2021 External Quality Review

EASTPOINTE

Submitted: November 19, 2021

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 2021 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of North Carolina Medicaid (NC Medicaid).

Goals of the review are to:

- Determine if 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 included 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 PIHPs 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 the 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 #9*, which 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 a comprehensive review of Eastpointe's health systems capabilities and provider credentialing and recredentialing documentation and processes. The review included validation of the PIHP's PIPs, PMs, and encounter data. Lastly, CCME conducted a thorough review of the Eastpointe's Utilization Management (UM), Grievances, and Appeals processes. The PIHP's network adequacy, availability of services, sub-contractual relationships, and Clinical Practice Guidelines (*42 CFR § 438.206, § 438.207, § 438.230, and § 438.236,* respectively*)* were not included in the review.

To assess Eastpointe's compliance with federal regulations and its contract, CCME's review was divided into eight areas. The following is a high-level summary of the review results for each area, as well as the status of the Recommendations and Corrective Action items from the 2020 EQR and the findings of the 2021 EQR. Additional information regarding the reviews, including strengths, weaknesses, and recommendations, is included in the narrative of this report.

Administration

42 CFR § 438.224 and 42 CFR § 438.242

In the 2020 EQR, Eastpointe met 100% of the Administrative Standards and received one Recommendation. The Recommendation was related to the higher than usual number of duplicate encounter data denials from NCTracks. During the 2021 Onsite, Eastpointe staff reported that they are still encountering a high number of denials due to duplicate encounter data submissions. In the 2021 EQR, Eastpointe again met 100% of the Administrative EQR standards, but received two Recommendations to address duplicate encounter data denials. These Recommendations are related to the 2020 Recommendation, which has not yet been implemented by Eastpointe, and the PIHP's inability to query their database to produce a count of encounters with specific dates of service, prior years, or a point in time.

Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

In the 2020 EQR of Eastpointe's Credentialing/Recredentialing, 100% of the standards in the Provider Services review were scored as "Met," and CCME issued three Recommendations. Eastpointe addressed the Recommendation regarding recredentialing every three years. The PIHP partially addressed the Recommendation to revise conflicting language about the composition of the Credentialing Committee and to correct the position title of one Eastpointe employee who was a non-voting member. However,

Eastpointe did not address the Recommendation to reconcile the language within the *Credentialing Manual* about the process.

In the current EQR, Eastpointe met 100% of the Provider Services standards. CCME issued three Recommendations, including the two Recommendations from the 2020 EQR that were not completely addressed.

Quality Improvement

42 CFR § 438.330

In the 2020 EQR, Eastpointe met 100% of the Quality standards and received three Recommendations related to the PIPs validated. All three Recommendations were implemented. For the 2021 EQR, Eastpointe met all standards with no Corrective Actions and four Recommendations. All PIPs were validated in the High Confidence range, but CCME issued three Recommendations. The three PIP Recommendations target revisions in interventions and additional interventions to improve rates.

In the 2021 EQR, Eastpointe was Fully Compliant for (b) Waiver and (c) Waiver PMs, but several (b) Waiver PMs showed a decline in rate compared to the previous measurement year. Due to the timing of the 2021 EQR, the file submitted for this review was the same file submitted for the 2020 EQR. CCME issued a Recommendation for monitoring to determine if rates with substantial improvement or decline represent trends or anomalies in the PMs.

Utilization Management

42 CFR § 438.208

Eastpointe met 96% of UM standards in the 2020 EQR. CCME issued one Corrective Action and two Recommendations. The two Recommendations were aimed at ensuring exemptions for waiver cost limits were identified and to clarify information regarding the qualifications for Children with Complex Needs. Both Recommendations were addressed. The Corrective Action was to revise the current monitoring plan to include a more comprehensive quality review of all I/DD progress notes and documentation. The Corrective Action was partially implemented.

For this EQR, Eastpointe met 96% of UM standards. CCME issued one Corrective Action aimed at improving Care Coordination service monitoring, service implementation, and follow-up activities. The Corrective Action also includes the development of training and guidelines for Care Coordination staff that 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 of21*, and *8P NC Innovations, NC Innovations Waiver Technical Guide*, and *NC Incident Response Improvement System Manual*.

Grievances and Appeals

42 CFR § 438, Subpart F, 42 CFR 483.430

In the 2020 EQR, Eastpointe met 90% of the Grievance and Appeal standards and received two Corrective Actions in Grievances and one Recommendation in Appeals. The two Corrective Actions in Grievances were targeted at documentation around extending the Grievance resolution timeframe and resolving the Grievance inside of the 90 days required by *42 CFR § 438.408 (b)1*. The Appeals Recommendation targeted documentation in the *Provider Operations Manual* around Eastpointe's responsibility to notify enrollees of their right to file a Grievance if they disagree with Eastpointe's extension of the Appeal resolution timeframe. There was evidence in the 2021 EQR that Eastpointe implemented the Recommendation and all Corrective Actions issued in the 2020 EQR.

In the 2021 EQR, eight of the 10 Grievance files met all timeliness requirements. There was one Grievance acknowledgement and two Grievance resolution letters sent outside of the required timeframes. CCME issued a Recommendation to Eastpointe to continue to routinely monitor Grievance files to ensure all notifications are issued in a timely manner. CCME also issued a Recommendation that Grievance staff be trained on Grievance Log data entry to ensure the data is consistent, complete, and accurate.

In the 2021 Appeals EQR, 10 files were reviewed. There was one Appeal resolution letter issued outside of the required timeframe. During the Onsite, Eastpointe staff explained this was an isolated incident and that a plan of correction was implemented. There were no other deficiencies in the files reviewed, and no Corrective Actions or Recommendations were issued in the 2021 EQR of Appeals.

Program Integrity

42 CFR § 455, 42 CFR § 438.455 and *1000* through *1008, 42 CFR § 1002.3(b)(3), 42 CFR 438.608 (a)(vii)*

In the 2020 EQR, Eastpointe met 100% of Program Integrity (PI) EQR standards, and no Corrective Actions or Recommendations were issued.

In the 2021 EQR, Eastpointe again met 100% of PI EQR standards. Through the Desk Review and Onsite, Eastpointe demonstrated strong investigative practices, including a risk assessment process that prioritizes cases considered to be a "major" risk. The PIHP does not have any pending cases older than 2020, which represents a very current case load. Eastpointe uses data mining to identify PI cases with support from both IBM and internal staff. Currently, more than a third of new Eastpointe PI cases result from data mining efforts. CCME's review of Eastpointe's PI functions showed strong interdepartmental collaboration with provider relations, claims, UM, and quality teams.

Encounter Data Validation

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

During the review, the most notable issue found was 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 payment model. 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, it is recommended that Eastpointe review the encounter data from NCTracks to look at encounters that pass front end edits and are adjudicated to either a paid or denied status. It is difficult to reconcile the various tracking reports with the data submitted by the PIHP. Reviewing an extract from NCTracks would provide insight into how the NCTracks is handling the encounter claims and could be reconciled to reports requested from Eastpointe. The goal is to ensure that Eastpointe is reporting all paid claims as encounters to NC Medicaid.

2020 Corrective Actions and Recommendations from Previous EQR

During the previous EQR, there was one Care Coordination standard scored as "Partially Met," and no standards scored as "Not Met." Following the 2020 EQR, Eastpointe submitted a Corrective Action Plan to address the identified deficiency. CCME reviewed and accepted Eastpointe's Corrective Action Plan on June 17, 2021. The deficiency identified in Eastpointe's 2020 EQR was within the file review of MH/SUD and I/DD Care Coordination. The 2020 file review showed a pattern of noncompliance with Eastpointe's Care Coordination policies and *NC Medicaid Contract, Section 6*, related to timeliness of progress notes, incomplete I/DD Monitoring Checklists, and a lack of person-centeredness and detail within the Individual Support Plans (ISPs) of the enrollee files reviewed. Concern regarding the frequency and method of monitoring I/DD enrollees was also noted. During the 2021 EQR, CCME assessed the degree to which Eastpointe implemented the Corrective Actions issued in the 2020 EQR. This assessment showed the one Corrective Action issued was only partially implemented. The 2021 EQR showed Eastpointe updated the I/DD Monitoring plan, but CCME again identified discrepancies in Care Coordination progress notes and other documentation that were similar to those identified in the 2020 EQR.

Additional details regarding the PIHP's 2020 Corrective Action Plan, the PIHP's response, and evidence, or lack thereof, of PIHP implementation of the 2020 Corrective Action are detailed in the Care Coordination section of this report.

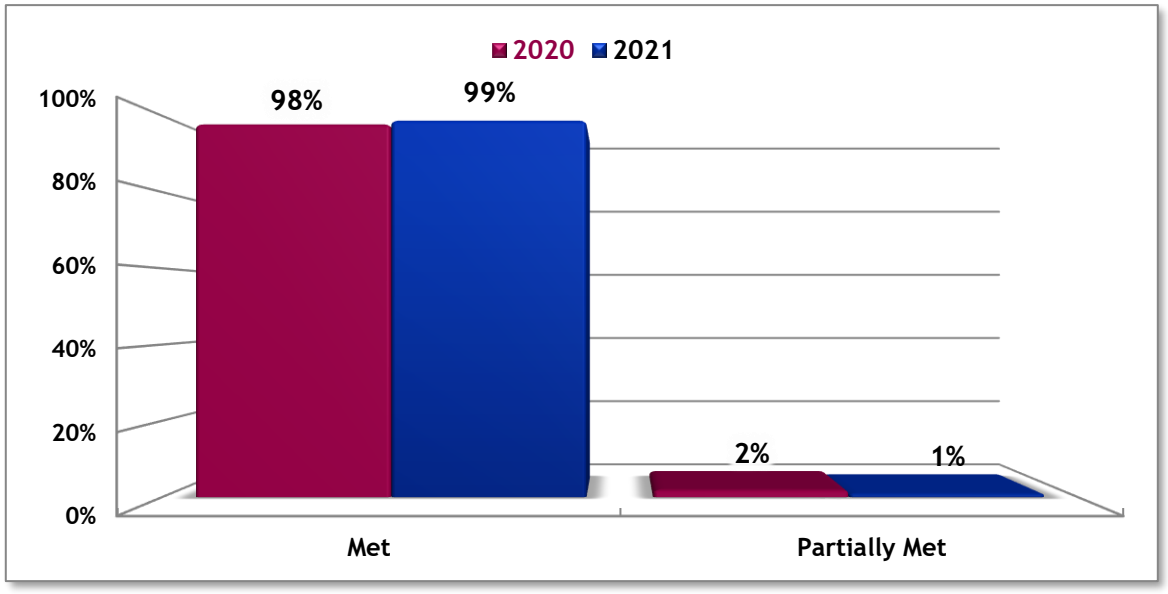
Conclusions

Overall, Eastpointe has met the requirements set forth in the contract with NC Medicaid. The 2021 Annual EQR shows that Eastpointe has achieved a "Met" score for 99% of the standards reviewed. As the following chart indicates, 1% of the standards were scored as "Partially Met," and none of the standards scored as "Not Met."

B. Overall Score

Figure 1: Annual EQR Comparative Results, provides an overview of the scoring of the current annual review as compared to the findings of the 2020 review.

Figure 1: Annual EQR Comparative Results



The following is a summary of key findings and recommendations or opportunities for improvement. Specific details of strengths, weaknesses, and Recommendations can be found in the sections that follow.

Table 1: Eastpointe's 2021 Overall Strengths, Weaknesses, and Recommendations

	Strengths	Weaknesses	Recommendations
Quality	Eastpointe can capture up to 24 ICD-10 Diagnosis codes on Institutional claims and 12 ICD-10 Diagnosis codes on Professional claims.	There were several (b) Waiver Measures with substantial declines.	***Recommendation: Continue to monitor (b) Waiver Measure rates to determine if rates with substantial improvement or decline represent a continued trend or an anomaly in the Performance Measures.***
	In submissions to NC Medicaid, Eastpointe can include all ICD-10 Diagnosis codes provided on claims via the encounter data extracts.	PIP rates did not improve for two of the validated PIPs.	***Recommendations: Increase the Percent of Individuals Who Receive a 2nd Service Within or Less Than (≤) 14 Days to 35% PIP: Determine if additional education needs to be implemented for providers. Assess impact of interventions to allow determination of most effective intervention. Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD) PIP: Continue interventions and conduct analysis of interim data to determine if additional interventions should be implemented to focus on the SSD rate. Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar disorder Who are Using Antipsychotic Medications to 80% (SSD)PIP: As data allow, conduct interventions assessment in relation to SSD rate to assess impact of each intervention.***
	Interdepartmental coordination was evident in the Grievance and Appeal files reviewed.	Eastpointe is encountering a higher than usual number of duplicate encounter data submission denials from NCTracks that are primarily due to the process of submitting adjusted and voided encounters.	***Recommendation: Continue to work with providers and the State to reduce the number of denied duplicate encounters from NCTracks.***

	Strengths	Weaknesses	Recommendations
	(b) Waiver Measures included all necessary documentation, and measures were reported according to specifications.	Eastpointe is unable to query the database to produce the count of encounters with specific dates of service	***Recommendation: 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.***
	(c) Waiver Measures met or exceeded State benchmark rates.		
	Review of Eastpointe's PI functions showed strong interdepartmental collaboration with provider relations, claims, Utilization Management, and quality teams.		
Timeliness	Eastpointe auto-adjudicates claims, including 98.81% of Institutional claims and 98.99% of Professional claims.	Two of the 10 Grievance files reviewed showed noncompliance with required notification timeframes.	***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 Stakeholder Grievance/ Complaint and Appeals.***
	Eastpointe's process for monitoring Appeals resulted in significant improvement in compliance when compared to the previous EQR.	The Eastpointe Grievance Log contained several data entry errors.	***Recommendation: Train staff on Grievance Log data entry to ensure data on the log is consistent, complete, and accurate.***
	Eastpointe uses data mining, supported by both IBM and internal staff. Currently, more than a third of new Eastpointe PI cases resulted from data mining efforts.		

	Strengths	Weaknesses	Recommendations
Access to Care	Eastpointe provides a Network Operations Call Center with a dedicated toll-free number to assist providers. Network Operations also has a designated email address.	As at the last EQR, some of the language in the *Credentialing Manual* regarding processes is conflicting (e.g., applications go to Medversant, versus applications are submitted to CAQH and are sent to Medversant, versus applications are submitted to the PIHP).	***Recommendation: As per the Recommendation at the last EQR, reconcile the language within the Credentialing Manual about the process.***
	Network Operations uses a two-tiered review process in which a credentialing staff member reviews the application for completeness and accuracy, followed by a review by the Provider Relations Supervisor.	As noted in the last EQR, there is conflicting language in the *Credentialing Committee By-Laws* and the *Credentialing Manual* about the composition of the Credentialing Committee.	***Recommendation: As recommended at the last EQR, revise the Credentialing Committee By-Laws, the Credentialing Manual, and any other documents that reference the composition of the Credentialing Committee, to consistently reflect the composition and correct position titles of the Credentialing Committee membership.***
	Due to the pandemic, Eastpointe obtained permission from NC Medicaid to provide home-delivered meals via a vendor to I/DD members.	There are additional errors in the submitted Credentialing Committee By-Laws (By-Laws), in the submitted Credentialing Manual, and in items posted on the website, as described in the Tabular Spreadsheet.	***Recommendation: Review language in the By-Laws, in the Credentialing Manual, and on the Eastpointe website and make corrections to ensure information is accurate and current.*** ***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 Credentialing Committee By-Laws 08272021, correct the date the By-Laws were "reviewed and approved by the Credentialing Committee" to August 27, 2021 and ensure posted information such as the MCO Provider Sanctions Grid is accurate and current.***

	Strengths	Weaknesses	Recommendations
	Eastpointe successfully passed initial NCQA accreditation as a Managed Behavioral Health Organization, scoring 100% on the Complex Case Management program for children.	The current monitoring plan does not include a quality review of Care Coordination documentation that ensures I/DD ISPs reflect needs identified in assessments, that services are implemented as outlined, that monitors how monthly contacts are made, and that follow-up notifications are made with all required parties when incidents occur.	***Corrective Actions: Enhance the current monitoring plan to include a quality review checklist of MH/SUD/I/DD Care Coordination documentation. The quality review should: Ensure that I/DD monthly Care Coordination service reviews are conducted face-to-face or by allowed methods listed in NC Contract Amendment 11, Section 7; Ensure that 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 that 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 that 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 of21, and 8P NC Innovations, NC Innovations Waiver Technical Guide, and NC Incident Response Improvement System Manual.***

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 September 7, 2021, 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 Eastpointe to participate in a pre-Onsite conference call with CCME and NC Medicaid to provide 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 September 28, 2021 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 21, 2021. This Onsite visit focused on areas not covered in the Desk Review and areas needing clarification. For a list of items requested for the Onsite visit, see *Attachment 2*. CCME's Onsite activities included:

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

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

FINDINGS

The findings of the EQR are summarized in the following pages of this report and are based on the regulations set forth in *42 CFR § 438.358* and the *NC Medicaid Contract* requirements between 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 § 438.224 and 42 CFR § 438.242

The review of Eastpointe's system capabilities included use of the Information Systems Capabilities Assessment (ISCA) tool and review of supporting documentation such as Eastpointe's claim audit reports, enrollment workflows, and Information Technology (IT) staffing patterns. This system analysis was completed as specified in the Centers for Medicaid and Medicare Services (CMS) protocol. During the Onsite, staff presented a member and claims systems review and answered questions regarding the ISCA tool.

In the 2020 EQR, Eastpointe met 100% of the administrative standards and received one Recommendation. The Recommendation was related to the higher than usual number of duplicate encounter data submission denials from NCTracks.

Table 2: 2020 EQR Administrative Findings

2020 EQR Administrative 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.	***Recommendation: Continue to work with providers and the State to reduce the number denied duplicate encounters from NCTracks, review the process of submitting the adjusted and voided encounters separately.***	**Y**
2021 EQR Follow up: In the 2021 EQR, Eastpointe received a Recommendation related to the higher than usual number of duplicate encounter denials from NCTracks. During the Onsite, Eastpointe stated that this issue has not been resolved completely and they are still encountering denials due to timing of the voided encounter submission to NCTracks.		

Eastpointe, like many other PIHPs in North Carolina, uses the AlphaMCS transactional, a hosted system environment produced by their vendor, WellSky. On October 4, 2021, Eastpointe transitioned from AlphaMCS to the Alpha+ platform noting that there were no major changes in processes or functionality of the platform. The hosting of the Alpha+ system has been updated to cloud-based hosting. While submitting the ISCA tool, Eastpointe was still using the AlphaMCS system but had transitioned to Alpha+ when the Onsite was conducted. The Alpha+ system is used to process member enrollment and claims, submit encounters, and generate reports.

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 Onsite, Eastpointe provided a demonstration of the Alpha+ enrollment system, which maintains a member's enrollment history. The Global Eligibility File (GEF) file is imported daily into the Alpha+ by their vendor, WellSky. WellSky also uploads the monthly 834 file to Alpha+. During the Onsite, Eastpointe stated that they use the quarterly GEF file to reconcile and update the records in Alpha+.

Eastpointe stores the Medicaid identification number received on the GEF. During the Onsite, Eastpointe indicated that they rarely see members with multiple IDs but are able to research and merge the information into one Member ID. Eastpointe validates the Medicaid ID that is submitted on a claim with the previous seven Medicaid IDs that are stored in the Alpha+ system while adjudicating a claim. The historical claims for the member are also merged into one Member ID.

During the Onsite system demonstration, staff displayed the enrollment information that is viewable and captured within Alpha+. The Alpha+ system is able to capture demographic data like race, ethnicity, and language.

