75%	2.21%	0.46%	5.22%	6.28%	1.06%
65+	Male	1.30%	1.68%	0.38%	0.16%	0.12%	-0.04%	0.36%	0.47%	0.11%	1.08%	1.54%	0.46%
	Female	0.28%	0.48%	0.20%	0.02%	0.03%	0.01%	0.07%	0.22%	0.15%	0.26%	0.38%	0.12%
	Total	0.58%	0.84%	0.26%	0.06%	0.06%	0.00%	0.16%	0.29%	0.13%	0.50%	0.73%	0.23%
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**	**2.64%**	**2.96%**	**0.32%**	**0.20%**	**0.24%**	**0.04%**	**0.85%**	**1.12%**	**0.27%**	**2.07%**	**2.39%**	**0.32%**
	Female	**2.56%**	**3.00%**	**0.44%**	**0.17%**	**0.18%**	**0.01%**	**0.83%**	**1.02%**	**0.19%**	**2.29%**	**2.60%**	**0.31%**
	Total	**2.59%**	**2.99%**	**0.40%**	**0.19%**	**0.20%**	**0.01%**	**0.83%**	**1.06%**	**0.23%**	**2.19%**	**2.51%**	**0.32%**

Table 16: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	3-12			13-17			18-20			21-34		
Bladen	0.10%	0.07%	-0.03%	1.07%	1.16%	0.09%	2.08%	1.76%	-0.32%	3.36%	4.72%	1.36%
Columbus	0.02%	0.02%	0.00%	1.07%	0.68%	-0.39%	1.63%	2.32%	0.69%	5.70%	6.01%	0.31%
Duplin	0.00%	0.00%	0.00%	0.31%	0.23%	-0.08%	0.97%	0.59%	-0.38%	2.96%	3.00%	0.04%
Edgecombe	0.02%	0.00%	-0.02%	1.13%	0.88%	-0.25%	1.56%	1.90%	0.34%	6.78%	4.42%	-2.36%
Greene	0.00%	0.06%	0.06%	0.24%	0.25%	0.01%	2.52%	2.84%	0.32%	5.19%	3.90%	-1.29%
Lenoir	0.03%	0.07%	0.04%	1.10%	1.68%	0.58%	2.53%	2.65%	0.12%	7.17%	8.23%	1.06%
Nash	0.02%	0.00%	-0.02%	0.88%	0.78%	-0.10%	1.83%	1.34%	-0.49%	5.30%	4.17%	-1.13%
Robeson	0.14%	0.14%	0.00%	3.20%	4.58%	1.38%	4.37%	5.54%	1.17%	7.95%	10.12%	2.17%
Sampson	0.03%	0.00%	-0.03%	0.29%	0.30%	0.01%	0.70%	1.47%	0.77%	2.76%	2.48%	-0.28%
Scotland	0.29%	0.13%	-0.16%	3.36%	4.17%	0.81%	3.00%	5.00%	2.00%	4.78%	8.22%	3.44%
Wayne	0.01%	0.02%	0.01%	0.78%	0.78%	0.00%	2.17%	1.74%	-0.43%	5.00%	4.97%	-0.03%
Wilson	0.01%	0.01%	0.00%	1.19%	0.76%	-0.43%	3.02%	3.55%	0.53%	6.47%	6.61%	0.14%
	35-64			65+			Unknown			Total		
Bladen	3.54%	3.91%	0.37%	0.39%	0.60%	0.21%	0.00%	0.00%	0.00%	1.63%	1.94%	0.31%
Columbus	3.49%	4.05%	0.56%	0.29%	0.61%	0.32%	0.00%	0.00%	0.00%	1.95%	2.12%	0.17%
Duplin	4.03%	4.06%	0.03%	0.32%	0.56%	0.24%	0.00%	0.00%	0.00%	1.16%	1.15%	-0.01%
Edgecombe	7.05%	6.69%	-0.36%	1.15%	1.20%	0.05%	0.00%	0.00%	0.00%	2.89%	2.50%	-0.39%

Greene	5.53%	6.26%	0.73%	0.66%	0.68%	0.02%	0.00%	0.00%	0.00%	1.83%	1.91%	0.08%
Lenoir	8.66%	9.70%	1.04%	1.04%	1.34%	0.30%	0.00%	0.00%	0.00%	3.22%	3.82%	0.60%
Nash	4.89%	3.89%	-1.00%	0.88%	0.42%	-0.46%	0.00%	0.00%	0.00%	2.14%	1.70%	-0.44%
Robeson	6.88%	8.74%	1.86%	1.06%	1.29%	0.23%	0.00%	0.00%	0.00%	3.48%	4.53%	1.05%
Sampson	2.43%	2.39%	-0.04%	0.30%	0.31%	0.01%	0.00%	0.00%	0.00%	0.88%	0.91%	0.03%
Scotland	5.81%	7.10%	1.29%	0.78%	0.97%	0.19%	0.00%	0.00%	0.00%	2.86%	3.92%	1.06%
Wayne	6.30%	6.55%	0.25%	0.40%	0.81%	0.41%	0.00%	0.00%	0.00%	2.20%	2.25%	0.05%
Wilson	8.38%	9.35%	0.97%	1.20%	1.46%	0.26%	0.00%	0.00%	0.00%	3.06%	3.31%	0.25%

Table 17: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	3-12			13-17			18-20			21-34		
Bladen	10.77%	8.25%	-2.52%	13.36%	12.06%	-1.30%	9.05%	10.54%	1.49%	11.38%	11.64%	0.26%
Columbus	12.01%	10.50%	-1.51%	15.51%	13.76%	-1.75%	8.33%	7.61%	-0.72%	11.63%	11.18%	-0.45%
Duplin	8.08%	7.57%	-0.51%	12.68%	13.05%	0.37%	9.42%	8.63%	-0.79%	15.93%	14.75%	-1.18%
Edgecombe	8.50%	7.09%	-1.41%	11.65%	10.37%	-1.28%	10.01%	5.78%	-4.23%	11.02%	9.30%	-1.72%
Greene	8.51%	7.06%	-1.45%	16.16%	14.02%	-2.14%	14.11%	10.82%	-3.29%	16.82%	14.60%	-2.22%
Lenoir	11.90%	11.80%	-0.10%	17.96%	17.85%	-0.11%	10.05%	9.97%	-0.08%	16.33%	15.49%	-0.84%
Nash	6.47%	5.95%	-0.52%	11.02%	9.82%	-1.20%	8.21%	6.92%	-1.29%	11.50%	9.22%	-2.28%
Robeson	9.05%	8.79%	-0.26%	13.94%	11.94%	-2.00%	9.40%	8.36%	-1.04%	13.52%	12.85%	-0.67%

Sampson	7.85%	7.72%	-0.13%	10.16%	11.09%	0.93%	9.16%	8.35%	-0.81%	10.05%	9.32%	-0.73%
Scotland	10.06%	9.77%	-0.29%	16.12%	14.62%	-1.50%	12.97%	7.73%	-5.24%	14.18%	13.93%	-0.25%
Wayne	9.73%	8.47%	-1.26%	17.49%	16.64%	-0.85%	12.41%	11.33%	-1.08%	16.80%	15.47%	-1.33%
Wilson	10.13%	10.13%	0.00%	14.58%	13.62%	-0.96%	9.55%	9.96%	0.41%	14.46%	13.26%	-1.20%
	35-64			65+			Unknown			Total		
Bladen	13.92%	14.77%	0.85%	3.99%	6.22%	2.23%	0.00%	0.00%	0.00%	11.06%	10.66%	-0.40%
Columbus	13.10%	12.83%	-0.27%	4.57%	5.07%	0.50%	0.00%	0.00%	0.00%	11.66%	10.76%	-0.90%
Duplin	21.99%	21.68%	-0.31%	8.50%	7.87%	-0.63%	0.00%	0.00%	0.00%	12.12%	11.67%	-0.45%
Edgecombe	16.95%	14.57%	-2.38%	5.64%	8.43%	2.79%	0.00%	0.00%	0.00%	10.90%	9.51%	-1.39%
Greene	17.97%	19.13%	1.16%	4.60%	7.67%	3.07%	0.00%	0.00%	0.00%	12.40%	11.56%	-0.84%
Lenoir	21.33%	21.32%	-0.01%	4.94%	7.23%	2.29%	0.00%	0.00%	0.00%	14.50%	14.61%	0.11%
Nash	16.89%	13.29%	-3.60%	3.62%	7.94%	4.32%	0.00%	0.00%	0.00%	9.85%	8.82%	-1.03%
Robeson	17.02%	17.67%	0.65%	3.53%	5.24%	1.71%	0.00%	0.00%	0.00%	11.56%	11.28%	-0.28%
Sampson	13.78%	12.63%	-1.15%	3.34%	6.49%	3.15%	0.00%	0.00%	0.00%	9.13%	9.20%	0.07%
Scotland	17.62%	17.14%	-0.48%	5.12%	10.33%	5.21%	0.00%	0.00%	0.00%	13.00%	12.54%	-0.46%
Wayne	24.75%	23.45%	-1.30%	7.80%	11.14%	3.34%	0.00%	0.00%	0.00%	14.68%	13.85%	-0.83%
Wilson	20.39%	20.00%	-0.39%	5.98%	9.16%	3.18%	0.00%	0.00%	0.00%	12.98%	12.90%	-0.08%

B Waiver Performance Measures Validation

The overall validation score was in the "Fully Compliant" range, with an average validation score of 100% across the ten measures. The code is well-organized and clearly notated where changes to programming logic have been edited or updated. The following Table displays the validation scores for each of the ten measures as well as the overall average validation score for Eastpointe.

Table 18: B Waiver Performance Measure Validation Scores 2018

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 Performance Measures

For reviews of 2016-2017 C Waiver measures, there were changes made to the measures that were validated. Eight new measures were chosen, and two previously-validated measures were retained. Documentation was included for all ten C waiver measures, although the label for some of the Excel files did not match the actual reported rate that was contained in the file. The rates reported by Eastpointe are displayed in the following Table.

Table 19: C Waiver Measures Rates 2016-2017

Performance Measure	Data Collection	Rate*
Proportion of Level of Care evaluations completed at least annually for enrolled participants	Semi Annually	565/569 = 99.30%
Proportion of Level of Care evaluations completed using approved processes and instrument	Semi Annually	556/566 = 98.23%
Proportion of New Level of Care evaluations completed using approved processes and instrument	Semi Annually	26/27 = 96%
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	Annually	1/1 = 100%
Proportion of monitored Innovations providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame	Annually	17/17 = 100%

Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	Annually	1258/1259 = 99.92%
Proportion of Individual Support Plans that address identified health and safety risk factors	Semi Annually	554/558 = 99.28%
Percentage of participants reporting that their Individual Support Plan has the services that they need	Annually	1259/1259 = 100%
Proportion of individuals for whom an annual ISP and/or needed updates took place	Annually	1257/1259 = 99.84%
Proportion of new waiver participants who are receiving services according to their ISP within 45 days of ISP approval	Quarterly	19/19 = 100%

* Latest reported rates are shown in the Table

C Waiver Performance Measures Validation

The overall validation score was in the "Fully Compliant" range, with an average validation score of 100% across the ten measures. Documentation included the data collection methodology, data validation, and data sources, as well as the latest reported rates. The validation scores are shown in Table 20. Validation worksheets based on the CMS protocol for validating performance measures for each the C waiver measures are provided in Attachment 3. CCME recommends Eastpointe ensure that submitted Excel files contain the information that is matched to the rate reported within the file. Example: File named 35.12. LOC Eval using approved pro-Ins FY2018_Semi_annual (Jan-June).xlsx contained the rate for "Proportion of Level of Care completed at least annually for enrolled beneficiaries."

Table 20: C Waiver Performance Measure Validation Scores 2018

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

Performance Improvement Projects (PIP)

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

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

PIP Validation

For 2017, CCME reviewed three of the six submitted PIPs. They included: Improve Encounter Claims Submissions to 95%, Increase number of individuals in the Priority Population served by a Fidelity Provider to 13 monthly (TCLI), and Increase the percent of individuals who receive a 2nd service within or less than 14 days to 35%. CCME noted several issues, including clear definition of indicators, personnel qualifications, barriers and interventions, data analysis plan, clear presentation of results, and lack of improvement in outcomes. During the CAP process, these items were addressed and corrected.

The PIPs validated for 2018 included: TCLI (individuals served), Percent of individuals who received 2nd service within or less than 14 days, Decrease state psychiatric hospital 30-day readmissions for high risk members, and emergency department (ED) Admissions. CCME noted several concerns during the validation process this year, including lack of clear indicators, lack of results being presented, and lack of information on barriers and interventions. Several of the documents did not contain results from the start of the PIP. They only contained information for the last few data analysis cycles. Additionally, the transition from Microsoft® (MS) Excel to MS Word documents appeared to cause issues with including all elements of the CMS protocol, such as data collection plan, data analysis plan, and data sources. Finally, one PIP report did not contain any results, but the rates were reported in a QI Workplan MS Excel file. The PIP documents should contain up-to-date information on results for all PIPs.

The following table is a summary of the validation scores for each PIP in 2017 and 2018:

Table 21: Performance Improvement Project Validation Scores

Project	2017 Validation Score	2018 Validation Score
Increase number of individuals in the priority population served by a fidelity provider to 50% monthly- Clinical	42/80=53% Reported Results Not Credible	74/80=93% High Confidence in Reported Results
Increase the percentage of individuals who received a 2nd service within or less than 14 days to 35%- Non-Clinical	79/85=93% High Confidence in Reported Results	51/80=64% Low Confidence in Reported Results
Decrease state psychiatric hospital 30-day readmissions for high risk members-Clinical	Not Validated	58/90=64% Low Confidence in Reported Results
Decrease emergency department admissions for active members to 20%-Clinical	Not Validated	42/52=81% Confidence in Reported Results

The tables that follow list the specific errors by project and include recommendations and corrective actions to correct the errors. If the PIP received an overall score of "Low Confidence" or "Not Credible," then there are corrective actions. PIPs that score in the "Confidence" or "High Confidence" range contain recommendations.

Table 22: Increase number of individuals in the priority population served by a fidelity provider to 50% monthly

Section	Reasoning	Recommendation
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	PIP report has findings presented by month from the start of the PIP to the most recent remeasurement, but the analysis is confusing as the first date is December 2017 and then the second date is January 2017 on page 10.	Check for typos, as the analysis for FY 2018 has January 2017 and it should say January 2018.
Was there any documented, quantitative improvement in processes or outcomes of care?	Rate has mostly failed to meet the 50% benchmark in 2018.	Improvement has not occurred, and action plans need to be put into place based on barriers and noted opportunities for improvement.

Table 23: Increase the percentage of individuals who received a 2nd service within or less than 14 days to 35%

Section	Reasoning	Corrective Action
Did the study design clearly specify the sources of data?	Sources of data were not clearly specified.	Specify sources of data.
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?	Data collection methods are not clearly documented.	Include information on how data are collected.
Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	Instruments for data collection were not documented.	Include data collection tools or instruments.
Did the study design prospectively specify a data analysis plan?	Data analysis was not clearly documented.	Document the data analysis plan in the report.
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	Results were clearly displayed in Tables and bar graphs. However, the first measurement	Data from all measurement periods throughout the entire

Section	Reasoning	Corrective Action
	periods are not shown, nor are any in 2016. There are only two measurement periods shown.	PIP should be presented in the report.
Was there any documented, quantitative improvement in processes or outcomes of care?	No, rates have not increased. They are steady around 25%.	Continue evaluating interventions to ensure they are addressing all barriers to increasing the rate.

Table 24: Decrease state psychiatric hospital 30-day readmissions for high risk members

Section	Reasoning	Corrective Action
Did the study use objective, clearly defined, measurable indicators?	The benchmark is not clearly listed. It appears to be 6%, but the baseline goal is also documented as 6%. These values should not be the same. The baseline goal is the immediate goal and the benchmark is the best practice rate.	Revise Section I:B so that benchmark is best practice rate and baseline goal is the short-term goal rate.
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Interventions are only documented for the most recent remeasurement.	Documentation should include barriers and interventions from the start of the project.
Was an analysis of the findings performed according to the data analysis plan?	Data analysis should be presented for quarters from start of the project which was noted as 2011.	Present findings from baseline through most recent measurement.
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly	Numerator and denominator for all measurement periods from start of the project should be documented.	Present rates for all quarters from start of project to most recent remeasurement.
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?	Initial and repeat measurements are not reported.	Include initial and repeat measurements in report, as well as analysis of each quarter.

Section	Reasoning	Corrective Action
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?	Analysis included most recent findings and follow-up activities, but previous measurement analyses were not included in the report.	Analyses and follow-up activities planned should be documented for all measurement periods.

Table 25: Decrease emergency department admissions for active members to 20%

Section	Reasoning	Recommendation
Did the study use objective, clearly defined, measurable indicators?	Indicator is defined but there is no benchmark rate listed. The short term goal is noted as 20%. The benchmark should be documented. Also, the measure has readmission in the title, but the numerator and denominator do not refer to readmissions. The first measurement period dates should be only one month, since data is collected monthly.	Document the best practice rate in Section I:B. Clarify if readmissions or admissions are the measure, as QI documents suggest readmission and the title suggests readmissions, but the rate does not discuss readmissions. First measurement period dates should be July 2017 only, since data are collected each month.

Figure 5 provides an overview of 2017 scores compared to 2018 scores. Please note, those standards that were scored "Not Applicable" are not reflected in Figure 5.

Figure 5: Quality Improvement Findings

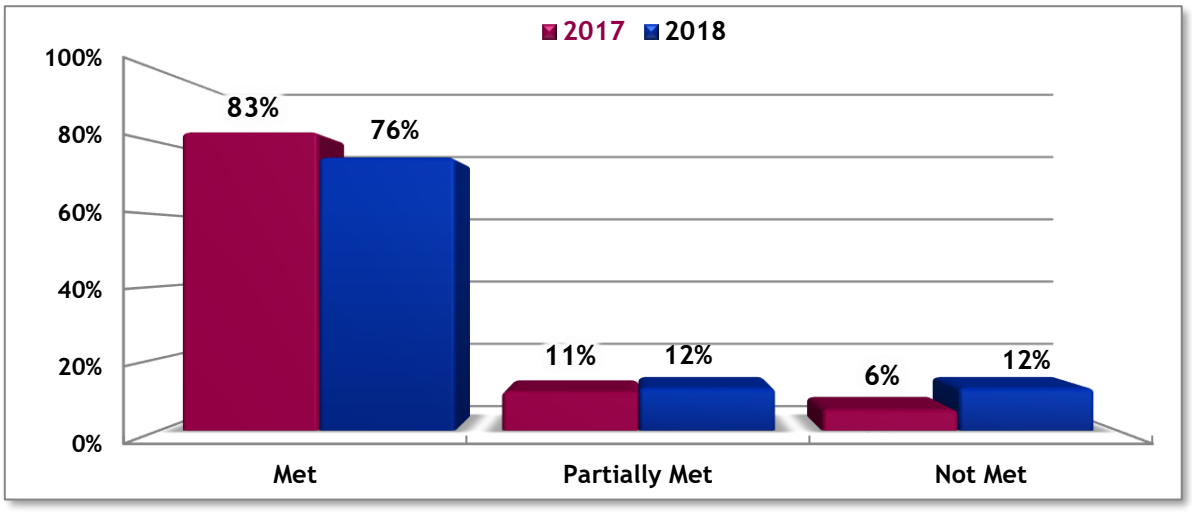


Table 26: Quality Improvement

Section	Standard	2018 Review
The Quality Improvement (QI) Program	The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	**Not Met**
Quality Improvement Committee	The QI Committee meets at regular intervals.	**Partially Met**
Quality Improvement Projects	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	**Partially Met**
Annual Evaluation of the Quality Improvement Program	A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	**Not Met**

Strengths

- During this review period a Cross Functional Workgroup started to develop a process to implement and monitor Clinical Practice Guidelines.
- In the June 2018 GQIC meeting, a motion carried to approve a sub-committee for the *Experience of Care and Health Outcomes (ECHO) Survey* measures that need improvement.
- The June 2018 GQIC meeting included a discussion of completed child and adult surveys. The Power Point named, Eastpointe Composites 2017 ECHO Report Adult and Children, provided comprehensive results by comparing 2016 results to 2017 and Eastpointe to the state average.

Weaknesses

- Eastpointe has mechanisms to detect and document under and over utilization of medical services as required by the contract. Although, there is no evidence of monitoring or analysis of utilization data for over/underutilization.
- GQIC meetings occurred on these dates, which did not follow a regular meeting interval: 10/13/17; 11/3/17; 2/16/18; 6/15/18.
- Meeting minutes are completed for the GQIC. However, the GQIC did not document discussion points for many of the meeting topics.
- Documentation was included for all ten C waiver measures, although the label for some of the MS Excel files did not match the actual reported rate that was contained in the file.
- Tables 22, 23, 24, and 25 in this report lists the specific PIP errors by project and includes recommendations/corrective actions to correct the errors. If the PIP received

an overall score of "Low Confidence" or "Not Credible," then there are corrective actions. PIPs that score in the "Confidence" or "High Confidence" range contain recommendations.

- There is not a requirement in the *FY2019 Quality Improvement Plan and Program Description* that states the providers are required to do individual QIPs.
- Provider meetings give feedback about QI activities at Eastpointe, but no feedback is given on a provider's individual QIPs.
- *Strengthening our Communities 2018 Annual Report* contains general and overall happenings at Eastpointe during the 2018 FY. The document is well done and highlights some positive outcomes from Eastpointe in FY 2018. It does NOT contain the following information expected:
    - Analysis of the quality projects for FY 2018
    - FY 2019 Strategy
    - Information about what was implemented in 2018, if those implementation efforts were successful or not, what barriers still exist, and what will be changed with each project for the 2019 FY to effect change.
    - There is no information about over and underutilization.
    - There is no overall summary of the Enrollee Surveys.

  This document is not a summary and assessment of the effectiveness of the QI program.

Corrective Action

- Documentation from meeting minutes and program evaluations should include evidence of monitoring rates, reasons/causes for over or underutilization, and the interventions or action steps that demonstrate how Eastpointe is addressing those reasons/causes of over or underutilization. Documentation did not include this evidence. To correct this, document the steps taken to address over and underutilization, as applicable. Include discussion of utilization in, for example, committee meeting minutes, including action steps that have been taken to address the issue. Additionally, the program evaluation(s) should contain information on (1) services that are being over/under utilized, (2) which services are currently focus of interventions, (3) specific interventions that are in place to address the problematic services.
- Ensure GQIC meets at regular intervals.
- Corrective actions apply for the following PIPs that scored "Low Confidence." Refer to Tables 23 and 24 for the specific corrective actions and document the revisions that have occurred based on the corrective actions in the PIP reports for:

- Increase the percentage of individuals who received a 2nd service within or less than 14 days to 35%
- Decrease state psychiatric hospital 30-day readmissions for high risk members.

- Create a document that is specifically a written summary, assessment, and evaluation of the QI program at the end of each program year, beginning with FY 2018.

Recommendations

- Capture GQIC Committee meeting discussion in the meeting minutes
- For C Waiver Measures, ensure that submitted Excel files contain the information that is matched to the rate reported within the file. Example: File named 35.12. LOC Eval using approved pro-Ins FY2018_Semi_annual (Jan-June).xlsx contained the rate for "Proportion of Level of Care completed at least annually for enrolled beneficiaries."
- Recommendations apply for these PIPs that Scored in the "Confidence" and "High Confidence" ranges. See Tables 22 and 25 for specific recommendations:
  - Increase number of individuals in the priority population served by a fidelity provider to 50% monthly
  - Decrease emergency department admissions for active members to 20%
- Develop and implement a written plan and process that will hold providers accountable for individual QIPs. Add provider QIP monitoring to that process.
- Begin to offer feedback to providers on individual QIPs they will be doing.

E. Utilization Management

For the purpose of this year's review of Eastpointe's utilization management (UM) standards, Eastpointe submitted 25 files of medical necessity, approval files and 25 medical necessity, denial files. These files included decisions on requests for mental health/substance use (MHSU) services, intellectual and developmental disabilities (I/DD) services and services provided to enrollees involved with the Transitions to Community Living Initiative (TCLI). Multiple policies governing UM were also reviewed.

Eastpointe's *Utilization Management (UM) Program* is overseen by Kelli Carson, LPCS, the Chief of Clinical Operations and Angela English, LCSW, the UM Director with oversight of daily functions in the UM Department. Dr. Sid Hosseini is the Medical Director and Dr. Venkata Doniparthi, Assistant Medical Director (AMD). During the Onsite interview and in print materials, Dr. Venkata Doniparthi was referenced as a Consultant, an Assistant Medical Director and Associate Medical Director. For the purpose of this UM section of this report, CCME references Dr. Doniparthi as Assistant Medical Director. The Onsite interview with staff clarified that both Dr. Sid Hosseini and Dr. Venkata Doniparthi share

responsibilities and involvement in various committees, provide clinical oversight and clinical consultation to the UM Department.

Eastpointe employs a set of policies that guide UM internal processes such as levels of medical necessity reviews, post stabilization processes, and inter-rater reliability (IRR). All recommendations and corrective actions noted in the UM section of last year's EQR were addressed. The *UM Plan/Program Overview* outlines the current activities and staffing of the department and is updated annually. Eastpointe implemented the requirement by providers of the *Child and Adolescent Needs and Strengths Assessment* (CANS) for children ages three to six years old. Eastpointe will need to include this information within the UM *Plan/Program Overview and* in *Policy C-3.2.37 Clinical Decision Support Tool*.

During the Onsite interview clarification regarding the Medical Director's involvement in the annual review of decision-making tools was provided; however, it is also not included in *Policy C-3.2.37 Clinical Decision Support Tool*.

Eastpointe uses a process to assess Over/Under Utilization of services. The *Over/Under Utilization Policy* provides a high-level overview without details of the process and steps that Eastpointe uses. Adding the additional information regarding the data analysis and review of the over and Over/Under Utilization of services will bolster the policy and support the process used in the UM Department.

Eastpointe, in May 2017, hired Dr. Hosseini as a full time Medical Director and Dr. Venkata Doniparthi continued as AMD. Dr. Hosseini is involved in the key aspects of the UM program including chairing the *Clinical Advisory Committee*, which approves Eastpointe's clinical decision support tools, staff training, Clinical Practice Guideline development, identification of barriers to admission, discharge and dispositions, and oversight of clinical decision-making.

Review of the UM decision process within the files provided showed a pattern of timely decision making. However, documentation of when an expedited service authorization request changes to a standard request was not present in the review notes. During the Onsite interview, it was clarified that staff enter a note in AlphaMCS and the provider is notified through the provider portal. Eastpointe should include this process of reviewing and documenting denials of requests for expedited UM decisions and how these denials are communicated to providers in *Policy C-3.2.38 Medical Necessity First Level*.

For the purpose of further understanding Eastpointe's Care Coordination functions, the Onsite interview included Lynette Gordon, LPC, Assistant Clinical director, Tara Sessoms, LPC, Director MH/SA Care Coordination and Kim Beneck, I/DD Clinical Director.

The Care Coordination staff is available around the clock to provide crisis services and interventions when needed. *Person Centered Plans* and *Individual Support Plans* are developed in a collaborative effort involving Care Coordinators, enrollees, family members and providers to ensure needs of enrollees are met. Hospital admissions and discharges are monitored, and Care Coordinators work collaboratively with hospital staff in the development of discharge plans. Care Coordinators continue to work with an enrollee for two weeks post inpatient discharge and hand off to the transition team to reduce the likelihood of readmission.

