2022 External Quality Review

EASTPOINTE

Submitted: November 22, 2022

Prepared on behalf of
North Carolina Medicaid

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EXECUTIVE SUMMARY

The *Balanced Budget Act of 1997* requires State Medicaid Agencies that contract with Prepaid Inpatient Health Plans (PIHPs) to evaluate their compliance with the state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358 (42 CFR § 438.358)*. This review determines the level of performance demonstrated by Eastpointe. This report contains a description of the process and the results of the 2022 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the North Carolina Medicaid (NC Medicaid).

Goals of the review are to:

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

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

A. Overall Findings

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

- Coordination and Continuity of Care (*§ 438.208*)
- Coverage and Authorization of Services (*§ 438.210*)
- Provider Selection (*§ 438.214 and § 438.240*)
- Confidentiality (*§ 438.224*)
- Grievance and Appeal Systems (*§ 438, Subpart F*)
- Health Information Systems (*§ 438.242*)
- Quality Assessment and Performance Improvement Program (*§ 438.330)*

Due to COVID-19 pandemic, CCME implemented a focused review. This decision was based on the issuance by the State of the COVID-19 flexibilities PIHP Contract Amendment #11. This PIHP contract amendment stated PIHPs "shall be held harmless for any documentation or other PIHP errors identified through the EQR that are not directly related to member health and safety through the Term of the Amendment." The focused review included comprehensive review of the PIHP's health systems capabilities and provider credentialing and recredentialing documentation and processes. The review includes validation of the PIHP's Performance Improvement Projects, Performance Measures, and Encounter data. Lastly, a thorough review of the PIHP's Utilization Management, Grievances, and Appeals processes were conducted. What was not reviewed were the PIHP's network adequacy, availability of services, Subcontractual relationships, and Clinical Practice Guidelines (*42 CFR § 438.206, § 438.207, § 438.230, and § 438.236*, respectively).

To access the health plan's compliance with fed regs and contract, CCME's review was divided into six areas. The following is a high-level summary of the review results for those areas. Additional information regarding the reviews, including strengths, weaknesses, and recommendations, are included in the narrative of this report.

B. Overall Recommendations

The following provides a global or high-level summary of the status of the Recommendations and Corrective Action items from the 2021 EQR and the findings of the 2022 EQR. Specific Recommendations and Corrective Actions are detailed in each section of this report.

Administration

42 CFR § 438.224 and 42 CFR § 438.242

In the 2021 EQR, Eastpointe met 100% of the Administrative standards and received one Recommendation. In the 2022 EQR, Eastpointe met 100% of the Administrative standards in the 2022 EQR as well and there was evidence Eastpointe addressed the Recommendation issued in the 2021 EQR.

In the 2022 EQR, two Recommendations were issued. Eastpointe is encouraged to continue to work with their providers around correct Taxonomy codes. Additionally, Eastpointe should ensure NCTracks updates are completed to address COVID-related code errors.

Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

In Eastpointe's 2021 EQR of Credentialing/Recredentialing, there were no items requiring Corrective Action. CCME issued three Recommendations, which were focused on ensuring

accurate language in documents and on the Eastpointe website. Eastpointe addressed the Recommendations. In the current EQR, Eastpointe met 100% of the Credentialing/ Recredentialing standards, with no identified Weaknesses, Corrective Action items or Recommendations.

Quality Improvement

42 CFR § 438.330

In the 2021 EQR, Eastpointe met 100% of the Quality standards and received three Recommendations related to the PIPs that were validated. One PIP that received a Recommendation in 2021 was no longer active in 2022. Therefore, Eastpointe's implementation of that Recommendation could not be evaluated in the 2022 EQR.

For the 2022 EQR, Eastpointe met all standards with no Corrective Actions. All PIPs were validated in the High Confidence range with no Recommendations. Eastpointe was Fully Compliant for (b) Waiver and (c) Waiver Performance Measures (PMs). Several PM rates showed a substantial decline, and a Recommendation was issued to monitor interim performance measure rates that declined substantially in the year over year trending.

Utilization Management

42 CFR § 438.208

In the 2021 EQR, Eastpointe met 96% of the UM standards and received one Corrective Action regarding the MH/SUD and I/DD files reviewed. In the 2022 EQR, CCME reviewed Eastpointe's Desk Materials to ensure the 2021 EQR Corrective Action Plan was implemented. The review confirmed that Eastpointe only partially implemented the 2021 Corrective Action Plan.

In the 2022 EQR, Eastpointe met 100% of the Utilization Management EQR standards. CCME is recommending Eastpointe address the portions of the 2021 Corrective Action not implemented. The Desk review also revealed two Eastpointe policies describing Innovations services and resources were missing language. As a result, CCME is recommending Eastpointe revise the two Innovations policies.

Grievances and Appeals

42 CFR § 438, Subpart F, 42 CFR 483.430

In the 2021 EQR, Eastpointe met 100% of the Grievance and Appeal standards, resulting in no Corrective Actions. CCME issued two Recommendations to address concerns noted primarily in the Grievance monitoring and staff training processes used for ensuring internal processes verify compliance to the PIHP *NC Medicaid Contract*, Eastpointe policies, and federal regulations.

In the 2022 EQR, Eastpointe met 100% of the Grievance and Appeal standards, resulting in no Corrective Actions and two Recommendations. The Grievance Recommendation centered around monitoring to ensure notification timeframes are issued in a timely manner according to the Eastpointe policy. The Appeals Recommendation was issued to ensure a notice of resolution is sent for each resolved Appeal.

Program Integrity

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

In the 2021 EQR, Eastpointe met 100% of PI standards. CCME's review of Eastpointe's PI functions showed strong interdepartmental collaboration with provider relations, claims, UM, and quality teams.

In the 2022 EQR, Eastpointe again met 100% of PI EQR standards, resulting in no Corrective Actions and one Recommendation. The Desk Review and Onsite revealed that Eastpointe is not capturing relevant trend data on the PI Case Log. CCME is recommending that Eastpointe develop a method that will ensure the PI Case Log reflects the actual source of PI referrals.

Encounter Data Validation

Based on the analysis of Eastpointe's encounter data, Aqurate concludes that the data submitted to NC Medicaid are complete and accurate as defined by NC Medicaid standards. The most notable issue is related to the infrequent reporting of Other Diagnosis codes. Although Other Diagnosis codes may not affect adjudication in certain instances, these codes are important for reporting, evaluating member health, and assessing a value-based payments. Eastpointe should conduct a review at the provider level to determine which of its providers are often not reporting Other Diagnosis codes and perform educational outreach to alert providers to the issue. Eastpointe should also continue to review and take necessary actions to ensure that they are capturing and reporting valid Procedure codes for Institutional claims when required based on the reported Revenue code (e.g., pharmacy, lab, radiology) so that all services billed on those claims can be identified.

For the next review period, Aqurate recommends that the encounter data from NCTracks be reviewed to assess 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. Additionally, the PIHP does not send their 837 files converted to a pipe- or comma-delimited file using an EDI translator. This makes reconciliation difficult as well. Reviewing an extract from NCTracks may provide insight into NCTracks' handling of the submitted encounters and could be reconciled back to reports received from Eastpointe. The goal is to ensure that Eastpointe is reporting all paid claims as encounters to NC Medicaid.

Corrective Actions and Recommendations from Previous EQR

During the previous EQR, there was one standard scored as "Partially Met" and no standards scored as "Not Met." Following the 2021 EQR, Eastpointe submitted a Corrective Action Plan to address the identified deficiencies. CCME reviewed and accepted Eastpointe's Corrective Action Plan on December 30, 2021.

During the 2022 EQR, CCME assessed the degree to which Eastpointe implemented the actions to address these deficiencies and found the Corrective Action Plan was partially implemented. Additional details regarding Eastpointe's 2021 Corrective Actions Plan, their response, and evidence, or lack thereof, of implementation of the 2021 Corrective Actions are detailed in the Utilization Management section of this report.

Conclusions

Overall, Eastpointe has met the requirements set forth in their contract with NC Medicaid. The 2022 Annual EQR shows that Eastpointe has achieved a "Met" score for 100% of the standards reviewed. As the following chart indicates, no standards were scored as "Partially Met" or "Not Met." *Figure 1, Annual EQR Comparative Results*, provides an overview of the scoring of the current annual review as compared to the findings of the 2021 review.

Figure 1: Annual EQR Comparative Results

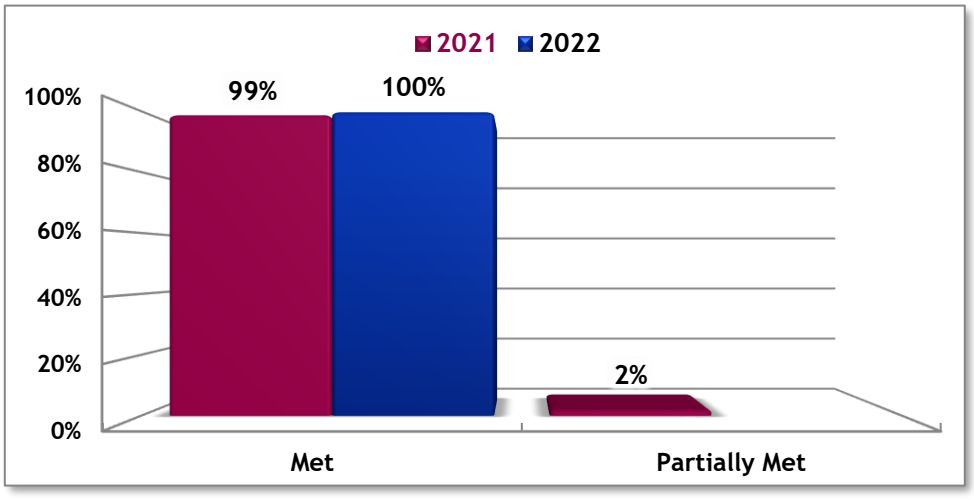


Table 1 provides a summary of key findings and Recommendations or opportunities for improvement. Specific details regarding each Strength, Weakness, and Recommendation can be found in the relative report sections.

Table 1: Eastpointe's 2022 Overall Strengths, Weaknesses, Recommendations and Corrective Actions

	Strengths	Weaknesses	Corrective Actions/ Recommendations
Quality	Eastpointe adjudicates claims on a nightly basis. Approximately, 98.38% of Professional claims and 81.16% of Institutional claims are auto-adjudicated.	Several performance measure rates showed a substantial decline including 30-day Readmission rates for PRTF, Follow-up rates After Hospitalization for Mental Illness for FBC, and Follow-up After Hospitalization of SA in the Detox and FBC populations.	***Recommendation: Monitor interim performance measure rates that declined substantially in the year over year trending.***
	Eastpointe submits up to 24 ICD-10 Diagnosis codes for Institutional encounters and up to 12 ICD-10 Diagnosis codes for Professional encounters.	Review of the Audit tools used by Eastpointe in the past year to identify and correct compliance issues around face-to-face monitoring of Innovations services showed staff were not capturing accurate information around monitoring.	***Recommendation: Work with staff completing enrollee file audits to clarify what data should be captured in the various elements within the Audit Tools.***
	(b) Waiver Measures included all necessary documentation, and measures were reported according to specifications.	Eastpointe was able to demonstrate that Child MH/SU Care Coordination staff were trained on protocols for handling incident reports, but no other Care Coordination staff were trained such as Adult MH/SU staff, TCLI, or IDD Care Coordination staff.	***Recommendation: Provide training to Adult MH/SU staff, TCLI, and IDD Care Coordination staff regarding the processes, follow up, and notifications that are required to occur around incident reports.***
	(c) Waiver Measures met or exceeded State benchmark rates.		
	All PIPs were in the High Confidence range.		

	Strengths	Weaknesses	Corrective Actions/ Recommendations
	Eastpointe's auditing of enrollee files has resulted in high compliance scores		
	Many experienced Appeals staff have been promoted to the managerial team		
	Eastpointe has resumed onsite investigations with providers after postponement during the Covid-19 pandemic.		
Timeliness	Eastpointe has significantly reduced the claims denial rate from prior years.	Eastpointe continues to encounter issues with denials related to Taxonomy codes.	***Recommendation: Continue working with providers to submit appropriate Taxonomy codes on claims.***
	Eastpointe explained a renewed focus on Grievance and Appeal documentation within the files, including regular staff meetings to encourage clear, timely, and accurate documentation.	Eastpointe continues to experience denials due to issues based on a Covid-related code.	***Recommendation: Eastpointe continues to experience denials due to issues based on a Covid-related code. While the issue is not with Eastpointe systems, it is recommended that they follow through to ensure that the NCTracks updates are completed to make sure the error is addressed.***
	Of the number of cases initiated in the past two years, Eastpointe has reduced the number of open cases to less than 30%.	Two Grievance files showed the resolution notice was sent outside of the 30-day Eastpointe policy requirement, and one file showed the acknowledgment notice was sent in six business days versus the 5 business days required by the policy.	***Recommendation: Continue to routinely monitor Grievance notification timeframes to ensure all notifications are issued in a timely manner per Eastpointe Policy Q-6.4.4, Member/Enrollee and Stake Holder Grievance/ Complaint and Appeals.***

	Strengths	Weaknesses	Corrective Actions/ Recommendations
		One Appeal file did not contain a written notice of resolution sent to the member, as required by the *NC Medicaid Contract, Attachment M (7).*	***Recommendation: Ensure a notice of resolution is sent for each resolved Appeal as required by the NC Medicaid Contract, Attachment M (7).***
		The PI Case Log does not accurately reflect whether the source of a concern or complaint originated internally or from an external stakeholder.	***Recommendation: Ensure the PI Case Log accurately reflects the original source (e.g., EOB, members, stakeholder, and other external sources) of a concern or complaint to better reflect trends in complaints and stakeholders' efforts towards preventing fraud, waste, and abuse.***
Access to Care	Eastpointe has a toll-free Provider Service Line which is open Monday through Saturday from 7:00 am until 6:00 pm.	Policy C-3.3.6, Individual and Family Directed Services, does not include Supported Living as a self-directed service.	***Recommendation: Revise Policy C-3.3.6 to include Supported Living as a self-directed service.***
	Eastpointe launched six RV mobile units in June 2022 to serve members with substance use disorders.	Policy C-3.3.9, Employee of Record, does not state Employee of Record participants must submit the out of State Travel Request for as indicated in Appendix J of the North Carolina Innovations Technical Guide.	***Recommendation: Revise Policy C-3.3.9, Employee of Record, to include Employee of Record participants must submit the out of State Travel Request when seeking reimbursement for out of state travel.***
	TCLI staff reported Eastpointe has a 100% diversion rate for individuals transitioning from Adult Care Homes.		

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 PMs, and validation of PIPs, as well as optional activity in the area of Encounter Data Validation, conducted by CCME's subcontractor, HMS. Additionally, as required by CCME's contract with NC Medicaid, an ISCA Audit and Medicaid program integrity (PI) review of the health plan was conducted by CCME's subcontractor, IPRO.

On August 29, 2022, 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 PIHP 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 requested by CCME.

The review consisted of two segments. The first was a Desk Review of materials and documents received from Eastpointe on October 4, 2022 and reviewed by CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the QI and Medical Management Programs. Also included in the Desk Review was a review of Credentialing, Grievance, Utilization, Care Coordination, and Appeal files.

The second segment of the EQR is typically a two-day, Onsite review conducted at the PIHP's offices. However, due to COVID-19, this Onsite was conducted through a teleconference platform on October 27, 2022. This Onsite visit focused on areas not covered in the Desk Review and areas needing clarification. For a list of items requested for the onsite visit, see *Attachment 2*. CCME's onsite activities included:

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

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

FINDINGS

The findings of the EQR are summarized in the following pages of this report and are based on the regulations set forth in *42 CFR § 438.358* and the *NC Medicaid Contract* requirements between Eastpointe and NC Medicaid. Strengths, Weaknesses, Corrective Action items, and Recommendations are identified where applicable. Areas of review were identified as meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), Not Applicable, or Not Evaluated, and are recorded on the Tabular Spreadsheet (*Attachment 4*).

A. Administration

42 CFR § 438.208

Information Systems Capabilities Assessment

The review of Eastpointe's system capabilities involved the use of the Information Systems Capabilities Assessment (ISCA) tool and review of supporting documentation such as Eastpointe's claim audit reports, enrollment workflows, and Eastpointe's Information Technology (IT) staffing patterns. This system analysis is completed as specified in the Centers for Medicare and Medicaid Services (CMS) External Quality Review protocol. During the virtual site review, Eastpointe's staff presented the enrollment and claims systems overview. Questions regarding the ISCA tool were discussed with Eastpointe staff during the virtual site review. In the 2021 EQR, Eastpointe met 100% of the Administration EQR standards and one Recommendation was issued. Table 2 outlines the Recommendations issued to Eastpointe in the 2021 EQR and CCME's follow up in the 2022 EQR.

Table 2: 2021 EQR Administration Findings

2021 EQR Administration Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The PIHP has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to NC Medicaid	Eastpointe is encountering a higher than usual number of duplicate encounter data submission denials from NCTracks, which are primarily due to the process of submitting adjusted and voided encounters. Eastpointe is unable to query the database to produce the count of encounters with specific dates of service. ***Recommendation:*** ***Continue to work with providers and the State to reduce the number of denied duplicate encounters from NCTracks.*** ***Update Eastpointe's code and encounter data reporting system to be able to query the database to produce the count of encounters based on specific dates of service, prior years, or a point in time.***	Y

2022 EQR Follow up: Eastpointe staff found that the timing and reprocessing of claims especially voided claims was a significant contributing factor for denials related duplicates. To address this concern, Eastpointe implemented a delay regarding submission of data to the state. Voided claims data are submitted on Mondays and resubmission claims data are sent on Thursdays. Eastpointe staff also implemented more stringent claims audits. The query to produce the denial counts was also updated to produce correct denial data. Eastpointe staff also indicated that they were working with providers regarding duplicate claims. Eastpointe sufficiently addressed the Recommendation from the 2021 EQR.

Eastpointe uses the Alpha+ System, a hosted system environment produced by their vendor, Alphaind. The Alpha+ system is used to process member enrollment and claims, submit encounters, and generate reports. Eastpointe uses Microsoft Dynamics to analyze their financial data. The ISCA tool and supporting documentation for the enrollment systems loading processes clearly defined the process for enrollment data updates in the Alpha+ system. During the virtual site review, Eastpointe provided a demonstration of the Alpha+ enrollment system, which maintains member enrollment history. The Global Eligibility File (GEF) file is imported daily into the Alpha+ by their vendor, Alphaind. Alphaind also uploads the monthly 834 file to Alpha+. The documentation provided in the ISCA tool indicates monthly reconciliation of eligibility data.