Eastpointe enrollment counts for the past three years are presented in Table 3.

Table 3: Enrollment Counts

2018	2019	2020
155,365	149,586	163,427

Eastpointe's authorizations and claims are processed in the Alpha+ system. 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. During the Onsite, Eastpointe staff demonstrated 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 Onsite, Eastpointe stated that claims from out-of-network providers are received on paper. Table 4 details the percentage of 2020 claims received through each of the three methods.

Table 4: Percent of claims with 2020 dates of service that were received via Electronic (HIPAA, Provider Web Portal) or Paper forms.

Source	HIPAA File	Paper	Provider Web Portal
Institutional	14%	1%	1%
Professional	56%	1%	27%

Eastpointe adjudicates claims on a nightly basis. Approximately, 98.99% of Professional claims and 98.81% 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. During the Onsite, Eastpointe confirmed that they can capture and submit telehealth modifier codes during the ongoing COVID-19 pandemic.

During the Onsite, Eastpointe stated that Eastpointe staff conducts random audits of 3% of all claims processed monthly. High dollar claims, those that are more than $5,000, 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 also audited daily. During the Onsite, Eastpointe clarified that the database is backed up incrementally each night and fully each week. Eastpointe did not have any negative business impact due to the ongoing COVID-19 pandemic.

The breakdown of encounter data acceptance/denial rates by claim service detail counts was provided for encounters submitted in 2020. Table 5 provides a comparison of 2019 and 2020.

Table 5: Volume of 2019 and 2020 Submitted Encounter Data

2020	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	88,335	31,766	2,007	122,108
Professional	1,163,580	66,592	2,384	1,232,556
2019	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	88,989	17,212	5,531	111,732
Professional	1,182,776	34,462	38,737	1,255,975

In Table 5, the count of encounters with 2019 dates of service are the same as stated in Eastpointe's 2020 ISCA. During the 2021 Onsite, CCME requested Eastpointe provide a follow-up item with revised counts for 2019 dates of service, but Eastpointe was unable to provide that information within the specified time. Eastpointe stated that there would be significant effort involved to recode their report to be able to produce the count of encounters with dates of service in 2019.

Eastpointe has a 99.7% acceptance rate for both Professional and Institutional encounters with dates of service in 2020. During the Onsite, Eastpointe provided the top three denial reasons for encounters submitted in 2020:

- 13,460 Possible Duplicates
- 7,001 Taxonomy for Rendering Provider Missing
- 97 State Incarceration

Eastpointe received a Recommendation from the 2020 EQR related to the higher than usual number of duplicate encounter denials from NCTracks. During the Onsite, Eastpointe staff stated that this issue has not been resolved completely and that they are still encountering denials due to timing of the voided encounter submission to NCTracks.

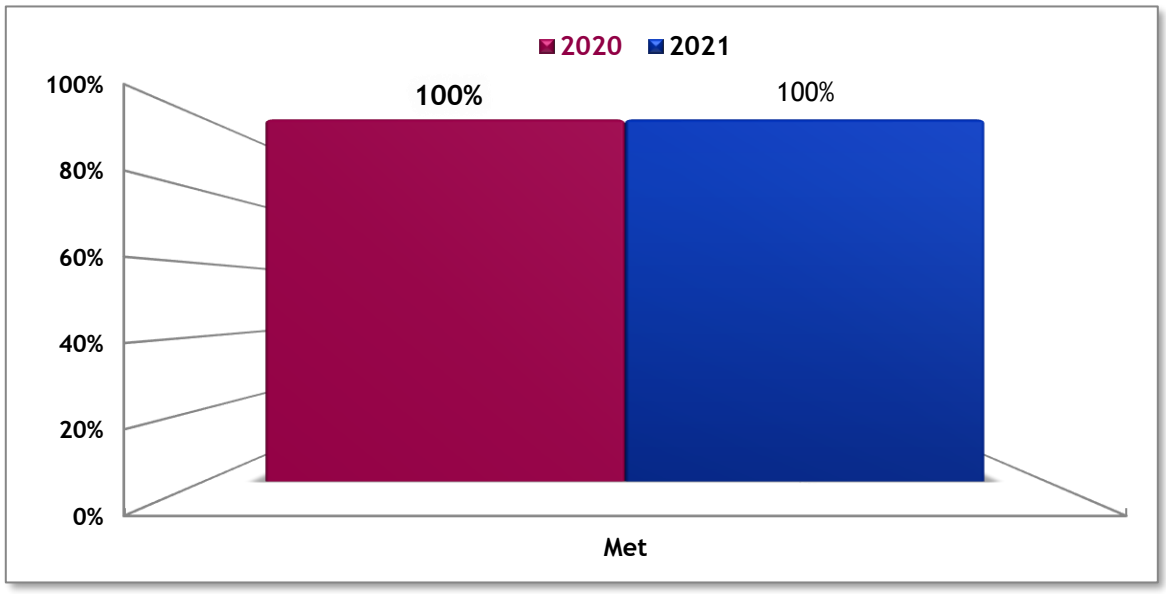
On average, Eastpointe submits an encounter to NC Medicaid within five days from the time of adjudication. It takes approximately 15 days to correct and resubmit an encounter to NC Medicaid. Eastpointe uses the Adam Holtzman's paid and denied reports to identify encounters that were denied. As stated in the ISCA, Eastpointe has 2,007 Institutional and 2,384 Professional encounters with dates of service in 2020 still awaiting

resubmission as of September 20, 2021. Eastpointe exceeds NC Medicaid standards for encounter submissions and has a denial rate of less than 0.4% for their encounter data submissions. During the Onsite, Eastpointe stated that they have greatly improved their encounter data acceptance rate due to the efforts of their staff to resolve the issues related to voided encounters and provider NPI. Eastpointe also conducts meetings across Information Technology (IT), Claims, Provider Networks and Contracts Departments weekly to address outstanding encounter submission issues.

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 ISCA EQR.

Figure 2: Administrative Comparative Findings



Strengths

- Eastpointe auto-adjudicates claims, including 98.81% of Institutional claims and 98.99% of Professional claims.
- Eastpointe can capture up to 24 ICD-10 Diagnosis codes on Institutional claims and 12 ICD-10 Diagnosis codes on Professional claims.
- In submissions to NC Medicaid, Eastpointe can include all ICD-10 Diagnosis codes provided on claims via the encounter data extracts.

Weaknesses

- Eastpointe is encountering a higher than usual number of duplicate encounter data submission denials from NCTracks that 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.

Recommendations

- 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.

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 Eastpointe's 2020 EQR of Credentialing/Recredentialing, 100% of the standards in the Provider Services review were scored as "Met", and three Recommendations were issued. Eastpointe addressed one Recommendation, partially addressed one Recommendation, and did not address one Recommendation, as presented in Table 6.

Table 6: 2020 EQR Provider Services Findings

2020 EQR Provider Services 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: Reconcile the language within the Credentialing Manual about the process (applications go to CAQH and are sent to Medversant, versus applications are submitted to the PIHP, etc.)***	N
2021 EQR Follow up: In this 2021 EQR, conflicting language remains in the Provider Credentialing Operations Manual/Plan regarding the process (applications go to CAQH and are sent to Medversant, versus applications are submitted to the PIHP, etc.). The Recommendation to revise the conflicting language continues in this EQR.		
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: Revise the Credentialing By-Laws, the Credentialing Manual, and any other documents that reference the composition of the Credentialing Committee, to consistently reflect the composition of the Credentialing Committee, reconciling both the composition of the provider representative members and the position titles of the non-voting members.***	N
2021 EQR Follow up: In this 2021 EQR, Eastpointe addressed some of 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. Some conflicting language remains, resulting in the Recommendation continuing in this EQR.		
Recredentialing every three years	***Recommendation: In order to comply with the Eastpointe Credentialing Manual, ensure: providers are recredentialed within three years of the initial credentialing or the most recent recredentialing; the Credentialing Committee is notified when the AMD approves provisional credentialing/ recredentialing; and quality of care issues are discussed with the Credentialing Committee.***	Y
2021 EQR Follow up: All recredentialing files submitted for the 2021 EQR showed recredentialing occurred within three years of the previous credentialing or recredentialing.		

The *Provider Credentialing Operations Manual/Plan* (the *Credentialing Manual*) and several policies guide the credentialing and recredentialing processes. Information regarding the Credentialing Committee is provided in the *Credentialing Manual* and in the *Credentialing Committee By-Laws* (*By-Laws*). The submitted *By-Laws* include a statement that they were "reviewed and approved by the Credentialing Committee on 08/27/2020", but Dr. Doniparthi's signature is dated 09/01/21. The Credentialing Committee minutes of the August 27, 2021 meeting include approval of the *By-Laws*. During the Onsite, Eastpointe staff verified that the approval date (08/27/2020) listed on the *By-Laws* document is a typo, as the Credentialing Committee approved the *By-Laws* on August 27, 2021.

CCME's review showed the credentialing and recredentialing files 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 submitted some documents and clarified the location of other documents in the Desk Materials.

As at the last EQR, some of the language in the *Credentialing Manual* regarding processes is conflicting (e.g., applications go to Medversant, versus applications are submitted to CAQH and are sent to Medversant, versus applications are submitted to the PIHP). Also, as at the last EQR, there is conflicting language in the *By-Laws* and the *Credentialing Manual* about the composition of the Credentialing Committee. Further, as previously noted, the *By-Laws* list an incorrect date of approval. Identified issues are detailed in the Tabular Spreadsheet of this report.

Dr. Venkata Doniparthi, Associate Medical Director (AMD) and a board-certified psychiatrist, chairs the Credentialing Committee. The *Credentialing Manual* states, "The meeting will not occur if the Associate Medical Director is not present at the meeting." However, during Onsite discussion, Dr. Doniparthi confirmed that this is not the case, as Dr. Hosseini, Eastpointe Medical Director, would chair the meeting in Dr. Doniparthi's absence. The sample of Credentialing Committee meeting minutes reviewed for this EQR indicated a quorum was present. In the event of a tie vote, Dr. Doniparthi breaks the tie. Eastpointe staff reported the Credentialing Committee now meets twice a month.

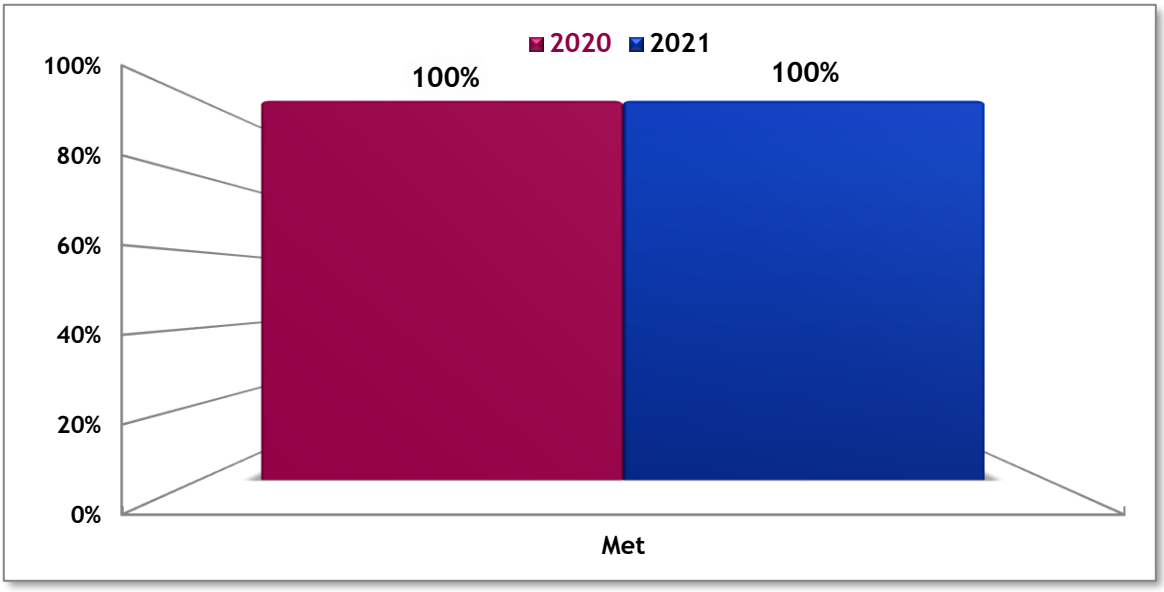
New providers receive a "Welcome" letter, directing them to the Provider Orientation section of the website, which includes the *Provider Operations Manual*. The Provider Orientation section of the website includes a Provider Orientation Training webinar, which is dated 02/23/18. The webinar references a "Getting Started" document, which is no longer on the website. During the Onsite, Eastpointe staff reported they no longer use that document, as they now just include the information in the Welcome letter. As part of the move to the tailored plan, they are creating new Orientation Packets.

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.

Under the COVID-19 flexibilities as outlined in *NC Medicaid Contract Amendment #9*, the annual *Network Adequacy and Accessibility Analysis* (Gaps Analysis) will be submitted "no later than ninety (90) calendar days after termination of the Amendment." During the Onsite, Eastpointe staff reported they have submitted an updated report to NC Medicaid, with *Exception Requests* submitted for seven Medicaid-funded services. Efforts to address gaps include the addition of PRTFs, pursuit of additional Partial Hospital programs, and the approval of an additional MST provider located in the Robeson County area with the agency staff in the process of being trained. Eastpointe staff discussed challenges, including with meeting "additional requirements added by the State last year", noting that "some of those require a lot of start-up." The pandemic has created additional challenges, with providers being short-staffed and licensures being delayed by the NC Division of Health Service Regulation.

Figure 3, Provider Services Comparative Findings, shows that 100% of the standards in the 2021 Credentialing/Recredentialing EQR were scored as "Met" and provides an overview of 2021 scores compared to 2020 scores.

Figure 3: Provider Services Comparative Findings



Strengths

- Eastpointe provides a Network Operations Call Center with a dedicated toll-free number to assist providers. Network Operations also has a designated email address.
- Network Operations uses a two-tiered review process in which a credentialing staff member reviews the application for completeness and accuracy, followed by a review by the Provider Relations Supervisor.
- Due to the pandemic, Eastpointe obtained permission from NC Medicaid to provide home-delivered meals via a vendor to I/DD members.

Weaknesses

- As at the last EQR, some of the language in the *Credentialing Manual* regarding processes is conflicting (e.g., applications go to Medversant, versus applications are submitted to CAQH and are sent to Medversant, versus applications are submitted to the PIHP).
- As noted in the last EQR, there is conflicting language in the *Credentialing Committee By-Laws* and the *Credentialing Manual* about the composition of the Credentialing Committee.
- There are additional errors in the submitted *Credentialing Committee By-Laws (By-Laws*), in the submitted *Credentialing Manual*, and in items posted on the website, as described in the Tabular Spreadsheet.

Recommendations

- As per the Recommendation at the last EQR, reconcile the language within the *Credentialing Manual* about the process.
- As recommended at the last EQR, revise the *Credentialing Committee By-Laws*, the *Credentialing Manual*, and any other documents that reference the composition of the Credentialing Committee, to consistently reflect the composition and correct position titles of the Credentialing Committee membership.
- Review language in the *By-Laws*, in the *Credentialing Manual*, and on the Eastpointe website and make corrections to ensure information is accurate and current.
    - 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 *Credentialing Committee By-Laws 08272021*, correct the date the *By-Laws* were “reviewed and approved by the Credentialing Committee” to August 27, 2021.
    - Ensure posted information such as the *MCO Provider Sanctions Grid* is accurate and current.

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) report for validation, using CMS standard validation protocols. An Onsite discussion clarified measurement rates for each of the areas.

In the 2020 EQR, Eastpointe Met 100% of the Quality standards and received three Recommendations related to three PIPs that were validated. The Recommendations and the status of implementation in this 2021 EQR are presented in Table 7.

Table 7: 2020 EQR PIP Recommendations

Project(s)	Recommendation	Recommendation Implemented in 2021 (Y/N/NA)
Increase the percentage of individuals who receive a 2nd service within or less than 14 days- Clinical: Initiation/Engagement Medicaid	***Recommendation: The PIP workgroup on 11/12/20 noted that they are going to focus on education to providers on initiation of services. Continue the initial interventions and the most recent interventions and monitor for improvement.***	**Y**
Decrease Emergency Department admissions for active members to 20%-Clinical	***Recommendation: March 2020 PIP workgroup meeting focused on implementation of self-study tool and workflow; as well as care specialist; d/c team; and care specialists. Continue these interventions to determine if they reduce ED admissions.***	**Y**
Decrease percentage of members who separate from transition to community living housing to 20% or less annually- Clinical/TCLI	***Recommendation: Determine if Freedom Funds can help keep rate decreasing; work on increasing compliance of members and providing consistent information, as documented.***	**Y**

Performance Measure Validation

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

Table 8: (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 9: (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 assessed 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

The Eastpointe 2020 EQR was conducted in March 2021. Due to the timing of the 2021 EQR, which was conducted October 2021, the file submitted for this review was the same file submitted for the 2020 EQR. Thus, the (b) Waiver measure results for the current EQR are unchanged from the 2020 EQR.

These measures' rates as reported by Eastpointe for FY 2020 are included in the Table that follows. The rate for follow-up after hospitalization for mental illness showed a substantial improvement for Facility Based Crisis (FBC) population for 7 and 30-days follow-up. The rate improved 26.3% for 7-day and 29.2% for 30-day follow-up. Initiation rates showed very steep declines for 2020 when compared to 2018 (2019 was not submitted due to the lag in EQR). All age groups showed substantial (>10%) declines. For Ages 13-17, there was a 34% decline; ages 18-20, a 41.2% decline; ages 21-34, a 43.5% decline; ages 35-64, 49.2% decline; ages 65+, a 62.8% decline. The total for all ages over 13 was a 46.9% decrease in percent with a second service or visit within 14 days. The current rate in comparison to the FY 2018 rate is presented in Tables 10 through 19.