The file review of Care Coordination notes revealed that several of the I/DD files had notes entered late by I/DD staff. Some notes were up to 11 months late. During the Onsite interview it was clarified that this issue was found following an internal audit completed by Eastpointe's Quality Management Department. A Corrective Action Plan (CAP) was developed to monitor timely completion of Care Coordination notes. The CAP includes quarterly monitoring of the Care Coordination notes. However, following the implementation of the CAP, there was a decrease in the timeliness of I/DD are coordination notes. *Policy C-3.6.4 Documentation of Care Coordination Activities* states that Eastpointe requires accurate and timely documentation occur and "not to exceed a seven-calendar day time frame from date of service contact." This policy does allow the provision of documenting if a note is late but does describe a process for C patterns of untimely note submission by staff or department. In addition to lack of timely submission, the I/DD Care Coordination notes and monitoring tools also showed a pattern of incompleteness. There were several notes where follow up activities were not documented, and monitoring notes often had blank sections where interventions or outcomes should have been documented.

The MH/SU files did include well-written Care Coordination notes, timely documentation, and captured follow up activities, including efforts to engage enrollees not actively participating in care coordination activities.

The TCLI EQR Desk Review included the review of 15 files of enrollees participating in TCLI. In eight files, Assertive Community Treatment (ACT) services were evident in the Person-Centered Plan. However, neither Peer Support services nor Supported Employment were indicated in any other plan. This includes several members who, per the TCLI notes, stated that they wanted obtain employment. Another concern was that these same TCLI members were referred to Vocational Rehabilitation versus being referred to Supported Employment services. During the Onsite staff interview, staff explained that the difficulty with engaging members into Supported Employment was their fear of losing services. During the interview questions regarding network providers who meet Supported Employment (SE) Fidelity were not answered. Eastpointe shared that they released a Request for Proposal (RFP) for Peer Support Pass-Through Services, because of the difficulty of finding Peer Support Staff. CCME recommends that Eastpointe continue to give members the opportunity to access Peer Supports and Supported

Employment through TCLI educational opportunities. CCME also recommends that Eastpointe work with local providers to ensure that members can access Peer Support and Supported Employment services to provide opportunities for independence in their transitioning process.

The *TCLI Program Description for 2018-2019* was reviewed, on page eight the Quality Improvement section states; "During FY 16 QI collaborated with TCLI to develop strategies and a Quality Improvement Project (QIP)...)" The information in the TCLI Program Description 2018-2019 needs to be updated to reflect the current QIP. CCME recommends that Eastpointe ensure that there is a process to review the TCLI Program description annually for correct and current data.

Eastpointe has a *TCLI Communication Plan* in place that includes different tiers of educational information sharing. These tiers involve education and training with internal clinical staff and across the organization. Training is also provided to providers at stakeholder meetings.

The following graph provides the scoring information for the 2018 EQR Review. Figure 6 provides an overview of 2017 scores compared to 2018 scores.

Figure 6: Utilization Management Findings

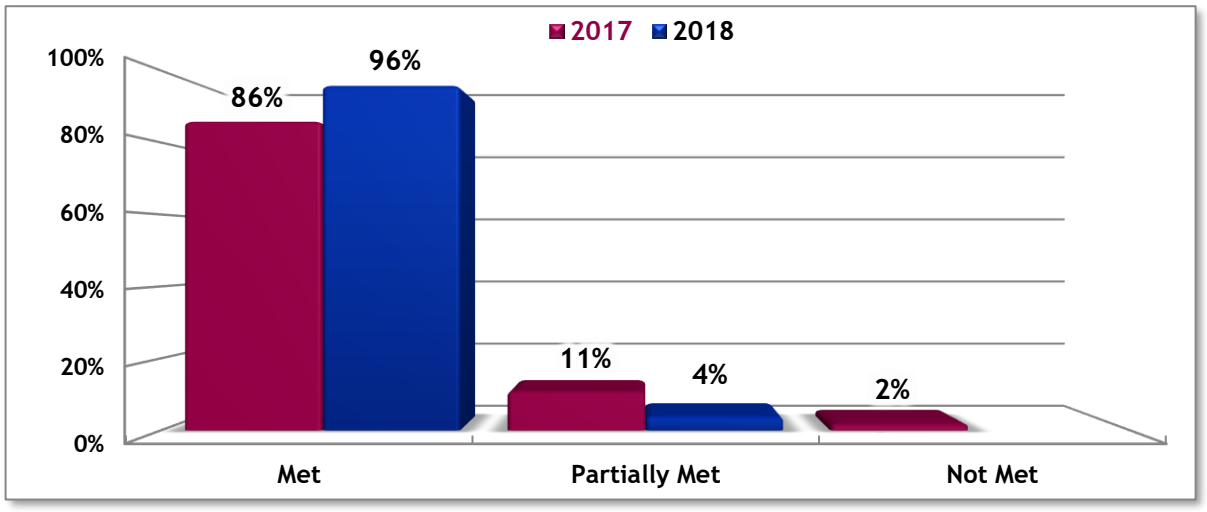


Table 27: Utilization Management

Section	Standard	2018 Review
Care Coordination	The PIHP applies the Care Coordination policies and procedures as formulated.	**Partially Met**

Section	Standard	2018 Review
Transition to Community Living Initiative	A review of files demonstrates the PIHP is following appropriate TCL policies, procedures and processes, as required by NC DMA, and developed by the PIHP.	**Partially Met**

Strengths

- Dr. Sid Hosseini is the Medical Director and Dr. Venkata Doniparthi are involved in various committees, provide oversight in structured meetings and are available for consultation.
- UM Director and Dr. Venkata Doniparthi set the standard for each vignette. At least eight to ten vignettes are completed quarterly by all licensed UM reviewers and delegated Peer Reviewers.
- The MH/SA files noted follow up activities, including multiple attempts to contact via phone and letter prior to discharging the member for lack of participation.
- The *TCLI Program Description* provides information regarding the educational and licensure requirements of the staff. Information is in *Policy C-3.7.9, Care Coordination in Transitioning People into the Community*.
- The *Transition Year Services (TYS) Funds* form was present in seven files and access of those funds referenced in the TCLI Care Coordination notes.
- Quality of Life Surveys were present in the files, when appropriate.
- Eastpointe's *TCLI Communication Plan* includes different tiers of educational and training provided to internal clinical staff and across the organization. Training is also provided to providers at stakeholder meetings.

Weaknesses

- *Policy C-3.2.38 Medical Necessity Review First Level* does not include the process for denying a request for an expedited UM decision or when and how a provider is notified of this denial.
- *Policy C-3.2.42 Over/Under Utilization* provides a high-level process overview; however, the process Eastpointe uses to review and analyze this over/under utilization data is included in the policy.
- *Policy C-3.2.37, Clinical Decision Support Tool* does not describe the Medical Director's involvement in the annual evaluation process or include the requirement that providers use the *Child and Adolescent Needs and Strengths assessment* (CANS) for children ages three to six years old.
- Several I/DD Care Coordination notes were submitted untimely. *Policy C-3.6.7 Documentation of Care Coordination Activities* does not indicate how monitoring of

Care Coordination Notes occurs nor the steps that are taken when notes are identified as late.

- The Quality Improvement section of the *TCLI Program Description* for 2018-2019 states, "During FY 16 QI collaborated with TCLI to develop strategies and a Quality Improvement Project (QIP)". This information needs to be updated to reflect the current QIP.
- Neither Peer Support services nor Supported Employment were indicated in any files reviewed. This includes several members who, per the TCLI notes, stated that they wanted obtain employment and were referred to Supported Employment services.

Corrective Actions

- Include in *Policy C-3.6.7 Documentation of Care Coordination Activities* how the monitoring of the notes occurs and the steps that are taken when late notes or trends of late notes by staff or departments are identified.
- Ensure there is evidence in TCLI progress notes of discussion, referral, and linkage to B3 services, when appropriate, including utilization of Supported Employment services.

Recommendations

- Add to *Policy C-3.2.38 Medical Necessity Review First Level,* the steps that staff take when an expedited service authorization request is transitioned to a standard review timeframe. Include how the process is documented and how and when notification to the provider occurs.
- Add to *Policy C-3.2.42 Over Under Utilization Management,* the process Eastpointe uses to review and analyze the over/under utilization data.
- Include in *Policy C-3.2.37 Clinical Decision Support Tool,* the Medical Director's involvement in the annual evaluation process of the decision-making tools and the requirement by providers to use the *Child and Adolescent Needs and Strengths (CANS)* for children ages 3 to 6 years.
- Ensure the *TCLI Program Description* is reviewed annually for correct and current information.

F. Grievances and Appeals

Grievances

Eastpointe submitted 20 grievance files for this EQR Desk Review along with the *Policy Q-6.4.4, Member/Enrollee and Stakeholder Complaints/Grievances* that governs the grievance process. The CCME Onsite interview included various staff regarding grievances/complaints.

The primary over-arching grievance policy for registering and responding to grievances is *Policy Q-6.4.4, Member/Enrollee and Stakeholder Complaint/Grievance*. In Policy *Q-6.4.4*, grievance is defined as; "A complaint/grievance is any form of dissatisfaction expressed orally or in writing, that the complainant perceives as a problem, other than an "action" as defined in this section". This is different from the definition in the *DMA Contract, Attachment M* and *42 CFR § 438.400* which defines a grievance as; "a grievance is any matter other than an adverse benefits determination. Possible subjects for grievances include….or failure by PHIP Network Provider to respect the rights of an enrollee. An enrollee can file a grievance with the PHIP at any time." In addition to updating the definition of a grievance, the definition of an Adverse Benefits Determination also needs to be refined to Policy *Q-6.4.4* to ensure consistency with the *DMA Contract, Attachment M* and *42 CFR § 438.400*.

In *Policy Q-6.4.4,* the terms complaint, grievances and concerns are used interchangeably throughout the policy. Statements such as "Upon notification of the submitted complaint…", "If the complaint/concern is a health and safety issue…", "grievances related to health and safety concerns…" make the policy unclear regarding definitions and processes. The use of one term would provide consistency in *Policy Q-6.4.4*. Similarly, keeping terms consistent within the *Enrollee/Member and Family Handbook* and the Provider *Operations Manual would* decrease confusion.

On page 4 of *Policy Q-6.4.4*, item 5 states, "If the complaint/concern is a health and safety issue, grievance and appeals staff will immediately (within 1 business day) complete the Quality of Care QOC Formdesk referral. Grievances related to health and safety concerns, including medical concerns, are reviewed by a physician as a part of the resolution process and Quality of Care Concern process." However, there was no additional information in *Policy C-6.4.4* about this process. More detail is needed in this policy that describes the steps staff take to address and resolve Quality of Care concerns. Include in these details how and where the physician review is documented.

Similarly, the files submitted for this EQR did not include documentation of the Medical Director consultation when a case was referred for QOC Review. During the Onsite interview, staff explained that screen shots of the Medical Director review notes are uploaded into AlphaMCS. This review is a part of the grievance record and should be included in any documentation that is submitted for any EQR or audit.

Appeals

EQR of Eastpointe's appeal process involved a review of 25 appeal files, Eastpointe's appeal *Policy C-3.2.6*, Eastpointe's appeal log, 5 second level appeal files, and discussion during the Onsite. Primary concerns noted during this year's EQR were related to information missing from the appeals policy, errors within appeal notifications, incorrect information in the *Provider Operations Manual and Enrollee/Member and Family Handbook*, and adherence by staff to Eastpointe's *Release of Information* policy.

Policy C-3.2.6 Appeal of UM Adverse Benefit Determination is the primary policy governing Eastpointe's appeal process. The items missing or incorrect from this policy include the following:

- The definition of who may file an appeal
- A clear timeframe that appellants have for filing a written request once an oral appeal has been filed
- The word "prompt" when describing the efforts by staff to orally notify an appellant when a request to expedite an appeal is denied by Eastpointe
- Key requirements when Eastpointe extends an appeal resolution timeframe
- A description of the process appeal staff follows to identify an invalid appeal and notify the appellant of the invalid appeal

Similarly, three notifications Eastpointe provided contain incorrect or missing information, including the following:

- The expedited appeal acknowledgement notification
- The appeal extension notification
- The invalid appeal notification

Discussion around invalid appeals also elicited a recommendation that Eastpointe review invalid and withdrawn appeals to identify any trends that would prompt quality improvement opportunities.

Incorrect information was also noted in the *Provider Operations Manual* and *Enrollee/Member and Family Handbook*. The definition of who may file an appeal and the timeframe to resolve an expedited appeal are incorrect in both documents. Also incorrect in the *Provider Operations Manual* is the timeframe for an appeal to be filed. This manual says the enrollee has 30 days to file an appeal, but appellants are allowed 60 days to file an appeal.

Details, including *DMA Contract* and federal guideline references, regarding the corrections needed to Eastpointe's appeal policy, notifications, *Provider Operations Manual* and *Enrollee/Member and Family Handbook* are explained in the tabular spreadsheet, *Attachment 4*.

Lastly, in one file reviewed, an enrollee's Protected Health Information (PHI) was mailed by staff, at the enrollee's request. The process outlined in Eastpointe's *Policy Q-6.3.5 Release of Medical Records* was not followed. CCME highlighted the need to have the appeals policy either reference *Policy Q-6.3.5 Release of Medical Record* or spell out the steps that staff must take when releasing the appeal record.

The following Figure 7 indicates the scoring for grievances and appeals for 2018 compared to the scores received in the 2017 EQR.

Figure 7: Grievances and Appeals Comparative Findings

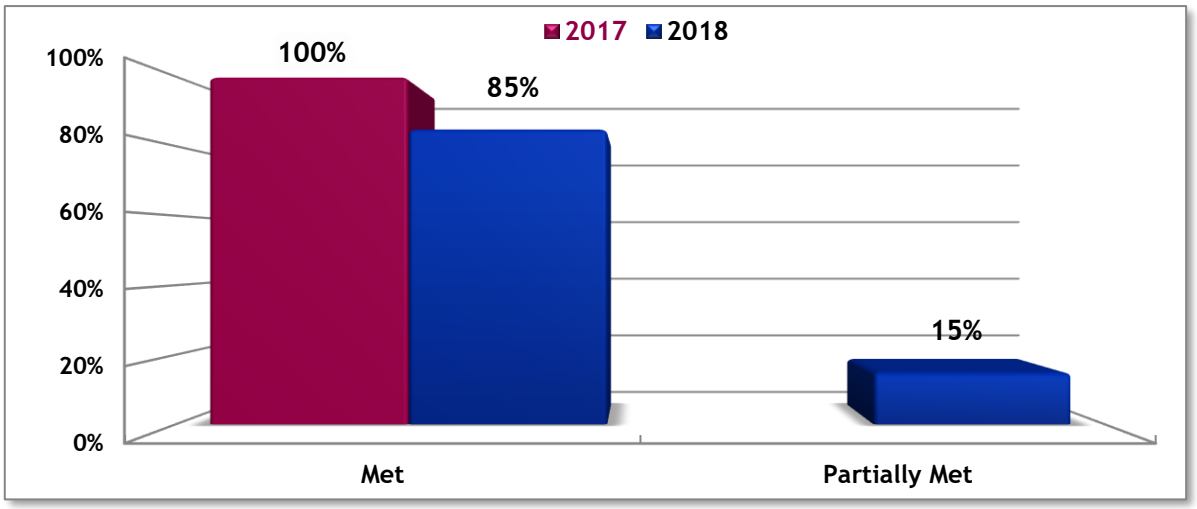


Table 28: Grievances and Appeals

Section	Standard	2018 Review
Appeals	The definitions of an adverse benefit determination and an appeal and who may file an appeal;	**Partially Met**
	Other requirements as specified in the contract.	**Partially Met**
	Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	**Partially Met**

Strengths

- There is oversight and regular consultation by Dr. Sid Hosseini and Dr. Venkata Doniparthi with the Grievance staff.
- The grievance process is completed within 30 calendar days.
- It was evident within the appeal files that staff provided support and assistance to appellants.

Weaknesses

- In *Policy Q-6.4.4*, grievance is defined as; "A complaint/grievance is any form of dissatisfaction expressed orally or in writing, that the complainant perceives as a problem, other than an "action" as defined in this section". This is different from the definition in the *DMA Contract, Attachment M* and *42 CFR § 438.400*.
- The definition an Adverse Benefits Determination also needs to be added to *Policy Q-6.4.4* to ensure consistency with the *DMA Contract, Attachment M* and *42 CFR § 438.400*.
- In *Policy Q-6.4.4* the terms "complaint", "concern" and "grievance" are used interchangeably throughout the policy which creates a lack of clarity regarding definitions and processes.
- *Policy Q-6.4.4* does not describe the steps staff take to address and resolve Quality of Care concerns, including details regarding how and where the physician review is documented.
- Documentation of the Medical Director's review of Quality of Care concerns were not submitted within the grievance files submitted for this EQR.
- *Policy C-3.2.6 Appeal of UM Adverse Benefit Determination* states "Medicaid eligible members or a Legally Responsible Person (LRP) have a right to appeal any adverse decision through the local reconsideration process and the State fair hearing process." However, the *DMA Contract, Attachment M, Section G.1* 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." The definition of who can file an appeal is also incorrect in the *Provider Operations Manual* and *Enrollee/Member and Family Handbook*.
- *Policy C-3.2.6 Appeal of UM Adverse Benefit Determination* does not provide clear information regarding the timeframe an appellant has for filing a written request for appeal once an oral request for appeal is filed. The policy says oral requests must be up with a signed reconsideration form within 60 days. However, it is unclear from when the 60 days starts. Since the files contained evidence of inconsistencies by staff in communicating written request due dates to appellants, this timeframe needs to be clarified in policy.
- *Policy C-3.2.6 Appeal of UM Adverse Benefit Determination* is missing the word "prompt" from section D.2.E of the policy that describes the notification process when Eastpointe denies a request to expedite an appeal.
- *Policy C-3.2.6 Appeal of UM Adverse Benefit Determination* addresses extensions to both standard and expedited appeals but is missing key elements required by *DMA Contract*.

- During the Onsite discussion, appeal staff could describe a process by which invalid appeals are resolved but there is no information within *Policy C-3.2.6 Appeal of UM Adverse Benefit Determination*.
- The expedited acknowledgement template Eastpointe provided states that Eastpointe has, "up to 45 days" to process an expedited appeal. This is incorrect and should be changed to 72 hours with up to an additional 14 days if the expedited appeal resolution timeframe is extended.
- The invalid appeal notification is misleading. The first page of this notification explains how the appeal will be processed and then a short statement on the second page explains that the appeal will not be processed.
- The appeal extension notification template does not inform the appellant of the right to file a grievance if they disagree with Eastpointe's extension to the appeal resolution timeframe.
- The *Provider Operations Manual* and *Enrollee/Member and Family Handbook* erroneously say the timeframe to resolve an expedited appeal is three days. *DMA Contract* requires expedited appeals to be resolved and notification provided to appellants within 72 hours of receipt of the appeal.
- The federal regulations and *DMA Contract* were changed to state an appellant has 60 days from the mailing date of the notice of Adverse Benefit Determination to file an appeal. However, the *Provider Operations Manual* was not updated to reflect this change.
- Appeals that are decided are tallied, categorized, and analyzed for trends then reported to the QI Committee. However, invalid and withdrawn appeal numbers are not reviewed for potential quality improvement opportunities.
- In one file reviewed, an enrollee's PHI was mailed by staff, at the enrollee's request. The process outlined in Eastpointe's *Policy Q-6.3.5 Release of Medical Records* was not followed.

Corrective Action

- Add the correct definition of who can file an appeal to *Policy C-3.2.6*. Ensure the *Provider Operations Manual* and *Enrollee/Member and Family Handbook* are corrected.
- Revise the expedited appeal acknowledgement letter to accurately inform appellants that their appeal will be processed within 72 hours, with up to an additional 14 days if the expedited appeal resolution timeframe is extended.
- Revise the invalid notification to clearly and consistently reflect that the appellants appeal will not be processed.

- Revise the appeal extension notification to inform the appellant of their right to file a grievance if they disagree with Eastpointe's decision to extend the appeal resolution timeframe.
- Either describe the steps staff must follow prior to releasing the appeal and/or medical record in the appeal policy or reference Policy Q-6.3.5 Release of Medical Records within the appeal policy.
- Review the file discussed during the Onsite and provide training on the applicable steps staff must take prior to releasing PHI.

Recommendations

- Revise *Policy Q-6.4.4, Member/Enrollee and Stake Holder Complaints/Grievances* to correct definition of a grievance as noted in *DMA Contract Amendment M* and *42 CFR § 438.402*. Ensure the definition of an Adverse Benefit Determination is also included in this policy.
- Revise *Policy Q-6.4.4, Member/Enrollee and Stake Holder Complaints/Grievances* to consistently use one term for "complaints", "concerns" and "grievances". Similarly, keep terms consistent within the *Enrollee/Member and Family Handbook* and the *Provider Operations Manual*.
- Describe the steps staff take to address and resolve Quality of Care concerns, including details regarding how and where the physician review is documented.
- To demonstrate Eastpointe is applying their policies as formulated, ensure files submitted as part of any EQR or audit are complete, including all communications and notifications between Eastpointe's staff and the grievant.
- Clarify in *Policy C-3.2.6 Appeal of UM Adverse Benefit Determination* the timeframe for submitting a written appeal request after an oral appeal request is filed by an appellant. Specify when the timeframe starts.
- Add the word "prompt" to the sentence in section *D.2.E of Policy C-3.2.6* to state, "UM Director or designee will make reasonable efforts to provide prompt, oral notice." This will align the policy with *DMA Contract, Attachment M, Section H.9*.
- Clarify within *Policy C-3.2.6* under both the standard and expedited sections of this policy, the *DMA Contract* requirements Eastpointe must follow when extending the appeal resolution timeframes.
- Add information to *Policy C-3.2.6 Appeal of UM Adverse Benefit Determination* regarding how Eastpointe defines and processes invalid appeals, including notification to the appellant.
- Correct the *Provider Operations Manual* and *Enrollee/Member and Family Handbook* to clearly and consistently state that an expedited appeal will be resolved in 72 hours.

- Correct the *Provider Operations Manual* to state an appeal can be filed within 60 days of the mailing date of the Adverse Benefit Determination notice.
- Include invalid and withdrawn appeals trends in the analysis of appeals to identify any potential quality improvement opportunities.

G. Delegation

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

Policy Q-6.5.2, Oversight of Delegated Functions, *Policy E-4.4.20, Quality Review of Data Reports from Delegated Credentialing*, and the *Delegation Program Description* guide and direct the delegation process.

Eastpointe reported four delegated entities, as evidenced in Table 29, *Delegated Entities*. The delegation agreement with Access Nurse, Inc. dba TeamHealth Medical Call Center ended on February 14, 2018. At the last EQR, Eastpointe also had a contract with Dr. Venkata Doniparthi for Medical Director Consultant services, and the contract with BHM had been amended to add Medical Director services effective September 30, 2016. Eastpointe ended the Delegation Agreement with BHM for Medical Director services effective May 15, 2018, but Eastpointe has a current contract with Dr. Doniparthi.

Table 29: Delegated Entities

Delegated Entities	Service
BHM Healthcare Solutions	• Clinical Peer Review • Appeal Peer Review
Medversant Technologies, LLC	Credentials Verification Organization (CVO)
Access Nurse, Inc. dba TeamHealth Medical Call Center – Contract ended February 14, 2018	Screening, Triage and Referral (STR)
Cardinal Innovations	Screening, Triage and Referral (STR)
Dr. Venkata Doniparthi	Medical Director Consultant services

Eastpointe has delegation agreements and Business Associate Agreements (BAAs) with each of is delegates. The delegation agreement with BHM Healthcare Solutions for Clinical Peer Review and Appeal Peer Review was effective November 28, 2016, though it was signed on July 11, 2017. A Consulting Services Agreement with BHM effective June 1,

2011 was for "URAC Call Center Accreditation and Waiver Readiness and any other general consulting." That contract includes a BAA that was fully executed in July 2011.

Medversant Technologies, LLC ("Medversant") performs credentialing and recredentialing functions for Eastpointe, including receiving and processing applications and conducting Primary Source Verifications (PSVs) at initial credentialing, recredentialing, as well as conducting required monthly queries. Eastpointe's original delegation agreement and BAA with Medversant was effective on February 13, 2012. There have been several revisions, including a revised delegation agreement and BAA effective August 1, 2017.

Eastpointe completed a Predelegation Assessment before entering into the most recent delegation agreement with Cardinal Innovations ("Cardinal") for Screening, Triage, and Referral (STR). The agreement was effective November 1, 2017, with an end date of June 30, 2018. A new delegation agreement and BAA were effective on July 1, 2018.

Policy Q-6.5.2, Oversight of Delegated Functions, states "Eastpointe evaluates Delegate performance by conducting an annual assessment utilizing the

appropriate Eastpointe Delegation Assessment Tool." For the current EQR, Eastpointe submitted the following evidence of delegate oversight/monitoring:

- *Team Health*: *Annual Monitoring* report, which states that, during fiscal year 2017-18, Team Health handled two calls, one of which was a test call.
- Medversant: *Delegation Assessment Tool*; verification of Medversant's National Committee for Quality Assurance (NCQA) accreditation. Delegation Oversight was reported to the Global Quality Improvement Committee (GQIC) on October 13, 2017. During Onsite discussion, Eastpointe staff indicated data related to Medversant is reported to the Credentialing Committee.
- BHM: quarterly reports from BHM with monthly concordance rates
- Cardinal Innovations: detailed monthly reports from Cardinal of calls taken for Eastpointe. The reports include the answer rate, abandonment rate, and an action plan if the target goal is not met. The Clinical Manager for Access at Cardinal submitted an Annual Delegation Report.

The only Corrective Action item from the last EQR was to develop monitoring tools and monitor the Medical Director delegates. Eastpointe did not develop monitoring tools nor monitor Dr. Doniparthi, so this remains an unaddressed Corrective Action item for the current EQR.

Figure 8, Provider Services Comparative Findings, provides a comparison of the 2017 scores versus the 2018 scores.

Figure 8: Delegation Comparative Findings

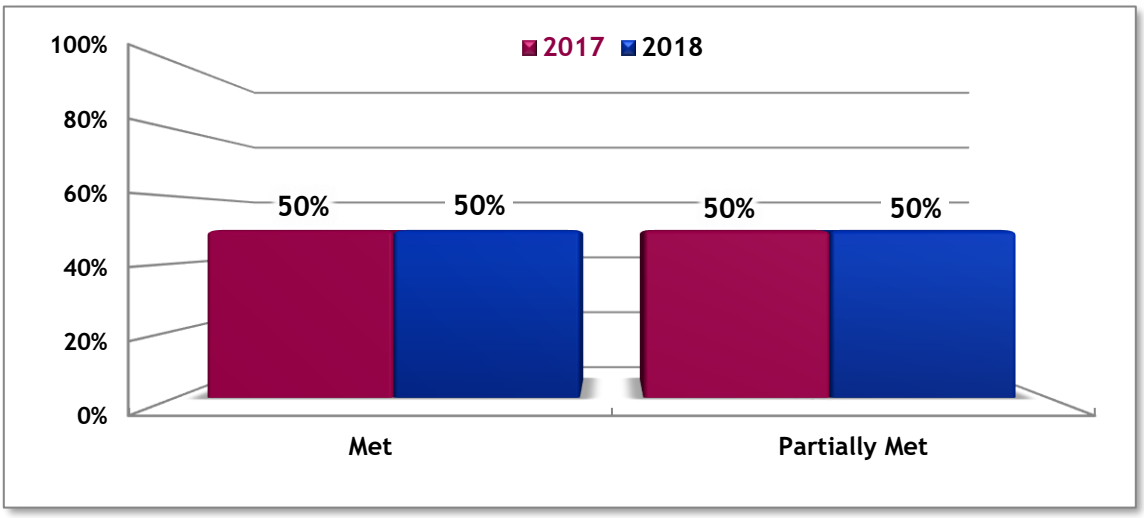


Table 30: Delegation

Section	Standard	2018 Review
Delegation	The PIHP conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the PIHP if the PIHP were directly performing the delegated functions	Partially Met

Strengths

- Eastpointe executed contracts and BAAs with its four delegates.
- Eastpointe submitted annual monitoring reports for three of its four current delegates. Eastpointe receives quarterly performance reviews from Cardinal and BHM.
- Eastpointe conducted a pre-delegation assessment before the current contract delegating STR to Cardinal.