Eastpointe stores the Medicaid identification number received on the GEF. During the virtual site review, Eastpointe indicated that they rarely see members with multiple IDs but are able to research and merge the information into one Member ID. Eastpointe specified that, in cases where a consumer is enrolled in the Alpha+ system under one name and identification number from State's GEF file and is then legally adopted and has a name change, then the record is required to be updated. The original information and member ID will remain in the system and a new member ID may be issued from the date of adoption forward. In instances where providers may create a new enrollment which creates a new ID, the Enrollment Department will proactively search for consumers with more than one ID so that records can be merged into one ID number. Alpha+ can store multiple Medicaid Member IDs per Member.

During the virtual site review system demonstration, staff displayed the enrollment information that is viewable and captured within Alpha+. The Alpha+ system is able to capture demographic data such as race, ethnicity, and language.

Eastpointe experienced nearly 70% reduction in enrollment after July 2021 due to transition of membership to NC Medicaid Managed Care. Eastpointe enrollment counts for the past three years are presented in Table 3.

Table 3: Enrollment Counts

2019	2020	2021
149,586	163,427	48,659

A review of Eastpointe's processes for collecting, adjudicating, and reporting claims was conducted through a review of its ISCA response and supporting documentation provided. Eastpointe's authorizations and claims are processed in the Alpha+ system. During the virtual site review, Eastpointe staff provided a demonstration of the provider web claims entry portal and the Alpha+ claims processing system.

Eastpointe receives claims through three methods, 837 electronic file, provider web portal, and paper claims. During the virtual site review, Eastpointe stated that claims from out-of-network providers are received on paper. Table 4 details the percentage of 2021 claims received through each of the three methods.

Table 4: Percent of claims with 2021 dates of service that were received via Electronic (HIPAA, Provider Web Portal) or Paper forms

Source	HIPAA File	Paper	Provider Web Portal
Institutional	13%	1%	1%
Professional	60%	1%	24%

Eastpointe adjudicates claims on a nightly basis. Approximately, 98.38% of Professional claims and 81.16% of Institutional claims are auto-adjudicated. On the Alpha+ claims system, Eastpointe captures up to 24 ICD-10 Diagnosis codes for Institutional claims via the provider web portal and HIPAA files. For Professional claims, the system can receive and store up to 12 ICD-10 Diagnosis codes from claims received from the provider web portal and HIPAA files. Eastpointe captures ICD-10 Procedure codes and Diagnosis-related Groups (DRGs) if they are submitted on the claim.

Eastpointe's Quality Improvement Department is responsible for external monthly claim audits which encompass 3% of all claims. High dollar claims, those that are more than $5,000, as well as Emergency Department claims are pended for manual review and are audited on a weekly basis. Newly hired claim examiners who perform manual review of claims are audited daily for the first three months. Claims examiners who have an error rate greater than 3% are retrained and subjected to a 100% claims audit for 10 days and monitored for decreased error rates or further corrective action.

The breakdown of encounter data acceptance/denial rates by claim service detail counts was provided for encounters submitted in 2021. Table 5 provides a comparison of 2020 and 2021. Although enrollment dropped significantly, similarly to other PIHPs, the members who were using the majority of the BH services still continued to use them, therefore not impacting the change in encounter volume significantly in relation to the decreased enrollment.

Table 5: Volume of 2020 and 2021 Submitted Encounter Data

2021	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	83,416	51,488	3	134,907
Professional	1,245,392	66,287	1,939	1,313,618
2020	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	88,335	33,759	14	122,108
Professional	1,163,580	68,643	333	1,232,556

Eastpointe has a 99.7% acceptance rate for both Professional and Institutional encounters with dates of service in 2021. Eastpointe has stated in the ISCA that the main denial reason is due to invalid taxonomy codes. Review of the encounter data and the Adam Holtzman report has identified the following top three denial reasons for encounters in 2021:

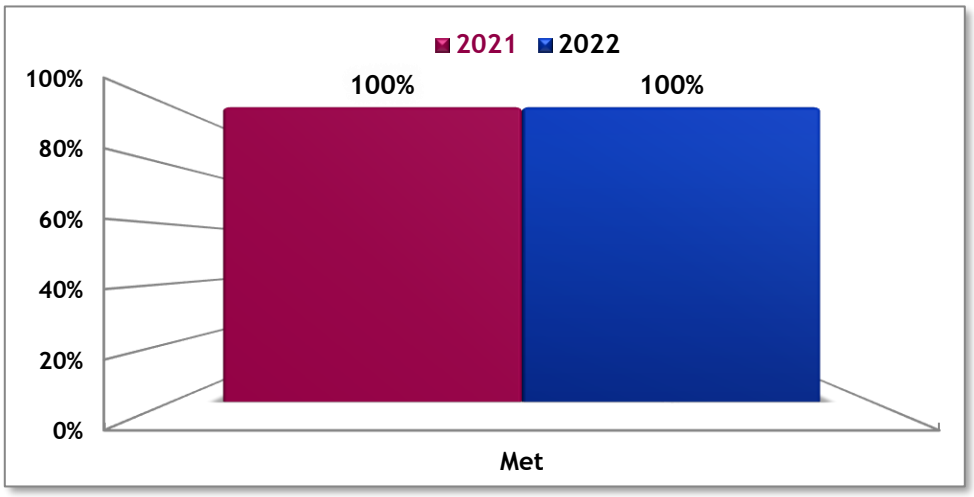
- Possible duplicate, same provider, same procedure code, overlapping dates of service.
- Duplicate Service or procedure.
- Procedure code invalid for billing provider taxonomy.

On average, Eastpointe submits an encounter to NC Medicaid within five days from the time of adjudication. It takes approximately 15 days to correct and resubmit an encounter to NC Medicaid. Eastpointe uses the Adam Holtzman's paid and denied reports to identify encounters that were denied. As stated in the ISCA, Eastpointe has three Institutional and 1939 Professional encounters with dates of service in 2021 still awaiting resubmission as of October 3, 2022.

Eastpointe exceeds NC Medicaid standards for encounter submissions and has a denial rate of less than 0.14% for their encounter data submissions. Eastpointe submits up to 24 ICD-10 Diagnosis codes for Institutional encounters and up to 12 ICD-10 Diagnosis codes for Professional encounters. Eastpointe submits DRG and ICD-10 Procedure codes on Institutional encounters to NCTracks.

Figure 2 demonstrates that Eastpointe met all of the standards in the 2021 and 2022 Administration EQRs.

Figure 2: Administration Comparative Findings



Strengths

- Eastpointe adjudicates claims on a nightly basis. Approximately, 98.38% of Professional claims and 81.16% of Institutional claims are auto-adjudicated.
- Eastpointe submits up to 24 ICD-10 Diagnosis codes for Institutional encounters and up to 12 ICD-10 Diagnosis codes for Professional encounters.
- Eastpointe has significantly reduced the denial rate from prior years.

Weaknesses

- Eastpointe continues to encounter issues with denials related to Taxonomy codes.
- Eastpointe continues to experience denials due to issues based on a Covid-related code.

Recommendations

- Continue working with providers to submit appropriate Taxonomy codes on claims.
- Eastpointe continues to experience denials due to issues based on a Covid-related code. While the issue is not with Eastpointe systems, it is recommended that they follow through to ensure that the NCTracks updates are completed to make sure the error is addressed.

B. Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

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

In the 2021 EQR, Eastpointe met 100% of the Credentialing/Recredentialing standards, resulting in no Corrective Actions. CCME issued three Recommendations, focused on ensuring accurate language in documents and on the Eastpointe website. Eastpointe addressed the three Recommendations, as presented in Table 6.

Table 6: 2021 EQR Provider Services Findings

2021 EQR Credentialing/Recredentialing findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The PIHP formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	***Recommendation: As recommended at the last EQR, reconcile the language within the Eastpointe Credentialing Manual about the process.***	**Y**
2022 EQR Follow up: In this 2022 EQR, Eastpointe reconciled the application process language in the *Provider Credentialing Operations Manual/Plan*.		
Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the PIHP.	***Recommendation: As recommended at the last EQR, revise the Credentialing By-Laws, the Credentialing Manual, and any other documents that reference the composition of the Credentialing Committee, to consistently reflect the correct composition and position titles of the Credentialing Committee membership. Further, as the Medical Director now chairs the committee meeting in the absence of the AMD, revise the Credentialing Manual to reflect this change.*** ***In the By-Laws dated 08272021, correct the date the By-Laws were "reviewed and approved by the Credentialing Committee" to August 27, 2021.***	**Y**

2021 EQR Credentialing/Recredentialing findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
2022 EQR Follow up: In this 2022 EQR, Eastpointe addressed the conflicting language in the *Credentialing Committee By-Laws* and the *Provider Credentialing Manual/Plan* regarding the composition of the provider representative members and the position titles of members of the Credentialing Committee.		
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.	***Recommendation: Ensure posted information, such as the MCO Provider Sanctions Grid, is accurate and current.***	**Y**
2022 EQR Follow up: The "Manuals and Information" section of the Provider section of the Eastpointe website still has the *MCO Provider Sanctions Grid* dated 5-17-17. The *Eastpointe Provider Sanctions Grid Reviewed 4-8-2021* is also now posted. During Onsite discussion, Eastpointe staff reported that suggested changes have been sent to the Executive Team and to the Legal Department for review.		

In the 2022 EQR, Eastpointe met 100% of the Credentialing/Recredentialing standards, with no identified Weaknesses, Corrective Action items or Recommendations. Per the direction of the NC DHHS, credentialing has now shifted from the PIHPs completing credentialing and recredentialing to the PIHPs verifying credentialing completed by NCTracks. Eastpointe completed the in-process credentialing and recredentialing files in May 2022.

The *Provider Credentialing Operations Manual/Plan* dated 9.23.21(*Credentialing Manual)* and *Credentialing Committee By-Laws 8-27-2021 (By-Laws)* directed the credentialing and recredentialing processes. The Credentialing Committee Composition is outlined in both the *Credentialing Manual* and the *By-Laws*. Both documents list the Associate Medical Director as the Chairperson of the committee. The "Composition" section in both documents states "The meeting will not occur if the Associate Medical Director or Eastpointe Medical Director is not present at the meeting. The Eastpointe Medical Director will chair the meeting in the Associate Medical Director's absence."

Dr. Venkata Lakshmi Doniparthi, Associate Medical Director / I/DD & TBI Clinical Director and a board-certified psychiatrist, chaired the Credentialing Committee meetings and served as a voting member. The six additional voting members of the committee were "participating practitioners from the provider network whose agency represent each disability group; Substance Abuse, Mental Health and Intellectual and Developmental Disabilities." Eight Eastpointe staff were non-voting members of the committee.

As outlined in the *Credentialing Manual* and the *By-Laws,* the Associate Medical Director "reviews and approves credentialing files that meet criteria for participation (e.g., 'clean applications')", and the Credentialing Committee reviewed and approved the list of approved "clean" files. The Credentialing Committee meeting minutes reflect discussion of, and the committee's decisions regarding, the applications with "criminal records hits, sanctions hits or other discrepancies."

A quorum was defined as "50% plus one of the identified voting members of the Committee." The sample of Credentialing Committee meeting minutes reviewed for this EQR indicated a quorum was present.

CCME's review of the submitted credentialing and recredentialing files showed they were organized and contained appropriate information, though CCME was initially unable to locate a few items. In response to CCME's request on the Missing Desk Materials list, Eastpointe provided part of the missing items. On the Onsite Request List, CCME asked for the remaining missing items and Eastpointe provided the requested items.

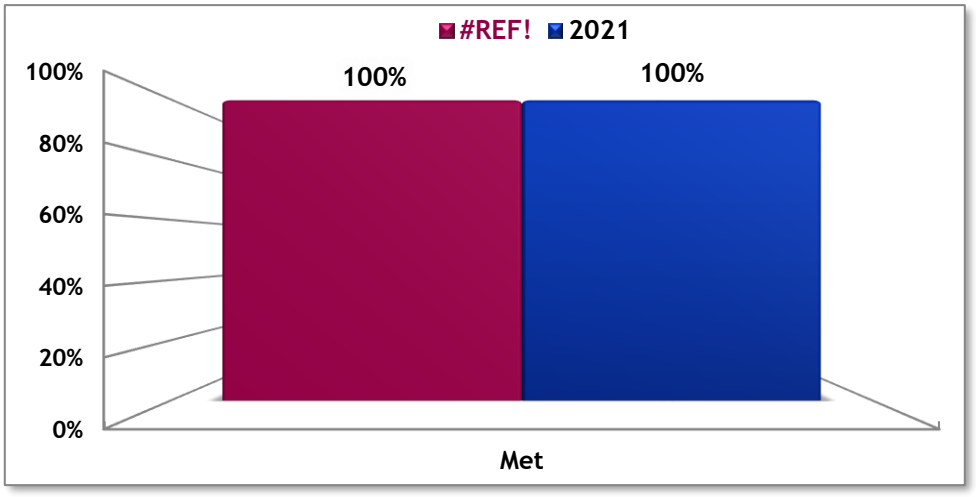
New providers receive a "Welcome" letter, directing them to the Becoming a Provider section of the website, which includes a link to the *Provider Operations Manual*, as well as a Provider Orientation Training webinar. The Meetings and Trainings section of the website includes minutes and presentations of provider meetings. The Trainings section includes trainings on a variety of topics. A Program Integrity training dated August 25, 2021, posted on the website, includes information regarding fraud, waste, and abuse.

During Onsite discussion regarding network adequacy, Eastpointe staff provided information regarding efforts to address the seven gaps identified at the last EQR, including adding an MST provider in the Robeson County area, which eliminated the identified gap for MST. Eastpointe also added a provider for SA Medically Monitored Community Residential Treatment. There was a "significant drop" between 2021 and 2022 in out-of-network requests, which Eastpointe staff cited as "evidence that we are meeting needs." A group meets weekly to discuss network adequacy gaps. Identified barriers include staffing shortages for providers, as well as the costs associated with services such as partial hospital and facility-based crisis services. During the pandemic, services that required licensure could not be added due to delays in the state issuing the required license.

Eastpointe staff reported an increase in providers wanting to join the network due to the planned implementation of the Tailored Plan. As a result of increased provider interest, Eastpointe was able to increase resources for services such as Applied Behavioral Analysis services for children with autism. Eastpointe staff reported a "need for child residential services." In May 2022, the six PIHPs launched the NC Child and Family Improvement Initiative, which is focused on expanding child residential care services. Numerous RFIs and RFPs for other services have been posted on the Eastpointe website this year.

Figure 3, Provider Services Comparative Findings, shows that 100% of the standards in the 2022 Credentialing/Recredentialing EQR were scored as "Met" and provides an overview of 2022 scores compared to 2021 scores.

Figure 3: Provider Services Comparative Findings



Strengths

- Eastpointe has a toll-free Provider Service Line which is open Monday through Saturday from 7:00 am until 6:00 pm.
- Eastpointe launched six RV mobile units in June 2022 to serve members with substance use disorders.

C. Quality Improvement

42 CFR § 438.330

The 2021 Quality Improvement (QI) EQR included Performance Measures (PMs) and Performance Improvement Projects (PIPs) validation. CCME conducted a Desk Review of the submitted (b) and (c) Waiver Performance Measures (PMs) and a review of each PIP's *Quality Improvement Project (QIP) Form* for validation, using CMS standard validation protocols. An Onsite discussion occurred to clarify measurement rates for each of the areas.

In the 2021 EQR, Eastpointe met 100% of the Quality standards and received three Recommendations related to the PIPs that were validated. The Recommendations and the status of implementation in the 2022 EQR are presented in Table 7.

Table 7: 2021 EQR PIP Recommendations

Project(s)	Recommendation	Recommendation Implemented in 2022 (Y/N/NA)
Increase the Percent of Individuals Who Receive a 2nd Service Within or Less Than (≤) 14 Days to 35%	***Recommendation: Determine if additional education needs to be implemented for providers. Assess impact of interventions to allow determination of most effective intervention.***	**N/A**
Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD)	***Recommendation: Continue interventions and conduct analysis of interim data to determine if additional interventions should be implemented to focus on the SSD rate.***	**Y**
Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD)	***Recommendation: As data allow, conduct interventions assessment in relation to SSD rate to assess impact of each intervention.***	**Y**

For the 2022 EQR, three PIPs were submitted: Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD), Decrease Emergency Department (ED) Admissions for Active Members to 20% DMH, and Decrease Percentage of Members Who Separate from Transition to Community Living Initiative (TCLI) Housing to 20% or Less Annually.

Table 8 displays the PIP project title and interventions for the current review year.

Table 8: 2021 EQR PIP Recommendations

Project(s)	Interventions
Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD)- Clinical	Provider Enrichment Forum, Provider Meeting on the importance of including Diabetes screening/monitoring as a goal on the member's Person-Centered Plan (PCP), Mailing letters to providers related to use of antipsychotics.
Decrease Emergency Department (ED) Admissions for Active Members to 20% DMH- Clinical	MH/SU Care Specialist daily calls to ED, Hospital Transition Team members to assist with discharge planning, interdepartmental meetings to address ED re-admissions concerns, Provider Self-Audit Tool, and data review and technical assistance calls with ACTT Providers
Transition to Community Living Initiative (TCLI) Housing to 20% or less annually (Non Clinical)	Use of My Strengths app with members, Permanent Supportive Housing (PSH) training, Motivational Interviewing training, and Engagement trainings, new inspectors, and ADANC Community Inclusion provider

Performance Measure Validation

As part of the EQR, CCME conducted the independent validation of NC Medicaid-selected (b) and (c) Waiver performance measures. Table 9 and 10 show those measures validated.

Table 9: (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 10: (c) Waiver Measures

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

CCME performed validations in compliance with the CMS developed protocol, *EQR Protocol 2: Validation of Performance Measures,* which requires a review of the following for each measure:

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

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

(b) Waiver Measures Reported Results

There were several rates with a substantial decline (>10%). The 30-day Readmission Rates for PRTF increased 11.3%. Follow-up Rates After Hospitalization for Mental Illness in the Facility Based Crisis (FBC) population declined 30.1% for 7- day Follow-up and declined 33.7% for the 30-day Follow-up. Follow up After Hospitalization for Substance Abuse in the Detox and FBC population decline 10% for the 3-day Follow-up rate. The average Length of Stay (LOS) for 13-17 Year Old Males increased by 27.7 days in the Mental Health Utilization Measure. Rates that improved include Engagement of Alcohol and Other Drug Dependence Treatment (AODDT) for 13-17 year olds by 20.5%, Engagement of AODDT for 18-20 year olds by 14.9%, and Engagement of AODDT for 65+ by 10.8%.

The current rate in comparison to last year's rate is presented in Tables 11 through 20.