Table 10: A.1. Readmission Rates for Mental Health

30-day Readmission Rates for Mental Health	FY 2018	FY 2020	Change
Inpatient (Community Hospital Only)	8.3%	13.6%	5.30%
Inpatient (State Hospital Only)	0.0%	0.0%	0.00%
Inpatient (Community and State Hospital Combined)	8.3%	13.7%	5.40%
Facility Based Crisis	9.1%	7.7%	-1.40%
Psychiatric Residential Treatment Facility (PRTF)	8.0%	0.0%	-8.00%
Combined (includes crossovers between services)	9.3%	14.3%	5.00%

Table 11: A.2. Readmission Rate for Substance Abuse

30-day Readmission Rates for Substance Abuse	FY 2018	FY 2020	Change
Inpatient (Community Hospital Only)	9.0%	10.6%	1.60%
Inpatient (State Hospital Only)	0.0%	0.0%	0.00%
Inpatient (Community and State Hospital Combined)	8.9%	10.2%	1.30%
Detox/Facility Based Crisis	6.0%	9.9%	3.90%
Combined (includes crossovers between services)	11.1%	13.1%	2.00%

Table 12: A.3. Follow-Up after Hospitalization for Mental Illness

Follow-up after Hospitalization for Mental Illness	FY 2018	FY 2020	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	37.7%	38.6%	0.90%
Percent Received Outpatient Visit Within 30 Days	54.1%	54.6%	0.50%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	20.0%	46.3%	26.30%
Percent Received Outpatient Visit Within 30 Days	40.0%	69.2%	29.20%
PRTF			
Percent Received Outpatient Visit Within 7 Days	29.3%	22.5%	-6.80%
Percent Received Outpatient Visit Within 30 Days	53.7%	47.5%	-6.20%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	37.4%	38.3%	0.90%
Percent Received Outpatient Visit Within 30 Days	54.0%	54.5%	0.50%

Table 13: A.4. Follow-Up After Hospitalization for Substance Abuse

Follow-up after Hospitalization for Substance Abuse	FY 2018	FY 2020	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	14.7%	11.9%	-2.80%
Percent Received Outpatient Visit Within 30 Days	21.8%	23.1%	1.30%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	22.5%	22.7%	0.20%
Percent Received Outpatient Visit Within 7 Days	27.2%	28.4%	1.20%
Percent Received Outpatient Visit Within 30 Days	37.9%	38.6%	0.70%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	21.2%	20.5%	-0.70%
Percent Received Outpatient Visit Within 30 Days	30.2%	31.3%	1.10%

**NR = Denominator is equal to zero.*

Table 14: B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FY 2018	FY 2020	Change
Ages 13-17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	53.9%	19.9%	-34.00%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	32.9%	29.1%	-3.80%
Ages 18-20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	55.7%	14.5%	-41.20%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	39.2%	37.3%	-1.90%
Ages 21-34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	61.8%	18.3%	-43.50%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	55.2%	50.8%	-4.40%
Ages 35-64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	64.0%	14.8%	-49.20%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	55.5%	57.4%	1.90%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	69.8%	7.0%	-62.80%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	52.3%	67.4%	15.10%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	62.5%	15.6%	-46.90%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	53.0%	53.3%	0.30%

Table 15: D.1. Mental Health Utilization-Inpatient Discharges and Average Length of Stay

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		FY 2018	FY 2020	Change	FY 2018	FY 2020	Change
3–12	Male	0.2	0.1	-0.1	30.2	44.3	14.1
	Female	0.1	0.2	0.1	18.4	27.3	8.9
	Total	0.2	0.1	-0.1	25.0	35.0	10.0
13–17	Male	1.0	1.0	0.0	54.0	54.8	0.8
	Female	1.3	1.5	0.2	32.2	29.7	-2.5
	Total	1.1	1.3	0.2	42.0	40.0	-2.0
18–20	Male	1.2	2.0	0.8	15.9	11.2	-4.7
	Female	1.3	1.2	-0.1	10.3	13.5	3.2
	Total	1.2	1.6	0.4	12.9	12.1	-0.8
21–34	Male	4.3	4.3	0.0	8.3	8.1	-0.2
	Female	1.3	1.4	0.1	7.5	6.8	-0.7
	Total	2.0	2.1	0.1	7.9	7.4	-0.5
35–64	Male	2.6	2.5	-0.1	10.6	8.4	-2.2
	Female	2.0	1.9	-0.1	8.5	7.8	-0.7
	Total	2.2	2.2	0.0	9.4	8.1	-1.3
65+	Male	0.6	0.4	-0.2	27.1	16.0	-11.1
	Female	0.3	0.3	0.0	18.7	12.5	-6.2
	Total	0.4	0.3	-0.1	22.6	14.0	-8.6
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	1.2	0.0	19.1	18.2	-0.9
	Female	1.0	1.0	0.0	13.2	13.8	0.6
	Total	1.1	1.1	0.0	16.0	15.8	-0.2

Table 16: 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 2018	FY 2020	Change	FY 2018	FY 2020	Change	FY 2018	FY 2020	Change	FY 2018	FY 2020	Change
3-12	Male	12.96%	11.54%	-1.42%	0.19%	0.01%	-0.18%	0.61%	0.57%	-0.04%	12.78%	11.40%	-1.38%
	Female	9.04%	7.90%	-1.14%	0.15%	0.03%	-0.12%	0.15%	0.14%	-0.01%	8.99%	7.88%	-1.11%
	Total	11.04%	9.76%	-1.28%	0.17%	0.02%	-0.15%	0.38%	0.36%	-0.02%	10.92%	9.67%	-1.25%
13-17	Male	14.01%	12.52%	-1.49%	1.05%	0.16%	-0.89%	0.33%	0.48%	0.15%	13.88%	12.37%	-1.51%
	Female	14.13%	14.11%	-0.02%	1.28%	0.12%	-1.16%	0.14%	0.20%	0.06%	13.96%	14.06%	0.10%
	Total	14.07%	13.29%	-0.78%	1.16%	0.14%	-1.02%	0.23%	0.34%	0.11%	13.92%	13.19%	-0.73%
18-20	Male	8.37%	8.30%	-0.07%	1.07%	0.04%	-1.03%	0.02%	0.00%	-0.02%	8.17%	8.30%	0.13%
	Female	10.74%	10.74%	0.00%	1.14%	0.00%	-1.14%	0.00%	0.00%	0.00%	10.48%	10.74%	0.26%
	Total	9.60%	9.56%	-0.04%	1.11%	0.02%	-1.09%	0.01%	0.00%	-0.01%	9.37%	9.56%	0.19%
21-34	Male	23.16%	23.40%	0.24%	3.63%	0.09%	-3.54%	0.02%	0.00%	-0.02%	22.72%	23.40%	0.68%
	Female	16.97%	17.28%	0.31%	1.24%	0.01%	-1.23%	0.02%	0.00%	-0.02%	16.83%	17.28%	0.45%
	Total	18.39%	18.74%	0.35%	1.79%	0.03%	-1.76%	0.02%	0.00%	-0.02%	18.19%	18.74%	0.55%

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2018	FY 2020	Change	FY 2018	FY 2020	Change	FY 2018	FY 2020	Change	FY 2018	FY 2020	Change
35-64	Male	19.15%	19.13%	-0.02%	2.06%	0.04%	-2.02%	0.02%	0.00%	-0.02%	18.96%	19.13%	0.17%
	Female	22.50%	21.93%	-0.57%	1.58%	0.03%	-1.55%	0.03%	0.00%	-0.03%	22.07%	21.93%	-0.14%
	Total	21.21%	20.84%	-0.37%	1.77%	0.03%	-1.74%	0.02%	0.00%	-0.02%	20.88%	20.84%	-0.04%
65+	Male	6.33%	5.38%	-0.95%	0.56%	0.00%	-0.56%	0.00%	0.00%	0.00%	6.08%	5.38%	-0.70%
	Female	5.88%	4.97%	-0.91%	0.26%	0.00%	-0.26%	0.01%	0.00%	-0.01%	5.78%	4.97%	-0.81%
	Total	6.02%	5.10%	-0.92%	0.35%	0.00%	-0.35%	0.01%	0.00%	-0.01%	5.88%	5.10%	-0.78%
Unknown	Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	Male	14.12%	13.12%	-1.00%	1.02%	0.05%	-0.97%	0.32%	0.33%	0.01%	13.92%	13.03%	-0.89%
	Female	13.66%	13.07%	-0.59%	0.87%	0.03%	-0.84%	0.07%	0.07%	0.00%	13.49%	13.05%	-0.44%
	Total	13.86%	13.09%	-0.77%	0.93%	0.04%	-0.89%	0.18%	0.18%	0.00%	13.67%	13.04%	-0.63%

Table 17: 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 2018	FY 2020	Change	FY 2018	FY 2020	Change	FY 2018	FY 2020	Change	FY 2018	FY 2020	Change
3–12	Male	0.03%	0.02%	-0.01%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%	0.02%	0.01%	-0.01%
	Female	0.03%	0.02%	-0.01%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%	0.01%	0.01%	0.00%
	Total	0.03%	0.02%	-0.01%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%	0.01%	0.01%	0.00%
13–17	Male	2.11%	1.15%	-0.96%	0.07%	0.00%	-0.07%	1.35%	0.47%	-0.88%	0.95%	0.79%	-0.16%
	Female	1.14%	0.67%	-0.47%	0.06%	0.00%	-0.06%	0.75%	0.28%	-0.47%	0.37%	0.42%	0.05%
	Total	1.63%	0.92%	-0.71%	0.06%	0.00%	-0.06%	1.06%	0.38%	-0.68%	0.67%	0.61%	-0.06%
18–20	Male	3.19%	2.96%	-0.23%	0.23%	0.04%	-0.19%	1.55%	1.26%	-0.29%	1.97%	2.01%	0.04%
	Female	3.00%	2.90%	-0.10%	0.18%	0.04%	-0.14%	1.39%	1.10%	-0.29%	1.96%	2.10%	0.14%
	Total	3.09%	2.93%	-0.16%	0.21%	0.04%	-0.17%	1.47%	1.18%	-0.29%	1.96%	2.06%	0.10%
21–34	Male	8.99%	7.79%	-1.20%	0.74%	0.47%	-0.27%	1.93%	1.71%	-0.22%	8.29%	7.26%	-1.03%
	Female	8.25%	9.06%	0.81%	0.51%	0.15%	-0.36%	1.79%	2.31%	0.52%	7.72%	8.25%	0.53%
	Total	8.42%	8.75%	0.33%	0.56%	0.22%	-0.34%	1.82%	2.17%	0.35%	7.85%	8.01%	0.16%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2018	FY 2020	Change	FY 2018	FY 2020	Change	FY 2018	FY 2020	Change	FY 2018	FY 2020	Change
35–64	Male	8.28%	9.09%	0.81%	0.91%	0.41%	-0.50%	2.41%	3.38%	0.97%	7.54%	8.16%	0.62%
	Female	6.34%	7.45%	1.11%	0.34%	0.17%	-0.17%	1.92%	2.92%	1.00%	5.88%	6.50%	0.62%
	Total	7.09%	8.08%	0.99%	0.56%	0.26%	-0.30%	2.11%	3.10%	0.99%	6.52%	7.14%	0.62%
65+	Male	1.94%	2.45%	0.51%	1.36%	0.08%	-1.28%	0.66%	1.29%	0.63%	1.51%	2.05%	0.54%
	Female	0.60%	0.93%	0.33%	0.20%	0.00%	-0.20%	0.21%	0.60%	0.39%	0.51%	0.63%	0.12%
	Total	1.02%	1.43%	0.41%	0.56%	0.03%	-0.53%	0.35%	0.83%	0.48%	0.82%	1.09%	0.27%
Unknown	Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	Male	2.88%	2.75%	-0.13%	0.34%	0.11%	-0.23%	0.98%	0.99%	0.01%	2.35%	2.37%	0.02%
	Female	3.21%	3.45%	0.24%	0.21%	0.06%	-0.15%	0.94%	1.18%	0.24%	2.84%	2.99%	0.15%
	Total	3.07%	3.14%	0.07%	0.26%	0.08%	-0.18%	0.96%	1.09%	0.13%	2.63%	2.72%	0.09%

Table 18: 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 2018	FY 2020	Change	FY 2018	FY 2020	Change	FY 2018	FY 2020	Change	FY 2018	FY 2020	Change
	3-12			13-17			18-20			21-34		
Bladen	0.00%	0.00%	0.00%	0.87%	0.40%	-0.47%	2.37%	1.52%	-0.85%	5.21%	5.87%	0.66%
Duplin	0.02%	0.00%	-0.02%	0.85%	0.30%	-0.55%	1.41%	1.50%	0.09%	5.15%	3.43%	-1.72%
Edgecombe	0.00%	0.00%	0.00%	0.35%	0.67%	0.32%	0.64%	1.74%	1.10%	2.71%	4.91%	2.20%
Greene	0.02%	0.00%	-0.02%	0.59%	0.47%	-0.12%	1.04%	1.17%	0.13%	4.27%	4.58%	0.31%
Lenoir	0.00%	0.02%	0.02%	0.23%	0.90%	0.67%	2.08%	2.91%	0.83%	4.67%	6.61%	1.94%
Robeson	0.05%	0.05%	0.00%	1.43%	1.90%	0.47%	3.36%	4.54%	1.18%	7.76%	12.72%	4.96%
Sampson	0.03%	0.00%	-0.03%	3.30%	0.23%	-3.07%	5.02%	1.15%	-3.87%	11.90%	3.46%	-8.44%
Scotland	0.02%	0.03%	0.01%	0.33%	0.45%	0.12%	0.89%	3.59%	2.70%	2.51%	7.26%	4.75%
Wayne	0.02%	0.03%	0.01%	2.34%	0.83%	-1.51%	3.61%	1.74%	-1.87%	9.45%	4.73%	-4.72%
Wilson	0.01%	0.00%	-0.01%	0.77%	0.69%	-0.08%	2.23%	1.99%	-0.24%	5.00%	6.10%	1.10%

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 2018	FY 2020	Change	FY 2018	FY 2020	Change	FY 2018	FY 2020	Change	FY 2018	FY 2020	Change
	35-64			65+			Unknown			Total		
Bladen	4.16%	4.96%	0.80%	0.50%	0.88%	0.38%	0.00%	0.00%	0.00%	2.02%	2.20%	0.18%
Duplin	4.23%	3.68%	3.13%	0.54%	0.46%	1.26%	0.00%	0.00%	0.00%	1.15%	1.21%	1.64%
Edgecombe	5.68%	7.36%	0.03%	1.20%	1.80%	-0.53%	0.00%	0.00%	0.00%	2.17%	2.79%	-0.38%
Greene	5.99%	5.71%	4.27%	0.66%	0.67%	1.70%	0.00%	0.00%	0.00%	1.86%	1.79%	1.85%
Lenoir	9.62%	10.26%	0.96%	1.76%	2.36%	0.24%	0.00%	0.00%	0.00%	3.79%	3.71%	1.09%
Robeson	8.43%	10.58%	-5.33%	1.20%	2.00%	-0.87%	0.00%	0.00%	0.00%	4.52%	4.88%	-3.40%
Sampson	2.44%	3.10%	3.95%	0.32%	0.33%	0.20%	0.00%	0.00%	0.00%	0.89%	1.12%	2.00%
Scotland	6.75%	6.39%	0.69%	1.47%	0.52%	0.05%	0.00%	0.00%	0.00%	3.72%	2.89%	-1.36%
Wayne	7.05%	7.44%	2.97%	0.65%	1.52%	2.37%	0.00%	0.00%	0.00%	2.36%	2.36%	0.97%
Wilson	9.22%	10.02%	0.78%	2.01%	3.02%	1.01%	0.00%	0.00%	0.00%	3.14%	3.33%	0.19%

Table 19: 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 2018	FY 2020	Change	FY 2018	FY 2020	Change	FY 2018	FY 2020	Change	FY 2018	FY 2020	Change
	3-12			13-17			18-20			21-34		
Bladen	9.08%	6.42%	-2.66%	11.80%	11.62%	-0.18%	8.89%	5.46%	-3.43%	11.02%	12.54%	1.52%
Duplin	11.03%	7.90%	-3.13%	12.34%	12.38%	0.04%	7.46%	9.45%	1.99%	9.75%	13.28%	3.53%
Edgecombe	7.66%	5.98%	-1.68%	12.07%	11.31%	-0.76%	9.74%	6.33%	-3.41%	14.05%	9.55%	-4.50%
Greene	6.19%	6.29%	0.10%	10.15%	11.60%	1.45%	5.45%	8.50%	3.05%	7.74%	11.76%	4.02%
Lenoir	6.93%	9.21%	2.28%	13.45%	15.88%	2.43%	6.49%	11.31%	4.82%	11.11%	14.52%	3.41%
Robeson	12.07%	8.79%	-3.28%	17.65%	12.40%	-5.25%	10.34%	8.77%	-1.57%	14.88%	13.10%	-1.78%
Sampson	9.90%	7.36%	-2.54%	12.55%	10.50%	-2.05%	8.58%	6.88%	-1.70%	13.51%	9.05%	-4.46%
Scotland	7.32%	9.76%	2.44%	10.50%	16.73%	6.23%	7.81%	10.27%	2.46%	10.27%	12.82%	2.55%
Wayne	11.53%	7.18%	-4.35%	15.41%	15.74%	0.33%	7.88%	9.66%	1.78%	12.68%	14.54%	1.86%
Wilson	8.35%	10.79%	2.44%	17.22%	15.47%	-1.75%	9.92%	9.20%	-0.72%	15.01%	14.21%	-0.80%

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 2018	FY 2020	Change	FY 2018	FY 2020	Change	FY 2018	FY 2020	Change	FY 2018	FY 2020	Change
	35-64			65+			Unknown			Total		
Bladen	14.34%	14.63%	0.29%	3.39%	5.07%	1.68%	0.00%	0.00%	0.00%	10.27%	9.62%	-0.65%
Duplin	12.44%	19.51%	7.07%	4.89%	7.80%	2.91%	0.00%	0.00%	0.00%	10.35%	11.23%	0.88%
Edgecombe	21.93%	13.09%	-8.84%	9.38%	4.75%	-4.63%	0.00%	0.00%	0.00%	11.69%	8.74%	-2.95%
Greene	12.37%	16.12%	3.75%	6.66%	6.90%	0.24%	0.00%	0.00%	0.00%	8.29%	9.83%	1.54%
Lenoir	17.72%	19.82%	2.10%	5.24%	6.33%	1.09%	0.00%	0.00%	0.00%	10.22%	13.00%	2.78%
Robeson	20.88%	17.21%	-3.67%	6.45%	4.40%	-2.05%	0.00%	0.00%	0.00%	14.43%	11.26%	-3.17%
Sampson	17.29%	11.14%	-6.15%	4.36%	2.96%	-1.40%	0.00%	0.00%	0.00%	11.73%	8.26%	-3.47%
Scotland	12.26%	15.53%	3.27%	5.63%	7.64%	2.01%	0.00%	0.00%	0.00%	8.91%	12.25%	3.34%
Wayne	15.73%	23.14%	7.41%	8.52%	7.85%	-0.67%	0.00%	0.00%	0.00%	12.57%	12.63%	0.06%
Wilson	22.83%	22.45%	-0.38%	11.14%	7.20%	-3.94%	0.00%	0.00%	0.00%	13.64%	13.74%	0.10%

(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 20 contains validation scores for each of the 10 (b) Waiver Performance Measures.

Table 20: (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 21: (c) Waiver Measures Reported Results 2020 - 2021*. Eastpointe provided documentation of data sources, data validation, source code, and calculated rate for the five measures. Additionally, all rates exceeded the State Performance Benchmarks.

Table 21: (c) Waiver Measures Reported Results 2020-2021

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	813/815 = 99.75%	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Annually	813/815 = 99.75%	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	24/25 = 96%	85%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	203/203 = 100%	85%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	Quarterly	2/2 = 100%	85%

** Latest reported rates are shown in Table from Excel files: Annual rates were reported in the 1Q-3Q September 2021 files labeled 16.C.1, 16.C.2, and 16.C.3; Quarterly rates were reported for 1Q-3Q 2021 in Excel files 16.C.4 and 16.C.5.*

(c) Waiver Validation

All (c) Waiver Measures met the validation requirements and were Fully Compliant as shown in *Table 22, (c) Waiver Performance Measure Validation Scores*. The validation worksheets offer detailed information on validation and calculation steps for (c) Waiver Measures.

Table 22: 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
- Data collection procedures
- Improvement strategies

PIP Validation Results

For the 2020 EQR, there were nine active PIPs submitted. Of those nine, four were validated. All PIPs scored in the High Confidence range.

In the 2021 EQR, there were eight PIPs submitted and four were validated: Increase the Percent of Individuals Who Receive a 2nd Service Within or Less Than (≤) 14 Days to 35%- Clinical, Decrease Emergency Department (ED) admissions for Active Members to 20% - Clinical, Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD)- Clinical, and Decrease Percentage of Members who Separate from TCLI Housing to 20% or Less Annually- Non-Clinical. PIP validation was conducted using the *CMS Protocol 1: Validating Performance Improvement Projects*.