Weaknesses

- Delegation monitoring for the contracted Medical Director consultants is not being completed.

Corrective Action

- Develop monitoring tools specific to each Medical Director delegate. The monitoring tools should include monitoring items to protect Eastpointe against any real or perceived conflicts of interest.

H. Program Integrity

As required by its contract with CCME, IPRO is tasked with assessing PIHP compliance with federal and state regulations regarding program integrity (PI) functions.

IPRO's review of Eastpointe began at the end of October 2018 with Desk Review of Eastpointe's PI files and documentation. IPRO analyzed the files and documentation and Onsite reviews were conducted on November 15, 2018 with the Chief of Regulations and Compliance, PI Director and PI staff to review the offsite documentation and file review findings.

IPRO requested the universe of PI files from Eastpointe for the 2017-2018 review period and selected a random sample of 15 files with a two-file oversample for a total of 17 files.

Contract Requirement

The PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of an allegation of fraud. If the PIHP determines that a complaint or allegation rises to potential fraud, the PIHP shall forward the information and any evidence collected to DMA within five (5) business days of the final determination of the findings. It is required that all case records be stored electronically by the PIHP.

Findings

Fifteen of fifteen files reviewed were compliant with this requirement.

Contract Requirement

In each case where PIHP refers to DMA an allegation of fraud involving a Provider, PIHP shall provide DMA Program Integrity with the following information on the DMA approved template:

- Subject (name, Medicaid provider ID, address, provider type)
- Source/origin of complaint
- Date reported to the PIHP or, if developed by the PIHP, the date the PIHP initiated the investigation
- Description of the suspected intentional misconduct, with specific details including: the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations, or policies violated, and dates of suspected misconduct
- Amount paid to the provider for the last three years or during the period of the alleged misconduct, whichever is greater

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

Findings

Four of 15 files were referred to NC Medicaid following a potential credible allegation of fraud involving a provider.

Four of four files that were referred to NC Medicaid were fully compliant with this requirement.

Contract Requirement

In each case of suspected enrollee fraud, the PIHP shall provide DMA program integrity with:

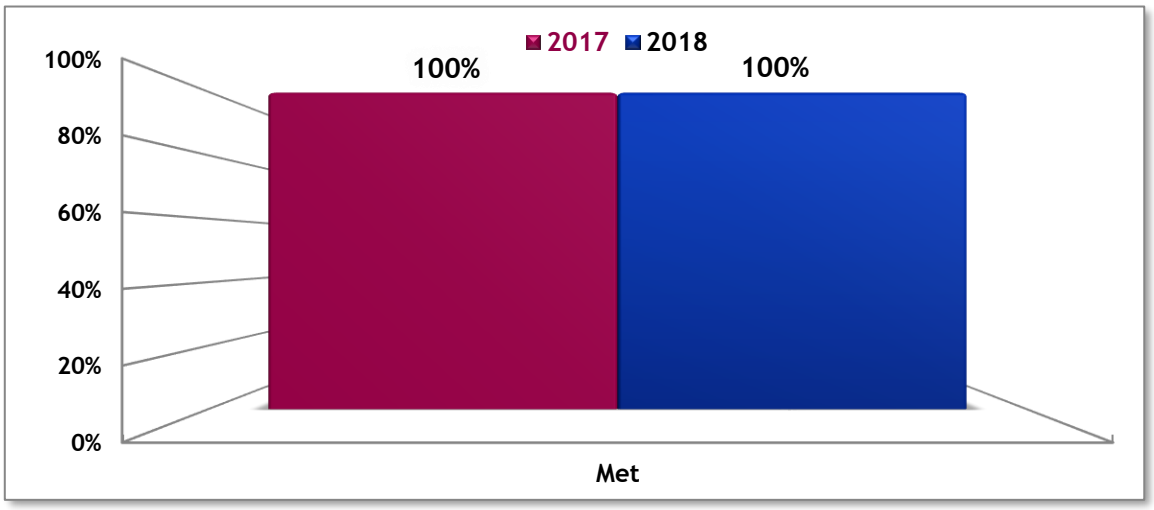
- The enrollee's name, birth date, and Medicaid number
- The source of the allegation
- The nature of the allegation
- Copies of all communications between the PIHP and the provider concerning the conduct at issue
- Contact information for PIHP staff persons with practical knowledge of the allegation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

Findings

No cases under review involved suspected enrollee fraud.

Figure 9 provides an overview of 2017 scores compared to 2018 scores.

Figure 9: Program Integrity Findings



Strengths

- Eastpointe has processes in place to thoroughly conduct investigations and prevent fraud, waste, and abuse within the organization.
- Eastpointe was able to engage in meaningful discussion Onsite about how they operationalize their policies regarding fraud, waste, and abuse.
- Eastpointe provided all of the necessary documentation and files both pre-Onsite and Onsite which contained all contractual requirements.
- The level of coordination, collaboration, and communication internally with Eastpointe staff and externally with h was demonstrable throughout the review of documentation as well as during the Onsite discussion.

Weaknesses

- Information about how providers can report to Eastpointe that they have received an overpayment was not accessible on the provider website for Eastpointe. Currently, the website only has newsletter archives from 2015/2016 and the referral form.

Recommendations

- Include links to information on how providers can report overpayment to the PIHP on the provider webpage of Eastpointe's website, along with the refund check form. Currently, the website only has newsletter archives from 2015/2016 and the referral form. This will ensure the information is up to date and readily accessible.

I. Financial Services

Eastpointe received all "Met" scores for the 2018 Financial Services EQR, with one "Partially Met" for timeliness of one risk reserve payment. CCME identified two policy enhancements. CCME recommends adding language to *Policy B-2.2.25, Risk Reserve* that payment is due within five business days of receipt of capitation payment. CCME also recommends adding the requirement for 10-year retention for Medicaid records to *Policy B-2.1.12, Data Storage, Maintenance and Destruction*. Eastpointe should ensure that all risk reserve payments are made within five business days of receipt of the capitation payment from the state.

CCME reviewed the following Eastpointe Desk Review materials before the Onsite visit:

- Financial policies
- Audited financial statements dated June 30, 2017
- Balance sheet and income statements dated June 30, 2018 and July 31, 2018
- Medicaid monthly financial reports for June and July 2018
- Claims processing aging report for June and July and as well as claims processing policies
- Finance and claims staffing structure
- Fiscal year budget for 2017-2018
- Budget to actual expenses report for Medicaid for June and July 2018

After reviewing Eastpointe's Desk Review materials, an Onsite visit and Interview were held at Eastpointe's office on November 15, 2018. In reviewing Eastpointe's financial operations, CCME used a *Standardized EQR Finance Desk Review* and *Onsite Administrative Interview Guide*. We reviewed whether deficiencies were noted in prior EQRs and determined if they were corrected. In addition to the standardized Desk Review inquiries, CCME asked interview questions in the following areas:

- Policies
- Staffing changes in finance
- Claims adjudication and re-adjudication
- Budget variances and development
- Board of directors' financial role
- Eastpointe's reinvestment plan

Eastpointe demonstrates overall financial stability. Eastpointe's audit report for the fiscal year ended June 30, 2017, received an unqualified opinion, and there were no findings on the report regarding internal control over financial reporting and compliance. During fiscal year 2017, Eastpointe's total net position increased by $3,522,023, or 3.5% to $103,996,081.

Eastpointe exceeded the *DMA Contract* benchmarks for current ratio, defensive interval, and medical loss ratio (MLR). Eastpointe's Medicaid current ratio was 2.90 with a total current ratio of 2.99 for June 2018. The Medicaid current ratio was 2.95 with a total current ratio of 3.01 for July 2018 (benchmark is 1.00). Eastpointe's Medicaid MLR was 88.7% fiscal year to date at July 31, 2018 before HCQI activities, and 91.5% including these activities (benchmark is 85%). Eastpointe's Medicaid total assets on June 30, 2018, were $105,814,980, and overall total assets were $157,680,502. At July 31, 2018, Eastpointe's Medicaid total assets were $106,654,612, and overall total assets were $159,091,762.

Eastpointe meets standard *42 CFR § 433.32(a)* for maintaining an appropriate accounting system (Great Plains). Great Plains 2018 modules used are purchasing, general ledger, accounts payable, fixed assets, cash management, human resources, and payroll. Eastpointe uses AlphaMCS for claims processing.

Eastpointe meets the minimum record retention of ten years that is required by standard *DMA Contract Section 8.3.2*. Eastpointe's *Policy B-2.1.12, Data Storage, Maintenance and Destruction* addresses Eastpointe's plan for record storage, and Eastpointe stated during the interview that they are following the North Carolina Department of Health and Human Services' (DHHS) records retention schedule. Financial records are maintained for ten years totally and longer if there is any legal action or unresolved audit findings. Eastpointe is converting to electronic record keeping for accounting records.

Eastpointe reviews their policies and modifies them, if necessary, on an annual basis. All finance policies reviewed by CCME had review dates within a year. Policies were detailed, and they included *DMA Contract* references, *Code of Federal Regulations* (CFR) references, and which staff was responsible for tasks, where applicable. Policies are updated by their owners. The staff is notified via email if there are new trainings that need to be completed, with deadlines and testing if appropriate. CCME recommends adding language to *Policy B-2.2.25 Risk Reserve* that payment is due within five business days of receipt of capitation payment. CCME also recommends adding the requirement for 10-year retention for Medicaid records to *Policy B-2.1.12, Data Storage, Maintenance and Destruction*.

Eastpointe's cost allocation plan meets the requirements for allocating the administrative costs between Medicaid, non-Medicaid, federal, state, and local entities based on revenue as required by *42 CFR § 433.34*. There were no costs disallowed per the audit

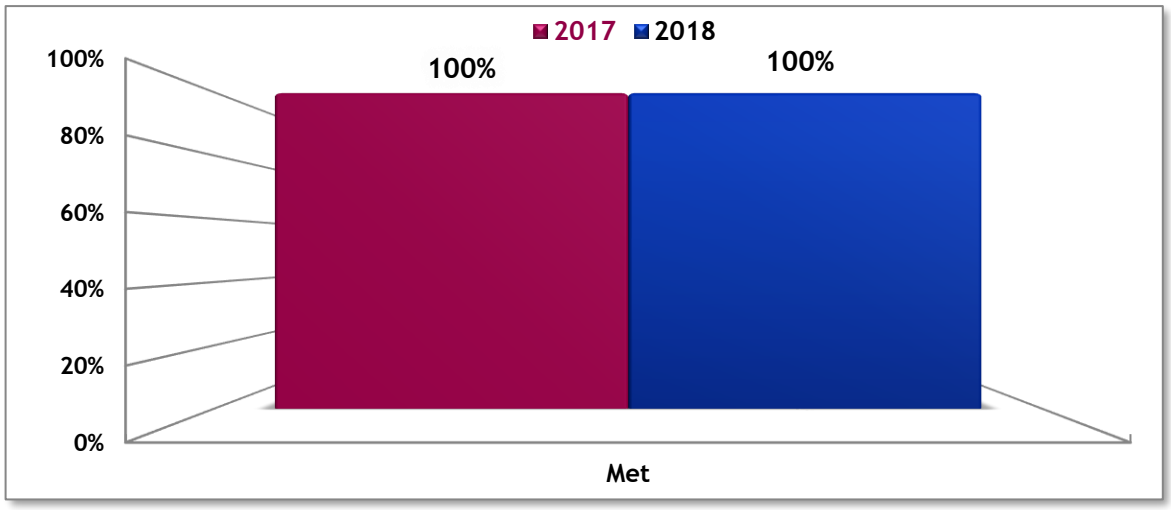
report and Onsite interview. Annually, Eastpointe submits a cost allocation plan to NC Medicaid to determine the percentage of Medicaid's share of administrative costs. Currently this percentage is 88%. The administrative expenses are recorded by expense type in the general ledger and are then allocated to the different funding sources based on a percentage of total revenues received (minus county funding). The cost allocation is calculated by the Director of Finance. Eastpointe's Medicaid funds are properly segregated through the chart of accounts in the general ledger of Great Plains (Medicaid is designated as 300 in the second segment of their account structure).

Eastpointe's Medicaid risk reserve account meets the minimum requirement of 2% of the capitation payment per month required by *DMA Contract, Section 1.9*. Eastpointe has reached 11.6% of their required percentage of annualized capitation maximum (15%) at July 31, 2018, with a balance of $30,476,092. Once the capitation payment is received from NC Medicaid, the General/Administrative State Contracts Liaison calculates the risk reserve payment, which is reviewed and paid electronically to PNC by the Finance Director within five business days of the capitation payment. All deposits were timely, with one exception which was late by one day, and there were no unauthorized withdrawals. Eastpointe provided CCME with bank statements demonstrating the risk reserve balance and deposits, which agreed with the 2% calculations from the Medicaid reports, and were made timely. Eastpointe documents their risk reserve process in *Policy B-2.2.25, Risk Reserve*. The one tardy payment was one day late due to staff transition.

The prior EQR recommended Eastpointe review and monitor the MLR proactively during the month to ensure that it did not fall below the 85% contractual requirement. Eastpointe is monitoring this rate with the NC Medicaid financial package, and the monthly dashboard reports sent to senior leadership.

Figure 10 provides an overview of 2017 scores compared to 2018 scores.

Figure 10: Financial Comparative Findings



Strengths

- Eastpointe has a strong financial position, as demonstrated by its key Medicaid financial ratios and balances.
- Medicaid reports are filed timely with no disallowed costs to Medicaid.
- Eastpointe met the record retention requirement of keeping records for a minimum of 10 years.
- Eastpointe's policies have references to the *DMA Contract* and External Quality Review Organization (EQRO) standards, as well as a policy on financial solvency.
- Eastpointe is working towards electronic accounting records, by scanning paper copies of records.

Weaknesses

- One Risk Reserve payment was made a day late due to staff transition.

Recommendations

- Add the five-business day transfer requirement after capitation payment to *Policy B-2.2.25, Risk Reserve*.
- Revise *Policy B-2.1.12, Data Storage* to refer to the 10-year requirement of financial records required by *DMA Contract, Section 8.3.2*.
- Implement a process to ensure risk reserve payments are deposited within five business days, to avoid any late payments.

J. Encounter Data Validation

Health Management Systems (HMS) has completed a review of the encounter data submitted by Eastpointe to North Carolina Medicaid, as specified in The Carolinas Center for Medical Excellence (CCME) agreement with NC Medicaid.

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

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

Results and Recommendations

Issue: Procedure Code

The procedure code for institutional claims should populated 99% of the time. In the encounter data provided, HMS found that the field was populated less than 36% of the time with valid values. These fields are required to adjudicate the claim appropriately and should be provided by the provider given the types of services being billed and supporting revenue codes provided.

Resolution

Eastpointe should check their claims processing system and data warehouse to ensure the procedure code is being captured appropriately. Claims submitted through the portal or an 837 should be denied by Eastpointe without the proper revenue code and procedure code combination. Eastpointe should double check their 837 encounter creation process and encounter data extract process to ensure data was not lost or manipulated during transformation.

Issue: Diagnosis Codes

Two items need to be addressed as it relates to diagnosis codes. The secondary diagnosis was populated less than 11% for professional claims and only the admitting and principal diagnosis was provided for institutional claims. In addition, there are never more than two diagnosis codes provided/submitted in the encounter data for professional or institutional claims.

Resolution:

The diagnosis issue will require action by Eastpointe and NC Medicaid. NC Medicaid will need to work with the plans and CSRA to determine what additional non-behavioral

health diagnosis codes should be submitted and accepted when available. Currently, NCTracks will deny any encounter with a non-behavioral health diagnosis regardless of the position of the diagnosis code value (i.e. primary, secondary, tertiary, etc.). There are behavioral health services provided by the plans that require medical services and medical diagnosis codes. Eastpointe will need to work collaboratively with the state and Alpha to ensure they can capture and report all diagnosis codes once NCTracks has been updated to accept. Eastpointe indicated that they are capturing all submitted diagnosis codes and can begin to transmit once NC Medicaid has a mechanism to accept the additional values.

Issue: Taxonomy code for Billing and Rendering providers

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

Resolution:

As outlined in their ISCA response, Eastpointe has a process in place to review denials and correctly resubmit encounters to the State that were denied due to invalid or missing taxonomy. Eastpointe should continue to follow their current process. The encounter data reviewed and NC Medicaid check write report reflects significant improvement over last year, so we know the process in place is making a positive impact.

Conclusion

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

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

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

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September 26, 2018

Ms. Sarah Stroud
Chief Executive Officer
Eastpointe
514 East Main Street
Beulaville, North Carolina 28518

Dear Ms. Stroud,

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

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

The CMS EQR protocols can be found at:

https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

The CCME EQR review team plans to conduct the onsite visit at Eastpointe on **November 14, 2018** through **November 15, 2018**. For your convenience, a tentative agenda for the two-day review is enclosed.

In preparation for the desk review, the items on the enclosed **Materials Requested for Desk Review** list are to be submitted electronically and are due no later than **October 17, 2018**. As indicated in item 42 of the review list, a completed Information Systems Capabilities Assessment (ISCA) for Behavioral Health Managed Care Organizations is required. The enclosed ISCA document is to be completed electronically and submitted by the aforementioned deadline.

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

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

The location for the file transfer site is:

https://eqro.thecarolinascenter.org

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

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

An opportunity for a pre-onsite conference call with your management staff, in conjunction with 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: Anna North, Eastpointe Contract Manager
Tasha Griffin, NC Medicaid Contract Manager
Renee Rader, NC Medicaid Quality Manager
Deb Goda, NC Medicaid Behavioral Health Unit Manager

External Quality Review 2018

MATERIALS REQUESTED FOR DESK REVIEW

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

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

3. Current Medical Director, medical staff job descriptions.

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

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

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

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

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

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

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

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

12. A current provider manual and provider directory.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

29. A copy of the provider contract/application.

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

31. Contracts for all delegated entities.

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

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

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

35. Information regarding the following selected Performance Measures:

1. B WAIVER MEASURES	
A.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

2. C WAIVER MEASURES	
Proportion of Level of Care evaluations completed at least annually for enrolled participants	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals

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

Required information includes the following <u>for each measure</u>:

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

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

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

data, barriers to improvement and interventions planned or implemented to address each barrier, calculated result, results, etc.)

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

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

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

The recredentialing files should include all of the following:

Proof of original credentialing date and all recredentialing dates, including the current recredentialing	Site visit/assessment reports, if the provider has had a quality issue or a change of address.

Proof of all insurance coverages .For practitioners who are employed at already-contracted agencies, include copies of the insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.	Ownership disclosure information/form

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

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

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

41. Provide the following for Program Integrity:
    a. File Review: Please produce a listing of all active files during the review period (September 2017 –August 2018) including:
        i. Date case opened
        ii. Source of referral
        iii. Category of case (enrollee, provider, subcontractor)
        iv. Current status of the case (opened, closed)
    b. Program Integrity Plan and/or Compliance Plan.
    c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.
    d. Workflow of process of taking complaint from inception through closure.
    e. All 'Attachment Y' reports collected during the review period.
    f. Provider Manual and Provider Application.
    g. Enrollee Handbook.
    h. Subcontractor Agreement/Contract Template.
    i. Training and educational materials for the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse and the False Claims Act.
    j. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse.
    k. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors and employees.

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

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

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

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

Section	Question Number	Attachment
Enrollment Systems	1b	Enrollment system loading process
Enrollment Systems	1e	Enrollment loading error process
Enrollment Systems	1f	Enrollment loading completeness reports
Enrollment Systems	2c	Enrollment reporting system load process
Enrollment Systems	2e	Enrollment reporting system completeness reports
Claims Systems	2	Claim process flowchart
Claims Systems	2t	Claim exception report.
Claims Systems	3e	Claim reporting system completeness process / reports.

Claims Systems	3h	Physician and institutional lag triangles.
Reporting	1a	Overview of information systems
DMA Submissions	1d	Workflow for DMA submissions
DMA Submissions	2b	Workflow for DMA denials
DMA Submissions	2e	DMA outstanding claims report

c. A copy of the IT Disaster Recovery Plan.

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

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

43. Provide the following for Financial Reporting:

a. Most recent annual audited financial statements.

b. Most recent annual compliance report

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

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

e. Most recent months' capitation/revenue reconciliations.

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

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

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

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

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

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

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

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

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

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

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

q. Description and procedures used to allocate direct and overhead expenses to Medicaid and State funded programs, if changed during the review period.
r. Claims still pending after 30 days.
s. Bank statements for the restricted reserve account for the most recent two months.
t. A copy of the most recent cost allocation plan.
u. A copy of the PIHP's accounting manual.
v. A copy of the PIHP's general ledger chart of accounts.
w. Any finance Corrective Action Plan
x. Detailed medical loss ratio calculation, including the following requirements under CFR § 438.8:
    i. Total incurred claims
    ii. Expenditures on quality improvement activities
    iii. Expenditures related to PI requirements under §438.608
    iv. Non-claims costs
    v. Premium revenue
    vi. Federal, state and local taxes, and licensing and regulatory fees
    vii. Methodology for allocation of expenditures
    viii. Any credibility adjustment applied
    ix. The calculated MLR
    x. Any remittance owed to State, if applicable
    xi. A comparison of the information reported with the audited financial report required under §438.3 (m)
    xii. The number of member months

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

a. Include all adjudicated claims (paid and denied) from January 1, 2017 – December 31, 2017. Follow the format used to submit encounter data to DMA (i.e., 837I and 837P). If you archive your outbound files to DMA, you can forward those to HMS for the specified time period. In addition, please convert each 837I and 837P to a pipe delimited text file or excel sheet using an EDI translator. If your EDI translator does not support this functionality, please reach out immediately to HMS.
b. Provide a report of all paid claims by service type from January 1, 2017 – December 31, 2017. Report should be broken out by month and include service type, month and year of payment, count, and sum of paid amount.

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

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2018

MATERIALS REQUESTED FOR REVIEW (PLEASE LIST ANY SPECIFIC PROVIDER NAMES ON A SEPARATE LIST BUT REFERENCE THE REQUEST ON THIS LIST).

1. Copies of all committee minutes for committees that have met since the desk materials were uploaded.
2. Credentialing Committee By-Laws
3. Electronic votes referenced in this sample of Credentialing Committee meeting minutes ("Approval of Electronic Votes since the Last Meeting"): 09/22/17; 11/17/17; 05/25/18
4. All electronic votes submitted by Credentialing Committee members pursuant to the 06/22/18 meeting (at which there was no quorum).
5. Please submit items missing from credentialing/recredentialing files, for providers identified on the supplemental ***Eastpointe Credentialing/Recredentialing Documentation list***, for information obtained during the credentialing/ recredentialing process. Also, please submit:
   a. Documentation of query of *The North Carolina Medicaid Provider Termination and Exclusion* list (known as the *State Exclusion List*), conducted during current/most recent credentialing/recredentialing process, for **all** submitted (practitioner **and** agency/facility) credentialing and recredentialing files.
   b. "Doctor's Approvals"/ "Clean" application lists submitted to the Credentialing Committee, for each of the submitted Credentialing and Recredentialing files. (These lists are referenced in the Credentialing Committee meeting minutes, but were not submitted in Desk Materials for the EQR.)
6. All appeal requests by appellants for all of the appeal files uploaded. Include documentation of "oral requests" (i.e., "G&A").
7. An appeal extension notification template and an invalid appeal notification template.
8. The appeal "Oral Request Form" for any of the 20, first level files submitted for this EQR.
9. Provide the allegation number (allegations 1-10, from pages 5-14) that corresponds to each of the following case(s)—they all appear to be part of one larger case. Please follow the below format:

Case number	Allegation number found in case file: "PI 2018-882; 884; 894; 908; 910; 911;912; 923; 924; 934; 935; 938; 939.pdf", pages 5-14
2018-908	
2018-911	
2018-923	
2018-935	

10. Any policy or procedure that addresses tracking provider overpayments and collections.
11. Any policy, procedure, or provider education materials that explain the mechanism by which providers report to Eastpointe that they have received an overpayment.

C. Attachment 3: EQR Validation Worksheets

- Performance Improvement Project Validation Worksheet
  - Increase number of individuals in the priority population served by a fidelity provider to 50% monthly
  - Increase the percentage of individuals who received a 2nd service within or less than 14 days to 35%
  - Decrease state psychiatric hospital 30-day readmissions for high risk members
  - Decrease emergency department admissions for active members to 20%

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

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Eastpointe**
Name of PIP:	**INCREASE NUMBER OF INDIVIDUALS IN THE PRIORITY POPULATION SERVED BY A FIDELITY PROVIDER TO 50% MONTHLY**
Reporting Year:	**2017-2018**
Review Performed:	**2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	State target is 13 per month or 50% and Eastpointe is not meeting that target.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This PIP addresses a key aspect of service.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All enrolled populations are included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research question is documented in PIP report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is not clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Measure assesses processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Medicaid enrollees that are included in study are documented.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Data collection captures all relevant data.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data source is documented (TCLI Dashboard).
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Method of data collection is documented.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments are consistent.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of staff and personnel used to collect data are documented.

Component / Standard (Total Points)	Score	Comments
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Barriers are listed and interventions are documented in Action IV.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data analysis is presented as monthly.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**PARTIALLY MET**	PIP report has findings presented by month from the start of the PIP to the most recent remeasurement, but the analysis is confusing as the first date is December 2017 and then the second date is January 2017 on page 10. **Recommendation: Check for typos, as the analysis for FY 2018 has January 2017 and it should say January 2018.**
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Initial and repeat measurements are included.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis was provided for measurement periods.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Methodology was the same across measurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	Rate has mostly failed to meet the 50% benchmark in 2018. **Recommendation: Improvement has not occurred and action plans need to be put into place based on barriers and noted opportunities for improvement.**

Component / Standard (Total Points)	Score	Comments
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Improvement was not reported in most recent rates.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analysis is not required for projects that do not utilized sampling.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Sustained improvement has not occurred.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	NA	NA
8.2	10	5
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	0
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify		
	NA	NA

Project Score	**74**
Project Possible Score	**80**
Validation Findings	**93%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Eastpointe**
Name of PIP:	**INCREASE THE PERCENTAGE OF INDIVIDUALS WHO RECEIVED A 2ND SERVICE WITHIN OR LESS THAN 14 DAYS TO 35%**
Reporting Year:	**2017**
Review Performed:	**2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Only 5,098 of 21,439 members received a second service within 14 days.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	It is important to members because it ensure continuity of care, reduces utilization of crisis services and promotes recovery.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question was documented.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure is clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measure is related to processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Not Met**	Sources of data were not clearly specified. **Corrective Action: Include data sources used to collect data in the 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)**	**Not Met**	Data collection methods are not clearly documented. **Corrective Action: Include information on how data are collected.**
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Not Met**	Instruments for data collection were not documented. **Corrective Action: Include data collection tools or instruments.**
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Not Met**	Data analysis was not clearly documented. **Corrective Action: Document the data analysis plan in the report.**
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Barriers and interventions were documented in Action IV.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**NA**	Data analysis plan was not documented; thus, this element cannot be judged.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Not Met**	Results were clearly displayed in Tables and bar graphs. However, the first measurement periods are not shown, nor are any in 2016. There are only two measurement periods shown. **Corrective Action: Data from all measurement periods throughout the entire PIP should be presented in the report.**
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Measurements are presented but not for all periods of the PIP (see Step 8.2). Statistical analysis is not needed due to non-sampling.