Table 11: A.1. Readmission Rates for Mental Health

30-day Readmission Rates for Mental Health	FY 2020	FY 2021	Change
Inpatient (Community Hospital Only)	13.6%	14.1%	0.5%
Inpatient (State Hospital Only)	0.0%	3.7%	3.7%
Inpatient (Community and State Hospital Combined)	13.7%	14.2%	0.5%
Facility Based Crisis	7.7%	2.5%	-5.2%
Psychiatric Residential Treatment Facility (PRTF)	0.0%	11.3%	**11.3%**
Combined (includes cross-overs between services)	14.3%	14.6%	0.3%

Table 12: A.2. Readmission Rate for Substance Abuse

30-day Readmission Rates for Substance Abuse	FY 2020	FY 2021	Change
Inpatient (Community Hospital Only)	10.6%	10.1%	-0.5%
Inpatient (State Hospital Only)	0.0%	0.0%	0.0%
Inpatient (Community and State Hospital Combined)	10.2%	10.0%	-0.2%
Detox/Facility Based Crisis	9.9%	9.2%	-0.7%
Combined (includes cross-overs between services)	13.1%	12.6%	-0.5%

Table 13: A.3. Follow-Up after Hospitalization for Mental Illness

Follow-up after Hospitalization for Mental Illness	FY 2020	FY 2021	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	38.6%	32.1%	-6.50%
Percent Received Outpatient Visit Within 30 Days	54.6%	48.2%	-6.40%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	46.2%	16.1%	**-30.10%***
Percent Received Outpatient Visit Within 30 Days	69.2%	35.5%	**-33.70%***
PRTF			
Percent Received Outpatient Visit Within 7 Days	22.5%	24.4%	1.90%
Percent Received Outpatient Visit Within 30 Days	47.5%	44.4%	-3.10%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	38.3%	31.5%	-6.80%
Percent Received Outpatient Visit Within 30 Days	54.5%	47.8%	-6.70%

***** *Denominator is < 30 in at least one measurement period for the measure*

Table 14: A.4. Follow-Up After Hospitalization for Substance Abuse

Follow-up after Hospitalization for Substance Abuse	FY 2020	FY 2021	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	11.9%	12.3%	0.40%
Percent Received Outpatient Visit Within 30 Days	23.1%	19.1%	-4.00%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	22.7%	12.7%	**-10.00%**
Percent Received Outpatient Visit Within 7 Days	28.4%	21.2%	-7.20%
Percent Received Outpatient Visit Within 30 Days	38.6%	30.2%	-8.40%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	20.5%	17.1%	-3.40%
Percent Received Outpatient Visit Within 30 Days	31.3%	25.1%	-6.20%

NR = Denominator is equal to zero.

Table 15: B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FY 2020	FY 2021	Change
Ages 13–17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	19.9%	13.5%	-6.40%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	29.1%	49.6%	**20.50%**
Ages 18–20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	14.5%	13.0%	-1.50%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	37.3%	52.2%	**14.90%**
Ages 21–34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	18.3%	18.2%	-0.10%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	50.8%	57.0%	6.20%
Ages 35–64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	14.8%	17.3%	2.50%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	57.4%	60.6%	3.20%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	7.0%	3.8%	-3.20%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	67.4%	78.2%	**10.80%**
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	15.6%	16.4%	0.80%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	53.3%	59.4%	6.10%

Table 16: D.1. Mental Health Utilization-Inpatient Discharges and Average Length of Stay

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
3–12	Male	0.1	0.1	0.1	44.3	44.8	0.5
	Female	0.2	0.1	0.2	27.3	23.4	-3.9
	Total	0.1	0.1	0.1	35.0	30.6	-4.4
13–17	Male	1.0	0.7	1.0	54.8	82.5	27.7
	Female	1.5	1.4	1.5	29.7	29.2	-0.5
	Total	1.3	1.0	1.3	40.0	47.2	7.2
18–20	Male	2.0	1.7	2.0	11.2	9.6	-1.6
	Female	1.2	0.9	1.2	13.5	7.9	-5.6
	Total	1.6	1.3	1.6	12.1	9.0	-3.1
21–34	Male	4.3	3.4	4.3	8.1	8.1	0.0
	Female	1.4	1.0	1.4	6.8	6.6	-0.2
	Total	2.1	1.6	2.1	7.4	7.4	0.0
35–64	Male	2.5	2.2	2.5	8.4	8.1	-0.3
	Female	1.9	1.4	1.9	7.8	8.0	0.2
	Total	2.2	1.7	2.2	8.1	8.1	0.0
65+	Male	0.4	0.4	0.4	16.0	23.5	7.5
	Female	0.3	0.2	0.3	12.5	9.5	-3.0
	Total	0.3	0.3	0.3	14.0	16.3	2.3
Unknown	Male	0.0	0.0	0.0	0.0	0.0	0.0
	Female	0.0	0.0	0.0	0.0	0.0	0.0
	Total	0.0	0.0	0.0	0.0	0.0	0.0
Total	**Male**	**1.2**	**1.0**	**1.2**	**18.2**	**19.5**	**1.3**
	Female	**1.0**	**0.8**	**1.0**	**13.8**	**13.5**	**-0.3**
	Total	**1.1**	**0.9**	**1.1**	**15.8**	**16.4**	**0.6**

Table 17: 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		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
3-12	Male	11.54%	8.89%	-2.65%	0.01%	0.02%	0.01%	0.57%	0.43%	-0.14%	11.40%	8.74%	-2.66%
	Female	7.90%	6.87%	-1.03%	0.03%	0.01%	-0.02%	0.14%	0.13%	-0.01%	7.88%	6.82%	-1.06%
	Total	9.76%	7.90%	-1.86%	0.02%	0.01%	-0.01%	0.36%	0.29%	-0.07%	9.67%	7.80%	-1.87%
13-17	Male	12.52%	11.03%	-1.49%	0.16%	0.18%	0.02%	0.48%	0.35%	-0.13%	12.37%	10.88%	-1.49%
	Female	14.11%	14.07%	-0.04%	0.12%	0.22%	0.10%	0.20%	0.15%	-0.05%	14.06%	14.03%	-0.03%
	Total	13.29%	12.51%	-0.78%	0.14%	0.20%	0.06%	0.34%	0.26%	-0.08%	13.19%	12.41%	-0.78%
18-20	Male	8.30%	6.70%	-1.60%	0.04%	0.02%	-0.02%	0.00%	0.02%	0.02%	8.30%	6.70%	-1.60%
	Female	10.74%	9.85%	-0.89%	0.00%	0.03%	0.03%	0.00%	0.00%	0.00%	10.74%	9.83%	-0.91%
	Total	9.56%	8.30%	-1.26%	0.02%	0.02%	0.00%	0.00%	0.01%	0.01%	9.56%	8.29%	-1.27%
21-34	Male	23.40%	19.07%	-4.33%	0.09%	0.07%	-0.02%	0.00%	0.00%	0.00%	23.40%	19.07%	-4.33%
	Female	17.28%	14.98%	-2.30%	0.01%	0.02%	0.01%	0.00%	0.00%	0.00%	17.28%	14.98%	-2.30%
	Total	18.74%	15.94%	-2.80%	0.03%	0.03%	0.00%	0.00%	0.00%	0.00%	18.74%	15.94%	-2.80%

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
35-64	Male	19.13%	16.91%	-2.22%	0.04%	0.07%	0.03%	0.00%	0.00%	0.00%	19.13%	16.91%	-2.22%
	Female	21.93%	18.97%	-2.96%	0.03%	0.03%	0.00%	0.00%	0.00%	0.00%	21.93%	18.97%	-2.96%
	Total	20.84%	18.18%	-2.66%	0.03%	0.05%	0.02%	0.00%	0.00%	0.00%	20.84%	18.18%	-2.66%
65+	Male	5.38%	3.97%	-1.41%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.38%	3.97%	-1.41%
	Female	4.97%	4.44%	-0.53%	0.00%	0.01%	0.01%	0.00%	0.00%	0.00%	4.97%	4.44%	-0.53%
	Total	5.10%	4.28%	-0.82%	0.00%	0.01%	0.01%	0.00%	0.00%	0.00%	5.10%	4.28%	-0.82%
Unknown	Male	0.00%	6.31%	6.31%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.31%	6.31%
	Female	0.00%	6.31%	6.31%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.31%	6.31%
	Total	0.00%	6.31%	6.31%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.31%	6.31%
Total	**Male**	**13.12%**	**10.88%**	**-2.24%**	**0.05%**	**0.06%**	**0.01%**	**0.33%**	**0.24%**	**-0.09%**	**13.03%**	**10.79%**	**-2.24%**
	Female	**13.07%**	**11.82%**	**-1.25%**	**0.03%**	**0.05%**	**0.02%**	**0.07%**	**0.06%**	**-0.01%**	**13.05%**	**11.80%**	**-1.25%**
	Total	**13.09%**	**11.42%**	**-1.67%**	**0.04%**	**0.05%**	**0.01%**	**0.18%**	**0.14%**	**-0.04%**	**13.04%**	**11.36%**	**-1.68%**

Table 18: 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		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
3–12	Male	0.02%	0.01%	-0.01%	0.00%	0.00%	0.00%	0.01%	0.00%	-0.01%	0.01%	0.01%	0.00%
	Female	0.02%	0.01%	-0.01%	0.00%	0.00%	0.00%	0.01%	0.00%	-0.01%	0.01%	0.00%	-0.01%
	Total	0.02%	0.01%	-0.01%	0.00%	0.00%	0.00%	0.01%	0.00%	-0.01%	0.01%	0.01%	0.00%
13–17	Male	1.15%	0.87%	-0.28%	0.00%	0.01%	0.01%	0.47%	0.27%	-0.20%	0.79%	0.63%	-0.16%
	Female	0.67%	0.63%	-0.04%	0.00%	0.01%	0.01%	0.28%	0.22%	-0.06%	0.42%	0.42%	0.00%
	Total	0.92%	0.76%	-0.16%	0.00%	0.01%	0.01%	0.38%	0.24%	-0.14%	0.61%	0.53%	-0.08%
18–20	Male	2.96%	1.92%	-1.04%	0.04%	0.06%	0.02%	1.26%	0.75%	-0.51%	2.01%	1.34%	-0.67%
	Female	2.90%	2.09%	-0.81%	0.04%	0.06%	0.02%	1.10%	0.76%	-0.34%	2.10%	1.59%	-0.51%
	Total	2.93%	2.00%	-0.93%	0.04%	0.06%	0.02%	1.18%	0.76%	-0.42%	2.06%	1.46%	-0.60%
21–34	Male	7.79%	6.47%	-1.32%	0.47%	0.37%	-0.10%	1.71%	1.25%	-0.46%	7.26%	6.01%	-1.25%
	Female	9.06%	7.31%	-1.75%	0.15%	0.22%	0.07%	2.31%	1.90%	-0.41%	8.25%	6.55%	-1.70%
	Total	8.75%	7.11%	-1.64%	0.22%	0.25%	0.03%	2.17%	1.75%	-0.42%	8.01%	6.42%	-1.59%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
35–64	Male	9.09%	7.88%	-1.21%	0.41%	0.23%	-0.18%	3.38%	2.55%	-0.83%	8.16%	7.27%	-0.89%
	Female	7.45%	6.72%	-0.73%	0.17%	0.09%	-0.08%	2.92%	2.45%	-0.47%	6.50%	5.99%	-0.51%
	Total	8.08%	7.16%	-0.92%	0.26%	0.14%	-0.12%	3.10%	2.49%	-0.61%	7.14%	6.48%	-0.66%
65+	Male	2.45%	2.02%	-0.43%	0.08%	0.10%	0.02%	1.29%	0.93%	-0.36%	2.05%	1.83%	-0.22%
	Female	0.93%	0.78%	-0.15%	0.00%	0.00%	0.00%	0.60%	0.57%	-0.03%	0.63%	0.61%	-0.02%
	Total	1.43%	1.20%	-0.23%	0.03%	0.03%	0.00%	0.83%	0.69%	-0.14%	1.09%	1.02%	-0.07%
Unknown	Male	0.00%	2.43%	2.43%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.43%	2.43%
	Female	0.00%	2.43%	2.43%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.43%	2.43%
	Total	0.00%	2.43%	2.43%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.43%	2.43%
Total	**Male**	**2.75%**	**2.34%**	**-0.41%**	**0.11%**	**0.08%**	**-0.03%**	**0.99%**	**0.72%**	**-0.27%**	**2.37%**	**2.09%**	**-0.28%**
	Female	**3.45%**	**3.09%**	**-0.36%**	**0.06%**	**0.06%**	**0.00%**	**1.18%**	**1.01%**	**-0.17%**	**2.99%**	**2.71%**	**-0.28%**
	Total	**3.14%**	**2.76%**	**-0.38%**	**0.08%**	**0.07%**	**-0.01%**	**1.09%**	**0.89%**	**-0.20%**	**2.72%**	**2.44%**	**-0.28%**

Table 19: 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		
	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
	3-12			13-17			18-20			21-34		
Bladen	0.00%	0.00%	0.00%	0.40%	0.33%	-0.07%	1.52%	1.62%	0.10%	5.87%	7.11%	1.24%
Duplin	0.00%	0.00%	0.00%	0.30%	0.46%	0.16%	1.50%	1.05%	-0.45%	3.43%	3.92%	0.49%
Edgecombe	0.00%	0.00%	0.00%	0.67%	0.67%	0.00%	1.74%	1.79%	0.05%	4.91%	4.29%	-0.62%
Greene	0.00%	0.00%	0.00%	0.47%	0.69%	0.22%	1.17%	0.75%	-0.42%	4.58%	4.72%	0.14%
Lenoir	0.02%	0.00%	-0.02%	0.90%	0.93%	0.03%	2.91%	2.63%	-0.28%	6.61%	7.77%	1.16%
Robeson	0.05%	0.02%	-0.03%	1.90%	1.31%	-0.59%	4.54%	3.19%	-1.35%	12.72%	12.23%	-0.49%
Sampson	0.00%	0.00%	0.00%	0.23%	0.43%	0.20%	1.15%	0.89%	-0.26%	3.46%	4.22%	0.76%
Scotland	0.03%	0.03%	0.00%	0.45%	0.61%	0.16%	3.59%	2.70%	-0.89%	7.26%	6.85%	-0.41%
Wayne	0.03%	0.00%	-0.03%	0.83%	0.50%	-0.33%	1.74%	1.60%	-0.14%	4.73%	4.06%	-0.67%
Wilson	0.00%	0.02%	0.02%	0.69%	0.46%	-0.23%	1.99%	2.08%	0.09%	6.10%	6.40%	0.30%

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		
	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
	35-64			65+			Unknown			Total		
Bladen	4.96%	6.17%	1.21%	0.88%	0.67%	-0.21%	0.00%	0.00%	0.00%	2.20%	2.64%	0.44%
Duplin	3.68%	3.93%	0.25%	0.46%	0.38%	-0.08%	0.00%	0.00%	0.00%	1.21%	1.31%	0.10%
Edgecombe	7.36%	7.05%	-0.31%	1.80%	1.57%	-0.23%	0.00%	0.00%	0.00%	2.79%	2.59%	-0.20%
Greene	5.71%	5.89%	0.18%	0.67%	1.12%	0.45%	0.00%	0.00%	0.00%	1.79%	1.90%	0.11%
Lenoir	10.26%	11.43%	1.17%	2.36%	3.15%	0.79%	0.00%	0.00%	0.00%	3.71%	4.13%	0.42%
Robeson	10.58%	9.40%	-1.18%	2.00%	1.07%	-0.93%	0.00%	0.00%	0.00%	4.88%	4.34%	-0.54%
Sampson	3.10%	3.29%	0.19%	0.33%	0.07%	-0.26%	0.00%	0.00%	0.00%	1.12%	1.26%	0.14%
Scotland	6.39%	5.20%	-1.19%	0.52%	0.31%	-0.21%	0.00%	0.00%	0.00%	2.89%	2.55%	-0.34%
Wayne	7.44%	6.78%	-0.66%	1.52%	1.35%	-0.17%	0.00%	0.00%	0.00%	2.36%	2.10%	-0.26%
Wilson	10.02%	11.39%	1.37%	3.02%	3.36%	0.34%	0.00%	0.00%	0.00%	3.33%	3.63%	0.30%

Table 20: 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		
	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
	3-12			13-17			18-20			21-34		
Bladen	6.42%	7.33%	0.91%	11.62%	12.38%	0.76%	5.46%	8.08%	2.62%	12.54%	12.42%	-0.12%
Duplin	7.90%	6.77%	-1.13%	12.38%	12.72%	0.34%	9.45%	9.56%	0.11%	13.28%	13.51%	0.23%
Edgecombe	5.98%	4.03%	-1.95%	11.31%	9.69%	-1.62%	6.33%	6.55%	0.22%	9.55%	8.24%	-1.31%
Greene	6.29%	5.85%	-0.44%	11.60%	13.63%	2.03%	8.50%	8.52%	0.02%	11.76%	11.87%	0.11%
Lenoir	9.21%	7.47%	-1.74%	15.88%	16.61%	0.73%	11.31%	9.78%	-1.53%	14.52%	14.01%	-0.51%
Robeson	8.79%	7.59%	-1.20%	12.40%	12.61%	0.21%	8.77%	8.77%	0.00%	13.10%	12.90%	-0.20%
Sampson	7.36%	6.83%	-0.53%	10.50%	11.92%	1.42%	6.88%	6.83%	-0.05%	9.05%	9.58%	0.53%
Scotland	9.76%	7.92%	-1.84%	16.73%	13.78%	-2.95%	10.27%	9.58%	-0.69%	12.82%	14.15%	1.33%
Wayne	7.18%	6.35%	-0.83%	15.74%	14.15%	-1.59%	9.66%	10.40%	0.74%	14.54%	15.38%	0.84%
Wilson	10.79%	8.65%	-2.14%	15.47%	16.20%	0.73%	9.20%	10.67%	1.47%	14.21%	14.01%	-0.20%

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		
	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
	35-64			65+			Unknown			Total		
Bladen	14.63%	14.31%	-0.32%	5.07%	4.04%	-1.03%	0.00%	0.00%	0.00%	9.62%	9.98%	0.36%
Duplin	19.51%	19.72%	0.21%	7.80%	7.22%	-0.58%	0.00%	0.00%	0.00%	11.23%	10.89%	-0.34%
Edgecombe	13.09%	11.65%	-1.44%	4.75%	3.99%	-0.76%	0.00%	0.00%	0.00%	8.74%	7.31%	-1.43%
Greene	16.12%	14.79%	-1.33%	6.90%	6.07%	-0.83%	0.00%	0.00%	0.00%	9.83%	9.79%	-0.04%
Lenoir	19.82%	17.86%	-1.96%	6.33%	6.18%	-0.15%	0.00%	0.00%	0.00%	13.00%	11.90%	-1.10%
Robeson	17.21%	15.28%	-1.93%	4.40%	4.34%	-0.06%	0.00%	0.00%	0.00%	11.26%	10.51%	-0.75%
Sampson	11.14%	11.68%	0.54%	2.96%	2.92%	-0.04%	0.00%	0.00%	0.00%	8.26%	8.48%	0.22%
Scotland	15.53%	14.40%	-1.13%	7.64%	7.43%	-0.21%	0.00%	0.00%	0.00%	12.25%	11.22%	-1.03%
Wayne	23.14%	23.01%	-0.13%	7.85%	7.93%	0.08%	0.00%	0.00%	0.00%	12.63%	12.33%	-0.30%
Wilson	22.45%	21.71%	-0.74%	7.20%	6.46%	-0.74%	0.00%	0.00%	0.00%	13.74%	12.98%	-0.76%

(b) Waiver Validation Results

All measures received a validation score of 100% and were found Fully Compliant. The stored procedures have been updated to address NC Medicaid's most recent changes to the measures. Table 21 contains validation scores for each of the 10 (b) Waiver Performance Measures.