Table 23: PIP Summary of Validation Scores

Project Type	Project	2020 Validation Score	2021 Validation Score
Clinical	Increase the Percent of Individuals Who Receive a 2nd Service Within or Less Than (≤) 14 Days to 35%	73/74=99% High Confidence in Reported Results	73/74 = 99% High Confidence in Reported Results
	Decrease Emergency Department (ED) admissions for Active Members to 20%	73/74=99% High Confidence in Reported Results	79/79 = 100% High Confidence in Reported Results
	Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD)	Not Validated	76/79 = 96% High Confidence in Reported Results
Non-Clinical	Decrease Percentage of Members who Separate from TCLI Housing to 20% or Less Annually	73/74=99% High Confidence in Reported Results	74/74 = 100% High Confidence in Reported Results

Table 24 displays the PIP project title and interventions reported by Eastpointe for the current review year aimed at improving PIP outcomes.

Table 24: 2021 Review PIP Interventions

Projects	Interventions
Increase the Percent of Individuals Who Receive a 2nd Service Within or Less Than (≤) 14 Days to 35%	Education to Provider Network (staff at front desk who make appointments) on Initiation of Services; Technical assistance call with walk-in clinics regarding peer support being utilized to increase follow-up rates; Collaborate with state/local hospitals regarding scheduling follow up appointments; Identify transportation resources/Chief of QM reached out to local DSS to inquire about transportation resources.
Decrease Emergency Department (ED) admissions for Active Members to 20%-Clinical	MH/SUD Care Specialist call ED daily; Hospital Transition team are assigned to local hospitals to assist with discharge planning; Clinical Operations to hold interdepartmental meeting to address ED re-admissions concerns; Development of Provider Self-Audit Tool and Workflow; Data review and technical assistance calls with ACTT Providers.
Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD)	Provider Enrichment Forum led by Medical Director and Associate Medical Director; Associate Medical Director presented at May Provider Meeting on the importance of including Diabetes screening/monitoring as a goal on the member's Person-Centered Plan (PCP).
Decrease Percentage of Members who Separate from TCLI Housing to 20% or Less Annually	One-on-one psychoeducation with natural supports, Provide motivational interviewing to TCLI members offering linkage to other supportive services and arranging trainings, monthly Meeting with TMS providers, Quarterly Meeting with IPS/SE, CST, and ACTT providers, Use of My Strengths app with members, ADANC Community Inclusion provider assists with decreasing separations, New CST service definition increases the clinical efficacy of the service, Permanent Supportive Housing (PSH) training, Motivational Interviewing training, and Engagement trainings, housing inspection forms presented to providers to assist members in identified areas.

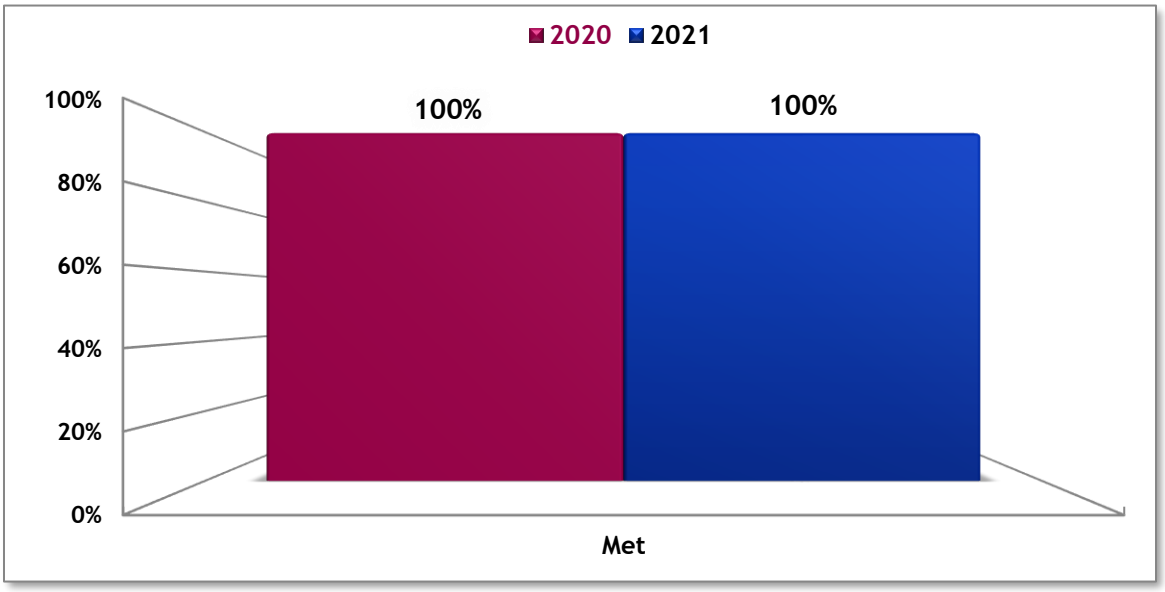
There are no Corrective Actions for the validated PIPS. For 2 of 4 PIPs, there are Recommendations regarding the assessment of interventions and consideration for additional interventions to improve rates due to lack of rate improvement. The project, section, reason, and Recommendations are displayed in Table 25.

Table 25: Performance Improvement Project Recommendations

Project(s)	Section	Reason	Recommendation
Increase the Percent of Individuals Who Receive a 2nd Service Within or Less Than (≤) 14 Days to 35%	Was there any documented, quantitative improvement in processes or outcomes of care?	Rate most recently decreased slightly from 28.5% in Q1 to 25.1% in Q2 for FY 2021. The goal is 35%.	Determine if additional education needs to be implemented for providers. Assess impact of interventions to allow determination of most effective intervention.
Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD)	Was there any documented, quantitative improvement in processes or outcomes of care?	The 2019 rate for SSD was 66.4% and 2020 was 65.5%. Goal is 80%. The SMD rate in 2019 was 36% and in 2020 it was 37%, so the SMD rate improvement (Goal is 70%).	Continue interventions and conduct analysis of interim data to determine if additional interventions should be implemented to focus on the SSD rate.
	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)?	The provider enrichment forum and quarterly data review are showing marginal improvement in SMD rate, but not SSD rate.	As data allow, conduct interventions assessment in relation to SSD rate to assess impact of each intervention.

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 2021 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.

Weaknesses

- There were several (b) Waiver Measures with substantial declines.
- PIP rates did not improve for two of the validated PIPs.

Recommendations

- Continue to monitor (b) Waiver Measure rates to determine if rates with substantial improvement or decline represent a continued trend or an anomaly in the performance measures.
- Increase the Percent of Individuals Who Receive a 2nd Service Within or Less Than (≤) 14 Days to 35% PIP: Determine if additional education needs to be implemented for providers. Assess impact of interventions to allow determination of most effective intervention.

- Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD) PIP: Continue interventions and conduct analysis of interim data to determine if additional interventions should be implemented to focus on the SSD rate.

- Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar disorder Who are Using Antipsychotic Medications to 80% (SSD)PIP: As data allow, conduct interventions assessment in relation to SSD rate to assess impact of each intervention.

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 and procedures, Eastpointe's Organizational Chart, the *Enrollee/Member and Family Handbook* and 11 files of enrollees participating in Mental Health/Substance Use Disorder (MH/SUD), Intellectual/Developmental Disability (I/DD), and TCLI Care Coordination.

In the 2020 EQR, Eastpointe met 96% of UM standards. CCME issued one Corrective Action to develop and document an enhanced quality monitoring process that routinely reviews I/DD Care Coordination documentation. Two Recommendations were issued to update eligibility criteria for Children with Complex needs and to update Eastpointe's Policy C-3.3.22 Resource Allocation and Individual Budgets. The implementation of the Corrective Action and Recommendations is presented in Table 26.

Table26: 2020 EQR Utilization Management Findings

2020 EQR Utilization Management Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Assess each Medicaid enrollee identified as having special health care needs;	***Recommendation: Update Policy C-3.4.16 Complex Case Management and the Enrollee/Member and Family Handbook to reflect the criteria listed in NC Medicaid Contract Section 6.11.3.(c) g, for Children with Complex Needs.***	**Y**
2021 EQR Follow up: For the 2021 EQR, this Recommendation was addressed. Eastpointe updated the Enrollee/Member and Family Handbook and provided clarification during the Onsite regarding the age eligibility listed in Policy C-3.4.16 Complex Case Management.		

2020 EQR Utilization Management Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Determination of which Behavioral Health Services are medically necessary;	***Recommendation: Update Policy C-3.3.22 Resource Allocation and Individual Budgets to include the exclusion to waiver cost limits as listed in NC Joint Communication Bulletin J362.***	**Y**
2021 EQR Follow up: For the 2021 EQR, this Recommendation was addressed. Eastpointe updated Policy C-3.3.22 Resource Allocations and Individual Budgets to include the exemptions listed in NC Joint Communication Bulletin J362.		
The PIHP applies the Care Coordination policies and procedures as formulated.	***Corrective Action: Develop and document an enhanced quality monitoring process that routinely reviews I/DD Care Coordination documentation. This quality monitoring process should review I/DD progress notes and I/DD Monitoring Checklists for completeness, accuracy and compliance with Eastpointe policies and the NC Medicaid Contract and NC Medicaid Contract Amendment 9, Section 9. The quality monitoring process should also include routine review of ISPs to ensure they are person-centered and reflect the needs identified in assessments and other support tools.***	**N**
2021 EQR Follow up: This Corrective Action was partially implemented. For the 2021 EQR, Eastpointe updated the I/DD Monitoring plan, but CCME identified discrepancies in Care Coordination progress notes and other documentation.		

The 2021 EQR of Care Coordination files showed significant improvement in the timeliness of progress notes and compliance with required Care Coordination activities, such as discharging enrollees from Care Coordination and TCLI programs. However, compliance issues were found in three Care Coordination files.

In the 2021 EQR of Care Coordination files, found one I/DD file did not follow the requirements, as outlined in the *NC Medicaid Contract* and *Contract Amendments*. The referenced case involved an adult enrollee whose Legal Responsible Person (LRP) was also a Relative as a Direct Support Employee (RADSE). For five months, the monthly service review was conducted via text messages with the adult enrollee. *NC Medicaid Contract 6.11.3.(h)(7)* requires monthly face-to-face monitoring of enrollees whose services are provided by guardians or relatives living in the home with the enrollee. Additional guidance outlined in *NC Medicaid Contract Amendment 11, Section 7*, allows the monthly

service review to be completed via telephone or video conference during the Covid-19 Stay at Home Order. Further, NC Medicaid recently clarified with all PIHPs, "that while the preferred method [to complete monthly Care Coordination service review] is face-to-face, telephone calls and or video conferencing are the allowed methods." Neither communication allows for review via texts.

In another I/DD Care Coordination file, services identified in the Risk Assessment and Individual Support Plan (ISP) were not implemented. The Risk Assessments for 2019 and 2020 identified Specialized Consultation Services as a need. However, the enrollee's current ISP did not show the implementation of this service. *NC Medicaid Contract Section 6.11.3 (h) o,* lists *"Monitoring of services delivery to verify that: (2) Services are furnished in accordance with the ISP"* as a function of the PIHP. Moreover, the *NC Innovations Waiver Technical Guide Chapter 9,* states that, "The Care Coordinator ensures that the authorized NC Innovations services in the ISP are implemented by working with the participant and/or the legally responsible person, and the providers selected by the participant".

The review of MH/SUD files found once incident of inadequate follow-up to ensure the health and well-being of an enrollee after allegations of abuse. In one MH/SUD file, an enrollee reported allegations of abuse while receiving treatment at a Psychiatric Rehabilitation Treatment Facility (PRTF). According to progress notes, the Care Coordinator made only one attempt to follow up with the PRTF and LRP two days after the allegation. *NC Medicaid Contract Section 6.11.3(f)* lists "Follow up and attempt to resolve any issues related to the Enrollee's health, safety or service delivery, bringing any unresolved issues to the attention of the appropriate PIHP staff member and designated behavioral health provider or medical provider for resolution" as a function of Care Coordination. CCME and NC Medicaid discussed this case and assert additional follow up to ensure the enrollee's safety, and the safety of any other enrollees residing at the PRTF, was needed.

CCME has issued a Corrective Action for Eastpointe to enhance the current monitoring plan to include a quality review checklist of MH/SUD/I/DD Care Coordination documentation. The quality review should:

- Ensure that I/DD monthly Care Coordination service reviews are face-to-face, or by allowed methods listed in *NC Contract Amendment 11, Section 7.*
- Ensure that needs and services identified in assessments and other support tools are reflected in the ISP and the implementation of services has been arranged by Care Coordination.
- Ensure that 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.

CCME issued a Recommendation that Eastpointe develop and implement staff trainings and guidelines regarding Care Coordination service monitoring, service implementation, and enrollee follow-up that 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*, *NC Innovations Waiver Technical Guide*, and *NC Incident Response Improvement System Manual*.

For this EQR, TCLI showed significant improvement in the timeliness of progress notes and other documentation. The review also found that TCLI staff took more proactive steps to address crises and barriers to services.

Figure 5 shows 96% of the UM standards in the 2021 EQR were scored as "Met" and 4% as "Partially Met" and provides an overview of 2021 scores compared to the 2020 scores.

Figure 5: Utilization Management Comparative Findings

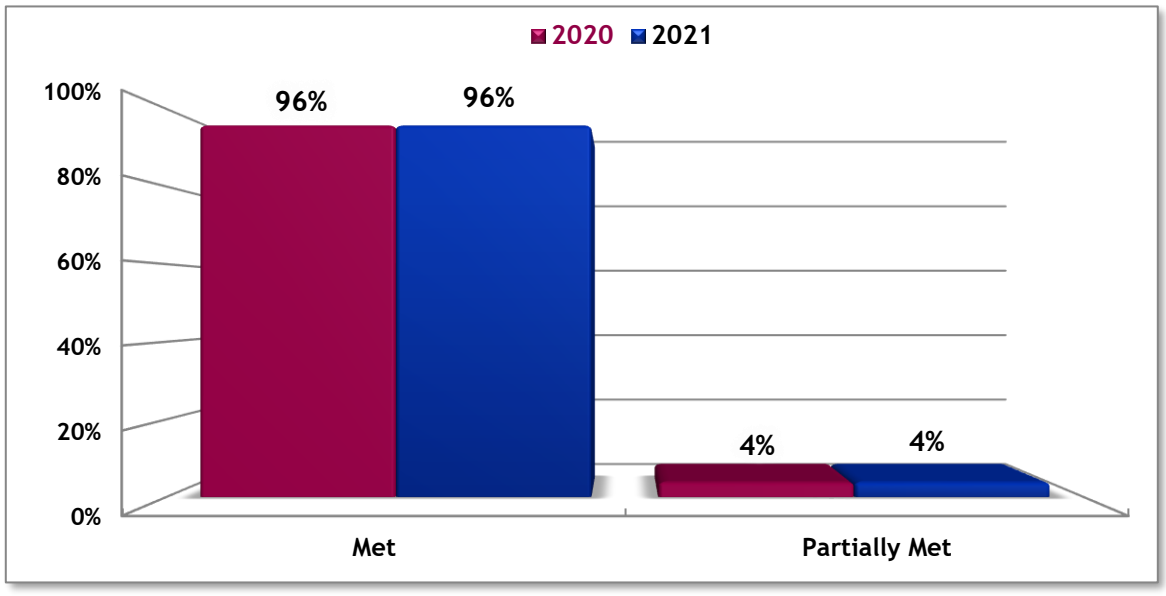


Table 27: Utilization Management

Section	Standard	2021 Review
Care Coordination	**The PIHP applies the Care Coordination policies and procedures as formulated.**	**Partially Met**

Strengths

- Eastpointe successfully passed initial NCQA accreditation as a Managed Behavioral Health Organization, scoring 100% on the Complex Case Management program for children.

- I/DD Care Coordination continued to make face-to-face visits during the Covid-19 Stay at Home Order to ensure the health and safety of members who were difficult to contact by phone.

Weaknesses

- The current monitoring plan does not include a quality review of Care Coordination documentation that ensures I/DD ISPs reflect needs identified in assessments, that ensures services are implemented as outlined, that monitors how monthly contacts are made, and that follow-up notifications are made with all required parties when incidents occur.

Corrective Action

- Enhance the current monitoring plan to include a quality review checklist of MH/SUD/I/DD Care Coordination documentation. The quality review should: Ensure that I/DD monthly Care Coordination service reviews are conducted face-to-face or by allowed methods listed in *NC Contract Amendment 11, Section 7*; Ensure that 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 that when incidents (as defined by 10A NCAC 27G .0103(b)(32) occur, the required notifications 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 that 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*, *NC Innovations Waiver Technical Guide*, and *NC Incident Response Improvement System Manual*.

E. Grievances and Appeals

42 CFR § 438, Subpart F

The Grievances and Appeals EQR included a Desk Review of policies and procedures, 10 Grievance and 10 Appeal files, the Grievance and Appeal Logs, the *Provider Operations Manual*, *The Enrollee/Member and Family Handbook,* and information about Grievances and Appeals available on the Eastpointe website. An Onsite discussion with Grievance and Appeal staff occurred to further clarify PIHP's documentation and processes.

In the 2020 EQR, Eastpointe met 90% of the Grievance and Appeal standards and received two Corrective Actions in Grievances and one Recommendation in Appeals. Follow up to the 2020 EQR Grievance and Appeal Recommendations is detailed in the following respective sections.

In this 2021 EQR, Eastpointe met 100% of the Grievance and Appeal standards, resulting in no Corrective Actions. CCME issued two Recommendations in the Grievance section and no Recommendations in the Appeal section.

Grievances

In the 2020 EQR, two Corrective Actions were issued, primarily targeting incorrect language within Eastpointe's Grievance policy and compliance issues within Eastpointe's Grievance files. In the 2021 EQR, there was evidence that Eastpointe addressed all Grievance Corrective Actions issued in the 2020 EQR.

Table 28 outlines CCME's review to ensure those Recommendations were implemented by Eastpointe.

Table 28: 2020 EQR Grievance Findings

2020 EQR Grievance Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Timeliness guidelines for resolution of the Grievance as specified in the contract.	***Corrective Action: Add language to Policy Q-6.4.4 that Eastpointe will notify enrollees of their right to file a Grievance if the enrollee disagrees with Eastpointe's decision to extend the Grievance resolution timeframe. This will bring Eastpointe's policy into compliance with NC Medicaid Contract, Attachment M.6 and 42 CFR § 438.408 (c)ii.***	**Y**
2021 EQR Follow Up: Eastpointe provided Policy Q-6.4.4, revised June 16, 2021, that included the information on the right to file a Grievance if the grievant disagrees with Eastpointe's Grievance resolution extension.		

2020 EQR Grievance Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The PIHP applies the Grievance policy and procedure as formulated.	***Corrective Action: Develop, document, and implement a monitoring plan to increase compliance with required Grievance notifications. This monitoring plan should include the timeline for implementation, frequency of monitoring, staff that will implement the monitoring, compliance benchmarks, and how and when outcomes of monitoring are captured, reviewed, and reported. Monitoring should ensure Grievance notifications are compliant with Eastpointe's Grievance policies, NC Medicaid Contract, Attachment M and 42 CFR § 438.408 (b)2. Include in this monitoring plan the timeframe by which Eastpointe will resolve any provider Grievances placed on hold by Provider Monitoring Department.***	**Y**
2021 EQR Follow Up: The 2021 EQR shows evidence that Eastpoint is using the Grievance & Appeal Documentation Checklist to monitor resolutions times and issue timely notifications.		

In the 2021 EQR, 10 Grievance files were reviewed. Eight of the 10 files were compliant with 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 Grievance file showed the acknowledgment notice was sent in 28 days versus the five business days required by Eastpointe's Grievance policy. This was an improvement over last year's EQR where there were four late resolution notifications. CCME has issued a Recommendation to continue to monitor Grievance notification timeframes to ensure all Grievance notifications are issued timely and in compliance with *NC Medicaid Contract, Attachment M, Section C, 42 CFR § 438* and Eastpointe's Policy Q-6.4.4, Member/Enrollee and Stake Holder Grievance/Complaint and Appeals.