Component / Standard (Total Points)	Score	Comments
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Conclusions were offered and revisions were made to increase success.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	The same methodologies were used at all measurement points.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	No, rates have not increased. They are steady around 25%. **Corrective Action: Continue evaluating interventions to ensure they are addressing all barriers to increasing the rate.**
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	There is no reported improvement, thus, too early to judge.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical tests were not conducted.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Improvement was not documented, thus, too early to judge.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	0
6.3	1	0

Steps	Possible Score	Score
Step 6		
6.4	5	0
6.5	1	0
6.6	5	5
Step 7		
7.1	10	0
Step 8		
8.1	NA	NA
8.2	10	0
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	0
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify		

Project Score	51
Project Possible Score	80
Validation Findings	64%

AUDIT DESIGNATION
LOW CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Eastpointe**
Name of PIP:	**DECREASE STATE PSYCHIATRIC HOSPITAL 30-DAY READMISSIONS FOR HIGH RISK MEMBERS**
Reporting Year:	**2017-2018**
Review Performed:	**2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Readmissions rates has been above the statewide average for 50% of quarters.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspect of enrollee care.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	Includes all enrolled populations.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Study question is listed on page 1.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**PARTIALLY MET**	The benchmark is not clearly listed. It appears to be 6%, but the baseline goal is also documented as 6%. These values should not be the same. The baseline goal is the immediate goal and the benchmark is the best practice rate. **Corrective Action: Revise Section I:B so that benchmark is best practice rate and baseline goal is the short-term goal rate.**
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures functional status and processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Enrollees are clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Data collection captures all enrollees to whom the question applies.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected is documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are clearly documented.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Method of collecting data is documented.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection provides accurate data.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is documented as quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Personnel and qualifications are documented.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**NOT MET**	Interventions are only documented for the most recent remeasurement. **Corrective Action: Documentation should include barriers and interventions from the start of the project.**
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**NOT MET**	Data analysis should be presented for quarters from start of the project which was noted as 2011. **Corrective Action: Present findings from baseline through most recent measurement.**
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NOT MET**	Numerator and denominator for all measurement periods from start of the project should be documented. **Corrective Action: Present rates for all quarters from start of project to most recent remeasurement.**

Component / Standard (Total Points)	Score	Comments
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NOT MET**	Initial and repeat measurements are not reported. **Corrective Action: Include initial and repeat measurements in report, as well as analysis of each quarter.**
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**PARTIALLY MET**	Analysis included most recent findings and follow-up activities, but previous measurement analyses were not included in the report. **Corrective Action: Analyses and follow-up activities planned should be documented for all measurement periods.**
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Methodology was same across all measurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The rate has been below the goal for the last two quarters (lower is better).
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to interventions that have been put into place.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analyses not conducted due to non sampling.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Due to only two periods being presented in the report, this information is unable to be judged,

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	0
Step 8		
8.1	5	0
8.2	10	0
8.3	1	0
8.4	1	0
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify		

Project Score	**58**
Project Possible Score	**90**
Validation Findings	**64%**

AUDIT DESIGNATION
LOW CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Eastpointe**
Name of PIP:	**DECREASE EMERGENCY DEPARTMENT ADMISSIONS FOR ACTIVE MEMBERS TO 20%**
Reporting Year:	**2017-2018**
Review Performed:	**2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	There is a high rate of members readmitted to ED.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This PIP addresses key aspects of enrollee care.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This PIP includes all enrolled populations.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Study question is documented on page 1.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**NOT MET**	Indicator is defined but there is no benchmark rate listed. The short-term goal is noted as 20%. The benchmark should be documented. Also, the measure has readmission in the title, but the numerator and denominator do not refer to readmissions. The first measurement period dates should be only one month, since data is collected monthly. **Corrective Action: Document the best practice rate in Section I:B. Clarify if readmissions or admissions are the measure, as QI documents suggest readmission and the title suggests readmissions, but the rate does not discuss readmissions. First measurement period dates should be July 2017 only, since data are collected each month.**
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Measures are related to health status and processes of care.

Component / Standard (Total Points)	Score	Comments
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Enrollees are defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	PIP captures all enrollees to whom the question applies.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Design clearly specified data to be collected.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are specified.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Collection methods are reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments allow for accurate data.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis is indicated as monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications are documented for personnel involved in the study.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**NA**	Project was approved in August 2018.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**NA**	No analysis conducted.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NA**	Results are not presented.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	No analysis conducted.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NA**	No study data to analyze.

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	No study data to analyze methods.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Unable to judge, as rates are not reported.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Unable to judge.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No statistical analysis conducted as study does not have sampling.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	0
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

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

Project Score	**42**
Project Possible Score	**52**
Validation Findings	**81%**

AUDIT DESIGNATION
CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PM Validation Worksheet

Plan Name:	**Eastpointe**
Name of PM:	**READMISSION RATES FOR MENTAL HEALTH**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**11/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Eastpointe**
Name of PM:	**READMISSION RATES FOR SUBSTANCE ABUSE**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**11/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Eastpointe**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**11/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Eastpointe**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR SUBSTANCE ABUSE**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**11/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Eastpointe**
Name of PM:	**INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**11/18**

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Eastpointe**
Name of PM:	**MENTAL HEALTH UTILIZATION- INPATIENT DISCHARGE AND AVERAGE LENGTH OF STAY**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**11/18**

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Eastpointe**
Name of PM:	**MENTAL HEALTH UTILIZATION**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**11/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Eastpointe**
Name of PM:	**IDENTIFICATION OF ALCOHOL AND OTHER DRUG SERVICES**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**11/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Eastpointe**
Name of PM:	**SUBSTANCE ABUSE PENETRATION RATE**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**11/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Eastpointe**
Name of PM:	**MENTAL HEALTH PENETRATION RATE**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**11/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N6. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.
N1. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N2. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N3. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N4. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Eastpointe**
Name of PM	**INNOVATIONS MEASURE: LEVEL OF CARE EVALUATION**
Reporting Year	**2017**
Review Performed	**11/18**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G2. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G3. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D3. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D4. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N7. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N8. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R3. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in SHC Innovations Waiver Excel file
R4. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

Plan's Measure Score	55
Measure Weight Score	55
Validation Findings	100%

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Eastpointe**
Name of PM	**INNOVATIONS MEASURE: LEVEL OF CARE EVALUATIONS COMPLETED USING APPROVED PROCESSES AND INSTRUMENTS**
Reporting Year	**2017**
Review Performed	**11/18**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G4. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G5. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D5. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D6. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N9. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N10. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R5. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in SHC Innovations Waiver Excel file
R6. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Eastpointe**
Name of PM	**INNOVATIONS MEASURE: NEW LEVEL OF CARE EVALUATIONS COMPLETED USING APPROVED PROCESSES AND INSTRUMENTS**
Reporting Year	**2017**
Review Performed	**11/18**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G6. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G7. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D7. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D8. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N11. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N12. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R7. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in SHC Innovations Waiver Excel file
R8. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Eastpointe**
Name of PM	**INNOVATIONS MEASURE: PROPORTION OF PROVIDERS THAT IMPLEMENTED AN APPROVED CORRECTIVE ACTION PLAN**
Reporting Year	**2017**
Review Performed	**11/18**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G8. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G9. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D9. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D10. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N13. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N14. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R9. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in SHC Innovations Waiver Excel file
R10. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Eastpointe**
Name of PM	**INNOVATIONS MEASURE: PROPORTION OF PROVIDERS WHEREIN ALL STAFF COMPLETED MANDATED TRAINING**
Reporting Year	**2017**
Review Performed	**11/18**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G10. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G11. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D11. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D12. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N15. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N16. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R11. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in SHC Innovations Waiver Excel file
R12. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Eastpointe**
Name of PM	**INNOVATIONS MEASURE: PROPORTION OF ISPS IN WHICH SERVICES AND SUPPORTS REFLECT PARTICIPANT ASSESSED NEEDS AND LIFE GOALS**
Reporting Year	**2017**
Review Performed	**11/18**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G12. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G13. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D13. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D14. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N17. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N18. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R13. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in SHC Innovations Waiver Excel file
R14. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Eastpointe**
Name of PM	**INNOVATIONS MEASURE: ISPS ADDRESS IDENTIFIED HEALTH AND SAFETY RISK FACTORS**
Reporting Year	**2017**
Review Performed	**11/18**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G14. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G15. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D15. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D16. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N19. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N20. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R15. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in SHC Innovations Waiver Excel file
R16. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Eastpointe**
Name of PM	**INNOVATIONS MEASURE: PARTICIPANTS REPORTING THAT ISP HAS SERVICES THEY NEED**
Reporting Year	**2017**
Review Performed	**11/18**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G16. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G17. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D17. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D18. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N21. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N22. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R17. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in SHC Innovations Waiver Excel file
R18. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Eastpointe**
Name of PM	**INNOVATIONS MEASURE: INDIVIDUALS FOR WHOM AN ANNUAL ISP AND OR NEEDED UPDATES TOOK PLACE**
Reporting Year	**2017**
Review Performed	**11/18**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G18. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G19. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D19. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D20. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N23. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N24. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R19. Reporting (10)	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R20. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Eastpointe**
Name of PM	**INNOVATIONS MEASURE: NEW WAIVER PARTICIPANTS ARE RECEIVING SERVICES ACCORDING TO ISP WITHIN 45 DAYS OF APPROVAL**
Reporting Year	**2017**
Review Performed	**11/18**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G20. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G21. Data Reliability(2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D21. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D22. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N25. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N26. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R21. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in SHC Innovations Waiver Excel file
R22. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

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

AVERAGE VALIDATION PERCENTAGE & AUDIT DESIGNATION
100% FULLY COMPLIANT

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

D. Attachment 4: Tabular Spreadsheet

CCME PIHP Data Collection Tool

Plan Name:	**EASTPOINTE**
Collection Date:	**2018**

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. A. General Approach to Policies and Procedures						
1. The PIHP has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					A sample of Eastpointe's policies were reviewed along with the *Policy and Procedure List* and the *P&P Manual Table of Contents*. When comparing this sample of policies (63 policies or 20%) to the *Policy and Procedure List* and the *P&P Manual Table of Contents*, 15 (or 24%) of the sample had incorrect information such as mis-numbered policies, missing policies and/or typos within the two tracking lists. ***Recommendation: Reconcile the Policy and Procedure List and the P&P Manual Table of Contents to ensure all policies are accounted for and all dates (revised/review dates and original effective dates) and policy labels are accurate and consistent within these two tracking documents.***
I. B. Organizational Chart / Staffing						
1. The PIHP's resources are sufficient to ensure that all health care products and services required by the State of North Carolina are provided to enrollees. At a minimum, this includes designated staff performing in the following roles:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 A full time administrator of day-to-day business activities;	X					Sarah Stroud continues in her role as Chief Executive Officer (CEO).
1.2 A physician licensed in the state where operations are based who serves as Medical Director, providing substantial oversight of the medical aspects of operation, including quality assurance activities.	X					In last year's EQR, CCME documented concerns with Eastpointe's current Medical Director services contractual arrangements. BHM Healthcare Solutions was providing 20 hours of Medical Director services. As BHM is also completing the peer clinical reviews for Eastpointe, this duality of roles brought to light several potential conflicts of interests. Eastpointe has since secured a full-time Medical Director and terminated this contract provision in May of 2018.
2. Operational relationships of PIHP staff are clearly delineated.	X					Dr. Doniparthi is not represented on the organizational chart as outlined in her job description and described during the Onsite. Her title is also inconsistent across the organizational chart and within committee minutes. ***Recommendation: Ensure Dr. Doniparthi's departmental oversight and title are consistent with her job description within the organizational chart and committee minutes.***
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all PIHP staff positions, including those that are required by DMA contract.	X					The organizational chart did not consistently reflect all staff degrees and licensure. ***Recommendation: Ensure the organizational chart reflects staff degrees and licensure consistently throughout the chart.***
I. C. Confidentiality						
1. The PIHP formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP provides HIPAA/confidentiality training to new employees and existing staff.	X					*Policy H-5.3.2* Employee Orientation and Training states, "New employees will report to the Human Resources Department on their first day of employment to complete the New Employee Orientation Session that includes HIPAA/Confidentiality training upon hire and offered through Essential Learning platform."
I D. Management Information Systems						
1. Enrollment Systems						
1.1 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Eastpointe uses defined processes for enrollment data updates. Wellsky uploads enrollment data received on the daily, quarterly GEF and the monthly 834 files. Eastpointe uses the monthly capitation file to reconcile the payment received per member and category monthly. Eastpointe also reconciles the monthly capitation file with the member eligibility records in the AlphaMCS to ensure accurate payment was received. Demographic data is captured in the AlphaMCS system and Patient IDs are unique to members. Historic enrollment information is captured for all members in the AlphaMCS system.
1.2 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					Eastpointe produces exception reports to verify the completeness of data following the GEF load.
1.3 The MCO's enrollment system member screens store and track enrollment and demographic information.	X					During the Onsite, Eastpointe demonstrated the AlphaMCS enrollment screens and their capability to store the demographic information.

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					Approximately, 20% of institutional and 80% of professional claims are auto-adjudicated. Auto-adjudication is performed daily. Claims more than $5,000 and emergency department claims are pended for manual review.
2.2 The MCO has processes and procedures in place to monitor review and audit claims staff.	X					Eastpointe audits a random sample of 3% of all claims processed in a one-month period monthly. Eastpointe conducts monthly and quarterly audits on claims processed. Claims more than $5,000 and paper claims are audited for accuracy.
2.3 The MCO has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 diagnosis codes received on an 837 Institutional and 837 Professional file, capabilities of receiving and storing ICD-10 procedure codes on an 837 Institutional file.	X					Eastpointe captures up to 24 ICD-10 diagnosis codes for institutional and 12 diagnosis codes for professional claims. Eastpointe's Provider Web Portal captures no more than 18 ICD-10 diagnosis codes since it mirrors the UB04 paper claim for institutional claims. Eastpointe's Provider Web Portal captures up to 12 ICD-10 diagnosis codes for professional claims. Eastpointe captures ICD-10 procedure codes and DRG codes that providers send. ***Recommendation: Eastpointe does not have the ability to receive, store, and report all secondary ICD-10 diagnosis codes for institutional claims. Eastpointe needs to capture all ICD-10 diagnosis codes providers submit on a claim.***
2.4 The MCO's claim system screens store and track claim information and claim adjudication/payment information.	X					Onsite Review of the claim system screens identified the capture of adjudication/payment information for the claims.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Reporting						
3.1 The MCO's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					Eastpointe captures all necessary data elements required for enrollment and claims reporting. Historical data is stored in the AlphaMCS system from the inception of the PIHP.
3.2 The MCO has processes in place to back up the enrollment and claims data repositories.	X					Wellsky backs up enrollment and claims data in the AlphaMCS system. Eastpointe also backs up the copy of the database that Wellsky sends nightly. A disaster recovery policy was provided along with the ISCA tool. Eastpointe was affected during the hurricane in September 2018. However, there was very little business impact and no disruption of business processes and services.
4. Encounter Data Submission						
4.1 The MCO has the capabilities in place to submit the State required data elements to DMA on the encounter data submission.		X				An update is needed to Eastpointe's encounter data submission process to allow for all ICD-10-CM secondary diagnosis codes submitted on an institutional and professional 837 HIPAA file to be submitted to NCTracks. 25 ICD-10-CM diagnosis codes are the maximum number of diagnosis codes that may be submitted on an 837I and the maximum number that is captured by NCTracks. NCTracks can capture up to 12 diagnosis codes for professional claims. Eastpointe indicated that the health plan and Wellsky are testing modifications to submit additional diagnosis codes to the NCTracks. Upon successful testing, Eastpointe will apply the change. ***Corrective Action: Update Eastpointe's encounter data submission process to be able to submit all ICD-10 diagnosis codes present on an 837I and 837P.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Eastpointe does not submit physical health related secondary ICD-10 diagnosis codes to NCTracks. Eastpointe should submit all secondary ICD-10 diagnosis codes providers include on their submitted claims to NCTracks.
4.2 The MCO has the capability to identify, reconcile and track the encounter data submitted to DMA.	X					Eastpointe updates and maintains details on encounters that are submitted for encounter data submission on 837 files and the details on the 999 response files.
4.3 MCO has policies and procedures in place to reconcile and resubmit encounter data denied by DMA.	X					Eastpointe has clear processes that address denied encounter submissions. Eastpointe uses paid and denied reports to research, correct and resubmit denied encounters. Eastpointe is manually resubmitting the corrected encounters. Approximately 25% of encounters submitted in 2016 were denied and not resubmitted to NCTracks. ***Recommendations: Develop a process that would allow the batch resubmission of specific denial reasons.*** ***Work with NC Medicaid to resubmit the 2016 encounters previously denied, to the degree that is possible***
4.4 The MCO has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to DMA	X					Eastpointe established communications between the MIS and Claim Departments to address NCTracks encounter denials and submission of encounters that were not included in earlier encounter data submissions. Eastpointe staff is well informed and is dedicated to improving encounter data submissions and reducing the number of denials.

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 *Provider Credentialing Operations Manual/Plan* (*Credentialing Manual)* and several policies and procedures describe the requirements and processes for credentialing and recredentialing network providers. Eastpointe contracts with Medversant Technologies, a Credentials Verification Organization (CVO), for "Primary Source Verification (PSV) for pre-screening, initial credentialing, and re-credentialing and continuous monitoring of participating providers within the network."
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 By-Laws 11.30.17* state, "The Committee Chairperson is Eastpointe's Medical Director." The *Provider Credentialing Operations Manual/Plan* indicates the Associate Medical Director chairs the Credentialing Committee. Dr. Doniparthi chairs the committee. On the *organization chart*, Dr. Doniparthi is listed as Consultant, and there is a Delegation Contract, listing her as Medical Director Consultant. During Onsite discussion, staff indicated her title is Associate Medical Director, while other staff said she is the Assistant Medical Director. The Credentialing Committee section of the *Provider Credentialing Operations Manual/Plan* states, "The meeting will not occur if the Medical Director is not present at the meeting." However, the Medical Director is not a member of the Credentialing Committee and does not attend the meetings. *Policy E-4.4.10, Application Process for Contracting with Agencies,* states, "the MCO allows it (*sic*) Medical Director to review and approve 'clean' re-credentialing applications." Onsite discussion and the file review confirmed the Dr. Doniparthi (not the Medical Director) reviews and approves the applications.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Credentialing Committee meetings are held via webinar. Votes are frequently conducted electronically. Credentialing Committee meeting minutes often do not reflect discussion of the "flagged" applications. Applications that are pended for more information are often never mentioned again, and some meeting minutes do not reflect votes on some applications, though the letter to the provider reflects approval or denial. Meeting minutes do not reflect why at least one file was pended. The 12/15/17 meeting minutes state, "Approval of Amended Minutes from September 22, 2017 Credentialing Committee Meeting: The September 22, 2017 Committee Meeting Minutes were amended to include the Confidentiality and Credentialing and Re-Credentialing for Credentialing Committee that was presented by Linda Isbell". However, no minutes were marked "Amended". During Onsite discussion, Eastpointe staff indicated flagged applications are discussed, and information obtained for pended applications is shared with the committee, prior to votes. The meeting minutes do not include the documentation supporting these practices. ***Corrective Action: Ensure Credentialing Committee meeting minutes and documentation include evidence of discussion prior to votes, and that minutes reflect closure of items that are "pending" for information. Revise the Credentialing Committee Bylaws, the Provider Credentialing Operations Manual/Plan and any other documents that detail credentialing processes to accurately reflect the Chair of the committee and committee processes. If meeting minutes are changed, mark them as "Amended".***
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 were organized and contained appropriate information. The following issues were identified in the file review:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					Two of the credentialing files were missing evidence of some of the required insurance (see *DMA Contract, Attachment B, Section 7.7*) verifications or waiver. Missing insurance information was provided in response to the *Onsite Request List*. Missing insurance documentation was also an issue in the last EQR. ***Recommendation: Verify credentialing files contain proof of all the required insurance coverages (or the relevant statement from practitioner about why it is not required), and that the individual practitioner is listed among those covered under the policies. See DMA Contract Attachment B, Section 7.7, DMA Contract, Attachment O, DMA Contract Attachment B, Section 7.9.***
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
3.1.3 Valid DEA certificate; and/or CDS certificate			X			Two of the credentialing files are for providers (one M.D., one PA-C) for whom a Drug Enforcement Agency (DEA) certificate is required. The file of the PA-C contains what appears to be a copy of a DEA certificate. The *Application Checklist* has "N/A" for the DEA certificate, the *Verified Profile* does not include the DEA certificate, and the credentialing file does not contain evidence of PSV of the DEA certificate. The PSV was requested in the *Onsite Request List*. Eastpointe provided a PSV dated 11/6/18 (after CCME requested the PSV). ***Corrective Action: Ensure recredentialing files contain all items, including the PSV of the DEA certificates. See DMA Contract Attachment O.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					
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					
3.1.8 Query of the National Practitioner Data Bank (NPDB) ;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);		X				Neither the *Credentialing Manual* nor Eastpointe *Policy E-4.4.17, Primary Source Verification and Enrollment Requirements for Licensed Independent Practitioners (LIPs*), includes the query of *The North Carolina Medicaid Provider Termination and Exclusion* list (known as the *State Exclusion List*). No evidence of a query of was found in any submitted credentialing file. During the Onsite visit, Eastpointe staff confirmed they have not been conducting this query as part of the credentialing or monthly verification processes. ***Corrective Actions: Revise the Credentialing Manual, Policy E-4.4.17 (and any other documents that list queries to be conducted) to include the query of the State Exclusion List.*** ***Verify all credentialing files include documentation of the query of the State Exclusion List. See DMA Contract Attachment B, Sections 1.14.4 and 7.6.4.***
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					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES)	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.15 Ownership Disclosure is addressed.	X					
3.1.16 Criminal background Check	X					
3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.	X					
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.	X					Recredentialing files reviewed were organized and contained appropriate information. Issues identified in the file review are outlined in the following:
4.1 Recredentialing every three years;	X					The *Credentialing Manual* states "At minimum, Eastpointe MCO must complete re-credentialing of each Network Provider no less than every 3 years." At the last EQR, Eastpointe *Policy E-4.4.17, Primary Source Verification and Enrollment Requirements for Licensed Independent Practitioners (LIPs)*, stated "The re-credentialing process must occur no later than every three years." That was removed from the current version of this policy.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Eight recredentialing files were submitted. One practitioner was credentialed in 2017 for only 1 year. That practitioner was recredentialed about 3 weeks late. The recredentialing file of one of the remaining 7 practitioners was approved nearly 3 months late. ***Recommendation: Ensure providers are recredentialed within three years of the initial or the previous recredentialing. See DMA Contract Attachment N, Section B.***
4.2 Verification of information on the applicant, including:						
4.2.1 Insurance Requirements	X					Several of the recredentialing files were missing some of the required insurance verifications or the relevant waiver. (See *DMA Contract, Attachment B, Section 7.7.*) ***Recommendations: If Eastpointe does not keep a copy of the relevant certificate of insurance (COI) or waiver in the individual credentialing file, copies must be made available for the credentialing file review. If the practitioner is not named on the COI, a letter from the agency provider or insurance company indicating that the practitioner is covered under the policy is acceptable. See DMA Contract, Attachment B, Section 7.7.***
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
4.2.8 Requery for state sanctions and/or license limitations (State Board of Examiners for specific discipline) since the previous credentialing event;		X				No evidence of a query of *The North Carolina Medicaid Provider Termination and Exclusion* list (known as the *State Exclusion List*) was found in any submitted recredentialing file. During the Onsite visit, Eastpointe staff confirmed they have not been conducting this query as part of the recredentialing or monthly verification processes and will include it, going forward. ***Corrective Action: Verify all recredentialing files include documentation of the query of the State Exclusion List. See DMA Contract Attachment B, Sections 1.14.4 and 7.6.4.***
4.2.9 Requery of the SAM.	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event;	X					
4.2.11 Query of the Social Security Administration's Death Master File	X					
4.2.12 Query of the NPPES;	X					
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.14 Ownership Disclosure is addressed.	X					
4.3 Site reassessment if the provider has had quality issues.	X					Page 23 of the *Eastpointe Provider Credentialing Operations Manual/Plan* states, "At the time of Re-Credentialing the Licensed Independent Practitioner who has their own contract and agency in the Eastpointe Provider Network will have a Site assessment conducted by the Provider Monitoring Department for each site with all outcomes reported to the Director of Network Operations or designee." The credentialing files of the two Licensed Independent Practitioners (LIPs) do not contain evidence of site assessments for practitioner applicants. Eastpointe submitted the site assessment reports in response to the *Onsite Request List*.
4.4 Review of provider profiling activities.	X					
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 E-4.4.24, Provider Termination, Suspension and/or Sanctioning*, outlines the termination and suspension decision process, including when providers have serious quality of care concerns.
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					The *Provider Credentialing Operations Manual/Plan* states, "Eastpointe monitors Accreditation for required providers at least on a quarterly basis and verifies at the time of re-credentialing as part of the application process." The "Facility Credentialing and Re-Credentialing" section of the *Credentialing Manual* includes "Copy of License" in the items that represent a "completed application, for Medversant's purposes." The *Credentialing Manual* also states, "Prior to Medversant conducting PSV, they will conduct certain pre-screens that have been mandated by NC Medicaid that MCOs must conduct." That list includes the "North Carolina Division of Health Service Regulations, MH Licensure &