Table 21: (b) Waiver Performance Measure Validation Scores

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

(c) Waiver Measures Reported Results

Five (c) Waiver Measures were chosen for validation. The rates reported by Eastpointe and the State benchmarks are displayed in *Table TBD: (c) Waiver Measures Reported Results 2021 - 2022*. Documentation on data sources, data validation, source code, and calculated rate for the five measures was provided. Additionally, all rates exceeded the State Performance Benchmarks.

Table 22: (c) Waiver Measures Reported Results 2021-2022

Performance measure	Data Collection	Latest Reported Rate	State Benchmark
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Annually	811/822 = 98.66%	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Annually	811/822 = 98.66%	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	40/43 = 93.02%	85%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	200/201 = 99.5%	85%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	Quarterly	3/3 = 100%	85%

** Latest reported rates are shown in Table from Excel files for each measure.*

(c) Waiver Validation

All (c) Waiver Measures met the validation requirements and were Fully Compliant as shown in *Table 23, (c) Waiver Performance Measure Validation Scores*. The validation worksheets offer detailed information on validation and calculation steps for (c) Waiver Measures.

Table 23: C Waiver Performance Measures Validation Scores

Measure	Validation Score Received
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	100%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	100%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	100%
Percentage of beneficiaries who received appropriate medication. IW G5	100%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	100%
Average Validation Score & Audit Designation	**100% FULLY COMPLIANT**

Performance Improvement Project (PIP) Validation

The validation of the PIPs was conducted in accordance with the protocol developed by CMS titled, *EQR Protocol 1: Validating Performance Improvement Projects, October 2019*. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

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

PIP Validation Results

For the 2021 review, 8 projects were submitted, and 4 were validated, including: Increase the percent of individuals who receive a 2nd service within or less than (≤) 14 days to 35 %- Initiation and Engagement, Reduce ED Active Admissions-Clinical, Diabetes Monitoring- Clinical, and TCLI Separation from Housing- Non Clinical. For this year's EQR, there were 3 PIPs submitted, and 3 were validated.

For the Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD) and increase SMD to 70% PIP, the rate slightly increased from 65.5% to 66.7%; for the SMD measure the goal is 70% and the rate increased slightly from 37% in 2020 to 37.6% in 2020/2021. Both measures have shown a steady, albeit slight improvement over the past three measurement periods. For the Decrease Emergency Department (ED) Admissions for Active Members to 20% monthly PIP, the most recent measurements showed a rate of 38% in Feb 2022 which declined to 34% in March 2022, thus, the PIP has shown improvement.

The third PIP, Decrease Percentage of Members Who Separate from Transition to Community Living Initiative (TCLI) Housing to 20% or Less Annually, showed FY 2020 and FY2021 rates were at the 20% rate for the two most recent remeasurement periods. There was no increase or decrease (improvement) in the rate. This was the same finding as the 2021 EQR since the same report was submitted for two consecutive review years due to timing of the data.

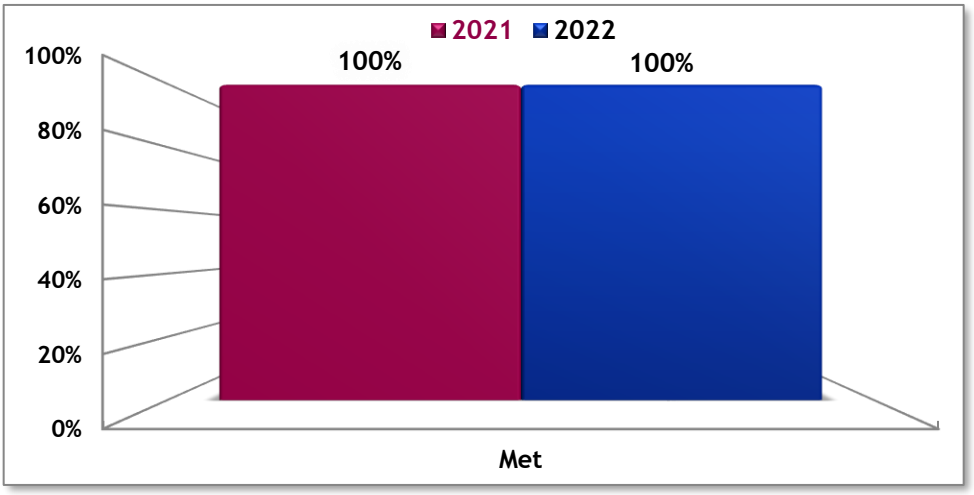
Table 24: PIP Summary of Validation Scores

Project Type	Project	2021 Validation Score	2022 Validation Score
Clinical	**Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD), and increase SMD to 70%**	76/79 = 96% High Confidence in Reported Results	79/79 = 100% High Confidence in Reported Results
	Decrease Emergency Department (ED) Admissions for Active Members to 20% DMH	79/79 = 100% High Confidence in Reported Results	79/79 = 100% High Confidence in Reported Results
Non Clinical	**Decrease Percentage of Members who Separate from Transition to Community Living Initiative (TCLI) Housing to 20% or Less Annually.**	74/74 = 100% High Confidence in Reported Results	74/74 = 100% High Confidence in Reported Results

There are no Corrective Actions for the validated PIPs in this EQR. There are no Recommendations as rates have been maintained or improved for all three validated PIPs. Details of the validation activities for the PMs and PIPs and specific outcomes related to each activity may be found in *Attachment 3, CCME EQR Validation Worksheets*.

As demonstrated in Figure 4, Eastpointe met all the Quality Improvement standards in the 2022 EQR.

Figure 4: Quality Improvement Comparative Findings



Strengths

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

Weaknesses

- Several performance measure rates showed a substantial decline including 30-day Readmission rates for PRTF, Follow-up rates After Hospitalization for Mental Illness for FBC, and Follow-up After Hospitalization of SA in the Detox and FBC populations.

Recommendations

- Monitor interim performance measure rates that declined substantially in the year over year trending.

D. Utilization Management

42 CFR § 438.208

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

In the 2021 EQR, Eastpointe met 96% of the UM standards and received one Corrective Action regarding the MH/SU and I/DD files reviewed. Table 25 outlines the 2021 findings and CCME's follow up in the 2022 EQR regarding Eastpointe's implementation of that Corrective Action.

Table 25: 2021 EQR Utilization Management Findings

2021 EQR Utilization Management Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The PIHP applies the Care Coordination policies and procedures as formulated.	***Corrective Action: Enhance the current monitoring plan to include a quality review checklist of MH/SU/I/DD Care Coordination documentation. The quality review should:*** • ***Ensure I/DD monthly Care Coordination service reviews are face-to-face or by allowed methods listed in NC Contract Amendment 11, Section 7.*** • ***Ensure needs identified in assessments and other support tools are reflected in the ISP and the implementation of services has been arranged by Care Coordination.*** • ***Ensure when incidents (as defined by 10A NCAC 27G .0103(b)(32) occur, the required notifications as listed in NC Incident Response Improvement System have been made.*** ***Develop and implement staff trainings and guidelines regarding Care Coordination service monitoring, service implementation, and enrollee follow-up aligns with Eastpointe policies and requirements outlined in NC Medicaid Contract and Contract Amendments, 42 CFR § 438.208 and 47 CFR § 64.1200, NC Clinical Coverage Policy 8D-1 Psychiatric Residential Treatment Facilities for Children under the Age of 21 and 8P NC Innovations, the NC Innovations Waiver Technical Guide and NC Incident Response Improvement System Manual.***	**N**

2022 EQR Follow up: Review of the Audit tools used by Eastpointe in the past year to identify and correct compliance issues around face-to-face monitoring of Innovations services showed staff were not capturing accurate information around monitoring. Rather than documenting the method of service monitoring, staff were capturing frequency of monitoring. Additionally, while Eastpointe was able to demonstrate Child MH/SU Care Coordination staff were trained on protocols for handling incident reports, no other Care Coordination staff were trained such as Adult MH/SU staff, TCLI, or IDD Care Coordination staff. Eastpointe was able to provide evidence Innovation enrollees' ISPs were being audited to ensure needs identified in assessments and support tools. Eastpointe also provided Policy Q-6.1.18, Quality of Care Concerns, which describes Eastpointe's processes around responding to incident reports.

In the 2021 EQR, Eastpointe received a Corrective Action to address issues identified in the 2021 MH/SU and I/DD enrollee file review. In the 2022 EQR, CCME reviewed Eastpointe's enrollee file Audit Tools and various reports showing file compliance scores. Review of the Audit tools used by Eastpointe in the past year to identify and correct compliance issues around face-to-face monitoring of Innovations services showed staff were not capturing accurate information around monitoring. For example, rather than capturing the method of service monitoring (i.e., face to face, Webex, telephone contact), staff were capturing frequency of monitoring.

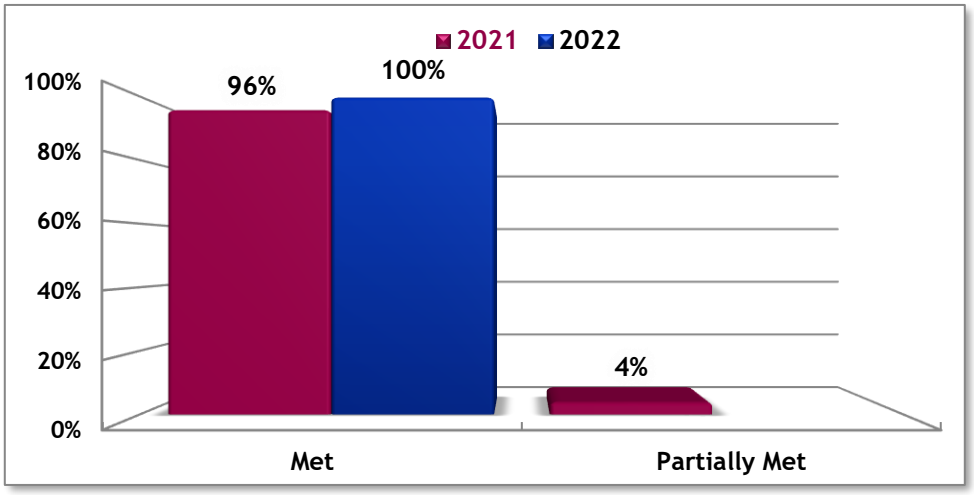
Additionally, part of the Corrective Action was to train staff on the appropriate follow up when an incident is filed in the IRIS system. While Eastpointe was able to demonstrate Child MH/SU Care Coordination staff were trained on protocols for handling incident reports, no other Care Coordination staff were trained such as Adult MH/SU staff, TCLI, or IDD Care Coordination staff. Eastpointe was able to provide evidence Innovation enrollees' ISPs were being reviewed to ensure needs identified in assessments and support tools.

Eastpointe was able to provide evidence Innovation enrollees' ISPs were being audited to ensure needs identified in assessments and support tools. Eastpointe also provided Policy Q-6.1.18, Quality of Care Concerns, which describes Eastpointe's processes around responding to incident reports.

Review of the MH/SU and I/DD enrollee files in the 2022 EQR showed no issues with compliance with Eastpointe Care Coordination policies, Clinical Coverage Policies, or the *NC Incident Response Improvement System Manual*. TCLI enrollee files were also compliant; Quality of Life Surveys were implemented on time, Transition Year Stability Revenue Funds were appropriately accessed, and frequency of Care Coordination engagement appropriate.

Figure 5 shows TBD% of the Utilization Management standards were scored as "Met" in the 2021 EQR and compares these to the 2021 EQR UM score.

Figure 5: Utilization Management Comparative Findings



Strengths

- Eastpointe's auditing of enrollee files has resulted in high compliance scores.
- TCLI staff reported Eastpointe has a 100% diversion rate for individuals transitioning from Adult Care Homes.

Weaknesses

- Policy C-3.3.6, Individual and Family Directed Services, does not include Supported Living as a self-directed service.
- Policy C-3.3.9, Employee of Record, does not state Employee of Record participants must submit the Out of State Travel Request form, as indicated in *Appendix J* of the *North Carolina Innovations Technical Guide*.
- Review of the Audit tools used by Eastpointe in the past year to identify and correct compliance issues around face-to-face monitoring of Innovations services showed staff were not capturing accurate information around monitoring.
- Eastpointe was able to demonstrate Child MH/SU Care Coordination staff were trained on protocols for handling incident reports, but no other Care Coordination staff were trained such as Adult MH/SU staff, TCLI, or IDD Care Coordination staff.

Recommendations

- Revise Policy C-3.3.6 to include Supported Living as a self-directed service.
- Revise Policy C-3.3.9, Employee of Record, to include Employee of Record participants must submit the out of State Travel Request when seeking reimbursement for out of state travel.
- Work with staff completing enrollee file audits to clarify what data should be captured in the various elements within the Audit Tools.
- Provide training to Adult MH/SU staff, TCLI, and IDD Care Coordination staff regarding the processes, follow up, and notifications that are required to occur around incident reports.

E. Grievances and Appeals

42 CFR § 438, Subpart F

The Grievances and Appeals EQR included a Desk Review of policies, 10 Grievance and 10 Appeal files, the Grievance and Appeal Logs, the *Provider Operations Manual* (Effective 7/1/2021), *the Enrollee/Member and Family Handbook* (Revised 9/21/22), and information about Grievances and Appeals available on the Eastpointe website. There was an Onsite discussion with Grievance and Appeal staff to further clarify the PIHP's documentation and processes.

In the 2021 EQR, Eastpointe met 100% of the Grievance and Appeal standards, resulting in no Corrective Actions. CCME issued two Recommendations to address concerns noted primarily in the Grievance monitoring and staff training processes used for ensuring internal processes verify compliance to the *NC Medicaid Contract*, Eastpointe policies, and federal regulations. In the 2022 EQR, Eastpointe met 100% of the Grievance and Appeal standards, resulting in no Corrective Actions and two Recommendations.

Grievances

In the 2021 EQR, Eastpointe received two Recommendations targeting monitoring and training to ensure timely notifications and accurate data on the Eastpointe Log. Eastpointe implemented one Recommendation. For the second Recommendation, the 2022 EQR file review had similar findings compared to the 2021 file review. Therefore, CCME issued that same Recommendation again this year.

Table 26: 2021 EQR Grievance Findings

2021 EQR Grievance Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The PIHP applies the grievance policy and procedure as formulated.	***Recommendation: Continue to routinely monitor Grievance notification timeframes to ensure all notifications are issued in a timely manner per NC Medicaid Contract, Attachment M, Section C, 42 CFR § 438, and Policy Q-6.4.4, Member/Enrollee and Stake Holder Grievance/ Complaint and Appeals.***	**N**
2022 EQR Follow up: Two files showed the resolution notice was sent outside of Eastpointe's policy of 30 days, and one file showed the acknowledgment notice was sent in six business days versus the five business days required by Eastpointe's policy. This is a very similar finding compared to the 2021 Grievance file review. Therefore, CCME issued the same Recommendation that was issued for the 2021 EQR.		
Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	***Recommendation: Train staff on Grievance Log data entry to ensure data on the log is consistent, complete, and accurate.***	**Y**
2022 EQR Follow up: In the 2022 EQR this Recommendation was implemented. The Grievance Log entries for the files reviewed were much improved. The only error was in one resolution date where the year was recorded incorrectly as 2021 instead of 2022. This was most likely a transcription error.		

In the 2022 EQR, 10 Grievance files were reviewed. Seven of the 10 files met all timeliness requirements. While *NC Medicaid Contract, Attachment M, Section C* and *42 CFR § 438.408 (b)1* require Grievances to be resolved within 90 days, Eastpointe's Grievance policy requires Grievances to be resolved with notification provided within 30 days. Two files showed the resolution notice was sent outside of 30 days, and one file showed the acknowledgment notice was sent in six business days versus the five business days required by Eastpointe's Grievance policy. This is a very similar finding compared to the 2021 Grievance file review. Therefore, CCME issues the same Recommendation that was issued for the 2021 EQR to continue to routinely monitor Grievance notification timeframes to ensure all notifications are issued in a timely manner per Policy Q-6.4.4, Member/Enrollee and Stake Holder Grievance/Complaint and Appeals.

The Grievance Log entries for the files reviewed for the 2022 EQR were much improved. The only noted error was in one resolution date in which the year was recorded incorrectly as 2021 instead of 2022. This was most likely a transcription error.

Appeals

In the 2021 Appeals EQR, Eastpointe met 100% of the Appeal standards, resulting in no Corrective Actions and no Recommendations.

Table 27 verifies there are no follow-up items from the 2021 EQR.

Table 27: 2021 EQR Appeal Findings

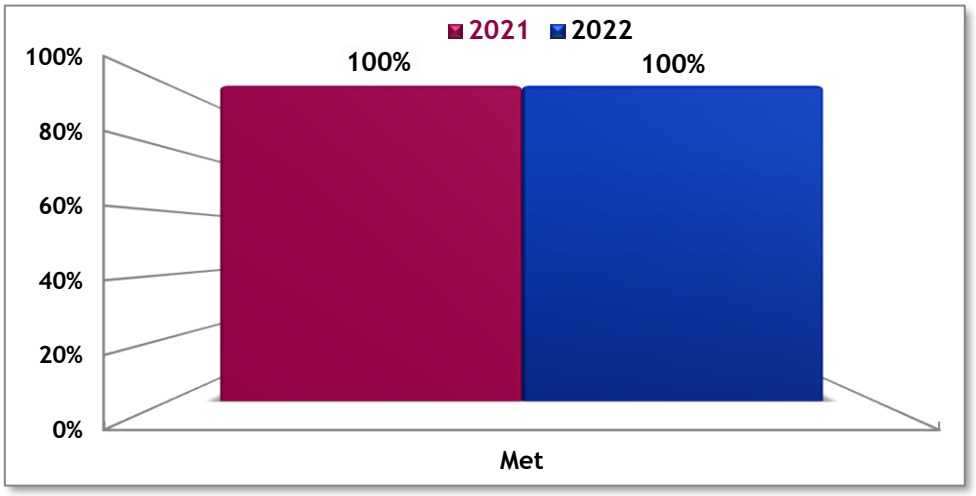
2021 EQR Appeals Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
2022 EQR Follow up: No Recommendations or Corrective Actions were issued in the 2021 EQR of Appeals.		