In addition, CCME noted errors on the Eastpointe Grievance Log when compared to the Grievance files reviewed. Eastpointe staff indicated that different staff enter data on the log at different times in the Grievance resolution process. CCME has issued a Recommendation to provide training to all staff entering data on the Grievance Log that guides them on documenting the correct dates and data points. This training is essential as the Grievance Log is the primary data source for Grievances and is used in compliance monitoring.

Appeals

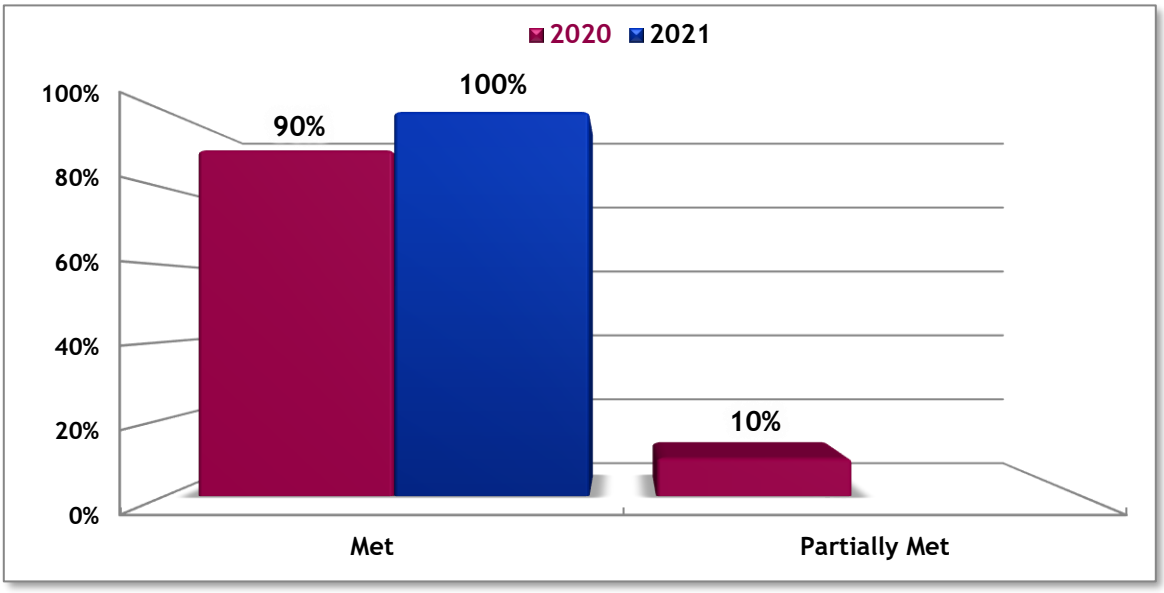
In the 2020 EQR of Appeals, CCME issued one Recommendation and no Corrective Actions. The Recommendation targeted documentation in the *Provider Operations Manual* around Eastpointe's requirement to notify enrollees of their right to file a Grievance if they disagree with Eastpointe's extension to the Appeal resolution timeframe. This notification is required by the *NC Medicaid Contract, Attachment M, 42 CFR 438.408 (c)*, and Eastpointe's Appeal policy. Table 29 outlines CCME's review to ensure Eastpointe implemented the Recommendations.

Table 29: 2020 EQR Appeals Findings

2020 EQR Appeal Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Other requirements as specified in the contract.	***Recommendation: Add to the Provider Operations Manual that Eastpointe will notify the enrollee of his right to file a Grievance if Eastpointe extends the Appeal resolution timeframe.***	**Y**
2021 EQR Follow Up: The Provider Operations Manual FY 2021-2022, effective July 1, 2021, showed that Eastpointe revised the manual to state Eastpointe will notify the enrollee of their right to file a Grievance if they disagree with Eastpointe's extension to the Appeal resolution timeframe.		

In the 2021 EQR, 10 Appeal files were reviewed. One file showed the Appeal resolution notification was mailed two days beyond the 30-day timeframe required by *NC Medicaid Contract, Attachment M, 42 CFR 438.408*, and Eastpointe's Appeal policy. Staff explained this was an isolated incident and a plan of correction was implemented to make sure all resolutions letters are ready by a specific cut-off time each day to ensure they are mailed timely. There were no other deficiencies in the files reviewed in this year's EQR, which was an overall improvement when compared to last year's EQR.

Figure 6: Grievances and Appeals Comparative Findings



Strengths

- Interdepartmental coordination was evident in the Grievance and Appeal files reviewed.
- Eastpointe's process for monitoring Appeals resulted in significant improvement in compliance when compared to the previous EQR.

Weaknesses

- Two of the ten Grievance files reviewed showed noncompliance with required notification timeframes.
- The Eastpointe Grievance Log contained several data entry errors.

Recommendations

- Continue to routinely monitor Grievance notification timeframes to ensure all notifications are issued timely 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.
- Train staff on Grievance Log data entry to ensure data on the log is consistent, complete, and accurate.

F. Program Integrity

42 CFR § 455, 42 CFR § 438.455 and *1000* through *1008, 42 CFR § 1002.3(b)(3), 42 CFR 438.608 (a)(vii)*

The 2021 Program Integrity EQR for Eastpointe encompassed a thorough Desk Review of PIHP Program Integrity (PI) function. The review included policies and procedures related to Special Investigations Unit (SIU), Provider Overpayments, and related aspects of compliance.

The EQR also covers PI staffing, workflows, reports, training materials, committee minutes, and data mining, as well as a file review of randomly sampled cases that were active during the period under review. Finally, interviews with the Eastpointe staff occurred during the Onsite. All reviews are based on federal codes of regulation, particularly *42 CFR § 438.455* and *42 CFR § 438.608*, as well as the *NC Medicaid Contract Section 14, Program Integrity*.

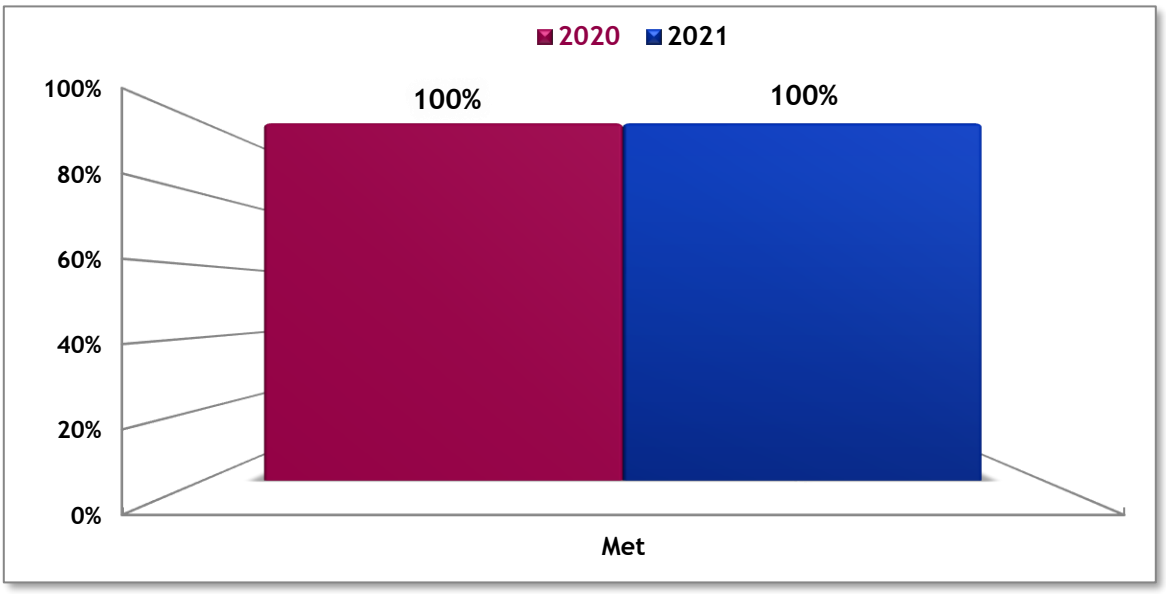
In the 2020 EQR, Eastpointe met all of the Program Integrity EQR standards, and no Corrective Actions or Recommendations were issued.

In the 2021 EQR, Eastpointe again met all of the Program Integrity EQR standards. Eastpointe's PI policies provide details regarding the following aspects of Eastpointe's PI function: staffing and organizational structure, training of PIHP staff, network providers and the Board of Directors, participation in regular meetings with NC Medicaid, committee structures, investigative processes (detecting, investigating, and reporting), required reports to NC Medicaid (attachment Y, K, Z), proper documentation of referrals to NC Medicaid, and the usage of FAMS. Eastpointe also provided a comprehensive PI Process Manual with detailed workflow instructions.

Eastpointe provided curriculum for training of staff, providers, and the Board of Directors. Eastpointe provided detailed meeting minutes from its monthly meetings with NC Medicaid, and NC Medicaid confirmed that Eastpointe had met all reporting requirements. There was detailed discussion on Eastpointe's PI caseload. During the interview, Eastpointe explained all investigations were put on hold from March 2020 through August 2020 due to the COVID 19 flexibilities Contract Amendment. However, the Director of PI detailed how the PI team continued to work internally on all open cases to be prepared to resume investigations. This preparation enabled the PI team to focus their efforts once the hold on investigations was lifted. During the Onsite discussion, staff also explained Eastpointe's risk rating system on new cases, which allows them to put their focus on cases considered to be "major" risks and keep their backlog of investigations small. Currently, Eastpointe has no open cases older than 2020.

In the 2021 EQR Desk Review, 15 files were reviewed to evaluate the timeliness of initiating the investigation and to ensure all required elements are documented in referrals to NC Medicaid. Eastpointe case files contained all the required elements.

Figure 7: Program Integrity Comparative Findings



Strengths

- Eastpointe uses data mining, with support from both IBM and internal staff. Currently, more than a third of new Eastpointe PI cases resulted from data mining efforts.
- Review of Eastpointe's PI functions showed strong interdepartmental collaboration with provider relations, claims, UM, and quality teams.

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 2020 through December 2020. 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 code was populated consistently where appropriate. However, Other Diagnosis codes were often missing, especially on Professional claims.

This issue has been present since at least the 2018 review, when it was noted that only the Principal and Secondary Diagnosis codes were being submitted. In general, claims from certain providers are missing the Other Diagnosis codes at an extremely high rate, including instances where they are missing on 100% of the claims. In the meantime, 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 on all claims are 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 claims are 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, CCME has concluded that the data submitted to NC Medicaid is complete and accurate as defined by NC Medicaid standards. The most notable issue involves 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 payment model. 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, it is recommended that the encounter data from NCTracks be reviewed to look at encounters that pass front end edits and are adjudicated to either a paid or denied status. It is difficult to reconcile the various tracking reports with the data submitted by the PIHP. Reviewing an extract from NCTracks would provide insight into how NCTracks is handling the encounter claims and could be reconciled back to reports requested from Eastpointe. The goal is to ensure that Eastpointe is reporting all paid claims as encounters to NC Medicaid.

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

September 7, 2021

Ms. Sarah Stroud
Chief Executive Officer
Eastpointe Behavioral Health
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 2021 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 #9, the 2021 EQR will be a focused review. The focus of this review will be on the PIHP's Corrective Actions from the previous EQR and PIHP functions that impact enrollee health and safety. Similarly, for the 2021 EQR, the two day Onsite previously performed at PIHP offices will conducted during a one day, virtual Onsite. The CCME EQR review team plans to conduct the virtual Onsite on **October 21, 2021**. For your convenience, a tentative agenda for this one-day, virtual review is enclosed.

In preparation for the Desk Review, the items on the enclosed **Desk Materials List** are to be submitted electronically. **Please note that, to facilitate a timely review, there are three items on the Desk Materials List (items 9, 10, and 19.a) that should be submitted by no later than September 10, 2021,** and the remaining items are due by no later than **September 28, 2021**. 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 **September 28, 2021.**

Also, please note that for this year's upload of Encounter Data, the data should be uploaded into the folder labelled "EDV" within CCME's secure documentation portal along with all other EQR materials. The location for the file transfer site is: https://eqro.thecarolinascenter.org

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

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

Enclosure(s) – 5

Cc: Anna North, Eastpointe Waiver Contract Manager
Tasha Griffin, NC Medicaid Waiver Contract Manager
Deb Goda, NC Medicaid Behavioral Health Unit Manager
Hope Newsome, NC Medicaid Quality Specialist
Doreatha McCoy, NC Medicaid Quality Specialist

Eastpointe

Focused External Quality Review 2021

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 10, 2021. The remainder of items must be uploaded by no later than September 28, 2021.**

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 (September 2020 through August 2021). Include the date of approval of initial credentialing and the date of approval of recredentialing.

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

7. Minutes of committee meetings for the following committees:

   a) Credentialing (for the three most recent committee meetings)
   b) UM (for the three most recent committee meetings)
   c) Any clinical committee meeting minutes showing discussion of Clinical Practice Guidelines impacted by COVID-19.

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

9. ****By September 10, 2021**, a copy of the complete Appeal log for the months of September 2020 through August 2021. Please indicate on the log: the appeal type (standard, expedited, extended, withdrawn, or invalid), the service appealed, the date the appeal was received, and the date of appeal resolution notification.

10. **By September 10, 2021, a copy of the complete Grievances log for the months of September 2020 through August 2021. Please indicate on the log: the nature of the grievance, the date received, and the date of grievance resolution.

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

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

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

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

15. For Care Coordination enrollees files, please provide:
    a. three MH/SU Care Coordination enrollee files (two active since 2019 and one recently discharged)
    b. three I/DD Care Coordination enrollee files (two active since 2019 and one recently discharged)
    c. four TCLI Care Coordination enrollee files (one active since 2019, 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:

        i. Insurance:

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

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

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

        iii. Ownership disclosure information/form.

    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 include 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.

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

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

v. Ownership disclosure information/form.

NOTE: Appeals, Grievances, and Program Integrity files will be selected from the logs submitted on September 10, 2021. A request will then be sent to the plan to send electronic copies of the files to CCME. The entire file will be needed.

19. Provide the following for Program Integrity:

a. ****File Review: By September 10, 2021**, Please produce a listing of all active files during the review period (September 2020 through August 2021). 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. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.

d. Workflow of process of taking complaint from inception through closure.

e. All 'Attachment Y' reports collected during the review period.

f. All 'Attachment Z' reports collected during the review period.

g. Provider Manual and Provider Application.

h. Enrollee Handbook.

i. Subcontractor Agreement/Contract Template.

j. Training and educational materials for the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse and the False Claims Act.

k. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse.
l. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors, and employees.
m. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to NC Medicaid or any other State or Federal agency.
n. Code of Ethics and Business Conduct.
o. Internal and/or external monitoring and auditing materials.
p. Materials pertaining to how the PIHP captures and tracks complaints.
q. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
    i. NC Medicaid approved reporting templates.
r. Sample Data Mining Reports.
s. NC Medicaid Monthly Meeting Minutes for entire review period, including agendas and attendance lists.
t. Monthly reports of NCID holders/FAMS-users in PIHP.
u. Any program or initiatives the plan is undertaking related to Program Integrity including documentation of implementation and outcomes, if appropriate.
v. Corrective action plans including any relevant follow-up documentation.
w. Policies/Procedures for:
    i. Program Integrity
    ii. HIPAA and Compliance
    iii. Internal and external monitoring and auditing
    iv. Annual ownership and financial disclosures
    v. Investigative Process
    vi. Detecting and preventing fraud
    vii. Employee Training
    viii. Collecting overpayments
    ix. Corrective Actions
    x. Reporting Requirements
    xi. Credentialing and Recredentialing Policies
    xii. Disciplinary Guidelines

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

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

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

c. A copy of the IT Disaster Recovery Plan.

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

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

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

b. Include all adjudicated claims (paid and denied) from January 1, 2020 – December 31, 2020. Follow the format used to submit encounter data to NC Medicaid (i.e., 837I and 837P). If you archive your outbound files to NC Medicaid, you can forward those to HMS for the specified time period. In addition, please convert each 837I and 837P to a pipe delimited text file or excel sheet using an EDI translator. If your EDI translator does not support this functionality, please reach out immediately to HMS.

c. Provide a report of all paid claims by service type from January 1, 2020 – December 31, 2020. Report should be broken out by month and include service type, month and year of payment, count, and sum of paid amount.

NOTE: THIS IS A CHANGE FROM PREVIOUS EQRS: Please upload the Encounter Data, along with the other Desk Materials, to CCME's secure portal into the folder labelled "EDV".

B. Attachment 2: EQR Validation Worksheets

CCME EQR PM Validation Worksheet

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

NOTE: DUE TO TIMING OF THE EQR, THE FY2020 RATES WERE REPORTED FOR TWO CONSECUTIVE REVIEWS FOR EASTPOINTE.

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS			
North Carolina Medicaid Technical Specifications			
GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Readmission Rates for Substance Abuse**
Reporting Year:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS			
North Carolina Medicaid Technical Specifications			
GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Follow-up After Hospitalization for Mental Illness**
Reporting Year:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Follow-up After Hospitalization for Substance Abuse**
Reporting Year:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

PIHPs Measure Score	**50**
Measure Weight Score	**50**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**
Reporting Year:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS			
North Carolina Medicaid Technical Specifications			
GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Mental Health Utilization- Inpatient Discharged and Average Length of Stay**
Reporting Year:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Mental Health Utilization**
Reporting Year:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Identification of Alcohol and Other Drug Services**
Reporting Year:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Substance Abuse Penetration Rate**
Reporting Year:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Mental Health Penetration Rate**
Reporting Year:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations PM Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC
Reporting Year:	**2020-2021**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS			
State PIHP Reporting Schedule- Innovations Measures			
GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations PM Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	Proportion of beneficiaries reporting they have a choice between providers. IW D10
Reporting Year:	**2020-2021**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS			
State PIHP Reporting Schedule- Innovations Measures			
GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations PM Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	Percentage of level 2 and 3 incidents reported within required timeframes. IW G2
Reporting Year:	**2020-2021**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS			
State PIHP Reporting Schedule- Innovations Measures			
GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations PM Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	Percentage of beneficiaries who received appropriate medication. IW G5
Reporting Year:	**2020-2021**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS			
State PIHP Reporting Schedule- Innovations Measures			
GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations PM Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8
Reporting Year:	**2020-2021**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS			
State PIHP Reporting Schedule- Innovations Measures			
GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Eastpointe**

Name of PIP:	INCREASE THE PERCENT OF INDIVIDUALS WHO RECEIVE A 2ND SERVICE WITHIN OR LESS THAN 14 DAYS TO 35%
Reporting Year:	2020/2021
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling 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 claims and encounter data- quarterly performance measures.
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 claims data.
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.

Component / Standard (Total Points)	Score	Comments
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed and reported quarterly.
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**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and line graphs for quarterly 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 quarters and interpretation of rate.
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)**	**NOT MET**	Rate most recently decreased slightly from 28.5% in Q1 t0 25.1% in Q2 for FY 2021. The goal is 35%. ***Recommendations: Determine if additional education needs to be implemented for providers. Assess impact of interventions to allow determination of most effective intervention.***
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 noted.
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	0
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	**73**
Project Possible Score	**74**
Validation Findings	**99%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PIP:	**Decrease Emergency Department (ED) admissions for Active Members to 20%**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported 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
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.

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection 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 rate reduced from 36% to 30% (improvement as lower rate is better). Goal is 20%.
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 impacting 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:	**INCREASE DIABETES SCREENING FOR PEOPLE (18-64) WITH SCHIZOPHRENIA OR BIPOLAR DISORDER WHO ARE USING ANTIPSYCHOTIC MEDICATIONS TO 80% (SSD)**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported 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
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.