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Certification Section" in the "Pre-Screening Reviews." The link (http://wwwncdhhs.gov/dhsr/mhlcs/facilities.html) is incorrect. The recredentialing files for agencies included a copy of the DHSR license and a copy of the letter from the accrediting body. The *Verified Profile* from Medversant includes a date, which Eastpointe reported is the date of the PSV completed by Medversant. Files of licensed organizational (agency and hospital) applicants do not include PSV of license or accreditation and no PSVs were submitted in response to CCME's *Onsite Request List*. Acceptable PSV is a screenshot of the NC DHSR website, showing the "As of" date and including the site information, verified during the credentialing process. A copy of the NC DHSR license is not PSV, nor is a statement from Medversant on the *Verified Profile* document. Acceptable PSV of accreditation is a dated screenshot of the accrediting agency's website, displaying the accreditation of the agency or facility. As noted during Onsite discussion, Eastpointe is responsible for PSV or confirming its vendor conducted PSV of all items. ***Recommendations: If a location is licensed by NC DHSR and/or if accreditation is required, conduct (or ensure the CVO conducts) the relevant PSV and retain dated documentation (screenshot of the website or web posting) of the accreditation and of the licensure. See DMA Contract Attachment B, Section 7.9.***
II B. Adequacy of the Provider Network						
1. The PIHP maintains a network of providers that is sufficient to meet the health care needs of enrollees and is consistent with contract requirements.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 Enrollees have a Provider location within a 30 – mile distance of 30 minutes' drive time of their residence. Rural areas are 45 miles and 45 minutes. Longer distances as approved by DMA are allowed for facility based or specialty providers.	X					*Policy E-4.4.32, Adequacy of Provider Network*, confirms the 30 mile/30 minutes (urban) and 45 mile/45 minutes (rural) requirement and addresses availability of providers to serve enrollees with "special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs." The *2018 Gaps Analysis* indicates 100% of enrollees have the choice of two providers within 30/45 miles/minutes of their residences, with the exception that 10.2% of Medicaid members in 3 identified counties had one provider for Opioid Treatment. One of the 3 counties (Columbus county) has disengaged from Eastpointe and joined another PIHP. Eastpointe is prioritizing Opioid Treatment provider capacity expansion for the other 2 counties (Wayne and Robeson counties). During Onsite discussion, Eastpointe staff verified that this information is accurate.
1.2 Enrollees have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the enrollee may utilize an out-of-network specialist with no benefit penalty.	X					This is addressed on page 27 of the *Enrollee/Member and Family Handbook*. The *2018 Gaps Analysis* reports that Eastpointe hired a full-time employee focused exclusively on children with complex needs. Providers submit their specialty areas during the credentialing and recredentialing processes and this information is entered into the Provider Choice database.
1.3 The sufficiency of the provider network in meeting enrollee demand is formally assessed at least annually.	X					Eastpointe conducts an annual gaps and needs assessment. The *2018 Gaps Analysis* includes this summary: "Across all respondents, 92.14% reported that they received the services they require. Those services include mental health, intellectual development disabilities, and substance use services."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.4 Providers are available who can serve enrollees with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Eastpointe staff report Spanish is the most prevalent non-English language in the catchment area. The *Provider Search* function on the Eastpointe website allows searches by a variety of categories, including Disabilities Served, Languages Served, and Specialty Served. The Specialty Served category includes Hearing Impaired and Visually Impaired. The *2018 Gaps Analysis* reports "Eastpointe hired a full-time employee focused exclusively on children with complex needs."
1.5 The PIHP demonstrates significant efforts to increase the provider network when it is identified as not meeting enrollee demand.	X					The primary barrier identified by respondents for the *2018 Gaps Analysis* was transportation. Respondents also identified insufficiency for crisis services. "When those who reported that they have experienced a crisis in the last year are asked if the required help was received, 46.67% responded 'no'. The highest share of those answering 'no' are in Columbus and Bladen counties." As noted, Columbus county disengaged from Eastpointe and joined another PIHP. Transportation information is available on the Eastpointe website, though it is not easy to find. During Onsite discussion, Eastpointe staff reported that the Call Center asks enrollees if they need transportation to get to their appointment, and, if transportation is a barrier, the Call Center staff connects the enrollee to the local department of social services. Eastpointe staff report there is a Quality Improvement Project for transportation issues, and Eastpointe is considering providing transportation vouchers in some situations.
2. Provider Accessibility						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.1 The PIHP formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.		X				Timeliness guidelines for emergent, urgent, and routine care are included in the *Provider Operations Manual*, in *Policy C-3.5.7, Call Center STR Process*, and in the *Member Call Center Manual*. The *October 17, 2018 Provider Meeting PowerPoint* posted on the Eastpointe website includes inaccurate information. The "Purpose" slide in the "Eastpointe Alpha Scheduler Training" section states "To get members seen within the triaged timeframe", then, for "Emergent", it states "2-hrs, 15-minutes". The *DMA Contract Attachment S* requires that "face-to-face emergency care be provided within two hours after request for emergency care is received" and that face-to-face emergency care be provided immediately for life threatening emergencies. The "Rescheduling" slide states "Routine: within 10 business days of the date member accessed services". The *DMA Contract Attachment S* requires that "initial face-to-face assessments and/or treatment" be provided "within fourteen (14) calendar days of the date a request for routine care is received". ***Corrective Actions: Correct the October 17, 2018 Provider Meeting PowerPoint (and any other documents that list the timeframes for access to care) to reflect the standards listed in the DMA Contract Attachment S, including 2 hours for emergency care, 1 hour for life-threatening emergencies, and 14 calendar days (not 10 business days) for routine appointments.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II C. Provider Education						
1. The PIHP formulates and acts within policies and procedures related to initial education of providers.	X					*Policy E-4.4.7, Provider Relations Program,* addresses new provider orientation. The Eastpointe website has a Training Calendar and offers several recorded trainings to providers. *New Provider Information* submitted in the Desk Materials included a *Welcome Letter*, the *Getting Started: For New Eastpointe Provider* document, and a *Provider Operations Manual*. The *Welcome Letter* for providers includes "Please go to our website www.eastpointe.net and go to Provider then go to Becoming a Provider New Provider Orientation and you will find our Eastpointe *Provider Operations Manual* and a copy of *Getting Started: For New Eastpointe Providers*, a listing of various links for providers." As was the case at the last EQR, the website "Becoming a Provider" section does not have a "New Provider Orientation" sub-section. It has a section named "Provider Orientation", which includes the *Welcome Letter*, the *Getting Started* document, and the *Eastpointe Provider Operations Manual*. There is also a link to a recorded *Provider Orientation Training Webinar*. The *Getting Started* document has several incorrect links. For example, the link to the *Provider Operations Manual* goes to a page that states, "Download URL is not correct". The link listed for *Eastpointe's Provider Meeting Documents/Handouts* goes to the *Authorization (UM) and Benefits Packages* section of the website, rather than to the *Meetings and Trainings* section of the website. ***Recommendation: Check the links in the Getting Started document and correct the ones that are incorrect.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Initial provider education includes:						Information for the following standards is provided in the *Provider Operations Manual* and/or on the Eastpointe website unless otherwise indicated.
2.1 PIHP purpose and mission;	X					
2.2 Clinical Practice Standards;	X					Clinical practice guidelines are posted on the Eastpointe website and referenced in the *Provider Operations Manual*.
2.3 Provider responsibilities;	X					
2.4 PIHP closed network requirements, including nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability.	X					
2.5 Access standards related to both appointments and wait times;	X					Timeliness guidelines for emergent, urgent, and routine care and appointment wait times are addressed in the *Provider Operations Manual*.
2.6 Authorization, utilization review, and care management requirements;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.7 Care Coordination and discharge planning requirements;	X					
2.8 PIHP dispute resolution process;	X					
2.9 Complaint investigation and resolution procedures;	X					
2.10 Compensation and claims processing requirements, including required electronic formats, mandated timelines, and coordination of benefits requirements;	X					Page 72 of the *Provider Operations Manual* is named "Section VII: Claims and Reimbursement". The only item on that page is a "Link to Claims Manual"; however, the link went to an error page. A "Search" for "Claims Manual" on the Eastpointe website provides access to the *Eastpointe Claims and Billing Manual FY 18/19*, which is found at this link: http://www.eastpointe.net/wpfd_file/claims-manual-fy-18-19/. ***Recommendations: Ensure links in the Provider Operations Manual to the Eastpointe Claims and Billing Manual FY 18/19 on Eastpointe's website are accurate and operable. Include a statement in the Provider Operations Manual that providers can download a copy from the website or request a copy from Eastpointe. See DMA Contract Attachment B, Section 7.11.***
2.11 Enrollee rights and responsibilities	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.12 Provider program integrity requirements that include how to report suspected fraud, waste and abuse, training requirements as outlined in the False Claims Act, and other State and Federal requirements.	X					Page 101 of the *Provider Operations Manual* addresses reporting fraud, waste, and abuse. The Eastpointe website lists choices of topics such as "Members and Families", "Provider", and "Contact". "Report Fraud and Abuse" is now included in these website menu choices. The "Report Fraud and Abuse" section includes a toll-free number for reporting internal fraud and abuse, a web-submission report form (which can be used for reporting fraud and abuse, either anonymously or not), and a toll-free number for reporting external fraud, waste, and abuse. A *Program Integrity Referral Form* is accessed via this section of the website, and via the Program Integrity (PI) sub-section of the Provider section of the website. Eastpointe provided PI training in 3 different locations in October and November 2017. The October 17, 2018 Provider Meeting included training about fraud, waste and abuse, including how to report.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The PIHP provides ongoing education to providers regarding changes and/or additions to its programs, practices, enrollee benefits, standards, policies and procedures.	X					The *Getting Started* document indicates the training calendar is accessed via the link to the News and Events section of the Eastpointe website; however, most training information is accessed via the Meetings and Trainings sub-section of the *Provider* section of the website or the calendar on the main page of the Eastpointe website. The main page of the Eastpointe website has a News and Events section, with rotating entries of training events. A calendar at the bottom of the main page of the Eastpointe website displays items by date, including events for the community and trainings and information for providers. From the calendar listings, it is possible to: • Get more information by clicking on the name of the listing • Add the item to your own calendar • Send an email reminder • Register for items that require registration Providers can sign up to receive List Serve communications from Eastpointe. Eastpointe updates providers *Communication Bulletins*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II D. Clinical Practice Guidelines for Behavioral Health Management						
1. The PIHP develops clinical practice guidelines for behavioral health management of its enrollees that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					Information about the Clinical Practice Guidelines is contained in the *Provider Operations Manual*. The Clinical Practice Guidelines are accessed via the Authorization and Benefits Packages tab on the Provider section of the Eastpointe website. A letter titled *Eastpointe Adopted Clinical Practice Guidelines* from Lynnette Gordon, dated October 7, 2015, is posted on the same webpage in a section titled "Clinical Practice Guidelines and Other General Information". The letter provides incorrect information about the location of the Clinical Practice Guidelines. ***Recommendation: As indicated at the last EQR, revise the reference in the October 7, 2015, letter to direct providers to the correct section of the Eastpointe website to access the Clinical Practice Guidelines. See DMA Contract, section 7.4.***
2. The PIHP communicates the clinical practice guidelines for behavioral health management and the expectation that they will be followed for PIHP enrollees to providers.	X					Page 123 of the *Provider Operations Manual* notes "The expectation is that when requests for services are submitted for medical necessity review with the identified diagnosis that the Clinical Practice Guideline will be followed and well documented within the Service Authorization Request (SAR)."
II E. Continuity of Care						
1. The PIHP monitors continuity and coordination of care between providers.	X					The Provider Monitoring Team monitors continuity and coordination of care between providers.
II F. Practitioner Medical Records						
1. The PIHP formulates policies and procedures outlining standards for acceptable documentation in the Enrollee medical records maintained by providers.	X					The *Provider Operations Manual* and *Policy Q-6.3.27, Enrollee Medical Record Maintained by Providers*, provide information about enrollee record documentation standards. Page 5 of the policy and page 140 of the *Provider Operations Manual* reference the *Basic Medicaid Billing*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Guide, as defined in the *DMA Contract*, *Section 8.2*. However, *The Basic Medicaid Billing Guide* has now been replaced by the *NCMMIS Provider Claims and Billing Assistance Guide*. ***Recommendation: Update/replace all references to The Basic Medicaid Billing Guide, which was replaced by the NCMMIS Provider Claims and Billing Assistance Guide.***
2. The PIHP monitors compliance with medical record documentation standards through formal periodic medical record audit and addresses any deficiencies with the providers.	X					*Policy E-4.2.1, Local Monitoring*, addresses medical record documentation monitoring. Medical record documentation is included in the standardized Routine Provider Monitoring and Post Payment Review tools completed by the Monitoring Team, in compliance with guidelines from the North Carolina Department of Health and Human Services.
3. The PIHP has a process for handling abandoned records, as required by the contract.	X					*Policy Q-6.3.12, Abandonment of Provider Records*, outlines the "action Eastpointe will take upon notification of abandoned provider records."

III. ENROLLEE SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III A. Enrollee Rights and Responsibilities						
1. The PIHP formulates policies outlining enrollee rights and procedures for informing enrollees of these rights.	X					Covered in *Policy C-3.5.10, Protection of Consumer Rights and Responsibilities*
2. Enrollee rights include, but are not limited to, the right:	X					Member rights and responsibilities are listed on pages 12-14 of the *Enrollee / Member and Family Handbook* and includes all rights outlined in this standard.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.1 To be treated with respect and due consideration of dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand;						
2.3 To participate in decisions regarding health care;						
2.4 To refuse treatment;						
2.5 To be free from any form of restraint of seclusion used as a means of coercion, discipline, convenience or retaliation;						
2.6 To request and receive a copy of his or her medical record, except as set forth in 45 C.F.R. §164.524 and in N.C.G.S. § 122C-53(d), and to request that the medical record be amended or corrected in accordance with 45 CFR Part 164.						
2.7 Of enrollees who live in Adult Care Homes to report any suspected violation of their enrollee rights, to the appropriate regulatory authority as outlined in NCGS§ 131-D21.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III B. Enrollee PIHP Program Education						
1. Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid waiver managed care program which they are contractually entitled, including:		X				*Policy C-3.5.14, Response to Customer/Member Services*, states "Within 14 days after and enrollee makes a request for services, Eastpointe's Community Relations Specialists shall provide the new Enrollee with written information on the Medicaid managed care program." All information is provided to enrollees unless noted differently in the following sub-standards.
1.1 A description of the benefits and services provided by the PIHP and of any limitations or exclusions applicable to covered services. These descriptions must have sufficient detail to ensure the Enrollees understand the benefits to which they are entitled and may include a web link to the PIHP Benefit Plan. This includes a descriptions of all Innovations Waiver services and supports;						
1.2 Benefits include access to a 2nd opinion from a qualified health care professional within the network, or arranges for the enrollees to obtain one outside the network, at no cost to the enrollee;						Information is located on page 12 of the *Enrollee/Member and Family Handbook* under "What Are My Rights" section.
1.3 Updates regarding program changes;						Information is located on page 20 of the *Enrollee/Member and Family Handbook*.
1.4 A description of the procedures for obtaining benefits, including authorizations and EPSDT criteria;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.5 An explanation of the Enrollee's responsibilities and rights and protection;						Information is located on page 12 of the *Enrollee/Member and Family Handbook* under "What Are My Rights" section.
1.6 An explanation of the Enrollee's rights to select and change Network Providers						
1.7 The restrictions, if any, on the enrollee's right to select and change Network Providers						
1.8 The procedure for selecting and changing Network Providers						
1.9 Where to find a list or directory of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients (a written list of current Network Providers shall be provided by PIHP to any Enrollee upon request);						Online *Provider Directory* has a statement that all providers are accepting new patients in a banner at the top. But the printed *Provider Directory* has several "NO" indications in the field of "Accepting New Patients." The providers with NO's in the printed document are also in the online version. Onsite discussion revealed that the printed provider directory is generated from the online version and fields can be added depending on the amount of information is requested. A printed copy is generated at the time of the enrollee request. At the last EQR, only the providers accepting new patients were to be in the online version. ***Corrective Action: Update the online Provider Directory in a way that all enrollees can see which providers are "Accepting New Patients". Include this indication as a field on the printed Provider Directory when it is generated.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.10 The non-English languages, if any, spoken by each Network Provider;						Hard copy of *Provider Directory* in Desk Materials does not have non-English language, if any, spoken by providers. The online *Provider Directory* has fields for "Cultures Served" and "Languages Served." This doesn't indicate the non-English language spoken by the provider. ***Recommendation: Clearly indicate the non-English languages spoken by providers in all versions of the Provider Directory.***
1.11 The extent to which, and how, after-hours and emergency coverage are provided, including:						
1.11.1 What constitutes an Emergency Behavioral Health Condition, Emergency Services, and Post Stabilization Services in accordance with 42 CFR§ 438.114 and EMTALA;						Definitions of both emergency Behavioral Health Condition, Emergency Services, and Post Stabilization Services are on page 25 of the *Enrollee/Member and Family Handbook*.
1.11.2 The fact that prior authorization is not required for emergency services;						Page 25 of the *Enrollee/Member and Family Handbook* and other areas throughout, states, "Emergency care does not require prior approval or authorization from Eastpointe. However, page 19 in the *Enrollee/Member and Family Handbook* under "Crisis Services," states "In cases where the care that is needed is emergent, a quick request for authorization, if necessary, is available 24 hours a day, 7 days a week. Medical necessity criteria must be established by the provider along with other clinical information. Eastpointe has created an environment that supports rapid access for many crisis services to prevent unnecessary inpatient hospitalization." ***Corrective Action: Emergent care for a member cannot require "a quick request for authorization." Remove this documentation from page 19 of the Enrollee/Member and Family Handbook.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.11.3 The process and procedures for obtaining Emergency Services, the use of 911 telephone services or the equivalent;						
1.11.4 The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under the contract;						Post Stabilization is defined on page 25 of the *Enrollee/Member and Family Handbook*. No locations are mentioned where Post Stabilization services are available. ***Corrective Action: Within enrollee written materials, add examples of where post stabilization services are available.***
1.11.5 A statement that, subject to the provisions of the DMA this contract, the Enrollee has a right to use any hospital or other setting for Emergency care;						
1.12 The PIHP's policy on referrals for Specialty Care to include cost sharing, if any, and how to access Medicaid benefits that are not covered under this Contract;						This is located on page 28 of *the Enrollee/Member and Family Handbook*: "If medically necessary specialty services are not available through an in-network provider Eastpointe will assist with you receiving these services through an out-of-network provider as long as we are not able to provide them with an in-network provider."
1.13 Any limitations that may apply to services obtained from Out-of Network Providers, including disclosures of the Enrollee's responsibility to pay for unauthorized behavioral health care services obtained from Out-of Network Providers, and the procedures for obtaining authorization for such services.						This is located on page 27 of the *Enrollee/Member and Family Handbook:* "You may be responsible for payment of services if you go to an out-of-network provider for non-emergency services that have not been pre-authorized by Eastpointe."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.14 How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost-sharing;						This is located on page 20 of *the Enrollee/Member and Family Handbook:* "Any service requests that are not covered under the North Carolina Medicaid Plan may be covered under the federal Medicaid law for individuals under the age of 21 years old. Requests for non-covered services can be submitted to Eastpointe by accessing the form at…"
1.15 Procedures for obtaining out-of-area or out-of-state coverage or services, if special procedures exist;						The *Enrollee/Member and Family Handbook* and other enrollee materials do not contain information on obtaining out-of-area or out-of-state coverage of services. Page 28 of the *Enrollee/Member and Family Handbook* provides information about receiving services from out-of-network providers. ***Corrective Action – In the Enrollee/Member and Family Handbook, add how members obtain out-of-area and out-of-state coverage of services. This is different from out-of-network coverage.***
1.16 Information about medically necessary transportation services by the department of Social Services in each country;						This is documented in the *Enrollee/Member and Family Handbook*.
1.17 Identification and explanation of State laws and rules Policies regarding the treatment of minors;						This is documented on page 14 of the *Enrollee/Member and Family Handbook*.
1.18 The enrollee's right to recommend changes in the PIHP's policies and procedures						This is documented in the *Enrollee/Member and Family Handbook*.
1.19 The procedure for recommending changes in the PHIP's policies and procedures;						This is documented in the *Enrollee/Member and Family Handbook*.
1.20 The Enrollee's right to formulate Advance Directives;						This is documented on page 36 of the *Enrollee/Member and Family Handbook*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.21 The Enrollee's right to file a grievance concerning non-actions, and the Enrollee's right to file an appeal if PIHP takes an action against an Enrollee;						There are 3 ways to file a grievance about privacy practices documented on page 52 of the *Enrollee/Member and Family Handbook*. None of the 3 ways tells the enrollee to call the Access to Care Line. There is another section telling enrollees about Grievance and Appeals on pages 28 – 30 of the *Enrollee/Member and Family Handbook*. ***Recommendation: Consolidate documentation on Grievances and appeals for the enrollee in the Enrollee/Member and Family Handbook.***
1.22 The accommodations made for non-English speakers, as specified in 42 CFR §438.10(c)(5);						
1.23 Written information shall be made available in the non-English languages prevalent in the PIHP's services area.						
1.24 The availability of oral interpretation service for non-English languages and how to access the service;						
1.25 The availability of interpretation of written information in prevalent languages and how to access those services						
1.26 Information on how to report fraud and abuse; and						
1.27 Upon an Enrollee's request, the PIHP shall provide information on the structure and operation of the agency and any physician incentive plans.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.28 Information on grievance, appeal and fair hearing procedures and information specified in CFR §438.10 (g) and CFR §438.10 (f) (6).						
2. Enrollees are notified annually of their right to request and obtain written materials produced for Enrollee use.	X					
3. Enrollees are informed promptly in writing of (1) any "significant change" in the information specified in CFR 438.10 (f) (61) and 438.10 (g) at least 30 days before calendar days before the intended effective date of the change; and (2) . termination of their provider within fifteen (15) calendar days after PIHP receives notice that DMA or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider.	X					Documentation from Eastpointe to providers and enrollees was reviewed on 5 terminated providers. Three of the providers have letters that were sent to enrollees. The other 2 providers didn't have patients currently being served. None of the enrollee letters tell the enrollee the date when the provider's service ends. They all say "(provider name) is, at this time, unable to provide the service you receive in our area. You will need to choose another provider." Page 20 of the *Enrollee/Member and Family Handbook* addresses both items in this standard. ***Recommendation: Inform the enrollees, in written communication, of the date when the provider will no longer be in the network.***
4. Enrollee program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation of prevalent non-English languages as required by the contract.		X				The light grey type on website is very hard to see. ***Recommendation: Consider changing the light grey type on the website to an easier to read, darker color.*** The *Enrollee/Member and Family Handbook* is written in a way that some topic areas are spread out in different sections making is hard to find all information on a specific topic. Some examples include: • Grievances/Appeals is in one section and how to report a Grievance on privacy issues is in a difference section. • Information on Emergency Care / Crisis is in several different sections. Some examples include:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						○ What is a Crisis Plan? (page 35) ○ Crisis Services (page 19 – this is the area with the incorrect reference to needing authorization in an emergency.) ○ What do I do in an Emergency (page 25)? ○ Mobile Crisis Services (pages 25-26) Information is written in a complex manner. Some examples include: • What is an Advanced Access Agency? To become an Advanced Access Agency, a Critical Access Behavioral Health Agency (CABHA) must serve at least two disability groups and provide five different services, including emergency services. (pages 26-27) • When receiving substance use services, Federal law allows disclosure in the following situations, (page 49) • When receiving services other than substance use, State law requires disclosure in specific situations that include, but are not limited to… (page 50). ***Corrective Action: More discussion at Eastpointe is needed to decide the best way to make improvements in the Enrollee/Member and Family Handbook. This may be an internal workgroup that looks at all the documentation that needs to be included and consolidates that information based on information enrollees need. Please provide the plan you will initiate as part of the Corrective Action Plan (CAP) process.***
5. The PIHP maintains and informs Enrollees of how to access a toll-free vehicle for 24-hours Enrollee access to coverage information from the PIHP, including the availability of free oral translation services for all languages and care management services such as crisis interventions.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III C. Behavioral Health and Chronic Disease Management Education						
1. The PIHP enables each enrollee to choose a Provider upon enrollment and provides assistance as needed.	X					"Whole Person Model and Integrated Care" initiative is on the website listing providers currently participating in this initiative.
2. The PIHP informs enrollees about the behavioral health education services that are available to them and encourages them to utilize these benefits.	X					Calendar at bottom of website page features several trainings available. Onsite, staff described the enrollee training offerings.
3. The PIHP tracks the participation of enrollees in the behavioral health education services.	X					Eastpointe tracks enrollee participation via a sign-in sheet at each event.
III D. Call Center						
1. The PIHP provides customer services that are responsible to the needs of the Enrollees and their families. Services include:	X					Pages 23-24 of the *Enrollee/Member and Family Handbook* refers to the function of the Call Center three different ways. "Call Center," "Access to Care Call Center," and "The Access Care Center." The greeting on page 8 of the *Member Call Center Manual* is, "Hello, my name is _____ with Eastpointe Member Call Center." ***Recommendation: Refer to the Call Center by the same name in all documentation.***
1.1 Respond appropriately to inquiries by enrollees and their family members (including those with limited English proficiency);	X					
1.2 Connect enrollees, family members and stakeholders to crisis services when clinically appropriate;	X					
1.3 Provide information to enrollees and their family members on where and	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
how to access behavioral health services;						
1.4 Train its staff to recognize third-party insurance issues, recipient appeals, and grievances and to route these issues to the appropriate individual;	X					
1.5 Answer phones and respond to inquiries from 8:30 a.m. until 5:00 p.m. weekdays;	X					
1.6 Process referrals twenty-four (24) hours per day, seven (7) days per week; 365 days per year; and	X					Cardinal contracts for roll over calls.
1.7 Process Call Center linkage and referral requests for services twenty-four (24) hours per day, seven (7) days per week, 365 days per year.	X					Cardinal contracts for roll over calls.

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV A. The Quality Improvement (QI) Program						
1. The PIHP formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to enrollees.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The scope of the QI program includes monitoring of provider compliance with PIHP practice guidelines.	X					During this review period a Cross Functional Workgroup started to develop a process to implement and monitor Clinical Practice Guidelines. The workgroup completed data analysis on the highest utilized diagnosis among two enhanced services: Intensive In Home (IIH) and Community Support Team (CST). Analysis revealed Conduct Disorder and PTSD was highest utilized for IIH. Bipolar Disorder and Depressive Disorders was highest utilized for CST. Clinical Tags were added to Service Authorization Request (SAR) to capture providers who adhere to Clinical Practice Guidelines Information was shared to providers at the August 2018 Provider Meeting.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.			X			Eastpointe has mechanisms to detect and document under and over utilization of medical services as required by the contract. However, there is no evidence of monitoring or analysis of utilization data for over/underutilization. ***Corrective Actions: Documentation from meeting minutes and program evaluations should include evidence of monitoring rates, reasons/causes for over or underutilization, and the interventions or action steps that demonstrate how Eastpointe is addressing those reasons/causes of over or underutilization. The next step is to keep a file with each service, the monthly and quarterly reports, and updates on action steps being taken to address over and underutilization, as applicable.***
4. The PIHP implements significant measures to address quality problems identified through the enrollees' satisfaction survey.	X					In the June 2018 GQIC meeting, a motion carried to approve a sub-committee for the *Experience of Care and Health Outcomes Survey (ECHO)* measures than need improvement.
5. The PIHP reports the results of the enrollee satisfaction survey to providers.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. The PIHP reports to the Quality Improvement Committee on the results of the enrollee satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					The June 2018 GQIC meeting included a discussion of completed child and adult surveys. The Power Point named, Eastpointe Composites 2017 ECHO Report Adult and Children, provided comprehensive results by comparing 2016 results to 2017 and Eastpointe to the state average.
7. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, time frame for implementation and completion, and the person(s) responsible for the project(s).	X					CCME reviewed 2018 and 2019 QI work plans. The 2019 plan has several items with "mark throughs." Onsite interview defined the mark throughs as completed items. The work plan is updated throughout the year.
IV B. Quality Improvement Committee						
1. The PIHP has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The GQIC consists of the Medical Director or Designee, Chief Executive Officer (CEO) in ex officio capacity, Chiefs of: Business Operations, Clinical Operations, External Operations, Compliance and Regulations and Quality Management (QM), Leadership Team, Network Providers and Consumer Family Advisory (CFAC) Chair. Officers of the GQIC include the Chair and voting members. The Chair is Eastpointe's Medical Director. The Chief of QM serves as Co-Chair of the GQIC.
2. The composition of the QI Committee reflects the membership required by the contract.	X					A provider representative from Community Innovations missed 3 meetings and was not on the attendee list for the June 2018 meeting. Onsite interview confirms the provider and Eastpointe agreed that obligations to attend could not be met and the provider resigned from the committee. There are new provider members as of June 2018. The CFAC member attended 2 of 4 meetings (50%). "Other member" attendance is 75% or more.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The QI Committee meets at regular intervals.		X				GQIC meetings occurred on these dates, which did not follow a regular meeting interval: 10/13/17; 11/3/17; 2/16/18; 6/15/18; have agenda only for Aug 2018. The GQIC Committee has already decided that GQIC will start meeting every other month. ***Corrective Action: Ensure GQIC meets at regular intervals.***
4. Minutes are maintained that document proceedings of the QI Committee.	X					Meeting minutes are completed for the GQIC. However, discussion points are not documented on many of the meeting topics. ***Recommendation: Capture GQIC Committee meeting discussion in the meeting minutes.***
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					Documentation was included for all ten C waiver measures, although the label for some of the Excel files did not match the actual reported rate that was contained in the file. ***Recommendation: Ensure that submitted Excel files contain the information that is matched to the rate reported within the file. Example: File named 35.12. LOC Eval using approved pro-Ins FY2018_Semi_annual (Jan-June).xlsx contained the rate for "Proportion of Level of Care completed at least annually for enrolled beneficiaries."***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".		X				Tables 23 and 24 in this report list the specific errors by project and includes recommendations/ corrective actions to correct the errors. If the PIP received an overall score of "Low Confidence" or "Not Credible," then there are corrective actions. PIPs that score in the "Confidence" or "High Confidence" range contain recommendations. ***Recommendation: Recommendations apply for PIPs that scored "Confidence" and "High Confidence" ranges and include:*** •***Increase number of individuals in the priority population served by a fidelity provider to 50% monthly*** •***Decrease emergency department admissions for active members to 20%*** ***Corrective Action: Corrective actions apply for PIPs that scored "Low Confidence" include:*** •***Increase the percentage of individuals who received a 2nd service within or less than 14 days to 35%*** •***Decrease state psychiatric hospital 30-day readmissions for high risk members***
IV E. Provider Participation in Quality Improvement Activities						
1. The PIHP requires its providers to actively participate in QI activities.	X					There is not a requirement in the Quality Improvement Plan and Program Description that states the providers are required to do individual QIPs.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						On page 95 of the Eastpointe *Provider Operations Manual*, the Performance Improvement section states, "Eastpointe will complete Quality Performance Improvement Projects (QIPs/PIP's) as indicated in *DMH* and *DMA Contracts* and URAC Standards. These Performance Improvement Projects may require provider participation. The Provider Performance Profile section states, "Eastpointe's Quality Management Committee will monitor a performance review system which targets specific quality initiatives for provider performance." Slide 13 of the Eastpointe *Provider Monitoring Annual Report (July 2017 – June 2018)*, Summary of Monitoring Activities, does NOT include monitoring on individual QIPs. ***Recommendation: Develop and implement a written plan and process that will hold providers accountable for individual QIPs. Add provider QIP monitoring to that process.***
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Provider meetings give feedback about QI activities at Eastpointe, but no feedback is given on provider's individual QIPs. Clinical advisory council is an active participant in quality initiatives affecting clinical initiatives. Onsite discussion revealed that Eastpointe will participate in individual provider QIPs moving forward. ***Recommendation: Begin to offer feedback to providers on individual QIPs they will be doing.***
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.			X			No Annual Evaluation that covered July 2017 – June 2018 was uploaded at the time the Desk Materials were due. The document titled, *Strengthening our Communities 2018 Annual Report*, was presented Onsite and uploaded to the Desk Material at that time. This document lacked many of the report features expected for an Annual Evaluation of the Quality Program. This is a different format

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						from what was submitted for the last EQR. For the last EQR the Annual Report FY 2016 was submitted. *Strengthening our Communities 2018 Annual Report* contains general and overall happenings at Eastpointe during the 2018 FY. The document is well done and highlights some positive outcomes from Eastpointe in FY 2018. It does not contain the following information: ●Analysis of the quality projects for FY 2018. ●FY 2019 Strategy ●Information about what was implemented in 2018, if those implementation efforts were successful or not, what barriers still exist, and what will be changed with each project for the 2019 FY to effect change. ●There is no information about over and underutilization. ●There is no overall summary of the Enrollee Surveys. This document is not a summary and assessment of the effectiveness of the QI program. There was no Annual Report submitted for FY 2017 for EQR this year or Last EQR. ***Corrective Action: Create a document that is specifically a written summary, assessment, and evaluation of the QI Program at the end of each program year, beginning with FY 2018.***
2. The annual report of the QI program is submitted to the QI Committee and to the PIHP Board of Directors.				X		This standard is not applicable when the previous standard (1.) is "Not Met."