In the 2022 EQR, 10 Grievance files were reviewed. Three of the 10 files were not compliant with Eastpointe's Grievance policy. *NC Medicaid Contract, Attachment M, Section C* and *42 CFR § 438.408 (b)1* require Grievances to be resolved within 90 days, however, Eastpointe's Grievance policy requires Grievances to be resolved with notification provided within 30 days. Eastpointe's policy also requires Grievances to be acknowledged within 5 business days. Two files showed the resolution notice was sent outside of 30 days, and one file showed the acknowledgment notice was sent in six business days. These files were discussed during the Onsite and staff acknowledged the timeliness issues were the result of human error.

During the Onsite discussion regarding the file in which the Grievance resolution notice was sent in 31 days, Eastpointe staff reported the Grievance came in on a weekday after 6:00 p.m. but the staff documented the date of receipt as the following day. CCME highlighted this practice is not supported by Eastpointe's policies and the date of receipt should not be impacted by factors such as weekends, holidays, and time of day. As the timeliness errors in the 2022 file review are very similar to the 2021 file review finding, CCME is again recommending Eastpointe closely monitor Grievance files and the Grievance Log to identify timeliness issues and any practices used by staff that are out of compliance with Eastpointe's policy.

Figure 6, Grievances and Appeals Comparative Findings, shows 100% of the standards in the 2022 Grievances and Appeals EQR were scored as "Met". This figure also provides an overview of 2022 scores compared to 2021 scores.

Figure 6: Grievances and Appeals Comparative Findings



Strengths

- Eastpointe explained a renewed focus on Grievance and Appeal documentation within the files, including regular staff meetings to encourage clear, timely, and accurate documentation.
- Many experienced Appeals staff have been promoted to the managerial team.

Weaknesses

- Two Grievance files showed the resolution notice was sent outside of the 30-day Eastpointe policy requirement, and one file showed the acknowledgment notice was sent in six business days versus the five business days required by the policy.
- One Appeal file did not contain a written notice of resolution sent to the member, as required by the *NC Medicaid Contract, Attachment M (7)*.

Recommendations

- Continue to routinely monitor Grievance notification timeframes to ensure all notifications are issued in a timely manner per Eastpointe Policy Q-6.4.4, Member/Enrollee and Stake Holder Grievance/ Complaint and Appeals.
- Ensure a notice of resolution is sent for each resolved Appeal as required by the *NC Medicaid Contract, Attachment M (7)*.

F. Program Integrity

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

The 2022 Program Integrity EQR for Eastpointe encompassed a thorough Desk Review of PIHP's Program Integrity (PI) functions. Eastpointe's policies related to Special Investigative Unit (SIU) investigations, Provider Overpayments, and related aspects of compliance were evaluated. The EQR also included review of PI staffing, workflows, reports, training materials, committee minutes, and data mining processes, and 10 investigation case files active during the period under review. An Onsite discussion was held with Eastpointe Compliance, Program Integrity, Claims, Waiver Programs, Special Investigations staff, and Eastpointe's Chief Compliance Officer (CCO) to address questions related to Eastpointe's PI functions.

In the 2021 EQR, Eastpointe met 100% of the PI standards and no Recommendations or Corrective Actions were issued.

Table 28: 2021 EQR Program Integrity Findings

2021 EQR Program Integrity Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
2022 EQR Follow up: No Recommendations or Corrective Actions were issued in the 2021 PI EQR.		

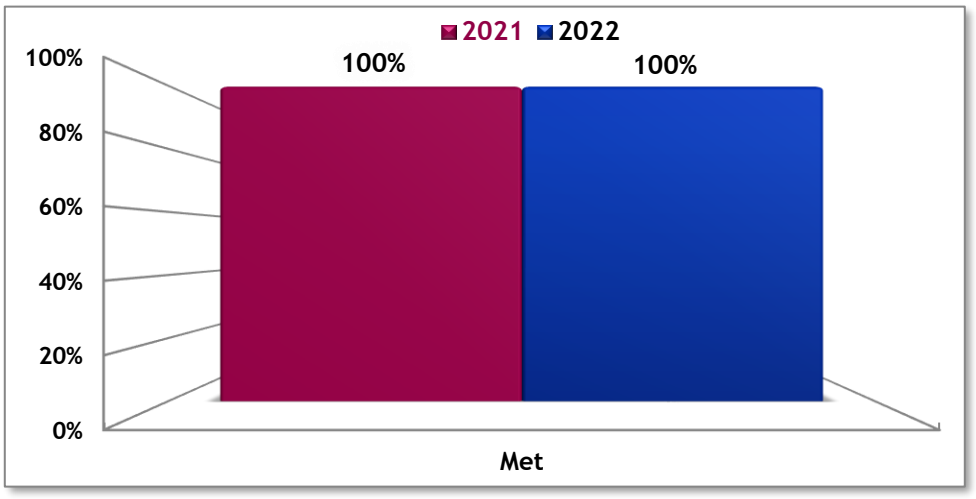
In the 2022 EQR, Eastpointe met 100% of PI standards. The *Compliance Plan 2022-2023*, described Eastpointe's compliance program and outlined methods used to prevent, detect, and report potential fraud, waste, and abuse (FWA). Eastpointe's policies clearly outline PI processes, requirements, and overall operations.

The review of Eastpointe's PI Case Log reflected most PI referrals are generated from internal sources, (e.g., Utilization Management, Quality Management and Care Coordination), while only 2.5% are generated from external sources or methods such as Members, Stakeholders and Eligibility of Benefits (EOBs). During the Onsite, Eastpointe staff clarified most external referrals come through the Quality Management Department, so they are documented as internal referral rather than the original external source. CCME is recommending Eastpointe ensure the PI Case Log accurately reflects the original source (e.g., EOB, members, stakeholder, and other external sources) of a concern or complaint to better reflect trends in complaints and stakeholders' efforts towards preventing fraud, waste, and abuse.

In the 2022 EQR Desk Review, 10 PI investigation cases were reviewed for timeliness of investigations and to ensure all required elements are documented in referrals to NC Medicaid. Review of the files showed all requirements were met and in accordance with Eastpointe's *NC Medicaid Contract* and policies.

Figure 7 shows 100% of PI standards were scored as "Met" and provides an overview of 2022 scores compared to the 2021 scores.

Figure 7: Program Integrity Comparative Findings



Strengths

- Of the number of cases initiated in the past two years, Eastpointe has reduced the number of open cases to less than 30%.
- Eastpointe has resumed onsite investigations with providers after postponement during the Covid-19 pandemic.

Weakness

- The PI Case Log does not accurately reflect whether the source of a concern or complaint originated internally or from an external stakeholder.

Recommendation

- Ensure the PI Case Log accurately reflects the original source (e.g., EOB, members, stakeholder, and other external sources) of a concern or complaint to better reflect trends in complaints and stakeholders' efforts towards preventing fraud, waste, and abuse.

G. Encounter Data Validation

The scope of the Encounter Data Validation review was guided by the CMS Encounter Data Validation Protocol and was focused on measuring the data quality and completeness of claims paid by Eastpointe for the period of January 2021 through December 2021. All claims paid by Eastpointe should be submitted and accepted as a valid encounter to NC Medicaid. CCME's 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: Other Diagnosis

Principal and Admitting Diagnosis codes were populated consistently where appropriate. However, Other Diagnosis codes were often missing, especially on Professional claims. In general, claims from certain providers are missing the Other Diagnosis codes including instances where they are missing on 100% of the claims while claims from other providers frequently show Other Diagnosis codes. This suggests some providers are simply not coding Other Diagnosis codes or failing to map them onto the claims.

Resolution:

Eastpointe should continue to educate its providers on the importance of ensuring the information provided on claims is complete and accurate, including the Diagnosis codes. This effort should include urging providers to review their billing software to make sure all available Diagnosis codes are being mapped to the 837s. For providers who submit claims via the web portal, Eastpointe should advise them to review all the information to make sure the claim is complete and accurate, rather than simply copying a previously billed claim and changing only the date of service, Procedure code, and billed charges. Eastpointe should also continue to review the 837 encounter mapping to ensure providers are reporting all applicable Diagnosis Codes and that the PIHP is reporting them to NC Medicaid.

Conclusion

Based on the analysis of Eastpointe's encounter data, Aqurate concludes the data submitted to NC Medicaid are complete and accurate as defined by NC Medicaid standards.

The most notable issue is related to the infrequent reporting of Other Diagnosis codes. Although Other Diagnosis codes may not affect adjudication in certain instances, these codes are important for reporting, evaluating member health, and assessing a value-based payments. Eastpointe should conduct a review at the provider level to determine which of its providers are often not reporting Other Diagnosis codes and perform educational outreach to alert providers to the issue. Eastpointe should also continue to review and take necessary actions to ensure they are capturing and reporting valid Procedure codes for Institutional claims when required based on the reported Revenue code (e.g., pharmacy, lab, radiology) so that all services billed on those claims can be identified.

For the next review period, Aqurate recommends the encounter data from NCTracks be reviewed to assess 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. Additionally, the PIHP does not send their 837 files converted to a pipe- or comma-delimited file using an EDI translator. This makes reconciliation difficult as well. Reviewing an extract from NCTracks may provide insight into NCTracks' handling of the submitted encounters and could be reconciled back to reports received from Eastpointe. The goal is to ensure Eastpointe is reporting all paid claims as encounters to NC Medicaid.

ATTACHMENTS

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

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

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

August 29, 2022

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

Dear Ms. Stroud,

At the request of the North Carolina Medicaid (NC Medicaid) this letter serves as notification that the 2022 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 one-day, virtual Onsite that will address contractually required services.

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

The CMS EQR protocols can be found at:

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

Due to COVID-19 and the issuance of the contractual flexibilities issued by the State outlined in Contract Amendment #11, the 2022 EQR will be a focused review. The focus of this review will be on Eastpointe's Corrective Actions from the previous EQR and Eastpointe's functions that impact enrollee health and safety. Similarly, for the 2022 EQR, the two-day Onsite previously performed at Eastpointe's offices will be conducted during a one-day, virtual Onsite. The CCME EQR review team plans to conduct the virtual Onsite on **October 27, 2022**. For your convenience, a tentative agenda for this one-day, virtual review is enclosed.

In preparation for the Desk Review, the items on the enclosed **Desk Materials List** are to be submitted electronically. **Please note that, to facilitate a timely review, there are three items on the Desk Materials List (items 9, 10, and 19.a) that should be submitted by no later than September 2, 2022,** and the remaining items are due by no later than **October 4, 2022**. Also, as indicated in item 20 of the Desk Materials List, a completed Information Systems Capabilities Assessment (ISCA) for Behavioral Health Managed Care Organizations is required. The enclosed ISCA document is to be completed electronically and submitted with the other Desk Materials on **October 4, 2022**.

All 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

Also, please note that for this year's upload of Encounter Data (item 21), the data should be uploaded into the folder labelled "EDV" within CCME's secure documentation portal along with all other EQR materials.

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

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

Enclosure(s) – 6

Cc: Anna North, Eastpointe Analytics Director/Waiver Contract Manager
Tasha Griffin, NC Medicaid Waiver Contract Manager
Deb Goda, NC Medicaid Associate Director, Behavioral Health and IDD
Christean Hunter, NC Medicaid Quality Management Specialist

Eastpointe

Focused External Quality Review 2022

MATERIALS REQUESTED FOR DESK REVIEW

****Please note that the lists requested in items 9, 10, and 19.a must be uploaded by no later than September 2, 2022. The remainder of the items must be uploaded by no later than October 4, 2022.**

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

2. Organizational Chart of all staff members including names of individuals in each position including their degrees, licensure, and any certifications required for their position. Include any current vacancies. In addition, please include any positions currently filled by outside consultants/vendors.

3. Description of major changes in operations such as expansions, new technology systems implemented, etc. Include any major changes to PIHP functions related to COVID-19.

4. A summary of the status of all Corrective Action items from the previous External Quality Review. Please include evidence of Corrective Action implementation.

5. List of providers credentialed/recredentialed in the last 12 months (August 2021 through July 2022). Include the date of approval of initial credentialing and the date of approval of recredentialing.

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

7. Minutes of committee meetings for the following committees:
   a) Credentialing (for the three most recent committee meetings)
   b) UM (for the three most recent committee meetings)

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

9. **By September 2, 2022, a copy of the complete Appeal log for the months of August 2021 through July 2022. Please indicate on the log: the appeal type (standard, expedited, extended, withdrawn, or invalid), the service appealed, the date the appeal was received, and the date of the appeal resolution notification.

10. **By September 2, 2022, a copy of the complete Grievances log for the months of August 2021 through July 2022. Please indicate on the log: the nature of the grievance, the date received, and the date of the grievance resolution notification.

11. Copies of all appeal notification templates used for expedited, invalid, extended, and withdrawn appeals.

12. For appeals and grievances, please submit a description of your monitoring process that reviews compliance of oral and written notifications, completeness of documentation within the appeal and grievance records, accuracy of appeal and grievance logs, etc. Provide details regarding frequency of monitoring and any benchmarks, performance metrics, and reporting of monitoring outcomes.

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

14. For MH/SU, I/DD, and TCLI Care Coordination, please submit a description of your monitoring plan that reviews compliance of Care Coordinator documentation. Include in the description the elements reviewed (timeliness of progress notes, timeliness of Innovations monitoring, timeliness of Quality of Life surveys, review of quality, completeness of discharge notes, accuracy of documentation, etc.). Provide details regarding frequency of monitoring, and any benchmarks, performance metrics, and reporting of monitoring outcomes.

15. For Care Coordination enrollee files, please provide:
    a. three MH/SU Care Coordination enrollee files (two active since 2020 and one recently discharged)
    b. three I/DD Care Coordination enrollee files (two active since 2020 and one recently discharged)
    c. four TCLI Care Coordination enrollee files (one active since 2020, one who received In-Reach, one who transitioned to the community and recently discharged).

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

16. Information regarding the following selected Performance Measures:

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

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

Required information includes the following for each measure:

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

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

c. Reporting frequency and format;

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

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

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

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

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

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

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

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

18. Provide copies of the following files:

    a. Credentialing files for the four most recently credentialed practitioners (as listed below)

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

    In addition, please include one file for a network provider agency.

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

    b. Insurance:

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

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

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

            ii. Ownership disclosure information/form.

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

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

        In addition, please provide one file for a network provider agency.

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

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

            ii. Insurance:

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

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

   i. All PSVs conducted during the current process, including current supervision contracts for all LPAs and all provisionally-licensed practitioners (*i.e.*, LCAS-A, LCSW-A).
   ii. Site visit/assessment reports if the provider has had a quality issue or a change of address.
   iii. Ownership disclosure information/form.

19. Provide the following for Program Integrity:

   a. ****File Review:** Please produce a listing of all active files during the review period (August 2021 through July 2022) by September 2, 2022. The list should include the following information:

      i. Date case opened
      ii. Source of referral
      iii. Category of case (enrollee, provider, subcontractor)
      iv. Current status of the case (opened, closed)

   b. Program Integrity Plan and/or Compliance Plan.
   c. Workflow of process of taking complaint from inception through closure.
   d. All 'Attachment Y' reports collected during the review period.
   e. All 'Attachment Z' reports collected during the review period.
   f. Provider Manual and Provider Application.
   g. Enrollee Handbook.
   h. 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.
   i. 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.
   j. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors, and employees.
   k. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to NC Medicaid or any other State or Federal agency.
   l. Code of Ethics and Business Conduct.
   m. Internal and/or external monitoring and auditing materials.
   n. Materials pertaining to how the PIHP captures and tracks complaints.
   o. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
      i. NC Medicaid approved reporting templates.
   p. Sample Data Mining Reports.

q. Monthly reports of NCID holders/FAMS-users in PIHP.

r. Any program or initiatives the plan is undertaking related to Program Integrity including documentation of implementation and outcomes, if appropriate.

s. Corrective action plans including any relevant follow-up documentation.

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

a. A completed ISCA.

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

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

c. A copy of the IT Disaster Recovery Plan.

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

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

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

    a. Include all adjudicated claims (paid and denied) from January 1, 2021 – December 31, 2021. Follow the format used to submit encounter data to NC Medicaid (i.e., 837I and 837P). If you archive your outbound files to NC Medicaid, you can forward those to CCME 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 CCME.

    b. Provide a report of all paid claims by service type from January 1, 2021 – December 31, 2021. Report should be broken out by month and include service type, month and year of payment, count, and sum of paid amount.

B. Attachment 2: Materials Requested for Onsite Review

MATERIALS REQUESTED FOR ONSITE REVIEW

1. New Provider Orientation: Item 13 on the "Materials Requested for Desk Review" sent to Eastpointe on August 29, 2022 is "Please submit a summary of new provider orientation processes and include a list of materials and training provided to new providers." Eastpointe submitted two training PowerPoint presentations and two "Welcome" letter templates. Please upload into folder 13.

   Please submit the requested "summary of new provider orientation processes" into folder 13.

2. Recredentialing: Please upload into folder 18.b.

   As requested on the Missing Desk Materials list, please upload the items listed below into folder 18b. Please note that we have reviewed the "Medversant Profile" and "Medversant Verified Profile" document in the files. What is needed is the PSV documentation of the listed items.

3. The "Eastpointe Provider Sanctions Grid 5-17-17" and "Eastpointe Provider Sanctions Grid Reviewed 4-8-2021" are posted on the "Manuals and Information" section of the "Provider" section of the Eastpointe website. Please confirm in writing whether both of these are currently in effect. Please upload into folder 18.

4. For Care Coordination, please submit a completed MH/SU Audit tool into folder 14. We have audit descriptions, summaries, and reports but no tool showing individual MH/SU file review findings. Please upload into folder 14.

5. For Care Coordination, please submit any documentation describing the expected frequency of contact with enrollees in Care Coordination based on the enrollee's ION level. Please upload into folder 15.