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection 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)**	**PARTIALLY MET**	The 2019 rate for SSD was 66.4% and 202 was 65.5%. Goal is 80%. The SMD rate in 2019 was 36% and in 2020 it was 37%, so the SMD rate improvement (Goal is 70%). ***Recommendation: Continue interventions and conduct analysis of interim data to determine if additional interventions should be implemented to focus on the SSD 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)**	**PARTIALLY MET**	The provider enrichment forum and quarterly data review are showing marginal improvement in SMD rate, but not SSD rate. ***Recommendation: As data allow, conduct interventions assessment in relation to SSD rate to assess impact of each intervention.***
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	0
9.2	5	3
9.3	NA	NA
9.4	NA	NA

Project Score	**76**
Project Possible Score	**79**
Validation Findings	**96%**

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:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling 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.
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.

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 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.*

C. Attachment 3: Tabular Spreadsheet

I. Information Systems Capabilities Assessment (ISCA)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I A. Management Information Systems						
1. Enrollment Systems						
1.1 The 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. WellSky uploads the daily and quarterly GEF files to the Alpha+ enrollment system. Eastpointe uses the monthly 820 capitation 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, and patients' IDs are unique to members. Historical enrollment information is captured and maintained for all members.
1.2 The PIHP is able to identify and review any errors identified during, or as a result, of the State enrollment file load process.	X					During the Onsite, Eastpointe stated that they capture and store GEF records that cannot be loaded to Alpha+ in an error table. Eastpointe typically encounters errors related to demographic data, date of birth issue, mismatch on Social Security Number, or date of birth.
1.3 The PIHP's enrollment system member screens store and track enrollment and demographic information.	X					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. Eastpointe validates the Medicaid ID that is submitted on a claim with the previous seven Medicaid IDs that are stored in the Alpha+ system while adjudicating a claim.

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%). For claims received in 2020, 98.81% of Institutional and 98.99% of Professional claims were auto-adjudicated on a nightly basis. 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 has processes in place to monitor and audit claims staff; routine audits are performed. Eastpointe audits a random sample of 3% of all claims processed on a monthly basis. High dollar claims, which are greater than $5,000, are pended for manual review and are audited on a weekly basis. Newly hired claim examiners who perform manual review of claims are audited for the initial three months daily. Claims examiners who have an error rate that is greater than 3% are also audited daily.
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, capabilities 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.

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					During the Onsite, 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.
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.
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. Eastpointe did not have any negative business impact due to the ongoing COVID-19 pandemic. A disaster recovery manual was provided along with the ISCA tool.
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.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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. During the Onsite, Eastpointe staff stated that their IT, Claims, Provider Networks and Contracts Departments conduct weekly meetings to resolve outstanding encounter data denial issues.
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 an encounter acceptance rate of 99.7%. Eastpointe has significantly increased their encounter acceptance rate from the 95% that was observed in last year's EQR.
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 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.***

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 describe 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 has 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). As was the case at the last EQR, there is some conflicting language within the *Credentialing Manual* about the credentialing/ recredentialing process (e.g., applications go to Medversant, versus applications are submitted to CAQH and are sent to Medversant, versus applications are submitted to the PIHP). ***Recommendation*: *As recommended at the last EQR, reconcile the language within the Eastpointe Credentialing Manual about the process.***
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 is not present at the meeting." During the Onsite, Dr. Doniparthi stated, "Dr. Hosseini now chairs the committee in my absence."

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. There is conflicting language in the *Credentialing Committee By-Laws* (*By-Laws*) and the *Credentialing Manual* about the composition of the Credentialing Committee. The voting members listed in the *By-Laws* are the Associate Medical Director (Chairperson) and "At least three active participating Network Practitioners to represent Mental Health, Substance Abuse and Intellectual and Developmental Disabilities. *A representative from a provider of Residential services" (though there is no additional information regarding the *). The "Composition" of the Credentialing Committee listed in the *Credentialing Manual* includes "2. I/DD and Residential provider At least three Active Participating Network Practitioners, representing the MCO Provider Network from the following provider types" (followed by a list of six provider types, such as Psychiatrist, Licensed Clinical Social Worker" and others). It is unclear if the "I/DD and Residential provider" is meant to be one or two different providers and whether that provider (or those providers) is/are in addition to the "At least three Active Participating Network Practitioners..." in item #2. The Non-Voting Members list in the *By-Laws* includes "Provider Relations Support Specialist", and the Non-Voting Members list in the *Credentialing Manual* lists "Network Support Specialist(s)", which appears to be the current position title. Further, the submitted *By-Laws* list an incorrect date for approval. The *By-Laws* state "The Credentialing Committee By-laws were reviewed and approved by the Credentialing Committee on 08/27/2020.", though it is followed by the electronic signature of the Associate Medical Director dated "9/1/2021", and the submitted Credentialing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Committee meeting minutes for the August 27, 2021, meeting indicate the *By-Laws* were approved at that meeting. During the Onsite, Eastpointe staff confirmed the *By-Laws* were approved on August 27, 2021, and the date of 08/27/2020 on the document is a typographical error. ***Recommendations: 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.***
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					
3.1.5 Work History	X					
3.1.6 Malpractice claims history;	X					
3.1.7 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.8 Query of the National Practitioner Data Bank (NPDB);	X					
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					
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. No issues were identified in the file review.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
4.2.5 Malpractice claims since the previous credentialing event;	X					
4.2.6 Practitioner attestation statement;	X					
4.2.7 Requery of the National Practitioner Data Bank (NPDB);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.8 Requery for state sanctions and/or license limitations (State Board of Examiners for specific discipline) since the previous credentialing event; and query of the State Exclusion List;	X					
4.2.9 Requery of the SAM.	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (OIG LEIE);	X					
4.2.11 Requery of the Social Security Administration's Death Master File	X					
4.2.12 Requery of the NPPES;	X					
4.2.13 Names of hospitals at which the physician has admitting privileges, if any.	X					
4.2.14 Ownership Disclosure is addressed.	X					
4.3 Site reassessment if the provider has had quality issues.	X					The *Credentialing Manual* addresses quality of care issues.
4.4 Review of provider profiling activities.	X					The *Provider Credentialing Operations Manual/Plan* states, "As part of the re-credentialing process, the PRAR sends out the Quality

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Review Tool (QRT) to Provider Monitoring, Program Integrity, Grievance and Appeal, Quality Assurance and Network Operations. These departments gather information related to the providers and report back to Network Operations related to any complaints and quality of care concerns for services provided. All Quality of Care (QOC) issues are reported to and discussed in the Credentialing Committee." 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. The *MCO Provider Sanctions Grid* is posted in the Manuals and Information section of the Provider section of the Eastpointe website. The *MCO Provider Sanctions Grid* is "Version date 5-17-17". 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. ***Recommendation: Ensure posted information, such as the MCO Provider Sanctions Grid, is accurate and current.***
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					The *Credentialing Manual* states, "Eastpointe monitors Accreditation for required providers at least on a quarterly basis and verifies at the time of re-credentialing as part of the application process."

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. The (b) Waiver measure validation was unchanged from the previous EQR due to the timing of the EQR. There were several (b) Waiver Measures with substantial declines. ***Recommendation: Continue to monitor (b) Waiver Measure rates to determine if rates with substantial improvement or decline represent a continued trend or an anomaly in the performance measures.***
III. B Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					Eastpointe submitted eight active projects for this 2021 EQR. These four were validated: • Increase the Percent of Individuals Who Receive a 2nd Service Within or Less Than (≤) 14 Days to 35% • Decrease Emergency Department (ED) admissions for Active Members to 20% • Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD) • Decrease Percentage of Members who Separate from TCLI Housing to 20% or Less Annually

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					All four validated PIPs scored in the High Confidence range, although two PIPs had sections with concerns that should be addressed by the Recommendations in Table 25. ***Recommendations:*** • ***Increase the Percent of Individuals Who Receive a 2nd Service Within or Less Than (≤) 14 Days to 35%: Determine if additional education needs to be implemented for providers. Assess impact of interventions to allow determination of most effective intervention.*** • ***Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD): Continue interventions and conduct analysis of interim data to determine if additional interventions should be implemented to focus on the SSD rate.*** • ***Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD): As data allow, conduct interventions assessment in relation to SSD rate to assess impact of each intervention.***

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					
2. The case coordination program includes:						
2.1 Staff available 24 hours per day, seven days per week to perform telephone assessments and crisis interventions;	X					
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	X					
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					During the 2020 EQR, CCME issued a Recommendation for Eastpointe to update Policy C-3.4.16 Complex Case Management and the *Enrollee/Member and Family Handbook* to reflect the criteria listed in *NC Medicaid Contract Section 6.11.3.(c), Section g*, for Children with Complex Needs. This Recommendation was addressed. During the Onsite, Eastpointe explained that the Complex Case Management program includes youth ages 3-21 years, and its criteria for Children with Complex Needs meets the NC Medicaid Contract requirements as listed in Eastpointe's *Enrollee/Member and Family Handbook* and *Complex Case Management Program Description*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 Guide the develop treatment plans for enrollees that meet all requirements;	X					
2.5 Quality monitoring and continuous quality improvement;	X					
2.6 Determination of which Behavioral Health Services are medically necessary;	X					During the 2020 EQR, CCME issued a Recommendation for Eastpointe to Update Policy C-3.3.22 Resource Allocation and Individual Budgets to include the exclusion to the Innovation Waiver cost limits as listed in *NC Joint Communication Bulletin J362*. This Recommendation was addressed.
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					
2.8 Coordinate care with each Enrollee's provider;	X					
2.9 Provide follow-up activities for Enrollees;	X					

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				For the 2020 EQR, CCME issued a Corrective Action for Eastpointe to develop and document an enhanced quality monitoring process that routinely reviews I/DD Care Coordination documentation to ensure compliance with Eastpointe policies and the *NC Medicaid Contract* and *NC Medicaid Contract Amendment 9, Section 9*. This quality monitoring process should include a review of I/DD progress notes and I/DD Monitoring Checklists for completeness and accuracy and a review of ISPs to ensure they are person-centered and reflect the needs identified in assessments and other support tools. The Corrective Action was partially addressed. Eastpointe updated the I/DD Monitoring Plan; however, similar discrepancies were identified for this EQR. The review of Care Coordination files for this year's EQR found three concerns, which included: • I/DD Care Coordination monthly service reviews did not follow the flexibilities outlined in *NC Medicaid Contract and Contract Amendments*. • Inadequate I/DD service implementation • Inadequate follow-up with the enrollee/LRP/Network Provider to ensure health and safety

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						I/DD Care Coordination monthly service review Documentation in one I/DD file revealed that, for five months, text messaging was the method used to complete monthly monitoring with an Innovations enrollee and LRP, who was also the Relative as a Direct Support Employee (RADSE). According to a December 16, 2020, progress note, text messaging was the preferred method of communicating with the enrollee and LPR/RADSE. *NC Medicaid Contract 6.11.3.(h)(7),* requires, "Monitoring must occur face to face on a monthly basis for Enrollees whose services are provided by guardians or relatives living in the home of the Enrollee." Additionally, flexibilities under the *NC Medicaid Contract Amendment 11, Section 7,* allow monitoring to be conducted using two-way real time video and audio conferencing, subject to member/ LRP access to such technology during the Covid-19 Stay at Home Order. Moreover, during a conference call with PIHPs, NC Medicaid representatives reiterated "that while the preferred method [to complete monthly Care Coordination service review] is face-to-face, telephone calls and or video conferencing are the allowed methods". During the Onsite, Eastpointe stated that the only directive given to Care Coordinators was to not use the enrollee's name in the text messages. **I/DD service implementation** In one I/DD file, the *ISPs* and *Risk Assessments* list several behavioral issues and medical concerns. The *Risk Assessments* for 2019 and 2020 listed Specialized Consultation services as a need and a current service. Only the ISP for 2019 included Specialized Consultation Services; however, the service was not implemented. *NC Medicaid Contract Section 6.11.3(h) o,* lists *"Monitoring of services delivery to verify that: (2) Services are furnished in accordance with the ISP"* as a function of the PIHP. Moreover, the *NC Innovations Waiver Technical Guide Chapter 9,* states that "The Care Coordinator

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						ensures that the authorized NC Innovations services in the ISP are implemented by working with the participant and/or the legally responsible person, and the providers selected by the participant". During the Onsite, Eastpointe listed several barriers that hindered implementation of Specialized Consultation, and it was believed by his guardian and supported by the Neurologist that the enrollee's increased behaviors were linked to increased seizure activity. **Inadequate follow-up with the enrollee/LRP/Network Provider to ensure the health and safety** In one MH/SUD file, the enrollee, who is a child, reported allegations of abuse while receiving treatment at a PRTF. According to progress notes, the Care Coordinator made only one attempt to follow up with the Network Provider and LRP. This attempt was made two days after the allegation and both were unsuccessful. *NC Medicaid Contract Section 6.11.3 (f)* lists "Follow up and attempt to resolve any issues related to the Enrollee's health, safety or service delivery, bringing any unresolved issues to the attention of the appropriate PIHP staff member and designated behavioral health provider or medical provider for resolution" as a function of Care Coordination. Additional documentation including the IRIS reports, provided by Eastpointe, showed that the Network Operations Provider Monitoring Department followed Eastpointe's Policy E-4.2.5 Incident Reporting and ensured that external organizations (i.e., Department of Social Services and Department of Health Services Regulations) were made aware of the allegations of abuse. ***Corrective Action: Enhance the current monitoring plan to include a quality review checklist of MH/SUD/I/DD Care Coordination documentation. The quality review should:***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						• *Ensure that I/DD monthly Care Coordination service reviews are face-to-face or by allowed methods listed in NC Contract Amendment 11, Section 7.* • *Ensure that 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 that 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 that 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*
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements.	X					
2.1 Care Coordination activities occur, as required.	X					
2.2 Person Centered Plans are developed as required.	X					
2.3 Assertive Community Treatment, Peer Support, Supported Employment, Community Support Team, Psychosocial Rehabilitation, and other services as set forth in the DOJ Settlement are included in the individual's transition, if applicable.	X					
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					
2.5 QOL Surveys are administered timely.	X					All Quality of Life (QOL) surveys were submitted timely.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Transition, diversion and discharge processes are in place for TCLI members as outlined in the DOJ Settlement and *DHHS Contract*.	X					
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to NC Medicaid within the timeframes determined by NC Medicaid.	X					
5. The PIHP will develop a TCLI communication plan for external and internal stakeholders providing information on the TCLI initiative, resources, and system navigation tools, etc. This plan should include materials and training about the PIHP's crisis hotline and services for enrollees with limited English proficiency.	X					
6. A review of files demonstrates the PIHP is following appropriate TCLI policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.	X					The review of TCLI files showed that Eastpointe is following all policies and procedures and the NC Medicaid Contract and Contract Amendments.

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					A Corrective Action was issued in the 2019 EQR and the 2020 EQR to address language missing from Policy Q-6.4.4 Member/Enrollee Stakeholder Grievances/Complaints and Appeals regarding extensions to the Grievance resolution timeframe. The 2020 Corrective Action was to update Policy Q-6.4.4 to explain the requirement of Eastpointe to "inform the enrollee of their right to file a grievance" if they disagree with Eastpointe's extension to the Grievance resolution timeframe. This requirement is outlined in *NC Medicaid Contract, Attachment M.6* and *42 CFR § 438.408 (c)ii*. In this year's EQR, Eastpointe initially uploaded Policy Q-6.4.4 revised February 23, 2021. This policy didn't have the correct information regarding the requirements around Grievance resolution extensions. At the Onsite, Eastpointe provided Policy Q-6.4.4 revised June 16, 2021 that included the correct information outlined in the Corrective Action and accepted by CCME during the Corrective Action process in 2020.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
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 timeframe PIHPs are contractually required to maintain Grievance files was evident in the Grievance policy.
2. The PIHP applies the grievance policy and procedure as formulated.	X					In the 2021 EQR, 10 Grievance files were reviewed. Eight 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 Grievance file showed the acknowledgment notice was sent in 28 days versus the 5 business days required by Eastpointe's grievance policy. This was an improvement over last year's EQR where there were four late resolution notifications. CCME issued a Recommendation to continue to monitor Grievance notification timeframes to ensure they are issued timely per *NC Medicaid Contract, Attachment M, Section C and 42 CFR §* 438 and Policy Q-6.4.4, Member/Enrollee and Stake Holder Grievance/Complaint and Appeals. ***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.***