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V A. The Utilization Management (UM) Program						
1. The PIHP formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The Utilization Management (UM) Program includes; Kelli Carson LPCS is Chief of Clinical Operations and Angela English is the Utilization Director with 3 clinical leads. Dr. Sid Hosseini is the Medical Director and Dr. Venkata Doniparthi are involved in various committees, provide oversight in structured meetings and available for consultation. There is a robust set of Policies that support the Utilization Management Program.
1.1 structure of the program;	X					
1.2 lines of responsibility and accountability;	X					The lines of responsibilities and accountability are clearly delineated in policy.
1.3 guidelines / standards to be used in making utilization management decisions;	X					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					*PolicyC-3-2.38 Medical Necessity Review First Level* provides the process for standard and urgent requests. The policy does not include the reviewer documentation from an urgent to standard review timeframe or notification to the provider when an urgent request is transferred to a standard request. Include the steps for documentation in the reviewer notes when an urgent request is transition to a standard review and how notification to the provider occurs when transitioning an urgent request to a standard request. ***Recommendations: Add to Policy C-3.2.38 Medical Necessity Review First Level, the steps that staff take when an expedited service authorization request is transitioned to a standard***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						review timeframe. Include how the process is documented and how and when notification to the provider occurs.
1.5 consideration of new technology;	X					*C-3.2.49 New Services, Technology Review* provides information for the consideration of new technology.
1.6 the appeal process, including a mechanism for expedited appeal;	X					*C-3.2.36 Appeal of UM Adverse Determination, the definition of "adverse benefits determination" is included.*
1.7 the absence of direct financial incentives to provider or UM staff for denials of coverage or services;	X					
1.8 mechanisms to detect underutilization and overutilization of services.	X					*Policy C-3.2.42 Over Under Utilization Management* provides a high level over view of the process but does not include the processes and steps taken to review over and underutilization is not included in the policy. ***Recommendation: Add to Policy C-3.2.42 Over Under Utilization Management, the process Eastpointe uses to review and analyze the over/under utilization data.***
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Dr. Hosseini, Medical Director and Dr. Doniparthi are involved in the key aspects of UM activities, with significant oversight of clinical decision-making.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The UM program design is reevaluated annually, including Provider input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The UM Plan is reviewed annually with oversight of the Medical Director.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					Per *Policy C-3.2.37 Clinical Decision Support Tool*, standards are used to determine the appropriate service and /level of care including the intensity, frequency and duration of the services/care.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					*Policy C-3.2.37, Clinical Decision Support Tool* indicates the tools used for decision making. However, it does not indicate the Medical Director's involvement in the annual evaluation process. Include the *Child and Adolescent Needs and Strengths (CANS)* into the polices' procedure section. ***Recommendations: Include in Policy C-3.2.37 Clinical Decision Support Tool, the Medical Director's involvement in the annual evaluation process of the decision-making tools and the requirement by providers to use the Child and Adolescent Needs and Strengths (CANS) for children ages 3 to 6 years.***
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Standards are reasonable and reviewed by LPC, MSW and RN. Denial reviews are reviewed by a clinician and then referred to a Medical Doctor with knowledge for final decision.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Utilization management standards/criteria are consistently applied to all enrollees across all reviewers.	X					*Policy C-3.2.34 Interrater Reliability and Analysis* describes the process and scoring. UM Director and Dr. Venkata Doniparthi set the standard for each vignette. At least eight to ten vignettes are completed quarterly by all licensed reviewers and Peer Reviewers. The benchmark is set at 85%.
5. Emergency and post stabilization care are provided in a manner consistent with contract and federal regulations.	X					
6. Utilization management standards/criteria are available for Providers.	X					Policies are in place that include the process used for request of authorization of services and denial of services.
7. Utilization management decisions are made by appropriately trained reviewers	X					*The Utilization Management Plan* indicates training provided to UM staff and Directors. *Policy C-3.2.38 Medical Necessity First Level Review* provides the details for the process for the review of requests, refers to the clinical decision guidelines and the clinical support that is available to the UM reviewers, that includes the Medical Director The policy also includes the Peer Reviewers who are only physician clinical reviewers, Peer-to-Peer Conversations and the details for the process.
8. Initial utilization decisions are made promptly after all necessary information is received	X					Initial UM decisions are made promptly upon receiving information and the notice letter is sent within the 14-day timeframe.
9. Denials						
9.1 A responsible effort that is not burdensome on the enrollee or the provider is made to obtain all pertinent information prior to making the decisions to deny services	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
9.3 Denial decisions are promptly communicated to the provider and enrollee and include the basis for the denials of service and the procedure for appeal	X					The review of the Denial files includes: • The denial files were completed showing reasonable efforts were made to obtain additional information. • All reviews were reviewed by a physician peer reviewer. • 3 Denial files were initially urgent / expedited requests however deemed to meet standard timeframes.
V C. Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					The *MH/SA Care Coordination Program Plan*, the *I/DD Program Plan*, *Policy C-3.3.20, Care Coordination for NC Innovations Participants and Other Individuals w/I/DD*, and *Policy C-3.4.6 MH/SA Care Coordination* includes the Special Health Care Needs members and the process to provide Care Coordination.
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					*Policy C.3.2.48 Emergency Behavioral Health Services* explains that members can contact Eastpointe's Call Center 24 hours per day/ 7 days per week/365 days operational member call center.
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	X					*Policy C-3.3.3, Process for Level of Care Evaluation/ Re-evaluation* provides the steps for members to obtain face-to-face pretreatment assessments.
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 Develop treatment plans for enrollees that meet all requirements;	X					*Policy C-3.3.10 Individual Support Plan (ISP) Development* clarifies the I/DD Care Coordination role in the development of the ISP for the I/DD population. *Policy C-3.4.36 MH/SA Care Coordination* indicated that the Care Coordinators will monitor the Tx Plan and consult with specialist.
2.5 Quality monitoring and continuous quality improvement;	X					
2.6 Determine of which Behavioral Health Services are medically necessary;	X					
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					*Policy C-3.4.5 Care Coordination with External Entities*, and through the Care Coordination file review it was evident that there was on going collaboration regarding admissions and discharge planning for members in MH/SU and I/DD.
2.8 Coordinate care with each Enrollee's provider;	X					
2.9 Provide follow-up activities for Enrollees;	X					The MS/SU files included notes with follow up activities. There were multiple attempts to contact via phone and letter prior to DC case. Follow up activities were included for some of the I/DD files.
2.10 Ensure privacy for each Enrollee is protected.	X\					
3. The PIHP applies the Care Coordination policies and procedures as formulated.		X				The Care Coordination application of policies file review findings include; • Multiple I/DD notes had late note entries • The I/DD notes did not consistently include follow-up activities and monitoring tools had several blank sections

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						• There were 2 I/DD files with notes up to 11 months late *Policy C-3.6.4 Documentation of Care Coordination Activities* states that Eastpointe requires accurate and timely documentation occur and "not to exceed a seven-calendar day time frame from date of service contact." This policy does allow the provision of documenting if a note is late but does describe a process for addressing patterns of untimely note submission by staff or department. ***Corrective Action: Include in Policy C-3.6.7 Documentation of Care Coordination Activities, how the monitoring of the notes occurs and the steps that are taken when late notes or trends of late notes by staff or departments are identified.***
V. D Transition to Community Living Initiative						
1. Transition to Community Living functions are performed by appropriately licensed, or certified, and trained staff.	X					The *Transition to Community Living Initiative (TCLI) Program Description* provides information regarding the educational and licensure requirements of the staff. Information is in *Policy C-3.7.9, Care Coordination in Transitioning People into the Community*.
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements includes all required elements.	X					There is one overarching policy *for Transition to Community Living Program (TCLI). Policy C-3.7.9, Care Coordination in Transitioning People into the Community* addresses many of the required elements.
2.1 Care Coordination activities occur as required.	X					The Care Coordination policy that apply to the TCLI Care Coordinators is *Policy C-3.3.3, Process for Level of Care Evaluation and Re-evaluation*, provides the steps for members to obtain face-to-face pretreatment assessments.
2.2 Person Centered Plans are developed as required.	X					*Policy C-3.3.10, Individual Support Plan (ISP) Development*, clarifies the I/DD Care Coordinators role in the development of the Individual Support Plan (ISP) for the I/DD population.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Policy C-3.4.6 MH/SA Care Coordination indicated that the Care Coordinator will monitor the Person-Centered Plan and consult with a specialist.
2.3 Assertive Community Treatment, Peer Support Services, and Supported Employment services 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					There are two policies with information/ mechanism to provide one-time transitional funds. *Policy C-3.7.10, Transition Department Cash Transactions* explains how to request the funds and monitor with members. *Policy C-3.7.18, B3 One Time Transition Cost* explains how funds are processed and monitored. These polices are connected to financial policy and indicated within the policy. The *Transition Year Services (TYS*) funds form was present in seven files and documented in the TCLI Care Coordination notes.
2.5 QOL Surveys are administered timely.	X					*Quality of Life (QOL*) surveys were found in 11 TCLI files when appropriate and included several files with the 11-month transition.
3. A diversion process is in place for individuals considering admissions into an Adult Care Home (ACH).	X					Several policies provide information regarding diversion process for individuals considering an *Adult Care Home (ACH*).
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to DMA within the timeframes determined by DMA.	X					The *TCLI Program Description* for 2018-2019 was reviewed and on page eight the Quality Improvement section states; "During FY 16 QI collaborated with TCLI to develop strategies and a Quality

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Improvement Project (QIP)." This information needs to be updated to reflect the current QIP. ***Recommendation: Ensure the TCLI Program Description is reviewed annually for correct and current information.***
5. The PIHP will develop a TCLI communication plan that includes materials and training about crisis hotline, services for enrollees with limited English proficiency and also to for external and internal stakeholders providing information on the TCL initiative, resources, and system navigation tools, etc.	X					Eastpointe has a TCLI Communication Plan in place. A copy of the plan was uploaded during the Onsite review. The plan includes different tiers of educational information sharing with internal clinical staff and across the organization. Training is also provided to providers at stakeholder meetings. Provider monitoring and network adequacy also look at trends to provide technical assistance to providers.
6. A review of files demonstrates the PIHP is following appropriate TCL policies, procedures and processes, as required by NC DMA, and developed by the PIHP.		X				*Assertive Community Treatment (ACT) Service*s are provided in eight (8) Person Centered Plan. However, neither Peer Support services nor Supported Employment were indicated in any files reviewed. This includes several members who, per the TCLI notes, stated that they wanted obtain employment and were referred to Supported Employment services. ***Corrective Action: Ensure there is evidence in TCLI progress notes of discussion, referral, and linkage to B3 services, when appropriate, including utilization of Supported Employment services.***

VI. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee grievances in a manner consistent with contract requirements, including, but not limited to:	X					*Policy Q-6.4.4, Member/Enrollee and Stakeholder Complaint/Grievance* is in place to guide staff in grievance processes.
1.1 Definition of a grievance and who may file a grievance;	X					*Policy Q-6.4.4, Member/Enrollee and Stake Holder Complaint/Grievance*, defines grievance as; "A complaint/grievance is any form of dissatisfaction expressed orally or in writing, that the complainant perceives as a problem, other than an "action" as defined in this section." According to the *DMA Contract, Attachment M* and 42 *CFR § 438.400* the definition for a grievance is "a grievance is any matter other than an adverse benefits determination. Possible subjects for grievances include…. or failure by PHIP Network Provider to respect the rights of an enrollee. An enrollee can file a grievance with the PHIP at any time." The definition of an *Adverse Benefits Determination* also needs to be added to *Policy Q-6.4.4.* to ensure consistency with the *DMA Contract, Attachment M* and 42 CFR § 438.400. ***Recommendations: Revise Policy Q-6.4.4, Member/Enrollee and Stake Holder Complaints/Grievances to correct definition of a grievance as noted in DMA Contract Amendment M and 42 CFR § 438.402. Ensure the definition of an Adverse Benefit Determination is also included in this policy.*** In *Policy Q-6.4.4*, the terms complaint, grievances and concerns are used interchangeably throughout the policy. Statements such as "Upon notification of the submitted complaint…", "If the complaint/concern is a health and safety issue…", "grievances

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						related to health and safety concerns…" make the policy unclear regarding definitions and processes. The use of one term would provide consistency in *Policy Q-6.4.4*. Similarly, keeping terms consistent within the *Enrollee/Member and Family Handbook* and the *Provider Operations Manual* would decrease confusion. ***Recommendations: Revise Policy Q-6.4.4, Member/Enrollee and Stake Holder Complaints/Grievances to consistently use one term for "complaints", "concerns" and "grievances". Similarly, keep terms consistent within the Enrollee/Member and Family Handbook and the Provider Operations Manual.***
1.2 The procedure for filing and handling a grievance;	X					
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	X					*Page 4 of Policy Q-6.4.4, Member/Enrollee and Stakeholder Complaints/Grievances, bullet five, states;* "Provides a written complaint/grievance resolution letter to the complainant and member/enrollee if the complaint/grievance is filed on behalf of a member/enrollee, within thirty (30) calendar days of receipt of the complaint/grievance."
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					On page 4 of *Policy Q-6.4.4*, item 5 states, "If the complaint/concern is a health and safety issue, grievance and appeals staff will immediately (within 1 business day) complete the Quality of Care QOC Formdesk referral. Grievances related to health and safety concerns, including medical concerns, are reviewed by a physician as a part of the resolution process and Quality of Care Concern process." However, there was no additional information in *Policy C-6.4.4* about this process. ***Recommendations: Describe the steps staff take to address and resolve Quality of Care concerns, including details regarding how and where the physician review is documented.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					
2. The PIHP applies the grievance policy and procedure as formulated.	X					The file review indicated the following: • A decision letter was sent to each grievant or their representative with information about the steps taken in the investigation. • 6 cases referred to Provider Monitoring and they provided a clear document of the steps taken to investigate the grievance. • Timeline/steps of the investigation was not provided in the file review. The letters to the grievant was used to understand the steps taken to investigate the case. • Documentation of Medical Director consultation in cases with QOC issues without a QOC Referral was missing. • 4 cases with a QOC Concern/concern issues do not appear to have been referred to the QOC Concern Review. • 4 cases were referred to PI and limited information was provided regarding the steps of investigation. The files submitted for this EQR did not include documentation of the Medical Director consultation when a case was referred for QOC Review. During the Onsite interview, staff explained that screen shots of the Medical Director review notes are uploaded into AlphaMCS. This review is a part of the grievance record and should be included in any documentation that is submitted for any EQR or audit. ***Recommendation: To demonstrate Eastpointe is applying their policies as formulated, ensure files submitted as part of the grievance process are complete, including all communications and notifications between Eastpointe's staff and the grievant.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The *Grievance Log* is referred to as the *Complaint Log*. During the Onsite interview it was clarified that only grievances are maintained in this log. The log includes the tally of the complaint/grievance, how it was received, the resolution status and the data used for analysis. ***Recommendation: To maintain consistency of the grievance process and data collection use a consistent term (i.e. complaint/grievance or grievance) in all records and data collection documents.***
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					
VI. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to enrollee and/or provider appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					*Policy C-3.2.6 Appeal of UM Adverse Benefit Determination* governs the appeals process.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;		X				*Policy C-3.2.6 Appeal of UM Adverse Benefit Determination* states "Medicaid eligible members or a Legally Responsible Person (LRP) have a right to appeal any adverse decision through the local reconsideration process and the State fair hearing process." However, the *DMA Contract, Attachment M, Section G.1* 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."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Corrective Action: Add the correct definition of who can file an appeal to Policy C-3.2.6. Ensure the Provider Operations Manual and Enrollee/Member and Family Handbook are corrected .
1.2 The procedure for filing an appeal;	X					*Policy C-3.2.6 Appeal of UM Adverse Benefit Determination* does not provide clear information regarding the timeframe an appellant has for filing a written request for appeal once an oral request for appeal is filed. This policy says oral requests "must be followed up with a signed reconsideration form within 60 days." However, it is unclear from when the 60 days starts. Since the files contained evidence of inconsistencies by staff in communicating written request due dates to appellants, this timeframe needs to be clarified in policy. ***Recommendations: Clarify in Policy C-3.2.6 Appeal of UM Adverse Benefit Determination the timeframe for submitting a written appeal request after an oral appeal request is filed by an appellant. Specify when the timeframe starts.***
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					All appeal files reviewed were decided by appropriate appeal peer reviewers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	X					*Policy C-3.2.6 Appeal of UM Adverse Benefit Determination* is missing the word "prompt" from section D.2.E of the policy that describes the notification process when Eastpointe denies a request to expedite an appeal. ***Recommendation: Add the word "prompt" to the sentence in section D.2.E of Policy C-3.2.6 to state, "UM Director or designee will make reasonable efforts to provide prompt, oral notice." This will align the policy with DMA Contract, Attachment M, Section H.9.***
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					*Policy C-3.2.6 Appeal of UM Adverse Benefit Determination* addresses extensions to both standard and expedited appeal resolution timeframes but is missing key elements required by *DMA Contract*. ***Recommendation: Clarify within Policy C-3.2.6 under both the standard (D.5) and expedited (E.2.g) sections of this policy Eastpointe shall:*** • ***Make reasonable effort to give the Enrollee prompt oral notice of the delay;*** • ***Within two (2) calendar days give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a grievance, if he or she disagrees with the decision;*** • ***Resolve the appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.***
1.6 Written notice of the appeal resolution as required by the contract;	X					During the Onsite discussion, appeal staff could describe a process by which invalid appeals are resolved but there is no information within *Policy C-3.2.6 Appeal of UM Adverse Benefit Determination*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Add information to Policy C-3.2.6 Appeal of UM Adverse Benefit Determination regarding how Eastpointe defines and processes invalid appeals, including notification to the appellant.
1.7 Other requirements as specified in the contract.		X				The expedited acknowledgement template Eastpointe provided states that Eastpointe has, "up to 45 days" to process an expedited appeal. This is incorrect and should be changed to 72 hours with up to an additional 14 days if the expedited appeal resolution timeframe is extended. The invalid appeal notification is misleading. The first page of this notification explains how the appeal will be processed and then a short statement on the second page explains that the appeal will not be processed. The appeal extension notification template does not inform the appellant of the right to file a grievance if they disagree with Eastpointe's extension to the appeal resolution timeframe. The *Provider Operations Manual* erroneously says the timeframe to resolve an expedited appeal is three days and the timeframe to file an appeal is 30 days. Expedited appeals are required to be resolved in 72 hours and the timeframe for an appellant to file an appeal is 60 days from the mailing date of the Adverse Benefit Determination notification. ***Corrective Actions: Revise the expedited appeal acknowledgement letter to accurately inform appellants that their appeal will be processed within 72 hours with up to an additional 14 days if the expedited appeal resolution timeframe is extended.*** ***Revise the invalid notification to clearly and consistently reflect that the appellant's appeal will not be processed.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Revise the appeal extension notification to inform the appellant of their right to file a grievance if they disagree with Eastpointe's decision to extend the appeal resolution timeframe. ***Recommendations: Correct the Provider Operations Manual and Enrollee/Member and Family Handbook to clearly and consistently state that an expedited appeal will be resolved in 72 hours.*** ***Correct the Provider Operations Manual to state an appeal can be filed within 60 days of the mailing date of the Adverse Benefit Determination notice.***
2. The PIHP applies the appeal policies and procedures as formulated.	X					Staff apply the policies as written, but corrections are needed to the policies to bring Eastpointe's appeal practices into compliance with *DMA Contract*.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Appeals that are decided are tallied, categorized, and analyzed for trends then reported to the QI Committee. However, invalid and withdrawn appeal numbers are not reviewed for potential quality improvement opportunities. ***Recommendation: Include invalid and withdrawn appeals trends in the analysis of appeals to identify any potential quality improvement opportunities.***
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.		X				In one file reviewed, an enrollee's Protected Health Information (PHI) was mailed by staff, at the enrollee's request. The process outlined in Eastpointe's *Policy Q.6.3.5 Release of Medical Records* was not followed. **Corrective Action: Either describe the steps staff must follow prior to releasing the appeal and/or medical record in the appeal**

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						policy or reference *Policy Q-6.3.5 Release of Medical Records* within the appeal policy. Review the file discussed during the Onsite and provide training on the applicable steps staff must take prior to releasing PHI.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. Delegation						
1. The PIHP has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Eastpointe has Delegation Agreements and BAAs with its four delegates.
2. The PIHP conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the PIHP if the PIHP were directly performing the delegated functions.		X				Eastpointe completed delegation oversight and monitoring of all of its delegates except for the Medical Director Consultant services. At the last EQR, Eastpointe received Corrective Action for failure to complete delegation monitoring for the delegated Medical Director services. During the current review period, Eastpointe did not develop monitoring tools for, nor complete any monitoring of, the Medical Director delegates. ***Corrective Actions: Develop monitoring tools specific to the Medical Director consultant delegate. The monitoring tools should include monitoring items to protect Eastpointe against any real or perceived conflicts of interest.***