C. Attachment 3: EQR Validation Worksheets

CCME Performance Measure Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Readmission Rates for Mental Health**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

Plan's Measure Score	**50**
Measure Weight Score	**50**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Readmission Rates for Substance Abuse**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

Plan's Measure Score	**50**
Measure Weight Score	**50**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Follow-up after Hospitalization for Mental Illness**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

Plan's Measure Score	**50**
Measure Weight Score	**50**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Follow-up after Hospitalization for Substance Abuse**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

Plan's Measure Score	**50**
Measure Weight Score	**50**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

Plan's Measure Score	**50**
Measure Weight Score	**50**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Mental Health Utilization –Inpatient Discharge and Average Length of Stay**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.
NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

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

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

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

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

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

Plan's Measure Score	**50**
Measure Weight Score	**50**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Mental Health Utilization**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

Plan's Measure Score	**50**
Measure Weight Score	**50**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Identification of Alcohol and Other Drug Services**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

Plan's Measure Score	**50**
Measure Weight Score	**50**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Substance Abuse Penetration Rate**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

Plan's Measure Score	**50**
Measure Weight Score	**50**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Mental Health Penetration Rate**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

Plan's Measure Score	**50**
Measure Weight Score	**50**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid PIHP Reporting Schedule- Innovations Measures

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

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

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

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

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

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

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

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

Plan's Measure Score	**50**
Measure Weight Score	**50**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Proportion of beneficiaries reporting they have a choice between providers**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid PIHP Reporting Schedule- Innovations Measures

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

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

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

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

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

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

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

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

Plan's Measure Score	**50**
Measure Weight Score	**50**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Percentage of level 2 and 3 incidents reported within required timeframes**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid PIHP Reporting Schedule- Innovations Measures

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

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

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

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

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

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

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

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

Plan's Measure Score	**50**
Measure Weight Score	**50**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Percentage of beneficiaries who received appropriate medication**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid PIHP Reporting Schedule- Innovations Measures

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

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

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

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

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

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

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

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

Plan's Measure Score	**50**
Measure Weight Score	**50**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid PIHP Reporting Schedule- Innovations Measures

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

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

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

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

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

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

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

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

Plan's Measure Score	**50**
Measure Weight Score	**50**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PIP:	**INCREASE DIABETES SCREENING FOR PEOPLE (18-64) WITH SCHIZOPHRENIA OR BIPOLAR DISORDER WHO ARE USING ANTIPSYCHOTIC MEDICATIONS TO 80% (SSD) AND INCREASE SMD TO 70%**
Reporting Year:	**2021**
Review Performed:	**2022**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported for SSD and SMD measures.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators?	**MET**	Measures are defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators are related to processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data are collected using medical records and paid claims/pharmacy data.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data source is documented

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected using paid claims.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed and reported monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	QIP workgroup collects and monitors data.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Monthly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts for annual HEDIS rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several years.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The SSD rate slightly increased from 65.5% to 66.7%; for the SMD measure the goal is 70% and the rate increased slightly from 37% in 2020 to 37.6% in 2020/2021. Both measures have shown a steady, albeit slight improvement over the past three measurement periods.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	The Provider Enrichment Forum, Provider Meeting on the importance of including Diabetes screening/monitoring as a goal on the member's Person-Centered Plan (PCP), and letters to providers appear to be improving rates.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge- target rate not yet met.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PIP:	**Decrease Emergency Department (ED) admissions for Active Members to 20%**
Reporting Year:	**2021**
Review Performed:	**2022**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported for ED admissions for active members.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator is related to processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data are collected using medical records.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data source is documented

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected using paid claims.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed and reported monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	QIP workgroup collects and monitors data.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Monthly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using graphical/chart format and Tabled data.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation for each month.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The most recent measurements showed a rate of 38% in Feb 2022 which declined to 34% in March 2022, thus, the PIP has shown improvement.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Daily calls, transition team, and technical assistance appear to be positively impact ED admits.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge- target rate not yet met.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PIP:	**DECREASE PERCENTAGE OF MEMBERS WHO SEPARATE FROM TCLI HOUSING TO 20% OR LESS ANNUALLY**
Reporting Year:	**2021**
Review Performed:	**2022**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators are related to functional status.

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 are collected using internal TCLI moves report.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data source is 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**	Data is collected using report in TCLI.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed and reported monthly and annually.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	QIP workgroup collects and monitors data.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Annual rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and for rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation for FY 2018 to FY 2021
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Rate has remained unchanged from FY2020 to FY2021 at 20%. This is at the goal rate.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement in rate. It was unchanged.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge. Another measurement required to show sustainment.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	74
Project Possible Score	74
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

D. Attachment 4: Tabular Spreadsheet

CCME PIHP Data Collection Tool

Plan Name:	**Eastpointe**
Collection Date:	2022

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. A Management Information Systems						
1. Enrollment Systems						
1.1 The PIHP capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Eastpointe has standard processes in place for enrollment data updates. Alphaind uploads the daily and monthly GEF files to the Alpha+ enrollment system. Eastpointe uses the monthly 834 file to reconcile the payment received every month to determine the categories of aid for which payments were received. Demographic data is captured in the Alpha+ system, with enrollment information captured and maintained for all members.
1.2 The PIHP is able to identify and review any errors found during, or as a result, of the State enrollment file load process.	X					Eastpointe stated that they capture and store GEF records that cannot be loaded to Alpha+ into an error table.
1.3 The PIHP's enrollment system member screens store and track enrollment and demographic information.						During the Onsite, Eastpointe demonstrated the Alpha+ enrollment screens and the capability to store demographic information. All historical data for members is stored and merged under one member ID.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Claims System						
2.1 The PIHP processes provider claims in an accurate and timely fashion.	X					The majority of claims received are electronic on a HIPAA file or through the provider web portal. Very few claims from out-of-network providers are received via paper (less than 1%). Approximately, 98.38% of Professional claims and 81.16% of Institutional claims are auto adjudicated, nightly. Claims in excess of $5,000 and Emergency Department claims are pended for manual review. Pended claims are reviewed daily.
2.2 The PIHP has processes and procedures in place to monitor, review and audit claims staff.	X					Eastpointe's Quality Improvement Department is responsible for external monthly claim audits which encompass 3% of all claims. High dollar claims, those that are more than $5,000, as well as Emergency Department claims are pended for manual review and are audited on a weekly basis. Newly hired claim examiners who perform manual review of claims are audited daily for the first three months. Claims examiners who have an error rate greater than 3% are retrained and subjected to a 100% claims audit for 10 days, monitoring for decreased error rates or further corrective action. This was confirmed during the 2022 Onsite.
2.3 The PIHP has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 Diagnosis codes received on an 837 Institutional and 837 Professional file. The PIHP has the capability of receiving and storing ICD-10 Procedure codes on an 837 Institutional file.	X					During the Onsite, Eastpointe demonstrated the Alpha+ claims system and capabilities to receive and store all ICD-10 Diagnosis codes. Eastpointe indicated that ICD-10 Procedure codes, revenue codes, and DRG codes are captured in the Alpha+ system electronically and via the provider web portal. The DRG and ICD-10 Procedure codes are also included for encounter data submission reporting. Up to 24 ICD-10 Diagnosis codes are captured for Institutional claims received via the web portal, electronically, and displayed on the claim screens. For Professional encounters, up to 12 ICD-10 Diagnosis codes are captured electronically, via the web portal and displayed on claim screens. This was confirmed during the 2022 Onsite.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 The PIHP's claim system screens store and track claim information and claim adjudication/payment information.	X					Eastpointe demonstrated their provider web portal, claim system screens, and claim adjudication/payment information. Eastpointe demonstrated the claim system's ability to capture all the ICD-10 Diagnosis codes, DRGs, revenue codes, CPT/HCPCS, ICD-10 Procedure codes, and adjudication information. This was confirmed during the 2022 virtual site review.
3. Reporting						
3.1 The PIHP's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					Eastpointe captures all required ICD-10 Diagnosis codes and is capable of capturing additional procedure, DRG, and revenue codes that are submitted on the claims. Eastpointe stores the DRG and ICD-10 Procedure codes for reporting. This was confirmed during the 2022 Onsite.
3.2 The PIHP has processes in place to back up the enrollment and claims data repositories.	X					During the Onsite, Eastpointe stated that the database is backed up incrementally on a nightly basis and fully on a weekly basis. This was confirmed during the 2022 Onsite.
4. Encounter Data Submission						
4.1 The PIHP has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission.	X					Eastpointe submits all secondary ICD-10 Diagnosis codes for both Institutional and Professional encounters to NCTracks. DRG and ICD-10 Procedure codes are captured in the Alpha+ system and submitted on Institutional encounters to NCTracks.
4.2 The PIHP has the capability to identify, reconcile and track the encounter data submitted to NC Medicaid.	X					Eastpointe uses the paid and denied encounters reports developed by Adam Holtzman to identify and reconcile encounter data denials. Denied encounters are worked on by the appropriate department for investigation and correction. This was confirmed during the 2022 Onsite.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.3 PIHP has policies and procedures in place to reconcile and resubmit encounter data denied by NC Medicaid.	X					Eastpointe has clear processes in place to address denied encounter submissions. Encounter denial reports were provided, and ISCA documentation shows flow charts and procedures for encounter data submissions to NC Medicaid. Eastpointe has a 99.7% acceptance rate for both Professional and Institutional encounters with dates of service in 2021.
4.4 The PIHP has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to NC Medicaid.	X					Eastpointe is encountering issues related to incorrect Taxonomy for Covid-related codes. This is an issue with NCTracks and not on their end. Eastpointe has created a ticket to have this addressed on NCTracks. ***Recommendations:*** • ***Continue working with providers to submit appropriate Taxonomy codes on claims.*** • ***Eastpointe continues to experience denials due to issues based on a Covid-related code. While the issue is not with Eastpointe systems, it is recommended that they follow through to ensure that the NCTracks updates are completed to make sure the error is addressed.***

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)*, the *Credentialing Committee By-Laws (By-Laws)*, and several policies described the requirements and processes for credentialing and recredentialing network providers. Information regarding the Credentialing Committee is provided in the *Credentialing Manual* and in the *By-Laws*. Eastpointe had a delegation agreement with Medversant Technologies, a Credentials Verification Organization (CVO), to conduct "the pre-screens, criminal records check, and all PSVs" (Primary Source Verifications).
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 Manual* states, "The Associate Medical Director chairs the Credentialing Committee, reviews and approves practitioners' credentialing files that meet criteria for participation (e.g., "clean applications"), provides input to policy changes and/or revision of policies and procedures, and follows up with practitioners as needed." The *Credentialing Manual* also states, "The meeting will not occur if the Associate Medical Director or Eastpointe Medical Director is not present at the meeting. The Eastpointe Medical Director will chair the meeting in the Associate Medical Director's absence." During the Onsite discussion, Eastpointe staff reported the Associate Medical Director is the only Eastpointe staff member who is a voting member of the Credentialing Committee. The other voting members are all providers who participate in the Eastpointe network.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The Credentialing Committee meeting minutes indicate which members are "voting" members, which members are present, which member(s) made specific motions, and the outcome of votes cast. The meeting notes contain evidence of the committee discussion and decision-making.
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of Provider.	X					Credentialing files reviewed for the EQR were organized and contained appropriate information. No issues were identified in the file review.
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
3.1.3 Valid DEA certificate; and/or CDS certificate	X					
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); and query of the State Exclusion List;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
3.1.14 Names of hospitals at which the physician has admitting privileges if any	X					
3.1.15 Ownership Disclosure is addressed.	X					
3.1.16 Criminal background Check	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.	X					Recredentialing files reviewed for the EQR were organized and contained appropriate information. Some materials were missing from the submitted desk materials. In response to CCME's requests, Eastpointe provided the missing items. No issues were identified in the file review.
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Insurance Requirements	X					
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
4.2.3 Valid DEA certificate; and/or CDS certificate	X					
4.2.4 Board certification if claimed by the applicant;	X					

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; and query of the State Exclusion List;	X					
4.2.9 Requery of the SAM.	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (OIG LEIE);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.11 Requery of the Social Security Administration's Death Master File	X					
4.2.12 Requery of the NPPES;	X					
4.2.13 Names of hospitals at which the physician has admitting privileges, if any.	X					
4.2.14 Ownership Disclosure is addressed.	X					
4.3 Site reassessment if the provider has had quality issues.	X					
4.4 Review of provider profiling activities.	X					The submitted recredentialing files include the completed *Quality Monitoring Review Tool For LME/MCO Re-Credentialing Application Process*. The Credentialing Committee meeting minutes reflect consideration of quality of care concerns and other items for recredentialing candidates.
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.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Eastpointe Provider Sanctions Grid 5-17-17 and *Eastpointe Provider Sanctions Grid Reviewed 4-8-2021* are both posted in the Manuals and Information section of the Provider section of the Eastpointe website. Eastpointe staff reported the two documents are the same, with the one dated 4-8-2021 being posted "to acknowledge that the Sanctions Grid was reviewed." During Onsite discussion, Eastpointe staff reported the *Sanctions Grid* has been updated and revised and has been sent for review by the Executive Team and the Legal Department, noting the grid is a "living document that is revised based on any changes that we get from the state, especially the contract." A cross-functional group, including staff from Provider Monitoring, Program Integrity, and Provider Network Operations review the grid based on changes received from the state, then makes recommendations to the Executive Team.
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					

III. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III. Quality Improvement						
III. A Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					All (c) Waiver Measures were above the State benchmark rates. The overall validation scores for all Performance Measures were in the Fully Compliant range, with an average validation score of 100% across the 10 (b) Waiver Measures and the five (c) Waiver Measures. There were several rates with a substantial decline (>10%). The 30-Day Readmission Rates for Psychiatric Residential Treatment Facility (PRTF) increased 11.3%. Follow-up rates After Hospitalization for Mental Illness in the Facility Based Crisis (FBC) population declined 30.1% for 7- day Follow-up and declined 33.7% for the 30-day Follow-up. Follow up After Hospitalization for Substance Abuse in the Detox and FBC population decline 10% for the 3-day Follow-up rate. The Average LOS for 13-17 year old males increased by 27.7 days in the mental health utilization measure. Rates that improved include Engagement of Alcohol and Other Drug Dependence Treatment (AODDT) for 13-17 year olds by 20.5%, Engagement of AODDT for 18-20 year olds by 14.9%, and Engagement of AODDT for 65+ by 10.8%. ***Recommendation: Monitor interim performance measure rates that declined substantially in the year over year trending.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III. B Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					Eastpointe submitted three projects for this 2022 EQR. These three were validated: Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD) and increase rate to 70% for SMD, Decrease Emergency Department (ED) Admissions for Active Members to 20% Monthly, and Decrease Percentage of Members who Separate From Transition to Community Living Initiative (TCLI) housing to 20% or Less Annually.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					All three validated PIPs scored in the High Confidence range. There were no Corrective Actions or Recommendations for PIPs as all rates improved or were maintained.

IV. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV. A Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					Eastpointe has in excess of twenty policies governing the MH/SU and I/DD Care Coordination functions and techniques. Review of these policies shows language is missing from two of Eastpointe's Innovations policies. Policy C-3.3.6, Individual and Family Directed Services, does not include Supported Living as a self-directed service. Also, Policy C-3.3.9, Employee of Record, does not state that Employee of Record participants must submit the out of State Travel Request, as indicated in *Appendix J* of the *North Carolina Innovations Technical Guide*. ***Recommendations: Revise Policy C-3.3.6 to include Supported Living as a self-directed service.*** ***Revise Policy C-3.3.9, Employee of Record, to include Employee of Record participants must submit the out of State Travel Request when seeking reimbursement for out of state travel.***
2. The care coordination program includes:						
2.1 Staff available 24 hours per day, seven days per week to perform telephone assessments and crisis interventions;	X					
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	X					Referral activities are explained in Policy C-3.4.6, MH/SU Care Coordination.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					Policy C-3.4.16, Complex Case Management and Eastpointe's *Enrollee/Member and Family Handbook* detail the Special Healthcare population criteria listed in *NC Medicaid Contract, Section 6.11.3*, defining the population served by Care Coordination.
2.4 Guide the develop treatment plans for enrollees that meet all requirements;	X					Eastpointe Policy C-3.3.10, Individual Supports Plan Development, describes how I/DD Care Coordinators develop Individual Support Plans (ISPs) through person-centered planning processes. Policy C-3.4.6-MH/SU Care Coordination states Care Coordinators, "ensure enrollees with special health care needs who need a course of treatment or regular monitoring have a treatment plan."
2.5 Quality monitoring and continuous quality improvement;	X					
2.6 Determination of which Behavioral Health Services are medically necessary;	X					
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					The role of Care Coordination in enrollee hospital admissions and discharges is explained in Policy C-3.4.6, MH/SU Care Coordination.
2.8 Coordinate care with each Enrollee's provider;	X					
2.9 Provide follow-up activities for Enrollees;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.10 Ensure privacy for each Enrollee is protected.	X					
2.11 NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	X					
3. The PIHP applies the Care Coordination policies and procedures as formulated.	X					In the 2021 EQR, Eastpointe received a Corrective Action to address issues identified in the 2021 enrollee file review. In the 2022 EQR, CCME reviewed Eastpointe's enrollee file Audit Tools and various reports showing file compliance scores. Review of the Audit tools used by Eastpointe in the past year to identify and correct compliance issues around face-to-face monitoring of Innovations services showed staff were not capturing accurate information around monitoring. For example, rather than capturing the method of service monitoring (i.e., face to face, Webex, telephone contact), staff were capturing frequency of monitoring. Additionally, part of the Corrective Action was to train staff on the appropriate follow-up when an incident is filed in the IRIS system. While Eastpointe was able to demonstrate that Child MH/SU Care Coordination staff were trained on protocols for handling incident reports, no other Care Coordination staff were trained such as Adult MH/SU staff, TCLI, or IDD Care Coordination staff. Eastpointe was able to provide evidence that Innovation enrollees' ISPs were being reviewed to ensure needs identified in assessments and support tools.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Eastpointe was able to provide evidence that Innovation enrollees' ISPs were being audited to ensure needs identified in assessments and support tools. Eastpointe also provided Policy Q-6.1.18, Quality of Care Concerns, which describes Eastpointe's processes around responding to incident reports. Review of the enrollee files in the 2022 EQR showed no issues with compliance with Eastpointe Care Coordination policies, Clinical Coverage Policies, or the *NC Incident Response Improvement System Manual*. ***Recommendations: Work with staff completing enrollee file audits to clarify what data should be captured in the various elements within the Audit Tools.*** ***Provide training to all Care Coordination staff regarding the processes, follow up, and notifications that are required to occur around incident reports.***
IV. B Transition to Community Living Initiative						
1. Transition to Community Living Initiative (TCLI) functions are performed by appropriately licensed, or certified, and trained staff.	X					The Organizational Chart submitted by Eastpointe for this year's EQR shows The TCLI Department is staffed with appropriately licensed and certified staff.
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements.	X					
2.1 Care Coordination activities occur, as required.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.2 Person Centered Plans are developed as required.	X					
2.3 Assertive Community Treatment, Peer Support, Supported Employment, Community Support Team, Psychosocial Rehabilitation, and other services as set forth in the DOJ Settlement are included in the individual's transition, if applicable.	X					Eastpointe's Policy 3.7.19, Enhanced Services Referrals for Transition to Community Living Initiative (TCLI) Members explains the access and availability of Assertive Community Treatment Team, Transition Management, Community Support Team, Peer Support, Individual Support, Substance Abuse Intensive Outpatient, Psychosocial Rehabilitation, and Supported Employment services to enrollees participating in TCLI.
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					
2.5 QOL Surveys are administered timely.	X					Policy C-3.7.6, Quality of Life Surveys, details the processes and requirements for implementation of the Quality of Life surveys. Additionally, the TCLI enrollee files reviewed in this year's EQR showed surveys were implemented within the required timeframes.
3. Transition, diversion and discharge processes are in place for TCLI members as outlined in the DOJ Settlement and *DHHS Contract*.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to NC Medicaid within the timeframes determined by NC Medicaid.	X					NC Medicaid reported no concerns or issues with Eastpointe's reporting of TCLI clinical reports submitted to the State.
5. The PIHP will develop a TCLI communication plan for external and internal stakeholders providing information on the TCLI initiative, resources, and system navigation tools, etc. This plan should include materials and training about the PIHP's crisis hotline and services for enrollees with limited English proficiency.	X					
6. A review of files demonstrates the PIHP is following appropriate TCL policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.	X					In the 2022 EQR, four files of enrollees participating in the TCLI program were reviewed. All of the files showed compliance with Eastpointe policies and their *NC Medicaid Contract*. Quality of Life Surveys were implemented on time, Transition Year Stability Revenue Funds were appropriately accessed, and frequency of Care Coordination engagement appropriate.

V. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy Q-6.4.4 Member/Enrollee and Stake Holder Grievances/ Complaints and Appeals is the primary policy governing Eastpointe's Grievance process.
1.1 Definition of a grievance and who may file a grievance;	X					
1.2 The procedure for filing and handling a grievance;	X					
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	X					
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
1.5 Maintenance of a grievance log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					The Grievance policy clearly indicates the timeframe for which PIHPs are contractually-required to maintain Grievance files.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP applies the grievance policy and procedure as formulated.	X					In the 2022 EQR, 10 Grievance files were reviewed. Three of the 10 files were not compliant with Eastpointe's Grievance policy. *NC Medicaid Contract, Attachment M, Section C* and *42 CFR § 438.408 (b)1* requires Grievances to be resolved within 90 days; however, Eastpointe's Grievance policy requires Grievances to be resolved with notification provided within 30 days. Eastpointe's policy also requires Grievances to be acknowledged within 5 business days. Two files showed the resolution notice was sent outside of 30 days, and one file showed the acknowledgment notice was sent in six business days. These files were discussed during the Onsite and staff acknowledged the timeliness issues were the result of human error. During the Onsite discussion regarding the file in which the Grievance resolution notice was sent in 31 days, Eastpointe staff reported that the Grievance came in on a weekday after 6:00 p.m. but the staff documented the date of receipt as the following day. CCME highlighted that this practice is not supported by Eastpointe's policies and the date of receipt should not be impacted by factors such as weekends, holidays, and time of day. As the timeliness errors in the 2022 file review are very similar to the 2021 file review finding, CCME is again recommending Eastpointe closely monitor Grievance files and the Grievance Log to identify timeliness issues and any practices used by staff that are out of compliance with Eastpointe's policy. ***Recommendation: Continue to routinely monitor Grievance notification timeframes to ensure all notifications are issued in a timely manner per Eastpointe Policy Q-6.4.4, Member/Enrollee and Stake Holder Grievance/Complaint and Appeals.***

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					In the 2021 EQR, errors were noted on the Eastpointe Grievance Log when compared to the reviewed Grievance files. CCME issued a Recommendation to train staff on Grievance Log data entry to ensure data on the log is consistent, complete, and accurate. In the 2022 EQR, this Recommendation was followed. The Grievance Log entries for the files reviewed were much improved. The only error was in one resolution date in which the year was recorded incorrectly as 2021 instead of 2022. This was most likely a transcription error.
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					
V. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					Policy C-3.2.36 Appeal of Utilization Management (UM) Adverse Benefit Determination is the primary policy guiding staff through the Appeal process.
1.1 The definitions an appeal and who may file an appeal;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.2 The procedure for filing an appeal;	X					
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					In the 2022 EQR file review, there was evidence that all Appeal reviewers were appropriately credentialed to render Appeal decisions and were not involved in previous decisions regarding service authorization requests.
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	X					The process for resolving expedited Appeals is in Policy C-3.2.36 Appeal of Utilization Management (UM) Adverse Benefit Determination. The file review contained four expedited Appeals, all processed per policy.
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					
1.6 Written notice of the appeal resolution as required by the contract;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.7 Other requirements as specified in the contract.	X					
2. The PIHP applies the appeal policies and procedures as formulated.	X					For this 2022 EQR, 10 Appeal files were reviewed. One file showed the resolution notification was mailed 5 days beyond the 30-day timeframe required by the *NC Medicaid Contract, Attachment M, 42 CFR 438.408*, and Eastpointe's Appeal policy. Based on Onsite discussion, this was an isolated incident and was administratively resolved in the member's favor with a Notice of Approval for services. There was not a notice of resolution sent to the member, which is required by the *NC Medicaid Contract, Attachment M (7)*. Eastpointe staff explained that processes were put in place after last year's EQR to ensure all Appeals were resolved with a written resolution. That process was implemented after this Appeal was processed. ***Recommendation: Ensure that a written notice of resolution is sent for each resolved appeal as required by the NC Medicaid Contract, Attachment M (7).***
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	X					
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	X					

VI. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI A. General Requirements						
1. PIHP shall be familiar and comply with *Section 1902 (a)(68)* of the *Social Security Act*, *42 CFR § 438.455* and *1000* through *1008*, as applicable, including proper payments to providers and methods for detection of fraud and abuse.	X					
2. PIHP shall have and implement policies and procedures that guide and require PIHP's, and PIHP's officers', employees', agents', and subcontractors,' compliance with the requirements of this *Section 14* of the *NC Medicaid Contract*.	X					
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					
VI B. Fraud and Abuse						
1. PIHP shall establish and maintain a written Compliance Plan consistent with *42 CFR § 438.608* that is designed to guard against fraud and abuse.	X					Eastpointe's *Compliance Plan 2022-2023* describes their Program Integrity (PI) strategies and compliance program.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. PIHP shall designate, however named, a Compliance Officer who meets the requirements of *42 CFR 438.608* and who retains authority to report directly to the CEO and the Board of Directors as needed irrespective of administrative organization. PIHP shall also establish a regulatory compliance committee on the PIHP board of directors and at the PIHP senior management level that is charged with overseeing PIHP's compliance program and compliance with requirements under this Contract. PIHP shall establish and implement policies outlining a system for training and education for PIHP's Compliance Officer, senior management, and employees in regard to the Federal and State standards and requirements under NC Medicaid Contract in accordance with *42 CFR § 438.608(a)(1)(iv).*	X					Eastpointe's Chief of Regulations and Compliance and Regulatory Compliance Committee oversee the compliance program.
3. PIHP shall establish and implement a special investigations or program integrity unit.	X					
4. PIHP's written Compliance Plan shall, at a minimum include:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.1 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					
4.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing, and development of corrective action initiatives;	X					
4.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					
4.4 The PIHP supplies all data in a uniform format provided by NC Medicaid and information requested for their respective investigations within seven (7) business days or within an extended timeframe determined by the Division as provided in *NC Medicaid Contract Section 13.2-Monetary Penalties.*	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. In accordance with *42 CFR § 438.608 (a)(vii),* PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under *NC Medicaid Contract*, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under *NC Medicaid Contract*; and making documentation of investigations and compliance available as requested by the State. PIHP shall include in each monthly Attachment Y Report, all overpayments based on fraud or abuse identified by PIHP during the prior month.						Eastpointe's *Organizational Chart* shows an additional PI Specialist was added since the last EQR. Currently, there is one vacancy in the PI department. During the Onsite, Eastpointe stated that they are actively recruiting to fill that position.
6. PIHP shall have and implement written policies and procedures to guard against fraud and abuse	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse.	X					
6.2 Detailed workflow of the PIHP process for taking a complaint from inception through closure.	X					Eastpointe Policy CC-3.5, Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA) outlines the process for taking a complaint from inception to closure. For the 2022 EQR, CCME reviewed 10 case files listed on the PI Case Log. Five cases were closed, and five cases were still under investigation. Two of the five closed cases identified an over payment, two were unfounded, and one unsubstantiated. The case file review found that Eastpointe processed these cases in compliance with Eastpointe's PI policies and *NC Medicaid Contract*.
6.3 In accordance with Attachment Y - Audits/Self-Audits/investigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.	X					Eastpointe Policy CC-3.5, Voluntary Provider Self Audit, outlines the process for a provider to return an overpayment identified by a provider. This process and the forms providers must use to report overpayments are available on Eastpointe's website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6.4 Process for tracking overpayments and collections based on fraud or abuse, including Program Integrity and Provider Monitoring activities initiated by PIHP and reporting on Attachment Y – Audits/Self-Audits/investigations.	X					
6.5 Process for handling self-audits and challenge audits.	X					Policy CC-3.3, Voluntary Provider Self Audit, outlines Eastpointe's process for handling self-audits and challenge audits. For this EQR, one PI file was the result of a Provider Self-Audit. The review found that Eastpointe followed the process required in Eastpointe's policies.
6.6 Process for using data mining to determine leads.	X					
6.7 Process for informing PIHP employees, subcontractors, and providers regarding the *False Claims Act.*	X					
6.8 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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains NC Medicaid-standardized elements or a NC Medicaid-approved template;	X					Eastpointe's Policy Q-6.1.22 Eligibility of Benefits (EOB) Questionnaire outlines the EOB process, implemented by the Quality Management (QM) Department. During the Onsite, Eastpointe explained when concerns or complaints are reported through the EOB and further investigation is needed, the QM Department sends the referral to the PI Department. Referrals are captured on the PI Case Log, listing QM as the source of the referral and not the original reporter or source. This practice, according to the PI Case Log, makes it appear that only 2.5% of Eastpointe PI referrals stem from the EOB process or from external sources, such as members, providers, or stakeholders. CCME is recommending that Eastpointe capture the original reporter or source of the complaint to better reflect trends in complaints and stakeholders' efforts towards preventing fraud, waste, and abuse. ***Recommendation: Ensure the PI Case Log accurately reflects the original source (e.g., EOB, members, stakeholder, and other external sources) of a concern or complaint to better reflect trends in complaints and stakeholders' efforts towards preventing fraud, waste, and abuse.***
6.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding overpayments, assessments, penalties, or fees due to any State or Federal agency deemed applicable by PIHP, subject to the accessibility of such financial information in a readily available database or other search mechanism.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
7. 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.	X					
8. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to NC Medicaid within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					For this EQR, the review found that all PI cases were initiated within 10 business days of receipt of the potential allegation of fraud.
9. In each case where PIHP refers to NC Medicaid an allegation of fraud involving a Provider, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						For this EQR period, a review of the *Attachment Y Report* showed that Eastpointe submitted one new referral and 13 supplemental referrals as potential cases of FWA. Additionally, the 2022 EQR Desk Review included one PI case that was submitted to NC Medicaid as supplemental on a provider currently under investigation. The supplemental referral contained all required information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9.1 Subject (name, Medicaid provider ID, address, provider type);	X					
9.2 Source/origin of complaint;	X					
9.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					
9.4 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					
9.5 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					
9.6 All communications between PIHP and the Provider concerning the conduct at issue, when available.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					
9.8 Total Sample Amount of Funds Investigated per Service Type	X					
9.8.1 Any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers;	X					
9.8.2 Details that relate to the original allegation that PIHP received which triggered the investigation;	X					
9.8.3 Period of Service Investigated – PIHP shall include the timeframe of the investigation and/or timeframe of the audit, as applicable.;	X					
9.8.4 Information on Biller/Owner;	X					
9.8.5 Additional Provider Locations that are related to the allegations;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9.8.6 Legal and Administrative Status of Case	X					
10. In each case where PIHP refers suspected Enrollee fraud to NC Medicaid, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template.	X					A review of the *Attachment Y Report* showed that there were no cases related to Enrollee fraud during the period under review.
11. If PIHP uses FAMS, PIHP shall notify the NC Medicaid designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.	X					
12. PIHP shall submit to the NC Medicaid Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP.	X					A review of the *FAMS Users Report* showed no changes in Eastpointe users for the review period.
VIII C. Provider Payment Suspensions and Overpayments						
1. Within thirty (30) business days of receipt from PIHP of referral of a potential credible allegation of fraud, NC Medicaid Program Integrity shall complete a preliminary investigation to determine whether there is sufficient evidence to warrant a full investigation.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
If NC Medicaid determines that a full investigation is warranted, NC Medicaid shall make a referral within five (5) business days of such determination to the MFCU/ MID and will suspend payments in accordance with *42 CFR § 455.23*. At least monthly, NC Medicaid shall provide written notification to PIHP of the status of each such referral. If MFCU/ MID indicates that suspension will not impact their investigation, NC Medicaid may send a payment suspension notice to the Provider and notify PIHP. If the MFCU/ MID indicates that payment suspension will impact the investigation, NC Medicaid shall temporarily withhold the suspension notice and notify PIHP. Suspension of payment actions under this *Section 14.3* shall be temporary and shall not continue if either of the following occur: PIHP or the prosecuting authorities determine that there is insufficient evidence of fraud by the Provider; or Legal proceedings related to the Provider's alleged fraud are completed and the Provider is cleared of any wrongdoing.						
1.1 In the circumstances described in *Section 14.3 (c)* above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.						
2. Upon receipt of a payment suspension notice from NC Medicaid Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of NC Medicaid Program Integrity's suspension and lasting until PIHP is notified by NC Medicaid Program Integrity in writing that the suspension has been lifted.	X					
3. PIHP shall provide to NC Medicaid all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.	X					
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to NC Medicaid Program Integrity due to allegations of suspected fraud without prior written approval from NC Medicaid Program Integrity or the MFCU/MID.	X					

E. Attachment 5: Encounter Data Validation Report

Table of Contents

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Background

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

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

Overview

The scope of the review, guided by the Centers for Medicare and Medicaid Services (CMS) External Quality Review Protocol for Encounter Data Validation, focused on measuring the data quality and completeness of claims paid and submitted to NC Medicaid by Eastpointe for the period of January 2021 through December 2021. All claims paid by Eastpointe are expected to be submitted and accepted as valid encounters by NC Medicaid. The 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 NCTracks and parsed using an EDI validator to check for errors and produce a 999 response to confirm receipt and any compliance errors. The encounter claims are then validated by applying a list of edits provided by the State (See Appendix 1) and adjudicated accordingly by NCTracks. Utilizing existing Medicaid pricing methodology and 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.

Once NCTracks processes the 837 files, it produces 835 files detailing the results of adjudication and pricing of encounter submissions. 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.

For claims with dates of service in 2021, Eastpointe submitted 1,448,525 unique encounters to the State. To date, 0.13% of all 2021 encounters submitted have not been corrected and accepted by NC Medicaid. This figure represents significant improvement in comparison to 14.58% and 3.24% denial rates seen in 2018 and 2019, respectively.

2021	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	134,907	83,416	51,488	3	0.00%
Professional	1,313,618	1,245,392	66,287	1,939	0.15%
Total	1,448,525	1,328,808	117,775	1,942	0.13%

Eastpointe has made consistent progress in their encounter data reporting, increasing the acceptance rate and quality of encounter data year over year. The table below shows the actual acceptance rates between 2017 and 2021 and large fluctuation in those rates during that time.

Year of Service	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
2017	2,004,846	1,657,212	179,219	168,415	8.40%
2018	2,238,435	1,720,265	191,894	326,276	14.58%
2019	1,367,707	1,271,765	51,674	44,268	3.24%
2020	1,354,664	1,251,915	98,358	4,391	0.32%
2021	1,448,525	1,328,808	117,775	1,942	0.13%

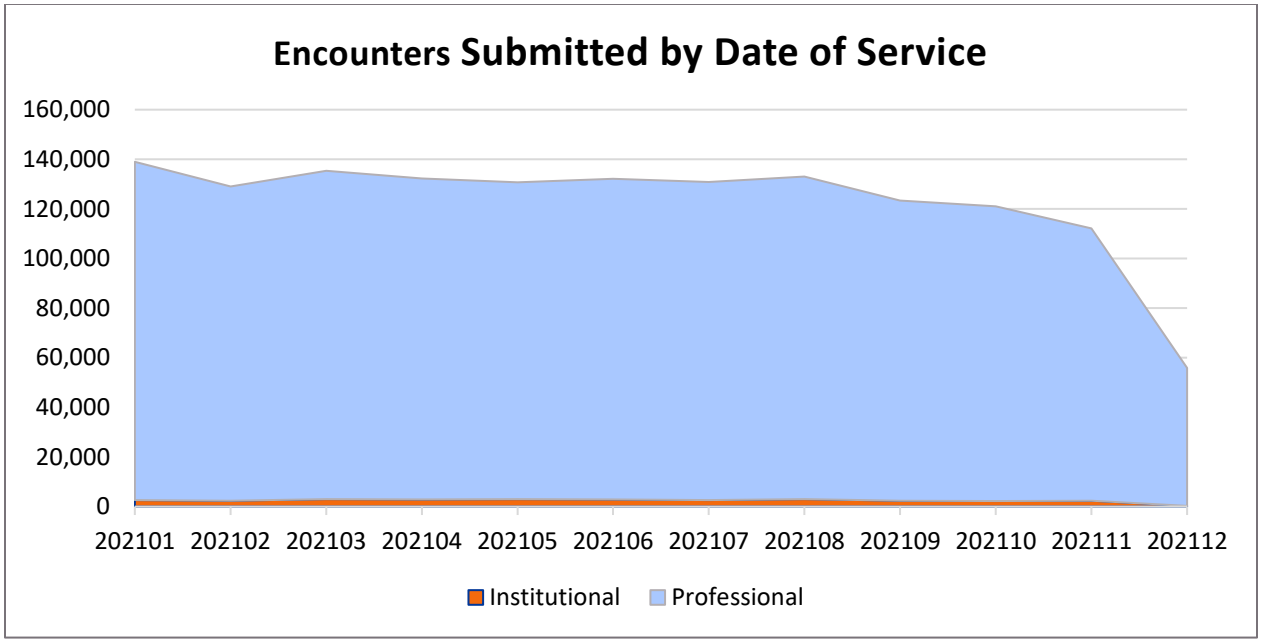
Eastpointe continued to experience a decrease in encounter denials in 2021 compared to 2020. While the denial rates have fluctuated over the past four years, Eastpointe has made significant improvements in the most recent two years. While errors related to provider taxonomy codes are still a concern, the volume has decreased significantly. Over the years, Eastpointe has taken a multi-team, multi-pronged approach to ensure the accuracy of the data submitted by providers, including data validation checks and provider outreach. The most recent results show that the corrective actions taken by Eastpointe have been effective in improving the overall quality of encounter data.

Eastpointe's overall approach includes using the "Encounter Summary by MCO Checkwrite" and other reports issued by NC Medicaid, with a particular emphasis on reviewing the denials. In addition, Eastpointe's claims team reviewed 835 responses and identified denials that need to be resolved. All denied encounter claims receive one denial code. Remark codes are used to narrow down the true denial reason. Eastpointe has a detailed reconciliation and correction process in place to ensure that all denials are reviewed, corrected, and resubmitted to NC Medicaid.