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					Errors were noted on the Eastpointe Grievance Log when compared to the Grievance files reviewed. Eastpointe staff indicated that different staff enter data on the log at different times in the Grievance resolution process. CCME issued a Recommendation to provide training to all staff entering data on the Grievance Log that guides them on documenting the correct dates and data points. This training is essential as the Grievance Log is the primary data source for Grievances and is used in compliance monitoring. ***Recommendation: Train staff on Grievance Log data entry to ensure data on the log is consistent, complete, and accurate.***
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-3.2.6 Appeal of 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					
1.2 The procedure for filing an appeal;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					In the 2020 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-3.2.6 Appeal of UM Adverse Benefit Determination.
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					
1.7 Other requirements as specified in the contract.	X					In response to a 2020 Appeal Recommendation, Eastpointe revised the *Provider Operations Manual FY21-22 effective July 1, 2021* to correctly state that Eastpointe will notify the enrollee of their right to file a Grievance if Eastpointe extends the Appeal resolution timeframe. This notification is required by *42 CFR § 438.408(2)(c)ii*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP applies the appeal policies and procedures as formulated.	X					In the 2021 EQR 10 Appeal files were reviewed. One file showed the Appeal resolution notification was mailed two days beyond the 30-day timeframe required by *NC Medicaid Contract, Attachment M, 42 CFR 438.408*, and Eastpointe's Appeal policy. Staff explained this was an isolated incident and a plan of correction was implemented to make sure all resolution letters are ready by a specific cut-off time each day to ensure they are mailed timely. There were no other deficiencies in the files reviewed in this year's EQR, which was an overall improvement when compared to last year's EQR.
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					Eastpointe provided a wide range of policies and procedures that guide officers, employees, providers, and relevant parties.
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					
4. PIHP shall investigate all grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI B. Fraud and Abuse						
1. PIHP shall establish and maintain a written Compliance Plan consistent with *42 CFR § 438.608* that is designed to guard against fraud and abuse. The Compliance Plan shall be submitted to the NC Medicaid Contract Administrator on an annual basis.	X					
2. PIHP shall designate, however named, a Compliance Officer who meets the requirements of *42 CFR 438.608* and who retains authority to report directly to the CEO and the Board of Directors as needed irrespective of administrative organization. PIHP shall also establish a regulatory compliance committee on the PIHP board of directors and at the PIHP senior management level that is charged with overseeing PIHP's compliance program and compliance with requirements under this Contract. PIHP shall establish and implement policies outlining a system for training and education for PIHP's Compliance Officer, senior management, and employees in regard to the Federal and State standards and requirements under NC Medicaid Contract in accordance with *42 CFR § 438.608(a)(1)(iv).*	X					The designation of a compliance officer and compliance committee is found in the Eastpointe's *FY 21 Corporate Compliance Plan*. Eastpointe also provided a detailed schedule of compliance and Fraud, Waste, and Abuse (FWA) trainings.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. PIHP shall establish and implement a special investigations or program integrity unit, however named, that is responsible for PIHP program integrity activities, including identification, detection, and prevention of fraud, waste, and abuse in the PIHP Closed Provider Network. PIHP shall identify an appropriately qualified contact for Program Integrity and Regulatory Compliance issues as mutually agreed upon by PIHP and NC Medicaid. This person may or may not be the PIHP Compliance Officer or the PIHP Contract Administrator. In addition, PIHP shall identify a primary point of contact within the Special Investigations Unit to receive and respond to data requests from MFCU/MID. The MFCU/ MID will copy the PIHP Contract Administrator on all such requests.	X					The establishment of SIU and contact requirements are addressed in the Eastpointe Policy CC-3.5, Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA). There has been no staff turnover in last two years. PI investigators have all received NCI basic or specialized training.
4. PIHP shall participate in quarterly Program Integrity meetings with NC Medicaid Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the N.C. Department of Justice ("MFCU/ MID').	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. PIHP shall send staff to participate in monthly meetings with NC Medicaid Program Integrity staff either telephonically or in person, at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.	X					
6. PIHP shall designate appropriately qualified staff to attend the monthly meetings, and the parties shall work collaboratively to minimize duplicative or unproductive meetings and information	X					
7. Within seven (7) business days of a request by the Division, PIHP shall also make portions of the PIHP's Regulatory Compliance and Program Integrity minutes relating to Program Integrity issues available for review, but the PIHP may, redact other portions of the minutes not relating to Regulatory Compliance or Program Integrity issues.	X					The requirement to provide Eastpointe's Regulatory Compliance minutes to NC Medicaid is found in Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA).
8. PIHP's written Compliance Plan shall, at a minimum include:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
8.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False Claims Act as identified in *Section 1902 (a)(66)* of the *Social Security Act;*	X					
8.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing, and development of corrective action initiatives;	X					
8.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					
8.4 Provision for full cooperation by PIHP and PIHP's employees, contractors, and Providers with any investigation conducted by Federal or State authorities, including NC Medicaid or MFCU/MID, and including supplying all data in a uniform format provided by NC Medicaid and information requested for their respective investigations within seven (7) business days or within an extended timeframe determined by the Division as	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
provided in *NC Medicaid Contract Section 13.2-Monetary Penalties.*						
9. 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. PIHP shall be penalized One Hundred Dollars ($100) for each overpayment that is not specified in an Attachment Y Report within the applicable month. In addition, PIHP shall have and implement written policies and procedures to guard against fraud and abuse.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse	X					
10.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse.	X					Detection procedures are found in Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA).
10.2 Detailed workflow of the PIHP process for taking a complaint from inception through closure. This process shall include procedures for logging the complaint, determining if the complaint is valid, assigning the complaint, investigating, appeal, recoupment, and closure. The detailed workflow needs to differentiate the steps taken for fraud versus abuse; PIHP shall establish and implement policies for treatment of recoveries of all overpayments from PIHP to Providers and contracted agencies, specifically including retention policies for treatment of recoveries of overpayments due to fraud, waste, or abuse. The retention policies shall include processes, timeframes, and required documentation for payment of recoveries of overpayments to the State in situations where PIHP is not permitted to retain some or all	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
of the recoveries of overpayments. This provision shall not apply to any amount of recovery to be retained under False Claims Act cases or through other investigations.						
10.3 In accordance with Attachment Y - Audits/Self-Audits/investigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.	X					
10.4 Process for tracking overpayments and collections based on fraud or abuse, including Program Integrity and Provider Monitoring activities initiated by PIHP and reporting on Attachment Y – Audits/Self-Audits/investigations.	X					The process for tracking overpayments is found in Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA).
10.5 Process for handling self-audits and challenge audits.	X					
10.6 Process for using data mining to determine leads.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.7 Process for informing PIHP employees, subcontractors, and providers regarding the *False Claims Act.*	X					
10.8 If PIHP makes or receives annual payments of at least $5,000,000, PIHP shall establish and maintain written policies for all employees, contractors, or agents that detail information about the *False Claims Act* and other federal and state laws as described in the *Social Security Act 1902 (a)(66)*, including information about rights of employees to be protected as whistleblowers.	X					
10.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains NC Medicaid-standardized elements or a NC Medicaid-approved template;	X					The verification of services billed process is found in the Eastpointe Policy E-4.2.1 Local Monitoring.
10.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding overpayments, assessments, penalties, or fees due to any State or Federal agency deemed applicable by PIHP, subject to the	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
accessibility of such financial information in a readily available database or other search mechanism.						
11. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements. Nothing in this Contract is intended to address any requirement for PIHP to offer Providers written notice of the process for appealing to the NC Office of Administrative Hearings or any other forum.	X					
12. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to NC Medicaid within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13. In each case where PIHP refers to NC Medicaid an allegation of fraud involving a Provider, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						The review of the 15 PI files provided for this EQR showed all required information was present on the NC Medicaid *DHB Program Integrity Referral*
13.1 Subject (name, Medicaid provider ID, address, provider type);	X					
13.2 Source/origin of complaint;	X					
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					
13.4 Description of suspected intentional misconduct, with specific details including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations, or policies violated; and dates of suspected intentional misconduct;	X					
13.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;	X					
13.6 All communications between PIHP and the Provider concerning the conduct at issue, when available.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					
13.8 Total Sample Amount of Funds Investigated per Service Type	X					
14. In each case where PIHP refers suspected Enrollee fraud to NC Medicaid, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						No cases of potential enrollee fraud were submitted for this year's EQR. However, the requirements for referrals to NC Medicaid are included in Eastpointe's SIU Investigation Business Process.
14.1 The Enrollee's name, birth date, and Medicaid number;	X					
14.2 The source of the allegation;	X					
14.3 The nature of the allegation, including the timeframe of the allegation in question;	X					
14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;	X					
14.5 Contact information for PIHP staff persons with practical knowledge of the allegation;	X					
14.6 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation; and	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.7 The legal and administrative status of the case.	X					
14.8 Any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers;	X					
14.9 Details that relate to the original allegation that PIHP received which triggered the investigation;	X					
14.10 Period of Service Investigated – PIHP shall include the timeframe of the investigation and/or timeframe of the audit, as applicable.;	X					
14.11 Information on Biller/Owner;	X					
14.12 Additional Provider Locations that are related to the allegations;	X					
14.13 Legal and Administrative Status of Case.	X					
15. PIHP and NC Medicaid shall mutually agree on program integrity and monitoring forms, tools, and letters that meet the requirements of State and Federal law, rules, and regulations, and are consistent with the forms, tools and letters utilized by other PIHPs.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
16. PIHP shall use the NC Medicaid Fraud and Abuse Management System (FAMS) or a NC Medicaid approved alternative data mining technology solution to detect and prevent fraud, waste, and abuse in managed care.	X					
17. If PIHP uses FAMS, PIHP shall work with the NC Medicaid designated Administrator to submit appropriate claims data to load into the NC Medicaid Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. If PIHP uses FAMS, PIHP shall notify the NC Medicaid designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.	X					PI reporting requirements are addressed in Policy CC-3.6 Program Integrity Reporting Requirements.
18. PIHP shall submit to the NC Medicaid Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month or the next business day if the 10th day is a non-business day (i.e., weekend or State or PIHP holiday). In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to NC Medicaid Program Integrity of all suspected and confirmed cases of Provider and	X					All of the requirements on monthly reporting including timeliness are found in the Eastpointe Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA). Evidence of implementation of this requirement was demonstrated in the monthly Program Integrity Activities FAMS reports, which cover the review period. The monthly Attachment Y and Attachment Z reports provided by the plan, which cover the review period, are evidence of the required monthly reports.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
Enrollee fraud and abuse, including but not limited to overpayments and self-audits. The monthly report shall be due by 11:59 p.m. on the tenth (10th) of each month in the format as identified in Attachment Y. PIHP shall also report to NC Medicaid Program Integrity all Network Provider contract terminations and non-renewals initiated by PIHP, including the reason for the termination or non-renewal and the effective date. The only report shall be due by 11:59p.m. on the tenth (10th) day of each month in the format as identified in attachment Z – Terminations, Provider Enrollment Denials, Other Actions. Compliance with the reporting requirements of Attachments X, Y and Z and any mutually approved template shall be considered compliance with the reporting requirements of this Section.						
VIII C. Provider Payment Suspensions and Overpayments						
1. Within thirty (30) business days of receipt from PIHP of referral of a potential credible allegation of fraud, NC Medicaid Program Integrity shall complete a preliminary investigation to determine whether there is sufficient evidence to warrant a full investigation. If NC Medicaid determines that a full investigation is warranted, NC Medicaid shall make a referral within five (5)						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 process all clean claims suspended in accordance with the prompt pay	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to NC Medicaid Program Integrity due to allegations of suspected fraud without prior written approval from NC Medicaid Program Integrity or the MFCU/MID. If PIHP takes administrative action, including issuing a Notice of Overpayment based on such fraud that precedes the submission date of a Division referral, the State will adjust the PIHP capitated payment in the amount of the original overpayment identified or One Thousand Dollars ($1,000) per case, whichever amount is greater.	X					Detailed procedures regarding sanctions are found in Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. Notwithstanding the foregoing, nothing herein shall be construed as prohibiting PIHP from taking any action against a Network Provider in accordance with the terms and conditions of any written agreement with a Network Provider, including but not limited to prepayment review, identification and collection of overpayments, suspension of referrals, de-credentialing, contract nonrenewal, suspension or termination or other sanction, remedial or preventive efforts necessary to ensure continuous, quality care to Enrollees, regardless of any ongoing investigation being conducted by NC Medicaid, MFCU/MID or other oversight agency, to the extent that such action shall not interfere with Enrollee access to care or with any such ongoing investigation being conducted by NC Medicaid, MFCU/MID or other oversight agency.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with *NCGS 108C-5*, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery.	X					The specific requirements for remittance of assessment to the Department is found in Policy B-2.7.24 Provider Paybacks (Fund Recovery).

D. Attachment 4: Encounter Data Validation Report

Eastpointe

Encounter Data Validation Report

performed on behalf of

North Carolina Medicaid

November 3, 2021

Prepared By:

hms

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

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Background

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

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

Overview

The scope of the review, guided by the CMS Encounter Data Validation Protocol, focused on measuring the data quality and completeness of claims paid and submitted to NC Medicaid by Eastpointe for the period of January 2020 through December 2020. 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 behavioral health 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.

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 2020, Eastpointe submitted 1,354,664 unique encounters to the State. To date, 0.32% of all 2020 encounters submitted have not been corrected and accepted by NC Medicaid. This figure represents significant improvement in comparison to 15% and 3% denial rates seen in 2018 and 2019, respectively.

2020	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	122,108	88,335	31,766	2,007	1.64%
Professional	1,232,556	1,163,580	66,592	2,384	0.19%
Total	1,354,664	1,251,915	98,358	4,391	0.32%

Eastpointe should make 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 2016 and 2020 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
2016	987,620	653,787	63,805	270,028	27.34%
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%

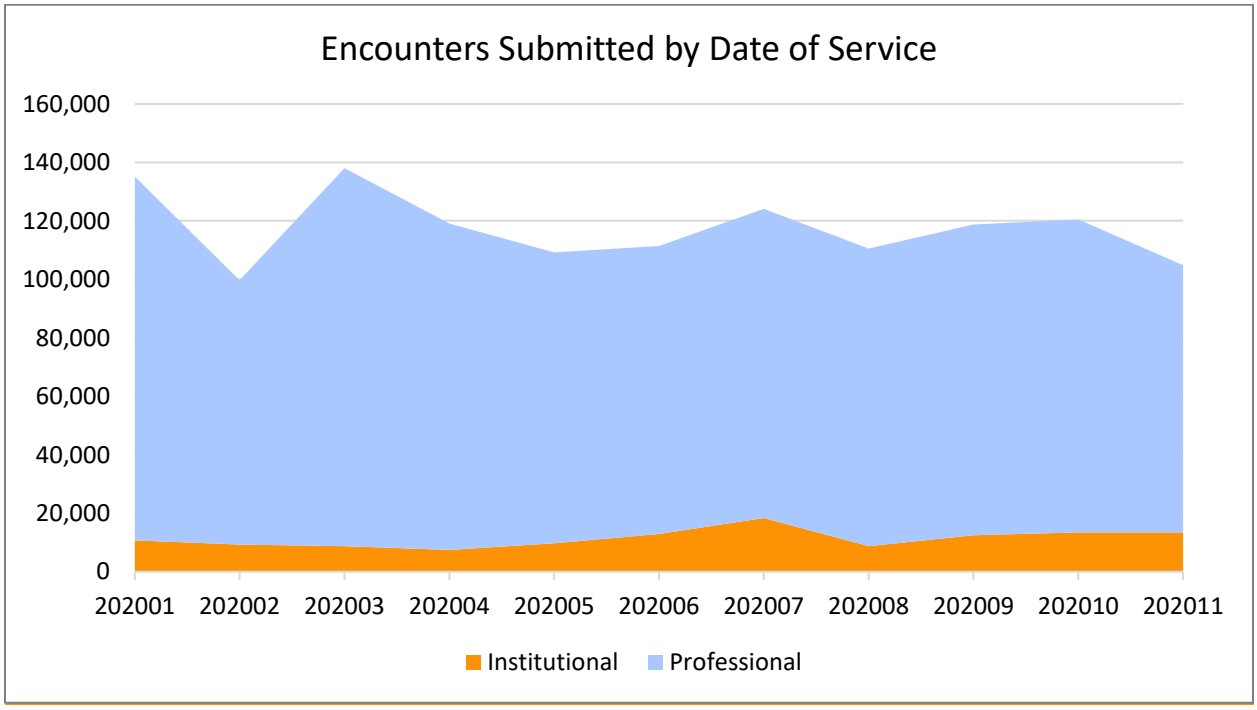
Eastpointe experienced a sizeable decrease in encounter denials in 2020 compared to 2019. While the denial rates have fluctuated over the past four years, Eastpointe has made significant improvements in the most recent two years. The single biggest improvement was in the reduction of errors related to provider Taxonomy codes. 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 highly 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 Department team reviews 835 responses and identifies denials that need to be resolved. All denied encounter claims receive at least one denial code; however, the remark codes have to be used to narrow down to 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 issues based on the denial error. Enrollment issues or eligibility issues are assigned over to the Medical Records Department. Provider related issues are assigned to an employee in the Contracts Department who was hired for this responsibility. 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, 2020, and December 31, 2020. Eastpointe extracted all claims adjudicated and submitted to NC Medicaid during 2020 and sent the files to HMS via SFTP. This included 1,305,980 Professional and 143,679 Institutional claim lines. These figures also included dates of service prior to 2020, resubmissions of previously denied encounters, and voids and adjustments.



Eastpointe provided HMS with copies of original 837 transactions submitted to NC Medicaid during calendar year 2020. 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, HMS consolidated the 837 batch files and then converted the data into a delimited file using an EDI translator. Once the data onboarding was completed, HMS applied proprietary, internally designed data analysis logic within SAS to review each data element, focusing on the data elements defined as required. HMS's logic evaluates the presence of data in each field within a record as well as whether the value for the field is within accepted standards. Results 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
Recipient Name	Should be captured in such a way that makes separating pieces of name easy. Expect data to be present and of good quality	85% present. Lengths should vary, but there should be at least some last names of >8 digits and some first names of < 8 digits, validating that fields have not been truncated. Also, a high percentage of names should have at least a middle initial.
Recipient Date of Birth	Should not be missing and should be a valid date.	< 2% missing or invalid
PIHP ID	Critical Data Element	100% valid
Provider ID	Should be an enrolled provider listed in the provider enrollment file.	95% valid
Attending Provider ID	Should be an enrolled provider listed in the provider enrollment file (will accept the MD license number if it is listed in the provider enrollment file).	> 85% match with provider file using either provider ID or MD license number
Provider Location	Minimal requirement is county code, but zip code is strongly advised.	> 95% with valid county code > 95% with valid zip code (if available)
Place of Service	Should be routinely coded, especially for physicians.	> 95% valid for physicians > 80% valid across all providers
Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% non-missing and valid on physician or other applicable provider type claims (e.g., other practitioners)

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

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

Encounter Accuracy and Completeness

The table 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 was valid. Although HMS reviewed the complete data set and validated all data values, the fields below are key to properly "shadow pricing" for the services paid by Eastpointe.

Table: Evaluation of Key Fields

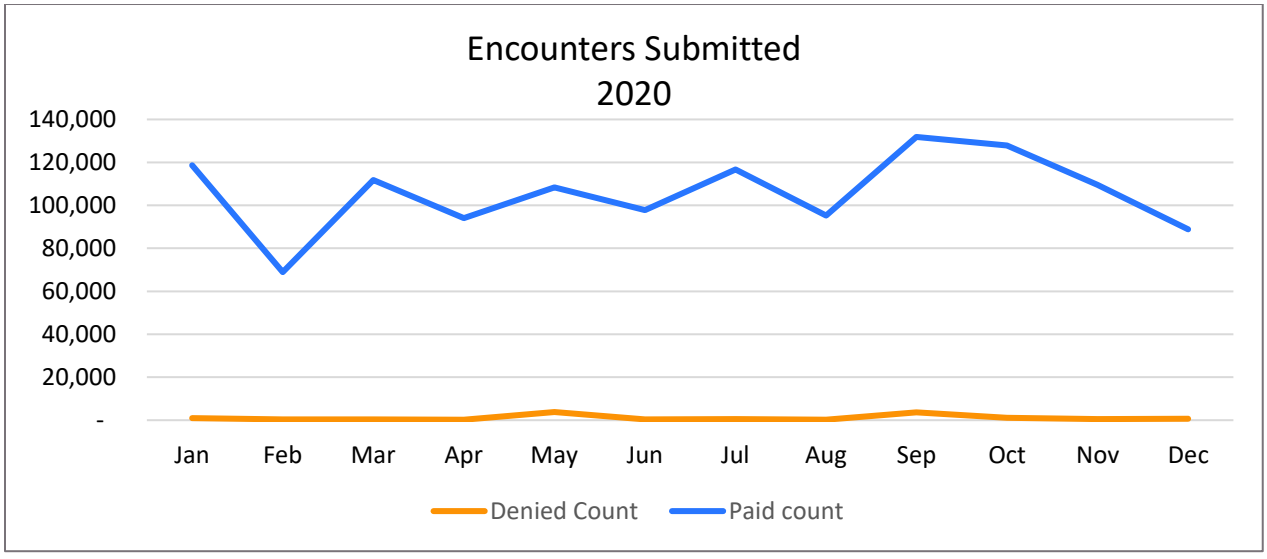
Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	1,449,659	100.00%	1,449,659	100.00%	1,449,659	100.00%	1,449,659	100.00%
Recipient Name	1,449,659	100.00%	1,449,659	100.00%	1,449,659	100.00%	1,449,659	100.00%
Recipient Date of Birth	1,449,659	100.00%	1,449,659	100.00%	1,449,659	100.00%	1,449,659	100.00%
PIHP ID	1,449,659	100.00%	1,449,659	100.00%	1,449,659	100.00%	1,449,659	100.00%
Provider ID	1,449,659	100.00%	1,449,650	100.00%	1,449,650	100.00%	1,449,650	100.00%
Attending/Rendering Provider ID	1,449,659	100.00%	1,449,636	100.00%	1,449,636	100.00%	1,449,636	100.00%
Provider Location	1,449,659	100.00%	1,449,659	100.00%	1,449,659	100.00%	1,449,659	100.00%
Place of Service	1,449,659	100.00%	1,449,659	100.00%	1,449,659	100.00%	1,449,659	100.00%
Specialty Code / Taxonomy - Billing	1,449,656	100.00%	1,449,656	100.00%	1,449,656	100.00%	1,449,656	100.00%
Specialty Code / Taxonomy - Rendering / Attending	1,449,659	100.00%	1,449,642	100.00%	1,449,642	100.00%	1,449,642	100.00%
Principal Diagnosis	1,449,659	100.00%	1,449,659	100.00%	1,449,659	100.00%	1,449,659	100.00%
Other Diagnosis	408,213	28.16%	408,213	28.16%	408,213	28.16%	408,213	28.16%
Dates of Service	1,449,659	100.00%	1,449,659	100.00%	1,449,659	100.00%	1,449,659	100.00%
Unit of Service (Quantity)	1,449,659	100.00%	1,449,659	100.00%	1,449,659	100.00%	1,449,659	100.00%
Procedure Code	1,423,917	98.22%	1,423,917	98.22%	1,423,917	98.22%	1,423,917	98.22%
Procedure Code Modifier	515,894	35.59%	515,894	35.59%	515,894	35.59%	515,894	35.59%
Patient Discharge Status Code Inpatient	143,679	100.00%	143,679	100.00%	143,679	100.00%	143,679	100.00%
Revenue Code	143,679	100.00%	143,679	100.00%	143,679	100.00%	143,679	100.00%

Overall, HMS 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 17 of the 18 key fields (94%) that meet or exceed CMS's Data Quality Standards. HMS identified a notable issue among the Other Diagnosis codes. Overall, 28.16% of all claim lines contained Other Diagnosis codes. While this is an improvement from 21.44% in 2019, the rate remains below CMS guidelines.