VIII. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VIII A. General Requirements						
1. PIHP shall be familiar and comply with Section 1902(a)(68) of the Social Security Act, 42 C.F.R. Parts 438,455 and 1000 through 1008, as applicable, including proper payments to Providers and methods for detection of fraud and abuse.	X					This requirement is addressed on page 1 of *Policy CC-3.5: Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)*.
2. PIHP shall have and implement policies and procedures that guide and require PIHP's, and PIHP's officers', employees', agents' and subcontractors,' compliance with the requirements of this Section 14.	X					This requirement is addressed *on page 1 of Policy CC-3.5: Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)*. The *Compliance Plan* governs compliance with the PIHP's policies.
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					This requirement is addressed on page 3 of *Policy CC-3.5: Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)*. The PIHP also provided this information on page 101 of the *Provider Operations Manual*.
4. PIHP shall investigate all grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	X					This requirement is addressed on page 5 of *Policy CC-3.5: Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)*.
VIII B. Fraud and Abuse						
1. PIHP shall establish and maintain a written Compliance Plan consistent with 42 C.F.R. 438.608 that is designed to guard against fraud and abuse. The Compliance Plan shall be	X					This requirement is addressed by the *2017-2018 Corporate Compliance Plan* submitted by the PIHP which is designed to guard against fraud and abuse. Onsite, the PIHP confirmed the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
submitted to the DMA Contract Administrator on an annual basis.						*Compliance Plan* is submitted to NC Medicaid on an annual basis and was submitted during the review period.
2. PIHP shall designate, however named, a Compliance Officer who meets the requirements of 42 C.F.R. 438.608 and who retains authority to report directly to the CEO and the Board of Directors as needed irrespective of administrative organization. PIHP shall also establish a regulatory compliance committee on the PIHP board of directors and at the PIHP senior management level that is charged with overseeing PIHP's compliance program and compliance with requirements under this Contract. PIHP shall establish and implement policies outlining a system for training and education for PIHP's Compliance Officer, senior management, and employees in regard to the Federal and State standards and requirements under DMA Contract in accordance with 42 CFR 438.608(a)(1)(iv).	X					This requirement is addressed on pages 6, and 12-13 of the *2017-2018 Corporate Compliance Plan*, which describes the Compliance Officer's role in the organization; on page 14 of the *2017-2018 Corporate Compliance Plan*, which describes the PIHP's Compliance Committee; and on pages 18-19 of the *2017-2018 Corporate Compliance Plan*, which describes the system for training and education of PI staff. This requirement and sub-requirements are also addressed in the *CC-1.1 Compliance Plan Policy*. Onsite, the PI team described that the Chief of Regulations and Compliance acts as the Compliance Officer. Additionally, the team described the difference between the Sub-committee and the Regulatory Compliance Committee, who sits on those committees, and what is reviewed in each Committee.
3. PIHP shall establish and implement a special investigations or program integrity unit, however named, that is responsible for PIHP program integrity activities, including identification, detection, and prevention of fraud, waste and abuse in the PIHP Closed Provider Network. PIHP shall identify an appropriately qualified contact for Program Integrity and Regulatory Compliance issues as mutually agreed upon by PIHP and DMA. This person may or may not be the PIHP	X					This requirement is addressed on pages 44-49 of the *2017-2018 Corporate Compliance Plan*, which describes the work plan of the Special Investigations Unit.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
Compliance Officer or the PIHP Contract Administrator.						
4. PIHP shall participate in quarterly Program Integrity meetings with DMA Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the N.C. Department of Justice ("MFCU/ MID').	X					NC Medicaid has stated that representation from the PIHP is always present at these meetings. Onsite, there was discussion about the quarterly meetings and who from the PIHP attends them. It was discussed that the PI Director is always in attendance, and if not, there is always representation from the PI team at these meetings. The PI team stated that at these meetings, the Committee reviews policy questions, updates from all PIHPs, complex PI cases and other updates such as the new referral form that was implemented by the PIHP.
5. PIHP shall participate in monthly meetings with DMA Program Integrity, in the most productive setting, either telephonically or in person at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.	X					This requirement is addressed by the PI Sub-committee meeting minutes that were submitted. The Committee meets monthly and has representation from a NC Medicaid liaison. As a follow up from the last EQR compliance review, individual roles/titles are now (after September 2017) indicated on the attendee list on the meeting minutes, making it easier to tell who is attending these meetings.
6. PIHP shall designate appropriately qualified staff to attend the monthly meetings, and the parties shall work collaboratively to minimize duplicative or unproductive meetings and information	X					This requirement is addressed by the PI Sub-committee meeting minutes that were submitted. The Committee appears to meet monthly, and it is evident from the minutes that meetings are focused on collaborative discussions and are productive.
7. PIHP shall also make Regulatory Compliance minutes and Program Integrity minutes, redacted as deemed appropriate by PIHP, available for review upon request by DMA.	X					This requirement is addressed by the PI Sub-committee meeting minutes that were submitted.
8. PIHP's written Compliance Plan shall, at a minimum include:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
8.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(66) of the Social Security Act;	X					This requirement is addressed on page 18 of the *2017-2018 Corporate Compliance Plan*, under Training and Education.
8.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing and development of corrective action initiatives;	X					This requirement is addressed on page 6 of the *2017-2018 Corporate Compliance Plan*, under Response and Prevention.
8.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					This requirement is addressed on page 5 of the *2017-2018 Corporate Compliance Plan*, under Enforcement & Discipline.
8.4 Provision for full cooperation by PIHP and PIHP's employees, contractors, and Providers with any investigation conducted by Federal or State authorities, including DMA or MFCU/MID, and including promptly supplying all data and information requested for their respective investigations	X					This requirement is addressed on pages 28-29 the 2017-2018 Corporate Compliance Plan.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9. In accordance with 42 CFR 436.606(a)(vii), PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under DMA Contract, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under DMA Contract; and making documentation of investigations and compliance available as requested by the State.	X					This requirement is addressed by *Policy CC-1.17 Internal Compliance Auditing and Monitoring*, compliance monitoring , and follow-up and Corrective Action planning in the event of noncompliance.
10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse.	X					This requirement is addressed by *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste, and Abuse (FWA)*.
10.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse;	X					This requirement is addressed on pages 12-13 *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste, and Abuse (FWA)*, which speak specifically to detecting and investigating Fraud, Waste and Abuse.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.2 Detailed workflow of the PIHP process for taking a complaint from inception through closure. This process shall include procedures for logging the complaint, determining if the complaint is valid, assigning the complaint, investigating, appeal, recoupment, and closure. The detailed workflow needs to differentiate the steps taken for fraud versus abuse; PIHP shall establish and implement policies for treatment of recoveries of all overpayments from PIHP to Providers and contracted agencies, specifically including retention policies for treatment of recoveries of overpayments due to fraud, waste, or abuse. The retention policies shall include processes, timeframes, and required documentation for payment of recoveries of overpayments to the State in situations where PIHP is not permitted to retain some or all of the recoveries of overpayments. This provision shall not apply to any amount of recovery to be retained under False Claims Act cases or through other investigations.	X					This requirement is addressed by *the Complaint Tracking Workflow* that was submitted by the PIHP, which provides the process for how incoming complaints are tracked and processed. *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste, and Abuse (FWA)* governs the *Complaint Tracking Workflow*.
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	X					This requirement is addressed on pages 24-25 of the *Provider Claims Manual*. However, information about how providers can report to Eastpointe that they have received an overpayment was not accessible on the provider website for Eastpointe. Currently, the website only has newsletter archives from 2015/2016 and the referral form.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
written notification to PIHP of the reason for the overpayment.						***Recommendations: Include links to information on how providers can report overpayment to the PIHP on the provider webpage of Eastpointe's website, along with the refund check form. Currently, the website only has newsletter archives from 2015/2016 and the referral form. This will ensure the information is up to date and readily accessible.***
10.4 Process for tracking overpayments and collections, and reporting on Attachment Y – Audits/Self- Audits/Investigations;	X					Onsite, the PIHP discussed that tracking of overpayments and collections occurs via Smartsheet where staff are sent a trigger in 30 days to check the status of payment. There is also a spreadsheet between the PI and Claims Teams to track provider, provider numbers, and total recoupment amounts. Additionally, this requirement is addressed by the Involuntary Recoup Workflow that was provided by the PIHP Onsite, which illustrates the process the PIHP follows to collect overpayments from providers.
10.5 Process for handling self-audits and challenge audits;	X					This requirement is addressed in *Policy CC-3.3 Voluntary Provider Self Audit* as it relates to providers; and *Policy CC-1.17 Internal Compliance Auditing and Monitoring* as it relates to the PIHP.
10.6 Process for using data mining to determine leads;	X					This requirement is addressed on page 4 of *Policy CC-1.17 Internal Compliance Auditing and Monitoring*.
10.7 Process for informing PIHP employees, subcontractors and providers regarding the False Claims Act;	X					As it relates to providers and subcontractors, this requirement is addressed by the provider trainings provided, which contain information about the False Claims Act. As it relates to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						employees, this requirement is addressed throughout the PI Department Training manual.
10.8 If PIHP makes or receives annual payments of at least $5,000,000, PIHP shall establish and maintain written policies for all employees, contractors or agents that detail information about the False Claims Act and other Federal and State laws as described in the Social Security Act 1902(a)(66), including information about rights of employees to be protected as whistleblowers.	X					This requirement is addressed in *Policy CC-1.15 Whistle Blower Protection*.
10.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains DMA-standardized elements or a DMA-approved template;	X					This requirement is addressed in *Policy E-4.2.1 Local Monitoring*, which describes the process by which the PIHP will verify services billed by provided were rendered. Additionally, Onsite, the PIHP confirmed that the NC Medicaid approved template is being utilized.
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	X					This requirement is addressed in *Policy B-2.7.24 Provider Paybacks*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
information in a readily available database or other search mechanism.						
11. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements. Nothing in this Contract is intended to address any requirement for PIHP to offer Providers written notice of the process for appealing to the NC Office of Administrative Hearings or any other forum.	X					This requirement is addressed *Policy B-2.7.24 Provider Paybacks* and on page 9 of *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)*.
12. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to DMA within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					This requirement is addressed on pages 6-8 of *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)* .
13. In each case where PIHP refers to DMA an allegation of fraud involving a Provider, PIHP shall provide DMA Program Integrity with the following information on the DMA approved template:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.1 Subject (name, Medicaid provider ID, address, provider type);	X					This requirement is addressed on page 8 of *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA).* File Review Results: Fifteen (15) of fifteen (15) files reviewed contained the required documentation.
13.2 Source/origin of complaint;	X					This requirement is addressed on page 8 of *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA).* File Review Results: 15 of 15 files reviewed contained the required documentation.
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					This requirement is addressed on page 8 of *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA).* File Review Results: 15 of 15 files reviewed contained the required documentation.
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					This requirement is addressed on page 8 of *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA).* File Review Results:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						15 of 15 files reviewed contained the required documentation.
13.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;	X					This requirement is addressed on page 8 of *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)*. File Review Results: 8 of 15 files reviewed contained the required documentation. 7 of the files were found to be not applicable for this requirement.
13.6 All communications between PIHP and the Provider concerning the conduct at issues, when available.	X					This requirement is addressed on page 8 of *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)*. File Review Results: 15 of 15 files reviewed contained the required documentation.
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					This requirement is addressed on page 8 of *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)*. File Review Results: 15 of 15 files reviewed contained the required documentation.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.8 Sample/exposed dollar amount, when available.	X					This requirement is addressed on page 8 of *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA).* File Review Results: 8 of 15 files reviewed contained the required documentation. 7 of the files were found to be not applicable for this requirement.
14. In each case where PIHP refers suspected Enrollee fraud to DMA, PIHP shall provide DMA Program Integrity with the following information on the DMA approved template:						
14.1 The Enrollee's name, birth date, and Medicaid number;	X					This requirement is addressed on page 2 of *Policy CC-3.4 Beneficiary Fraud and Abuse*. File Review Results: No file within the sample of 15 files involved a case of suspected enrollee fraud.
14.2 The source of the allegation;	X					This requirement is addressed on page 2 of *Policy CC-3.4 Beneficiary Fraud and Abuse*. File Review Results: No file within the sample of 15 files involved a case of suspected enrollee fraud.
14.3 The nature of the allegation, including the timeframe of the allegation in question;	X					This requirement is addressed on page 2 of *Policy CC-3.4 Beneficiary Fraud and Abuse*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						File Review Results: No file within the sample of 15 files involved a case of suspected enrollee fraud.
14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;	X					This requirement is addressed on page 2 of *Policy CC-3.4 Beneficiary Fraud and Abuse*. File Review Results: No file within the sample of 15 files involved a case of suspected enrollee fraud.
14.5 Contact information for PIHP staff persons with practical knowledge of the allegation;	X					This requirement is addressed on page 2 of *Policy CC-3.4 Beneficiary Fraud and Abuse*. File Review Results: No file within the sample of 15 files involved a case of suspected enrollee fraud.
14.6 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation; and	X					This requirement is addressed on page 2 of *Policy CC-3.4 Beneficiary Fraud and Abuse*. File Review Results: No file within the sample of 15 files involved a case of suspected enrollee fraud.
14.7 The legal and administrative status of the case.	X					This requirement is addressed on page 2 of *Policy CC-3.4 Beneficiary Fraud and Abuse*. File Review Results: No file within the sample of 15 files involved a case of suspected enrollee fraud.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
15. PIHP and DMA shall mutually agree on program integrity and monitoring forms, tools, and letters that meet the requirements of State and Federal law, rules, and regulations, and are consistent with the forms, tools and letters utilized by other PIHPs.	X					This requirement is addressed on page 10 of *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)* where the PIHP indicates it will use all PI tools supplied by NC Medicaid.
16. PIHP shall use the DMA Fraud and Abuse Management System (FAMS) or a DMA approved alternative data mining technology solution to detect and prevent fraud, waste and abuse in managed care.	X					This requirement is addressed on page 4 of *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)*, under "Detection Activities."
17. If PIHP uses FAMS, PIHP shall work with the DMA designated Administrator to submit appropriate claims data to load into the DMA Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. If PIHP uses FAMS, PIHP shall notify the DMA designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.	X					This requirement is addressed on page 4 of *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)*, under "Detection Activities."
18. PIHP shall submit to the DMA Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month. Section 9.8 Fraud and Abuse Reports. In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to DMA Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not limited to	X					This requirement is addressed on page 4 of *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)*, under "Detection Activities." The policy indicates FAMS reports, *Attachment Y* being submitted to NC Medicaid no later than the fifth of each month. There is no indication of a deadline for Attachment Z, however, reports were provided that are all dated appropriately within the report itself. In the case of FAMS users reports, all reports issued meet the timeliness requirement, as evidenced by the date on the reports

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
overpayments and self-audits. The monthly report shall be due by 11:59p.m. on the tenth (10th) of each month in the format as identified in Attachment Y. PIHP shall also report to DMA Program Integrity all Network Provider contract terminations and non-renewals initiated by PIHP, including the reason for the termination or non-renewal and the effective date. The only report shall be due by 11:59p.m. on the tenth (10th) day of each month in the format as identified in attachment Z – Terminations, Provider Enrollment Denials, Other Actions. Compliance with the reporting requirements of Attachments X, Y and Z and any mutually approved template shall be considered compliance with the reporting requirements of this Section.						provided (first of each month) and the date within the report itself. In the case of the *Attachment Y* report (all suspected cases of provider and enrollee FWA, all reports issued meet the timeliness requirement, as evidenced by the date on the reports provided (first of each month) and the date within the report itself. In the case of the *Attachment Z* report (network contract terminations and non-renewals), all reports issued meet the timeliness requirement, as evidenced by the date on the reports provided (first of each month) and the date within the report itself.
19. On a quarterly basis, DMA shall review a sample of cases where the PIHP's Special Investigation Unit has identified overpayments, investigated or audited a provider. The results of these reviews will be discussed during the PIHP monthly Program Integrity meetings to assure that DMA is providing consistent guidance on expectations with regard to referrals for potential cases of fraud. DMA shall also determine what additional technical assistance may be available to PIHP to support PIHP's efforts in making referrals.	X					This requirement is addressed on page 9 of *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)*, bullet 2.
VIII C. Provider Payment Suspensions and Overpayments						
1. Within thirty (30) business days of receipt from PIHP of referral of a potential credible allegation of fraud, DMA Program Integrity shall complete a						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
preliminary investigation to determine whether there is sufficient evidence to warrant a full investigation. If DMA determines that a full investigation is warranted, DMA shall make a referral within five (5) business days of such determination to the MFCU/ MID and will suspend payments in accordance with 42 CFR § 455.23. At least monthly, DMA shall provide written notification to PIHP of the status of each such referral. If MFCU/ MID indicates that suspension will not impact their investigation, DMA may send a payment suspension notice to the Provider and notify PIHP. If the MFCU/ MID indicates that payment suspension will impact the investigation, DMA shall temporarily withhold the suspension notice and notify PIHP. Suspension of payment actions under this Section 14.3 shall be temporary and shall not continue if either of the following occur: PIHP or the prosecuting authorities determine that there is insufficient evidence of fraud by the Provider; or Legal proceedings related to the Provider's alleged fraud are completed and the Provider is cleared of any wrongdoing.						
1.1 In the circumstances described in Section 14.3 (c) above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.	X					This requirement is addressed on page 11 of *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)*, bullet 5.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Upon receipt of a payment suspension notice from DMA Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of DMA Program Integrity's suspension and lasting until PIHP is notified by DMA Program Integrity in writing that the suspension has been lifted.	X					This requirement is addressed on pages 10-11 of *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA).*
3. PIHP shall provide to DMA all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.	X					This requirement is addressed on page 11 of *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)*, bullet 6.
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to DMA Program Integrity due to allegations of suspected fraud without prior written approval from DMA Program Integrity or the MFCU/MID.	X					This requirement is addressed on page 11 of *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)*, bullet 7.

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 DMA, MFCU/MID or other oversight agency, to the extent that such action shall not interfere with Enrollee access to care or with any such ongoing investigation being conducted by DMA, MFCU/MID or other oversight agency.	X					This requirement is addressed on page 11 of *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)*, bullet 8.
6. In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with N.C.G.S. 108C-5, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery.	X					This requirement is addressed on page 4 of *Policy B-2.7.24 Provider Paybacks*, under "G. DMA Overpayment."

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

IX. FINANCIAL SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IX. Financial						
1. The PIHP has policies and systems in-place for submitting and reporting financial data.	X					Eastpointe conducts an annual policy review . All reports are submitted on time to NC Medicaid. *Policy B-2.2.24, Financial Report Certification* details their monthly procedure. ***Recommendations: Add the five-business day transfer requirement after capitation payment of risk reserve payment to Policy B-2.2.24, Risk Reserve.*** ***Revise Policy B2.2, Record Retention and Disposition to refer to the 10-year requirement of financial records required by DMA Contract, Section 8.3.2.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP has and adheres to a cost allocation plan that meets the requirements of 42 CFR 433.34.	X					Eastpointe recalculates its administrative cost allocation by spreadsheet monthly, based on year-to-date service revenues. The indirect cost percentage does not vary greatly and is currently 88% Medicaid and 12% state/other.
3. PIHP maintains detailed records of the administrative costs and expenses incurred as required by the DMA contract. (DMA Contract, Section 8.3).	X					The administrative costs are captured by the general ledger in Great Plains and allocated to Medicaid via the monthly NC Medicaid report.
4. Maintains an accounting system in accordance with 42 CFR 433.32 (a).	X					Eastpointe uses Great Plains, version 2018, for its accounting system, and AlphaMCS for claims processing.
5. The PIHP follows a record retention policy of retaining records for ten years.	X					Eastpointe's *Policy B-2.2.26, Accounting by Funding Source*, states that Eastpointe follows all federal record retention requirements. Eastpointe staff confirmed that Medicaid records are retained for ten years during the Onsite interview.
6. The PIHP maintains a restricted risk reserve account with a federally guaranteed financial institution.	X					Eastpointe's *Policy B-2.2.25 Risk Reserve* states in Procedure 1, that "A restricted risk reserve account is established and maintained with a federally guaranteed financial institution licensed to do business in the state of North Carolina." Eastpointe's account is held with PNC Bank.
7. The required minimum balance of the Risk Reserve Account meets the requirements of the DMA contract. (DMA Contract, Section 1.8 Restricted Risk Reserve Account)		X				Eastpointe's *Policy B-2.2.25, Risk Reserve* states in Procedures 2-9 the procedures that Eastpointe follows regarding the Restricted Risk Reserve payment, transfer, reconciliation, interest, possible withdrawals, and property at the end of contract. All staff roles are adequately explained in the policy, and *DMA Contract* and External Quality Review Organization (EQRO) requirements are referenced. ***Recommendation: Implement a process to ensure all risk reserve payments are made within 5 days of receipt of capitation payment.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
8. All funds received by PIHP are accounted for by tracking Title XIX Medicaid expenditures separately from services provided using other funding, as required by the DMA contract (DMA Contract, Section 1.9).	X					The general ledger structure of the Great Plains chart of accounts provides adequate separation of Medicaid expenditures from other funding, as demonstrated in *Policy B-2.2.26, Accounting by Funding Source*, Procedure 7 (Medicaid costs are in segment 2.)
9. The Medical Loss Ratio (MLR) meets the requirements of 42 CFR 438.8 and the DMA contract (Amendment 2, Section 12.3 Item k).	X					Medical loss ratio (MLR) calculation is detailed in *Policy B-2.2.28, Medical Claims Liability*, and mentioned in *Policy B-2.2.26, Accounting by Funding Source*. The MLR is calculated monthly, and included in their dashboard, which is monitored and shared with their leadership team.

E. Attachment 5: Encounter Data Validation Report

Eastpointe

Encounter Data Validation Report

performed on behalf of

North Carolina Medicaid

December 5, 2018

Prepared By:

hms

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

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Background

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

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

Overview

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

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

Review of Eastpointe's ISCA response

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

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

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

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

Looking at claims with dates of service in 2017, Eastpointe submitted 2,004,846 unique encounters to the state. To date, 8% of all encounters submitted have not been corrected and accepted by NC Medicaid.

2017	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	118,891	98,319	18,114	2,458	2%
Professional	1,885,955	1,558,893	161,105	165,957	9%
Total	2,004,846	1,657,212	179,219	168,415	8%

Compared to claims submitted in 2016, Eastpointe has decreased the number of initial denials and total number of outstanding denials for claims submitted in 2017. However, there are a large number of 2016 claims that are outstanding that Eastpointe is not planning to submit. This issue was discussed openly during the Onsite review.

2016		Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	10,724	10,344	12	368	3%
Professional	2,478,333	457,202	1,389,009	632,122	26%
Total	2,489,057	467,546	1,389,021	632,490	25%

The reason for the large number of outstanding encounters is due to the transition by Eastpointe to a different claims processing system. Because of the age of the encounters, there is not an easy way to submit them successfully without turning off numerous edits that did not exist in 2016. NC Medicaid should revisit the outstanding encounters and ensure that both parties are comfortable with the gap of 2016 encounters in NCTracks.

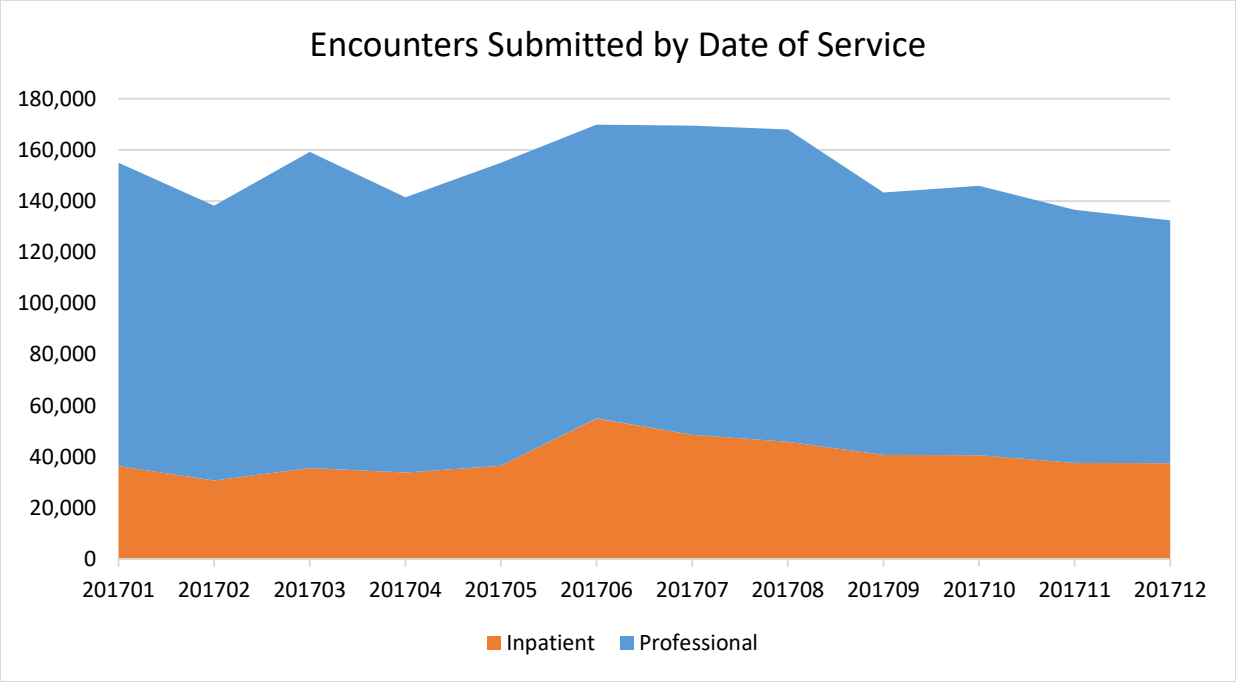
According to Eastpointe's response and review of NC Medicaid's acceptance report, 18% of all outstanding and ongoing denials are still related to invalid taxonomy codes for the billing and rendering provider or invalid combination of procedure code and taxonomy. Taxonomy errors are the main denials for all of the PIHPs, although Eastpointe is experiencing fewer denials for invalid taxonomy than the other plans. Eastpointe's strategy to continue to reduce, correct and resubmit encounter denials includes the following steps:

- Provider education guidelines
- Rebilling corrected encounter denials
- Created a Quality Improvement Project (QIP) that has identified all the interventions and barriers that are associated with encounter reporting
- Created an internal working committee that is designed to track and work through issues as they are identified

As a result of their strategy, denied claims from 2016 that were reported in the EDV review last year has decreased from 9% (109,983 claims) to less than 1% (1,614 claims).

Analysis of Encounters

The analysis of encounter data evaluated whether Eastpointe submitted complete, accurate, and valid data to NC Medicaid for all claims paid between January 1, 2017 through December 31, 2017. Eastpointe pulled all claims adjudicated and submitted to NC Medicaid during 2017 and sent to HMS via SFTP. This included more than 1.25 million professional claims and just over 478,000 institutional claims. Data transmitted included voids and resubmissions for previously denied claims, so the numbers do not reconcile back to the metrics reported in the ISCA response.



In order to evaluate the data, Eastpointe provided HMS with a data extract of all encounters submitted. Other plans typically convert their 837 files to a delimited file using an EDI translator; however, Eastpointe does not have a tool to perform this function. After data onboarding was completed, HMS applied proprietary, internally designed data analysis logic within SAS to review each data element, focusing on the data elements defined as required. Our logic evaluates the presence of data in each field within a record as well as whether the value for the field is within accepted standards. Results of these checks were compared with general expectations for each data field and to the CMS standards adopted for encounter data. The table below depicts the specific data expectations and validity criteria applied.

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

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

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

Data Element	*Expectation*	*Validity Criteria*
Principal Diagnosis	Well-coded except by ancillary type providers.	> 90% non-missing and valid codes (using International Statistical Classifications of Diseases, Ninth Revision, Clinical Modification [ICD-10-CM] lookup tables) for practitioner providers (not including transportation, lab, and other ancillary providers)
Other Diagnosis	This is not expected to be coded on all claims even with applicable provider types, but should be coded with a high frequency.	90% valid when present
Dates of Service	Dates should be evenly distributed across time.	If looking at a full year of data, 5%–7% of the records should be distributed across each month.
Unit of Service (Quantity)	The number should be routinely coded.	98% nonzero <70% should have one if Current Procedural Terminology (CPT) code is in 99200–99215 or 99241–99291 range.
Procedure Code	Critical Data Element	99% present (not zero, blank, or 8- or 9-filled). 100% should be valid, State-approved codes. There should be a wide range of procedures with the same frequency as previously encountered.
Procedure Code Modifier	Important to separate out surgical procedures/ anesthesia/assistant surgeon, not applicable for all procedure codes.	> 20% non-missing. Expect a variety of modifiers both numeric (CPT) and Alpha (Healthcare Common Procedure Coding System [HCPCS]).
Patient Discharge Status Code (Hospital)	Should be valid codes for inpatient claims, with the most common code being “Discharged to Home.”	For inpatient claims, expect >90% “Discharged to Home.”