When an error is identified, it is assigned to appropriate staff to resolve the issue(s) based on the denial error. Enrollment issues or eligibility issues are assigned to their Medical Records Department. Provider-related issues are assigned to a dedicated resource in the Contracts Department who was hired for this specific task. Once issues have been updated, the claims staff rebills the claim(s) to NC Medicaid for processing.

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, 2021, and December 31, 2021. Eastpointe extracted all claims adjudicated and submitted to NC Medicaid during 2021 and sent the files to Aqurate via SFTP. This included 1,569,360 Professional and 32,488 Institutional claim lines. These figures also included dates of service prior to 2021, resubmissions of previously denied encounters, and voids and adjustments. Therefore, these numbers may not match the metrics reported in Eastpointe's ISCA response for 2021.



Eastpointe provided Aqurate with copies of original 837 transactions submitted to NC Medicaid during calendar year 2021. Other PIHPs typically convert their 837 files to a pipe or comma-delimited file using an EDI translator. However, Eastpointe does not have a tool to perform this data conversion. Instead, Aqurate consolidated the 837 batch files and then converted the data into a delimited file using an EDI translator. Once the data onboarding was completed, Aqurate applied proprietary, internally designed data

analysis logic using SAS to review each data element, focusing on the data elements defined as required. Aqurate's logic evaluated the presence of data in each field within a record as well as whether the value for the field was within accepted standards. Results were then compared with general expectations for each data field and to the CMS standards adopted for encounter data. The table that follows 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. Medicaid IDs are 9 numeric long followed by 1 alpha.
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 may 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.
Recipient Date of Birth	Should not be missing and should be a valid date.	Existence of a valid date
PIHP ID	Critical Data Element	100% valid for PIHP
Provider ID	Should be an enrolled provider listed in the provider enrollment file.	10 digits
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. 10 digits
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 Standard UB POS
Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% non-missing and valid on physician or other applicable provider type claims (e.g., other practitioners). This is the taxonomy code and is a standard code set.

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 ICD codes for practitioner providers. Codes should be within standard ICD 9 and 10 code sets. ICD-9s have generally stopped appearing on files for current records.
Other Diagnosis	This is not expected to be coded on all claims even with applicable provider types but should be coded with a fairly high frequency.	90% valid when present. Codes should be within standard ICD 9 and 10 code sets. ICD-9s have generally stopped appearing on files for current records.
Dates of Service	Dates should be evenly distributed across time.	Valid date Dates spread throughout reporting year.
Unit of Service (Quantity)	The number should be routinely coded.	The number should be routinely coded. Current Procedural Terminology (CPT) code is in 99200–99215 or 99241–99291 range.
Procedure Code	Critical Data Element	There should be a wide range of procedures appropriate for the services covered by the PIHP
Procedure Code Modifier	Important to separate out surgical procedures/ anesthesia/assistant surgeon, not applicable for all procedure codes.	Expect a variety of modifiers both numeric (CPT) and Alpha (Healthcare Common Procedure Coding System [HCPCS])
Patient Discharge Status Code (Hospital)	Should be valid codes for inpatient claims, with the most common code being “Discharged to Home.” For outpatient claims, the code can be “not applicable.”	Expect a variety of values, with "Discharge to Home" being most common, and includes "Still-in" and transfers
Revenue Code	If the facility uses a UB04 claim form, this should always be present	Valid code is present

Encounter Accuracy and Completeness

The table that follows outlines the key fields that were reviewed to determine if information was present, whether the information was the correct type and size, and whether the data populated were valid. Although Aqurate reviewed the complete data set and validated all data values, the fields identified below are key to properly shadow price for the services paid by Eastpointe.

Table: Evaluation of Key Fields

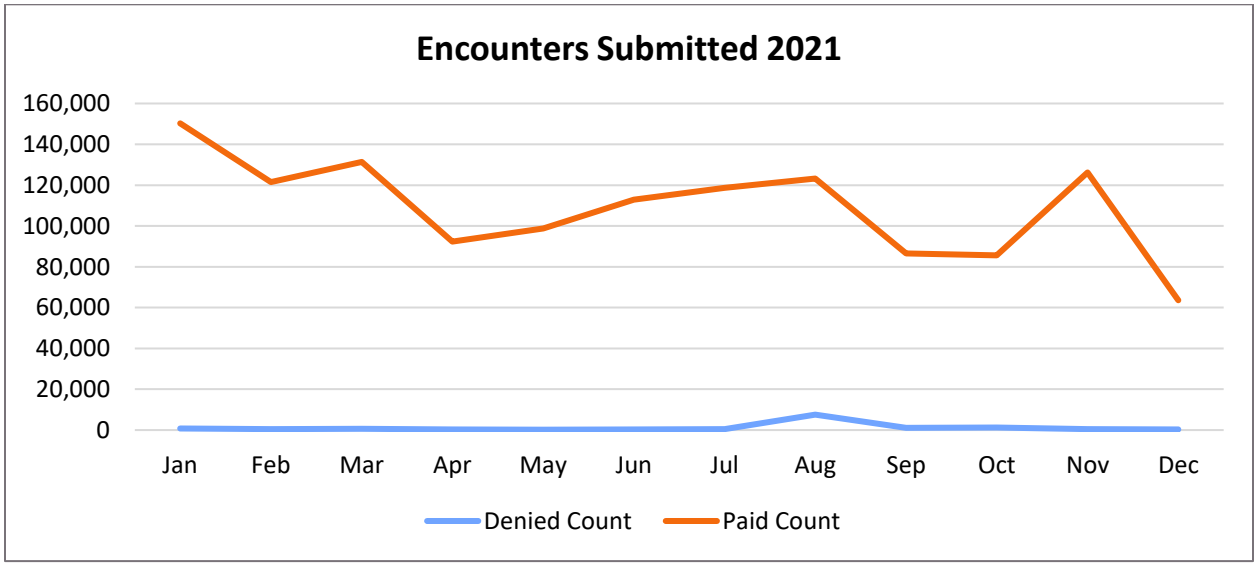
Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%
Recipient Name	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%
Recipient Date of Birth	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%
PIHP ID	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%
Provider ID	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%
Attending/Rendering Provider ID	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%
Provider Location	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%
Place of Service	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%
Specialty Code / Taxonomy - Billing	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%
Specialty Code / Taxonomy- Rendering / Attending	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%
Principal Diagnosis	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%
Other Diagnosis	41,265	2.58%	41,265	2.58%	41,265	2.58%	41,265	2.58%
Dates of Service	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%
Unit of Service (Quantity)	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%	1,601,848	100.00%
Procedure Code	1,574,325	98.28%	1,574,325	98.28%	1,574,325	98.28%	1,574,325	98.28%
Procedure Code Modifier	465,838	29.08%	465,838	29.08%	465,838	29.08%	465,838	29.08%
Patient Discharge Status Code Inpatient	32,488	100.00%	32,488	100.00%	32,488	100.00%	32,488	100.00%
Revenue Code	31,723	97.65%	31,723	97.65%	31,723	97.65%	31,723	97.65%

Overall, Aqurate did not find many inconsistencies in the data other than the denial issues highlighted in Eastpointe's ISCA response and NC Medicaid's encounter acceptance report. Institutional claims contained complete and valid data in 14 of the 18 key fields (78%) that meet or exceed CMS's Data Quality Standards. Aqurate identified an issue among the Other Diagnosis codes for institutional claims. Overall, only 8.16% of the institutional claims contained Other Diagnosis codes.

Professional encounter claims submitted contained complete and valid data in 14 of the 16 key Professional fields (87.50%). The primary issue identified for professional claims also involved Other Diagnosis codes being populated infrequently. The Principal Diagnosis code was populated 100% of the time; however, there was little consistency in Other Diagnosis codes being present. While some corrective actions were implemented a couple of years ago, where Eastpointe now submits up to 12 Diagnosis codes for Professional claims, many practitioners often do not report Other Diagnosis codes. There were also a high number of records without a procedure code modifier, but a review of the files indicated that this might be appropriate for certain types of claims.

Encounter Acceptance Report

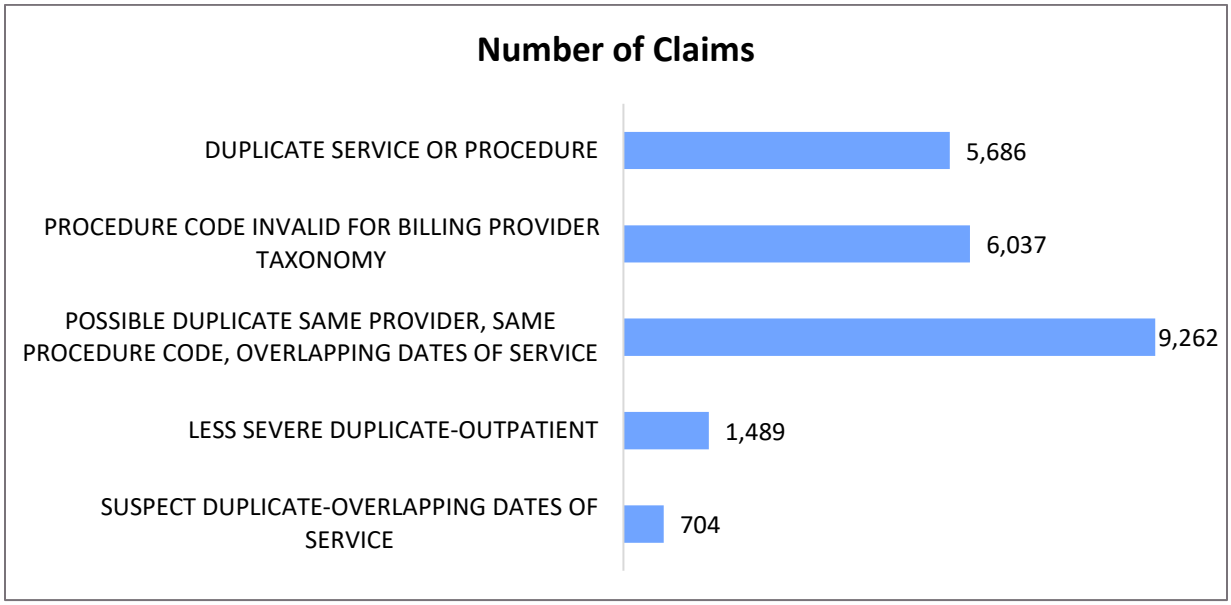
In addition to performing evaluation of the encounter data submitted, Aqurate reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by check write and excludes duplicate or resubmitted claims which made it difficult to tie back to the ISCA response and the converted encounter files. Data provided by Eastpointe for this review included all submission and resubmissions during 2021, which included older dates of service. Based on the 2021 ISCA response, Eastpointe submitted a total of 1,448,525 encounters to NC Medicaid. On average, 8.26% of all encounters submitted were initially denied, which was roughly the same as what was seen with data submitted in 2020. Most of these denials were caused by timing issues involving adjustments. Before adjusted claims can be submitted, previously submitted claims must be voided. If the voids are not processed before the adjusted encounters are submitted, adjustments will be denied as suspected duplicates. Eastpointe has corrected such denials and is actively working to reduce these timing errors. Voided claims data are submitted on Mondays and resubmission claims data are sent on Thursdays.



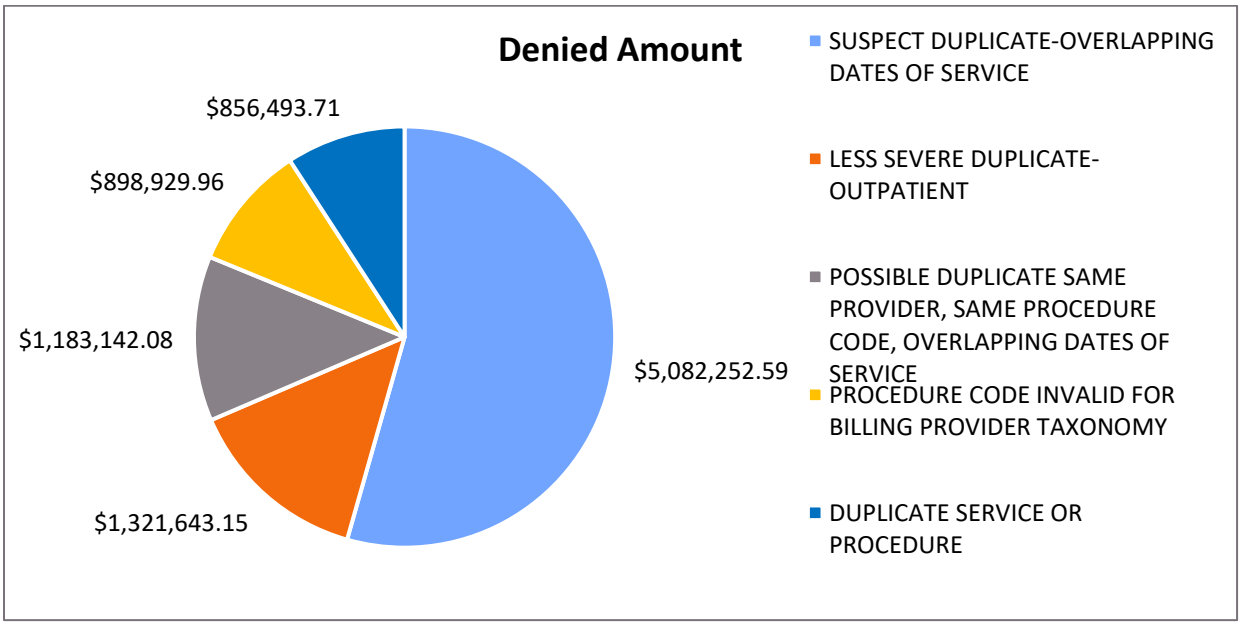
Evaluation of the top denials for Eastpointe encounters correlates with the data deficiencies identified in the Key Field described previously. Encounters were denied primarily for:

- Possible duplicate, same provider, same Procedure code, overlapping dates of service
- Procedure code invalid for billing provider taxonomy
- Duplicate service or procedure
- Less severe duplicate-outpatient
- Suspect duplicate-overlapping dates of service

The chart that follows reflects the top five denials by claim volume.



The pie chart that follows reflects the top five denials by claim dollar amount.



Results and Recommendations

Issue: Other Diagnosis

Principal and Admitting Diagnosis codes were populated consistently, where appropriate. However, Other Diagnosis codes were often missing, especially on Professional claims. In general, claims from certain providers are missing the Other Diagnosis codes including instances where they are missing on 100% of the claims while claims from other providers frequently show Other Diagnosis codes. This suggests that some providers are simply not coding Other Diagnosis codes or failing to map them onto the claims.

Resolution:

Eastpointe should continue to educate its providers on the importance of ensuring that the information provided on claims is complete and accurate, including the Diagnosis codes. This effort should include urging providers to review their billing software to make sure all available Diagnosis codes are being mapped to the 837s. For providers who submit claims via the web portal, Eastpointe should advise them to review all the information to make sure the claim is complete and accurate, rather than simply copying a previously billed claim and changing only the date of service, Procedure code, and billed charges. Eastpointe should also continue to review the 837 encounter mapping to ensure that providers are reporting all applicable Diagnosis Codes and that the PIHP is reporting them to NC Medicaid.

Conclusion

Based on the analysis of Eastpointe's encounter data, Aqurate concludes the data submitted to NC Medicaid are complete and accurate as defined by NC Medicaid standards.

The most notable issue is related to the infrequent reporting of Other Diagnosis codes. Although Other Diagnosis codes may not affect adjudication in certain instances, these codes are important for reporting, evaluating member health, and assessing a value-based payments. Eastpointe should conduct a review at the provider level to determine which of its providers are often not reporting Other Diagnosis codes and perform educational outreach to alert providers to the issue. Eastpointe should also continue to review and take necessary actions to ensure they are capturing and reporting valid Procedure codes for Institutional claims when required based on the reported Revenue code (e.g., pharmacy, lab, radiology) so that all services billed on those claims can be identified.

For the next review period, Aqurate recommends that the encounter data from NCTracks be reviewed to assess 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. Additionally, the PIHP does not send their 837 files converted to a pipe- or comma-delimited file using an EDI translator. This makes reconciliation difficult as well. Reviewing an extract from NCTracks may provide insight into NCTracks' handling of the submitted encounters and could be reconciled back to reports received 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

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
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

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
00326	REND PROV NUM CHECK	PAY AND REPORT
00328	PEND PER DHB REQ FOR FIN REV	IGNORE
00334	ENCOUNTER TAXON M/I	PAY AND REPORT
00335	ENCOUNTER PROV NUM MISSING	DENY
00337	ENC PROC CODE NOT ON FILE	PAY AND REPORT
00339	PRCNG REC NOT FND FOR ENC CLM	PAY AND REPORT
00349	SERV DENIED FOR BEHAV HLTH LM	IGNORE
00353	NO FEE ON FILE	PAY AND REPORT
00355	MANUAL PRICING REQUIRED	PAY AND REPORT
00358	FACTOR CD IND PROC NON-CVRD	PAY AND REPORT
00359	PROV CHRGS ON PER DIEM	PAY AND REPORT
00361	NO CHARGES BILLED	DENY
00365	DRG - DIAG CANT BE PRIN DIAG	DENY
00366	DRG - DOES NOT MEET MCE CRIT.	PAY AND REPORT
00370	DRG - ILLOGICAL PRIN DIAG	PAY AND REPORT
00371	DRG - INVLD ICD-9-CM PRIN DIAG	DENY
00374	DRG PAY ON FIRST ACCOM LINE	DENY
00375	DRG CODE NOT ON PRICING FILE	PAY AND REPORT
00378	DRG RCC CODE NOT ON FILE DOS	PAY AND REPORT
00439	PROC\REV CD INVLD FOR AGE	IGNORE
00441	PROC INVLD FOR DIAG	IGNORE
00442	PROC INVLD FOR DIAG	IGNORE
00613	PRIM DIAG MISSING	DENY
00628	BILLING PROV ID REQUIRED	IGNORE
00686	ADJ/VOID REPLC TCN INVALID	DENY
00689	UNDEFINED CLAIM TYPE	IGNORE
00701	MISSING BILL PROV TAXON CODE	DENY
00800	PROC CODE/TAXON REQ PSYCH DX	PAY AND REPORT
00810	PRICING DTE INVALID	IGNORE
00811	PRICING CODE MOD REC M/I	IGNORE
00812	PRICING FACTOR CODE SEG M/I	IGNORE
00813	PRICING MOD PROC CODE DTE M/I	IGNORE
00814	SEC FACT CDE X & % SEG DTE M/I	IGNORE
00815	SEC FCT CDE Y PSTOP SEG DT M/I	IGNORE
01005	ANTHES PROC REQ ANTHES MODS	IGNORE
01060	ADMISSION HOUR INVALID	IGNORE
01061	ONLY ONE DOS PER CLAIM	IGNORE
01102	PRV TAXON CHCK - RAD PROF SRV	IGNORE
01200	INPAT CLM BILL ACCOM REV CDE	DENY
01201	MCE - ADMIT DTE = DISCH DTE	DENY

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
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

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
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