Professional encounter claims submitted contained complete and valid data in 14 of the 15 key Professional fields (93%). The primary issue identified also involved Other Diagnosis codes being populated infrequently. The Principal Diagnosis code was populated 100% of the time; however, there was very little consistency in Other Diagnosis codes being present. One Corrective Action that has been completed since the 2018 review is that Eastpointe now submits up to 12 Diagnosis codes for Professional claims and that continued to be case in 2020. However, many practitioners often do not report Other Diagnosis codes, with some never reporting beyond the Primary Diagnosis code.

Encounter Acceptance Report

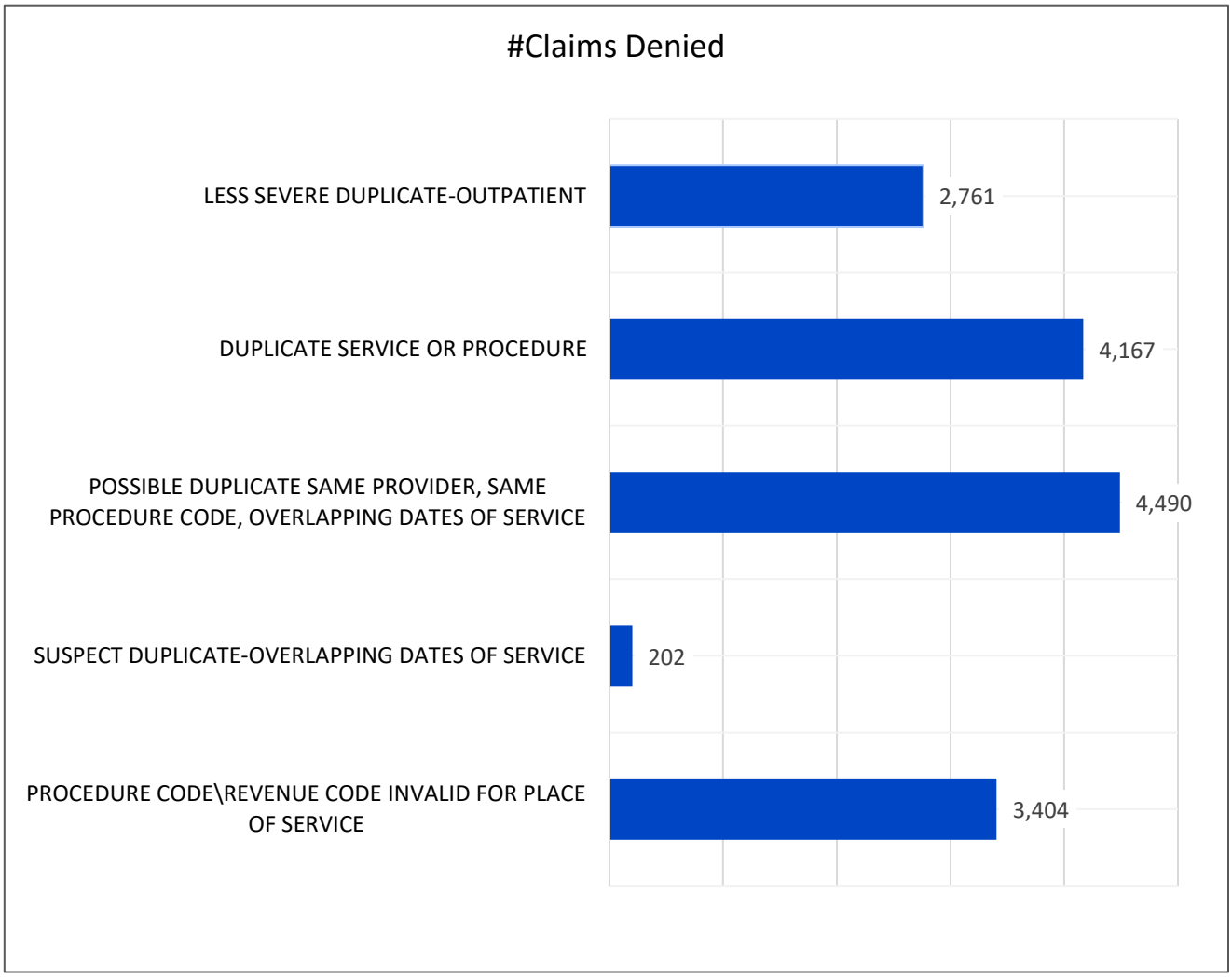
In addition to performing evaluation of the encounter data submitted, the HMS analyst reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by check write and excludes duplicates or resubmission which made it difficult to tie back to the ISCA response and converted encounter files. Data provided by Eastpointe for this review included all submission and resubmissions during 2020, which may include older dates of service. During the 2020 weekly check write schedule, Eastpointe submitted a total of 1,354,664 encounters to NC Medicaid. On average, 8% of all encounters submitted were initially denied, which was roughly the same as what was seen in 2019. 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.



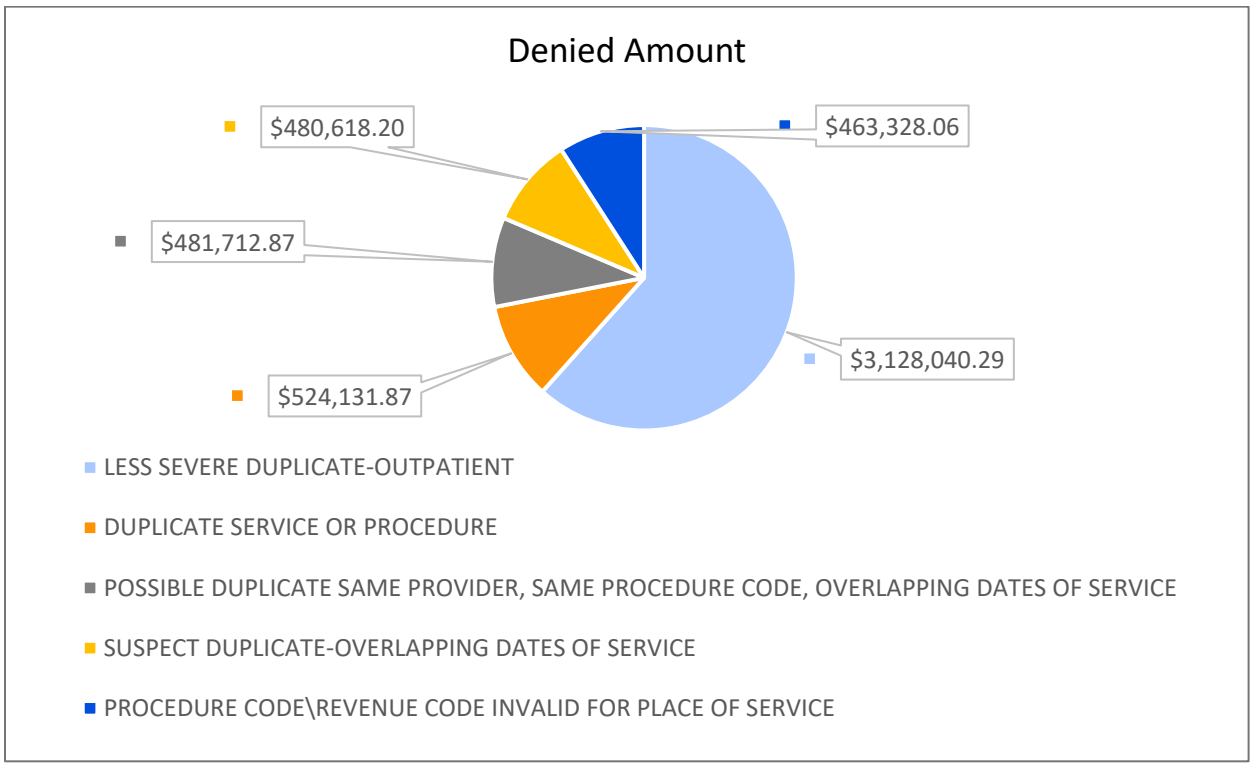
Evaluation of the top denials for Eastpointe encounters correlates with the data deficiencies identified by the HMS analyst in the Key Field analysis in the ISCA review. Encounters were denied primarily for:

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

The graph 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. This issue has been present since at least the 2018 review, when it was noted that only the Principal and Secondary Diagnosis codes were being submitted. In general, claims from certain providers are missing the Other Diagnosis code at an extremely high rate, including instances where they are missing on 100% of the claims. In the meantime, 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 on all claims are 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, HMS has concluded that the data submitted to NC Medicaid is complete and accurate as defined by NC Medicaid standards.

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

Appendix 1

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

00143	REVIEW FOR MEDICAL NECESSITY	IGNORE
00144	FDOS AND TDOS MUST BE THE SAME	IGNORE
00146	PROC INVLD - BILL PROV TAXON	PAY AND REPORT
00148	PROC\REV CODE INVLD FOR POS	PAY AND REPORT
00149	PROC\REV CD INVLD FOR AGE	IGNORE
00150	PROC CODE INVLD FOR RECIP SEX	IGNORE
00151	PROC CD/RATE INVALID FOR DOS	PAY AND REPORT
00152	M/I ACC/ANC PROC CD	PAY AND REPORT
00153	PROC INVLD FOR DIAG	PAY AND REPORT
00154	REIMB RATE NOT ON FILE	PAY AND REPORT
00157	VIS FLD EXAM REQ MED JUST	IGNORE
00158	CPT LAB CODE REQ FOR REV CD	IGNORE
00164	IMMUNIZATION REVIEW	IGNORE
00166	INVALID VISUAL PROC CODE	IGNORE
00174	VACCINE FOR AGE 00-18	IGNORE
00175	CPT CODE REQUIRED FOR RC 0391	IGNORE
00176	MULT LINES SAME PROC, SAME TCN	IGNORE
00177	HCPCS CODE REQ W/ RC 0250	IGNORE
00179	MULT LINES SAME PROC, SAME TCN	IGNORE
00180	INVALID DIAGNOSIS FOR LAB CODE	IGNORE
00184	REV CODE NOT ALLOW OUTPAT CLM	IGNORE
00190	DIAGNOSIS NOT VALID	DENY
00192	DIAG INVALID RECIP AGE	IGNORE
00194	DIAG INVLD FOR RECIP SEX	IGNORE
00202	HEALTH CHECK SHADOW BILLING	IGNORE
00205	SPECIAL ANESTHESIA SERVICE	IGNORE
00217	ADMISSION TYPE CODE INVALID	PAY AND REPORT
00250	RECIP NOT ON ELIG DATABASE	DENY
00252	RECIPIENT NAME/NUMBER MISMATCH	PAY AND REPORT
00253	RECIP DECEASED BEFORE HDR TDOS	DENY
00254	PART ELIG FOR HEADER DOS	PAY AND REPORT
00259	TPL SUSPECT	PAY AND REPORT
00260	M/I RECIPIENT ID NUMBER	DENY
00261	RECIP DECEASED BEFORE TDOS	DENY
00262	RECIP NOT ELIG ON DOS	DENY
00263	PART ELIG FOR LINE DOS	PAY AND REPORT

00267	DOS PRIOR TO RECIP BIRTH	DENY
00295	ENC PRV NOT ENRL TAX	IGNORE
00296	ENC PRV INV FOR DOS	IGNORE
00297	ENC PRV NOT ON FILE	IGNORE
00298	RECIP NOT ENRL W/ THIS ENC PRV	IGNORE
00299	ENCOUNTER HMO ENROLLMENT CHECK	PAY AND REPORT
00300	BILL PROV INVALID/ NOT ON FILE	DENY
00301	ATTEND PROV M/I	PAY AND REPORT
00308	BILLING PROV INVALID FOR DOS	DENY
00313	M/I TYPE BILL	PAY AND REPORT
00320	VENT CARE NO PAY TO PRV TAXON	IGNORE
00322	REND PROV NUM CHECK	IGNORE
00326	REND PROV NUM CHECK	PAY AND REPORT
00328	PEND PER DHB REQ FOR FIN REV	IGNORE
00334	ENCOUNTER TAXON M/I	PAY AND REPORT
00335	ENCOUNTER PROV NUM MISSING	DENY
00337	ENC PROC CODE NOT ON FILE	PAY AND REPORT
00339	PRCNG REC NOT FND FOR ENC CLM	PAY AND REPORT
00349	SERV DENIED FOR BEHAV HLTH LM	IGNORE
00353	NO FEE ON FILE	PAY AND REPORT
00355	MANUAL PRICING REQUIRED	PAY AND REPORT
00358	FACTOR CD IND PROC NON-CVRD	PAY AND REPORT
00359	PROV CHRGS ON PER DIEM	PAY AND REPORT
00361	NO CHARGES BILLED	DENY
00365	DRG - DIAG CANT BE PRIN DIAG	DENY
00366	DRG - DOES NOT MEET MCE CRIT.	PAY AND REPORT
00370	DRG - ILLOGICAL PRIN DIAG	PAY AND REPORT
00371	DRG - INVLD ICD-9-CM PRIN DIAG	DENY
00374	DRG PAY ON FIRST ACCOM LINE	DENY
00375	DRG CODE NOT ON PRICING FILE	PAY AND REPORT
00378	DRG RCC CODE NOT ON FILE DOS	PAY AND REPORT
00439	PROC\REV CD INVLD FOR AGE	IGNORE
00441	PROC INVLD FOR DIAG	IGNORE
00442	PROC INVLD FOR DIAG	IGNORE
00613	PRIM DIAG MISSING	DENY
00628	BILLING PROV ID REQUIRED	IGNORE

00686	ADJ/VOID REPLC TCN INVALID	DENY
00689	UNDEFINED CLAIM TYPE	IGNORE
00701	MISSING BILL PROV TAXON CODE	DENY
00800	PROC CODE/TAXON REQ PSYCH DX	PAY AND REPORT
00810	PRICING DTE INVALID	IGNORE
00811	PRICING CODE MOD REC M/I	IGNORE
00812	PRICING FACTOR CODE SEG M/I	IGNORE
00813	PRICING MOD PROC CODE DTE M/I	IGNORE
00814	SEC FACT CDE X & % SEG DTE M/I	IGNORE
00815	SEC FCT CDE Y PSTOP SEG DT M/I	IGNORE
01005	ANTHES PROC REQ ANTHES MODS	IGNORE
01060	ADMISSION HOUR INVALID	IGNORE
01061	ONLY ONE DOS PER CLAIM	IGNORE
01102	PRV TAXON CHCK - RAD PROF SRV	IGNORE
01200	INPAT CLM BILL ACCOM REV CDE	DENY
01201	MCE - ADMIT DTE = DISCH DTE	DENY
01202	M/I ADMIT AND DISCH HRS	DENY
01205	MCE: PAT STAT INVLD FOR TOB	DENY
01207	MCE - INVALID AGE	PAY AND REPORT
01208	MCE - INVALID SEX	PAY AND REPORT
01209	MCE - INVALID PATIENT STATUS	DENY
01705	PA REQD FOR CAPCH/DA/CO RECIP	PAY AND REPORT
01792	DME SUPPLIES INCLD IN PR DIEM	DENY
02101	INVALID MODIFIER COMB	IGNORE
02102	INVALID MODIFIERS	PAY AND REPORT
02104	TAXON NOT ALLOWED WITH MOD	PAY AND REPORT
02105	POST-OP DATES M/I WITH MOD 55	IGNORE
02106	LN W/ MOD 55 MST BE SAME DOS	IGNORE
02107	XOVER CLAIM FOR CAP PROVIDER	IGNORE
02111	MODIFIER CC INTERNAL USE ONLY	IGNORE
02143	CIRCUMCISION REQ MED RECS	IGNORE
03001	REV/HCPCS CD M/I COMBO	IGNORE
03010	M/I MOD FOR PROF XOVER	IGNORE
03012	HOME HLTH RECIP NOT ELG MCARE	IGNORE
03100	CARDIO CODE REQ LC LD LM RC RI	IGNORE
03101	MODIFIER Q7, Q8 OR Q9 REQ	IGNORE

03200	MCE - INVALID ICD-9 CM PROC	DENY
03201	MCE INVLD FOR SEX PRIN PROC	PAY AND REPORT
03224	MCE-PROC INCONSISTENT WITH LOS	PAY AND REPORT
03405	HIST CLM CANNOT BE ADJ/VOIDED	DENY
03406	HIST REC NOT FND FOR ADJ/VOID	DENY
03407	ADJ/VOID - PRV NOT ON HIST REC	DENY
04200	MCE - ADMITTING DIAG MISSING	DENY
04201	MCE - PRIN DIAG CODE MISSING	DENY
04202	MCE DIAG CD - ADMIT DIAG	DENY
04203	MCE DIAG CODE INVLD RECIP SEX	PAY AND REPORT
04206	MCE MANIFEST CODE AS PRIN DIAG	DENY
04207	MCE E-CODE AS PRIN DIAG	DENY
04208	MCE - UNACCEPTABLE PRIN DIAG	DENY
04209	MCE - PRIN DIAG REQ SEC DIAG	PAY AND REPORT
04210	MCE - DUPE OF PRIN DIAG	DENY
04506	PROC INVLD FOR DIAG	IGNORE
04507	PROC INVLD FOR DIAG	IGNORE
04508	PROC INVLD FOR DIAG	IGNORE
04509	PROC INVLD FOR DIAG	IGNORE
04510	PROC INVLD FOR DIAG	IGNORE
04511	PROC INVLD FOR DIAG	IGNORE
07001	TAXON FOR ATTND/REND PROV M/I	DENY
07011	INVLD BILLING PROV TAXON CODE	DENY
07012	INVLD REND PROV TAXONOMY CODE	DENY
07013	INVLD ATTEND PROV TAXON CODE	PAY AND REPORT
07100	ANESTH MUST BILL BY APPR PROV	IGNORE
07101	ASC MODIFIER REQUIREMENTS	IGNORE
13320	DUP-SAME PROV/AMT/DOS/PX	DENY
13420	SUSPECT DUPLICATE-OVERLAP DOS	PAY AND REPORT
13460	POSSIBLE DUP-SAME PROV/PX/DOS	PAY AND REPORT
13470	LESS SEV DUPLICATE OUTPATIENT	PAY AND REPORT
13480	POSSIBLE DUP SAME PROV/OVRLAP	PAY AND REPORT
13490	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13500	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13510	POSSIBLE DUP/SME PRV/OVRLP DOS	PAY AND REPORT
13580	DUPLICATE SAME PROV/AMT/DOS	PAY AND REPORT

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