Data Quality Standards for Evaluation of Submitted Encounter Data Fields Adapted and Revised from CMS Encounter Validation Protocol		
Data Element	***Expectation***	***Validity Criteria***
	For outpatient claims, the code can be "not applicable."	Expect 1%–5% for all other values (except "not applicable" or "unknown").
Revenue Code	If the facility uses a UB04 claim form, this should always be present	100% valid

Encounter Accuracy and Completeness

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

Table: Evaluation of Key Fields

Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	1,729,749	100.00%	1,729,749	100.00%	1,729,749	100.00%	1,729,749	100.00%
Recipient Name	1,729,749	100.00%	1,729,749	100.00%	1,729,749	100.00%	1,729,749	100.00%
Recipient Date of Birth	1,729,749	100.00%	1,729,749	100.00%	1,729,749	100.00%	1,729,749	100.00%
MCO/PIHP ID	1,729,749	100.00%	1,729,749	100.00%	1,729,749	100.00%	1,729,749	100.00%
Provider ID	1,729,694	100.00%	1,729,694	100.00%	1,729,694	100.00%	1,729,694	100.00%
Attending/Renderring Provider ID	1,728,888	99.95%	1,728,888	99.95%	1,728,888	99.95%	1,728,888	99.95%
Provider Location	1,729,749	100.00%	1,729,749	100.00%	1,729,749	100.00%	1,729,749	100.00%
Place of Service	1,718,471	99.35%	1,718,471	99.35%	1,718,471	99.35%	1,718,471	99.35%
Specialty Code / Taxonomy - Billing	1,525,951	88.22%	1,525,951	88.22%	1,525,951	88.22%	1,525,951	88.22%
Specialty Code / Taxonomy - Rendering / Attending	1,728,888	99.95%	1,729,749	100.00%	1,729,749	100.00%	1,729,749	100.00%
Principal Diagnosis	1,729,749	100.00%	1,729,749	100.00%	1,729,749	100.00%	1,729,749	100.00%
Other Diagnosis	436,357	25.23%	436,357	25.23%	436,357	25.23%	436,357	25.23%
Dates of Service	1,729,749	100.00%	1,729,749	100.00%	1,729,749	100.00%	1,729,749	100.00%
Unit of Service (Quantity)	1,729,631	99.99%	1,729,631	99.99%	1,729,631	99.99%	1,533,680	88.66%
Procedure Code	1,729,749	100.00%	1,729,749	100.00%	1,421,484	82.18%	1,421,484	82.18%
Procedure Code Modifier	415,670	24.03%	415,670	24.03%	415,670	24.03%	415,670	24.03%
Patient Discharge Status Code Inpatient	477,430	99.72%	477,430	99.72%	477,430	99.72%	477,430	99.72%
Revenue Code	478,752	100.00%	478,752	100.00%	478,752	100.00%	478,752	100.00%

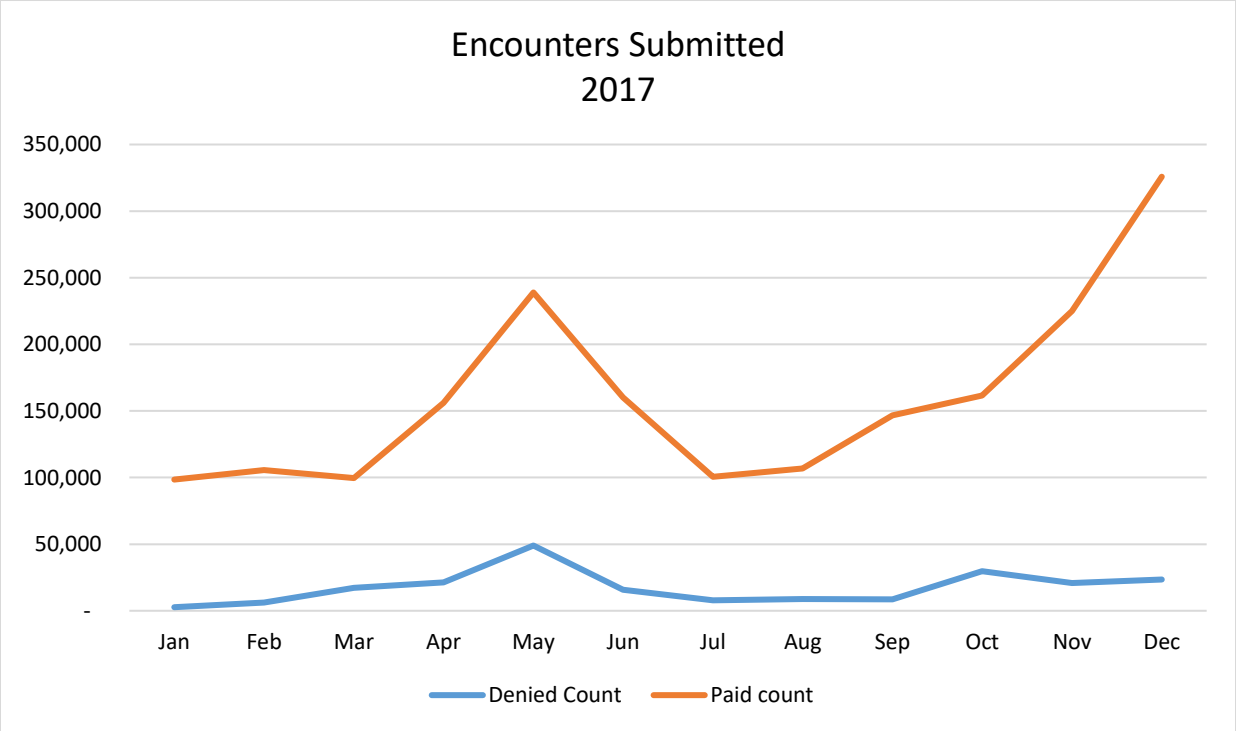
Overall, Eastpointe has significantly improved the quality and accuracy of the encounter data submitted compared to last year's review of 2016 claims. Institutional claims contained complete and valid data in 15 of the 18 key fields (83%) with noted issues for procedure code, diagnosis codes, and taxonomy values. The procedure code was populated with revenue code values for 64% of the claims. Given the

services provided and revenue codes submitted, the procedure code should have been more consistently populated. In addition, only two diagnosis codes were provided -- the secondary diagnosis was never submitted. Taxonomy values were not populated consistently for the billing or rendering providers in the extract Eastpointe provided and is a significant driver in NCTracks to adjudicate a claim properly.

Professional encounter claims submitted contained complete and accurate data in 13 of the 15 key professional fields (93%). Only the principal and secondary diagnosis codes were reported in the data. Although this is common across each of the PIHPs, only 11% of the encounters had the secondary diagnosis code populated. The taxonomy code was not populated consistently, similar to the institutional data feed. Taxonomy codes are required.

Encounter Acceptance Report

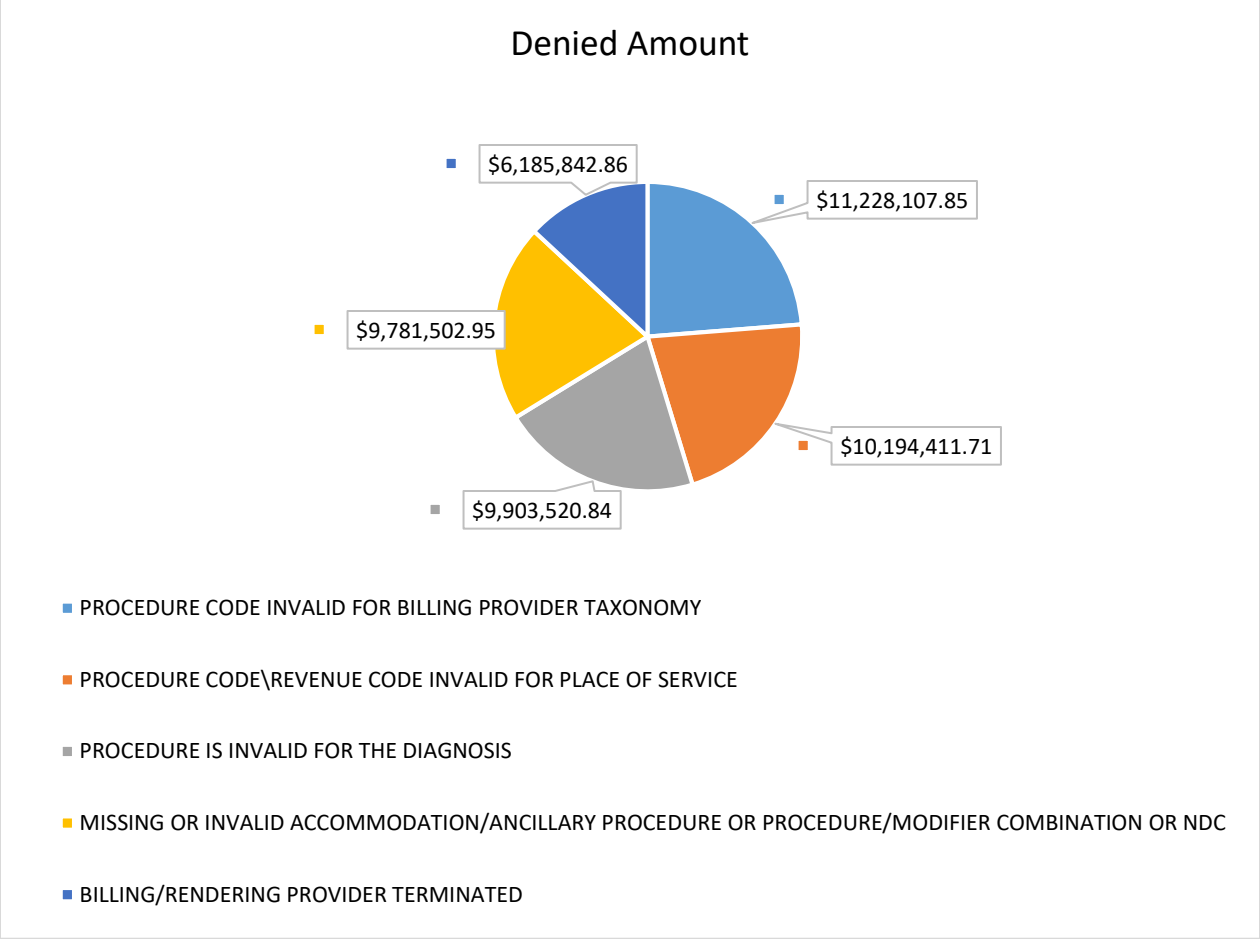
In addition to performing evaluation of the encounter data submitted, the HMS analyst reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by check write, which made it difficult to tie back to the ISCA response and the submitted encounter files since only the Date of Service for each is available. During the 2017 weekly check write schedule, Eastpointe submitted 1,925,296 encounters to NC Medicaid. On average, 11% of all encounters submitted were initially denied. Approximately 8% of claims denied are still outstanding -- the rest have been reviewed, resubmitted, and accepted by NC Medicaid.

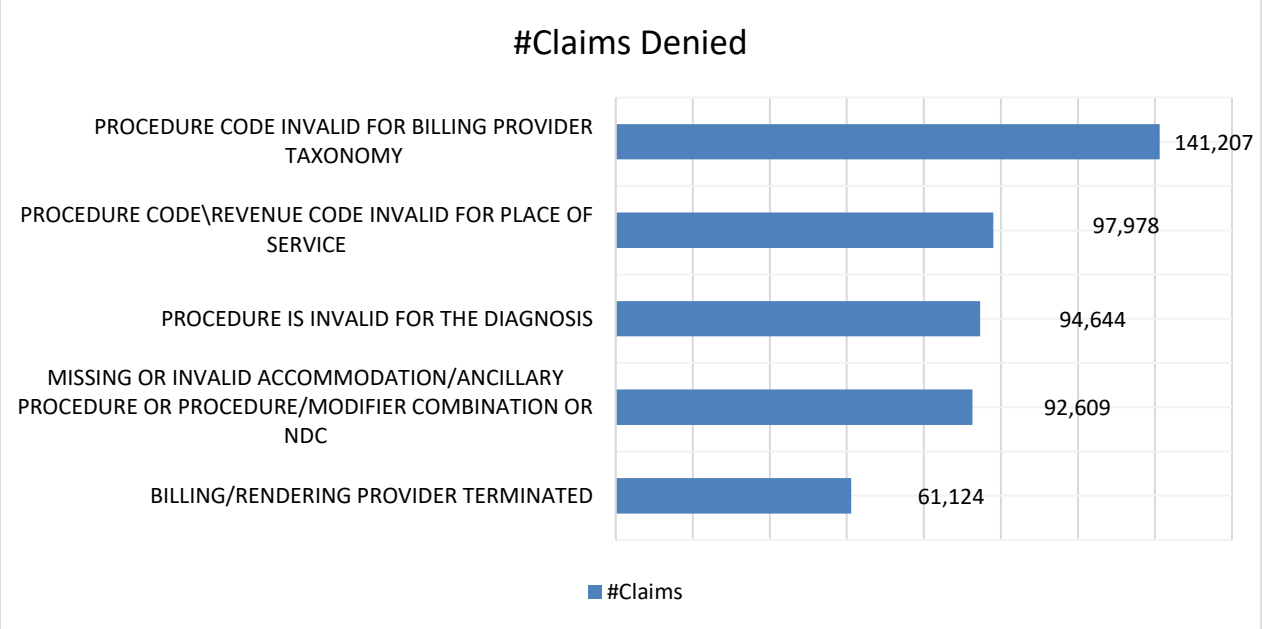


Evaluation of the top denials for Eastpointe encounters correlates with the some of the data deficiencies identified by the HMS analyst in the Key Field analysis above. Encounters were denied primarily for:

- Procedure code invalid for billing provider taxonomy
- Procedure code\revenue code invalid for place of service
- Procedure is invalid for the diagnosis
- Missing or invalid accommodation/ancillary procedure or procedure/modifier combination
- Billing / Rendering provider terminated

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





Results and Recommendations

Issue: Procedure Code

The procedure code for institutional claims should populated 99% of the time. In the encounter data provided, HMS found that the field was populated less than 36% of the time with valid values. These fields are required to adjudicate the claim appropriately and should be provided by the provider given the types of services being billed and supporting revenue codes provided.

Resolution:

Eastpointe should check their claims processing system and data warehouse to ensure the procedure code is being captured appropriately. Claims submitted through the portal or an 837 should be denied by Eastpointe without the proper revenue code and procedure code combination. Eastpointe should double check their 837 encounter creation process and encounter data extract process to make sure data was not lost or manipulated during transformation.

Issue: Diagnosis Codes

Two items need to be addressed as it relates to diagnosis codes. The secondary diagnosis was populated less than 11% for professional claims and only the admitting and principal diagnosis was provided for institutional claims. In addition, there are never more than two diagnosis codes provided/submitted in the encounter data for professional or institutional claims.

Resolution:

The diagnosis issue will require action by Eastpointe and NC Medicaid. NC Medicaid will need to work with the PIHPs and CSRA to determine what additional non-behavioral health diagnosis codes should be submitted and accepted when available. Currently, NCTracks will deny any encounter with a non-behavioral health diagnosis regardless of the position of the diagnosis code value (i.e. primary, secondary,

tertiary, etc.). There are behavioral health services provided by the PIHPs that require medical services and medical diagnosis codes. Eastpointe will need to work collaboratively with the state and Alpha to ensure they can capture and report all diagnosis codes once NCTracks has been updated to accept. Eastpointe indicated that they are capturing all submitted diagnosis codes and can begin to transmit once NC Medicaid has a mechanism to accept the additional values.

Issue: Taxonomy code for Billing and Rendering providers

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

Resolution:

As outlined in their ISCA response, Eastpointe has a process in place to review denials and correctly resubmit encounters to the State that were denied due to invalid or missing taxonomy. Eastpointe should continue to follow their current process. The encounter data reviewed and NC Medicaid check write report reflects significant improvement over last year, so we know the process in place is making a positive impact.

Conclusion

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

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

Appendix 1

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
00001	HDR BEG DOS INVLD/ > TCN DATE	DENY
00002	ADMISSION DATE INVALID	DENY
00003	HDR END DOS INVLD/ > TCN DATE	DENY
00006	DISCHARGE DATE INVALID	PAY AND REPORT
00007	TOT DAYS CLM GTR THAN BILL PER	PAY AND REPORT
00023	SICK VISIT BILLED ON HC CLAIM	IGNORE
00030	ADMIT SRC CD INVALID	PAY AND REPORT
00031	VALUE CODE/AMT MISS OR INVLD	PAY AND REPORT
00036	HEALTH CHECK IMMUNIZATION EDIT	IGNORE
00038	MULTI DOS ON HEALTH CHECK CLM	IGNORE
00040	TO DOS INVALID	DENY
00041	INVALID FIRST TREATMENT DATE	IGNORE
00044	REQ DIAG FOR VITROCERT	IGNORE
00051	PATIENT STATUS CODE INVALID	PAY AND REPORT
00055	TOTAL BILLED INVALID	PAY AND REPORT
00062	REVIEW LAB PATHOLOGY	IGNORE
00073	PROC CODE/MOD END-DTE ON FILE	PAY AND REPORT
00076	OCC DTE INVLD FOR SUB OCC CODE	PAY AND REPORT
00097	INCARCERATED - INPAT SVCS ONLY	DENY
00100	LINE FDOS/HDR FDOS INVALID	DENY
00101	LN TDOS BEFORE FDOS	IGNORE
00105	INVLD TOOTH SURF ON RSTR PROC	IGNORE
00106	UNABLE TO DETERMINE MEDICARE	PAY AND REPORT
00117	ONLY ONE DOS ALLOWED/LINE	PAY AND REPORT

00126	TOOTH SURFACE MISSING/INVALID	IGNORE
00127	QUAD CODE MISSING/INVALID	IGNORE
00128	PROC CDE DOESNT MATCH TOOTH #	IGNORE
00132	HCPCS CODE REQ FOR REV CODE	IGNORE
00133	HCPCS CODE REQ BILLING RC 0636	IGNORE
00135	INVL POS INDEP MENT HLTH PROV	PAY AND REPORT
00136	INVLD POS FOR IDTF PROV	PAY AND REPORT
00140	BILL TYPE/ADMIT DATE/FDOS	DENY
00141	MEDICAID DAYS CONFLICT	IGNORE
00142	UNITS NOT EQUAL TO DOS	PAY AND REPORT
00143	REVIEW FOR MEDICAL NECESSITY	IGNORE
00144	FDOS AND TDOS MUST BE THE SAME	IGNORE
00146	PROC INVLD - BILL PROV TAXON	PAY AND REPORT
00148	PROC\REV CODE INVLD FOR POS	PAY AND REPORT
00149	PROC\REV CD INVLD FOR AGE	IGNORE
00150	PROC CODE INVLD FOR RECIP SEX	IGNORE
00151	PROC CD/RATE INVALID FOR DOS	PAY AND REPORT
00152	M/I ACC/ANC PROC CD	PAY AND REPORT
00153	PROC INVLD FOR DIAG	PAY AND REPORT
00154	REIMB RATE NOT ON FILE	PAY AND REPORT
00157	VIS FLD EXAM REQ MED JUST	IGNORE
00158	CPT LAB CODE REQ FOR REV CD	IGNORE
00164	IMMUNIZATION REVIEW	IGNORE
00166	INVALID VISUAL PROC CODE	IGNORE
00174	VACCINE FOR AGE 00-18	IGNORE
00175	CPT CODE REQUIRED FOR RC 0391	IGNORE

00176	MULT LINES SAME PROC, SAME TCN	IGNORE
00177	HCPCS CODE REQ W/ RC 0250	IGNORE
00179	MULT LINES SAME PROC, SAME TCN	IGNORE
00180	INVALID DIAGNOSIS FOR LAB CODE	IGNORE
00184	REV CODE NOT ALLOW OUTPAT CLM	IGNORE
00190	DIAGNOSIS NOT VALID	DENY
00192	DIAG INVALID RECIP AGE	IGNORE
00194	DIAG INVLD FOR RECIP SEX	IGNORE
00202	HEALTH CHECK SHADOW BILLING	IGNORE
00205	SPECIAL ANESTHESIA SERVICE	IGNORE
00217	ADMISSION TYPE CODE INVALID	PAY AND REPORT
00250	RECIP NOT ON ELIG DATABASE	DENY
00252	RECIPIENT NAME/NUMBER MISMATCH	PAY AND REPORT
00253	RECIP DECEASED BEFORE HDR TDOS	DENY
00254	PART ELIG FOR HEADER DOS	PAY AND REPORT
00259	TPL SUSPECT	PAY AND REPORT
00260	M/I RECIPIENT ID NUMBER	DENY
00261	RECIP DECEASED BEFORE TDOS	DENY
00262	RECIP NOT ELIG ON DOS	DENY
00263	PART ELIG FOR LINE DOS	PAY AND REPORT
00267	DOS PRIOR TO RECIP BIRTH	DENY
00295	ENC PRV NOT ENRL TAX	IGNORE
00296	ENC PRV INV FOR DOS	IGNORE
00297	ENC PRV NOT ON FILE	IGNORE
00298	RECIP NOT ENRL W/ THIS ENC PRV	IGNORE
00299	ENCOUNTER HMO ENROLLMENT CHECK	PAY AND REPORT

00300	BILL PROV INVALID/ NOT ON FILE	DENY
00301	ATTEND PROV M/I	PAY AND REPORT
00308	BILLING PROV INVALID FOR DOS	DENY
00313	M/I TYPE BILL	PAY AND REPORT
00320	VENT CARE NO PAY TO PRV TAXON	IGNORE
00322	REND PROV NUM CHECK	IGNORE
00326	REND PROV NUM CHECK	PAY AND REPORT
00328	PEND PER NC MEDICAID REQ FOR FIN REV	IGNORE
00334	ENCOUNTER TAXON M/I	PAY AND REPORT
00335	ENCOUNTER PROV NUM MISSING	DENY
00337	ENC PROC CODE NOT ON FILE	PAY AND REPORT
00339	PRCNG REC NOT FND FOR ENC CLM	PAY AND REPORT
00349	SERV DENIED FOR BEHAV HLTH LM	IGNORE
00353	NO FEE ON FILE	PAY AND REPORT
00355	MANUAL PRICING REQUIRED	PAY AND REPORT
00358	FACTOR CD IND PROC NON-CVRD	PAY AND REPORT
00359	PROV CHRGS ON PER DIEM	PAY AND REPORT
00361	NO CHARGES BILLED	DENY
00365	DRG - DIAG CANT BE PRIN DIAG	DENY
00366	DRG - DOES NOT MEET MCE CRIT.	PAY AND REPORT
00370	DRG - ILLOGICAL PRIN DIAG	PAY AND REPORT
00371	DRG - INVLD ICD-9-CM PRIN DIAG	DENY
00374	DRG PAY ON FIRST ACCOM LINE	DENY
00375	DRG CODE NOT ON PRICING FILE	PAY AND REPORT
00378	DRG RCC CODE NOT ON FILE DOS	PAY AND REPORT
00439	PROC\REV CD INVLD FOR AGE	IGNORE

00441	PROC INVLD FOR DIAG	IGNORE
00442	PROC INVLD FOR DIAG	IGNORE
00613	PRIM DIAG MISSING	DENY
00628	BILLING PROV ID REQUIRED	IGNORE
00686	ADJ/VOID REPLC TCN INVALID	DENY
00689	UNDEFINED CLAIM TYPE	IGNORE
00701	MISSING BILL PROV TAXON CODE	DENY
00800	PROC CODE/TAXON REQ PSYCH DX	PAY AND REPORT
00810	PRICING DTE INVALID	IGNORE
00811	PRICING CODE MOD REC M/I	IGNORE
00812	PRICING FACTOR CODE SEG M/I	IGNORE
00813	PRICING MOD PROC CODE DTE M/I	IGNORE
00814	SEC FACT CDE X & % SEG DTE M/I	IGNORE
00815	SEC FCT CDE Y PSTOP SEG DT M/I	IGNORE
01005	ANTHES PROC REQ ANTHES MODS	IGNORE
01060	ADMISSION HOUR INVALID	IGNORE
01061	ONLY ONE DOS PER CLAIM	IGNORE
01102	PRV TAXON CHCK - RAD PROF SRV	IGNORE
01200	INPAT CLM BILL ACCOM REV CDE	DENY
01201	MCE - ADMIT DTE = DISCH DTE	DENY
01202	M/I ADMIT AND DISCH HRS	DENY
01205	MCE: PAT STAT INVLD FOR TOB	DENY
01207	MCE - INVALID AGE	PAY AND REPORT
01208	MCE - INVALID SEX	PAY AND REPORT
01209	MCE - INVALID PATIENT STATUS	DENY
01705	PA REQD FOR CAPCH/DA/CO RECIP	PAY AND REPORT

01792	DME SUPPLIES INCLD IN PR DIEM	DENY
02101	INVALID MODIFIER COMB	IGNORE
02102	INVALID MODIFIERS	PAY AND REPORT
02104	TAXON NOT ALLOWED WITH MOD	PAY AND REPORT
02105	POST-OP DATES M/I WITH MOD 55	IGNORE
02106	LN W/ MOD 55 MST BE SAME DOS	IGNORE
02107	XOVER CLAIM FOR CAP PROVIDER	IGNORE
02111	MODIFIER CC INTERNAL USE ONLY	IGNORE
02143	CIRCUMCISION REQ MED RECS	IGNORE
03001	REV/HCPCS CD M/I COMBO	IGNORE
03010	M/I MOD FOR PROF XOVER	IGNORE
03012	HOME HLTH RECIP NOT ELG MCARE	IGNORE
03100	CARDIO CODE REQ LC LD LM RC RI	IGNORE
03101	MODIFIER Q7, Q8 OR Q9 REQ	IGNORE
03200	MCE - INVALID ICD-9 CM PROC	DENY
03201	MCE INVLD FOR SEX PRIN PROC	PAY AND REPORT
03224	MCE-PROC INCONSISTENT WITH LOS	PAY AND REPORT
03405	HIST CLM CANNOT BE ADJ/VOIDED	DENY
03406	HIST REC NOT FND FOR ADJ/VOID	DENY
03407	ADJ/VOID - PRV NOT ON HIST REC	DENY
04200	MCE - ADMITTING DIAG MISSING	DENY
04201	MCE - PRIN DIAG CODE MISSING	DENY
04202	MCE DIAG CD - ADMIT DIAG	DENY
04203	MCE DIAG CODE INVLD RECIP SEX	PAY AND REPORT
04206	MCE MANIFEST CODE AS PRIN DIAG	DENY
04207	MCE E-CODE AS PRIN DIAG	DENY

04208	MCE - UNACCEPTABLE PRIN DIAG	DENY
04209	MCE - PRIN DIAG REQ SEC DIAG	PAY AND REPORT
04210	MCE - DUPE OF PRIN DIAG	DENY
04506	PROC INVLD FOR DIAG	IGNORE
04507	PROC INVLD FOR DIAG	IGNORE
04508	PROC INVLD FOR DIAG	IGNORE
04509	PROC INVLD FOR DIAG	IGNORE
04510	PROC INVLD FOR DIAG	IGNORE
04511	PROC INVLD FOR DIAG	IGNORE
07001	TAXON FOR ATTND/REND PROV M/I	DENY
07011	INVLD BILLING PROV TAXON CODE	DENY
07012	INVLD REND PROV TAXONOMY CODE	DENY
07013	INVLD ATTEND PROV TAXON CODE	PAY AND REPORT
07100	ANESTH MUST BILL BY APPR PROV	IGNORE
07101	ASC MODIFIER REQUIREMENTS	IGNORE
13320	DUP-SAME PROV/AMT/DOS/PX	DENY
13420	SUSPECT DUPLICATE-OVERLAP DOS	PAY AND REPORT
13460	POSSIBLE DUP-SAME PROV/PX/DOS	PAY AND REPORT
13470	LESS SEV DUPLICATE OUTPATIENT	PAY AND REPORT
13480	POSSIBLE DUP SAME PROV/OVRLAP	PAY AND REPORT
13490	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13500	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13510	POSSIBLE DUP/SME PRV/OVRLP DOS	PAY AND REPORT
13580	DUPLICATE SAME PROV/AMT/DOS	PAY AND REPORT
13590	DUPLICATE-SAME PROV/AMT/DOS	PAY AND REPORT
25980	EXACT DUPE. SAME DOS/ADMT/NDC	PAY AND REPORT

34420	EXACT DUP SAME DOS/PX/MOD/AMT	PAY AND REPORT
34460	SEV DUP-SAME PX/PRV/IM/DOS/MOD	DENY
34490	DUP-PX/IM/DOS/MOD/$$/PRV/TCN	PAY AND REPORT
34550	SEV DUP-SAME PX/IM/MOD/DOS/TCN	PAY AND REPORT
39360	SUSPECT DUPLICATE-OVERLAP DOS	PAY AND REPORT
39380	EXACT/LESS SEVERE DUPLICATE	PAY AND REPORT
49450	PROCDURE CODE UNIT LIMIT	PAY AND REPORT
53800	Dupe service or procedure	PAY AND REPORT
53810	Dupe service or procedure	PAY AND REPORT
53820	Dupe service or procedure	PAY AND REPORT
53830	Dupe service or procedure	PAY AND REPORT
53840	Limit of one unit per day	PAY AND REPORT
53850	Limit of one unit per day	PAY AND REPORT
53860	Limit of one unit per month	PAY AND REPORT
53870	Limit of one unit per day	PAY AND REPORT
53880	Limit of 24 units per day	DENY
53890	Limit of 96 units per day	DENY
53900	Limit of 96 units per day	DENY